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Part 1: WHO WE ARE

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.

We save lives and protect the people of Washington from the health threats of public health emergencies.
Team
Knowing ourselves and how we contribute as productive team members working towards the program mission.

Integrity
Accountable to ourselves, each other, partners, customers, and funders; dependable and reliable.

Respect
Treat each other with dignity.

Achievement
Recognize individual and team accomplishment.

Competency
Sufficient skills, knowledge, attitude, experience to be proficient in job duties, & seek continuous improvement.

Trust
Empower all to make the best decisions.

Ethics
Exercise professional judgment to ensure we are doing the right things for the right reasons.

Honesty
Transparent, truthful, and forthright.

Collaboration
Work with partners, communities, and each other to meet program strategic goals.
Part 2: PRIORITIES

In 2015 and 2016, we worked on the following priorities.

1. Actively engage and expand partnerships to enhance statewide, sustainable capabilities.

**Completed strategies**

- Increase the number of pharmacy chains signed on to the statewide pharmacy agreement.
- Establish statewide mutual aid among medical examiners and coroners.
- Partner with state agencies and Local Health Jurisdictions (LHJs) to finalize state-level isolation and quarantine capability.

**In the works**

- Partner with medication distributors to distribute Strategic National Stockpile (SNS) resources on behalf of DOH.
- Partner with healthcare systems to distribute SNS medications across their networks.
- Partner with state and federal agencies, and multi-county private organizations to expand closed Points of Dispensing (POD) coverage across Washington.
2

Ensure statewide healthcare incident response capability.

Completed strategies
Ensure that contact can be established between critical healthcare facilities and local public health, emergency management, healthcare coalition, and DOH.

Ensure that Health and medical incident information can be collected and coordinated by local public health, emergency management, healthcare coalition, and DOH.

Route resource requests for assistance from critical healthcare facilities through local Emergency Operation Center (EOC) to state EOC.

In the works
Ensure processes are in place for mutual aid support among healthcare facilities statewide.

Ensure processes are in place for enacting, via a Governor’s proclamation, crisis standards of care during disasters.

Establish statewide surge capacity teams to support both chronic disease management and acute care management during disasters.

3

Establish field response capability to address all public health and medical disasters anywhere in Washington.

Completed strategies
Establish Environmental Public Health Response Team.

Finalize deployable Epidemiology Task Force.

Establish multiple Incident Management Teams (IMTs) for field deployment and ACC operations.

Expand the number Emergency Support Function 8 liaisons ready for deployment.

Regularly drill all teams and ensure they are fully staffed and trained.

Register all DOH employees into WASECURES, the Washington Secure Electronic Communications, Urgent Response and Exchange System for secure messaging and public health alerts.

In the works
Establish Health and Medical Impact Assessment Team. (Team is under development)

Complete the roster for the Receipt, Stage, and Store (RSS) Team.

Incident Commander and Agency Administrator setting objectives during radiation exercise
Part 3:  FUNDING

EPR works to build sustainable and effective statewide emergency response capabilities.

We fund activities through two federal preparedness program grant that support local, regional, state, and tribal preparedness for any public health emergency:

- Public Health Emergency Preparedness Cooperative Agreement funding from the Centers for Disease Control and Prevention (CDC)
- Hospital Preparedness Program (HPP) from the Assistant Secretary for Preparedness and Response (ASPR).

DOH provided $9,655,238 (64%) in direct funding, to LHJs, tribal governments, and other public health partners. When the U.S. Department of Health and Human Services (HHS) decided to reduce public health preparedness funding to all states in order to fund Zika preparedness and response work, Washington State experienced a cut of nearly $950,000. We did not, however, reduce funding to tribal governments or make any subsequent allocation changes to our LHJ partners or healthcare coalitions. We focused, instead, on improving efficiency while continuing to address priorities. We changed vendors for our SECURES system, eliminated a communications position, reevaluated and balanced work between our grants, and halted work on several projects. We also created efficiencies in our training program by building training capability within our agency instead of hiring external trainers.

