Primary Agency:

Department of Health (DOH)

Support Agencies:

Department of Agriculture (WSDA)
Department of Ecology (ECY)
Department of Enterprise Services (DES)
Department of Fish and Wildlife (WDFW)
Department of Labor and Industries (L&I)
Department of Licensing (DOL)
Department of Social and Health Services (DSHS)
Department of Transportation (WSDOT)
Washington Military Department (WMD)
Washington State Health Care Authority (HCA)
Washington State Patrol (WSP)
Washington State Pharmacy Association (WSPA)

INTRODUCTION

Purpose

Emergency Support Function (ESF) 8 — Public Health, Medical, and Mortuary Services provides direction, coordinated procedures, and clarity of responsibility for statewide health and medical response during disasters. The mission of ESF 8 responders is to deliver critical response capability when and where it is needed to save lives and to minimize morbidity during a crisis.

Scope

This plan reflects an all hazards approach to preparing, responding, and recovering from disasters. Services, functions, and partners covered in this plan include state government agencies, local health jurisdictions, tribes, healthcare facilities and their critical functions, mortuary services, medical surge response, resource and information management, and policy decision making. Functional roles within the scope of ESF 8 include:

- Coordinating, mobilizing, and directing the statewide health, medical, and mortuary response during disasters.
- Supporting local assessment and identification of public health and medical needs in impacted regions.
- Supporting monitoring, investigating, and controlling potential and known public health threats through disease, environmental, and injury surveillance.
- Providing rapid detection, characterization, confirmatory testing, data reporting, investigative support, and laboratory networking to address actual or potential exposures to all hazards.

- Recommending public health and medical regulatory and statutory waivers to the Governor's Office for enactment when necessary.
- Coordinating statewide mutual aid among local health jurisdictions, medical examiners, and coroners.
- Coordinating interstate mutual aid requests for public health and medical assistance, and initiating requests for federal health and medical assistance and resources during disasters.
- Providing all-hazard public health and medical consultation, technical assistance, and support.
- Collecting, disseminating, and coordinating accurate and timely public health and medical information to public health partners and the general public.
- Directing the staging, storage, and statewide distribution of medical surge supplies and equipment.
- Providing pharmaceutical supply information and access to chronic care prescriptions.
- Supporting and implementing non-pharmaceutical interventions to control the spread of public health threats.
- Supporting mass fatality management, victim identification, and activation of Family Assistance Centers.
- Coordinating statewide radiological and nuclear incident response, stabilization, and recovery actions, including management of Community Reception Centers (locations where the public can be screened and decontaminated after a significant radiological event).
- Coordinating with local public health and medical officials to move patients within the state or to locations outside the state in support of optimal healthcare surge during disasters.
- Supporting the mobilization of crisis intervention and behavioral health services following disasters.
- Identifying and monitoring the safety and health of emergency responders and healthcare personnel during and after a disaster.

The Department of Health (DOH) will activate, coordinate, and deploy ESF 8 resources and capabilities when any emergency or public health threat:

- Exceeds or may exceed local, tribal, or healthcare facility resources or capabilities.
- Warrants state-level direction and coordination of information and resources.
- Requires policy decision making by the Secretary of Health.

Policies

Key state authorities that govern our emergency response:

RCW 43.70.130 and 43.70.020(3) State Department of Health – Powers and duties of the Secretary of Health (Excerpt)

1. Enforce the public health laws of the state and the rules and regulations promulgated by the Department or the Board of Health in local matters, when in its opinion an emergency exists and the local board of health has failed to act with sufficient promptness or efficiency, or is unable for reasons beyond its control to

act, or when no local board has been established, and all expenses so incurred shall be paid upon demand of the Secretary of the Department of Health by the local health department for which such services are rendered, out of moneys accruing to the credit of the municipality or the local health department in the current expense fund of the county;

2. Investigate outbreaks and epidemics of disease that may occur and advise local health officers as to measures to be taken to prevent and control the same;
3. Exercise general supervision over the work of all local health departments and establish uniform reporting systems by local health officers to the state Department of Health;
4. Have the same authority as local health officers, except that the Secretary of Health shall not exercise such authority unless the local health officer fails or is unable to do so, or when in an emergency the safety of the public's health demands it, or by agreement with the local health officer or local board of health;
5. Take such measures as the Secretary of Health deems necessary in order to promote the public health, to establish or participate in the establishment of health educational or training activities, and to provide funds for and to authorize the attendance and participation in such activities of employees of the state or local health departments and other individuals engaged in programs related to or part of the public health programs of the local health departments or the state Department of Health. The Secretary of Health is also authorized to accept any funds from the federal government or any public or private agency made available for health education training purposes and to conform with such requirements as are necessary in order to receive such funds; and
6. Establish and maintain laboratory facilities and services as are necessary to carry out the responsibilities of the Department of Health.

RCW 43.70.680 Volunteers for emergency or disaster assistance

The Washington State Department of Health is authorized to contact persons issued credentials to ask them if they will register as volunteer workers.

RCW 70.26 – Pandemic Preparedness

The Secretary of the Washington State Department of Health establishes requirements and performance standards, consistent with any requirements or standards established by the United States Department of Health and Human Services (HHS), regarding the development and implementation of local pandemic flu preparedness and response plans.

RCW 70.94.422 – Department of Health powers regarding radionuclides

The Washington State Department of Health shall have all the enforcement powers as provided in RCW 70.94.332, 70.94.425, 70.94.430, 70.94.431 (1) through (7), and 70.94.435 with respect to emissions of radionuclides.

RCW 70.98 – Radiation Control

RCW Chapter 70.98.050 designates the Washington State Department of Health as the state radiation control agency having sole responsibility for administration of the regulatory, licensing, and radiation control provisions in that Chapter.

RCW 38.56.020 Intrastate Mutual Aid System – Established

Local jurisdictions and tribes provide mutual assistance to each other in emergencies. This includes response, mitigation, or recovery activities related to an emergency or participation in drills or exercises in preparation for an emergency.

RCW 68.50 Human Remains

A coroner has jurisdiction over human remains when death is due to a violent contagious disease which may be a public health hazard, or when death results from events including drowning, an accident, radiation, or exposure. Reports and records of autopsies or postmortems are confidential. Only the following people may view these confidential records: the personal representative of the decedent, any family member, the attending physician or advanced nurse practitioner, the prosecuting attorney or law enforcement agencies with jurisdiction, public health officials, the department of labor and industries or the secretary of the department of social and health services. A coroner, medical examiner, or their designee may publicly discuss their findings except when there is a pending investigation or court proceedings. These officials may also release identifying information of the deceased to aid in identification. The coroner, medical examiner or the attending physician will meet with the family of the decedent to discuss autopsy findings if they request. If the county coroner or county medical examiner investigating a death is unable to identify the decedent he or she shall have a qualified dentist carry out a dental examination. If the county coroner or medical examiner is still unable to identify the decedent, they will forward the dental examination records to the dental identification system of the state patrol to be matched and scored for identification.

WAC 246-500 Handling of Human Remains

This WAC includes the guidelines that funeral directors, embalmers, medical examiners, coroners, health care providers and others directly handling or touching human remains must follow in addition to management of human remains in refrigerated storage and transportation protocols. The local health officer may impose additional requirements for the handling, care, transport or disposition of human remains or suspend the requirements of this chapter.

RCW 70.02 Medical Records

Health care information is personal and sensitive and if it is used improperly or released may be harmful to a patient's privacy, health care or other interests. Patients and other qualified entities need access to health care records in order to inform their health care decisions, protect the health of the public, and more, but records must be disclosed appropriately and in appropriate circumstances, as noted in this RCW. Authorization must be obtained prior to disclosure of records. A health care provider or health care facility may disclose health care information without a patient's authorization if the disclosure is to protect the health of the public or if it is for research that has been approved by an institutional review board. A personal representative of a deceased patient may exercise all of the deceased patient's rights, as noted in this RCW. All state and local agencies that obtain patient health care information must adopt and make available on their websites the rules and policies in accordance with this RCW regarding record acquisition, retention, destruction, and security. If patient information is improperly disclosed by a state or local agency the patient must be notified. The Department of Social and Health Services is authorized to release patient information that is necessary to protect the public.

RCW 70.58 Vital Statistics

The Department of Health (DOH) is authorized to prescribe the rules, schedule and system for electronic and hard copy transmission of birth and death certificates and marriage licenses as noted in this RCW. DOH also maintains rules for releasing copies of vital records through secure and confidential means. Local and city health officers are generally the entities responsible for registration activities which are supervised by the state registrar. Each local registrar may appoint deputy registrars to assist them. Washington State vital statistics documents include, at minimum, the items recommended by the federal agency responsible for national vital statistics. Information may be added to or removed from documents if the state board of health requires an addition. Vital records copies may be shared with federal, state and local governmental agencies if the record is to be used for official agency duties. A certificate of every death or fetal death must be filed with the local registrar in the district where the death occurred. Only qualified officials may file death certificates, as noted in this RCW. A county coroner, medical examiner or prosecuting attorney with jurisdiction may file a certificate of presumed death if the certificate includes sufficient evidence to indicate a person has died within the county and if it is unlikely that the body will be recovered.

RCW 70.168 Statewide Trauma Care System

In order to improve trauma care across Washington State this Emergency Medical Services (EMS) Trauma Care System was created. It aims to decrease the incidence of trauma through prevention activities, provide optimal care for trauma patients, prevent unnecessary deaths and disabilities from trauma and contain costs due to trauma. The state has an EMS and trauma care steering committee with representatives from DOH. The committee advises DOH regarding emergency medical services and trauma care throughout the state. DOH has established standards for facilities, equipment, transport, development, and personnel for multiple levels of adult and pediatric trauma care services. DOH authorizes facilities and transport agencies to provide a designated level of trauma care service. To address quality of care, DOH maintains a statewide data registry to collect and analyze data on the incidence, severity and causes of trauma. This registry and quality assurance program is used to improve the availability and delivery of prehospital and hospital trauma care services.

WAC 246-100 Communicable Diseases

It is the responsibility of every health care provider to provide adequate instruction in control measures to prevent the spread of disease to patients, care takers, and others. Health care providers must also cooperate with public health authorities during investigation of suspected or confirmed cases of notifiable conditions or communicable diseases and during outbreaks. The local health officer establishes plans, policies and procedures for instituting emergency measures necessary to prevent the spread of communicable disease or contamination, conduct investigations, and institute disease control and contamination control measures. This WAC includes the procedures for isolation or quarantine. Isolation or quarantine may be issued by a local health officer, or be voluntarily completed by a person if the health officer determines that emergency detention of a person or group is necessary to limit spread of communicable diseases. This WAC denotes the conditions and principles under which a local health officer may order involuntary detention of a person or group of persons for purposes of isolation or quarantine. In addition to the conditions and principles for isolation and quarantine that must be adhered to, there are conditions that must be followed regarding the isolation or quarantine premises. Control measures to prevent human disease from animals are also

included with sections specific to rabies and psittacosis. A state or local health officer within his or her jurisdiction may issue orders for medical examination, testing and/or counseling as well as orders to cease and desist specific activities when he or she knows or has a reason to believe that a person has a sexually transmitted disease and is engaging in conduct endangering the public's health.

Additional State Authorities:

Air quality – RCW 70.94: The Department of Ecology and Regional Clean Air agencies have jurisdiction over ambient air quality. DOH has air quality subject matter experts available to consult with those having authority regarding the effects of poor air quality on the public's health.

Chem/Toxicology – RCW 70.104.030: The Department of Health may investigate all suspected human cases of pesticide poisoning and such cases of suspected pesticide poisoning of animals that may relate to human illness. DOH shall immediately notify WSDA, L&I, and other appropriate agencies of the results of its investigation for such actions as the other departments or agencies deem appropriate. RCW 70.104.040 gives DOH authority in the event of a pesticide emergency to make such orders and take such actions as are appropriate to assume control of the property and to dispose of hazardous substances, prevent further contamination, and restore any property involved to a nonhazardous condition. DOH shall work closely with and advise WSDA, as appropriate, in the enforcement of this chapter.

Key Federal Authorities that govern our emergency response:

Legal Authority When the Secretary for the US Department of Health and Human Services (HHS) Declares a Public Health Emergency

In addition to regular authorities, the HHS Secretary may be authorized or directed to take other actions when the President declares a major disaster or an emergency under the Robert T. Stafford Act or an emergency under the National Emergencies Act. Under Section 319 of the Public Health Service (PHS) Act, the Secretary of the Department of Health and Human Services can declare a Public Health Emergency (PHE) if the HHS Secretary determines, after consulting with such public health officials as may be necessary, that 1) a disease or disorder presents a PHE or 2) a PHE, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists. A PHE declaration allows the Secretary to take certain actions in response to the PHE. In addition, a PHE can be a necessary step in authorizing the Secretary to take a variety of discretionary actions to respond to the PHE under the statutes HHS administers including:

- Developing and taking necessary steps to implement a plan to assist states and localities to control epidemics and to meet other health emergencies or problems.
- Establishing isolation and quarantine.
- Maintaining the Strategic National Stockpile (SNS).
- Activating the U.S. Public Health Service (USPHS) Commissioned Corps and the National Disaster Medical System (NDMS) and deploying select members of the Medical Reserve Corps (MRC).

The HHS Secretary is authorized to take the following actions when a Public Health Emergency is declared.

- Emergency Medical Treatment and Labor Act (EMTALA) (see EMTALA description on page ESF8-7) sanctions for direction or reallocation of an individual to another location to receive medical screening pursuant to an appropriate state emergency preparedness plan or a state pandemic preparedness plan for the transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared federal public health emergency. A waiver of EMTALA requirements is effective only if actions under the waiver do not discriminate on the basis of a patient's source of payment or ability to pay.
- Regulatory waivers that the HHS Secretary can enforce.
- In addition, the Secretary may waive Health Insurance Portability and Accountability Act (HIPAA) sanctions and penalties in certain situations.

Homeland Security Presidential Directive (HSPD)-21

HSPD-21 is built on the principles of earlier directives – HSPD-9 and HSPD-10 – which collectively describe the role of the federal government in building a national capability to detect a biological event.

- Establishes a National Strategy for Public Health and Medical Preparedness.
- Defines a "Catastrophic Public Health Event."
- Identifies four critical components of public health and medical preparedness: biosurveillance, countermeasure distribution, mass casualty care, and community resilience.

National Health Security Strategy (NHSS)

The NHSS is a strategic plan developed by HHS to help minimize the consequences associated with significant health incidents. The NHSS is designed to achieve two goals:

- Build community resilience.
- Strengthen and sustain health and emergency response systems.

Section 2802 of the Public Health Service Act provides the statutory authority and requirements for the NHSS.

Public Law 107-188, Public Health Security Bioterrorism Preparedness and Response Act of 2002

The Act amends the Public Health Service Act to "improve the ability of the United States to prevent, prepare for, and respond to bioterrorism and other public health emergencies." The Act requires the Secretary of HHS to "develop and implement" a coordinated strategy in the form of a national preparedness plan.

Emergency Medical Treatment and Active Labor Act (EMTALA)

EMTALA requires that hospitals accepting Medicare payments provide patients coming to the emergency department appropriate medical screening for emergency medical conditions without regard to citizenship, legal status, or ability to pay. If the patient is found to have an emergency medical condition, the hospital must either provide further examination and treatment until the patient is stabilized, or, if the hospital is unable to

stabilize the patient, the hospital must arrange for transfer of the individual to a capable facility. Patients cannot be denied stabilizing treatment or be discharged prematurely based on prior unpaid debts to the hospital. While patients cannot be held criminally liable, hospitals may seek judgments against non-paying patients in civil court for the amounts owed.

Public Law 104-191 Health Information Portability and Accountability Act (HIPAA) of 1996: Privacy Rule

The HIPAA Privacy Rule protects certain patient information (including health insurance and billing information, medical records, and conversations with providers) from being disclosed by covered entities (including most health insurance companies, health care providers, and health information clearinghouses) for reasons other than providing treatment and care, billing and payment, protecting the public's health (such as through surveillance of specific diseases), or reporting required information to police (such as gunshot wounds). Information cannot be disclosed outside of the HIPAA provisions without the patient's express written permission. Covered entities must have safeguards in place to protect patient health information to ensure that it is not mishandled. If a Section 319 Emergency has been declared, the Secretary of HHS may waive certain sanctions for non-compliance with HIPAA.

Note that The Centers for Disease Control and Prevention (CDC) is not a covered entity under HIPAA, nor are state or local public health departments unless they also treat patients. Regulations are found at 34 C.F.R. Part 160 and Subparts A and E of 164.

Executive Order 13295: Revised List of Quarantinable Communicable Diseases (April 4, 2003, amended July 31, 2014)

This Executive Order identifies the eight communicable diseases (cholera; diphtheria; infectious tuberculosis; plague; smallpox; yellow fever; viral hemorrhagic fevers; and severe acute respiratory syndromes), for which an individual can be apprehended, detained, examined, or conditionally released by federal public health authorities under 42 C.F.R. §§ 70 and 71.

Public Health and All Hazards Reauthorization Act (PAHPRA)

The purpose of the Pandemic and All-Hazards Preparedness Act is "to improve the Nation's public health and medical preparedness and response capabilities for emergencies, whether deliberate, accidental, or natural."

The Secretary of HHS may, based upon one of the preceding determinations, declare that circumstances exist to justify an Emergency Use Authorization (EUA) for an unapproved drug, device, or biological product, or for an unapproved use of an approved drug, device, or biological product. Once an emergency is declared, the Food and Drug Administration (FDA) Commissioner may issue an EUA for a particular product or products, assuming other statutory criteria and conditions are met. The EUA expires when the declaration of emergency terminates or when authorization is revoked. The FDA Commissioner may impose conditions on the use of the drug or device. Emergency Use Investigational New Drug (IND) allows the FDA to authorize use of an experimental drug in an emergency situation that does not allow time for submission of an IND in accordance with 21CFR, Sec. 312.23 or Sec. 312.34. It is also used for patients who do not meet the criteria of an existing study protocol, or if an approved study protocol does not exist.

Emergency Prescription Assistance Program (EPAP)
The purpose of EPAP is to perform the activities related to processing prescription drug claims for medications and durable medical equipment (DME) for designated eligible individuals in a federally-identified disaster area. EPAP allows any enrolled pharmacy in the United States and its territories to use existing electronic pharmacy systems as an infrastructure to efficiently process prescriptions and DME for individuals that are eligible for EPAP. This effort is performed under the authority cited in Sections 403 and 502(a) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act), 42 USC 5170b and 5192(a). EPAP activities provide "essential assistance" to support state and local jurisdictions as defined in Section 403 of the Stafford Act, 42 USC 5170b. The President must first issue an Emergency Declaration or Major Disaster Declaration under the Robert T. Stafford Disaster Relief Act, or declare an Incident of National Significance. Once declared, FEMA has the authority to issue a mission assignment to deploy HHS under ESF 8, if appropriate.

Additional Local Authorities:

RCW 70.05.070 Local health officer – powers and duties
Enforce the public health statutes of the state, rules of the state board of health and the Secretary of Health, and all local health rules, regulations, and ordinances within his or her jurisdiction including imposition of penalties authorized under RCW 70.119A.030.

1. Take such action as is necessary to maintain health and sanitation supervision over the territory within his or her jurisdiction;
2. Control and prevent the spread of any dangerous, contagious, or infectious diseases that may occur within his or her jurisdiction;
3. Inform the public as to the causes, nature, and prevention of disease and disability and the preservation, promotion, and improvement of health within his or her jurisdiction;
4. Prevent, control, or abate nuisances which are detrimental to the public health;
5. Attend all conferences called by the Secretary of Health or his or her authorized representative;

As well as other activities to support the public's health.
[1999 c 391 § 5; 1993 c 492 § 239; 1991 c 3 § 309; 1990 c 133 § 10; 1984 c 25 § 7; 1979 c 141 § 80; 1967 ex.s. c 51 § 12.]

