2007 Summary Report

Cross Border Public Health Collaboration: Opportunities and Challenges

May 14-16, 2007
Victoria, British Columbia

Alaska
Alberta
British Columbia
Idaho
Montana
North Dakota
Oregon
Washington
Yukon
2007 Summary Report

Cross Border Public Health Collaboration: Opportunities and Challenges

May 14-16, 2007
Victoria, British Columbia

For more information or additional electronic copies of this report contact:

**British Columbia Ministry of Health**
Emergency Management Branch
1515 Blanshard Street
Victoria, British Columbia V9E 2C3
Tel: (250) 952-3334
Fax: (250) 952-1713
Email: Amy.Sheridan@gov.bc.ca

**Washington State Department of Health**
Public Health Preparedness and Response Program
101 Israel Rd SE, P.O. Box 47890
Olympia, Washington, 98504-7890
Tel: (206) 418-5559
Fax: (206) 418-5515
Email: Wayne.Turnberg@doh.wa.gov

Honourable George Abbott
Minister of Health
British Columbia Ministry of Health

Mary Slectky
Secretary of Health
Washington State Department of Health
Table of Contents

Page

iii Executive Summary
vi Acknowledgements
1 Introduction
1 Plenary Session Summary – May 15, 2007
5 Plenary Session Summary – May 16, 2007
8 Breakout Workgroup Sessions
8 Epidemiology Workgroup
11 Public Health Laboratory Workgroup
13 Surge Capacity Workgroup
15 Emergency Medical Services Workgroup
17 Communications Workgroup
19 Public Health Law Workgroup

APPENDICES

22 Appendix A - Workshop Agenda
26 Appendix B - Draft Surge Capacity Operational Plan
30 Appendix C - Draft Epidemiology Data Sharing Agreement
33 Appendix D - Draft Pacific Northwest Border Health Alliance – Conceptual Framework
36 Appendix E - Speaker Biographies
46 Appendix F - Workshop Evaluation
60 Appendix G - Cross Border Workgroup Membership
65 Appendix H - List of Registered Participants

Electronic Copies of Workshop Materials

Electronic copies of workshop materials, including this report, the available speaker presentations, agreement examples and an updated participant list in Microsoft Excel may be obtained by contacting Wayne Turnberg, Washington State Department of Health at (206) 418-5559 or by email at Wayne.Turnberg@doh.wa.gov.
Pacific Northwest Cross Border Workshop
May 14-16, 2007

Executive Summary

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

Status of Cross Border Agreements


- **WA/BC Public Health MOU** – Secretary Mary Selecky and Prime Minister George Abbott signed a “first of its kind” binational public health preparedness and response memorandum of understanding on June 20, 2006.

- **Pacific NW Cross Border Alliance** – A draft conceptual framework establishing *The Pacific NW Regional Alliance* was proposed during the Victoria workshop to formalize relationships between Pacific Northwest public health partners to continue efforts leading towards seamless public health preparedness and response capabilities across our binational borders.

- **Cross Border Operational Plans and MOUs** – Operational plans and MOUs are being developed between U.S. and Canadian jurisdictions using authorities of the Pacific Northwest Emergency Management Arrangement, addressing:
  - Confidential data sharing for epidemiology investigations.
  - Movement of medical personnel across the WA/BC border.
  - Public health laboratory surge capacity MOU between labs in WA and BC (a public health laboratory surge capacity MOU currently exists between WA, ID, OR, and AK).

Next Steps

**Epidemiology Workgroup**

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

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

Public Health Laboratory Workgroup

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

Surge Capacity/EMS Workgroup

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

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

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

Communications Workgroup

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

Public Health Law Workgroup

- Complete legal review of the draft Conceptual framework for the Pacific Northwest Border Health Alliance proposal.

- With regard to the draft agreement for moving personnel across BC/WA border during an emergency, develop and review a list of the differences in liability, licensing and worker’s compensation/death benefits among the PNEMA states/provinces will be compiled.
Acknowledgements

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

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

Cross Border Workshop Planning Committee

**Epidemiology**

David Patrick, MD, MHSc, FRCPC  
Director, Epidemiology Services  
BC Centre for Disease Control

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

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

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

Barbara Smith  
Nurse Epidemiologist  
Alaska Dept of Health & Social Services

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

**Communications**

Peter Dalton  
Communications Officer  
BC Ministry of Health Services

Laura Blaske  
Communications Systems Manager  
WA State Department of Health

**Exercise Planning**

Chris Smith  
Director Emergency Management Branch  
BC Ministry of Health

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

**Public Health Law**

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

**Additional Members**

Regina Delahunt  
Director  
Whatcom County Health Department

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

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

Jim Matsuyama  
Environmental Health Director  
Northeast Tri-County Health District

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

Gail Zimmerman  
Cross Border Workshop Organizer  
Washington State Department of Health
Acknowledgements (Continued)

Workshop Facilitators and Recorders

Laura Blaske
Communications Systems Manager
WA State Department of Health

Larry Champine
WA State Department of Health

Cathy Cochrane
Regional Risk Communications Specialist
Spokane Regional Health District

Shari Mattson-Cooper
Regional Risk Communications Specialist
Snohomish Health District

Greg Nordlund
WA State Department of Health

____________________________________________________________________________________

Workshop Organizers

Gail Zimmerman
WA State Department of Health

Carrie McGee
WA State Department of Health

Susan Chamberland
WA State Department of Health

Amy Sheridan
BC Ministry of Health

____________________________________________________________________________________

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

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

Plenary Session Summary – May 15, 2007

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

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

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

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

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

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

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

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

QUESTION: At a local working level we are doing effective things, but what are the implications of formalizing working together, what are legal implications and how might they constrain us?
Dr. Young: Problems are managed at a local level. There are lots of local groups, relationships and collaborations we don’t know about. We need to continue to identify them and bring them into the process. The attorneys' job is to watch our actions and protect us, not constrain us. They are there to help us, not prevent us from doing what needs to be done.

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Young: In trying to plan we do ignore unintended consequences. We need to reexamine our approach because there are so many significant consequences that we don’t look at.
**RADM Vanderwagen:** At the federal level we are trying to model and quantify results of possible policy actions. We push our modelers very hard. We tend to want to see the positive effects but we need to look at our actions up and down.

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

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

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

**U.S. National Biosurveillance Integration System** – Dr. William Lyerly, Director of International Affairs, Special Assistant for Global Health Security, U.S. Department of Homeland Security provided an overview of the Department of Homeland Security’s National Biosurveillance Integration System (NBIS). Key points from Dr. Lyerly’s presentation are as follows:
• NBIS is an integrator of data from other agency surveillance systems—a system that leads to supporting decision making
• NBIS does not confirm a terrorist event
• NBIS does not include information on individuals
• NBIS will come fully operational in Sept 2008
• The chief product of the NBIS is tailored surveillance products
• Products include annual assessments that can be used to establish baselines and also “hotlists”
• The report can be used to determine what is normal as well as what is abnormal
• International, state, intergovernmental and interagency partners participate in development of NBIS
• Focus on 4 areas: Avian influenza and zoonotic diseases, food safety, contagious foreign animal diseases, environmental monitoring (Biowatch)
• Early response is important to reduce intensity and duration of events. NBIS provides the big picture to accomplish this.

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

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

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

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

Details about the project are available at http://www.nwcphp.org/centers-projects/assessing-regional-public-health-preparedness.
Plenary Session Summary – May 16, 2007

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

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

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

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

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

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

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

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

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

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

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

Use of Antiviral Medicines

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

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

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

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

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

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

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

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

QUESTION: How effective is pre-flight screening?

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

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

PANELIST RESPONSE: They would probably be closed depending on severity of the event.
Breakout Workgroup Sessions

Epidemiology Workgroup

Epidemiology Cross Border Accomplishments 2007

- Epidemiology activities fostered joint collaborations to address a Public Health Data Sharing Agreement. A draft agreement was submitted to the Public Health attorneys from WA State DOH and British Columbia CDC. The attorneys will review and discuss the agreement during their breakout session at the Cross Border Workshop. Feedback and recommendations for signatories will be provided to Drs Hofmann and Patrick. It is anticipated that the agreement will be revised and implemented by December 2007.

- The WA State epidemiologists attempted to share secure confidential information, that contained person health identifies (PHI), with British Columbia epidemiologists. The test data was exchanged via the CDC's Epi-X confidential list serve and included an attachment with factious names of individuals that were exposed to a highly infectious disease. The attachment to the message was able to be viewed by additional editorial and development staff at the CDC. This method of confidential information exchange that included PHI was determined to be unsatisfactory due to the access to it by persons who did not have a “need to know” the information. Further discuss with Dr Rossanne Philen, Medical Director for Epi-X, assured WA State that Epi-X is a level 3 security system and PHIN Certified to process data that includes personal health identifiers (PHI). Staff at Epi-X has signed confidentiality agreements and the system can track all persons who have accessed the system. DOH and other cross border partners will need to discuss and agree if this system meets their needs for secure electronic file transfer of information that includes PHI.

- The Pacific Northwest border regions shared and tested updated 24/7 emergency contact lists.

- As part of PNEMA activities, WA DOH compiled a table comparing disease reporting requirements across PNEMA jurisdictions. The commonalities and differences for immediately notifiable conditions were compared. The jurisdictions each have a list of immediately reportable conditions in all jurisdictions. This multi-jurisdiction list of notifiable conditions will assist in alerting neighboring jurisdictions and facilitate timely reporting and response activities.

- Pacific NW epidemiologists conducted an exercise to test epidemiology preparedness and response capabilities across national and international Pacific NW borders. This exercise was conducted during the annual cross border workshop in Victoria, BC on May 15, 2007.

- Washington State and cross border partners in British Columbia have taken steps towards establishing electronic connectivity through Epi-X and CIOSC for sharing health alerts and other outbreak information. A list of interested partners in the Pacific NW States has submitted their names to BC CDC who is facilitating connectivity for the U.S. to the Canadian system. Currently interested Canadian partners can request access to Epi-X.
Presentations and discussions took place during the Victoria workshop to strengthen cross border relationships and enhance cross public health surveillance and response capabilities in preparation for the 2010 Olympic and Paralympic Games in British Columbia. Next steps include establishing cross border (real time) surveillance systems, and surge agreements.

Presentations

• Cross-Border Collaboration: Interior Health Authority, BC; Panhandle Health District, Idaho, North East Tri-County, WA: Dr. Rob Parker, Medical Health Officer, Interior Health, BC / Jim Matsuyama, RS, NE Tri-County, WA

• Measles as a Model for Public Health Disaster Response – Dr. Jo Hoffman, WA DOH

• Measles Exercise International Ports; British Columbia, Anchorage, Seattle- Dan Banks, Eric Sergienko

• Quarantine Station Operations in Response to Measles: Peter Houck, MD US, DGMQ, CDC Quarantine Station; Thomas Kind, RN, Vancouver International Airport; Shah Roohi, RN MPH DGMQ, CDC, Anchorage International Airport

Next Steps

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

2. Continue to explore secure public health information exchange with personal health information.

3. Continue to test data exchanged via CDC's Epi-X confidential list serve.

4. As part of PNEMA activities, continue to compile a table comparing disease reporting requirements across PNEMA jurisdictions.

5. Continue to test epidemiology preparedness and response capabilities.

6. Continue to address land border issues in Alaska.

7. Research information: Vancouver needs more information from the cargo industry.

8. Continue to fold emergency issues into all-hazards public awareness approach; share best practices.

9. Continue work on a cross border data sharing agreement between PNEMA jurisdictions.
**Web Resources**

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

Canadian Network for Public Health Intelligence (CNPHI)
- A secure internet-based suite of applications and resources, primarily directed towards strategic public health information and intelligence sharing. Applications include:
  - Canadian Integrated Outbreak Surveillance Centre (CIOSC)
    - CIOSC Goal: To enhance public health’s capacity to anticipate and detect health risks associated with communicable disease threats.

Canadian Integrated Public Health Surveillance (CIPHS)
- Homepage: http://www.phac-aspc.gc.ca/surveillance_e.html
Public Health Laboratory Workgroup

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

Presentation

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

Progress on Identified Key Issues:

- Resource Sharing – Conducted real-life request of sharing of laboratory resources and found that the system worked as expected in time of need. Our familiarity with one another made it easy to call for help when the Washington State Public Health Laboratory needed supplies during a disease investigation. We received assistance from other labs in the states as well as from British Columbia. In light of the success of this situation, we decided not to hold the exercise of a similar event. We discussed the need to continue to update one another on individual and group laboratory issues.

- Contact List – Developed comprehensive contact list of key laboratory contacts. Group members have been in communication over the past year as needs arose. The list will be redistributed on a regular basis to maintain accuracy.

- Terms of Reference – Finalizing Cross Border Public Health Laboratories Team Terms of Reference. The workgroup looked at the Draft Terms of Reference and suggested that it be worded as a more informal agreement. Morshed and Yolanda will work on this and provide copies to the rest of the workgroup.

Next Steps and Goals:

- To sign the Memorandum of Understanding (MOU) between the British Columbia Centre for Disease Control (BC CDC) Laboratory and the Washington State Public Health Laboratory (WA PHL). It is currently going through draft review steps.

- Include the Montana Public Health Laboratory in the existing Region 10 Laboratory MOU. This is also going through the draft review process.

- Complete full access for BC CDC to the U.S. Centers for Disease Control and Prevention (U.S. CDC) Laboratory Response Network (LRN). British Columbia CDC currently has
“read” access to the LRN and is working with their federal partners in Winnipeg to gain complete access rights. Washington Public Health Laboratory (WA PHL) Director will continue to assist their efforts.

- Research and evaluate using a web-based coordinating resource to improve communication for the working group. Propose that other working groups network through similar systems.

