Part 1: WHO WE ARE

We save lives and protect the people of Washington from the health threats of public health emergencies.

Purpose
The public relies on the Department of Health (DOH) to be ready for all public health hazards, to make the best decisions during crisis situations, and to deliver critical response capability when and where it is needed. The Office of Emergency Preparedness and Response (EPR) facilitates the development of response capabilities and strategic partnerships across DOH and with a variety of external organizations. The quality of our work and the proficiency of our efforts affect every person in Washington and reflect the character of our organization. This responsibility to our communities implores us to strive for excellence in our work.

Mission Statement
The Office of Emergency Preparedness and Response strengthens all-hazards preparedness capabilities within DOH and supports local, state, tribal and non-profit partners in preparing for, responding to, and recovering from the health impacts of disasters.

Values
To create a culture of excellence within our office, we are committed to practicing and advancing the following values:

- **Integrity**: Accountable to ourselves, each other, partners, customers, and funders; dependable and reliable.
- **Competency**: Sufficient skills, knowledge, attitude, experience to be proficient in job duties, & seek continuous improvement.
- **Collaboration**: Work with partners, communities, and each other to meet program strategic goals.
- **Team**: Knowing ourselves and how we contribute as productive team members working towards the program mission.
- **Honesty**: Transparent, truthful, and forthright.
- **Respect**: Treat each other with dignity.
- **Achievement**: Recognize individual and team accomplishments.
- **Ethics**: Exercise professional judgment to ensure we are doing the right things for the right reasons.
- **Trust**: Empower all to make the best decisions.
I see DOH as an all-hazards, first-response agency that works in tandem with local health jurisdictions, tribal nation, and other partners across the state to react quickly and effectively when an emergency or disaster occurs. For our agency to succeed in protecting the health and safety of Washingtonians, each one of us has to have the skills necessary to fulfill our roles in an emergency.

John Wiesman
Secretary of Health
Part 2: PRIORITIES

Over the past decade, we have invested in preparedness activities across Washington State, and in so doing have created valuable partnerships and strengthened foundational emergency response capabilities within DOH and across local health jurisdictions (LHJs), tribal nations, and healthcare system partners.

We enhanced state and local disease surveillance capabilities, and greatly improved the capacity and efficiency of our state public health lab. We provided basic, intermediate, and advanced incident command training to many partners from local health, local emergency management, healthcare organizations, other state agencies, and tribal nations. We improved risk communications materials. We established and maintain eight healthcare coalitions, improved healthcare facility plans, trained healthcare staff, and acquired vast amounts of medical supplies and equipment.

However, throughout 2014, public health disasters challenged our collective ability to initiate, coordinate, and lead a comprehensive Emergency Support Function 8 (ESF–8) response: the State Route 530 Slide, the multi-county measles and pertussis outbreaks, the Carlton Complex Fire, and our statewide response to the Ebola threat. For over 100 days between March and November 2014, we mobilized an array of capabilities including:

- fatality management
- behavioral health response
- medical surge response in support of evacuating healthcare facilities
- environmental health response to air and water quality impacts
- disease surveillance
- lab testing
- isolation and quarantine response
- emergency operations and incident command
- risk communications
- responder safety and health
- continuity of operations
- support for our most vulnerable and disproportionately impacted community members

Although the dedication and commitment of local public health staff, tribes, healthcare facilities, and DOH through each incident was outstanding, our ability to quickly mobilize robust response capabilities across the state remains limited.

For small or large incidents involving single counties, tribal nations, or the entire state; we must be ready to mobilize an efficient and well-resourced health, medical, and mortuary response anywhere in Washington, whenever the need arises.

After 12 years of preparing, we must shift our energy to developing and enhancing measurable statewide public health and healthcare response and recovery capability.

In support of the Secretary’s priorities for DOH and in recognition of the health impacts during disasters, we focused our efforts on the following priorities to become a national leader in public health preparedness:

First Priority
We will develop and sustain operational readiness within DOH to ensure we can respond effectively to disasters. We will establish a team of well trained, equipped, experienced, knowledgeable and motivated public health professionals to lead DOH’s response during disasters.
We can deploy staff to support local jurisdictions or other states in need. Operational readiness is our top priority.

a. Determine and communicate the roles and responsibilities for DOH Policy Group, Incident Management Team (IMT), and public health response teams.

b. Establish an Agency Coordination Center (ACC) with the communications infrastructure to effectively support the Policy Group and DOH IMT.

c. Develop a training curriculum for emergency operations personnel that includes incident leadership as well as the traditional Incident Command training.

d. Develop DOH policies, tools and protocols to support emergency response operations.

e. Recruit staff and external partners, and train them to serve in emergency response roles.

f. Clarify roles and responsibilities between DOH's IMT and the State Emergency Operations Center (EOC) during disasters.

g. Develop a framework to support policy decision-making for the Secretary of Health in during disasters.