RCW 70.05.060 Powers and duties of local board of health
Each local board of health shall have supervision over all matters pertaining to the preservation of the life and health of the people within its jurisdiction and shall:

1. Enforce through the local health officer or the administrative officer appointed under RCW 70.05.040, if any, the public health statutes of the state and rules promulgated by the state board of health and the Secretary of Health;
2. Supervise the maintenance of all health and sanitary measures for the protection of the public's health within its jurisdiction;
3. Enact such local rules and regulations as are necessary in order to preserve, promote, and improve the public's health and provide for the enforcement thereof;

4. Provide for the control and prevention of any dangerous, contagious, or infectious disease within the jurisdiction of the local health department;
5. Provide for the prevention, control, and abatement of nuisances detrimental to the public's health.

[1991 c 3 § 308; 1984 c 25 § 6; 1979 c 141 § 79; 1967 ex.s. c 51 § 10.]

Planning Assumptions

In addition to the nature, scope, and severity of a public health emergency or disaster and the level of response capability in place at the local, state, tribal, and federal levels, the following factors could affect the statewide ESF 8 response:

1. Preservation of life safety is a top incident priority in the field and at an Emergency Operations Center (EOC) level.
2. The Secretary of Health may direct the statewide health, medical, and mortuary response as necessary and authorized by state law to protect the public's health.
3. The Secretary of Health will determine prioritization of available medical services when resources are scarce across multiple jurisdictions, implementation of crisis standards of care on a regional level, and direction of federal and interstate mutual aid resources.
4. During a public health emergency, disease and environmental surveillance and investigation activities are prioritized to directly support life safety.
5. Public health and medical services, resources, facilities, and personnel may be limited in availability or capacity during and following disasters.
6. The resources and abilities of local health jurisdictions to coordinate the local ESF 8 response to public health and medical emergencies vary widely across the state.
7. Additional local, state, or federal capabilities may be needed to assist state and local governments and tribes in the triage and treatment of casualties in the disaster area and transporting casualties to the closest appropriate hospital or healthcare facility.
8. Large-scale public health emergencies may require implementation of public health measures, including implementation of legal authorities, to control the spread of communicable diseases or environmental health hazards.
9. Public health emergencies may require receipt, staging, storing, distribution, and dispensing of medications and medical supplies in large quantities over short time periods.
10. During disasters, damage to critical infrastructure including roads, bridges, communications lines, power grids, and water and sewer systems may exacerbate public health impacts and hamper response efforts.
11. Inpatient healthcare facilities will have plans in place to maintain operations and support patients for up to 96 hours. We don't believe that healthcare facilities will be able to support patients for up to 96 hours without additional support.
12. A large-scale medical disaster may generate patient volumes well exceeding the capacity of healthcare facilities requiring medical surge response at the local, state, and federal levels.
13. Public health emergencies and disasters disproportionately impact populations that are low income, medically frail, have disabilities or special medical needs, are culturally or geographically isolated, and are heavily dependent on social services to support daily health needs.

14. The transportation of patients to areas with available healthcare resources outside the state and region may be required.
15. Demand for behavioral health services, including crisis counseling for disaster survivors and response personnel, may quickly overwhelm local providers warranting state and federal assistance.
16. There is a risk of increased disease outbreaks when large numbers of people are sheltered together for any length of time.
17. Primary medical treatment facilities may be damaged or inoperable. Rapid damage assessments and prioritizing medical service restoration during disaster recovery may be necessary to stabilize the medical support system.
18. Protecting food and water systems will be one of the areas requiring resources.

CONCEPT OF OPERATIONS

ESF 8 Coordinator and Primary Agency: Department of Health

- The Revised Code of Washington (RCW) authorizes DOH to respond to public health emergencies. DOH is required to provide leadership and coordination by identifying and resolving threats to the public's health by:
  - Working with local health departments and local governments, tribes, and healthcare facilities to strengthen state, tribal, and local governmental partnerships for providing public health protection;
  - Developing disease or environmental public health intervention strategies;
  - Providing expert advice to response partners, first response agencies, local and tribal public health officials, healthcare facilities, and the executive and legislative branches of state government;
  - Providing active and fair enforcement of public health rules;
  - Working with other federal, state, and local agencies, tribes, and healthcare facilities by facilitating their involvement in planning and implementing health preservation measures;
  - Providing information to the public to prevent disease, promote health, and protect the public's health;
  - Carrying out other related actions as appropriate for the situation; and
  - Enforcing public health laws and rules in accordance with RCW 43.70.130(4).
- Because emergencies and communicable diseases know no boundaries, DOH may need to contact bordering states or Canadian provinces for resource assistance using the Emergency Management Advisory Compact (EMAC) or the Pacific Northwest Emergency Management Arrangement (PNEMA).
- When faced with complex ethical issues and clinical decision making requiring healthcare and health community input, the Secretary of Health can call upon the Washington State Disaster Medical Advisory Committee (DMAC), which can serve in an advisory capacity during disasters for healthcare and medical decision making and the DOH Policy Group for public health and population-based decision making.

General

The DOH Duty Officer is the central point of notification for incidents that warrant ESF 8 response. Incident notification to the DOH Duty Officer may originate from the State Emergency Operations Center (SEOC) Alert and Warning Center, local health jurisdictions, tribes, healthcare facilities, state agencies, or other response partners. Upon receiving notification, the DOH Duty Officer will communicate with the appropriate DOH staff and ESF 8 partners to mobilize the appropriate response.

DOH will lead ESF 8 partners in conducting impact assessments in coordination with appropriate state and local medical and public health officials and organizations to determine the character and extent of the incident. Assessments will be conducted to outline:

- Incident impact on the local community and immediate threats to life, health, and safety;
- Incident impact on healthcare infrastructure;
- Priorities for rapid response;
- Resources currently available within the local community; and
- Strategies for long-term recovery.

ESF 8 representatives actively participate in the State Emergency Operations Center planning process and provide updated information regarding public health and medical activities.

DOH will activate its incident management team (IMT), as appropriate, to establish overall health and medical response objectives, coordinate incident information with ESF 8 partners, and manage medical resources. The DOH IMT will serve as the clearinghouse for ESF 8 incident information and medical resource management during emergencies and disasters.

DOH Communicable Disease Epidemiology will conduct surveillance and detection activities. This can include forensic epidemiology activities. DOH will share key information with law enforcement agencies.

Public Health Policy Group
The Public Health Policy Group is an advisory body that supports the Secretary of Health's decision making role during disasters. When activated, the Public Health Policy Group consists of DOH staff, including the Secretary, the State Health Officer, the Deputy Secretary for Public Health Operations, the Deputy Secretary for Administrative Operations, and the Agency Administrator. Technical advisors may be requested by the Secretary to participate in Public Health Policy Group discussions on an as-needed basis. Technical advisors may include DOH staff, local health officers, other state agencies, federal agencies, healthcare or private sector individuals, or the Disaster Medical Advisory Committee (see below).

The role of the Public Health Policy Group is to provide structure, technical assistance, and expertise to the Secretary on policy decisions regarding:

- The need to request federal assistance or interstate mutual aid to support the public health and medical response;

- The need to ration and prioritize medical resources and services;
- The need to change medical system practices or regulatory waivers to reflect crisis conditions;
- The need to solve ethical issues arising from the incident; and
- The need to prioritize sustainment of critical functions and operations within DOH during emergencies.

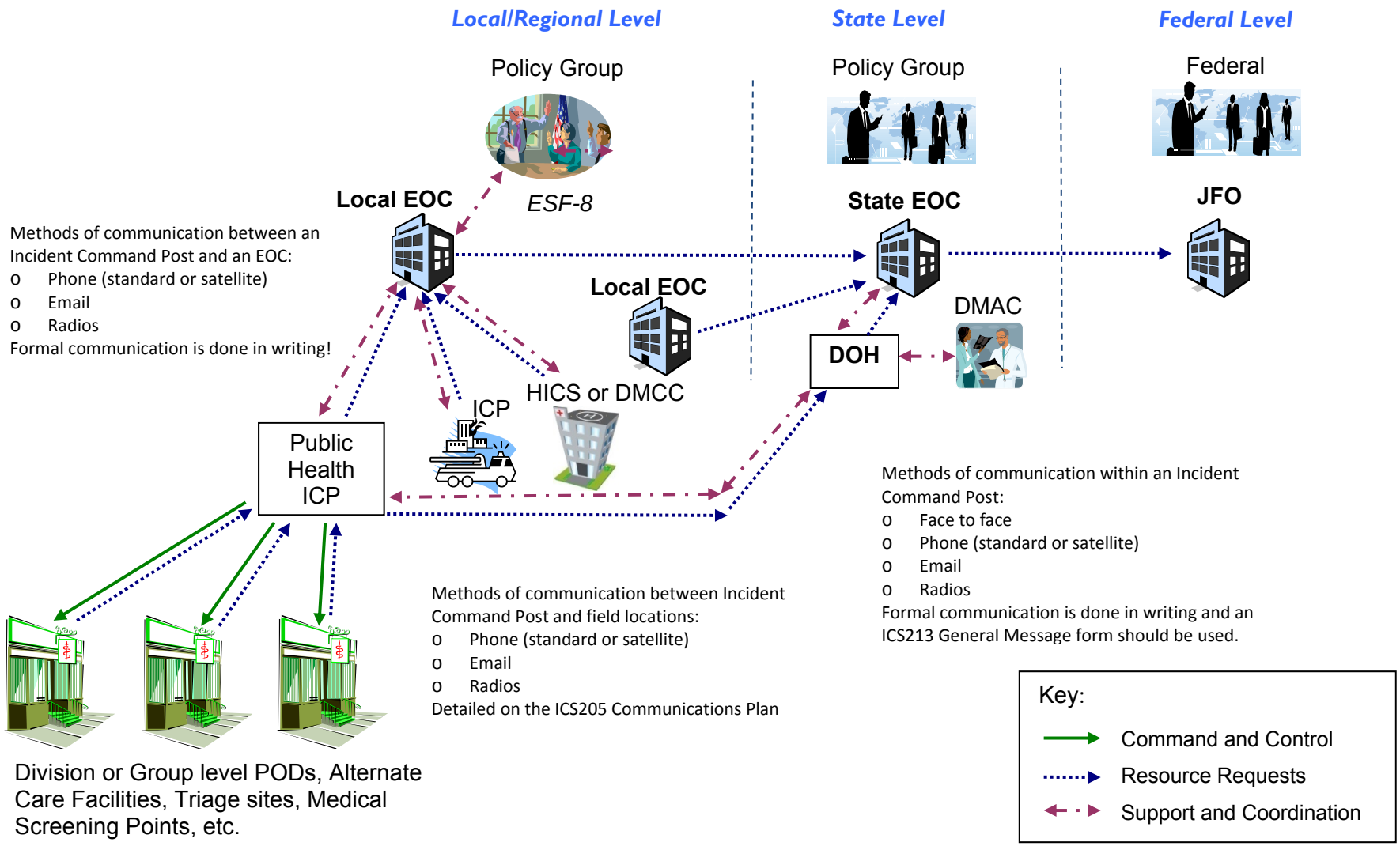
Disaster Medical Advisory Committee

The Disaster Medical Advisory Committee (DMAC) consists of a broad array of medical, clinical, and ethical experts whose role is to advise the State Health Officer and the Secretary of Health, when requested, on policy decisions during disasters. When activated, the DMAC may be requested to provide input on the following issues:

- The need to activate multi-regional surge capacity strategies;
- Recommendations for mobilizing, prioritizing, and allocating federal medical resources (e.g., SNS, NDMS, or federal teams);
- Recommendations on the need to implement crisis standards of care based on current and anticipated circumstances; and
- Recommendations for solving medical ethics issues.

Local and tribal public health and medical officials will route requests for state assistance through the emergency management organization responsible for their jurisdiction to the ESF 8 station at the SEOC. The SEOC may access state agency resources, intrastate mutual aid, interstate mutual aid, private industry resources, or turn to federal agencies to accomplish the mission.

DOH will manage medical resources in support of local, tribal, and healthcare facility response efforts. DOH will leverage, to the greatest extent possible, partnerships with private sector, healthcare systems, non-profit organizations and other partners to mobilize resource and service support to local communities. If resource needs cannot be met locally or through local mutual aid, the Secretary of Health may establish resource priorities, authorize requests for interstate mutual aid, or authorize requests for federal assistance. The DOH IMT will communicate all requests for interstate mutual aid or federal assistance through the SEOC.


Local/Regional Level
State Level
Federal Level
Policy Group
Policy Group
Federal
ESF-8
Local EOC
State EOC
JFO
Methods of communication between an Incident Command Post and an EOC:
o Phone (standard or satellite)
o Email
o Radios
Formal communication is done in writing!
Local EOC
DMAC
DOH
HICS or DMCC
ICP
Public Health ICP
Methods of communication within an Incident Command Post:
o Face to face
o Phone (standard or satellite)
o Email
o Radios
Formal communication is done in writing and an ICS213 General Message form should be used.
Methods of communication between Incident Command Post and field locations:
o Phone (standard or satellite)
o Email
o Radios
Detailed on the ICS205 Communications Plan
Key:
Command and Control
Resource Requests
Support and Coordination
Division or Group level PODs, Alternate Care Facilities, Triage sites, Medical Screening Points, etc.

Organization

State-Level Response Structure

- In response to public health and medical emergencies, DOH may activate incident command to coordinate the resources and actions of the Department and ESF 8 partners.
- DOH will notify and request ESF 8 partner agencies to provide a representative to support ESF 8 activities at the DOH agency coordination center (ACC) or SEOC, as needed.
- DOH will communicate directly with local health, tribes, healthcare facilities, and other partners during an incident to create a common operating picture and share information.
- The DOH IMT will coordinate with the ESF 8 representatives in the SEOC to accomplish the following during all public health and medical emergencies:
  - Establish incident priorities and objectives for the statewide health and medical response;
  - Collect and report the situational status of public health and medical impacts, threats, and response actions;
  - Deploy ESF 8 Liaisons to field locations, local health jurisdictions and tribes, and other operational settings for enhanced coordination as necessary;
  - Provide resource management support including equipment, medical supplies, and pharmaceuticals for local health jurisdictions, tribes, and healthcare organizations;
  - Collaborate with the SEOC to provide logistical support for locally managed medical needs shelters, alternate care facilities, medication centers, mortuary operations, family assistance centers, and other field response locations;
  - Implement statewide distribution strategies for medications and medical supplies received through the Strategic National Stockpile;
  - Coordinate with regional Disaster Medical Coordination Centers (DMCC) to manage statewide bed availability and patient movement;
  - Determine the need for federal or interstate assistance and direct resource requests through the SEOC;
  - Direct statewide surge capacity strategies to support local health jurisdictions, tribes and healthcare facilities;
  - Develop health messaging in coordination with ESF 8 partner agencies and local health officers;
  - Support policy decision making by the Secretary of Health; and
  - Track costs associated with DOH response functions and activities.

Regional- and Local-Level Response Structure

- Local ESF 8 response activities will be coordinated in accordance with local or tribal public health or medical plans and the local emergency operations center (EOC). In some cases regional ESF 8 response activities will be coordinated in accordance with regional or tribal plans and with the EOC of the lead regional jurisdiction.

Response Operations

Upon notification of a potential public health emergency or disaster, DOH may activate ESF 8 partners and the DOH IMT to mobilize personnel, supplies, and equipment to save lives, protect the public, and support local needs. During response, ESF 8 representatives support four primary missions:

1. Support and coordination to agencies and partners responding under health and medical missions;
2. Facilitate mutual aid among local health jurisdictions, tribes, and healthcare facilities;
3. Directly assist local health jurisdictions, tribes, and healthcare facilities in their response; and
4. Support policy decision making by the Secretary of Health through upward leadership.

- Assess Public Health and Medical Needs: ESF 8 representatives make initial assessments of health and medical needs from reports provided by local health jurisdictions, tribes, and healthcare systems. State or federal damage assessment teams may provide additional information. In coordination with ESF 8 partner agencies, the U.S. Department of Health and Human Services (HHS) may mobilize and deploy a team to the disaster area to assist with determining specific health and medical needs and priorities. This function includes assessment of healthcare system functionality and supporting infrastructure.
- Patient Movement: ESF 8 representatives may request assistance from non-affected jurisdictions, the National Guard, or the federal ESF 8 function, to move patients from the affected area to locations where medical care is available when local capability to provide for and move patients is overwhelmed. Under these circumstances, DOH may activate a state-level DMCC to coordinate the movement of patients across multiple regions of the state and to advise the Secretary of Health, in conjunction with DMAC, regarding the need for out-of-state patient movement. Regional DMCCs can assist the state DMCC or DOH IMT with patient destination decisions by analyzing bed availability data and patient allocations.
- Health and Medical Equipment and Supplies: The state may request federal assistance with providing health/medical/veterinary equipment and supplies (pharmaceuticals, biologic products, and blood or blood products) that support the response or for restocking healthcare facilities in the impacted area.
- The Centers for Disease Control and Prevention (CDC) Strategic National Stockpile (SNS): ESF 8 representatives coordinate with the Governor or their designee to request resources from the SNS when needed. SNS is a national repository of potentially life-saving pharmaceuticals and medical supplies for use in a public health emergency in which local supplies have been or may be depleted. The SNS contains medical countermeasures that include pharmaceutical interventions (e.g., vaccines, antimicrobials, antidotes, and antitoxins) and non-pharmaceutical interventions (e.g., ventilators and personal protective equipment (PPE)) that may be used to treat adverse health effects from an intentional, accidental, or naturally occurring public health emergency.
- CHEMPACK: ESF 8 representatives coordinate with local authorities and the CDC when a CHEMPACK cache has been activated. The CHEMPACK program procures and provides project areas with caches of chemical nerve

agent antidotes placed in centralized locations to assist first responders in quickly administering life-saving antidotes.

- Pharmaceutical Supply Chain: ESF 8 representatives will coordinate with the Washington State Pharmacy Association (WSPA) to track and monitor the status of the pharmaceutical supply during incidents.
- Food Safety and Security: ESF 8 representatives may task the DOH Food Safety Program and WSDA to assist local officials with the safety and security of food supplies.
- Worker Safety and Health: ESF 8 representatives work with L&I to deploy appropriate personnel to oversee worker safety and health, including providing guidance on the regulatory requirements covering PPE; determining when a facility/industry is safe for occupancy and resumption of activity; and providing state laboratory services and/or equipment to support the detection, identification, and analysis of hazardous substances that may present a threat to the public's health in accordance with L&I response plans.
- All Hazard Public Health and Medical Consultation, Technical Assistance, and Support: ESF 8 representatives may request assistance from support agencies to assess the public health and medical effects resulting from an incident. Specific tasks may include (but are not limited to):
  - Assessing general population and high-risk population exposure;
  - Conducting field investigations;
  - Investigating indirect exposure through contaminated food, drugs, water supply, and other media; and
  - Providing technical assistance and consultation regarding medical treatment and decontamination of individuals.
- Behavioral Health Care: If the local capability to provide behavioral health services is exceeded during any size or type of disaster, the impacted county or tribe may request assistance from the SEOC. ESF 8 representatives coordinate with support agencies, human and social service agencies, non-profit organizations, regional support networks (RSNs), and HHS to determine viable options for support.
- Public Health and Medical Information: The Joint Information Center (JIC) or Joint Information System (JIS) managed from the SEOC will coordinate the collection, development, and dissemination of public information messaging during disasters. For agency-specific information, DOH will serve in the lead role in communicating public health risks associated with the emergency and actions the public can take to protect themselves. The DOH IMT Incident Commander must approve all health related messages prior to release.
- Vector Control: DOH may request ESF 8 partner agencies to assist with assessing the threat of vector-borne diseases following an incident. Activities may include: conducting field investigations, including the collection and laboratory analysis of relevant samples; providing vector control equipment and supplies; and providing technical assistance and consultation on protective actions regarding vector-borne diseases and medical treatment of victims of vector-borne diseases.