- Discuss the recently proposed Pacific Northwest Health Alliance as it applies to the Cross-Border Laboratory Work Group.

- Explore funding opportunities for cross-border laboratory collaboration. Determine types of high profile, high public health impact laboratory testing needed related to the 2010 Olympic Games to develop and ensure common laboratory procedures.
Surge Capacity Workgroup

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

Presentations

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

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

Washington’s Draft Operational Plan for Sharing Healthcare Personnel Across Borders During an Emergency — The draft agreement is intended for use as a template that any jurisdiction could apply when drafting agreements for requesting, sending and receiving emergency surge personnel.
- If adopted, the draft plan will become part of Washington’s Comprehensive Emergency Management Plan.
- EMAC-like procedures and paperwork for implementing the process described in the plan will be developed by June.
- It hoped that agreements based on this template will be useful for a variety of situations from large scale disasters to smaller medical emergencies.
**Movement of Emergency Service Personnel Across Borders** – There is an existing Cross-Border Ambulance Reciprocity Policy Statement between British Columbia and Washington covering emergency medical services. The Policy Statement is dated November 30, 2003 and is currently the basis for cross-border EMS service between Washington, BC, Oregon and Idaho.

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

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

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

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

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

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

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

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

- Discussed the existing procedures used by BC and Whatcom County EMS and USCBP to move patients from Point Roberts, WA, through BC to Washington. Discussed the use of the PNEMA between Washington, Alaska and British Columbia, along with Alaska’s process and procedures to cross the borders.

**Recommendations:**

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

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

- Discussed capabilities both in Canada and Washington per above notes.
- Discussed capacities both in Canada and Washington per above notes.
- A barrier during disasters and Mass Casualty Incidents (MCI) was discovered in subparagraph #3 of the Washington State EMS, Cross Border Ambulance Reciprocity Policy. This paragraph states “3. While transporting patients to medical, residential, convalescent, and nursing facilities in Washington State, but not from point to point, was identified as a barrier during a declared MCI or disaster.
Recommendation: Add to the end of #3 May be superseded when a state of emergency is declared in the case of a disaster or MCI as determined by the local incident commander.  
Point of Contact: Mike Smith

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

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

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

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

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

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

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

Presentations

- Pandemic Influenza – Public Outreach (Washington State)
- West Nile Virus (British Columbia and Washington State)
- Antiviral Deliberative Dialogue Project (Public Health Agency of Canada)
- Virtual Joint Information Center (Oregon State)
- Emergency Communications Toolkit (Washington State)
- Collaborative software (Public Health Agency of Canada)

- (For more information, see Web Resources section below.)

Group Discussions

- Pan flu outreach materials and need for collaboration –
  - Antiviral messaging on US/Canada differences; state/province differences
  - Using personal video Web sites for outreach (YouTube, MySpace, etc.)
  - Strategies to combat possible waning public interest.

- West Nile virus –
  - Using an all-hazards approach.
  - Potential for point-of-sale outreach.
  - Need for discussion on disclosure differences.

- Special Needs Communities –
  - Collaboration on outreach materials (including translations).
  - Best practices; how to engage community groups, partnering with existing programs as communication channels.
  - Testing materials in the community.

- Information-sharing across borders –
  - One-stop shop for people to see how issues are being addressed in provinces/states.
• Identify differences in our region and possible public awareness issues.
• Call Center Capacity –
  • Possible surge capacity issues.
  • Public will call numbers from other states/provinces; how can we share messages?
• Tribes/First Nations –
  • How can we better engage in developing collaborative communications strategies?
• Emerging Issues/Special Events –
  • Possible communication issues regarding upcoming Olympics.

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

Web Resources
Public Health Agency of Canada –
  • Information on Antiviral Deliberative Dialogue Project – www.phac-aspc.gc.ca
  • Public awareness materials – www.healthycanadians.ca

Washington State Department of Health –
  • Communications Toolkit – www.doh.wa.gov/phepr/toolkit
  • Medication Center resources – www.doh.wa.gov/phepr/signs
  • Pandemic Flu resources – www.doh.wa.gov/panflu
Public Health Law Workgroup

The public health law workgroup discussed these three documents:

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

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

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

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

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

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

**Washington state guide for local health**

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

Among the issues in the outline are:
- the authority, roles, and responsibilities of local health officers and other public health entities;
- the limitations of due process;
- disease surveillance, investigation, and reporting;
- continuity during emergencies;
- isolation and quarantine;
- altered standards of care/alternate care facilities
The group discussed the use of administrative warrants in each state or province. The laws regarding them were vastly different from jurisdiction to jurisdiction especially when pertaining to commercial property.

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

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

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

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

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

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

Appendix A - Workshop Agenda
Appendix B - Draft Surge Capacity Operational Plan
Appendix C - Draft Epidemiology Data Sharing Agreement
Appendix D - Draft Pacific Northwest Border Health Alliance – Conceptual Framework
Appendix E - Speaker Biographies
Appendix F - Workshop Evaluation
Appendix G - Cross Border Workgroup Membership
Appendix H - List of Registered Participants
Appendix A

Cross Border Public Health Collaboration: Opportunities and Challenges

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

May 14 – 16, 2007

Agenda

Pre-Workshop Workgroup Meetings
Monday, May 14, 2007

1:30-4:30  Pre-Workshop Workgroup Meetings
- Epidemiology Workgroup
- Public Health Laboratories Workgroup
- Emergency Management Surge Capacity Workgroup
- Emergency Medical Services Workgroup
- Communications Workgroup
- Exercise Planning Workgroup
- Public Health Law Workgroup

Noon-7:00  Registration

Pre-Workshop Workgroup Meetings Purpose: To update participants on discipline-specific cross border activities as a precursor to the workshop’s May 15th breakout sessions. All workshop participants are invited to attend the pre-workshop meetings. Participants are encouraged to attend a workgroup meeting in their field of expertise.
Workshop Day 1  
Tuesday, May 15, 2007  
(Morning Plenary Session)

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

8:00-8:40 **Welcome and Introduction** – Dr. Eric Young, Deputy Provincial Health Officer, British Columbia Ministry of Health  
- Hon. George Abbott, Minister of Health, British Columbia Ministry of Health  
- MarySelecky, Secretary, Washington State Department of Health

8:40-10:00 **Keynote Addresses** –  
- Dr. James Young, MD, Special Advisor to the Minister, Public Safety and Emergency Preparedness Canada  
- RADM Craig Vanderwagen, MD, Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services

10:00-10:30 **Break**

10:30-11:30 **2010 Olympic and Paralympic Winter Games** (Wayne Dauphinee, Presiding)  
- Dr. Jack Taunton, Chief Medical Officer, Vancouver 2010 Olympic Games  
- Robert Bryan, Emergency Management Director, Vancouver Coastal Health  
- Ron Weaver, Joint Chief of Staff, Washington State Military Department

11:30-11:45 **Overview of the National Biosurveillance Integration System** – Dr. William Lyerly, Director of International Affairs, Special Assistant for Global Health Security, U.S. Department of Homeland Security

11:45-Noon **Pacific NW Cross Border Alliance**  
- Wayne Dauphinee, Emergency Management Consultant, BC Ministry of Health  
- John Erickson, Special Assistant, Washington State Department of Health

Noon-1:30 **Lunch** – Dr. Jude Van Buren, Assistant Secretary, Washington State Department of Health, Presiding)

- **A Framework for Assessing Regional Public Health Preparedness** –  
  RADM Patrick O’Carroll, MD, MPH, Regional Health Administrator, Office of Public Health and Science, U.S. Department of Health & Human Services, Region X
Workshop Day 1 (continued)
Tuesday, May 15, 2007
(Afternoon Breakout Sessions)

1:30-5:00  Facilitated Workgroup Sessions*

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

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

❖ Emergency Management Surge Capacity/Emergency Medical Services
  • Canadian Leads: Wayne Dauphinee, British Columbia Ministry of Health;
    Bruce Harford, British Columbia Ambulance Service
  • U.S. Leads: John Erickson, Washington State Department of Health;
    Michael Smith, Washington State Department of Health

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

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

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

5:30-7:30  Meet and greet mixer (cash bar) followed by dinner on your own
Workshop Day 2  
Wednesday, May 16, 2007 
(Morning Plenary Session)

7:00-8:00  Continental Breakfast

8:00-8:50  Opportunities and Challenges (John Erickson, WA Dept of Health, Presiding)

- Dr. Richard Besser, Centers for Disease Control and Prevention – Opportunities and Challenges in Cross Border Public Health Preparedness and Response
- Dr. Bonnie Henry, British Columbia Centre for Disease Control – Lessons Learned from SARS in Toronto

8:50-9:30  Tribes and First Nations: Cross Border Collaboration (Dr. Mark Oberle, NW Center for Public Health Practice, Presiding)

- Byron Loucks, Emergency Management Consultant / Dr. David Martin, Program Medical Officer, Health Canada, British Columbia Region, First Nations and Inuit Health – First Nations Preparedness in British Columbia
- Joe Finkbonner, Executive Director, NW Portland Area Indian Health Board – Tribal Preparedness in the Pacific Northwest

9:30-10:00  Break

10:00-Noon  Panel Discussion: Pandemic Influenza Planning in Canada and the United States: Similarities and Differences (Moderator: RADM Patrick O’Carroll, MD)

10:00-10:40  Community (Non-Pharmaceutical) Measures to Mitigate Spread
- Jill Sciberras, Senior Epidemiologist, Public Health Agency of Canada
- Dr. Marty Cetron, Director, CDC, Division of Global Migration and Quarantine

10:40-11:20  Use of Antiviral Medicines
- Jill Sciberras, Senior Epidemiologist, Public Health Agency of Canada
- Dr. Benjamin Schwartz, Senior Science Advisor, HHS, National Vaccine Program Office

11:20-Noon  Travel and Border Issues
- Dennis Brodie / Thomas Kind – Public Health Agency of Canada
- Dr. Marty Cetron, Director, CDC, Div. of Global Migration and Quarantine

Noon-12:30 Workshop Accomplishments and Closing Remarks
- Mary Selecky, Secretary, Washington State Department of Health
- Wayne Dauphinee, Emergency Management, BC Ministry of Health

12:30  Farewell Break - Afternoon beverages and snacks will be available at 12:30 PM
Appendix B

Draft Surge Capacity Operational Plan

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

I. Authority: This operational plan is developed in accordance with the Pacific Northwest Emergency Management Arrangement (PNEMA) and ANNEX B of PNEMA.

II. Purpose: The purpose of this plan is to operationalize timely and efficient movement and utilization of health professionals across the Washington border with British Columbia.

III. Activation: This operational plan will be activated on the authority or direction of the Governor or designee.

IV. Concept of Operations:

A. General: When a party to PNEMA (state, province, or territory) suffers a disaster that exhausts or threatens to exhaust physician and/or nursing resources, the Governor or Premier may request assistance from across the international border. Requests for such assistance will be presented formally from the requesting state/provincial Emergency Operations Center (EOC) directly to other state/provincial EOC. Requests for assistance from local jurisdictions in the state must be routed from the local EOC through the state/provincial EOC.

B. Format: Requests can be verbal or written. Verbal requests will be followed up in writing. State request forms will be used as the written request form. (See PNEMA Administrative Procedures). Requests should include the following information:

1. Description of services need (mission)
2. Number and type of professionals (using pre-identified resource typing designations whenever practical)
3. Estimated length of time needed
4. Specific time and place for mobilization center (staging location) and contact person
5. Location of service delivery
6. Specific information must be provided in written form (see Licensure and Credentialing issues sections of this plan)
C. **Staging and Deployment:**

1. State and/or BC EOC will provide information on staging locations to the jurisdiction providing personnel resources. Requested personnel will report to the identified staging location(s) of the requesting state/province for deployment to operational commands.

2. **Expedited Processing:**

   a. Mobilization centers will be hosted by the state or province to provide a centralized processing facility from which administrative matters can be executed expeditiously. Personnel will not be deployed from the mobilization center until they have been briefed on administrative requirements (travel, communications, and length of deployment) and have necessary protective equipment and vaccinations (as appropriate). Operation of the mobilization center is the joint responsibility of DOH and EMD.

   b. When Canadians are deployed to Washington, EMD will provide staff at the mobilization center to assure that personnel are registered as emergency workers as provided for in WAC 118-04 prior to allowing them to deploy from the mobilization center.

   c. When Washingtonians are deployed to Canada, EMD will provide staff at the provincial mobilization center to verify that deployed personnel are registered in Washington as emergency workers. Those that are not registered may then be registered on the spot.

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

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

V. **Legal and Administrative**

A. **Liability Protection:** In order to receive personal and professional liability protections of PNEMA and state law, personnel deployed to Washington must be
registered as emergency workers by the receiving local emergency management agency as specified under chapter 118-04 Washington Administrative Code.

B. Workforce Identification and Training:

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

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

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

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

F. **Border Crossing:**

1. As part of the Western Hemisphere Travel Initiative (WHTI), beginning January 23, 2007, all persons, including U.S. citizens, traveling by air between the United States and Canada will be required to present a valid passport, Air NEXUS card, or U.S. Coast Guard Merchant Mariner Document.

2. As early as January 1, 2008, all persons including U.S. citizens, traveling between the U.S. and Canada by land or sea (including ferries), will be required to present a valid passport or other acceptable documents that denote identity and citizenship as determined by the Department of Homeland Security. While recent legislative changes permit a later deadline, the Departments of State and Homeland Security are working to meet all requirements as soon as possible.

3. The Department of Homeland Security has granted the state of Washington permission to develop, as a pilot project, an enhanced drivers license (or personal identification card) that will denote identity and citizenship and that will allow the holder to cross the land border between Washington and British Columbia under WHTI requirements. This document would be based on the standard Washington State driver license or identification card, but would be enhanced to meet the requirements of the WHTI.