Second Priority
We will implement strategic initiatives that increase and sustain statewide disaster response capability. Through innovation and partnerships, we will establish and communicate clear, strategic direction for enhancing statewide capabilities over time. We will anticipate opportunities and challenges, and proactively adjust course to gain the greatest advantage.

a. Develop and expand strategic partnerships with public, private, and non-profit entities as part of a “whole community” approach to preparedness.

b. Emphasize partnerships that directly support statewide response efforts (e.g., create a Disaster Medical Advisory Committee in support of the Secretary; developed partnerships for all-hazards health information call center; continue developing partnerships with pharmacies and large health systems; and facilitate implementation of statewide mutual aid agreements for LHJs).

c. Prioritize competitive opportunities so our partner organizations can develop innovative ideas to help build greater statewide, sustainable capability.

Third Priority
We will support preparedness efforts of tribal nations, LHJs, healthcare systems, and other partners across Washington. We will assist our partners in identifying preparedness priorities, prioritizing gaps, and standardizing capability across the state.

a. Using the Public Health Emergency Preparedness (PHEP) capabilities, we will assist LHJs in identifying local preparedness priorities.

b. Consult with and support tribal nations in identifying tribal preparedness priorities.

c. Support regional healthcare coalitions in developing sustainable structures for maintaining preparedness activities into the future.

d. Identify opportunities to standardize capabilities across LHJs and healthcare systems statewide.

Goals

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<tr>
<td>Our value is known by our customers and stakeholders.</td>
<td>Our statewide technology systems and infrastructure are aligned to add value to our customers, partners, and stakeholders.</td>
<td>Our program can support the needs of the public health and medical system as it surges to respond to threats.</td>
<td>Our internal and external customers, stakeholders, and partners are diverse, engaged, and moving forward with a common purpose across the response network.</td>
<td>Our program is healthy both organizationally and financially to continue public health and medical emergency preparedness services.</td>
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## Performance Measures

1. Percent of DOH staff completing Public Health Infrastructure Training (PHIT).
2. Total number of DOH trained staff assigned to emergency response roles.
3. Percent of Technical Assistance site visits completed.
4. Number of contract amendments generated due to processing issues.
5. Percent of Washington State population within 5 miles of a pharmacy signed to statewide agreement.
6. Percent of DOH emergency response team members fully trained for their position.
7. Percent of DOH emergency response teams completing exercises according to exercise plans.
8. Percent of Corrective Action Program improvement plan items completed by due date.
9. Percent of DOH Duty Officer notifications received not related to an emergency incident.
10. Percent of DOH Duty Officer notifications routed successfully.
12. Percent of EPR staff professional development objectives completed.
13. Percent of successful DOH SECURES alerts (high/medium) confirmed within 60 minutes of receipt by LHJs.
14. Percentage of DOH staff with active SECURES accounts.
15. Successful DOH SECURES alerts (high/medium) confirmed within 60 minutes of receipt by DOH staff.

“We implemented sweeping changes to the statewide health and medical preparedness program. We became much more response–focused, and transformed the process for allocating grant resources.”

Michael Loehr
Chief of Emergency Preparedness and Response
Part 3: FUNDING

EPR develops partnerships to respond to and recover from emergency events that can affect the public’s health.

EPR Program and Funding

EPR works to build sustainable and effective statewide emergency response capabilities. We fund activities through two federal preparedness program grants: PHEP grant from the Centers for Disease Control and Prevention (CDC) and HPP grant from the Assistant Secretary for Preparedness and Response (ASPR). The two grants require us to develop capabilities that will increase our readiness for any emergency. We provided $16,180,780 in direct funding (approximately 65 percent of our program funding) to LHJs, tribal nations, and other partners.