- Drinking Water: DOH may support water utilities and local health jurisdictions in (1) assessing infrastructure damage, reliability, and safety of public drinking water supplies; (2) securing emergency supplies of potable water; (3) delivering public health messages; and keeping the Governor's Office and SEOC informed of the public water system status.
- Fatality Management, Victim Identification, and Family Assistance Centers: Fatality management operations are led by local medical examiners or coroners and may be necessary following public health disasters. ESF 8 representatives support local fatality management response with resources, facilitation of statewide mutual aid, and requests for federal assistance as appropriate. During multi-county disasters where federal mortuary assistance resources are needed and must be prioritized, the Secretary of Health may identify an Incident Medical Examiner to function on behalf of DOH and in support of impacted jurisdictions, and oversee the deployment and operation of federal mortuary response assets across multiple local jurisdictions.
- Non-pharmaceutical interventions: Disease control functions will include coordinated surveillance, outbreak investigations, epidemiological analysis, and appropriate laboratory testing. Non-medical interventions including measures to increase social distancing, community containment measures (i.e., school closings), isolation, and quarantine may be implemented by local health officers or the Secretary of Health, as appropriate, to stop or slow the spread of communicable diseases. The Isolation & Quarantine Annex to the DOH Emergency Response Basic Plan will guide implementation of non-pharmaceutical interventions during a communicable disease incident.
- Veterinary Medical Support: ESF 8 representatives provide veterinary assistance to ESF-11 as needed with containment of diseases transmitted from animals to humans and to protect the health of livestock, companion, and services animals. Support of the National Veterinary Stockpile drugs will be maintained by the DOH Receipt, Stage, and Store (RSS), and oversight will remain with WSDA.
- Radiological Incident Response: DOH will lead the state's response to radiological incidents. The Radiological Response Plan details the response and recovery actions for any public health emergency involving radiological contamination. The scope of the state response could include activation of the DOH IMT and SEOC, mobilization of field teams, requests for federal resources, and activation of Community Reception Centers (CRC). CRCs are used for large-scale population monitoring and decontamination for radiological or nuclear events (terrorism, fixed nuclear facility, or transportation/industrial accident). Local authorities with support from the DOH Radiation Response Team will lead initial sorting of people who may have been exposed to a radiological incident. Screening and monitoring for external and internal contamination will happen at the CRCs to protect hospitals from being overwhelmed and contaminated.
- Volunteer Management: The majority of medical and non-medical volunteers in Washington State are members of their local Medical Reserve Corps, are registered as Emergency Workers through their local emergency management agency, and their contact information is housed in WAserv. DOH maintains volunteer teams to support state and local capabilities. Teams in place and under development include a pharmacy team to provide chronic disease care in

congregate settings and routine medication to affected people, an impact assessment team to include volunteer building evaluators and engineers familiar with healthcare facilities, and volunteer medical teams to support acute care needs. DOH coordinates with in-state and out-of-state medical volunteer organizations to facilitate the mobilization of volunteers across the state and from other states during disasters.

Response Tools

ESF 8 primary and support agencies maintain the following systems to monitor and support incident response:

- National Syndromic Surveillance Sys-P: Sys-P is a public health surveillance system that increases the ability of health officials at local, state, and national levels to efficiently, rapidly, and collaboratively monitor and respond to harmful health effects of exposure to disease or hazardous conditions. Sys-P provides public health officials a common electronic health information system with standardized tools and procedures for rapidly collecting, sharing, and evaluating information. With Sys-P, health officials can exchange information faster, improve their common awareness of health threats over time and across regional boundaries, and better coordinate investigations and community actions to protect health.

- BioWatch Detection System: BioWatch is a federally-managed, locally-operated, environmental bio-surveillance system designed to detect the intentional release of harmful aerosolized biological agents in a select number of urban areas across the country. The system detects *Bacillus anthracis* (anthrax), Variola major (smallpox),*Yersinia pestis* (plague), *Francisella tularensis* (tularemia), and *Burkholderia mallei* (glanders). Early detection may aid local and state public health officials in analyzing the extent of the public health threat and determining appropriate actions needed to protect the public.

- ESSENCE Syndromic Surveillance System: The Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE I) is a syndromic surveillance system used to capture and analyze public health indicators for early detection of disease outbreaks and all hazards associated health outcomes. The ESSENCE system is the primary syndromic surveillance database and tool used in the Office of Washington State Communicable Diseases Epidemiology.

- Washington Disease Reporting System (WDRS): WDRS is a public health surveillance system used to increase the ability of identifying confirmed, suspect, or probable cases of infectious disease agents within the state of Washington by linking Electronic Lab Reporting with clinical disease information. WDRS is a prototype system for monitoring communicable diseases and communicable disease outbreaks across the state of Washington. WDRS will be the primary surveillance tool for identifying laboratory confirmed cases of communicable diseases. This information will be integrated with ESSENCE to better assess outbreak and incident response within the state of Washington.

- HAN/SECURES: Washington SECURES is the Health Alert Network (HAN) application managed by DOH. This system shares information about emerging public health threats, recovery efforts, and other guidance with our State's primary public health partners,

which include local health jurisdictions, tribes, military hospitals, DOH staff, hospitals, healthcare facilities, neighboring states and provinces, and state and federal agencies. WA SECURES can deliver messages in several formats including e-mail, telephone, pager, fax, or text message. Washington receives HAN messages through a CDC system called Epi-X functioning similarly to SECURES at a national level.

- Washington Tracking Network (WTN): WTN gathers and analyzes data about environmental health hazards, exposure to hazards, and health outcomes based on exposure. Two of the six air pollutants (fine particulate matter (PM2.5) and ground-level ozone) monitored by EPA are widespread pollutants in Washington State. WTN database can be searched to find county-level air quality, asthma, lead, radon, and biomonitoring data.

- WATrac: WATrac is Washington's information management system for healthcare response. WATrac includes a bed-capacity tracking system, patient tracking system, database of healthcare resources, and repository of contact information and planning documents. WATrac allows healthcare and public health partners to view real-time data related to the status of healthcare facilities and functions in Washington. It can also track resources and pharmaceuticals within healthcare facilities, post and share documents internally and externally in a virtual library, and conduct on-line chats.

- Waserv: Waserv is Washington's Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP). It is an electronic registration and notification system for medical and non-medical volunteers who are available to respond to public health and medical emergencies. The system verifies volunteers' identification and health professionals' credentials so they can be mobilized and provide needed help during an emergency.

Operational Objectives

I. Activate and deploy personnel, supplies, and equipment to support state-level missions, local and tribal needs, and healthcare facilities. ESF 8 primary and support agencies maintain the following resources to support incident responses and can procure additional resources as necessary for the response. Task forces and strike teams can be activated at the discretion of DOH to support response objectives.

    - Department of Health Duty Officer (DOH DO): The DOH DO provides a 24-hour, seven-days-a-week point of contact for others to notify DOH of urgent or emergent events affecting the health of Washington State residents. The DOH DO analyzes incoming calls or emails and determines the appropriate staff to contact as necessary. The DOH DO coordinates response activities with the various programs in DOH as appropriate; develops and distributes daily updates to DOH leadership; reviews CDC Health Alert Network messages and distributes via SECURES; coordinates the development and distribution of DOH-initiated Health Alert Network messages via SECURES; coordinates the distribution of DOH-generated general messages through SECURES; and assists in the coordination of other general emergency response activities. The DOH DO can activate the DOH IMT as required.

    - Office of Radiation Emergency Response Duty Officer (ERDO): The ERDO is the main point of contact for notification of the Office of Radiation Protection (ORP) for all radiological emergencies. The ERDO receives notification from either the 206-

NUCLEAR line during the work day or from the State Emergency Operations Officer (SEOO) via cellular messaging. The ERDO must differentiate between minor responses, requiring one field team or less plus the possible inclusion of a liaison to the local Emergency Operations Center (EOC) or Incident Command Post (ICP), and major responses potentially involving activation of all response positions. The ERDO will initiate the appropriate response for incidents at fixed nuclear facilities: Columbia Generating Station (CGS), U.S. Department of Energy – Richland Operations site (DOE-RL), or Naval Nuclear Propulsion Program (NNPP) sites; or incidents involving significant releases of radioactive materials from a Non-Fixed Nuclear Facility (Non-FNF) location such as a rail or transportation incident or an act of terrorism. The ERDO contacts the DOH DO who can activate the DOH IMT as required.

- Public Health Incident Management Teams (IMTs): These teams provide on-scene command and control for an incident that requires direct response, support, and coordination at an EOC or field location, or supporting a jurisdiction's response team. These teams are capable of responding to single jurisdiction, multi-jurisdiction, multi-region, or statewide incidents that will last for more than one operational period and require a written incident action plan. The IMTs may also coach other response team members in how to provide command and control. These teams are ready to deploy with a full complement of command and general staff.

- Epidemiology (Epi) Task Force: This team has the capability lead or support core epidemiology outbreak functions including: surveillance, detection, investigation, and contact tracing. The team can provide this function with 24-hour coverage and is scalable and modular in the duties it can perform. The team is ready to deploy with the necessary hardware, software, PPE, and diagnostic tools to conduct epidemiological surveillance and investigation functions.

- Environmental Public 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, activate environmental health response capabilities, such as assessing and monitoring the environment, monitoring air and water quality, ensuring safe food, providing vector control (when appropriate), and demobilizing environmental health operations.

- Radiation Response Team: When notified of a radiological emergency, the Office of Radiation Protection (ORP) will dispatch technical staff and subject matter experts to various emergency response centers. Staff will be dispatched to the SEOC, local county EOCs, the DOH ACC, the ICP or involved facility response center, and Joint Information Center. Field monitoring staff will be dispatched to the incident site to gather in-field measurements and samples, assist at local hospitals, or provide other support to local responders.

  Technical staff at the Facility Response Center or ICP assess radiological information to share with 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.

- Receipt, Stage, and Store (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 SNS as a 12-hour push package or managed inventory. Medical resources are distributed to pharmacy and healthcare distribution centers and local health jurisdictions to distribute via points of dispensing (PODs) and to other facilities. During demobilization, the team can effectively recover unused medical resources, inventory, and reorganize to return to pre-incident levels. This task force works in coordination with DES, WSP, and WSDOT.

- Pharmacists Response Network (PRN): The PRN is an entity housed under the Washington State Pharmacy Association (WSPA). Its mission is to provide access to prescriptions for chronic care medications and medication therapy management for displaced disaster survivors in the state of Washington. This volunteer network consists of state registered volunteer pharmacists that are deployed when instructed by WSPA. In a state declared emergency within WA State a mission number is issued by the Washington Emergency Management Division (EMD). DOH will coordinate with the PRN within WSPA for activation in large scale disasters lasting more than 24 hours or to be deployed to local jurisdictions faced with formation of alternative care sites or mass care shelters. In support of local jurisdictions, DOH will contact and mobilize volunteer pharmacists who have registered through the state as emergency workers.

- Public Health and Medical System Assessment Task Force: This task force can be formed from existing DOH and partner agency resources to provide immediate and ongoing assessments of a disaster-affected community's public health and medical systems. 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 and infrastructure. The task force can fully function 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.

- Construction Review Services (CRS) Strike Team: These teams provide two trained Washington Safety Assessment Facility Evaluation (Wasafe) building evaluators and one Structural Engineers Association of Washington (SEAW) licensed structural engineer. These teams are trained and experienced in assessing post-disaster conditions in healthcare construction and licensed healthcare delivery facilities.

- Call Center: During the initial phase of an incident, the DOH Call Center can be deployed to field locations and route incoming phone calls on behalf of local health jurisdictions, tribal partners, or healthcare facilities. As the incident progresses, the Poison Control Call Center or the originating entity may take this over.

II. Core Public Health, Medical, and Mortuary Missions:

A. Control Disease Outbreaks
   - Epidemiological Investigations

- Disease Surveillance
- Laboratory Testing
- Non-Pharmaceutical Interventions (social distancing, public education, isolation, and quarantine)
- Coordinating with local health jurisdictions and CDC and other federal partners

B. Provide Environmental Public Health Services and Coordination
   - Human Health effects regarding Water, Air Quality, Toxic Chemicals, Zoonotic Diseases (diseases that can be transmitted from animals to humans), and Radiation. These services include:
     - Sampling
     - Lab Testing
     - Coordinating
     - Sharing Info and Technical Assistance
     - Providing Health Protection Orders/Guidance
     - Supporting Local Health Jurisdictions and other responders with technical assistance in Environmental Public Health areas of expertise

C. Coordinate Medical Countermeasure Dispensing
   - Request and distribute the SNS
   - Coordinate dispensing of CHEMPACK caches

D. Provide Healthcare Support to:
   - Hospitals
   - Long-term Care Facilities
   - Behavioral Health Services
   - Blood Centers
   - Kidney Centers

   By providing:
   - Medical Surge Support
   - Medical Materiel
   - Crisis Standards of Care
   - Pharmaceutical Support and Supply Information
   - Facilitation of Coordination with Healthcare Partners
     - Interstate Mutual Aid for Healthcare Response

E. Provide Mortuary Coordination
   - Body Recovery
   - Morgue Operations
   - Family Assistance Centers
   - Data Management

ESF 8 partner agencies will send staff to the SEOC ESF 8 desk as soon as possible following a request for assistance. Alternatively, ESF 8 partner agency staff may be directed to report to their usual places of work and thereafter maintain continual communication with the ESF 8 representatives in the SEOC.

If ESF 8 capabilities are anticipated to be in short supply or exhausted at the state or local level, resource support may be requested from federal partner agencies.

Continuing Actions

Situation Assessment: The DOH IMT and ESF 8 representatives at the SEOC review and assess public health and medical information about the disaster. Staff works to identify the nature and extent of public health and medical issues and needs. ESF 8 representatives work collaboratively to establish appropriate monitoring and surveillance activities as required and provide essential information and recommendations. Other sources of information may include federal ESF 8 support agencies, various federal officials in the disaster area, local health officials, local emergency managers, emergency medical services authorities, local response authorities, or officials of the responsible jurisdiction in charge of the disaster scene.

Information Sharing: The DOH IMT and ESF 8 representatives at the SEOC collect and share relevant health response information with any partner that needs information necessary to save lives and stabilize the incident.

Coordination of Requests for Medical Transportation: Local transportation requirements will be handled by local authorities. If it is determined by ESF 8 representatives that regional or local resources are inadequate to meet the requirements, a state request for federal medical transportation assistance will be forwarded through the SEOC to federal ESF 8.

Support Agencies

Agency	Functions
Department of Agriculture	Assist in the areas of food safety and animal disease surveillance as provided for in state law and in agency plans, policies, procedures and/or practices. DOH, through an interagency agreement, will assist WSDA if the National Veterinary Stockpile (NVS) is requested by managing their medical resources.
Department of Ecology	Assist in the area of air quality, sampling, laboratory analysis, and waste disposal.
Department of Enterprise Services	Assist by providing facilities, staff, trucks, and drivers to RSS for the SNS as provided for under an interagency agreement with DOH.
Department of Fish and Wildlife	Assist in the area of animal-borne diseases that may be transmitted to humans.
Department of Labor and Industries	Lead agency for worker health and safety issues as provided for in state law and in agency plans, policies, procedures, and/or practices.
Department of Licensing	• Regulate funeral directors, embalmers, and funeral establishments. • Maintain a plan for use in a fatality management response and operate as an ESF 8 partner when required and as provided for in state law and in agency plans, policies, procedures, and practices.

Department of Social and Health Services	• Lead state agency for behavioral health issues as provided for in state law and in agency plans, policies, procedures, and practices. Collaborates with partners around behavioral health issues when outside the scope provided for in state law and in agency plans, policies, procedures, and practices. • Administer institutions that may be impacted by or available to support in an emergency.
Department of Transportation	• Assist in the area of route and load planning when moving medical countermeasures to or from the DOH RSS.
Military Department	• The Emergency Management Division supports ESF 8 representatives during activation. • The 10th Civil Support Team, Washington National Guard when activated, may support ESF 8 response activities through the collection and transportation of field samples of potential biological agents to the Public Health Laboratories (PHL) for analysis. • The Washington National Guard also operates armories, which may be made available to public health officials to facilitate the emergency distribution of medicine. • The Washington National Guard may support ESF 8 response activities through the deployment of their Fatality Search and Recovery Teams (FSRT).
Washington State Health Care Authority	• The Health Care Authority can help ESF 8 partners understand health and healthcare information and policy regarding health insurance coverage. • The Health Care Authority shares information about the healthcare status of special needs and vulnerable populations within Washington State communities.
Washington State Patrol	• The services of the State Patrol may be required to facilitate the movement of emergency medical resources over state highways to locations identified by public health authorities. • The State Patrol coordinates security requirements for the SNS with the U.S. Marshal Service and other law enforcement agencies as appropriate. • The State Patrol provides security for the RSS site.
Washington State Pharmacy Association	• The WSPA provides information to DOH regarding the status of the pharmaceutical supply chain during incidents. • The WSPA deploys the PRN to provide access to prescriptions for chronic care medications and medication therapy management for displaced disaster survivors in the state of Washington.

Demobilization and Recovery

- Support local communities with the restoration of the public health and medical infrastructure, including hospitals, long-term care centers, behavioral health services, kidney centers, and blood centers and assure the continuum of care.
- Support long-term monitoring of the population's health status.
- Support efforts to restore primary care systems in local communities and assure medical providers are operating in safe environments.
- Seek financial reimbursement from the responsible party.
- Support health and medical components of essential service centers or recovery centers.

Mitigation Objectives

- Strengthen surveillance to prevent disease outbreaks.
- Provide health promotion activities to residents to mitigate the spread of disease.
- Provide training and access to statewide HAN/WA SECURES communications systems for direct contact to timely situation/status reports and send alerts to local health jurisdictions, tribes, healthcare coalitions, military hospitals, and support agencies.
- Utilize geographical information systems and resource management data to identify vulnerable populations and critical infrastructure.
- Stockpile critical medical supplies, equipment, and pharmaceuticals in strategic locations throughout Washington.
- Develop and implement corrective action reports and improvement plans based on exercises and real incidents/events to improve preparedness plans.

Supporting Appendices

- Department of Health Emergency Response Basic Plan
- Appendix 1 – Emergency Medical Resources
- Appendix 2 – Medical Surge Plan
- Appendix 3 – Mass Fatality Incident Support
- Appendix 4 – Pandemic Influenza and Viral Respiratory Disease Plan
- Appendix 5 – Air Quality Response Plan
- Appendix 6 – Crisis Counseling and Emergency Mental Health Services

ESF 8: Public Health, Medical, and Mortuary Services

Appendix #1: Emergency Medical Resources

ESF Coordinating Agency:

Department of Health

Primary Agency:

Department of Health

Support Agencies:

Washington State Patrol
Emergency Management Division
Washington National Guard
Washington State Department of Enterprise Services
Washington State Department of Agriculture
Washington State Department of Transportation
Washington State Pharmacy Association
United States Department of Health and Human Services
Local Health Jurisdictions
Tribal Governments

I. Introduction

A. Purpose

The purpose of this Emergency Support Function (ESF) 8 Public Health, Medical, and Mortuary Services is to support people in Washington State during public health emergencies and disasters with necessary biologicals, medical equipment, and supplies. ESF 8 also provides technical assistance and guidance to state agencies, local government jurisdictions, military installations, and tribal governments following an emergency or disaster. This ESF also provides the capability for requesting, receiving, distributing, and tracking health and medical resources to protect or save lives. Federal assistance will primarily be obtained through the Centers for Disease Control and Prevention (CDC), Division of Strategic National Stockpile (DSNS), or the United States Department of Health and Human Services (US HHS) Assistant Secretary of Preparedness and Response (ASPR).