This enhanced driver license would:

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

Draft Epidemiology Data Sharing Agreement

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

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

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

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

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

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

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

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

A sending signatory is a signatory to this Arrangement that sends or delivers information to the jurisdiction of another signatory with its permission and/or at its request;
Regional cross-border communication and coordination

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

Document repository

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

Dissemination of health data

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

Purpose of disseminating health data

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

When health data are disseminated

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

Protection of health data

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

The signatories understand that it would be impractical to attempt to adopt uniform standards for the protection of health data at this time or to attempt to impose law related to the privacy of health data of any of the signatories. The signatories therefore intend to transmit health data subject to the understanding that it is to be received and maintained by receiving signatories according to the laws or regulations by which the receiving signatories are bound, subject to any restrictions of applicable privacy laws within the sending jurisdiction. Signatories will
furthermore endeavor to protect data received from another signatory to the fullest extent permissible under law. Signatories will endeavor to notify a sending signatory, at the earliest possible time, if a request for health data provided by that jurisdiction is made under the receiving signatory’s Freedom of Information Act or the equivalent of such an act under that jurisdiction’s laws and regulations. Nothing in this Arrangement is to be construed so as requiring any signatory to transmit health data in contravention of the laws or regulations under which the sending signatory is bound.

Effective date

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

Signatures

________________________________   ______________________________
Signatory             Signatory
Washington State          British Columbia

* Edited by Jo Hofmann, MD
Appendix D

Draft Pacific Northwest Border Health Alliance – Conceptual Framework

I. Name

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

II. Purpose

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

- Plans and provides inter-jurisdictional mutual aid and support for multi-jurisdictional response to public health crises not warranting a declared emergency.

- Provides regional, all-hazards public health response system with mechanisms and processes for escalating capability.

- Establishes a jurisdiction-based pilot program for testing public health readiness / performance indicators.

III. Steering Committee

Committee Mandate and Key Tasks

The Alliance Steering Committee’s mandate and key tasks are:

- To identify opportunities to improve collaborative early warning infectious disease surveillance and surveillance information sharing between the above mentioned jurisdictions.

- To reach agreement regarding the type of early warning infectious disease information to be shared, and the manner in which it will be shared, including developing and agreeing upon a 24/7 response protocol between our jurisdictions that would include appropriate contacts, and their roles for all jurisdictions.

- To explore the development of a Memorandum of Understanding (MOU) for resource sharing, as appropriate, in an emergency between the above mentioned jurisdictions and to identify opportunities for additional collaboration.1

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

Core

- Steering Committee Co-Chair – a U.S. State and British Columbia co-chair
- Representative (s) from the State of Alaska
- Representative (s) from the State of Idaho
- Representative (s) from the State of Oregon
- Representative (s) from the State of Washington
- Representative (s) from the Province of British Columbia
- Representative (s) from the Yukon Territory

- Public Health Communications Sub-Committee Co-chairs
- Laboratory Sub-Committee Co-chairs
- Legal Sub-Committee Co-chairs
- Emergency Response/Surge Sub-Committee Co-chairs
- Surveillance/Epidemiology Subcommittee Co-chair
- Emergency Medical Services Sub-Committee Co-chairs

Liaison

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

Structure

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

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

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

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

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

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

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

**Organizational Structure**
Appendix E

Speaker Biographies
(In order of appearance)

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

After graduating with a Bachelor of Science (BSc. – cum laude) at the University of Ottawa in 1970, Dr. Eric Young completed his medical school training (MD) at the same university in 1974. He did an internship at the Toronto East General Hospital, then followed up with a year as a Senior House Officer in Christchurch, New Zealand and a year as a resident in Internal Medicine at St. Paul’s Hospital in Vancouver, BC. He subsequently worked as a general practitioner in Surrey, BC until 1992. During that time, he was active in both Surrey Memorial Hospital and the BC Medical Association committees.

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

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

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

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

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

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

He was first elected in 1996 to represent the riding of Shuswap and was re-elected in 2001 and 2005. Before his election to the Legislative Assembly, Mr. Abbott was a political science
instructor at Okanagan University College. He also owned the oldest and largest berry farm in the Interior.

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

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

Mary C. Selecky has been Secretary of the Washington State Department of Health since March 1999. In February 2005 she was reappointed to the position by Governor Christine Gregoire. Prior to working for the state, Mary served for 20 years as administrator of the Northeast Tri-County Health District in Colville, Washington.

Throughout her career, Mary has been a leader in developing local, state and national public health policies that recognize the unique health care challenges facing both urban and rural communities. As Secretary of Health, Mary has made tobacco prevention and control, nutrition and physical activity and emergency preparedness her top priorities. Mary is known for bringing people and organizations together to improve the public health system and the health of people in Washington State.

Mary has served on numerous boards and commissions; she is a past president of the Association of State and Territorial Health Officials, receiving the 2004 McCormack Award for excellence in public health, and a past president of the Washington State Association of Local Public Health Officials. A graduate of the University of Pennsylvania, she’s been a Washington State resident for 33 years.

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

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

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

Most recently on June 26, 2002, Dr. Young was appointed Ontario's first Commissioner of Public Security. Dr. Young is responsible for maintaining and enhancing physical and economic security in Ontario by working with a number of diverse partners and stakeholders located both within and outside the province. The Assistant Deputy Minister oversees: Emergency Measures Ontario; the Centre of Forensic Sciences; the Office of the Fire Marshal; and the Office of the Chief Coroner. This position is also responsible for administering the Ontario Society for the Prevention of Cruelty to Animals Act.
From April 1994 to June 1997, he was appointed an Associate Professor in the Department of Laboratory Medicine and Pathobiology at the University of Toronto. Since July 1997, he has held the position of Associate Professor, Department of Laboratory Medicine and Pathobiology at the University of Toronto. In April 2001, he became an Associate Professor in Forensic Sciences, University of Toronto at Mississauga.

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

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

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

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

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

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

RADM Vanderwagen is a board-certified family physician. He is published in several medical journals covering family practice, including, Medical Education, Children Today, and Hospital and Community Psychiatry.
Wayne E. Dauphinee
Emergency Management Consultant
British Columbia Ministry of Health

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

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

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

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

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

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

Robert Bryan, Regional Director
Vancouver Coastal Health Authority

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

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

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

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

COL (Ret) Weaver military service spans 37 years and includes an active duty tour in the Republic of Viet Nam and leadership positions within the Washington Army National Guard.
ranging from platoon leader, Company and Battalion command, culminating with the position of Commander, 205th Leadership Regiment. This Regimental headquarters is responsible for the training and leadership development of future Army leaders covering the entire western region for the reserve component. Colonel Weaver retired from military service in 2006.

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

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

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

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

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

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

Mr. Lyerly is a registered Medical Technologist, MT(ASCP); a graduate of the USAF Academy (BS), Central Michigan University (MA), and Johns Hopkins University (MPH) where he has completed all course and residence requirements for 3 Doctorates; and recipient of the International Diploma in Humanitarian Assistance (IDHA).
John Erickson, Special Assistant  
Washington State Department of Health  
Director of the Public Health Emergency Preparedness and Response Program  

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

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

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

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

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

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

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

For the past four years she has served as an Senior Executive for a technical state health Division that supports over 190 employees in two locations and provides technical and analytical services to local public health, state public health programs, tribal organizations, and consultation services to academic institutions and clinical laboratories. This Division is composed of public health practitioners, including epidemiologists, physicians, researchers, laboratorians, the State Registrar and informatics and health assessment staff. They address infectious and non-infectious epidemiology, vital statistics, health research and data informatics and provide clinical and environmental analytical laboratory services at the Public Health Laboratories located in Shoreline, north of Seattle.
Her Masters and Doctoral level degrees in public health are from The Johns Hopkins School of Public Health; her doctoral work being in the field of environmental epidemiology. Her BS degree is from the University of Washington with a focus in environmental health and her nursing degree is an Associate Degree from the Columbia Basin College located in Pasco, Washington.

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

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

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

RADM O’Carroll received his medical degree and his Masters in Public Health from Johns Hopkins University in 1983. After training in family practice and preventive medicine, he joined CDC as an Epidemic Intelligence Service Officer. Initially assigned to work in the area of violence epidemiology, RADM O’Carroll later led the epidemiology research unit for the prevention of suicide and violence at CDC’s National Center for Injury Prevention and Control. He was elected as a Fellow of the American College of Preventive Medicine in 1988.

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

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

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

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

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

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

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

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

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

Dr. David Martin, MD  
Program Medical Officer  
Health Canada, British Columbia Region  
First Nations and Inuit Health  
First Nations Preparedness in British Columbia

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

Byron Loucks  
JEL Protection Ltd.  
Emergency Management Consultant  
Emergency Services Consulting Company

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

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

In the past 2 years Byron has worked with over 65 First Nation communities in the development of Pandemic Influenza preparedness, and has conducted 2 major Tabletop exercises involving Pandemic Scenario’s with a multidisciplinary approach. He has worked closely with the First Nations and Inuit Health Program in BC and Health Authorities during these projects.
Joe Finkbonner, RPh, MHA, Executive Director  
Northwest Portland Area Indian Health Board

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Where is your work location?

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

93

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

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

93

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

<table>
<thead>
<tr>
<th>Day</th>
<th># of Responses</th>
<th>% of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Monday, May 14, 2007 (Pre-Workshop Workgroup Meetings)</td>
<td>65</td>
<td>70%</td>
</tr>
<tr>
<td>2. Tuesday, May 15, 2007 (Workshop Day 1)</td>
<td>89</td>
<td>96%</td>
</tr>
<tr>
<td>3. Wednesday, May 16, 2007 (Workshop Day 2)</td>
<td>83</td>
<td>89%</td>
</tr>
<tr>
<td>4. I did not attend the workshop</td>
<td>1</td>
<td>1%</td>
</tr>
</tbody>
</table>
4. What pre-workshop workgroup meeting did you attend on Monday, May 14th?

<table>
<thead>
<tr>
<th>Workgroup Meeting</th>
<th># of Responses</th>
<th>% of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidemiology</td>
<td>13</td>
<td>15%</td>
</tr>
<tr>
<td>Public Health Laboratories</td>
<td>7</td>
<td>8%</td>
</tr>
<tr>
<td>Emergency Management Surge Capacity</td>
<td>19</td>
<td>22%</td>
</tr>
<tr>
<td>Emergency Medical Services</td>
<td>7</td>
<td>8%</td>
</tr>
<tr>
<td>Public Health Law</td>
<td>13</td>
<td>15%</td>
</tr>
<tr>
<td>Communications</td>
<td>3</td>
<td>4%</td>
</tr>
<tr>
<td>Exercise Planning</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Floated between different workgroup meetings</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Did not attend a pre-workshop workgroup meeting</td>
<td>20</td>
<td>24%</td>
</tr>
</tbody>
</table>

Total Responses: 85

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

<table>
<thead>
<tr>
<th>Agreement Options</th>
<th># of Responses</th>
<th>% of Participants</th>
</tr>
</thead>
<tbody>
<tr>
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<td>36</td>
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</tr>
<tr>
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<tr>
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<tr>
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<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Did not attend a pre-workshop workgroup meeting</td>
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</table>

Total Responses: 84

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

<table>
<thead>
<tr>
<th>Breakout Session</th>
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<th>% of Participants</th>
</tr>
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<tr>
<td>Epidemiology</td>
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<tr>
<td>Public Health Laboratories</td>
<td>9</td>
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<tr>
<td>Joint Emergency Management Surge Capacity / EMS</td>
<td>24</td>
<td>26%</td>
</tr>
<tr>
<td>Communications</td>
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<tr>
<td>Exercise Planning</td>
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<tr>
<td>Public Health Law</td>
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</tr>
<tr>
<td>Floated between different breakout sessions</td>
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</tr>
<tr>
<td>Did not attend a breakout session on Tues. afternoon</td>
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<td>14%</td>
</tr>
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</table>

Total Responses: 93
7. The workgroup breakout session that you attended on Tuesday afternoon was useful in enhancing cross border partnerships and collaboration.

<table>
<thead>
<tr>
<th>Responses</th>
<th># of Responses</th>
<th>% of Participants</th>
</tr>
</thead>
<tbody>
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<td>2. Agree</td>
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</tr>
<tr>
<td>3. Undecided</td>
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<td>3%</td>
</tr>
<tr>
<td>4. Disagree</td>
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<td>0%</td>
</tr>
<tr>
<td>5. Strongly Disagree</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>6. Did not attend a breakout session on Tuesday afternoon</td>
<td>11</td>
<td>12%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Responses</th>
<th># of Responses</th>
<th>% of Participants</th>
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</thead>
<tbody>
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<tr>
<td>2. Agree</td>
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<td>58%</td>
</tr>
<tr>
<td>3. Undecided</td>
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<td>8%</td>
</tr>
<tr>
<td>4. Disagree</td>
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<td>13%</td>
</tr>
<tr>
<td>5. Strongly Disagree</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>6. Did not attend a workgroup session</td>
<td>11</td>
<td>12%</td>
</tr>
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9. There was enough unstructured time during the workshop to informally converse with colleagues.