64% of our funding is passed to LHJs, tribal nations, and other partners.
## Expenditures: Public Health Emergency Preparedness Fund (PHEP)

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<thead>
<tr>
<th>Category</th>
<th>Amount</th>
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<tr>
<td>Partners</td>
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**Total** = $11,199,973
**Expenditures: Hospital Preparedness Program (HPP)**

- **Partners**: $62,800,901 (73.39%)
- **Base work**: $899,913 (23.58%)
- **Training for partners**: $43,121 (1.13%)
- **WAServ**: $72,300 (1.89%)

**Total = $3,816,235**
Part 4: ACCOMPLISHMENTS

Cross Borders Capability Development

For over a decade, DOH has partnered with public health agencies in Oregon, Idaho, Alaska, British Columbia, and other Canadian Provinces in the Pacific Northwest to build strong, cross-border relationships regarding public health response, disease surveillance, environmental health, risk communications, and medical surge. In April 2016, DOH participated in discussions with our partners to shift the focus of our cross-borders coordination toward developing specific response capabilities. This includes developing a cross-borders work plan that focuses, at a minimum, on four key areas:

1. Develop consistent tools to collect and share essential elements of information across borders during major disasters;

2. Identify materiel and staffing resources, including response teams, that could be readily mobilized across borders to support healthcare and public health response and recovery;

3. Develop a pediatric strike team that could be mobilized across borders to augment critical capacity during disasters;

4. Test the Pacific Northwest Emergency Management Arrangement (PNEMA) mutual aid agreement through a series of drills focused on the mobilization of a pediatric strike team across borders.

Planning meetings and drills with our cross-borders partners will occur throughout the next grant year to address each element of the work plan and expand operational capabilities.
Ebola Preparedness

Washington is the HHS Region 10 lead for Ebola and other special pathogens preparedness. Providence Sacred Heart Medical Center and Children’s Hospital (PSHMC) volunteered to serve as the designated Region 10 Regional Ebola Treatment Center (RETC) and received funding to build a special pathogens unit, acquire necessary equipment, train staff, conduct exercises, and other necessary preparedness activities. Facility renovations are in progress. Our state now has six assessment hospitals and three treatment hospitals to serve patients with Ebola and other highly infectious diseases.

Gap analysis of frontline hospital capabilities

In coordination with Washington State University and healthcare system partners, we conducted a gap analysis survey of frontline hospital capabilities throughout the state. The purpose of the gap analysis was to identify core levels of capability among all frontline hospitals with regard to patient screening, treatment, PPE, training, and drilling. We received a response rate of approximately 53% and are currently awaiting a report and analysis of the data. This will give us important insight into the status of hospital preparedness for Ebola and other highly infectious pathogens throughout the state and will inform training, exercise, and preparedness activities in the years to come.

DOH along with Spokane Regional Health District and PSHMC hosted a successful multi-site virtual tabletop exercise with the state of Alaska. The tabletop tested concepts and processes to move a patient with Ebola from Anchorage, AK to the Special Pathogens Unit (SPU) at PSHMC. We also hosted a notification drill with the state of Oregon to validate processes for initial notification of the need to transport an Ebola patient.

Assessment of all 12 ambulance services’ current capabilities

There are 12 ambulance services throughout the state prepared to provide patient transport to and between healthcare facilities for patients with Ebola or other highly pathogenic diseases. Emergency Medical Services (EMS) Preparedness has been challenging due to limited guidance and lack of specific funding for EMS. However, this grant year, we conducted a formal assessment of all 12 ambulance services’ current capabilities. While we still have more work to do, our investment and time thus far have substantially improved our preparedness to Ebola and other special pathogens.
Funded special projects
DOH funded special projects at four LHJs and one tribal nation to address gaps specific to Ebola readiness. These include:

- building a regional cache of personal protective equipment in eastern WA;
- improvements in information sharing and public information;
- improvements in planning for non-pharmaceutical interventions including isolation and quarantine;
- engagement with at-risk cultural and religious groups; and
- state-level isolation and quarantine facility improvements.