B. Scope

ESF 8 activates medical resource support when state agencies, local government jurisdictions, military installations, or tribal governments exhaust their resources or

expect to exhaust their resources and capacity to provide medical services due to either an increase in patient numbers or limitations in personnel and medical resources during an emergency or disaster. During emergencies communities and healthcare providers may implement crisis standards of care. This plan is applicable regardless of the implementation of crisis standards of care.

C. Policies

Emergency Health and Medical Resources Request:

1. Medical resources during such an incident will be sourced and/or procured locally prior to requesting assistance through mutual aid and/or the State Emergency Operations Center (SEOC).

2. When a jurisdiction anticipates that local resources will be exhausted and that the jurisdiction does not have the ability to procure them quickly, it becomes the responsibility of state ESF 8 to assist local jurisdictions in obtaining health and medical resources.

3. All state, local, and tribal governments, as well as military installations, are responsible for assessing and planning for people with unique access, functional, or language needs within a jurisdiction. Additionally they are expected to focus on equitable communication to all populations and necessary planning to ensure public points of dispensing (PODs) or medication centers are accessible for everyone.

   Examples of accessibility include:

   a. Individuals who may not be reached through standard procedures (traditional public media/outreach efforts)

   b. Groups that may not be able to obtain services at PODs without accommodation/wrap-around services (interpreters, access considerations, transportation, etc.)

4. The SEOC will process and assign all requests for medical resources to those representatives staffing the ESF 8 desk. ESF 8 staff will work to locate and procure the needed medical resources within the state (through the state or medical procurement system or mutual aid). If the needed resources cannot be readily procured, ESF 8 will begin the process of requesting federal assistance. There are currently two distinct methods of requesting assistance from our US HHS partners. These methods are dependent on an emergency declaration under the Stafford Act.

   a. The decision to request and if necessary, allocate limited public health and medical resources is the responsibility of the Secretary of Health or designee. The Secretary may rely on any advisory group deemed necessary to inform that decision.

b. For requests under the Stafford Act: SEOC ESF 8 representative(s) will work with our federal liaisons to complete a Federal Action Request Form (ARF).

    1) SEOC ESF 8 representative(s) will forward the ARF through SEOC Logistics Section (ESF 7). The Logistics Section processes and forwards the ARF to the Regional Response Coordination Center.

    2) The SEOC ESF 8 representative(s) will notify the US HHS Regional Emergency Coordinator and complete the documentation.

c. If the declaration does not fall under the Stafford Act, the Governor of the state of Washington may request deployment of federal health and medical resources.

    1) The US HHS, ASPR may mobilize public health and medical assets under the following circumstances:

        i. At the direction of the US HHS Secretary, typically, but not always, through a declared public health emergency by the Secretary

        ii. In response to a designated National Security Special Event (e.g., the Olympics, Inauguration, National Political Convention, etc.)

        iii. At the discretion of the ASPR, under their own authority, and under US HHS policies and procedures, when there has been no emergency declaration

    2) The CDC's Strategic National Stockpile (SNS) may be deployed when the Governor or designee as specified in the Governor's letter of delegation for activating the SNS (attached to this appendix), determines that it is prudent to do so to protect the public's health. The decision to request deployment of SNS resources to Washington State rests with the Governor. Should the Governor not be available, the Secretary of Health or the State Health Officer or the Washington State Department of Health (DOH) Chief of Emergency Preparedness and Response – in that order – may act in the Governor's stead.

    3) When the SNS is requested, the DOH Incident Management Team (IMT) and ESF 8 will forward the ARF through SEOC Operations and ESF 7 (SEOC Logistics Section). The Logistics Section processes and forwards the ARF to the Regional Response Coordination Center. Informal coordinating during the process between SEOC ESF 8 representative(s) and support and regional federal ESF 8 staff is encouraged.

5. The DOH Office of Emergency Preparedness and Response, Operational Readiness section will maintain appropriate license(s) to receive, store, and distribute pharmaceuticals.

6. Under the provisions of the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA), the US HHS Secretary can work with the Food and Drug Administration (FDA) to expand options related to emergency medical countermeasures (MCM).

7. During public health emergencies, Investigational New Drugs (INDs) may be identified as a lifesaving option. If an IND is employed for the incident, the CDC will obtain approval from the FDA to use the specific IND and/or obtain an Emergency-Use Authorization (EUA). The EUA associated with an IND will confer specific indemnifications to personnel dispensing drugs and/or using equipment or supplies. The state of Washington will follow these protocols.

8. There are pre-established EUA protocols for the MCM that are currently in the DSNS. The EUA associated with an existing SNS medical countermeasure will confer specific indemnifications to personnel dispensing drugs.

9. Specific recommended policies for local health jurisdictions (LHJs), military installations, and tribal governments or the state of Washington concerning emergency MCM are listed as follows:

    a. DOH policy is that all people impacted by any public health emergency will be treated with respect, dignity, and equality. LHJs, military installations, and tribal governments will receive emergency MCM based on their exposure to the disease or agent and will be provided the countermeasures in a timely manner.

    b. In an event that the needed countermeasures, equipment, and supplies are in short supply, they will be allocated based on a number of factors ultimately aiming for the most equitable and ethical approach.

10. The chain of custody, which establishes each person having custody/being in possession of the MCM, will be completed with the transfer of possession throughout the transport and distribution process.

11. The Secretary of Health is responsible for making decisions regarding the allocation of state and federal health and medical resources in accordance with guidance in Section III, B, 3 of this document.

D. Legal Authorities

See ESF 8 Annex Policies section starting on page 8-2 for the key state authorities that govern our emergency response. Other than those listed in the ESF 8 Annex, the following apply:

1. RCW 69.50.302 (Uniformed Control Substances Act, Registration Requirements)

This RCW provides that the Pharmacy Commission rules must be adhered to. Registration must be obtained from the State Department of Health annually for anyone who manufactures, distributes, or dispenses any controlled substances or who proposes to within the state of Washington.

2. RCW 69.50.308 (Uniformed Control Substances Act, Prescriptions)

   This RCW provides specific guidance on who, what, when and where a controlled substance may be dispensed.

3. RCW 18.71.205 (Emergency Medical Services Personnel-Certification)

   RCW section 18.71.205 provides the ability for the Secretary of the Department of Health to certify emergency medical service personnel. This section also allows the department to prescribe standards and performance requirement procedures for certification and recertification of physician's trained advanced emergency medical technicians and paramedics.

4. RCW 42.56.210 (Certain personal and other records exempt)

   This RCW provides for the protection from public disclosure information, which is confidential and would violate personal private or vital government interests.

5. WAC 246-879 (Pharmaceutical wholesalers)

   WAC 246-879 provides the minimum requirements for the storage and handling of prescription drugs and for the establishment and maintenance of prescription drug distribution records by wholesale drug distributors and their officers, agents, representatives, and employees.

6. WAC 246-907 (Pharmaceutical licensing periods and fees)

   WAC 246-907 provides the licensing periods and fees for pharmacists, pharmacy technicians, and pharmacy interns. Licenses must be renewed every year on the practitioner's birthday as provided in Chapter 246-12 WAC, Part 2. The Secretary may require payment of renewal fees less than those established in this section if the current level of fees is likely to result in a surplus of funds.

7. 21 USC 9 (Federal Food, Drug & Cosmetic Act)

   The United States Code that empowers the Federal Food and Drug Administration to regulate drugs and devices branding and labeling.

8. 21 USC 353 (Prescription Drug Marketing Act)

   This is the United States Code that provides the FDA the ability to issue exemptions and consideration for certain drugs, devices, and biological products.

9. Legal issues specific to support medical supplies management and distribution and/or mass MCM:

    a. Medical practitioners authorized to issue standing orders and protocols for emergency dispensing sites in Washington are designated by the local health officer and are covered in RCW 70 and RCW 43.

    b. Personnel authorized to dispense medications during a state of emergency are covered in WAC 246 in chapters 851, 858, 869, 887, and/or an EUA issued by US HHS and the FDA.

II. Situations and Assumptions

A. Situations

This plan is implemented when there has been an event that requires extensive medication, medical supplies, or medical equipment. The incident is such that local jurisdictions, military installations, and tribes do not have sufficient resources of these kinds to provide treatment or prevent the spread of disease. DOH through the SEOC is responsible for locating, requesting, receiving, and redistributing the required medical materiel in order to save lives.

B. Limitations & Assumptions

1. All communities and healthcare providers will work to provide the highest standard of care possible within the constraints created by the incident and all emergency management procedures and processes will be followed.

2. The National Incident Management System (NIMS) will be used to guide all aspects of the multi-agency coordination necessary to manage emergency medical resources.

3. Any incident requiring the deployment of federal resources is a major event, likely affecting thousands of people in multiple local jurisdictions.

4. It takes time to mobilize resources. The most rapid resources that can be accessed often exist at the local level. Resources that can be accessed in a relatively short amount of time typically reside at the state level and might be available from US HHS Region X partners. Federal resources may take additional time to mobilize.

5. It may take DOH up to 12 hours to repackage and redistribute procured medical resources to local health, military installations, or tribal governments from the time resources are received.

6. A deployment of a Federal Medical Station (FMS) will be a direct federal deployment to the pre-determined facility housing the FMS and will not go through the DOH Receipt, Stage, and Store (RSS) facility.

7. Moving resources during a disaster can be a challenge with damaged infrastructure and with displaced populations.

8. Sufficient storage and operational space that meet the minimum legal requirements for distributing pharmaceuticals will be available.

9. All levels of government will likely declare a disaster and the National Guard may be activated as conditions warrant.

10. Staff will be available to implement this plan.

11. Local governments, military installations, tribal governments, state agencies, and organizations will be capable of executing their responsibilities for ultimate distribution of the medical resources to the population.

12. Local governments, military installations, tribal governments, state agencies and organizations will allow a head of household or single family member to pick up a regimen of emergency MCM for each family or household member listed on the screening and dispensing form(s).

13. Local governments, military installations, tribal governments, state agencies, and organizations will allow unaccompanied minors to pick up needed emergency MCM for themselves and their immediate household or family members as described above in paragraph 12.

14. Local governments, military installations, tribal governments, state agencies, and organizations will accept as the identification needed to receive emergency MCM the name, age, and address recorded on the screening and dispensing form(s). Proof of residency is not recommended and should not be used to determine the need of a medical countermeasure, which may save the life of the person in question.

15. Local governments, military installations, tribal governments, state agencies, and organizations are responsible for their security protocols within their MCM system.

16. Local governments, military installations, tribal governments, state agencies, and organizations are responsible for planning for and implementing policies listed in section 1. C. Policies of this appendix.

17. A pandemic influenza and catastrophic incident response will require a resource push strategy rather than the standard of responding to requests for resources and is covered in the appropriate ESF 8 and DOH emergency response plans.

18. One important source of medical countermeasures, critical burn therapies, and quickly available medical supplies is the federal strategic national stockpile (SNS).

III. Concept of Operations

A. General

1. DOH's key mission is to save lives.

2. State Agency Medical Countermeasures Dispensing is intended to provide key state agencies with response roles the ability to provide MCM to their personnel and associated family members to protect them from a biological disease agent. DOH is responsible for development and maintenance of the operational plan and guide.

3. CHEMPACK Program, Chemical Nerve Agent Response Capability, the CHEMPACK Program assists states in strategically forward deploying chemical nerve agent countermeasures in hospitals and emergency medical services (EMS) agencies. Maintaining these caches in Washington State is a collaborative effort between federal, state, and city/local officials who are participating in the CHEMPACK program. CHEMPACK is intended as a secondary response to supplement local supplies. Forward placement of chemical nerve agent antidote and treatment makes it readily available when every moment saved translates into lives saved.

4. Federal Medical Stations (FMS) are assets owned by the US HHS and managed by the CDC's DSNS. The SECO ESF 8 responsibilities include identifying locations to deploy the FMS during disasters, arranging for wrap-around services during deployment, and demobilization and return to federal health officials. Greater detail on the FMs and their role in response can be found in the ESF 8 Medical Surge Appendix.

5. DOH's role in medical materiel management is to locate, procure, and receive needed resources, process it, break it down, and ship it out to key locations within Washington State.

6. DOH will make shipments of the needed MCM and/or medical materiel regardless of regional boundaries.

7. DOH will minimize the time from receiving an order for MCM and/or medical materiel to delivering that resource.

8. DOH is developing agreements with critical infrastructure entities, other state agencies, certain large corporations, and federal partners for dispensing medications to their staff during large-scale incidents.

9. DOH is implementing state-level mass dispensing with strategic partners to reduce the number of people that would require services at public PODs supported at the local level.

10. DOH is working with large healthcare systems and pharmacy chains to expedite deliveries of medications to dispensing locations during an emergency.

11. DOH works directly with large pharmaceutical distributors (such as Cardinal and McKesson) to minimize redundant medication delivery systems currently used by CDC.

    - DOH depends on LHJs to develop "Hub" distribution capability for the local distribution system (LDS) (hubs are local delivery sites and are not expected to maintain the same capabilities as regional distribution sites (RDS)). DOH helps local jurisdictions decrease the number of planned public PODs and emphasizes the importance of closed PODs as a more realistic method of distributing MCM.
    - DOH will partner with LHJs to provide technical assistance and support for identifying vulnerable populations not already serviced by the multi-layered MCM distribution system and work to develop "push" strategies to enhance overall connectivity to the distribution system by leveraging statewide partnerships and critical infrastructure networks to reach identified populations.
    - Overall state-level medical resource operations will be directed and controlled from the SEOC. DOH will deploy representatives to the ESF 8 desk and provide a liaison to the Multi-Agency Coordination Group in the Policy Room. ESF 8 representatives connect the SEOC to the DOH IMT.

12. Actions undertaken by the DOH ESF 8 representatives and the RSS Task Force will be documented and kept current in WebEOC to maintain situational awareness.

13. DOH maintains Inter-Agency Agreements with the Department of Enterprise Services (DES), Spokane County, and other agencies for the use and support as RSS facilities and transportation.

14. DOH will coordinate all incident public information with SEOC and supporting state, local, tribal, and federal agencies.

The figure below is intended to graphically describe the key dispensing modalities that will be applied in order to maximize efficiency, best utilize existing infrastructure, and reduce the overall operational burden on governmental public health agencies during an incident where mass dispensing of MCM is necessary.

Figure 1, Distribution Strategy

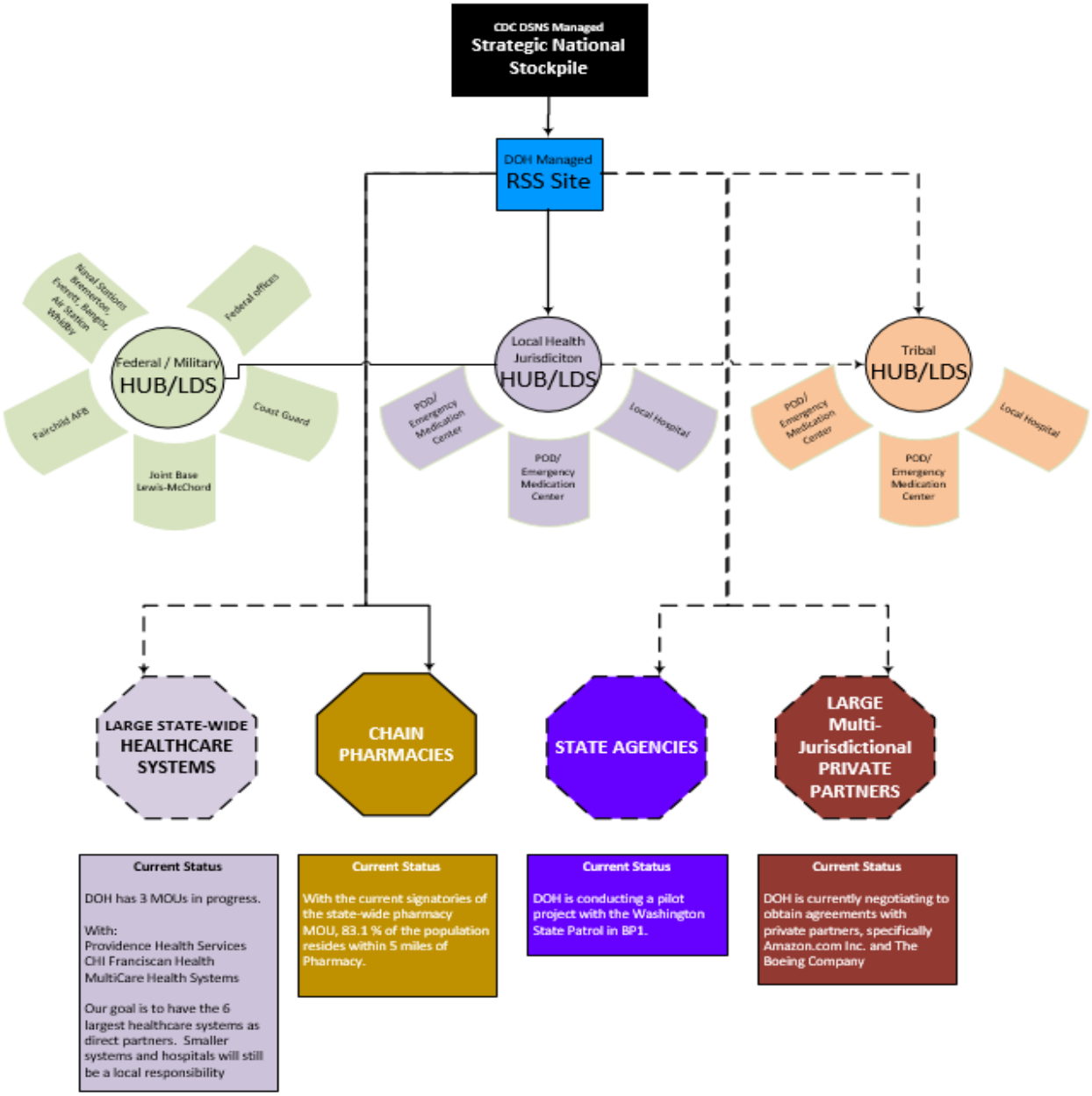
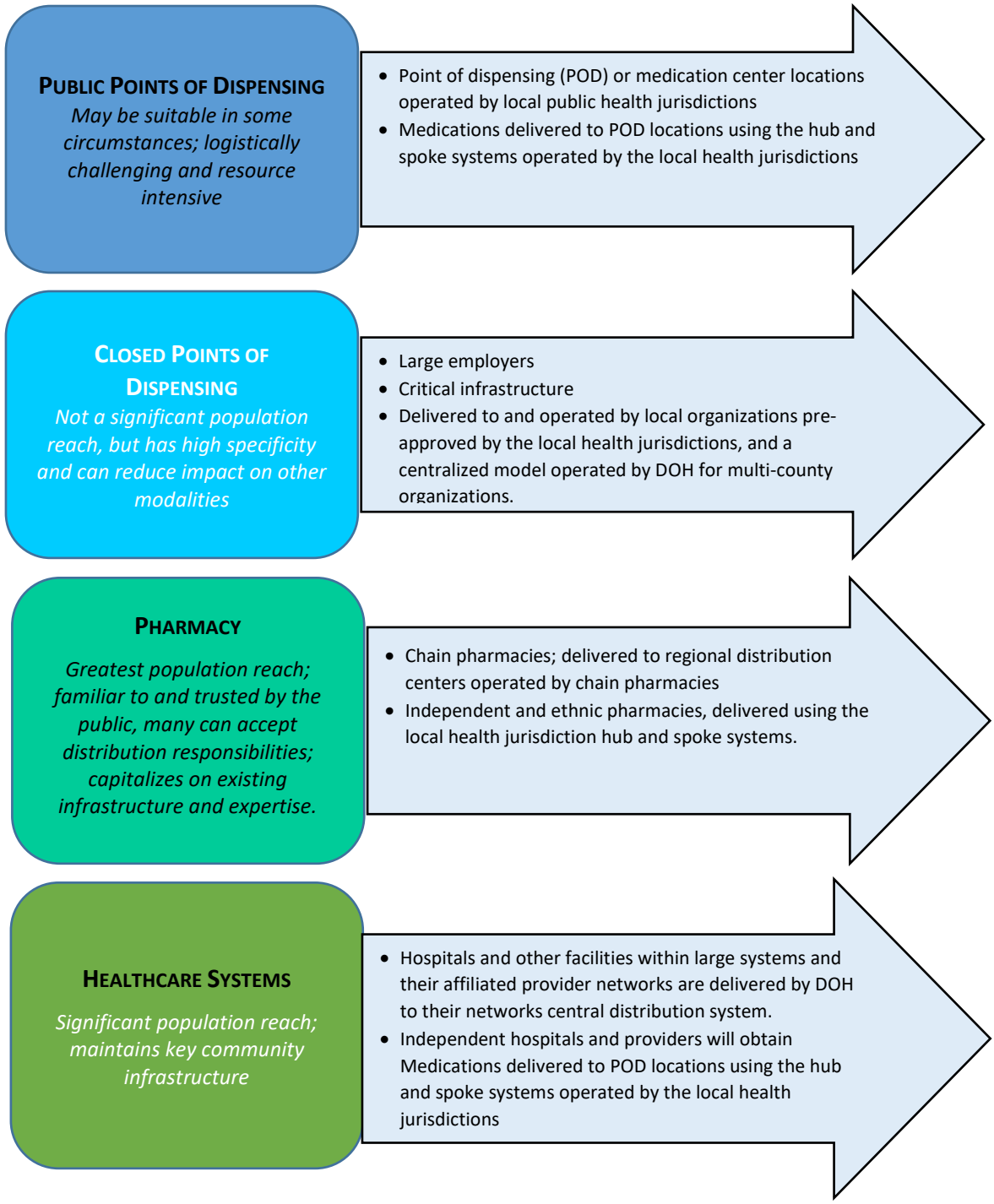


Figure 2, State Dispensing Network



B. The Decision-Making Process

The Governor or designee (Secretary of Health) will request federal medical resources and/or SNS deployment when, in the judgment of the Governor and state health officials, available in-state supplies of essential drugs, vaccines, medical equipment, and medical supplies will be insufficient to meet the demand generated by the incident.