For the 2014–2015 fiscal year, DOH experienced a 39.8% reduction in HPP funding and a 5.5% increase in PHEP funding, resulting in an overall loss in statewide public health and medical preparedness funding from the previous year of $2,152,818. After gathering input from healthcare coalition representatives, DOH quickly revised preparedness and budget priorities for the HPP program. Maintaining planning functions at the coalition level, providing training to healthcare providers, and developing statewide medical surge capability became the top priorities while equipment purchases were eliminated. This shift in program priorities enables us to pursue core healthcare response and recovery capability while addressing a dramatic loss of revenue.
Funding July 1, 2014 to June 30, 2015

- CDC Base: 44.57% ($11,064,407)
- ASPR Base: 16.97% ($4,211,758)
- ASPR Ebola part A: 14.04% ($3,485,778)
- CDC Ebola Supplemental #2: 10.26% ($2,547,759)
- ASPR Ebola part B: 9.6% ($3,485,778)
- CDC Cities: 4.29% ($1,064,071)
- CDC Ebola: 0.27% ($66,381)
PHEP Grant Spending  July 1, 2014 to June 30, 2015

- **Operational Readiness**: 12%
- **Training for partners**: 3%
- **Risk Communications**: 2%
- **Lab and Epi Information Technology Training**: 6%
- **Epidemiology/ Surveillance**: 3%
- **Laboratory (Bio and Chem)**: 5%
- **Ebola**: 2%
- **CRI**: 1%
- **Administrative**: 5%

HPP Grant Spending  July 1, 2014 to June 30, 2015

- **Base work**: 19%
- **Training for partners**: 4%
- **Ebola**: 2%
- **Partners**: 75%
Part 4: ACCOMPLISHMENTS

During this grant year, we responded to multiple disasters, trained over 500 people and participated in exercises. We developed response teams to address public health emergencies for a variety of incidents and we will continue to evaluate the teams and conduct regular drills in the coming years.

Developed Incident Management Teams and Response Teams

In 2014, we increased our focus on emergency response training, by offering position-specific training and team based ICS training. By July 2015, we developed seven teams to respond to public health emergencies:

Reception Staging and Storage (RSS) Task Force
This task force receives, tracks, and distributes medical resources throughout the state during a public health response. Supplies may come from the Strategic National Stockpile (SNS) as a 12-hour push package or managed inventory. Medical resources are delivered to local entities to distribute via Points of Dispensing (PODs) and to other health systems/facilities. During demobilization, the team can effectively recover unused medical resources, conduct inventories, and return to pre-incident levels.

Team Size: 68

Incident Management Teams (IMT)
These teams provide leadership during a public health emergency. These teams can response to multi-region, multi-jurisdiction, or statewide incidents. They provide on-scene command and control for an incident that requires direct response, support, and coordination at an Emergency Operation Center (EOC), or can assist a jurisdiction’s response team. The IMTs also have the capability for coaching other response team members in how to provide command and control. These teams are ready to be deployed with a full set of command and general staff.

Team Size: 57

Environmental Health Strike Team
This team has the capacity to identify and reduce environmental threats to human health from water, food, waste, and indoor and outdoor air. The team can manage environmental health tactical operations, develop environmental health procedures/systems, activate environmental health response capabilities, and demobilizing environmental health operations.

Team Size: 18

Epidemiology (Epi) Task Force
This team has the capability to identify, monitor, and investigate disease outbreaks, injuries, or other conditions of public health concerns. The team can provide this function with 24-hour coverage. The Epi Task Force has the capacity to use interoperable software and hardware tools necessary to communicate in secure and unsecured environments. The team is ready to deploy with the applicable Personal Protective Equipment (PPE) and diagnostic tools to conduct epidemiological surveillance and investigations.

Team Size: 28
Radiation Response Team
This team is composed of technical staff and subject matter experts from the DOH Office of Radiation Protection (ORP). When notified of a radiological emergency, the team is dispatched to various emergency response centers. Field monitoring staff will be dispatched to the incident site to gather in-field measurements and samples or to assist at local hospitals or provide other support to the local responders.

Technical staff at the facility response center or incident command post assess radiological information to pass on to local decision makers. Subject matter experts will review the radiological information provided by the assessment staff and the involved facility and provide Protective Action Recommendations to the local government based on radiological information. Other subject matter experts will assist public information officers with interpreting the technical information and providing a unified message to the public. **Team Size: 23**

Public Health and Medical Task Force
This task force provides immediate and ongoing assessments of public health and medical systems of a disaster-affected community. A health system consists of all organizations, people, and actions whose primary intent is to promote, restore, or maintain health. The team has the capability to conduct initial and ongoing system-level assessments of medical and public health resources/infrastructure. The task force is able to be fully functional and operate in a low-tech post-disaster environment. This team is equipped with tools, transportation, and supplies to conduct windshield surveys (observations made from a moving vehicle) as well as Community Assessment for Public Health Emergency Response (CASPER) surveys of the community as needed in post-disaster environments. **Team Under Development**

Construction Review Services Strike Teams
These teams provide two trained Washington Safety Assessment Facility Evaluation (WAsafe) building evaluators and one Structural Engineers Association of Washington licensed structural engineer with a vehicle and sufficient supplies for 3-5 days’ operations. These teams are trained and experienced in assessing post-disaster conditions in healthcare construction and licensed healthcare facilities **Team Size: 9**

In the coming year, we will continue to provide emergency response training and recruit new members for the teams.