<table>
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<th># of Responses</th>
<th>% of Participants</th>
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<td>2. Agree</td>
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<td>60%</td>
</tr>
<tr>
<td>3. Undecided</td>
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<td>13%</td>
</tr>
<tr>
<td>4. Disagree</td>
<td>6</td>
<td>7%</td>
</tr>
<tr>
<td>5. Strongly Disagree</td>
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<td>3%</td>
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90
10. In general, there was enough time for questions and discussion from the audience during the plenary speaker presentations of Tuesday and/or Wednesday morning

<table>
<thead>
<tr>
<th></th>
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<th>% of Participants</th>
</tr>
</thead>
<tbody>
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<tr>
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<tr>
<td>Did not attend either of the morning plenary sessions</td>
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93

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

<table>
<thead>
<tr>
<th></th>
<th># of Responses</th>
<th>% of Participants</th>
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</thead>
<tbody>
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</tr>
<tr>
<td>Agree</td>
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</tr>
<tr>
<td>Strongly Disagree</td>
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<td>0%</td>
</tr>
</tbody>
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92

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

<table>
<thead>
<tr>
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<th># of Responses</th>
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<tbody>
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<tr>
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</tr>
<tr>
<td>Strongly Disagree</td>
<td>0</td>
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</tbody>
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92

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

<table>
<thead>
<tr>
<th></th>
<th># of Responses</th>
<th>% of Participants</th>
</tr>
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<tbody>
<tr>
<td>Three day workshop (pre-meeting day followed by two formal workshop days)</td>
<td>61</td>
<td>67%</td>
</tr>
<tr>
<td>Two day workshop (no pre-meeting activities)</td>
<td>20</td>
<td>22%</td>
</tr>
<tr>
<td>One day workshop</td>
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<td>3%</td>
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<td>No workshop</td>
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</tr>
<tr>
<td>Other:</td>
<td>7</td>
<td>8%</td>
</tr>
</tbody>
</table>

91
14. What cross border issues would you like to see addressed at the next cross border workshop?

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

25. Same.

26. Rather than esoteric discussions of what we do or do not do, I would rather see a functional exercise where we actually convened staff and called across borders to actually obtain help.

27. How the disease reporting systems of both countries are meeting the new International Health Regulations.

28. I think "contracting" for preparedness has become a question in my mind. What works and what doesn't?

29. Continue work to formalize communication and processes among partnerships. e.g. create algorithms/flowsheets illustrating lines of communication across borders; triggers to initiate notification, etc.

30. Updates on planning for 2010 Olympics, on C. gattii, and on pandemic influenza. Also present examples of specific cross-border planning and/or response efforts, where the cross-border agreements have been implemented.

31. I think more emphasis on local issues is needed, as that is where response first occurs.

32. All Hazards Risk Communication

33. Updates from this year.

34. Follow up on the legal issues needing addressing to make PNEMA Annex B workable, such as licensing, liability, immunity or indemnification, workers comp and death benefits, law waiver.

35. Cross border staff placements (1-3 month exchanges); information transfer platforms; environmental issues


37. I think it would be good to work on what our exact interactions will be during the 2010 Olympics.

38. Finalization of legal response agreements and MOUs

39. Joint project development on common cross border issue,

40. Cross border job shadowing for EMS personnel.
   Formal agreement for expediting cross border movement of patients, equipment and personnel.
   Training & Education for EMS providers regarding expediting cross border movement.

41. Technical aspects of communication, internet, radios, phones etc.

42. professional competencies and standards

43. Maybe by the next meeting - The goal of having MOUs in place across all borders (countries, States/Providences, Indian nations. etc). Progress/updates on 2010 Olympic Games cross border planning.
44. Preparations for 2010 Olympics—Sharing Health Care Providers Across Borders
   - Conduct a table top exercise and emphasize the role of Federal government during a
     Pacific NW response
   - What areas of Annex B can be operationalized
   - Best practices from other border alliances

45. Moving patients across borders during disasters irrespective of patient nationality.

46. Discussion about national stockpiles

47. Scenarios such as the measles scenario covered in the Epidemiology breakout section.
   It was interesting and useful to understand how the port authorities operated and it
   sparked some interesting dialogue with local public health officials.

48. More emphasis on hospital and medical staff issues. I know the emphasis is on PH, but
   the rest of the medical world needs to have a stronger and more recognized place in the
   proceedings.

49. Medical Surge, resource typing, paper work involved in PNEMA, case studies of cross-
   border issues, hospital issues

50. Pandemic flu preparedness data sharing agreements 2010 Olympics planning -
    surveillance for disease

51. More focus on interaction between states and the cross state border problems.

52. Identification of legal barriers and what states/jurisdictions can do to overcome them.

53. Continuation of work on medical surge issues.

54. Progress reports on key issues....credentialing, international logistics, data sharing

55. Electronic access to medical records.

56. Speaker addressing any of the many legal issues

57. Monitor of surveillance data

58. Legal issues around the delivery of health services during a pandemic.
15. What did you like most about this workshop?

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

29. Learning the details of activities occurring on both sides of the border and how they are managed.


31. The opportunity to discuss our approach and compare it to other approaches.

32. Networking opportunities

33. Panel discussions and speakers who addressed how issues will be dealt with on the ground.

34. Meeting and making connections with other Lab groups.

35. the laboratory break out sessions were most valuable

36. Use of scenarios to identify responses in different geographical areas and to discuss cross border notification/assistance.

37. Opportunity to meet and talk to regional and national partners, and to address dilemmas and gaps in PH emergency planning and response.

38. Organization

39. Meeting with our Canadian counterparts, as well as attorneys from neighboring states who are grappling with the same issues.

40. Opportunity to get together with others from multiple states and provinces

41. Dr. Cetron's presentation; high level attendance; Victoria was great; easy to get to, nice venue and setting and weather

42. Good speakers.

43. It is always good to get to speak face-to-face with colleagues and to learn about the exciting things they are doing and the issues they have had over the past year. Having informal time together really does contribute to that ability to work with one another on sticky issues.

44. Opportunity to jointly plan with BC colleagues, and interact with federal representatives from both countries.

45. Meeting colleagues, share findings with each other, mock exercise on real issue etc.

46. The opportunity to learn what plans Canada had in place. Since it is a different premise than the US, I found this very useful

47. The collaborative atmosphere was very refreshing! Enjoyed getting to know my Canadian peers.

48. Breakout session

49. Very collaborative and participative; The Monday pre-workshop was very valuable, Tuesday afternoon exercise was very useful and Wednesday morning was very interesting

50. The workgroup work sessions; Wednesday morning topics & speakers; Tuesday Keynote Addresses

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

1. Additional opportunities for unstructured time to meet with colleagues.
2. Bellingham is nice but maybe something better like Seattle.
3. Would like to see projections re: participants, daily attendance, workers, anticipated border traffic, etc. available on the website or as section in program binder. More screens or better seating to view slides. Sitting in large circles works with conversations but not necessarily for listening to speakers. Less formal presentations at the pre-workshop meetings and more time for discussion.
4. The layout of the plenary room was awkward and detracted from the presentations and discussion; should ensure better set up next year.
5. More concise Powerpoint presentations...
6. More state and local level presentations / sharing of info. Less federal level stuff
7. Include all activities as part of the full workshop to encourage participation through the entire time. Work out the times to fit with transportation. The Clipper schedule for returning meant you either missed the last 2 hours of the workshop or had to wait around another 7 hours.
8. Continue with institutionalization of systems. Time for reports and issues of other break out sessions.
10. Including provision for pre-workshop sessions from public and environmental health officers and health services (hospitals) sector
11. Keep the high level speakers in the program CDC Atlanta for example. BCCDC etc.
12. Select an attractive venue, such as this year's program
13. I would suggest that there be a panel discussion on a particular topic [which includes local, state and fed reps] and then dive deeper on the topic. Otherwise--excellent workshop. Well done again.
14. Need more representation from BC! In other than epidemiology, BC was poorly represented.
15. More time for plenary session, especially when there are so many good speakers.
16. Focus Groups: Health Officers; Emergency Management; State and Prov. (Not just DOH)
17. I’ve attended 3 of the 4 meetings and I’m struck by the fact that we are still rehashing SARS and 9/11. I realize that this is an attempt to get the newbies up to speed. But I think that if part of the first plenary session was report outs by the various subject workgroups, it would be just as beneficial and more interesting. I also recommend that events within the year are appropriate for the plenary. For example the fungus outbreak in shellfish would have been great.
19. Have a few less speakers, SCHEDULED breaks and allowances for discussions, especially question and answer periods for the "experts". A more "round table" approach might be fun too, with discussion among the presenters, discussing and arguing various roadblocks and solutions.
20. Invite more people who have expertise in the area of disaster psychosocial response and as well as an understanding of emergency management. Education in this area is critical as emergency planners do not tend to have it on their ‘radar’, and yet disaster behavioural health has been shown to have significant impact on the overall disaster response.

21. Build an actual, full scale, exercise where medical personnel, patients, equipment and supplies cross the border from north and south. Practice our plans!

22. Start with a scientific presentation, like Dr. Henry’s, rather than 1/2 day of political intros.

23. I like Bellingham, but can we try someplace else?

24. I enjoyed the presentation on SARS Wednesday morning. However, it seems that SARS is an annual discussion at these workshops. The presentation this year went way too far into the background and statistics of the event. Not only do we here this at the annual workshops, but we are getting or have gotten a lot of this detail at other national meetings. I think at this point the presentation would have better served the audience if the discussion had focused more on the international cross-border issues of SARS. The level of detail caused the speaker to go way too far into other speaker’s time. I would suggest at these plenary sessions that there be a time monitor at the table nearest the speaker to keep things moving along so as to 1) not interfere with subsequent speakers and 2) allow more time for questions.

25. Do not sit participants at round tables - some had to sit backwards during talks, some didn't have room to write.

26. If the next one is in Washington, please do NOT go to Bellingham. How about Lake Chelan or some comparable place that would match the natural beauty of Victoria?

27. Continue your thoughtful design.

28. U.S. Federal level speakers (excluding CDC) have been extremely disappointing for the past two years. Maybe that is reflective of this administration but it is too bad, and more than a little embarrassing because the Canadian speakers are so much better by comparison. This does not include the CDC speakers who have been very good.

29. For the Lab group. No representation from Alberta.

30. Please don't conflict with the APHL meeting scheduled for May 18-21, 2008

31. Have handouts available during the conference, or immediately afterward (have staff ready to load presenters files directly onto web site).

32. More Tribal involvement

33. When the conference is in the home location of some participants, they tend to go home rather than stay and socialize. Better to locate where no one is at home to facilitate relationships outside the conference setting.

34. Consider brief presentations to the plenary of progress made in the work group’s breakout sessions.

35. Dig a bit more in depth into some specific issues, to note the variation and similarities between Canadian and U.S. approaches

36. I really don't have any.
37. More unstructured time for discussion. Demonstrations and sharing of some of our best practices via lobby posters. A planned after-work activity, such as a tour or other recreational item.

38. The current format is excellent. Need to continue at its current speed

39. Hold the next cross border at Lake Chelan, Washington. (Campbell's Resort)

40. Less federal bureaucrats

41. Assure we address goals set this year (progress, achievements & stumbling blocks)

42. Consider a location other than Bellingham. Spokane? Port Townsend? Port Angeles? Tacoma?

43. Clear objectives.

44. An earlier-to-later social event to network more.

45. Have many opportunities for interactive sessions. Maybe a little shorter presentations that encourage or enable discussions.

46. I would say about half of the presentations during the plenary sessions were a complete waste of time. Some of the speakers were so general and bland that I felt as though I was sitting in the classroom of a Peanuts cartoon...Wha-wha-wha wha-wha wha wha. So, I understand it is difficult to screen who will be a good presenter, but maybe we could cut down on the number of speakers and allow more time for facilitated activities (such as the break out sessions).

47. I think having a dinner presentation would be an excellent way of keeping people engaged for the entire time. While I realize that "getting out and seeing where you are" is very nice, not everyone was invited to be a part of some group for dinner.

48. Bring someone for areas from my state where we are represented in all working groups.

49. Too many talking heads from U.S. Fed government - they really were not prepared and did not add to the discussion = except for Dr. ______ on SARS and preparedness

50. Let's have it in Sitka.

51. Fewer speeches, more structured workshop time.

52. While the breakout sessions were very helpful, there was no sharing of what was happening in each group. For example, if I wanted to know how the Epidemiology group was working, I could not find out if I attended another breakout. Is it possible to have a brief report from each group sometime during the meeting?

53. Some direct participation from Dept of Foreign Affairs and Dept of State. I understand that most of the senior federal officials backed out late in the planning this time. Maybe next year, commit them to presentations explaining how they are supporting local and regional cross-border initiatives.