1. The need for federal assistance may be identified by state health officials as they continually assess and reassess the public health and medical impacts of the incident and the availability of pharmaceuticals, vaccines, medical supplies, medical equipment, and other healthcare resources. Assessments may include evaluated common operating picture using epidemiological data, healthcare infrastructure information, disease surveillance data, and intelligence information.

2. The Secretary of Health is responsible for making decisions regarding the allocation of state and federal health and medical resources. In making these decisions, the Secretary relies on information from the following groups. This list is neither exhaustive nor binding.

    a. DOH Policy Group
    b. Disaster Advisory Group (DAG)
    c. Disaster Medical Advisory Committee (DMAC)
    d. Impacted Local Health Officers
    e. Subject matter experts
    f. Other state and federal health officials

3. There are four basic considerations that inform ethical and equitable decisions for distribution of MCM when responding to the public health consequences of emergencies:

    a. Should we distribute the MCM using the geographic concentration of people?
    b. How do we address serving populations disparately affected, broader social and cultural expectations, and the ethical dimensions of social justice in allocating MCM?
    c. Which are the most effective distribution mechanisms for MCM – specifically government PODs, pharmacies, private sector PODs, or healthcare systems (or combinations)?
    d. To what extent should the allocation approach focus on preserving continuity of society?
        1) Public health officials must determine that a particular case or cluster of cases indicates a potential public health emergency.
        2) Epidemiological investigation will be conducted to determine the population most affected, cause, and extent of any outbreak.

3) At the local jurisdiction, military installation, or tribal level, a surge in medical need has been identified and resources have been requested from the state.

4. Rapid consultation among appropriate officials must take place once initial information reveals the potential need for federal resources (i.e., that a major public health incident may have occurred). The coordination and consultation will normally include representatives from the Governor's office, Department of Health, Military Department (Emergency Management Division), and the local health jurisdiction(s) and/or tribal government affected. Due to the urgency of these situations, consultation will not be delayed. Other persons may be consulted as well (such as local pharmaceutical wholesalers and hospital representatives) in order to assess the need for the federal assistance.

C. Essential Elements of Information

In order to make these decisions, key information is required. The following essential elements of information are related to an incident in which medical materiel management is required.

1. Has there been any change in the status of critical resources or any resource shortfalls?

2. Has there been any change in the status of critical facilities and distribution systems, specifically emergency operations centers and RSS facilities?

3. Has there been any significant change in the status of the disaster or emergency, such as any change in the affected agency(ies), any change in the known boundaries of the hazard, or any change in the CDC threat condition to red?

4. Is this a nonstandard request for support?

5. Are non-stockpile items being requested?

6. What infectious disease or agent is involved in the incident?

7. What is the likelihood of further spread of the disease?

8. Are any pre-identified RSS facilities, routes, or areas likely to be unsafe?

9. Will the threat impede movement of the logistics personnel or assets?

10. Is the threat capable of disrupting communications or logistical connectivity?

11. What obstacles would prevent delivery of the SNS assets to the RSS facility?

D. Requesting Federal Medical Resources

Medical resource requests will be made in accordance with Policy 1 in section I. C. of this appendix found on page 1. DOH will procure health and medical resources from specific entities in this order:

1. In-state, privately owned resource procurement through private sector vendors, pharmacies, and government-owned supplies.

2. Regionally through an Emergency Management Assistance Compact (EMAC) request to our FEMA Region X partners in Alaska, Idaho, and Oregon. Resources can also be requested from other nearby states through EMAC, such as Montana or California.

3. Regional international partners in Canada through the Pacific Northwest Emergency Management Agreement (PNEMA) request with specific resources that are allowable by law.

4. A request to our federal partners for the deployment of SNS resources.

E. Organization

1. The DOH ESF 8 representative at the SEOC serves as the conduit for receiving local government, military installation, and tribal government resource requests.

2. DOH is responsible for establishing a logistics system to receive, stage, store, inventory, fill orders, and distribute federal and state resources to local governments, military installations, and tribal governments within the state. In order to meet this responsibility, DOH has:

    a. Organized, trained, and equipped the RSS Task Force;

    b. Maintained a set of DOH RSS procedures; and

    c. Created an RSS Task Force Field Operations Guide (FOG).

3. There are several resources produced by DOH that support the work of ESF 8, which include:

    a. Governor's Letter of Authorization (Attachment 1) – This letter provides authorization in the Governor's absence for the Secretary of Health, the State Health Officer, or DOH Office of Emergency Preparedness and Response Chief to request resources from the SNS.

    b. Emergency Repackaging of Pharmaceuticals – The SNS pharmaceuticals are configured in 10-day, unit-of-use regimens. The likelihood of receiving bulk packaged pharmaceuticals is remote, however still possible. Therefore, the state repackaging of bulk pharmaceuticals is covered in DOH RSS procedures.

c. DOH maintains the RSS procedures to distribute Antiviral Drugs (AVDs). AVDs may prove to be effective in the management of the response to pandemic influenza. Two AVDs have been approved to counter influenza A and avian influenza: Oseltamivir (brand name Tamiflu®) and Zanamivir (Relenza®) under EUA.

F. Whole Community Involvement & Non-Discrimination

The "Whole Community" includes individuals, families, and households; communities; the private and nonprofit sectors; faith-based organizations; and local, tribal, state, and federal governments. This appendix is committed to communicating with the Whole Community as needed during emergency response and disaster recovery operations. The Whole Community includes populations with Limited English Proficiency (LEP), individuals with disabilities, and Access and Functional Needs (AFN).

IV. ESF Responsibilities Aligned to Core Capabilities

The following table aligns the Core Capabilities that this ESF most directly supports, and the agencies and organizations identified provide services and resources in accordance with their individual missions, legal authorities, plans, and capabilities in coordination with the SEOC. All ESFs support the core capabilities of Planning, Operational Coordination, and Public Information and Warning.

Coordinating State Agency	Responsibilities	Core Capabilities
Department of Health	• Coordinate the planning of MCM and medical materiel management and distribution response activities.	**Planning** **Public Health, Healthcare, and Emergency Medical Services** **Logistics and Supply Chain Management**

Primary Agencies	Responsibilities & Actions	Core Capabilities
Department of Health	• Develop, maintain, implement, train on, and test procedures, field operations guides, and tools to conduct RSS operations. • In conjunction with partners and stakeholders develop, implement, train on, and test procedures, field operations guides, and tools to conduct point of dispensing POD operations. • Maintain an inventory control system capable of tracking all pharmaceuticals from receipt to distribution.	**Planning** **Public Health, Healthcare, and Emergency Medical Services** **Operational Coordination** **Logistics and Supply Chain Management**
Local Government Public Health Agencies	• In conjunction with partners and stakeholders develop, implement, train on, and test procedures, field operations guides, and tools to conduct local distribution (hub & spoke) and point of dispensing POD operations.	**Planning** **Public Health, Healthcare, and Emergency Medical Services**

Support Agency	Responsibilities & Actions	Core Capabilities
Washington Military Department	• Develop, implement, train on, and test procedures and tools to coordinate MCM and MMMD operations.	**Operational Coordination**
Washington State Patrol	• Develop, implement, train on, and test procedures, field operations guides, and tool to provide for the safety and security of the resources.	**On-Scene Security, Protection, and Law Enforcement** **Physical Protective Measures** **Intelligence and Information Sharing**
Department of Enterprise Services (DES)	• Develop, implement, train on, and test procedures, field operations guides, and tool to provide for the transport and movement of resources throughout the state and provide technical expertise to the RSS Task Force.	**Logistics and Supply Chain Management**
Washington Department of Agriculture	• Provide specific zoonotic disease technical assistance. • Provide additional staffing support for RSS operations • Provide support to service and companion animals, as well as livestock.	**Planning** **Public Health, Healthcare, and Emergency Services**
Washington State Department of Transportation (WSDOT)	• Provide route planning assistance. • Provide detour passes for delivery vehicles and route status information.	**Critical Transportation** **Operational Communications**

V. Resource Requirements

A. Delivery Locations

As part of the management of medical materiel, DOH must maintain an inventory of delivery locations for local health jurisdiction hubs, chain pharmacy distribution locations, state agency hubs, private partners, and healthcare systems' preferred delivery locations.

B. RSS Facilities

An additional resource requirement for medical materiel management is RSS facilities that can serve the state geographically. Currently there are two pre-identified RSS facilities.

- The primary Western Washington RSS location is:
  Department of Enterprise Services
  7511 New Market Street
  Tumwater, WA 98001

- The RSS location in Eastern Washington is:
  Spokane County Fair & Expo
  404 North Havana Street
  Spokane, WA 99202-4663

- DOH has a functional pharmaceutical storage facility that can be used as an alternate location at:
  Department of Health
  Pharmaceutical Cache Storage Site
  7745 Arab Drive SE
  Tumwater, WA 98001

C. RSS Task Force

DOH maintains a Receive, Stage, and Store Task Force able to run all of the logistical functions associated with an RSS facility.

D. Interagency Agreements

The final set of resources DOH maintains are interagency agreements for medical materiel distribution and transport, MCM dispensing, and warehousing facilities.

VI. References & Support Plans

A. Resource Management (DOH ERP Annex 5)

The SNS is a large federal cache of medical resources including pharmaceuticals, vaccines, antitoxins, and other medical and surgical supplies and equipment. The cache is managed by the CDC DSNS whose mission is to deliver critical medical assets to the site of a national emergency. This DOH Annex is the resource management plan for logistical support including receiving, staging, storing, and distributing these medical resources.

B. Emergency Repackaging of Pharmaceuticals (Attachment to DOH ERP Annex 5)

The SNS pharmaceuticals are configured in 10-day, unit-of-use regimens. The likelihood of receiving bulk packaged pharmaceuticals is remote, however still possible. Therefore, the state repackaging of bulk pharmaceuticals is covered in DOH ERP Annex 5 Resource Management.

C. Antiviral Drugs (AVDs) (ESF 8 Appendix 4)

AVDs may prove to be effective in the management of the response to pandemic influenza. Two AVDs have been approved to counter a novel influenza and avian influenza. Oseltamivir (brand name Tamiflu®) and Zanamivir (Relenza®) under EUA.

D. Medical Countermeasures (MCM) Strike Team Operating Procedures (Attachment to DOH ERP Annex 9)

The DOH Prevention and Community Health, Office of Immunization and Child Profile has the primary responsibility for the MCM Strike team, procedures, field operations guides and any MOUs or contracts to support the emergency response activities of the MCM Strike Team.

The MCM Strike team will adhere to the specific procedures and or field operations guides (FOG) to recall staff, conduct pre-deployment actions, deploy, and provide or supplement MCM services and demobilize upon mission completion

E. CHEMPACK Program, Chemical Nerve Agent Response Plan (DOH ERP Annex 9)

The CHEMPACK Program, working with the Local jurisdictions and other private entities, assists in the strategic "forward" placement of these products into cache sites selected by state and city/local officials, where they are maintained by the CHEMPACK program as a sustainable supply of pharmaceuticals readily available to emergency first responders and hospital treatment facilities. CHEMPACK is intended as a secondary response to supplement local supplies. Forward placement of antidote and treatment – every moment saved translates into lives saved.

VII. Terms, Acronyms & Definitions

AFN – Access and Functional Needs
ARF – Action Request Form
ASPR – Assistant Secretary of Preparedness and Response
AVD – Antiviral Drugs
CDC – Centers for Disease Control and Prevention
DAG – Disaster Advisory Group
DES – Department of Enterprise Services
DMAC – Disaster Medical Advisory Committee
DOH – Department of Health
DSNS – Division of Strategic National Stockpile
EMAC – Emergency Management Assistance Compact
EMS – Emergency Medical Services
ESF – Emergency Support Function
EUA – Emergency-Use Authorization
FDA – Food and Drug Administration
FMS – Federal Medical Station
FOG – Field Operations Guide
IMT – Incident Management Team
IND – Investigational New Drugs
LDS – Local Distribution System
LEP – Limited English Proficiency
LHJ – Local Health Jurisdiction
MCM – Medical Countermeasure
NIMS – National Incident Management System
PAHPRA – Pandemic and All-Hazards Preparedness Reauthorization Act
PNEMA – Pacific Northwest Emergency Management Arrangement
POD – Point of Dispensing
RDS – Regional Distribution Site
RSS – Receipt, Stage, and Store
SEOC – State Emergency Operations Center
SNS – Strategic National Stockpile
US HHS – United States Department of Health and Human Services
WSDOT – Washington State Department of Transportation

VIII. Appendices/Attachments

Attachment 1, Governor's Letter of Designation

Attachment 1, Governor's Letter of Designation

JAY INSLEE
Governor

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR
P.O. Box 40002 • Olympia, Washington 98504-0002 • (360) 902-4111 • www.governor.wa.gov

November 8, 2016

Dr. Thomas R. Frieden, Director
Centers for Disease Control and Prevention
Department of Health and Human Services
1600 Clifton Road, NE
Atlanta, Georgia 30333

Dear Dr. Frieden:

In the event that Washington State has a health emergency that requires deploying resources from the Strategic National Stockpile and I am unavailable, I authorize the following state officials to act on my behalf in requesting such resources:

- Secretary of Health
- State Health Officer
- Public Health Emergency Preparedness and Response Chief

If you need additional information, please contact John Wiesman, Secretary of Health, at (360) 236-4030.

Very truly yours,

Jay Inslee
Governor

cc: Major General Bret D. Daugherty, Washington State Military Department
John Wiesman, Secretary of Health, Department of Health
Robert Ezelle, Director, Emergency Management Division
Michael Loehr, Chief, Emergency Preparedness and Response

ESF 8: Public Health, Medical, and Mortuary Services

Appendix 2: Medical Surge Response

ESF Coordinating Agency:

Department of Health (DOH)

Primary Agency:

Support Agencies:

Washington Military Department
Washington State Department of Social and Health Services (DSHS)
Washington State Healthcare Authority (HCA)
Washington State Patrol (WSP)
Washington State Department of Transportation (WSDOT)
US Department of Health and Human Services (HHS)
US Northern Command (USNORTHCOM)
Local Health Jurisdictions
Tribal Governments
Regional Healthcare Coalitions
Regional and State Disaster Medical Coordination Centers (DMCC)

I. Introduction

A. Purpose

The purpose of this appendix is to establish and communicate the respective roles and responsibilities of each major public health, healthcare, and emergency medical services (EMS) partner in Washington State during each phase of response to a medical surge incident. It describes how state entities will provide support and coordination to local jurisdictions and tribal governments throughout the state during a medical surge incident that impacts or might impact healthcare delivery within Washington State. Additionally, this document focuses on coordination and support activities to address public health, healthcare, and EMS needs of jurisdictions responding to a medical surge incident.

The objectives of this appendix are to:

1. Provide common terminology and common framework for public health, healthcare, and EMS system preparedness and response to medical surge.

2. Support coordination between state and federal officials regarding effective response to medical surge.

3. Communicate roles and responsibilities of state and federal agencies with major involvement in response to medical surge.

B. Scope

This appendix is intended to inform but not supersede nor supplant existing local, regional, state, tribal, or federal plans, or plans maintained by healthcare entities, healthcare coalitions (HCCs), and other partner agencies. Rather, this document is intended to provide a unifying framework under which state and federal agencies develop and execute their own plans, protocols, policies, and procedures for response to medical surge incidents in a cohesive manner.

The scope of this plan is not limited by the nature or cause of any particular medical surge incident.

Portions of this appendix remain active during steady state operations, in the absence of a medical surge incident or other emergency condition. Full implementation of this appendix should be considered when one or more of the following occurs:

1. An emergency is declared/proclaimed in any political subdivision of Washington State due to a medical surge threat.
2. Any local or tribal public health partner, state or federal agency, healthcare organization, or HCC requests assistance in response to a medical surge threat that overwhelms or threatens to overwhelm the capability of that organization.
3. When in the judgment of the Secretary of Health, or other individual having statewide authority, there is the need for enhanced coordination of resources to respond to an imminent medical surge incident.
4. The Secretary of Health or Department of Health (DOH) Chief of Emergency Preparedness and Response anticipates an emerging risk to Washington's public health, healthcare, and EMS system that has the potential to overwhelm local capabilities and requires state support to prepare and/or respond effectively.

Coordination responsibilities between DOH and local health jurisdictions (LHJ), HCCs, tribal governments, healthcare entities, and all other non-state or federal agencies and associations are outside the scope of this plan. These relationships are described in the Medical Surge Annex 11 to the DOH Emergency Response Plan-Basic.

C. Policies

RCW 43.70.130 and 43.70.020(3) State Department of Health – Powers and duties of the Secretary of Health

RCW 38.56.020 Intrastate Mutual Aid System – Established

RCW 70.168 Statewide Trauma Care System

II. Situations and Assumptions

A. Situations

A medical surge incident occurs when a greater-than-typical volume of patients enters the healthcare system, threatening overall healthcare system resiliency and resulting in shortages of the capabilities and resources necessary to deliver adequate patient care. In Washington State, medical surge incidents can result from:

- Natural disasters such as earthquakes, volcanic activities, wildfires, flooding
- Extreme weather: severe winter weather, extreme heat
- Communicable diseases: influenza, severe acute respiratory syndrome (SARS)
- Mass casualty incidents: transportation accidents, structure fires
- Terrorist activities: explosive devices, biological attacks

The United States Department of Health and Human Services (HHS) Office of the Assistant Secretary of Preparedness and Response (ASPR) is solely committed to supporting local, regional, state, tribal, and national efforts to prepare for and respond to major medical incidents. The following definitions are excerpted from http://www.phe.gov/:

Medical surge describes the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of healthcare organizations to survive a hazard impact and maintain or rapidly recover operations that were compromised (a concept known as medical system resiliency).