Number of Staff Trained

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<tr>
<td><strong>Prerequisite Trainings</strong></td>
<td><strong>249</strong></td>
<td><strong>533</strong></td>
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<tr>
<td><strong>Position Specific Trainings</strong></td>
<td><strong>126</strong></td>
<td><strong>210</strong></td>
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<tr>
<td><strong>FEMA &amp; NIMS Trainings</strong></td>
<td><strong>92</strong></td>
<td><strong>56</strong></td>
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<td><strong>267</strong></td>
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Conducted Exercise

Annual Preparedness Exercise (APEX) Medical Countermeasures
We conducted the APEX Medical Countermeasures exercise on October 1-2, 2014. This full-scale Medical Countermeasure exercise involved over 90 agency staff and partners, including sponsors Public Health Seattle and King County, Tacoma – Pierce County Health Department, Snohomish Health District, Kitsap Public Health District, and Northwest Healthcare Response Network.

The overarching objectives were to assess the capability of the participating agencies to:
• Implement medical countermeasure plans and procedures to respond to a biological incidents including requesting medical countermeasure resources,
• Dispense medical countermeasures to impacted population, and
• Receive and distribute medical resources (pharmaceuticals) at dispensing sites and healthcare facilities.

Additionally, the exercise provided an opportunity for all participants to assess the capability of local, state, and federal emergency operations centers to support response efforts including fulfilling resource requests, deploying response teams, sharing information, and coordinating emergency operations.

A key aspect of this exercise was testing protocols for rationing limited amounts of medical supplies across affected jurisdictions and across different dispensing modalities (e.g., pharmacies and health systems). DOH policy leaders coordinated with a variety of partners to discuss and decide upon proportional allocations to pharmacy chains, healthcare systems, LHJs, and tribal nations.

APEX Medical Countermeasure exercise at the DOH warehouse - Tumwater, WA
Responded to Incidents

2014 Carlton Complex Fire

The 2014 Washington wildfires were a series of 1,480 wildfires that burned 386,972 acres over the course of the year. The largest fire started by lightning strikes on July 14, 2014 in the Methow River valley of Okanogan County. The original four fires merged and rapidly spread southeast on July 17, burning approximately 300 homes in and around the towns of Pateros and Malott and other rural areas. Fire threatened the towns of Brewster, Carlton, and Methow. Twisp and Winthrop lost power for extended periods of time.

DOH activated its IMT to coordinate the agency’s response to the health effects of this record-breaking year of wildfires. The DOH IMT officially assumed the mission of supporting our LHJs, tribal nations, and healthcare partners on July 21, 2014, although DOH had been supporting our partners in this incident by leading the ESF–8 position at the State EOC, several days earlier. The DOH Environmental Public Health offices and Communications office also coordinated with local partners prior to the DOH IMT activation offering public communication about health effects of smoke inhalation and drinking water announcements. Once the DOH IMT was activated, all DOH response activities were coordinated through the IMT.

National Guard medics provided medical support to wildland firefighters. Some of these personnel were not certified Emergency Medical Technicians (EMTs) in Washington State so DOH Health Systems Quality Assurance staff activated an emergency credentialing system to allow them to respond to this need quickly. This helped fire crews access enough EMTs to work safely.

The public was concerned about the amount of smoke emitted from the fires and asked their local health departments about adverse health effects from smoke, especially among medically vulnerable populations. DOH Environmental Public Health staff worked with the Washington State Department of Ecology, the US Forest Service, and other state agencies to communicate the issues around smoke by updating the Washington Smoke Blog. This website shows models of smoke plumes, current smoke monitoring levels, and gives health information and advisories about smoke and safe outdoor activities. This information was also supplied to the media for dissemination to the public.
Many residents with well water systems and local wastewater systems lost access to drinking water in the Central Washington area due to the widespread power outages. DOH Environmental Public Health staff coordinated with LHJs and tribal nations to get safe drinking water to the affected areas as well as to initiate grants from the Department of Commerce to reimburse for emergency damage to drinking water and wastewater systems.

The DOH IMT coordinated with other state agencies, mass sheltering organizations, mental health professionals and the US Department of Health and Human Services to support behavioral health services and sheltering needs in the affected area. The American Red Cross, LHJs, and tribal nations provided needed assistance to the public.