Communicable disease and pandemic response concept of operations
DOH has developed a statewide communicable disease and pandemic response concept of operations (ConOps) to conduct isolation and quarantine at the state level. We also:

- improved our public outreach/risk communications processes and tools;
- enhanced our capability for direct active monitoring (i.e. sending a medical staff member to a person’s home who is being monitored for symptoms of disease to take their temperature); and
- engaged with the EMS community, under the auspices of the Washington State EMS and Trauma Steering Committee, to support EMS providers in large-scale and catastrophic disaster response.

Patient movement workgroup
We are coordinating a multi-agency, multi-disciplinary patient movement workgroup with the goal of producing a formal concept of operations for mass patient movement during a no-notice catastrophic incident. Planning for mass patient movement started in the spring of 2016 and was exercised during the Cascadia Rising Exercise.
**Disaster Medical Advisory Committee**

DOH contracted with the Northwest Healthcare Response Network (NWHRN) to administer the Disaster Medical Advisory Committee (DMAC) on behalf of the Secretary of Health and the State Health Officer. DMAC is comprised of clinical experts in a variety of medical specialties from across the state. Each member has agreed to serve as part of an advisory body should the Secretary of Health or State Health Officer request their counsel during a large-scale medical surge incident with ongoing healthcare system impacts. Specifically, DMAC may advise on ethical decision-making around the allocation of scarce medical resources, or the thresholds for considering a formal declaration at the state level of crisis standards conditions. This group meets quarterly and participates in discussion-based scenario exercises to share ideas and develop norms around how their recommendations to DOH will be guided.

**Completed emergency response plan elements**

This year, we established an agency-wide emergency planning workgroup led by the Office of Emergency Preparedness and Response including representatives across the agency. This group is currently developing standard processes and guidance documents to promote effective, well-coordinated planning. We have solidified processes for reviewing and vetting plans with internal and external partners, enabling us to obtain input from diverse stakeholder groups.

This year, we overhauled the agency basic plan and associated annexes with educational seminars delivered to key agency response staff and external partners. Recent exercises and real world events have informed our planning efforts. We are also working on the Medical Countermeasures Operational Plan. We finalized the ESF8 Annex and associated appendices this year.

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**Diagram:**

- **State CEMP**
  - ESF-5
  - ESF-6
  - ESF-7
  - ESF-8
  - ESF-9
  - ESF-10
  - ESF-11

- **DOH Basic Plan**
  - Command & Control annex
  - Public Information annex
  - Communications annex
  - Laboratory annex
  - Epi annex
  - MCM annex
  - Fatality Management annex

- Draft

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**Response plans completed and in progress**
WATrac

At the beginning of the fiscal year, DOH assumed responsibility for managing the statewide, web-based healthcare information system known as WATrac. This system had been managed by the Northwest Healthcare Response Network (NWHRN) on behalf of DOH since 2009. WATrac allows healthcare facilities to enter data regarding facility impacts and status; patient volumes and tracking information; and includes notification and survey functions. DOH, NWHRN, and all healthcare coalitions felt that given the statewide scope of WATrac, it was appropriate for DOH to assume responsibility for management and ongoing sustainability. An advisory committee co-chaired by DOH and NWHRN has supported the WATrac program for several years, and this function will continue.

Medium and Large LHJ Site Visits

For the first time, EPR team members conducted discussion sessions with each of the 21 large and medium sized LHJs and healthcare coalitions. Through this process, team members traveled to each of the medium and large local jurisdictions and facilitated a 2-hour, face-to-face discussion using a qualitative guide. These discussions were designed to increase our understanding of the response capabilities our partners have developed. Our goal is to strengthen relationships toward building statewide capability and deployable response resources. We have received overwhelmingly positive feedback on these site visits. We will continue our visits in the next fiscal year to include the small LHJs.