Medical Surge Capacity
Medical surge capacity refers to the ability to evaluate and care for a markedly increased volume of patients—one that challenges or exceeds normal operating capacity. The surge requirements may extend beyond direct patient care to include such tasks as extensive laboratory studies or epidemiological investigations.

Because of its relation to patient volume, most current initiatives to address surge capacity focus on identifying adequate numbers of hospital beds, personnel, pharmaceuticals, supplies, and equipment.

Medical Surge Capability
Medical surge capability refers to the ability to manage patients requiring unusual or very specialized medical evaluation and care. Surge requirements span the range of specialized medical services (expertise, information, procedures, equipment, or personnel) that are not normally available at the location where they are needed (e.g.: pediatric care provided at non-pediatric facilities). Surge capability also includes patient problems that require special intervention to protect medical providers, other patients, and the integrity of the healthcare organization.

B. Limitations & Assumptions

The following assumptions are made in the development and implementation of this framework:

1. Preservation of life safety including the prevention of morbidity and mortality is the primary mission objective for all involved agencies during any emergency.
2. Supporting health equity and making provisions for people with access or functional needs are critical.
3. The Secretary of Health may direct the statewide public health, healthcare, and EMS response as necessary and is authorized by state law to protect the health of the public (RCW 43.70.130 and 43.70.020(3)).
4. DOH is the lead agency for responding to multijurisdictional public health emergencies in Washington.
5. Public health, healthcare, and EMS services, resources, facilities, and personnel may be limited in availability or capacity during and following a medical surge incident.
6. LHJs, HCCs, tribal governments, and healthcare facilities will implement their emergency response plans, including mutual aid agreements, and will request additional resources when their own resources are, or it is anticipated their resources will soon be, exhausted as outlined in the Washington State Comprehensive Emergency Management Plan (CEMP) and the ESF 8 Annex.
7. Responding to a medical surge incident may require resources from intrastate, interstate, and international mutual aid, as well as from Washington State and U.S. government agencies, none of which may be immediately available. Other than intrastate mutual aid agreements, resource requests from any of the aforementioned resource providers must be made through the State Emergency Operations Center (SEOC) using the Emergency Management Assistance Compact (EMAC) or the Pacific Northwest Emergency Management Arrangement (PNEMA).
8. Medical surge incidents might require exercising legal authorities in a shift from conventional to contingency to crisis standards of care in terms of how care is provided and/or how medical resources are allocated. In certain circumstances, medical resources and care may be rationed in alignment with operational objectives.
9. All healthcare entities may need to provide care to a greater number of patients, different patient populations, and provide different types of care than the entity normally provides to meet the needs of the population during a medical surge incident.
10. An alternate medical care site or system of sites may be needed in order to meet the medical needs of the public during a widespread medical surge incident.

11. Public perception of the severity of the incident may not be consistent with reality. For this reason, effective coordination of information sharing between response partners and timely public information during a medical surge incident is essential.

III. Concept of Operations

A. General

Most minor medical surge incidents are managed through normal operations of EMS and healthcare providers. This section describes the ongoing roles and responsibilities for managing low-impact medical surge incidents.

1. Inpatient healthcare facilities
   Inpatient healthcare facilities, particularly hospitals, commonly experience a chronic stress on the capacity of their facilities. As noted in the Planning Assumptions section of this appendix, internal strategies are frequently implemented to alleviate the impacts of a patient surge and to hasten the delivery of necessary medical care to patients who need it. Some of these strategies may include:
   - Assessing situational awareness and availability of non-standard healthcare capacity
   - Activating the facility's Medical Surge Plan and following the mitigation strategies outlined therein, including notifying DOH Health Systems Quality Assurance (HSQA) division
   - Using the WATrac bed tracking system to indicate that an emergency department is temporarily not accepting non-trauma patients (subject to regional protocols)
   - Utilizing in-facility capacity to admit or hold patients
   - Referring patients to other supportive services that may better suit their needs
   - Calling in additional staff members and/or shifting to alternate staffing ratios

All of the above actions, and others, can be used at any hospital or long-term care facility at any time to manage their internal patient surge. This does not typically require coordination with any external partners, though facilities may elect to reach out to partner agencies to share information.

As conditions persist, hospitals may employ additional tactics to create available capacity, such as:

- Decompressing their census by discharging patients with lower acuity conditions to a more appropriate level of care
- Postponing elective surgical and other procedures

Disaster response by inpatient facilities to a medical surge incident is discussed in further detail in the Medical Surge Annex to the DOH Emergency Response Plan.

2. Emergency Medical Services (EMS)
   EMS agencies may be the first to know that a medical surge incident is developing, based on their presence in the field and their awareness of what is occurring in the region. In this case, EMS dispatch centers can communicate with hospitals and use WATrac to help inform decisions about patient destination, often directing ambulances to transport patients to the most appropriate destination. This prevents overloading any particular emergency department with a disproportionate number of patients.

B. Organization

In the event that a medical surge incident exceeds local or regional healthcare resources, the following strategies may be implemented: regional and state decision making systems, patient distribution, alternate facilities for patient care, and scarce resource allocation. This section describes the state-level organizations with whom DOH would coordinate and develop response strategies in support of healthcare facilities, local, and tribal partners.

1. Washington Military Department
   As per the State CEMP, the Washington Military Department, Emergency Management Division (EMD) is the host agency for the Washington State Emergency Operations Center (SEOC). The SEOC remains activated and staffed 24 hours a day, 7 days a week, in a monitoring posture (Level 3 activation). At the onset of an incident, EMD raises the activation levels to either enhanced or full (Levels 2 and 1 respectively) to support the response efforts of political subdivisions (also called local governments) and partner agencies, or to coordinate a statewide response effort. During an increased activation level (i.e., beyond Level 3), all necessary Emergency Support Functions (ESFs) are staffed to meet the needs of the incident. DOH is the coordinating agency for ESF 8 (Public Health, Medical, and Mortuary Services) and provides the majority of personnel to staff ESF 8, when activated. During an incident, the SEOC is the statewide central coordination point for receiving incident-related information and requesting state and federal resources. DOH would route requests for federal medical resources though the SEOC.

   The Army and Air National Guard have medical personnel and logistic capabilities that may be requested during a medical surge incident.

2. Department of Social and Health Services
   The Department of Social and Health Services (DSHS) licenses, coordinates with, and maintains information regarding all long-term care facilities across the state. During medical surge incidents, DOH would utilize DSHS as a source of information regarding impacts to and functionality of long-term care facilities to support statewide healthcare situational awareness.

3. Health Care Authority
   The Health Care Authority (HCA) serves as an additional source of information regarding impacts to and functionality of healthcare systems,

facilities, and providers. During medical surge incidents, the HCA can help facilitate communication with key national partners, healthcare organizations, associations, and stakeholders. The HCA may also take additional steps, such as assisting in the identification of healthcare resources, system capacity and capability; providing data for analytics, coordinating outreach with contracted organizations; and developing protocols for patients who need specialized care or have co-morbidities who may be at higher risk.

4. Washington State Patrol
   Support of local law enforcement agencies in coordinating law enforcement and security in medical surge-related medical shelters and alternate care sites will be directed to ESF 13.

5. Department of Transportation
   The Department of Transportation can assist in the area of route planning when moving patients during or after an emergency.

During medical surge incidents, DOH coordinates extensively with a wide range of partner organizations including Disaster Medical Coordination Centers (DMCC), LHJs, tribal government, HCCs, statewide health and medical associations, and large healthcare systems. Details regarding coordination with these partners are included in the Medical Surge Annex to the DOH Emergency Response Plan-Basic.

Federal Partners

1. Department of Health and Human Services (HHS)
   HHS will provide response and recovery support by acting as a liaison between DOH and other federal agencies (Department of Defense, Veteran's Administration, Indian Health Services, Federal Aviation Administration, etc.) to assist with surging resources in and/or moving patients out of state. HHS will help to vet, prioritize, and fulfill state-level medical surge resource requests. Additionally, it may provide incident management and coordination resources and support.

2. U.S. Northern Command (USNORTHCOM)
   Joint Regional Medical Plans and Operations (JRMPO) will serve as a technical specialist to DOH regarding all Department of Defense logistical, public health, medical, and mortuary services resources and capabilities that could be applied to addressing ESF-8 missions.

Proclaiming or Declaring Emergencies

A governor's emergency proclamation is a last-step approach to addressing medical surge. Additionally, proclaiming an emergency may not provide the level of relief that some partners envision.

First and foremost, it should be noted that local health officers cannot waive any federal requirements, such as the 25-bed limit that the Center for Medicare &

Medicaid Services (CMS) has defined for critical access hospitals. In fact, no agency or policy decision maker within Washington State has this power.

As per Chapter 43.06 RCW, the governor may proclaim a state of emergency. However, the governor's powers pursuant to a proclamation currently do not include authorizing crisis standards of care, nor the ability to bring about CMS waivers (as noted above).The governor's proclamation enables state agencies to use their resources, and doing everything "reasonably possible," to assist affected political subdivisions. This supports the DOH response, and can provide indirect benefits to healthcare facilities, but does not provide any direct benefit to them.

However, a governor's proclamation is a required first step to receiving both a presidential disaster declaration, and a public health emergency declaration from the United State Secretary of HHS. Both of these are essential to receiving the types of waivers from which hospitals may benefit most (such as the CMS 1135 waiver).

As for triggers and indicators for the governor proclaiming an emergency to support healthcare facilities, DOH considers several factors including:

- the extent to which facilities across multiple counties have activated emergency plans;
- the extent to which all facilities are at or above capacity;
- limitations on critical infrastructure that supports healthcare facilities, or access to medical supplies by those facilities
- no signs of the crisis abating; and
- all facilities within a region having thoroughly exhausted all options available to them to enhance capacity.

When there is no federal emergency declaration, Region 10 HHS/ASPR is a resource for discussing potential federal HHS support options (e.g., Using existing CMS rules, assistance to healthcare facilities can sometimes occur without a declared emergency.).

C. Whole Community Involvement & Non-Discrimination

The "Whole Community" includes individuals, families, and households; communities; the private and nonprofit sectors; faith-based organizations; and local, tribal, state, and federal governments. This ESF is committed to communicating with the Whole Community as needed during emergency response and disaster recovery operations. The Whole Community includes populations with Limited English Proficiency (LEP), individuals with disabilities, and Access and Functional Needs (AFN).

IV. ESF Responsibilities Aligned with Core Capabilities

The following table aligns the Core Capabilities that this ESF most directly support, and the agencies and organizations identified provide services and resources in accordance with their individual missions, legal authorities, plans and capabilities in coordination with the State Emergency Operations Center (SEOC). All ESFs support the core capabilities of Planning, Operational Coordination, and Public Information and Warning.

Coordinating State Agency	Responsibilities	Core Capabilities
Department of Health	• Coordinate and develop response strategies in support of healthcare facilities, local, and tribal partners • Provide the majority of personnel to staff ESF 8, when activated • Coordinate extensively with a wide range of partner organizations including Disaster Medical Coordination Centers (DMCC), LHJs, tribal government, HCCs, statewide health and medical associations, and large healthcare systems to obtain and share situational awareness • Route requests for federal medical resources though the SEOC	**Planning** **Public Info & Warning** **Operational Coordination** **Intelligence and Information Sharing** **Public Health, Healthcare, and Emergency Medical Services** **Situational Assessment**

Support Agency	Responsibilities & Actions	Core Capabilities
Washington Military Department	• Support the response efforts of political subdivisions (also called local governments) and partner agencies • Coordinate a statewide response effort • statewide central coordination point for receiving incident-related information and requesting state and federal resources • Washington Army and Air National Guard have medical personnel and logistic capabilities that may be requested	**Operational Coordination** **Logistics and Supply Chain Management** **Situational Assessment**
Department of Social and Health Services (DSHS)	• Provide information regarding impacts to and functionality of long-term care facilities to support statewide healthcare situational awareness	**Planning** **Intelligence and Information Sharing** **Health and Social Services** **Public Health, Healthcare, and Emergency Medical Services**

Healthcare Authority (HCA)	• Facilitate communication with key national partners, healthcare organizations, associations, and stakeholders • Assist in the identification of healthcare resources, system capacity and capability; providing data for analytics, coordinating outreach with contracted organizations; and developing protocols for patients who need specialized care or have co-morbidities who may be at higher risk	**Intelligence and Information Sharing** **Public Health, Healthcare, and Emergency Medical Services**
Washington State Patrol (WSP)	• Supporting local law enforcement agencies in coordinating security, protection, and law enforcement in medical surge-related medical shelters and alternate care sites	**On-scene Security, Protection, and Law Enforcement**
Washington State Department of Transportation (WSDOT)	• Assist in the area of route planning when moving patients during or after an emergency	**Planning** **Intelligence and Information Sharing**
US Department of Health and Human Services (HHS)	• Response and recovery support by acting as a liaison between DOH and other federal agencies • Help to vet, prioritize, and fulfill state-level medical surge resource requests • Provide incident management and coordination resources and support	**Operational Coordination** **Intelligence and Information Sharing** **Public Health, Healthcare, and Emergency Medical Services** **Situational Assessment**
US Northern Command (USNORTHCOM)	• Serve as a technical specialist to DOH regarding all requested Department of Defense logistical, public health, medical, and mortuary services resources and capabilities	**Logistics and Supply Chain Management** **Public Health, Healthcare, and Emergency Medical Services**
Local Health Jurisdictions	• Provide situational awareness to DOH	**Planning** **Public Info & Warning** **Operational Coordination** **Intelligence and Information Sharing** **Public Health, Healthcare, and Emergency Medical Services** **Situational Assessment**

Tribal Governments	• Provide situational awareness to DOH • Support the health and medical needs of tribal populations	**Intelligence and Information Sharing**
Regional Healthcare Coalitions	• Provide situational awareness to DOH • Respond to support the information and resource needs of healthcare facilities within coalition regions	**Planning** **Public Info & Warning** **Operational Coordination** **Intelligence and Information Sharing** **Public Health, Healthcare, and Emergency Medical Services** **Situational Assessment**
Regional and State Disaster Medical Coordination Centers (DMCC)	• Provide situational awareness to DOH • Coordinate patient placement across regions	**Operational Coordination** **Intelligence and Information Sharing** **Public Health, Healthcare, and Emergency Medical Services**

V. Resource Requirements

The Region X Resources Catalog is a FEMA Region X (Alaska, Oregon, Idaho, and Washington) joint catalog that provides responders with an up-to-date list of resources available within the Region. The catalog provides not only the available resources but a complete logistical information about the items, including photos. This catalog is a living document and each state is responsible for maintaining their individual section.

VI. References & Support Plans

ESF 8 – Public Health, Medical, and Mortuary Services Annex to State CEMP

Regional Patient Tracking Concept of Operations

Pierce County Patient Reception Area Operational Plan (PRA OPLAN)

VII. Terms, Acronyms & Definitions

AFN – Access and Functional Needs

ASPR – Assistant Secretary of Preparedness and Response

CEMP – Comprehensive Emergency Management Plan

CMS – Center for Medicare & Medicaid Services

DMCC – Disaster Medical Coordination Centers

DOH – Department of Health

DSHS – Department of Social and Health Services

EMAC – Emergency Management Assistance Compact

EMD – Emergency Management Division

EMS – Emergency Medical Services

HCA – Health Care Authority

HCC – Healthcare Coalitions

HHS – United States Department of Health and Human Services

HSQA – Health Systems Quality Assurance Division

JRMPO – Joint Regional Medical Plans and Operations

LEP – Limited English Proficiency

LHJ – Local Health Jurisdiction

PNEMA – Pacific Northwest Emergency Management Arrangement

SARS – Severe Acute Respiratory Syndrome

SEOC – State Emergency Operations Center

USNORTHCOM – US Northern Command

ESF 8: Public Health, Medical, and Mortuary Services

Appendix 3: Fatality Management Incident Support

ESF Coordinating Agency:

Department of Health

Primary Agencies:

American Red Cross (ARC)
Department of Social and Health Services (DSHS)

Support Agencies:

Department of Licensing (DOL)
Emergency Management Division (EMD)
Governor's Office of Indian Affairs (GOIA)
Washington Military Department (MIL)
Washington National Guard (WNG)
Washington State Department of Transportation (WSDOT)
Washington State Patrol (WSP)
Washington State Forensic Investigation Council
Washington Association of Coroners and Medical Examiners (WACME)
Washington State Funeral Directors Association
Washington State Department of Labor and Industries (LNI)
National Transportation Safety Board
U.S. Department of Health and Human Services
Federal Bureau of Investigation
U.S. Department of Justice
U.S. Department of Defense

I. Introduction

A. Purpose

The purpose of this plan is to describe and define state-level responsibilities to support local health jurisdictions (LHJs) and tribes that experience a mass fatality incident (MFI) by coordinating cross-jurisdictional, state, interstate, and federal mutual aid.

B. Definitions

An MFI is an event producing a number of deaths that exceed the capacity of local authorities, thereby requiring assistance from outside the local jurisdiction(s).

Regardless of the agencies or organizations that respond, whether they are governmental agencies, private entities, or non-governmental organizations (NGOs), the responsibility to coordinate and manage these outside resources rests with local authorities.

The following excerpt from *Centers for Disease Control and Prevention, Public Health Emergency Preparedness Capability 5: Fatality Management* defines the necessary activities included in this capability. "Fatality Management is the ability to coordinate with other organizations to ensure the proper recovery, handling, identification, transportation, tracking, storage and disposal of human remains and personal effects; certify cause of death; and facilitate access to mental/behavioral health services to the family members, responders, and survivors of the incidents."

C. Scope

This plan reflects an all-hazards approach to preparing for, responding to, and recovering from disasters. Services, functions, and partners covered in this plan include state and federal government agencies, LHJs, tribes, non-governmental organizations, and mortuary services. Functional roles within the scope of Emergency Support Function 8 (ESF 8) include:

- Coordinating a statewide mortuary response during disasters.
- Coordinating statewide mutual aid among LHJs, medical examiners, and coroners.
- Coordinating interstate mutual aid requests for mortuary assistance and initiating requests for federal assistance and resources during disasters.
- Supporting fatality management, victim identification, and activation of Family Assistance Centers.
- Coordinating with ESF 6 partners the mobilization of crisis intervention and behavioral health services following disasters.
- Secretary of Health temporary appointment of an incident-specific State Fatality Management Coordinator to assist LHJs and facilitate mutual aid within the state, regional, and/or federal level.
- Coordinating sociocultural considerations with state, local, and non-governmental ESF 8 partners for fatality management operations including cultural values and religious beliefs to minimize public health risk, promote recovery, and reduce additional harm to surviving family members while assuring the dignity of the deceased.

D. Authorities-Policies

Under current state law, the local 39 County Coroners or Medical Examiners have jurisdiction over human remains due to an unnatural or suspicious manner of death in their respective jurisdiction. Positive identification of the victims and certification of their cause and manner of death is the responsibility of the Medical Examiner or County Coroner (ME/C). A medico-legal death investigation for tribal nations is provided by either the tribes or ME/C for the county within which the tribal land resides.

Washington has a decentralized 39-county, 3-tier system for fatality management/death investigations:

- Tier 1 populations above 250,000 – authorized Medical Examiner (currently 6)
- Tier 2 populations above 40,000 – authorized elected County Coroner (currently 19)
- Tier 3 populations below 40,000 – authorized County Prosecutor/Coroner (currently 14)

Staffing levels vary by jurisdictions, with most Tier 2 and 3 entities using contract services.