We anticipated the potential for nursing homes and hospital evacuations due to the fires, so the DOH IMT stored sheltering and alternate care facility items such as cots, bedding, and medical supplies in a cache in Eastern Washington. This proactive approach to resource staging will become standard practice for the DOH IMT in future incidents.

The Carlton Complex was the largest wildfire in Washington State’s recorded history.

### Capabilities Mobilized: Carlton Complex Fire

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<th>Capabilities</th>
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<td>Emergency Operations Coordination</td>
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<td>Emergency Public Information and Warning</td>
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<td>Information Sharing</td>
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<td>Mass Care</td>
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<td>Medical Materiel Management and Distribution</td>
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<td>Volunteer Management</td>
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2014 Ebola Response

On March 21, 2014 the World Health Organization (WHO) was notified of an outbreak of Ebola Virus Disease (EVD) in Guinea. Over the next year the outbreak spread widely across Guinea, Liberia, and Sierra Leone. Travel-associated cases occurred in Senegal, Spain, Mali, the United Kingdom, and the United States. The outbreak became an international health threat, and many international organizations sent both responders and aid to West Africa to help mitigate the spread of the disease.

In order to prepare for a patient suspected of having or confirmed to have EVD arriving in Washington, DOH activated its IMT. The IMT was activated from October 8, 2014 to November 26, 2014. The team developed and tested plans to improve readiness throughout the EVD continuum of care (the process beginning with a suspected case and ending with treatment and discharge from an EVD-ready facility). This activation was the longest response DOH has led and involved approximately 60 staff from more than 10 divisions and offices.

Highlights included:
- This activation provided a needed opportunity for DOH to develop and test plans. This included the Isolation and Quarantine Plan, the Communicable Disease Emergency Response Plan, and the Epidemiology Task Force Plan.
- This activation provided a significant amount of hands-on training for IMT staff in using ICS.
- DOH rapidly developed and tested statewide quarantine capability, including necessary logistical support systems.
- DOH developed two significant guidance documents for environmental health for protecting wastewater personnel and sewage workers, and to address what to do with hospital wastewater before disposal.
- The DOH Tumwater office learned how to coordinate more efficiently with satellite offices in Shoreline and Spokane. This coordination was a major challenge, but through this response, staff learned additional skills for sharing information, creating clear communications, and working with colleagues in multiple locations.
- The daily policy briefings provided policy makers up-to-date information to help inform their decisions and established DOH expectations around regular briefings and engaging executive leadership during emergencies.
- The heavy investment the agency had recently made in training responders significantly improved our ability to effectively and efficiently address emergencies.

Capabilities Mobilized: Ebola Response

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<td>Information Sharing</td>
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<td>Non-pharmaceutical Interventions</td>
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<td>Public Health Laboratory Testing</td>
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<td>Public Health Surveillance and Epidemiological Investigation</td>
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<td>Responder Safety and Health</td>
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In December 2014, several groups of bird populations were infected with HPAI in Washington. Highly Pathenic means that the virus spreads quickly and kills fast. Washington State Department of Agriculture (WSDA), Washington State Department of Fish and Wildlife, and US Department of Agriculture (USDA) set up a Unified Command that same month to respond to the outbreaks. These agencies tested livestock and wild birds around the state for HPAI.

DOH IMT activated on January 21, 2015 to monitor the potential outbreak in humans. Whenever birds tested positive, the Unified Command contacted DOH Communicable Disease Epidemiology (CD Epidemiology) who contacted the LHJ. The LHJ would then make contact with the exposed community and monitor them for 10 days for any symptoms of influenza like illness. If any exposed people developed symptoms, such as fever, they would be tested for influenza at the public health laboratory where testing can be done to differentiate seasonal flu from avian flu. DOH CD Epidemiology also sent blood samples to the CDC for people who had been exposed to infected birds but who did not display any symptoms in order to look for evidence of asymptomatic infection. Thankfully, there were no human cases of HPAI in Washington.

The IMT made antiviral medications available through the RSS to provide prophylaxis to exposed persons.

Capabilities Mobilized: High Path Avian Influenza 5 Day Activation

- Medical Materiel Management and Distribution
- Public Health Surveillance and Epidemiological Investigation
- Emergency Operations Coordination
- Emergency Public Information and Warning
- Public Health Laboratory Testing
2015 Pertussis Activation
The response included epidemiologic, media, and vaccine support to LHJs. The group worked closely with DOH leadership to monitor and manage the outbreaks and inform the public about the outbreak and of the need to get the maternal Tetanus, Diphtheria and Pertussis (Tdap) vaccine.