Washington Tracking Network new subtopic

We used the data from the medium and large LHJ discussion sessions to create a new subtopic on the Washington Tracking Network (WTN). WTN is administered by DOH Environmental Public Health division and funded by a grant from the CDC. WTN is Washington State's portal for CDC's National Tracking Network. WTN is a public website where users can find information about environmental health.
hazards, community and population characteristics, health disparities, and vulnerable populations. The new subtopic, entitled “Emergency Preparedness and Response”, provides data for emergency planners and response teams on a variety of subjects such as Public Information and Warning, Emergency Operations Coordination, Medical Surge, Information Sharing, and Non-Pharmaceutical Interventions. WTN used the data to generate maps on each of the capabilities, and each map has different layers available. For example, the Medical Surge map features hospitals, medical clinics, and tribal health clinics. Additional layers are under development for release in the next fiscal year. Our partnership with WTN has allowed us to leverage the existing data within the system to improve on our evidence-based decision making when planning for and during emergencies.

**Fatality Management Accomplishments**

During early 2016, DOH held statewide fatality management workshops (Eastside and Westside) focusing on mutual aid capabilities and resources. Participants included Emergency Management staff, local public health, tribal partners, coroners and medical examiners, FEMA, American Red Cross, state Emergency Management Division, and the Washington National Guard.

During this fiscal year, we also accomplished the following:

- developed a cache of fatality management supplies around the state;
- worked with local fatality management planners to pre-identify casualty collection sites and storage sites;
- contracted with private vendors to provide portable body storage capability to aid with mobility during a mass fatality event;
- developed state level caches of body bags with 24/7 on-call contract supplies capabilities; and
- partnered with the Confederated Tribes of the Colville Reservation to establish a cache of fatality management supplies for central Washington.

**Statewide Mass Fatality Mutual Aid Agreement**

The State Emergency Management Council endorsed and deployed the Washington Mutual Aid Compact (also known as Washington Mutual Aid Assistance System, or WAMAS) on July 9, 2015. This mutual aid compact and deployment guide provides the legal authorities and framework for Washington counties, cities and tribes to request mutual aid across jurisdictions. This creates a framework for county coroners and medical examiners to provide cross-jurisdictional assistance.

The mutual aid provides the legal authorities and framework for counties, cities and tribes to request aid across jurisdictions.
Part 5: EVENTS OF NOTE

Staff had many opportunities to share best practices and present on our work including at the following events:

- 2016 Partners In Emergency Preparedness Conference
- 2016 Preparedness Summit
- Region 2 Isolation and Quarantine Workshop
- Washington State Hospital Association Disaster Preparedness Conference

**Tribal Public Health and Emergency Management Conference**

The Annual Tribal Emergency Preparedness Conference was held in Spokane from May 2 – May 6, 2016. The theme this year was “Public Health and Emergency Management Working Together” and the agenda focused on ways to improve and enhance inter-agency and cross-jurisdictional collaboration for tribal emergency preparedness and response. New this year, the conference offered pre-conference training in addition to the 2.5 days of main conference activities.

Approximately 200 people attended including more than 40 tribes from Washington, Oregon, Idaho, and Nevada. Highlights of the conference included the Fireside Chat attended by Washington State Secretary of Health, John Wiesman, among others. The Fireside Chat serves as an opportunity for conference attendees and tribal leaders to speak one-on-one with state health representatives on public health emergency preparedness issues.