The following key authorities enumerate mass fatality responsibilities:

RCW 68.50.010 – Coroner's Jurisdiction over Remains
The jurisdiction of bodies of all deceased persons who come to their death suddenly when in apparent good health without medical attendance within the thirty-six hours preceding death; or where the circumstances of death indicate death was caused by unnatural or unlawful means; or where death occurs within one year following an accident; or where the death is cause by any violence whatsoever, or where death results from a known or suspected abortion; whether self-induced or otherwise; where death apparently results from drowning, hanging, burns, electrocution, gunshot wounds, stabs or cuts, lightning, starvation, radiation, exposure, alcoholism, narcotics or other addictions, tetanus, strangulation, suffocation or smothering; or where death is due to premature birth or still birth; or where death is due to a violent contagious disease or suspected contagious disease which may be a public health hazard; or where death results from alleged rape, carnal knowledge or sodomy, where death occurs in a jail or prison; where a body is found dead or is not claimed by relatives or friends, is hereby vested in the county coroner, which bodies may be removed and placed in the morgue under such rules as are adopted by the coroner with the approval of the county commissioners, having jurisdiction, providing therein how the bodies shall be brought to and cared for at the morgue and held for proper identification where necessary.

RCW 68.50 Human Remains
A coroner has jurisdiction over human remains when death is due to a violent contagious disease which may be a public health hazard, or when death results from events including drowning, an accident, radiation, or exposure. Reports and records of autopsies or postmortems are confidential. Only the following people may view these confidential records: the personal representative of the decedent, any family member, the attending physician or advanced nurse practitioner, the prosecuting attorney or law enforcement agencies with jurisdiction, public health officials, the department of labor and industries or the secretary of the department of social and health services. A coroner, medical examiner, or their designee may publicly discuss their findings except when there is a pending investigation or court proceedings. These officials may also release identifying information of the deceased to aid in identification. The coroner, medical examiner or the attending physician will meet with the family of the decedent to discuss autopsy findings if they request. If the county coroner or county

medical examiner investigating a death is unable to identify the decedent he or she shall have a qualified dentist carry out a dental examination. If the county coroner or medical examiner is still unable to identify the decedent, they will forward the dental examination records to the dental identification system of the state patrol to be matched and scored for identification.

WAC 246-500 Handling of Human Remains
This WAC includes the guidelines that funeral directors, embalmers, medical examiners, coroners, health care providers and others directly handling or touching human remains must follow in addition to management of human remains in refrigerated storage and transportation protocols. The local health officer may impose additional requirements for the handling, care, transport or disposition of human remains or suspend the requirements of this chapter.

RCW 70.02 Medical Records
Health care information is personal and sensitive and if it is used improperly or released may be harmful to a patient's privacy, health care or other interests. Patients and other qualified entities need access to health care records in order to inform their health care decisions, protect the health of the public, and more, but records must be disclosed appropriately and in appropriate circumstances, as noted in this RCW. Authorization must be obtained prior to disclosure of records. A health care provider or health care facility may disclose health care information without a patient's authorization if the disclosure is to protect the health of the public or if it is for research that has been approved by an institutional review board. A personal representative of a deceased patient may exercise all of the deceased patient's rights, as noted in this RCW. All state and local agencies that obtain patient health care information must adopt and make available on their websites the rules and policies in accordance with this RCW regarding record acquisition, retention, destruction, and security. If patient information is improperly disclosed by a state or local agency the patient must be notified. The Department of Social and Health Services is authorized to release patient information that is necessary to protect the public.

RCW 70.58 Vital Statistics
The Department of Health (DOH) is authorized to prescribe the rules, schedule and system for electronic and hard copy transmission of birth and death certificates and marriage licenses as noted in this RCW. DOH also maintains rules for releasing copies of vital records through secure and confidential means. Local and city health officers are generally the entities responsible for registration activities which are supervised by the state registrar. Each local registrar may appoint deputy registrars to assist them. Washington State vital statistics documents include, at minimum, the items recommended by the federal agency responsible for national vital statistics. Information may be added to or removed from documents if the state board of health requires an addition. Vital records copies may be shared with federal, state and local governmental agencies if the record is to be used for official agency duties. A certificate of every death or fetal death must be filed with the local registrar in the district where the death occurred. Only qualified officials may file death certificates, as noted in this RCW. A county coroner, medical examiner or prosecuting attorney with

jurisdiction may file a certificate of presumed death if the certificate includes sufficient evidence to indicate a person has died within the county and if it is unlikely that the body will be recovered.

RCW 70.58.170 Certificate of death or fetal death -- By whom filed.
The funeral director or person having the right to control the disposition of the human remains under RCW 68.50.160 shall file the certificate of death or fetal death. In preparing such certificate, the funeral director or person having the right to control the disposition of the human remains under RCW 68.50.160 shall obtain and enter on the certificate such personal data as the certificate requires from the person or persons best qualified to supply them. He or she shall present the certificate of death to the physician, physician's assistant, or advanced registered nurse practitioner last in attendance upon the deceased, or, if the deceased died without medical attendance, to the health officer, medical examiner, coroner, or prosecuting attorney having jurisdiction, who shall certify the cause of death according to his or her best knowledge and belief and shall sign or electronically approve the certificate of death or fetal death within two business days after being presented with the certificate unless good cause for not signing or electronically approving the certificate within the two business days can be established. He or she shall present the certificate of fetal death to the physician, physician's assistant, advanced registered nurse practitioner, midwife, or other person in attendance at the fetal death, who shall certify the fetal death and such medical data pertaining thereto as he or she can furnish.
[2009 c 231 § 2; 2005 c 365 § 154; 2000 c 133 § 1; 1979 ex.s. c 162 § 1; 1961 ex.s. c 5 § 13; 1945 c 159 § 2; Rem. Supp. 1945 § 6024-2.]

RCW 70.58.240 Duties of funeral directors.
Each funeral director or person having the right to control the disposition of the human remains under RCW 68.50.160 shall obtain a certificate of death, sign or electronically approve and file the certificate with the local registrar, and secure a burial-transit permit, prior to any permanent disposition of the human remains. He or she shall obtain the personal and statistical particulars required, from the person best qualified to supply them. He or she shall present the certificate to the attending physician or in case the death occurred without any medical attendance, to the proper official for certification for the medical certificate of the cause of death and other particulars necessary to complete the record. He or she shall supply the information required relative to the date and place of disposition and he or she shall sign or electronically approve and present the completed certificate to the local registrar, for the issuance of a burial-transit permit. He or she shall deliver the burial permit to the sexton, or person in charge of the place of burial, before interring the human remains; or shall attach the transit permit to the box containing the corpse, when shipped by any transportation company, and the permit shall accompany the corpse to its destination.
[2009 c 231 § 5; 2005 c 365 § 158; 1961 ex.s. c 5 § 17; 1915 c 180 § 6; 1907 c 83 § 8; RRS § 6025.]

Additional State Authorities:

RCW 38.56.020 Intrastate Mutual Aid System – Established
Local jurisdictions and tribes provide mutual assistance to each other in emergencies. This includes response, mitigation, or recovery activities related to an emergency or participation in drills or exercises in preparation for an emergency.

II. Situations and Assumptions

A. Situations

An incident causing an unusual number of deaths, such that they overwhelm local capacity, serves to activate the State Emergency Management Comprehensive Management Plan (CEMP) ESF 8-Public Health, Medical, and Mortuary Services Annex and this appendix. This occurs when local public health notifies their local emergency management organizations that state-level emergency management assistance is requested. Or, when a tribal government requests direct state-level or federal assistance from agencies. The State Emergency Operations Center (SEOC) staff coordinate between state agencies, federal agencies, tribal governments, military, non-governmental organizations (NGOs), and the local EOCs. As the SEOC coordinates with state agencies that require activation, those state agencies involved can respond from their department Agency Coordination Center (ACC).

Upon activation of ESF-8 staff to support a mass fatality incident, Washington State Department of Health (DOH) will activate its Incident Management Team (IMT) and dispatch ESF-8 staff to the SEOC. DOH will use the National Incident Management System (NIMS)/Incident Command System (ICS) when responding to emergencies. Authority to manage the incident is delegated through the Secretary of Health.

B. Limitations & Assumptions

In addition to the nature, scope, and severity of a public health emergency or disaster and the level of response capability in place at the local, state, tribal, and federal levels, the following factors could affect the statewide ESF 8 response:

1. The Secretary of Health may direct the statewide mortuary response as necessary and authorized by state law to protect the public's health.
2. The Secretary of Health will determine prioritization of available services when resources are scarce across multiple jurisdictions and direction of federal and interstate mutual aid resources.
3. Public health and medical services, resources, facilities, and personnel may be limited in availability or capacity during and following disasters.
4. The resources and abilities of LHJs to coordinate the local ESF 8 response to public health and medical emergencies vary widely across the state.
5. Demand for behavioral health services, including crisis counseling for disaster survivors and response personnel, may quickly overwhelm local providers warranting state and federal assistance.
6. For planning purposes, it is assumed that federal, Department of Defense, and the Washington National Guard (Fatality Search and Recovery) resources are available.

7. Final disposition of human remains requires a death certificate. There may be some circumstances where a death certificate is not complete. Close coordination between state vital records during a mass fatality event is critical.
8. Washington Electronic Death Registration System (EDRS) is operational.
9. Local funeral directors/homes staff and resources are called upon to support a mass fatality event.

III. Concept of Operations

A. General

While emergencies and disasters may vary in size and significance, the population density, multi-jurisdictional environment, and concentration of critical infrastructure can magnify the impacts.

Public health emergency response activities will be managed from a NIMS-compliant public health incident command post (PHICP) at the local level. Local jurisdictions will develop and maintain protocols and policies needed to operate an incident command post during an emergency requiring a public health response.

As requests for fatality management services flow up to the SEOC (ESF-8 Desk), the DOH IMT will begin assessment of resource availability including state agency resources, intrastate or interstate mutual aid, such as Washington Association of Coroners and Medical Examiners (WACME), Washington State Funeral Director Association, private resources, and federal capabilities.

The DOH incident commander is responsible for notifying the appropriate partners when the DOH IMT is activated.

Federal Resources
The missions of the federal partners responsible for fatality management follow:

- **Centers for Disease Control and Prevention (CDC) Public Health Emergency Preparedness (PHEP)**
  "Fatality Management is the ability to coordinate with other organizations to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal effects; certify cause of death; and facilitate access to mental/behavioral health services to family members, responders, and survivors of an incident."

- **Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program (HPP)**
  "Fatality management is a process that occurs in the community and is led by agencies dependent on the state in which the incident occurs. Fatality management needs to be incorporated in the surveillance and intelligence sharing networks, to identify sentinel cases of bioterrorism and other public health threats. Fatality management operations are conducted through a unified command structure.

  Integration with public health aligns during the planning process. This is done in coordination with emergency management and the lead fatality management planning agencies and is specifically addressed to manage in-facility death surges and the need for human remains temporary storage space. This capability also addresses surges of concerned citizens and the need for mental/behavioral health support. To integrate this capability, public health and healthcare emergency planners should coordinate planning according to the content in the functions of Capability 5 from the Healthcare Preparedness Capability and cross-referenced to the Public Health Preparedness Capability."

- **Disaster Mortuary Response Teams (DMORT)**
  Support death investigations, mortuary services and Family Assistance Center activities in federal emergency response situations involving natural disasters and mass fatalities associated with transportation accidents and terrorism. DMORT may also supply a disaster area with resources ranging from these specialists to mortuary supplies depending on the scope of the disaster.

  There are three specialty DMORTs: Disaster Mortuary Operational Response Team (DMORT), Victims Information Center (VIC) team, and DMORT All Hazards. The Disaster Portable Morgue Unit (DPMU) is a cache and logistical team equipped to set up, operate, and maintain the Disaster Portable Morgue Units. The standard DMORT can staff and operate either a DPMU or another established facility to examine remains. The Victim Information Center (VIC) team can set up and operate in a Family Assistance Center (FAC) to assist state and local authorities in collecting ante-mortem data for victim identification. The point of contact to coordinate a request for DMORT support assessment is the ASPR Region X Seattle Regional Coordinator.

- **Washington National Guard –Fatality Search and Recovery Team**
  This team can provide immediate response capabilities to local, state, and federal agencies by recovering fatalities in a contaminated area. Specifically trained in criminal investigation recovery efforts to protect evidence and accurately identify fatalities. The unit comes equipped with two portable temperature controlled holding units and other equipment/supplies. The unit mission is to provide:

  a. Ground evacuation of contaminated remains.
  b. Timely security and temporary storage of fatalities.

c. Maintain security and temporary storage of remains.
d. Movement of remains to state directed processing facility.

- **Defense Support of Civil Authorities (DSCA)**
  DSCA can provide Department of Defense mortuary services personnel and equipment to support federal/state processing facilities.

State Resources
The missions of the state partners responsible for fatality management follow:

- **Washington Department of Licensing (Funeral Board)** can provide a listing of available facilities and capacity that can support a mass fatality response within a community.

- **Washington Poison Center** can provide a 24-hour informational hotline which provides critical information during a mass fatality incident. Contracting options would be determined by the magnitude of the incident (i.e., state vs. local contracting).

Public/Private Sector Resources
The missions of the private sector partners responsible for fatality management follow:

- **Washington State Funeral Directors Association** can assist by providing personnel, facilities and equipment to support a mass fatality incident.

- **Port authorities and or transportation companies** have a variety of refrigerated portable storage trailers available to support temporary storage requirements.

- **Private sector aviation** has a variety of hanger spaces located next to adjacent airstrips that can support temporary casualty collection and or processing sites.

- **Caches of fatality management supplies:** Currently DOH maintains a cache of approximately 500 body bags located at its Tumwater warehouse. DOH also has access to a vendor available 24/7 that can surge bags as needed.

Washington State Department of Health

- Activates the DOH IMT to support a mass fatality incident.
- Represents ESF-8 at the SEOC.
- Interfaces with federal, state, local, and non-governmental partners including the Washington Military Department, Emergency Management Division, American Red Cross, and health jurisdictions to support the local response.
- Provides state assistance and coordinates mutual aid support within the state and outside organizations.
- Supports public messaging during the incident.

- Coordinates statewide call center requirements (Washington Poison Center).
- Provides Secretary of Health-appointed State Fatality Management Coordinator (who could be a Medical Examiner from non-impacted area) to advise, support, and coordinate state and federal mutual aid with local jurisdictions.
- Provides technical assistance on registration and issuance of death certificates.
- Provides technical assistance to local Emergency Managers and Medical Examiners/Coroners on Fatality Planning/Response before and during the incident.

B. Organization

State-Level Response Structure

- DOH will communicate directly with local health, tribes, healthcare coalitions, and other partners during an incident to create a common operating picture and share information.
- The DOH IMT will coordinate with the ESF 8 representatives in the SEOC to accomplish the following during all public health and medical emergencies:
    - Collaborate with the SEOC to provide logistical support for locally managed mortuary operations and family assistance centers.
    - Determine the need for federal or interstate assistance and direct resource requests through the SEOC.

Regional- and Local-Level Response Structure

- Local ESF 8 response activities will be coordinated in accordance with local or tribal public health or medical plans and local emergency management. In some cases regional ESF 8 response activities will be coordinated in accordance with regional or tribal plans and with emergency management of the lead regional jurisdiction.

Response Operations

Upon notification of a potential public health emergency or disaster, DOH may activate ESF 8 partners and the DOH IMT to mobilize personnel, supplies, and equipment to save lives, protect the public, and support local needs. During response, ESF 8 representatives support four primary missions:

1. Support and coordination to agencies and partners responding under health and medical missions;
2. Facilitate mutual aid among LHJs, tribes, and healthcare coalitions;
3. Directly assist LHJs, tribes, and healthcare coalitions in their response; and
4. Support policy decision making by the Secretary of Health.
    - Behavioral Health Care: If the local capability to provide behavioral health services is exceeded during any size or type of disaster, the impacted county or tribe may request assistance from the SEOC. ESF 8 representatives coordinate with support agencies, human and social

service agencies, non-profit organizations, regional support networks (RSNs), and HHS to determine viable options for support.

- Fatality Management, Victim Identification, and Family Assistance Centers: Fatality management operations are led by local medical examiners or coroners and may be necessary following public health disasters. ESF 8 representatives support local fatality management response with resources, facilitation of statewide mutual aid, and requests for federal assistance as appropriate. During multi-county disasters where federal mortuary assistance resources are needed and must be prioritized, the Secretary of Health may temporarily appoint a State Fatality Management Coordinator to function on behalf of DOH and in support of impacted jurisdictions, and oversee the deployment and operation of federal mortuary response assets across multiple local jurisdictions.

Response Tools

ESF 8 primary and support agencies maintain the following systems to monitor and support incident response:

Electronic Death Registration System (EDRS): web application for filing death records in Washington State. The system is used by those with the legal authority to complete a death certificate. Those with legal authority to complete a death certificate include funeral home directors, physicians, medical examiners, coroners, and deputy registrars.

EDRS can produce reports in near real-time to aid in assistance requests. The system has a message board and can advertise storage capacity, and who needs help and who can provide assistance.

With a memorandum of understanding (MOU) and a DOH-initiated change in EDRS permissions, county registrars can assist in approving other county's death certificates. With a MOU medical examiners/coroners can assist in certifying other county's death records.

Operational Objectives

Core Public Health, Medical, and Mortuary Missions:

Provide Mortuary Coordination:

- Body Recovery
- Morgue Operations
- Family Assistance Centers
- Data Management

ESF 8 partner agencies will send staff to the SEOC ESF 8 desk as soon as possible following a request for assistance. Alternatively, ESF 8 partner agency staff may be directed to report to their usual places of work and thereafter maintain continual communication with the ESF 8 representatives in the SEOC.

If ESF 8 capabilities are anticipated to be in short supply or exhausted at the state or local level, resource support may be requested from federal partner agencies.

C. Whole Community Involvement & Non-Discrimination

The "Whole Community" includes individuals, families, and households; communities; the private and nonprofit sectors; faith-based organizations; and local, tribal, state, and federal governments. This ESF is committed to communicating with and providing accessibility to the Whole Community as needed during emergency response and disaster recovery operations. The Whole Community includes, but is not limited to, populations with Limited English Proficiency (LEP), individuals with disabilities, and Access and Functional Needs (AFN). Any agency or organization that receives federal funding is required to have a plan or policy for addressing the needs of individuals with Limited English Proficiency (LEP), pursuant to Title VI, the Civil Rights Act, as well as, comply with Department of Justice standards for accessibility and reasonable accommodations in alignment with the American with Disabilities Act of 1990 and other applicable federal and state titles or requirements.. The Washington State Emergency Management Division and this ESF expects all agencies and organizations to comply with federal law. For more information on how each agency or organization complies with federal law, please contact the individual agency or organization.

https://www.federalregister.gov/articles/2011/04/18/2011-9336/guidance-to-federal-financial-assistance-recipients-regarding-title-vi-prohibition-against-national

IV. Mitigation / Preparedness / Response / Recovery Activities

Mitigation: The *Washington State Enhanced Hazard Mitigation Plan (October 2013)* identifies hazard mitigation goals, objectives, actions and initiatives for Washington State government to reduce or eliminate the long-term risk to human life and property from hazards.

Preparedness (includes Prevention/Protection): Preparedness actions are put in place to develop operational capabilities in advance of an emergency or incident in order to prevent or stop an imminent or actual incident, and to protect citizens, residents, visitors, assets, systems and networks against the greatest threats and hazards.

Response: The *Washington Comprehensive Emergency Management Plan (CEMP)* provides response activities for state agencies to respond quickly to save lives, protect property and the environment, and meet basic human needs in the aftermath of an incident.

Recovery: ESF 14-Long Term Community Recovery provides a state-level structure to coordinate state and federal recovery resources, facilitate the transition of resources from response to recovery, and prepare Presidential Disaster Declaration requests. ESF 14 also leads the development of a recovery-focused common operating picture through information sharing among agencies responsible for economic recovery, housing, infrastructure systems, mass care, and the preservation of natural and cultural resources.