54. Option for pre-arranged dinner in the 5:30 - 7:30 time slot

55. Better representation from all provinces and U.S. States; More time for questions and answers; Better enforcement on restrictions on length of presentations; Shorter presentations with better formatting (i.e. minimal text that is visible)

56. Keep it going as is. Great work.

57. Confusion with who should attend pre-workshops. Best to have all part of the scheduled workshop and if needed have special sessions/breakout groups to meet specific
objectives. Screen placements made it difficult to see, should have one placed closer to speakers as well.
# Appendix G

## Cross Border Workgroup Membership

### Epidemiology Workgroup

**Alaska**

Barbara Smith  
Nurse Epidemiologist  
Alaska Dept of Health & Social Services

**British Columbia**

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

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

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

**Montana**

Kammy Johnson, DVM, PhD  
Epidemiologist  
Montana DPHHS

**Idaho**

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

**Oregon**

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

**Washington**

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

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

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

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

**Yukon**

Bryce Larke, MD, DCISc  
Chief Medical Health Officer  
Yukon Health and Social Services
Public Health Laboratories Workgroup

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

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

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

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

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

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

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

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

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

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

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

**Alaska**

Jim Mackin  
AK Dept of Health

**British Columbia**

Jeanette Beattie  
Coastal Health Authority

Wayne Dauphinee (Workgroup Lead)  
BC Ministry of Health

John Lavery  
BC Provincial Health Services Authority

Chris Smith  
BC Ministry of Health

**Idaho**

Angela Wickham  
ID Dept of Health

**Oregon**

Mike Harryman  
Oregon PHEPR Manager

**Washington**

Dennis Anderson  
WA Dept of Health

Cynthia Dold  
WA Region VI, Regional Public Health

John Erickson (Workgroup Lead)  
WA Dept of Health

Verne Gibbs  
WA Dept of Health

Ben Haworth  
Providence Health Systems

Marianne Klaas  
Swedish Medical Center

Judith May  
WA Dept of Health

Cindy Miron  
WA Region V, Regional Public Health

Valerie Munn  
WA Dept of Health

Anne Newcombe  
Harborview Medical Center

Peggi Shapiro  
Washington State Hospital Association

Johnese Spisso  
Harborview Medical Center

Wayne Turnberg  
WA Dept of Health

Jon Vansant  
WA Region IX, Regional Public Health

Ron Weaver  
WA Military Department

Nathan Weed  
WA Region IV, Regional Public Health

Chris Williams  
WA Dept of Health

**Canada Federal**

Betsy McKenzie  
Public Health Agency of Canada

**U.S. Federal**

Debbie Engels  
U.S. Customs and Border Protection

Andy Stevermer  
DHHS, Region 10

Alvin Lee  
DHHS, Region 10
Emergency Medical Services (EMS) Workgroup

**British Columbia**

Lauren Boon  
Western Coordinator National Defense  
Canada

Bruce Harford (Workgroup Lead)  
Superintendent  
BC Ambulance Services

Chris Nickerson  
Executive Director  
BC Emergency Health Services Commission

**Washington**

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

Cindy Button  
North Central Region EMS & Trauma Care Council

Garth Eimers  
Retired San Juan Fire Chief

Tom Hardy  
Director, U.S. Customs and Border Protection

Darrel Kirking  
North Central Region EMS & Trauma Care Council

Jonathon Larsen  
Paramedic, Seattle Fire Dept

Gayle Pollock  
Director of EMS  
Pend Oreille County Fire District #2

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

Jim Ricks  
E911 Coordinator  
Paramedic, Region 1

Bonnie Robinson  
North Region EMS

Michael Smith (Workgroup Lead)  
EMS Terrorism and Disaster Response  
WA Dept of Health

Wayne Turnberg  
Cross Border Workshop Coordinator  
WA Dept of Health

Dr. Marvin Wayne  
Bellingham Medic One

**Canada Federal**

Tony Wong  
CBSA-ASFC, Canada

Kirsten Carrier  
CBSA-ASFC, Canada

**U.S. Federal**

Debbie Engels  
U.S. Customs and Border Protection
Public Health Law Workgroup Leads

Paul Bailey
Executive Director, Health Protection
BC Provincial Ministry of Health

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

Communications Workgroup Leads

Peter Dalton
Communications, Public Affairs
BC Ministry of Health

Laura Blaske
Communication System Manager
WA State Department of Health

Exercise Planning Workgroup Leads

Dan Banks
Emergency Response Exercise Coordinator
WA State Department of Health

Chris Smith
Emergency Management Branch
BC Ministry of Health
Appendix H
List of Registered Participants - 2007

Abbott, George
Minister of Health
British Columbia Ministry of Health
655 Belleville Street
Victoria, British Columbia V8V 1X4
250 953-3547
Jamie.Braman@gov.bc.ca

Abbott, Sally, MSN
ANP
Alaska Division of Public Health
3601 C Street, Suite 760
Anchorage, Alaska 99516
907-334-2274 / Fax 907-269-2048
sally_abbott@health.state.ak.us

Anderson, Dennis
Risk & Emergency Manager
Washington State Department of Health
Box 47816
Olympia, Washington 98504-7816
360-236-4416 / Fax 360-236-2299
dennis.anderson@doh.wa.gov

Anderson, Kimberly, BA, LLB
Barrister & Solicitor
BC Ministry of Attorney General
P.O. Box 9280 Stn. Provincial Government
Victoria, British Columbia V8W 9J7
250-953-3179 / Fax (250) 356-8992
Kimberly.Anderson@gov.bc.ca

Arcement, Brian
Washington State Region 2 Public Health
345 6th Street, Suite 300
Bremerton, Washington 98337-1866
360-337-5267 / Fax 360-475-9267
arcemb@health.co.kitsap.wa.us

Bailey, Paul
Executive Director, Health Protection
BC Provincial Ministry of Health
4-2, 1515 Blanshard Street
Victoria, Canada V8W 3C9
250-952-1724 / Fax 250-952-1713
paul.bailey@gov.bc.ca

Banks, Daniel, MA
Exercise Coordinator
Washington State Department of Health
PO Box 47816
Olympia, Washington 98504-7816
360-236-4539 / Fax (360) 236-2299
dan.banks@doh.wa.gov

Barraza, Evelyn, MD, MPH
Preventive Medicine
Madigan Army Medical Center
Madigan Army Medical Center, ATTN: MCHJ-PV
Tacoma, Washington 98431
253-968-4487 / Fax 253-968-4483
evelyn.barraza@us.army.mil

Beaton, Randal, PhD, EMT
Research Professor
Northwest Center for Public Health Practice
University of Washington
Box 357263, University of Washington
Seattle, Washington 98195-7263
206-543-8551 / Fax 206.685.9551
randyb@u.washington.edu

Beech, Brian, BSc, MS (OEH), CIH, ROH
EPR -- CBRN Western Canada
Health Canada
515, 757 West Hastings Street
Vancouver, British Columbia V6C 1A1
604-666-3080 / Fax 604-666-7487
Brian_Beech@hc-sc.gc.ca
<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
<th>Address</th>
<th>Phone / Fax</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beery, Madeline, M Ed</td>
<td>Pan Flu Coordinator</td>
<td>WA State Dept. of Health</td>
<td>PO Box 47811</td>
<td>360-236-4270 / Fax 360-236-4245</td>
<td><a href="mailto:madeline.beery@doh.wa.gov">madeline.beery@doh.wa.gov</a></td>
</tr>
<tr>
<td>Berube, Sylvie, MBA</td>
<td>Regional Director</td>
<td>Public Health Agency of Canada</td>
<td>440F-757 West Hastings Street</td>
<td>604-666-7128 / Fax 604-666-8986</td>
<td><a href="mailto:sylvie_berube@phac-aspc.gc.ca">sylvie_berube@phac-aspc.gc.ca</a></td>
</tr>
<tr>
<td>Besser, Richard, MD</td>
<td>Director, Coordinating Office for Terrorism</td>
<td>Centers for Disease Control and Prevention</td>
<td>1600 Clifton Road NE MS D44</td>
<td>404-639-7405 / Fax 404-639-7977</td>
<td><a href="mailto:rbesser@cdc.gov">rbesser@cdc.gov</a></td>
</tr>
<tr>
<td>Blaske, Laura</td>
<td>Communication System Manager</td>
<td>Washington State Department of Health</td>
<td>PO Box 47890</td>
<td>360-236-4070 / Fax 360-236-4024</td>
<td><a href="mailto:laura.blaske@doh.wa.gov">laura.blaske@doh.wa.gov</a></td>
</tr>
<tr>
<td>Boon, Lauren</td>
<td>Health Services</td>
<td>National Defence - Canada</td>
<td>PO Box 10500 Stn Forces</td>
<td>(780) 973-4011 #4877 / Fax (780) 973-1402</td>
<td><a href="mailto:boon.lk2@forces.gc.ca">boon.lk2@forces.gc.ca</a></td>
</tr>
<tr>
<td>Bowness, Corey, BA</td>
<td>Policy Analyst</td>
<td>British Columbia Ministry of Health</td>
<td>5-2 1515 Blanshard St.</td>
<td>250-952-1622 / Fax 250 952-2205</td>
<td><a href="mailto:Corey.Bowness@gov.bc.ca">Corey.Bowness@gov.bc.ca</a></td>
</tr>
<tr>
<td>Brooks, Trewia, MPA</td>
<td>Public Health Advisor</td>
<td>CDC/COTPER/DSLR</td>
<td>1600 Clifton Road</td>
<td>404-639-7613 / Fax 404-639-7424</td>
<td><a href="mailto:tnb9@cdc.gov">tnb9@cdc.gov</a></td>
</tr>
<tr>
<td>Bryan, Robert, MA</td>
<td>Regional Director, Emergency Management</td>
<td>Vancouver Coastal Health Authority</td>
<td>Suite 721 - 601 West Broadway</td>
<td>604-875-5749 / Fax 604-875-5229</td>
<td><a href="mailto:robert.bryan@vch.ca">robert.bryan@vch.ca</a></td>
</tr>
<tr>
<td>Buell, Rick</td>
<td>Manager</td>
<td>Washington State Department of Health</td>
<td>PO Box 47890</td>
<td>360-236-4037 / Fax 360-586-7424</td>
<td><a href="mailto:rick.buell@doh.wa.gov">rick.buell@doh.wa.gov</a></td>
</tr>
<tr>
<td>Burke-Cain, Melissa, JD</td>
<td>Sr. Counsel</td>
<td>Washington State Attorney General</td>
<td>PO Box 40109</td>
<td>360-586-6500 / Fax 360-586-3564</td>
<td><a href="mailto:melissab@atg.wa.gov">melissab@atg.wa.gov</a></td>
</tr>
</tbody>
</table>
Butler, Jay, MD
State Health Officer; Director
Division of Public Health
State of Alaska Department of Health and Social Services
3601 C Street, Suite 540
Anchorage, Alaska 99503
907-269-8000 / Fax 907-561-6588
jay_butler@health.state.ak.us

Carmichael, Dave
Superintendent Aviation
BC Ambulance Service
PO Box 9600 Stn. Prov. Govt
Victoria, Canada V8W 9P1
250-952-6061 / Fax 250-953-3170
dave.carmichael@gov.bc.ca

Cetron, Martin, MD
Centers for Disease Control
1600 Clifton Rd., NE
Atlanta, Other 30329
404 639-4364 / Fax 404 639-4441
fpx9@cdc.gov

Chamberland, Susan
Secretary Admin
Department of Health
PO Box 47890
Tumwater, Washington 98501
360.236.4029 / Fax 360.586.7424
Susan.Chamberland@doh.wa.gov

Champine, Larry
Emergency Communications Specialist
WA State Department of Health
101 Israel Road
Tumwater, Washington 98501
360-236-4470 / Fax
larry.champine@doh.wa.gov

Chin, Neil
Biological Safety Officer
BC Centre for Disease Control/PHSA Labs
655 West 12th Avenue
Vancouver, British Columbia V5Z 4R4
604 660-4934 / Fax 604 660-6073
Neil.Chin@bccdc.ca

Christensen, Roger
Assistant Chief
Bellingham Fire Department
1800 Broadway Street
Bellingham, Washington 98225
360-676-6831 x102 / Fax 360-738-7312
rchristensen@cob.org

Christian, Ken
Director, Health Protection
Interior Health Authority
519 Columbia Street
Kamloops, British Columbia V2C 2T8
250-851-7309 / Fax 250-851-7339
ken.christian@interiorhealth.ca

Church, Tim
Communications Director
Department of Health
101 Israel Road, S.E.
Tumwater, Washington 98501-7890
360-236-4077 / Fax (360) 236-4024
timothy.church@doh.wa.gov

Cochrane, Cathy
Regional Communications Specialist
Spokane Regional Health District
1101 W. College Ave., #330
Spokane, Washington 99201
509-324-1689 / Fax 509-324-1507
ccochrane@spokanecounty.org
Cook, Greg, MD, MHSc
JTIFP Medical Advisor
Canadian Forces
8566 Moxon Terrace
N. Saanich, British Columbia  V8L 1K6
250-363-7067 / Fax 250-363-4405
cook.gj@forces.gc.ca

Copley, Brian, BA, MSP
Management Consultant
BC Centre for Disease Control
655 west 12th Avenue
Vancouver, British Columbia  V5Z 4R4
250-888-1432
brian.copley@bccdc.ca

Crouse, Karen
Director - Laboratory/Vital Records
Spokane Regional Health District
1101 W. College Ave.
Spokane, Washington 99201
509/324-1450 / Fax 509-324-1492
kcrouse@spokanecounty.org

Dalton, Peter, BA
Communications
Public Affairs, BC Ministry of Health
1515 Blanshard
Victoria, British Columbia  V8W 3C8
250-952-1280
peter.dalton@gov.bc.ca

Daly, Patricia, MD, FRCPC
Medical Health Officer
Vancouver Coastal Health
#800-601 West Broadway
Vancouver, British Columbia  V5Z 4C2
604-675-3924 / Fax 604-731-2756
patty.daly@vch.ca

D'Ambrosio, Luann, M Ed
Assistant Director
Northwest Center for Public Health Practice,
University of Washington
1107 NE 45th Street, Suite 400
Seattle, Washington 98105
206-543-2659 / Fax 206-616-9415
ldambr@u.washington.edu

Dauphinee, Wayne, BPE, MHA
Emergency Management Consultant
British Columbia Ministry of Health
854 Beckwith Ave
Victoria, British Columbia  V8X 3S3
250-216-3196
wayne.dauphinee@gov.bc.ca

David, Patrick, MD, FRCPC, MHSc
Director, Epidemiology Services
BC Center for Disease Control
655 West 12th Ave
Vancouver, Canada  V5Z 4R4
604-660-3199 / Fax 604-660-0197
david.partick@bccdc.ca

Dawson, Jacqueline, PhD
Region 7 Public Health Epidemiologist
Public Health
200 Valley Mall Parkway
E Wenatchee, Washington 98802
509-886-6428 / Fax 509-886-6449
Jacqueline.dawson@cdhd.wa.gov