A new feature this year was the inclusion of a Tribal Caucus, open to tribal members and representatives only, to discuss relevant public health preparedness topics and promote a better understanding of tribal-state issues to approach collaboratively in the coming years.
Part 6: NOTABLE EXERCISES & ACTIVATIONS

Exercises

**Noble Lifesaver Patient Movement Workshop**

The Noble Lifesaver Patient Movement Workshop was conducted on November 19, 2015 in partnership with the US Department of Health and Human Services. The scenario focused on responding to and recovering from a catastrophic earthquake and tsunami. The scenario detailed a 9.0-magnitude earthquake and 40-foot tsunami impacting the Cascadia Region. The earthquake and tsunami inflicted extensive damage on the region’s healthcare system and other critical infrastructure requiring local, regional, state, and federal government agencies to plan and execute patient movement operations. The workshop exposed significant gaps in readiness for large-scale patient movement, especially when transport involved both fixed and rotary wing aircraft, and when transport distances greatly exceed day-to-day occurrences. The after action report and improvement plan will influence program priorities and response plan in the next program year.
Cascadia Rising Exercise
In June 2016, Washington conducted the largest full-scale exercise in its history. Cascadia Rising simulated a full rupture of the Cascadia Subduction Zone, including massive earthquake damage across the entire western half of the state, and catastrophic damage from tsunamis impacting the coast. DOH tested several capabilities during the multi-day exercise, including:

- integrating the DOH Incident Management Team (IMT) with a federal Incident Response Coordination Team (IRCT);
- enhancing participation from across DOH to model a “One Agency” response;
- improved our ability to request and prioritize federal resources;

Cascadia Rising exercise detailed a 9.0 magnitude earthquake and 40 foot tsunami impacting the Cascadia Region.
The Agency Coordination Center - Cascadia Rising Exercise

- deployed an Incident Management Team (IMT), environmental health team, and a hospital construction review services team to field locations;
- developed a strategy for transporting thousands of patients to eastern WA and out of state;
- tested the DOH continuity of operations plan;
- tested policy decision making and the authorities of the Secretary and Governor.

- tested a new concept around establishing an incident Fatality Management Coordinator, as a direct report to the Secretary of Health, to oversee federal Disaster Mortuary Operational Response Teams.

This was a challenging scenario and we pushed our teams, agency, and partners to get an honest view of our current capabilities and limitations. Lessons identified during this exercise will greatly influence future work plans.

**DOH IMT participated in Columbia Generating Station exercise for the first time**

The DOH IMT supported the October 25, 2016 exercise for the Columbia Generating Station (CGS) nuclear plant. The purpose of this exercise was to evaluate our ability to assess the impacts to our citizens from a radiological release at the nuclear plant. These exercises incorporate a multitude of responding state and local agencies in multiple jurisdictions to properly assess the situation, and then recommend protective actions and provide messages to both the public and emergency responders. DOH deployed 14 responders for this exercise to fulfill the following objectives:

- Development of a radioactive plume footprint using computer modeling.
- Deployment and coordination of environmental monitoring teams to confirm areas affected by radioactive contamination.
- Review and analysis of data to develop protective action recommendations for both the public and responders.
- Development and delivery of public messages.
- Coordination of protective action decisions made by each jurisdiction to develop a common operating picture among all responding agencies.

A key issue identified during this exercise was the need to develop a Joint Information System inclusive of all responding agencies.
Incidents

Chelan County Wildfires July 2015
The state Emergency Operations Center (EOC) activated Emergency Support Function 8 (ESF 8), Public Health and Medical Services, to support activities around the Sleepy Hollow Fire in Chelan County. The activation included a small number of DOH staff within ESF 8 to coordinate information sharing with state agencies and local health partners impacted by the fire. Due to the rapid pace of the fire and the level of evacuations, DOH remained activated in a supportive role for four days. During the response, DOH coordinated with many partners on air quality related issues, clean air shelters and evacuations that included specialized support for vulnerable populations. The activation did not require a full Incident Management Team and ESF 8 deactivated once the evacuations and air quality issues diminished.