Highlights included:
• Reached healthcare providers and health partners across the state to share surveillance updates, prevention messages, vaccine guidance, and actions to take.
• Assessed the vaccination status for reported infant pertussis cases to understand the impact of the recommendations made by the Advisory Committee on Immunization Practices (ACIP) to vaccinate pregnant women during the third trimester.
• Provided 100% of the whooping cough vaccines needed for all children less than 19 years of age. We also provided over 25,700 doses of whooping cough vaccine for adults to support outbreak response.
• Implemented a statewide campaign to raise awareness among pregnant women about getting the whooping cough vaccine during each pregnancy. Our public awareness campaign received over 41 million views.
• Initiated a Tdap in pregnancy workgroup to explore ways to obtain data about Tdap vaccine uptake among pregnant women in Washington State.

Measles Outbreaks Activation
We responded to two measles outbreaks during this federal grant year. The first activation was the Clallam County Measles Outbreak which lasted from February – May 2015. We provided support to Clallam County Department of Health and Human Services (CCDHHS) through deployment of the Epi Task Force for the entire response and a one-day deployment of an IMT. The IMT was staffed by three employees from EPR, CD Epidemiology, and the Office of Communications. The IMT oversaw activities conducted by the Epidemiology Task Force and provided surge support to develop a press release, develop a situation report, and propose some incident objectives. The Epidemiology Task Force was staffed by two epidemiologists from CD Epidemiology and provided extensive epidemiology and assessment support for measles response. Activities included training of local health care providers for measles recognition and reporting, developing case line lists as well as contact lists, school nurse outreach activities related to immunization of staff and students, and ad hoc assessment of needs.

Highlights included:
• DOH tested the Communicable Disease Emergency Response Plan and the Epidemiology Task Force Plan.
• CD Epidemiology confirmed the relevance and value of field deployment of subject matter experts in a response.
• CD Epidemiology tested coverage plans and continuity of operations for the day-to-day communicable disease responsibilities in the context of a response with key staff out of the office.

Capabilities Mobilized: Pertussis Activation

| Emergency Operations Coordination |
| Emergency Public Information and Warning |
| Information Sharing |
| Medical Countermeasure Dispensing |
| Medical Materiel Management and Distribution |
| Non-pharmaceutical Interventions |
| Public Health Laboratory Testing |
| Public Health Surveillance and Epidemiological Investigation |
- CD Epidemiology staff and DOH IMT staff received positive feedback from CCDHHS for multiple aspects of the support provided. CCDHHS praised the Epidemiology Task Force staff in particular as critical to their success.
- A LHJ Measles toolkit was developed and piloted for use among LHJ staff at CCDHHS and in a subsequent response in Spokane County. Those tools have since been rolled out statewide.
- For the first time, we deployed an IMT to a LHJ. This activation resulted in the development of an ICS 100 and ICS 200 refresher training and tabletop exercise for LHJs and tribal nations.

The **second activation** was for the Spokane (Rainy Day) Measles Outbreak which lasted from April – June 2015. CD Epidemiology sprang into action on April 21, 2015 after receiving a report of a confirmed case of measles in Spokane County. While the case did not report travel outside the county, there was travel inside the county. The day after DOH received notification, we deployed an Epidemiology Task Force member to assess the situation and provide just-in-time training to Spokane Regional Health District (SRHD) staff. Together they identified a staffing shortage and the need for more epidemiologists so DOH deployed two more staff members the following day. While the task force was deployed, they helped develop a disease management database.

During this time, SRHD was experiencing high call volumes from the public and requested assistance from DOH. EPR assisted by activating the Washington Poison Center as a statewide public health call center. Task force members provided just-in-time training to Poison Center staff on contact tracing strategies. The call center was up and running by 5 p.m. on April 24, 2015.

### Capabilities Mobilized: Measles Outbreaks

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Key Accomplishments

Pharmacy Agreement
Public health emergencies may necessitate distribution and dispensing of medications or vaccines to large numbers of people for treatment or prevention of disease. DOH facilitated an agreement between pharmacies and LHJs to create a statewide public-private partnership for public health emergency response. The agreement defines roles and responsibilities of LHJs and pharmacies during public health incidents that involve mobilization and dispensing of medications to the public. The goal of this effort is to have all 35 LHJs signed on to the agreement and at least 85 percent of Washington’s population within five miles of a signed pharmacy. As of June 2015, we are at 79.1 percent of the state population living within 5 miles of a signed pharmacy.