Delahunt, Regina
Director
Whatcom County Health Department
509 Girard Street
Bellingham, Washington 98225-4005
360 676-6724 x 50801 / Fax 360 676-6771
rdelahun@whatcomcounty.us
<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
<th>Address</th>
<th>Phone/Fax</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dold, Cynthia, MPP, MPH</td>
<td>Healthcare Coalition Program Manager</td>
<td>Public Health – Seattle and King County</td>
<td>999 Third Ave, 12th Floor, Seattle, Washington 98199</td>
<td>206-205-0456</td>
<td><a href="mailto:cynthia.dold@metrokc.gov">cynthia.dold@metrokc.gov</a></td>
</tr>
<tr>
<td>Dopson, Stephanie, MSW, MPH</td>
<td>Terrorism Public Health Advisor</td>
<td>Centers for Disease Control</td>
<td>1600 Clifton Road, MS D-29, Atlanta, Other 30333</td>
<td>404-639-7441 / Fax 404-639-7424</td>
<td><a href="mailto:sld9@cdc.gov">sld9@cdc.gov</a></td>
</tr>
<tr>
<td>Douglas, Bill, MSW</td>
<td>Consultant</td>
<td>SP Associates</td>
<td>7560 Mark Lane, Victoria, British Columbia V9E 2A1</td>
<td>250-744-6192</td>
<td><a href="mailto:bill.douglas@canada.com">bill.douglas@canada.com</a></td>
</tr>
<tr>
<td>Edstrom, Bill, MPH</td>
<td>Epidemiologist</td>
<td>Spokane Regional Health District</td>
<td>1101 W College Avenue, Spokane, Washington 99208</td>
<td>509-324-1655 / Fax 509-232-1706</td>
<td><a href="mailto:wedstrom@spokanecounty.org">wedstrom@spokanecounty.org</a></td>
</tr>
<tr>
<td>Eimers, Garth, Masters in Engineering</td>
<td>Council President</td>
<td>North Region EMS &amp; Trauma Care Council</td>
<td>PO Box 547, Eastsound, Washington 98245</td>
<td>360-376-5441 / Fax 360-336-9236</td>
<td><a href="mailto:thezins@aol.com">thezins@aol.com</a></td>
</tr>
<tr>
<td>Embree, Glen</td>
<td>Manager - Environmental Health Services</td>
<td>Fraser Health Authority</td>
<td>11245-84th Avenue (2nd Floor), Delta, British Columbia V4C 2L9</td>
<td>604-507-5425 / Fax 604-507-5492</td>
<td><a href="mailto:glen.embree@fraserhealth.ca">glen.embree@fraserhealth.ca</a></td>
</tr>
<tr>
<td>Emerson, Brian, MD</td>
<td>Medical Consultant</td>
<td>BC Ministry of Health</td>
<td>4-2 1515 Blanshard St., Victoria, British Columbia V8W 3C8</td>
<td>250-952 1701 / Fax 250 952 1570</td>
<td><a href="mailto:brian.emerson@gov.bc.ca">brian.emerson@gov.bc.ca</a></td>
</tr>
<tr>
<td>Erickson, John</td>
<td>Special Assistant</td>
<td>Washington State Department of Health</td>
<td>P.O. Box 47890, Olympia, Washington 98504-7890</td>
<td>360-236-4034 / Fax 360-586-7424</td>
<td><a href="mailto:jlerickson@doh.wa.gov">jlerickson@doh.wa.gov</a></td>
</tr>
<tr>
<td>Ferguson, Susan, JD</td>
<td></td>
<td>Washington State Department of Health</td>
<td>PO Box 47890, Olympia, Washington 98504-7890</td>
<td>360-236-4011 msg / Fax 360-586-7424</td>
<td><a href="mailto:vashon12@msn.com">vashon12@msn.com</a></td>
</tr>
</tbody>
</table>
Finkbonner, Joe, RPh, MHA  
Executive Director  
Northwest Portland Area Indian Health Board  
527 SW Hall St, Suite 300  
Portland, Oregon 97201  
503-228-4185 / Fax 503-228-8182  
jfinkbonner@npaihb.org

Fleming, Ian, MD, MHSc  
CF Med LO to NORAD-USNORTHCOM  
Canadian Forces  
4155 Saddle Rock Rd.  
Colorado Springs, Other 80918  
719-554-5022 / Fax 719-554-7227  
fleming.im@forces.gc.ca

Flett, Glen, RN, BSN  
Program Clinical Leader  
BC Bedline  
4170 Still Creek Drive  
Burnaby, British Columbia V5C 6C6  
604-215-5909 / Fax 604-215-5927  
gflett@tcmtelecare.ca

Foster, Jennifer, MPH  
State Emergency Response Coordinator  
Washington State Department of Health  
20435 72nd Avenue South, Suite 200  
Kent, Washington 98032  
253-395-6716 / Fax 253-395-6759  
jennifer.foster@doh.wa.gov

Furtick, Jay, JD  
Assistant Regional Counsel  
HHS/Office of General Counsel  
2201 6th Avenue, Suite 902  
Seattle, Washington 98121  
206-615-2268 / Fax 206-615-2286  
jay.furtick@hhs.gov

Fyfe, Murray, MD  
Vancouver Island Health Authority  
430-1900 Richmond Ave  
Victoria, Canada  
250-519-7066  
murray.fyfe@viha.ca

Galanis, Eleni, MD  
BC Centre for Disease Control  
655 West 12th Ave  
Vancouver, British Columbia V5Z 4R4  
Fax 604-660-0197  
eleni.galanis@bccdc.ca

Gale, Jim  
Professor Emeritus, Epidemiology  
University of Washington  
Box 357236  
Seattle, Washington 98195  
206-543-8873  
jlg@u.washington.edu

Gautom, Romesh, MS, PhD  
Public Health Laboratories Director  
Washington State Department of Health  
1610 NE 150th St.  
Shoreline, Washington 98155  
206-418-5450 / Fax 206-418-5445  
romesh.gautom@doh.wa.gov

Gobis Ogle, Barbara, BSc(Pharm), ACPR, MScPhm  
VP Clinical Services  
Pharmacist Network  
445-5600 Parkwood Way  
Richmond, British Columbia V6V 2M2  
604-231-3245 / Fax 604-244-7835  
bogle@networkhealthcare.ca
Gow, Fiona, BA, LLB
Barrister & Solicitor
BC Ministry of Attorney General
P.O. Box 9280 Stn. Provincial Government
Victoria, British Columbia V9B 1N5
250-356-8453 / Fax (250) 356-8992
Fiona.Gow@gov.bc.ca

Grist, Christine, MA
BC Ministry of Health
Emergency Management Branch
1-2 1515 Blanshard Street
Victoria, British Columbia V8W 3C8
250-952-2795 / Fax 250-952-2072
christine.grist@gov.bc.ca

Harford, Bruce
Officer in Charge - International Programmes
British Columbia Ambulance Service
Suite 302 - 2955 Virtual Way
Vancouver, British Columbia V5M 4X6
604-660-6897 / Fax 604-660-6702
Bruce.Harford@gov.bc.ca

Harmon, TJ, MBA
Region 1 PHEPR Coordinator
Snohomish Health District
3020 Rucker Ave., Suite 300
Everett, Washington 98201
425-339-5278 / Fax 425-339-8706
tharmon@shd.snohomish.wa.gov

Harryman, Mike, BSB/M
Oregon Public Health Emergency Preparedness Manager
Oregon Department of Human Services
800 NE Oregon Street, Ste. 360
Portland, Oregon 97232-2162
971-673-1320 / Fax 971-673-1307
mike.harryman@state.or.us

Harveyman, Bonnie, MD, MPH, FRCCP
Physician Epidemiologist
BC Center for Disease Control
655 West 12th Ave
Vancouver, Canada V5Z 4R4
604-660-3199 / Fax 604-660-0197
bonnie.henry@bccdc.ca

Hastings, Heather, MPH
Officer in Charge
U.S. CDC
4306 SW 104th St
Seattle, Washington 98146
206-553-4519 / Fax 206-553-0855
hhh8@cdc.gov

Henry, Bonnie, MD, MPH, FRCCP
Physician Epidemiologist
BC Center for Disease Control
655 West 12th Ave
Vancouver, Canada V5Z 4R4
604-660-3199 / Fax 604-660-0197
bonnie.henry@bccdc.ca

Hofmann, Jo, MD
State Epidemiologist for Communicable Disease
WA State Dept of Health
1610 NE 150th Street
Shoreline, Washington 98155
206-418-5510 / Fax 206-418-5515
jo.hofmann@doh.wa.gov

Holliday, Martha, MPH
HHS Divion Director
Colville Tribes
PO Box 150
Nespelem, Washington 99155
509-634-2433 / Fax 509-634-2432
martha.holliday@colvilletribes.com

Holmgren, J. Christie, APR, B
Oregon Public Health Preparedness PIO
Oregon Dept. of Human Services
800 NE Oregon Street, Ste. 930
Portland, Oregon 97232
971-673-1310 / Fax 971-673-1299
christie.j.holmgren@state.or.us
Hotte, Alan  
A/Team Leader  
Public Health Agency of Canada  
130 Colonnade Rd.  
Nepean, Canada K1A 0K9  
613-957-7896 / Fax 613-952-3196  
alan_hotte@phac-aspc.gc.ca

Houck, Peter, MD  
Supervisory Medical Officer  
CDC - Quarantine  
6002 28th Ave NE  
Seattle, Washington 98115  
206-355-4676  
phouck@cdc.gov

Houze, Yolanda, BS  
Bioterrorism/Public Health Threats Lab Manager  
Washington State Public Health Lab  
1610 NE 150th St.  
Shoreline, Washington 98155  
206-418-5471 / Fax 206-418-2932  
yolanda.houze@doh.wa.gov

Howard, Mike, BA  
External Affairs Director  
Federal Emergency Management Agency  
(425) 487-4610  
mike.howard@dhs.gov

Isaac-Renton, Judith, MD, DPH, FRCP(C)  
BC Centre for Disease Control  
655 West 12th Avenue  
Vancouver, British Columbia V5Z 4R4  
604-660-1764 / Fax 604-660-6073  
judy.isaac-renton@bccdc.ca

Ives, Danette, MPA  
Health Department Director  
Port Gamble S'Klallam Tribe  
31912 Little Boston Road NE  
Kingston, Washington 98346  
(360) 297-9664 / Fax (360) 297-9615  
dives@pgst.nsn.us

James, Frank, MD  
Health Officer San Juan County  
San Juan County/Nooksack Tribe  
3511 Chuckanut Ave  
Bellingham, Washington 98229  
360-378-0447 / Fax (360) 378-4474  
frankjamesmd@comcast.net

Johnson, Chuck  
Emergency Response Coordinator  
Chelan-Douglas Health District  
200 Valley Mall Parkway  
East Wenatchee, Washington 98802  
509-886-6421 / Fax 509-886-6436  
chuck.johnson@cdhd.wa.gov

Johnson, Kammy, DVM, PhD  
Epidemiologist  
MT DPHHS  
1400 Broadway St Rm C-216  
Helena, Montana 59601  
406-444-7453 / Fax 406-444-0272  
drkjohnson@mt.gov

Jones, Maggie, MPH Candidate  
Research Assistant  
Northwest Center for Public Health Practice, University of Washington  
1107 NE 45th Street, Suite 400  
Seattle, Washington 98105  
206-685-2147 / Fax 206-616-9415  
mjones3@u.washington.edu
<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Organization/Address</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kind, Thomas</td>
<td>Quarantine Officer Supervisor</td>
<td>Public Health Agency of Canada</td>
<td><a href="mailto:thomas_kind@phac-aspc.gc.ca">thomas_kind@phac-aspc.gc.ca</a></td>
</tr>
<tr>
<td>Kirking, Darrel</td>
<td>Administrator</td>
<td>North Central Region EMS</td>
<td><a href="mailto:dkirking@northcentralems.net">dkirking@northcentralems.net</a></td>
</tr>
<tr>
<td>Kloes, Dale</td>
<td>Program Specialist</td>
<td>Whatcom Co. Sheriff/DEM</td>
<td><a href="mailto:dkloes@co.whatcom.wa.us">dkloes@co.whatcom.wa.us</a></td>
</tr>
<tr>
<td>Knight, Jeannie</td>
<td>Epidemiologist</td>
<td>Thurston County Public Health and Social Services Department</td>
<td><a href="mailto:knightj@co.thurston.wa.us">knightj@co.thurston.wa.us</a></td>
</tr>
<tr>
<td>Kocay, Debbie</td>
<td>Emergency Preparedness &amp; Response Officer</td>
<td>Public Health Agency of Canada</td>
<td><a href="mailto:debbie_kocay@phac-aspc.gc.ca">debbie_kocay@phac-aspc.gc.ca</a></td>
</tr>
<tr>
<td>Koenig, Leslie, MPH</td>
<td>Regional Emergency Response Coordinator</td>
<td>Region 8 PHEPR</td>
<td><a href="mailto:lesliek@bfhd.wa.gov">lesliek@bfhd.wa.gov</a></td>
</tr>
<tr>
<td>Kohn, Mel, MD, MPH</td>
<td>Oregon State Epidemiologist</td>
<td>Oregon State Public Health Division</td>
<td><a href="mailto:melvin.a.kohn@state.or.us">melvin.a.kohn@state.or.us</a></td>
</tr>
<tr>
<td>Kuschak, Theodore, B.Sc. (Hons) MSc PhD</td>
<td>Manager - CPHLN</td>
<td>Public Health Agency of Canada</td>
<td><a href="mailto:theodore_kuschak@phac-aspc.gc.ca">theodore_kuschak@phac-aspc.gc.ca</a></td>
</tr>
<tr>
<td>Lam, Andrea, MSc; BSc</td>
<td>Research Assistant</td>
<td>Ministry of Health</td>
<td><a href="mailto:andrea.lam@gov.bc.ca">andrea.lam@gov.bc.ca</a></td>
</tr>
<tr>
<td>LaPlante, Jay</td>
<td>Training and Outreach Specialist</td>
<td>Northwest Center for Public Health Practice, University of Washington</td>
<td><a href="mailto:jay11@u.washington.edu">jay11@u.washington.edu</a></td>
</tr>
</tbody>
</table>
Larke, Bryce, MD, DCI Sc
Yukon Medical Health Officer
Yukon Medical Health
4 Hospital Road
Whitehorse, YT, Other YT V1A EH8
867-667-5716 / Fax 867-667-8349
bryce.larke@gov.yk.ca