Capabilities mobilized:

• Emergency Operations Coordination
• Information Sharing
• Mass Care
• Medical Surge
• Medical Materiel Management and Distribution

2015 Wildfires August – September 2015
The 2015 Firestorm was the largest outbreak of wildfires in state history. Smoke from the wildfires created the largest air quality related response in Washington State, causing significant health risks in communities across the state. The Washington State Department of Ecology classified air quality as hazardous in many Eastern Washington counties, and a few in Western Washington.

During the incident, DOH coordinated with state and local partners as well as the Confederated Tribes of the Colville Reservation, Spokane Tribe, Sauk-Suiattle Indian Tribe, American Indian Health Commission, and the Northwest Portland Area Indian Health Board to respond to the health needs and concerns of the people across the state. DOH IMT supported impacted areas with the following assistance:

• thousands of N-95 respirators to protect at-risk and vulnerable populations;
• nearly two dozen indoor air purifiers to protect air quality within critical facilities; and
• technical assistance and public health recommendations related to air quality.

This was the first time that the DOH IMT received and supported direct requests from tribal governments and tribal partners, and the first time DOH deployed IMT members to Indian Reservations.

Capabilities mobilized:
• Community Preparedness,
• Emergency Operations Coordination
• Emergency Public Information and Warning
• Information Sharing
• Responder Health and Safety
• Mass Care
• Volunteer Management
• Medical Surge
• Medical Materiel Management and Distribution
• Environmental Health.

Map of Washington areas affected by the wildfire smoke in 2015

For the first time, during the wildfires, the DOH IMT received and supported direct requests from tribal governments and tribal partners.
E. Coli Outbreak (multi-county) November 2015
The Office of Communicable Disease Epidemiology received a notification of 19 Washington cases of Shiga Toxin producing E.coli 026E spanning multiple counties (King, Skagit, Clark, and Cowlitz). The DOH IMT activated on October 31, 2015 to:

• support and develop mechanisms for case and contact investigation, monitoring, and prevention efforts;
• collaborate with local, state and federal partners to investigate a multi-state cluster of illnesses;
• collect environmental and clinical specimens;
• coordinate, collect and test clinical specimens for confirmation of outbreak cases; and
• develop environmental guidance for restaurant chains across the state.

Capabilities mobilized:

• Emergency Operations Coordination
• Emergency Public Information and Warning
• Information Sharing
• Public Health Surveillance and Epidemiological Investigation
• Public Health Laboratory Testing
• Environmental Health

Zika Virus Outbreak Response February – March 2016
Zika virus disease (Zika) is caused by the Zika virus that is spread to people primarily through the bite of an infected Aedes species mosquito. The most common symptoms of Zika are fever, rash, joint pain, and conjunctivitis (red eyes). The illness is usually mild with symptoms lasting for several days to a week after being bitten by an infected mosquito. People usually don’t get sick enough to be hospitalized, and they very rarely die of Zika. For this reason, many people might not realize they have been infected.

In May 2015, the Pan American Health Organization issued an alert regarding the first confirmed Zika infection in Brazil. On February 1, 2016, the World Health Organization declared Zika a public health emergency of international concern. Local transmission has been reported in many other countries and territories. The CDC believes Zika likely will continue to spread to new areas.

On February 8, 2016 key stakeholder groups from multiple divisions within DOH gathered on a conference call to develop a plan to rapidly prepare to respond to Zika as a threat to public health. A small DOH IMT activated on February 8 and remained active until March 4, 2016 when enhanced coordination and resource support was no longer necessary.