This agreement took effect December 2012, and the following LHJs and pharmacies are participating as of the end of June 2015 (the end of this reporting period):

Participating Local Health Jurisdictions

- Asotin
- Chelan-Douglas
- Clallam
- Clark
- Columbia
- Cowlitz
- Jefferson
- Kitsap
- Mason
- Seattle-King
- Snohomish
- Spokane
- Tacoma-Pierce
- Whatcom
- Yakima

Participating Pharmacies

- Walgreens
  - 136 locations
- Fred Meyer
  - 59 locations
- QFC
  - 30 locations
- Costco
  - 29 locations

State-Level Disaster Medical Coordination Center
We coordinated with Harborview Medical Center, Deaconess Hospital, and all Disaster Medical Coordination Centers (DMCC) in the state to establish a system for supporting hospital evacuations during large-scale disasters, including finding inpatient capacity for patients being transported across multiple regions. This effort brings together DMCCs, healthcare coalitions, DOH, the U.S. Department of Health and Human Services, emergency management, EMS, and other partners to establish multiregional hospital evacuation capability.

This coordination enhances the overall capability of DMCC in every region of the state; this is a key piece of healthcare infrastructure that must be enhanced.
Capabilities Under Development

New Medication Distribution Model
We are working with partners to establish a new model for medical countermeasures distribution that we are calling the “Spoke and Hub” model. In this new model, DOH will distribute medical countermeasures to large points of dispensing (PODs) or distribution centers in each jurisdiction, and they will further distribute to their PODs and dispensing partners. DOH can only deliver to a limited amount of PODs in an affected area due to distance covered and time. Tribal nations continue to choose how they want to receive medications from the Federal Strategic National Stockpile during a public health emergency. This could include delivery from DOH, from the federal government, or through the nearest LHJ.

Washington Poison Center
We are developing a Memorandum of Understanding with the Washington Poison Center to have them act as the statewide public health call center during an emergency. The Washington Poison Center’s call center is staffed by nurses, pharmacists, and other providers that have all passed a national toxicology exam to qualify as poison information specialists. The Washington Poison Center’s call center services provided valuable assistance during the Spokane measles outbreak. Having an agreement in place for future activations would allow the Poison Center to immediately start providing services during medical surge events.

Statewide Mass Fatality Agreement
We are facilitating discussions with the State Emergency Management Council regarding the use of the Washington Mutual Aid Compact and Deployment Guide as the legal authorities and framework for Washington counties, cities, and tribal nations to request mutual aid across jurisdictions.

Crisis Standards of Care Legislation
The Washington State Hospital Association, with support from DOH, proposed legislation for the 2015 legislative session to allow the Governor through emergency proclamation to provide liability protections to healthcare practitioners and their employing healthcare organizations when operating under crisis conditions during catastrophic disasters. The proposed immunity protections would cover a wide range of health professionals (e.g., nursing assistants, respiratory therapists, home care aids, physicians, physicians assistants, nurses, etc.) when they continue to provide healthcare services under extreme emergency (crisis) conditions.

Current state law provides legal protection for first responders, unpaid volunteers, good samaritans, and certain emergency workers who are registered with their local emergency management agency. However, that protection is not available currently for healthcare providers who continue caring for patients in hospitals, community congregate care facilities, outpatient clinics, or in-home care in extraordinary emergency conditions. These legal protections would be implemented following a Governor–declared emergency. Such protections would be of limited duration and geographic location to cover immediate needs only.

Although the proposed legislation did not pass, we will continue policy discussions around immunity for healthcare providers with various stakeholder groups and may revisit this proposal for upcoming legislative sessions.

Cross Jurisdictional Efforts
The Pacific Northwest faces a significant threat of a catastrophic earthquake. We have worked closely with federal and tribal partners and state emergency management and public health agencies in Washington, Oregon, California, Alaska, and British Columbia to develop a coordinated response concept. The functional exercise to test the concept is scheduled for June 2016.
Events of Note

2015 Cross Border Public Health Preparedness Workshop
In April 2015, the Pacific Northwest Border Health Alliance (PNWBHA) hosted its 12th Annual Cross-Border Workshop in Victoria, British Columbia. This year’s theme “Back to Basics: Lessons Learned – Experiences Shared,” focused on the importance of coordinating preparation and response efforts. We supported the workshop and presented on a number of topics including Quarantine Planning, Catastrophic Disaster Planning, and Ebola Response. Nearly 200 attendees from Canada and the US participated in the 3-day workshop.