Larsen, Jonathan
Lieutenant
Seattle Fire Department
17210 68th Ave W
Edmonds, Washington 98026
206-386-1774 / Fax 206-386-1669
jonahtan.larsen@seattle.gov

Lavery, John
Executive Director
Emergency Management Branch
Ministry of Health
1515 Blanshard Street
Victoria, British Columbia V8W 3C8
250-952-1700 / Fax 250-952-1362
john.lavery@gov.bc.ca

Lavery, John
Executive Director
Emergency Management Branch
Ministry of Health
1515 Blanshard Street
Victoria, British Columbia V8W 3C8
250-952-1700 / Fax 250-952-1362
john.lavery@gov.bc.ca

Leonard, Jayme, BS, MSPH in progress
Public Health Microbiologist
Alaska State Virology Laboratory
901 Koyukuk Dr. AHB 239
Fairbanks, Alaska 99775
907-474-1969 / Fax 907-474-4036
jayme_leonard@health.state.ak.us

Leslie, Mira, DVM, MPH
PH Epidemiologist
Public Health Consulting
10017 11th ave NW
Seattle, Washington 98177
206-789-0449
miraleslie@stellaassociates.com

Lesperance, Ann, BA, MSPH
Sr. Public Health Researcher
Pacific Northwest National Laboratory
1100 Dexter Ave, Suite 400
Seattle, Washington 98109
206-528-3223 / Fax 206-528-3325
ann.lesperance@pnl.gov

Lindquist, Scott, MD MPH
Director of Health
Kitsap County Health District
345 6th Street, Suite 300
Bremerton, Washington 98337
360-337-5237 / Fax 360-475-9295
lindqs@health.co.kitsap.wa.us

Living, Patricia
Director, Communications, Health and Social Services
Yukon Health and Social Services
Box 2703
Whitehorse, Other Y1A 2C6
867-667-3673 / Fax 1-867-667-3096
patricia.living@gov.yk.ca

Locke, Thomas Locke, MD, MPH
Clallam and Jefferson County Health Officer
Clallam County Health Department
223 E. 4th Street, Suite 14
Port Angeles, Washington 98362
360-417-2437 / Fax (360) 417-2519
tlocke@co.clallam.wa.us
Loucks, Byron  
President  
JEL Protection Ltd.  
3191 Carman Street  
Victoria, British Columbia V8P 4M2  
250-888-3799 / Fax 250-370-7086  
jelprotection@shaw.ca

Lu, James, MD  
Medical Health Officer  
Vancouver Coastal Health  
7000 Westminster Highway  
Richmond, British Columbia V6X 1A2  
604-244-5129 / Fax 604.244.5191  
james.lu@vch.ca

Lyerly, William  
Director of International Affairs and Special  
Assistant for Global Health Security  
Immediate Office of the Assistant Secretary  
for Health Affairs, U.S. Department of  
Homeland Security  
388 Yorkshire Lane  
Riva, Other 21140  
202-441-6944 / Fax  
William.Lyerly@DHS.gov

MacDougall, Laura, MSc  
Epidemiologist  
BC Centre for Disease Control  
655 W 12th Avenue  
Vancouver, British Columbia V5Z 4R4  
604-660-0590 / Fax 604-660-0197  
laura.macdougall@bccdc.ca

MacEachern, Dorothy, MS, MPH  
Epidemiologist  
Spokane Regional Health District  
1101 W College  
Spokane, Washington 99201  
509-324-1569 / Fax 509-324-3623  
dmaceachern@spokanecounty.org

MacKenzie, Betsy, MHSc  
Regional EPR Coordinator  
Public Health Agency of Canada  
510-1230 Government Street  
Victoria, British Columbia V8W 3Y2  
250-363-3113 / Fax 250-363-0179  
betsy_mackenzie@phac-aspc.gc.ca

Mackin, James, BS  
Alaska Director of Public Health Preparedness  
Alaska Division of Public Health  
3601 C Street Suite 760  
Anchorage, Alaska 99503  
907-269-2040 / Fax 907-269-2048  
jim_mackin@health.state.ak.us

Manji, Natasha  
Communications  
Public Health Agency of Canada  
130 Colonnade Road  
Ottawa, Canada K1A 0K9  
613-957-4257 / Fax 613-941-3605  
natash_manji@phac-aspc.gc.ca

Manning, John, MPH  
Director  
San Juan County Health Dept.  
P.O. Box 607  
Friday Harbor, Washington 98250  
360-378-4474 / Fax 360-378-7036  
johnm@co.san-juan.wa.us

Marsden-Haug, Nicola, MPH  
Epidemiologist  
Washington State DOH  
1610 NE 150th St., MS K17-9  
Shoreline, Washington 98155  
206-418-5558 / Fax 206-418-5515  
Nicola.Marsden-Haug@DOH.WA.GOV
Martin, David
Graduate Research Assistant
OSU College of Health and Human Services
001 Milam Hall
Corvallis, Oregon  97331
541-737-9190 / Fax
martind@onid.orst.edu

Matsuyama, James, BS, Preventive Medicine
Director, Environmental Health
NE Tri-County Health District
PO Box 270
Colville, Washington  99114
509-684-2262 / Fax 509-684-8506
jmatsuyama@netchk.org

Mattson-Cooper, Shari
Region 1 & 7 Risk Communication Specialist
Snohomish Health District
3020 Rucker Ave., Suite 300
Everett, Washington  98277
425-339-5278 / Fax 425-339-8706
scooper@shd.snohomish.wa.gov

May, Judith, BSN, MPH
Bioterrorism Epidemiology and Surveillance Program Manager
Washington State Department of Health
1610 N.E. 150th Street
Shoreline, Washington  98155
206-418-5428 / Fax 206-418-5515
judith.may@doh.wa.gov

Mc Cartney, Ken, BSP
Deputy CEO/Director, Professional Services
British Columbia Pharmacy Association
Suite 1530-1200 West 73rd Avenue
Vancouver, British Columbia  V6P 6G5
604-269-2862 / Fax 604-261-2097
ken.mccartney@bcpharmacy.ca

McGee, Carrie
Admin Assistant
WA DOH
101 Israel St SE
Olympia, Washington  98504-7890
360-236-4032 / Fax 360-586-7424
carrie.mcgee@doh.wa.gov

McLaughlin, Joe, MD
Alaska Department of Health
3211 Providence Dr, DPL 404
Anchorage, Alaska  99508
907-269-8000
Joe_McLaughlin@health.state.ak.us

Meuse, Sabine, MPH
Program Analyst
Washington State Department of Health
PO Box 47890
Olympia, Washington  98504-7890
360-236-4069 / Fax 360-586-7424
sabine.meuse@doh.wa.gov

Michael, Howard
External Affairs Director
Department of Homeland Security
FEMA Region X
425-487-4610
mike.howard@dhs.gov

Mitchell, Robert, MD
Disaster Response Advisor
Stevens Hospital
9211 Cascade Drive
Edmonds, Washington  98020
425-879-3567 / Fax 425-640-4010
lvfrtennis@gmail.com
Morshed, Muhammad, PhD
Clinical Microbiologist
PHSA/BCCDC
655 West 12th Avenue
Vancouver, British Columbia  V5Z 4R4
604-660-6074 / Fax 604-660-6073
muhammad.morshed@bccdc.ca

Mowery, Bobbie
Executive Officer
U.S. Department of Health and Human Services
2201 6th Ave., Ste 1036, MS-01
Seattle, Washington  98121
206-615-2010 / Fax 206-615-2087
bobbie.mowery@hhs.gov

Moyer, Donn
Media Relations Manager
Department of Health
101 Israel Road, S.E.
Tumwater, Washington  98501-7890
360-236-4076 / Fax (360) 236-4024
donn.moyer@doh.wa.gov

Munn, Valerie, BA, MHPA
Coalition Coordinator
Washington Dept of Health
West 1500 4th Avenue, Suite 305
Spokane, Washington  99201
509-456-2726
valerie.munn@doh.wa.gov

Nault, Patricia, MPA
Health Program Manager
Alaska Division of Public Health
P. O. Box 110610
Juneau, Alaska  99811
907 465-8617 / Fax 907 465-8637
patricia_nault@health.state.ak.us

Nicholas, Cheryl, BSN
R1 Epidemiologic Response Coordinator
Snohomish Health Dist.  R1 PHEPR
3020 Rucker
Everett, Washington  98201
425-339-8712 / Fax 425-339-8706
cnicholas@shd.snohomish.wa.gov

Nickerson, Chris
Executive Director - Northern Region
BC Ambulance Service
3732 Opie Cres.
Prince George, Canada  V2N 4P7
250-614-9936
chris.nickerson@gov.bc.ca

Nicola, Bud, MD, MHSA
Assoc Prof; CDC Assignee
UW/ CDC
Box 357660
Seattle, Washington  98195-7660
(206) 221-6179
bnicola@u.washington.edu

Nienhuis, Shelley, BSN
Communicable Disease Nurse Coordinator
Fraser Health
32618 Logan Avenue
Mission, British Columbia  V2V 6C7
604-814-5546 / Fax 604-814-5517
shelley.nienhuis@fraserhealth.ca

Nieratko, Jennifer, MPH
Senior Analyst, Preparedness Policy
ASTHO
1275 K Street NW, Suite 800
Washington, Other  20010
202-715-1617 / Fax 202-371-9797
jnieratko@astho.org
Nordlund, Greg
Emergency Communications Specialist
Washington State Department of Health
101 Israel Rd SE
Olympia, Washington 98501
360-236-4427
greg.nordlund@doh.wa.gov

Nunes, Mark
Technical Advisor
WA State Hospital Association
425-531-2680
mtnunes@comcast.net

Oberle, Mark, MD, MPH
Assoc Dean for Public Health Practice
University of Washington, School of Public Health and Community Medicine
Box 357230
Seattle, Washington 98195-7230
206-616-9394 / Fax 206-543-3813
moberle@u.washington.edu

O'Connor, Brian, MD; MHSc
Medical Health Officer
Vancouver Coastal Health
132 West Esplanade
North Vancouver, British Columbia V7M 1A2
604-983-6701 / Fax 604-983-6839
brian.o'connor@vch.ca

O'Fallon, Shannon, JD
Sr. Assistant Attorney General
Department of Justice - Human Services Section
1515 SW 5th Ave., Suite 410
Portland, Oregon 97201
971-673-1880 / Fax 971-673-1902
shannon.ofallon@doj.state.or.us

Oswald, Tyler, BSc, LLB
Planning Assistant
BC Ministry of Health
(Population Health and Wellness)
1515 Blanshard St.
Victoria, British Columbia V8W 3C8
250-952-1716
toswald@gmail.com

Parker, Pamela, JD
Chief Counsel
HHS/Office of General Counsel
2201 Sixth Avenue, Suite 902
Seattle, Washington 98121
206-615-2268 / Fax 206-615-2286
pamela.parker@hhs.gov

Parker, Robert, MD, MHSc, FRCP(CM)
Interior Health Authority, BC
1340 Ellis Street
Kelowna, British Columbia V1Y 9N1
250-868-7832 / Fax 250-868-7826
robert.parker@interiorhealth.ca

Patrick, David, MD, FRCPC, MHSc
BC Centre for Disease Control
655 West 12th Ave
Vancouver, British Columbia V5Z 4R4
604-660-3199 / Fax 604-660-0197
david.patrick@bccdc.ca

Periwal, Sukumar
BC Intergovernmental Relations
548 Michigan Street
Victoria, British Columbia V8V 1S2
250-387-0761 / Fax 250-387-1920
sukumar.periwal@gov.bc.ca

78
Pollock, Gayle, RN
Director of EMS
Pend Oreille County Fire District #2
PO Box 435
Metaline Falls, Washington 99153
509-446-2240 / Fax 509-446-2406
lpollock@potc.net

Pollock, Larry
Chief
Pend Oreille County Fire District #2
PO Box 435
Metaline Falls, Washington 99153
509-446-2240 / Fax 509-446-2406
lpollock@potc.net

Rataul, Sangeeta, PhD
Regulatory Microbiologist
FDA / PRLNW
22201, 23rd Drive SE
Bothell, Washington 98275
425-483-4942 / Fax 425-483-4996
Sangeeta.Rataul@fda.hhs.gov

Reyna, Jesus, BSN, RN
Medical Reserve Corps Region X
HHS
2201 Sixth Ave.
Seattle, Washington 98121
206 615-3678 / Fax 206 615-2481
jesus.reyna@hhs.gov

Richards, Blair, MPH
Region 1 Surveillance Coordinator
Region 1 Public Health/Snohomish Health District
3020 Rucker Ave
Everett, Washington 98201
425-339-8713
brichards@shd.snohomish.wa.gov

Ricks, Jim
E911 Coordinator / Paramedic
San Juan County Sheriff
P.O. Box 669
Friday Harbor, Washington 98250
360-622-6911 / Fax 360-378-7125
e911sanjuan@rockisland.com

Riehm, Barbara, RN, MSN
RN, Region IV Epi
Region IV PHERP, Clark County Public Health
17409 NE Stoney Meadows Drive
Vancouver, Washington 98682
360-397-8003
barbara.riehmk@clark.wa.gov

Rocheleau, Catherine, MBA, RD
Executive Director
NutritionLink Services Society
Suite 649, 718-333 Brooksbank Avenue
North Vancouver, British Columbia V7J 3V8
604-984-6828 / Fax 604-984-6899
crochele@axion.net