Capabilities mobilized:

• Community Preparedness
• Emergency Operations Coordination
• Emergency Public Information and Warning
• Information Sharing
• Public Health Laboratory Testing
• Public Health Surveillance and Epidemiological Investigation
• Responder Safety and Health
• Healthcare System Preparedness
• Environmental Health

On February 1, 2016, the World Health Organization declared Zika a public health emergency of international concern.
Lead Response April 2016

The DOH IMT was activated on April 22, 2016 in response to lead in drinking water as a threat to public health. The mission was to unify agency resources and efforts in order manage our response and to add support and value to local government incident command structures. This response was somewhat different from traditional DOH IMT activations because it did not involve any operational response goals or objectives. Rather, the primary mission was to serve in a coordination role supporting a Unified Command in Tacoma, and an Incident Command lead by Seattle Public Utilities. This included providing clear DOH policy, state-level public information, technical direction, situational awareness, coordination between the involved response partners, and a liaison deployed directly to Seattle Public Utilities. On May 5, 2016, the IMT demobilized its response after coming to the conclusion that the structure and enhanced coordination provided by the IMT was no longer needed to support ongoing planning and preparedness efforts for the Lead Response.

Capabilities:

• Community Recovery
• Emergency Operations Coordination
• Public Information and Warning
• Information Sharing
• Non-pharmaceutical interventions
• Public Health Laboratory Testing
• Public Health Surveillance and Epidemiological Investigation
• Environmental Health

Secretary of Health John Wiesman at press conference for Lead Response
Part 7: WORKING WITH PARTNERS

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

Whole Community Subcommittee

The Washington State Emergency Management Council (EMC) established a Whole Community Subcommittee (WCS) co-chaired by DOH and the Washington State Independent Living Council (WASILC). The subcommittee includes representation from all 29 tribal governments, and 20 government and non-profit organizations and commissions. The objectives of the subcommittee include:

• providing a forum to collectively address issues that disproportionately impact various functional communities across the state; and

• strengthening the ability of government and non-government organizations to minimize disproportionate impacts during disasters on communications across Washington.

Coalition on Inclusive Emergency Planning (CIEP)

Partnering with WASILC, EPR has formalized the development of an inclusive emergency planning group comprised of state-level agencies, non-governmental organizations, and community advocates for the advancement of emergency preparedness for people with disabilities and others with access and functional needs. This group held its preliminary meeting identifying the following areas for engagement:

• provide access and integration of emergency management training to representative communities;

• evaluate proposed law and legislation at intersection of people with disability and access and functional needs for emergency preparedness;

• provide technical assistance and guidance for emergency support functions and related state and local agencies to improve integration of 'whole community' theory to address the needs of people with disability and others who may become vulnerable during and after emergencies;

• engage those state-level agencies with local facilities statewide in local emergency planning, and provide situational awareness back to WASILC Inclusive Planner during response.

EPR will engage the CIEP as an advisory group for issues related to community resilience and inclusive emergency planning and response.
Local Health Jurisdictions

We work closely with Washington’s 35 LHJs, to provide technical assistance, subject matter expertise, and funds 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

There are eight healthcare coalitions across Washington made up of hospitals, clinics, home care providers, public health, local government, emergency medical services, trauma care councils, and others that work together to plan a coordinated regional healthcare response for emergencies. The coalitions help healthcare systems create, exercise, and update regional response plans and integrate with local and state emergency responders.

Tribal Governments

The Office of Emergency Preparedness and Response through the two federal funding streams works in partnership with the 29 federally recognized tribes within Washington State and tribal associations such as the Northwest Portland Area Indian Health Board, American Indian Health Commission for Washington State, and the Northwest Tribal Emergency Management Council.

Throughout the year grant funding supports tribally-driven projects and technical assistance to enhance public health preparedness planning and capacity building. The relationship between EPR and tribal governments extends to cross borders relationships with Health Canada First Nations and Inuit Health. Work produced in collaboration with tribal partners and the EPR program has been recognized nationally as a model for excellence.

Our Tribal Association Partners

- 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

We worked in partnership with the 29 federally recognized tribes and tribal associations within Washington.
Additional Partners

• 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
• Washington Association of Coroners and Medical Examiners
• Providence Sacred Heart Medical Center and Children’s Hospital
• Harborview Medical Center
• Washington State University
• United States Marshals Service