2015 Tribal Public Health Emergency Preparedness Conference
We partnered with the Northwest Portland Area Indian Health Board to conduct the annual conference themed “The Power of Positive Partnerships” on June 9–10 at the Quinault Beach Resort in Ocean Shores, Washington. During the conference, 120 attendees participated in interactive breakouts, speak with representatives at table sessions, view posters and other materials from partner agencies such as the American Indian Health Commission, Northwest Center for Public Health Practice, Oregon Health Authority Public Health Division, and Indian Health Service. Each year, there is an opportunity for conference attendees and tribal leaders to speak directly with state leaders from Oregon, Idaho, and Washington on current public health emergency preparedness issues at an informal setting called the Fireside Chat. Attendees shared personal testimonies about their growing concerns for climate change with a focus on impacts not only sustaining cultural resources, but also facing increased all-hazard emergency events such as wildfires due to extreme weather and other ecological shifts. Tribal and state leaders agreed collaboration and on-going dialogue between state and tribal nations will help increase response capabilities and help prepare future generations.

Emergency Planning Statewide Conference for People with All Abilities
DOH started working with the Washington State Independent Living Council (WASILC) to build community partnerships to support health preparedness for people with disabilities and those with access and functional needs. DOH and WASILC partnered to host three workshops throughout the state to engage community leaders, Center for Independent Living staff, and disability advocates culminating with the Emergency Planning Statewide Conference for People with All Abilities on June 29–30, 2015 with over 170 people in attendance. Our work partnering with WASILC has been recognized as an emerging best practice for “Whole Community” planning and engagement nationally by FEMA’s Office of Disability Integration and Coordination.
Part 5: WORKING WITH PARTNERS

We collaborate with a wide range of partners to better prepare Washington State for all types of disasters and emergencies.

Local Health Jurisdictions

We work closely with Washington’s 35 LHJs, providing technical assistance, subject matter expertise, and funding to build local public health response capability. Jurisdictions contribute expertise, local knowledge, and community support. Nine jurisdictions also serve as regional leads, providing resources, guidance, and opportunities for cross-jurisdictional collaboration to local partners.

Regional Healthcare Coalitions

The coalitions are made up of hospitals, clinics, home care providers, local government, emergency medical services and trauma care councils, and others that work together to help plan a coordinated regional healthcare response for emergencies. The coalitions help healthcare systems to create, exercise, and update their response plans and participate in emergency response training.

Tribal Nations

We offer federal grant funding and technical assistance to enhance preparedness planning and capacity building to the 29 federally-recognized tribes residing within Washington State. This partnership has produced work that is nationally recognized for excellence.

Our tribal partners include:
• Northwest Portland Area Indian Health Board
• American Indian Health Commission of Washington State
• Northwest Tribal Emergency Management Council
• Health Canada First Nations and Inuit Health

Additional Partners Contributing to EPR Work

• Washington Association of Community and Migrant Health Centers
• Home Care Association of Washington
• Washington Poison Center
• Department of Social and Health Services
• Washington Emergency Management Division (Washington Military Department)
• Regional Emergency Medical Services and Trauma Care Councils
• Washington State Patrol
• Department of Enterprise Services
• Department of Agriculture
• Spokane County/Spokane County Fair & Expo facility
• Washington State Hospital Association
• University of Washington Northwest Center for Public Health Practice
Part 6: CONTACT INFORMATION

**Michael Loehr**
Chief of Emergency Preparedness and Response  
Phone: 360-236-4068  
Michael.Loehr@doh.wa.gov

**Lori Van de Wege**
Deputy Chief of Administrative Operations  
Phone: 360-236-4064  
Lori.VandeWege@doh.wa.gov

**Nathan Weed**
Deputy Chief of Operations  
Phone: 360-236-4534  
Nathan.Weed@doh.wa.gov

**Dianna Trotter**
Partner Relations Coordinator  
Phone: 360-236-4026  
Dianna.Trotter@doh.wa.gov

**Andrea Dos Santos**
Administrative Operations Manager  
Phone: 360-236-4075  
Andrea.Dossantos@doh.wa.gov

**Shawn Roberts**
Planning, Operations, Exercise Section  
Phone: 360-236-4539  
Shawn.Roberts@doh.wa.gov

**Cristina Labra**
Emergency Communications Consultant  
Phone: 360-236-4035  
Cristina.Labra@doh.wa.gov

**Brian Hiatt**
Biological Laboratory Response, Lead  
Phone: 206-418-5471  
brian.hiatt@doh.wa.gov

**Blaine N. Rhodes**
Chemical Laboratory Response, Lead  
Phone: 206-418-5520  
blaine.rhodes@doh.wa.gov

**Mike Boysun**
Epidemiology and Surveillance, Lead  
Phone: 206-418-5518  
mike.boysun@doh.wa.gov

**Dale Alexander**
Medical Countermeasures and Training Section  
Phone: 360-236-4541  
Dale.Alexander@doh.wa.gov