Roohi, Shah, RN, MPH
Officer in Charge
CDC Anchorage Quarantine Station
4600 Postmark Drive, STE NC206
Anchorage, Alaska 99515
907-271-6301 / Fax 907-271-6325
sroohi@cdc.gov

Roper, Joyce, JD
Sr. Assistant Attorney General
Washington State Office of the Attorney General
PO Box 40109
Olympia, Washington 98504-0109
360-586-6500 / Fax 360-586-3564
JoyceR@atg.wa.gov
<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Role</th>
<th>Organization</th>
<th>Address</th>
<th>Phone/Fax</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rowe, Charles</td>
<td>Corporate Director</td>
<td>Vancouver Island Health Authority</td>
<td>1952 Bay Street, Victoria, British Columbia V8R 1J8</td>
<td>250-370-8111 / Fax 250-370-8750</td>
<td><a href="mailto:chuck.rowe@viha.ca">chuck.rowe@viha.ca</a></td>
</tr>
<tr>
<td>Ruth, Patricia</td>
<td>BC Ministry of Health</td>
<td></td>
<td>4th fl, 1515 Blanshard, Victoria, British Columbia V8W 3C8</td>
<td>250 952-1110 / Fax 250 952-1713</td>
<td><a href="mailto:Patricia.Ruth@gov.bc.ca">Patricia.Ruth@gov.bc.ca</a></td>
</tr>
<tr>
<td>Sadovich, Julie, PhD</td>
<td>Director, EMMRI</td>
<td>DHS/OHA</td>
<td>Washington DC, Other 20528</td>
<td>202-254-5652 / Fax 202-254-2295</td>
<td><a href="mailto:julie.sadovich@dhs.gov">julie.sadovich@dhs.gov</a></td>
</tr>
<tr>
<td>Sandvik, Heleen</td>
<td>Provincial Coordinator</td>
<td>Ministry of Health</td>
<td>555 West 12 ave, Vancouver, British Columbia V5Z 3X7</td>
<td>604-877-6000 ext 2316 / Fax 604-877-6146</td>
<td><a href="mailto:hsandvik@phsa.ca">hsandvik@phsa.ca</a></td>
</tr>
<tr>
<td>Schmitz, Lourdes, BA, GCPH</td>
<td>Health Services Manager</td>
<td>Port Gamble S’Klallam Tribe</td>
<td>31912 Little Boston Road NE, Kingston, Washington 98346</td>
<td>360-297-9664 / Fax (360) 297-9615</td>
<td><a href="mailto:lrschmitz@pgst.nsn.us">lrschmitz@pgst.nsn.us</a></td>
</tr>
<tr>
<td>Schwartz, Benjamin, MD</td>
<td>Senior Science Advisor</td>
<td>National Vaccine Program Office</td>
<td>1600 Clifton Rd, NE, Mailstop E-05, Atlanta, Other 30333</td>
<td>404 639-8953 / Fax 404 639-0108</td>
<td><a href="mailto:bxs1@cdc.gov">bxs1@cdc.gov</a></td>
</tr>
<tr>
<td>Sciberras, Jill, BNSc, MHSc</td>
<td>Public Health Agency of Canada</td>
<td></td>
<td>PL 0602B Tunney's Pasture, Ottawa, Other K1A 0K9</td>
<td>905-841-0999 / Fax 905-841-2544</td>
<td><a href="mailto:jill_sciberras@phac-aspc.gc.ca">jill_sciberras@phac-aspc.gc.ca</a></td>
</tr>
<tr>
<td>Selecky, Mary</td>
<td>Secretary of Health</td>
<td>WA State Department of Health</td>
<td>PO Box 47890, Olympia, Washington 98504-7890</td>
<td>360-236-4030 / Fax 360-586-7424</td>
<td><a href="mailto:secretary@doh.wa.gov">secretary@doh.wa.gov</a></td>
</tr>
<tr>
<td>Sergienko, Eric, MD</td>
<td>Head Public Health Emergency Planning</td>
<td>Navy Medicine</td>
<td>2427 Summit Ridge Drive, Odenton, Other 21113</td>
<td>202-962-0473</td>
<td><a href="mailto:emsergienko@us.med.navy.mil">emsergienko@us.med.navy.mil</a></td>
</tr>
<tr>
<td>Seydel, Angela</td>
<td>Risk Communications</td>
<td>Region 8 PHEPR</td>
<td>100 N. Fruitland Suite D, Kennewick, Washington 99338</td>
<td>509-586-0673 x2 / Fax 509-582-0164</td>
<td><a href="mailto:angelas@bfhd.wa.gov">angelas@bfhd.wa.gov</a></td>
</tr>
<tr>
<td>Name</td>
<td>Title and Affiliation</td>
<td>Address</td>
<td>Phone / Fax</td>
<td>Email</td>
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</tr>
<tr>
<td>Shapiro, Peggi</td>
<td>Director, Disaster Readiness, WA State Hospital Association</td>
<td>300m Elliott Ave West Suite 300, Seattle, Washington 98119</td>
<td>206-216-2864 / <a href="mailto:peggis@wsha.org">peggis@wsha.org</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sheridan, Amy, BFA</td>
<td>Emergency Management Analyst, Ministry of Health</td>
<td>4-2, 1515 Blanshard Street, Victoria, British Columbia V9E 2C3</td>
<td>250-952-3334 / Fax 250-952-1713 / <a href="mailto:Amy.Sheridan@gov.bc.ca">Amy.Sheridan@gov.bc.ca</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shirley, Gayle</td>
<td>Public Affairs Officer, Montana Dept. of Public Health &amp; Human Services</td>
<td>PO Box 4210, Helena, Montana 59604</td>
<td>406-444-2596 / 406-444-1970 / <a href="mailto:gshirley@mt.gov">gshirley@mt.gov</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smith, Barbara, BSN</td>
<td>Nurse Epidemiologist, Alaska Division of Public Health - Section of Epidemiology</td>
<td>3601 C. Street, Suite 540, Anchorage, Alaska 99503</td>
<td>907-269-8023 / Fax 907-562-7802 / <a href="mailto:barb_smith@health.state.ak.us">barb_smith@health.state.ak.us</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smith, Michael, BA, MPA</td>
<td>EMS Terrorism and Disaster Response, DOH/EMS</td>
<td>1500 W 4th Ave, Suite 403, Spokane, Washington 99201</td>
<td>509-456-2904 / Fax 509-456-3127 / <a href="mailto:mike.smith@doh.wa.gov">mike.smith@doh.wa.gov</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soldier, Robert, MPH</td>
<td>Emergency Response Planner, WA DOH</td>
<td>1610 NE 150th Street, Shoreline, Washington 98155</td>
<td>206 418 5542 / Fax 206 418 5445 / <a href="mailto:Robert.Soldier@doh.wa.wa">Robert.Soldier@doh.wa.wa</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soloway, Laurie, BEd, MEd, LLB</td>
<td>Barrister &amp; Solicitor, British Columbia Ministry of Attorney General</td>
<td>P.O. Box 9280 Stn. Provincial Government, Victoria, British Columbia V8W 9J7</td>
<td>250-387-0697 / Fax 250-356-8992 / <a href="mailto:Laurie.Soloway@gov.bc.ca">Laurie.Soloway@gov.bc.ca</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solven, Suzanne, BSc Pharm</td>
<td>Deputy Registrar, College of Pharmacists of BC</td>
<td>200-1765 West 8th Ave, Vancouver, British Columbia V6J 5C6</td>
<td>604-676-4202 / Fax 604-733-2493 / <a href="mailto:suzanne.solven@bcpharmacists.org">suzanne.solven@bcpharmacists.org</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stanwick, Richard, MD, MSc, FRCPC, FAAP</td>
<td>Chief Medical Health Officer, Vancouver Island Health Authority</td>
<td>1900 Richmond Avenue, #430, Victoria, British Columbia V8R 4R2</td>
<td>250-519-7066 / Fax 250-519-7079 / <a href="mailto:richard.stanwick@viha.ca">richard.stanwick@viha.ca</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stergachis, Andy, PhD, RPh</td>
<td>Professor, Northwest Center for Public Health Practice, University of Washington</td>
<td>1107 NE 45th St, Ste 400, Seattle, Washington 98105</td>
<td>206-616-9460 / Fax 206-616-9415 / <a href="mailto:stergach@u.washington.edu">stergach@u.washington.edu</a></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Stergachis, Katherine, BA
Student
Gonzaga University School of Law
PO Box 3528, 721 N Cincinnati St
Spokane, Washington 99220
206-972-0959
kstergachis@lawschool.gonzaga.edu

Stern, Greg, MD
Health Officer
Whatcom County Health Department
509 Girard Street
Bellingham, Washington 98225
360-676-6724 ext 50800 / Fax 360-676-7646
gstern@co.whatcom.wa.us

Stevermer, Andrew, MSN, ARNP
Regional Nurse Practitioner
DHHS, ASPR
MS RX-20 2201 Sixth Ave
Seattle, Washington 98121
206-615-2266 / Fax 206-615-2481
andrew.stevermer@hhs.gov

Stout, Kathy, JD
Privacy Officer
Department of Health
PO Box 47890
Olympia, Washington 98504-7890
360-236-4221 / Fax 360-236-3706
kathy.stout@doh.wa.gov

Taunton, Jack, MSc MD, Dipl Sport Medicine (CASM)
Dr
VANOC
3585 Graveley Street
Vancouver, British Columbia V5K 5J5
778-328-6288 / Fax 778-328-2011
jack_taunton@vancouver2010.com

Turnberg, Wayne, PhD, MSPH
Epidemiologist
Washington State Department of Health
1610 NE 150th Street, MS:K17-9
Shoreline, Washington 98155
206-418-5559 / Fax 206-418-5515
wayne.turnberg@doh.wa.gov

Van Buren, Jude, DrPH, MPH, RN, RS
Assistant Secretary
Department of Health
PO Box 47811
Olympia, Washington 98504-7811
360-236-4204 / Fax 360-236-4245
Jude.VanBuren@doh.wa.gov

Vanderwagen, Craig, MD
Assistant Secty, Preparedness and Response
US-HHS
12105 Blue Paper Trail
Columbia, Other 21044
301-854-3416
william.vanderwagen@hhs.gov

VanSant, John
Regional Emergency Response Coordinator
Spokane Regional Health District
1101 W. College Ave
Spokane, Washington 99201
509-324-1669 / Fax 509-232-1706
jvansant@spokanecounty.org

Vedder, Karen
Deputy Prosecuting Attorney
San Juan County Prosecutor's Office
P. O. Box 760
Friday Harbor, Washington 98250
360-378-4101 / Fax 360-378-3180
karenv@co.san-juan.wa.us
Vega, Robert
Oregon State Public Health Laboratory
1717 SW 10th Avenue
Portland, Oregon 97201
503-229-5882
robert.vega@state.or.us

Wadstein, Deanna
Communications Officer
Interior Health
#200 1815 Kirschner Road
Kelowna, British Columbia V1Y 4N7
250-870-5898 / Fax 250-870-4682
dee.wadstein@interiorhealth.ca

Walden, Jeremy
Admin Assistant
BC Ministry of Health
655 Belleville Street
Victoria, Canada V8V 1X4
250-953-3547
jeremy.walden@gov.bc.ca

Weaver, Ron
Joint Chief Of Staff
Wa. Military Dept
WA. NAT. Guard Bld 1
Camp Murray, Washington 98430-5000
253-512-8530 / Fax 253-512-8497
ronald.weaver@wa.ngb.army.mil

Weber, Anne, MS
Laboratory Director
Montana Public Health Laboratory
PO Box 6489
Helena, Montana 59604
406-444-5559 / Fax 406-444-1802
aweber@mt.gov

Wentworth, Pat, RN, MS
Director - Trauma, Emergency and Observation Services
St. Joseph Hospital
2901 Squalicum Parkway
Bellingham, Washington 98225
360-788-6727 / Fax 360-738-6335
pwentworth@peacehealth.org

White, James
Lt. Colonel
U.S. Northern/Surgeon General
jamesmac.white@us.army.mil

Wiedrich, Tim
Section Chief
North Dakota Department of Health
Emergency Preparedness & Response
918 E Divide Avenue-Suite 107
Bismarck, Washington 58501-1959
701-328-2270 / Fax 701-328-0357
twiedric@nd.gov

Williams, Chris, MA
Healthcare Preparedness System Manager
Washington State Department of Health
PO Box 47890
Olympia, Washington 98504-7890
360-236-4075 / Fax 360-586-7424
chris.williams@doh.wa.gov

Wing, Ken, JD, MPH
Professor
Seattle University Law School
5009 N. Mildred St
Tacoma, Washington 98407
206-398-4031
kwing@seattleu.edu
Wohrle, Ron, DVM
Environmental Health Veterinarian
WA, DOH
PO Box 47825
Olympia, Washington 98504-7825
360-236-3369 / Fax
ron.wohle@doh.wa.gov

Young, Eric, MD, BSc, MHS, CCFP, FRCPC
Deputy Provincial Health Officer
BC Ministry of Health
1515 Blanshard Street
Victoria, British Columbia V8W 3C8
250-52-1329 / Fax 250-952-1362
eric.young@gov.bc.ca

Young, James, MD
Special Advisor to the Deputy Minister
Public Safety Canada
4900 Yonge Street, Suite 240
Toronto, Canada M2N 6A4
416-952-3115 / Fax 416-973-2362
james.young@ps.gc.ca

Zimmerman, Gail, BA
Meeting Coordinator, WA State PHEPR
Stakeholder Coordinator
Department of Health
PO Box 47890
Olympia, Washington 98501
360-236-4087 / Fax 360-586-7424
gail.zimmerman@doh.wa.gov