V. ESF 8 Responsibilities Aligned to Core Capabilities

The following table aligns the Core Capabilities that this ESF most directly support, and the agencies and organizations identified that provide services and resources in accordance with their individual missions, legal authorities, plans and capabilities in coordination with the SEOC. All ESFs support the core capabilities of Planning, Operational Coordination, and Public Information and Warning.

Primary Agencies	Responsibilities & Actions	Core Capabilities
American Red Cross (ARC)	• Provides support for Friends and Family Center and Family Assistance Center activities in coordination with other agencies. This may include Center staff and supplies as well as Mental Health and Health Services personnel.	**Fatality Management Services**
Department of Social and Health Services (DSHS)	• Lead state agency for behavioral health issues as provided for in state law and in agency plans, policies, procedures, and practices. Collaborates with partners around behavioral health issues when outside the scope provided for in state law and in agency plans, policies, procedures, and practices. • Administer institutions that may be impacted by or available to support in an emergency. • Through its representative at the State EOC, DSHS is responsible for coordinating sources of mental health resource requests from local jurisdictions, state resources or commercial providers.	**Planning** **Mass Care Services**
Department of Licensing	• Regulate funeral directors, embalmers, and funeral establishments. • Maintain a plan for use in a fatality management response and operate as an ESF 8 partner when required and as provided for in state law and in agency plans, policies, procedures, and practices. • As the agency that regulates the funeral industry, provide technical assistance as necessary to DOH and the SEOC. In coordination with DSHS, assist in responding to requests from local governments for family grief assistance from the funeral industry.	**Fatality Management Services**

Military Department	• Support coordination with DOD/Nat. Guard for military resources. • Coordination with FEMA Region X Defense Coordination Office. (including prevention and protection), response and recovery pre- and post-disaster responsibilities and actions.	**Logistics and Supply Chain Management**
Emergency Management Division	• WAMAS: legislation (RCW 38.56) that allows member jurisdictions throughout Washington State to efficiently and effectively share resources during times of emergency and anticipated drills or exercises. o Members include: cities, towns, counties, and federally recognized tribes o Provides a responsive and straightforward mutual aid system for sharing resources o Maximizes the use of all available member jurisdiction resources o Provides immunity and tort protection o Works in harmony with the National Response Framework • The Emergency Management Division supports ESF 8 representatives during activation. • The 10th Civil Support Team, Washington National Guard when activated, may support ESF 8 response activities through the collection and transportation of field samples of potential biological agents to the Public Health Laboratories (PHL) for analysis. • The Washington National Guard also operates armories, which may be made available to public health officials to facilitate the emergency distribution of medicine. • The Washington National Guard may support ESF 8 response activities through the deployment of their Fatality Search and Recovery Teams (FSRT).	**Fatality Management Services**
Government Office of Indian Affairs	• Coordinate key messages and serve as a liaison between state and tribal governments in a consultation and advisory capacity for response activity.	**Fatality Management Services**
Washington National Guard	• State Active Duty: state funded, state controlled • Title 32: federally funded, state controlled • Title 10: federally funded, federally controlled	**Fatality Management Services**

Washington State Department of Transportation	• Situational awareness for highways, rails, aviation and marine systems • Damage and impact assessments • Movement restrictions	**Critical Transportation**
Washington State Patrol	• Provide assistance with crime scene investigation through the Crime Scene Response Team. • Assist in providing perimeter control and security, and limiting access to the scene. • Provide DNA identification and/or assist in arranging for private DNA contracts.	**On-Scene Security and Protection** **Access Control and Identity Verification**
Washington State Department of Labor and Industries	• The Crime Victims Compensation Program is responsible for coordinating and processing benefits for eligible victims.	**Fatality Management Services**
Washington State Forensic Investigations Council	• Responsible for the oversight of the WSP Crime Lab and Toxicology Lab, as well as, training and autopsy reimbursement for coroners and medical examiners.	**Fatality Management Services**
Washington Association of Coroners and Medical Examiners	• Resource for training, legislation issues, and latest updates of death investigation for all its members throughout the state.	**Fatality Management Services**
Washington State Funeral Directors Association	• Provide assistance in identifying needed mortuary service personnel and resources, and can assist in providing technical guidance regarding mortuary affairs.	**Fatality Management Services**
National Transportation Safety Board	Following major aviation and significant accidents in other modes of transportation, the NTSB has by law responsibility to: • Conduct a federal investigation to determine the cause of the accident. • Coordinate federal assistance efforts with local and state authorities and the carrier. Federal and non-governmental partners supporting these efforts include the FBI, ARC, Department of State, NDMS/DMORT, and DOD. • Coordinate and conduct briefings for victims' families and friends to provide information about the progress of victim search and recovery, progress of the investigation, the identification of victims, and management of their personal effects.	**Fatality Management Services**

U.S. Department of Health and Human Services	• The Assistant Secretary for Preparedness and Response (ASPR) Region X office (Seattle) is available 24/7 to assist states in coordinating federal requirements to support a mass fatality or catastrophic incident.	**Fatality Management Services**
Federal Bureau of Investigation	• Assist local jurisdictions through FBI crisis response assets with fingerprint identification for criminal and non-criminal events. • Provide FBI Evidence Response Team and HAZMAT assistance. • Provide state, local, and tribal governments with advice concerning identification of human remains.	**Fatality Management Services**
U.S. Department of Justice Office of Victims of Crimes	• Provide information through the Office of Victims of Crime to victims of criminal acts and their families about programs or benefits to which they may be entitled. • Work in coordination with local law enforcement agencies to support a call center for the Family Assistance Center to provide information, and take missing persons reports related to the MFI event and collect antemortem information.	**Fatality Management Services**
U.S. Department of Defense Mortuary Affairs Unit	• Assist in the management of human remains, including victim identification, recovery, storage, transportation, and other mortuary affairs according to the National Response Framework ESF 8 Health and Medical Services.	**Fatality Management Services**

VI. References & Support Plans

Homeland Security Presidential Directive/HSPD 12/2003
Washington State Comprehensive Emergency Management Plan 6/2016
ESF 8 – Public Health, Medical, and Mortuary Services Annex 6/2015
Washington State Department of Health Emergency Response Plan-Basic 1/2016

VII. Definitions

See definitions on page 2.

VIII. Attachments

Target Capabilities List: A companion to the National Preparedness Guidelines, U.S. Department of Homeland Security, September 2007 https://www.fema.gov/pdf/government/training/tcl.pdf. The attached Fatality Management preparedness tasks and measures/metrics are used to guide local planning.

I. INTRODUCTION

A. Background

Despite the advancement of medical and public health sciences, communicable diseases, particularly new emerging and reemerging diseases, remain a threat to public health worldwide. Six categories explain the emergence or re-emergence of communicable diseases. These categories include: human demographics and behavior; technology and industry; economic development and land use; international commerce; microbial adaptation; and breakdown of public health measures. This, combined with modern global travel, has produced an environment in which diseases emerge and quickly spread with no regard for international or continental borders. Careful attention on the part of the public health and healthcare systems constitutes one the most effective lines of defense for the people of Washington against the threat of communicable disease.

Washington's international border with Canada, shared borders with neighboring states, major international seaports, and airports present considerable opportunity for the introduction of communicable diseases to the state. Occasionally, spread of disease is rapid enough, or the impacts of an outbreak are severe enough, to create a situation requiring a greater degree of public health response and intervention. Any large outbreak of a communicable disease, whether it occurs primarily as a natural event (e.g., *E. coli* O157:H7, MERS-CoV, pandemic influenza, etc.), a result of an intentional act (e.g., anthrax mailings, intentional contamination of food or water sources, etc.), or a natural disaster, may result in significant morbidity and mortality.

Effective and well-coordinated response by the public health, healthcare, and other key response partners will limit the impacts of communicable disease, maximize resource availability, and save lives.

This document is driven in part by the requirements expressed within the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA) (Public Law 113-5). This document strengthens ". . . the ability of States, local communities, and tribal communities to prepare for, respond to, and be resilient in the event of public health emergencies, whether naturally occurring, unintentional, or deliberate by optimizing alignment and integration of medical and public health preparedness and response planning and capabilities with and into routine daily activities; and promoting familiarity with local medical and public health systems" (H.R. 307-3 (8)(A-B)).

B. Mission

The public health and healthcare system in Washington State consists of numerous entities. During an incident of public health significance all system partners must work together in order to meet the health and medical needs of the people of Washington State. In response to communicable disease outbreaks, the unified mission of all public health agencies, healthcare organizations, and other assisting and cooperating entities is to limit morbidity and mortality due to the disease. All agencies must combine their strengths and capabilities in a complimentary manner to maximize success in protecting the lives and safety of the people of Washington.

C. Purpose

The purpose of this Concept of Operations is to establish and communicate the respective roles and responsibilities of each major public health and healthcare partner in Washington State during each phase of response to a communicable disease incident of public health significance.

The objectives of this Concept of Operations are to:

1. Provide common terminology and framework for public health and healthcare system preparedness and response to communicable disease.
2. Support decision-making processes of local, state, tribal, and private sector officials to carry out effective response to communicable disease outbreaks.
3. Communicate roles and responsibilities of all agencies with major involvement in response to communicable disease outbreaks.
4. Provide unified support for development of plans and integration of response at the local, regional, state, tribal, and federal levels.
5. Provide framework for multi-agency coordination during a communicable disease emergency or pandemic.

D. Scope

This Concept of Operations is applicable during any communicable disease incident of public health significance, including a single case, cluster of cases, or widespread outbreak (epidemic or pandemic) of a known or novel disease that could result in illness, death, disability, other adverse health effects, and/or significant public concern. The scope of this plan is not limited by the nature of any particular communicable disease.

This Concept of Operations is also applicable when emergence or reemergence of a communicable disease and/or increased public concern regarding a communicable disease threat prompts extraordinary preparedness and coordination efforts, even in the absence of disease cases in Washington State or in the United States. The Ebola Virus Disease (EVD) epidemic of 2014 and to a lesser extent, the 2016 Zika Virus pandemic, are examples of such situations.

This Concept of Operations is intended to provide a framework for all agencies involved in response to communicable disease in Washington State, and applies to all such agencies. It is intended to inform but not supersede existing plans maintained by governmental agencies, public health jurisdictions, healthcare entities, Healthcare Coalitions (HCCs), and other response partners. This document is intended to provide a unifying framework under which all partner agencies develop and execute their own plans, protocols, policies, and procedures for response to communicable disease in a well-coordinated manner.

Portions of this Concept of Operations remain active during steady state operations (i.e. in absence of an emergency), in the absence of a communicable disease incident of public health significance or other emergency condition. Full implementation of this Concept of Operations should be considered when one or more of the following occurs:

1. An emergency is declared/proclaimed in any political subdivision of Washington State due to a communicable disease threat.

2. Any local or tribal public health partner, state or federal agency, healthcare entity, or HCC requests assistance in response to a communicable disease threat that overwhelms or threatens to overwhelm the capability of that organization.
3. Any state agency recognizes the need for statewide coordination in order to effectively respond to a real or anticipated communicable disease threat.
4. When, in the judgment of the State Communicable Disease Epidemiologist, State Health Officer, Secretary of Health, or other assigned individual having statewide authority, there is the need for enhanced coordination of resources to prepare for or respond to a potential or actual threat to public health posed by a communicable disease.
5. The Secretary of Health or Department of Health (DOH) Chief of Emergency Preparedness and Response anticipates an emerging risk to Washington's public health and medical system that has the potential to overwhelm local capabilities and requires state support to prepare and/or respond effectively.

Specific tactical operations of local health jurisdictions (LHJ), tribal governments, healthcare entities, other state agencies, and all other partner agencies and entities are outside the scope of this plan and understood to be documented in various emergency response plans and protocol documents maintained by each entity.

E. Planning Assumptions

The following assumptions are made in the development and implementation of this framework:

1. Preservation of life safety including the prevention of further transmission, as well as prevention of morbidity and mortality is the primary mission objective for all involved agencies during any emergency.
2. Supporting health equity and making provisions for people with access and functional needs are critical.
3. The Secretary of Health may direct the statewide public health and medical response as necessary and is authorized by state law to protect the health of the public (RCW 43.70.130 and 43.70.020(3)).
4. The Department of Health (DOH) is the lead agency for responding to multijurisdictional public health and medical emergencies in Washington.
5. During a communicable disease incident, epidemiological surveillance and investigation activities are prioritized to understand the nature and scope of the incident and to protect the public by preventing the spread of the disease.
6. Public health and medical services, resources, facilities, and personnel may be limited in availability or capacity during and following a communicable disease incident.
7. Intrastate and interstate mutual aid, as well as federal agency resources, may be needed to effectively respond to a communicable disease incident.
8. All responding agencies and organizations will follow their existing emergency operations plans and procedures in response to a communicable disease emergency.
9. Communicable disease incidents may require exercising legal authorities to control the spread of the disease. In certain circumstances, individual liberties and freedoms may be compromised in order to protect public health. In a case where individual liberties may be compromised, the authority having jurisdiction will carefully weigh the scientific evidence and public health benefit of such a

measure against the liberties of the individual and will only implement such a measure when it is necessary to control the spread of the disease.
10. Healthcare facilities may have to surge beyond normal capacity to meet the needs of the population during a communicable disease incident.
11. Options other than hospital care may be needed in order to meet the medical needs of the public during a widespread communicable disease incident.
12. Empirical data to guide public health and medical response to a communicable disease may be limited. In such circumstances it is assumed that authorities and medical providers will carry out evidence-based interventions when possible, and when impossible, will use their expertise and professional judgment to act in the best interest of the public.
13. Public perception of the severity of the threat may not be consistent with the true nature of the threat. For this reason, inclusive and effective coordination of information sharing and public information during a communicable disease incident is essential.
14. Two-way information sharing among all partners and all levels of government involved in communicable disease response is critical to the effectiveness of the response.
15. Capabilities may vary significantly from one agency or jurisdiction to another. It is important to remain aware of varying capability levels to anticipate challenges and resource needs in advance.

F. Guiding Principles

Development and implementation of this Concept of Operations is rooted in the following principles:

1. Ethics – All actions taken in response to a communicable disease incident must be undertaken with the primary motivation of protecting the health, wellbeing, and interests of the Whole Community of Washington.
2. Responder Safety – The safety of public health and healthcare system personnel must be paramount in order to prevent the erosion of capability should such personnel become impacted by the incident. All agencies are expected to take all reasonable measures to protect the safety and wellbeing of their response personnel.
3. Unity – In order to maximize the ability of each agency to carry out its mission of preventing morbidity and mortality due to the incident, all agencies must respond in a well-coordinated manner under the framework described in this document.
4. Openness – Information sharing is critical during any emergency response, but is particularly important in response to a communicable disease incident. All involved agencies must openly share information to the greatest extent possible.
5. Evidence-Based Practice – Evidence-based practice in the public health and healthcare systems in response to communicable disease is essential. Whenever possible, entities involved in response to a communicable disease incident should seek to gather data to guide their actions and contribute to the body of knowledge to inform future practice.

G. Relevant Laws and Authorities

For relevant excerpts of these state and federal laws and regulations, please see Attachment I.

RCW 43.70.020(3) – State Department of Health

RCW 43.70.130 – Powers and duties of the Secretary of Health

RCW 70.05.070 – Local health officer – powers and duties

RCW 70.05.060 – Powers and duties of local board of health

RCW 49.60.218 – Use of dog guide or service animal

RCW 71A.10.040 – Protection from discrimination

WAC 246-100-021 – Responsibilities and duties – Health care providers

WAC 246-100-036 – Responsibilities and duties – Local health officers

WAC 246-100-070 – Enforcement of local health officer orders

WAC 246-101-101 – Notifiable conditions and the healthcare provider

WAC 246-101-105 – Duties of the healthcare provider

WAC 246-101-401 – Notifiable conditions and the responsibilities and duties of others

WAC 246-101-505 – Duties of the local health officer or the local health department

WAC 246-101-605 – Duties of the local health officer or the local health department

42 U.S.C. § 247d–3a - Improving State and local public health security

42 U.S.C. § 264 - Regulations to control communicable diseases

28 CFR Part 35 – Nondiscrimination on the Basis of Disability in State and Local Government Services

H.R. 307 – Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA)

The purpose of the Pandemic and All-Hazards Preparedness Act (PAHPRA) is “to improve the Nation’s public health and medical preparedness and response capabilities for emergencies, whether deliberate, accidental, or natural.” PAHPRA is also intended “to reauthorize certain programs under the Public Health Service Act and the Federal Food, Drug, and Cosmetic Act with respect to public health security and all-hazards preparedness.”

The Pandemic and All-Hazards Preparedness Act of 2006 (PAHPA) and PAHPRA in 2013 amended the Public Health Service Act (Title 42 USC). Amendments include authorizing funding for public health and medical preparedness programs. PAHPRA also provides standards and benchmarks for all-hazards and pandemic planning, including specifications for pandemic influenza plans. This Concept of Operations is intended to address the standards expressed in PAHPRA and meet the benchmarks specified therein.

II. CONCEPT OF OPERATIONS

A. Ongoing and Routine Actions

Most communicable disease incidents are managed through normal operations of healthcare facilities, local health jurisdictions (LHJs), the Department of Health (DOH), and other public health and healthcare system partners. This section describes the roles and responsibilities for detecting, reporting, investigating, and containing the spread of communicable disease.

Routine Detection and Reporting of Communicable Disease

Healthcare System

- Public Safety Answering Points (PSAPs) should conduct routine screening for communicable disease during emergency calls. This includes assessing for history of potential exposure to communicable disease, which may include international travel, particularly to areas with endemic or active transmission of communicable disease(s) of public health concern. Call takers should identify patients with recent travel history combined with concerning signs or symptoms and communicate this to first responders if possible
- First responders including Emergency Medical Services (EMS) personnel, fire department personnel, and law enforcement officers should identify patients with history of potential exposure to communicable disease, which may include international travel, as well as concerning signs or symptoms. First responders will communicate this to other responders as well as receiving healthcare facilities.
- Healthcare providers and healthcare facilities are expected to conduct routine screening for communicable disease including assessment of patients for history of domestic and international travel to areas with endemic or active transmission of communicable disease(s) of public health concern. Healthcare providers will identify patients with recent travel history combined with concerning signs or symptoms.
- Healthcare providers, healthcare facilities, and laboratories are required to provide notification to the LHJ or DOH for certain notifiable conditions (http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/NotifiableConditions/ListofNotifiableConditions) including rare diseases of public health significance and any emerging condition with outbreak potential. This facilitates epidemiological investigation of the source and possible contacts, enables identification of other potential cases and prevention of further transmission, and may help to detect a potential bioterror incident.

Veterinarians

- Veterinarians must report the presence of any notifiable conditions to the LHJ and must provide notification of animal cases of certain diseases to the Washington State Department of Agriculture (WSDA). WSDA will communicate with DOH regarding reports of suspected cases of communicable disease of public significance in animals.

Public Health

- Per Washington State Administrative Code (WAC) 246-101, LHJs must report specific notifiable conditions to DOH within the timeframes listed in the WAC.

- In cases where the healthcare facility is located in a jurisdiction different from the patient's residence, the LHJ in both the county/state of patient residence as well as the county where the healthcare facility is located will be notified.
- If the patient may have been exposed to the pathogen in another jurisdiction, that LHJ will also be notified. If the exposure may have occurred in another state, the public health jurisdiction in that state will be notified.
- DOH is required to report the presence of some specific notifiable conditions to the United States Centers for Disease Control and Prevention (CDC).
- Washington State utilizes the Rapid Health Information Network (RHINO) to gather data on a variety of communicable and non-communicable conditions in a public health effort to detect outbreaks or clusters of illness prior to widespread impacts within the community.
- Per WAC 246-440-100 and Revised Code of Washington (RCW) 43.70.056, reports of specific Healthcare Associated Infections (HAI) are routinely monitored by DOH to assess the impact of HAI on the healthcare system, and to provide public health guidance to mitigate spread of communicable disease within healthcare facilities across the state.

Healthcare Coalitions

- The role of Healthcare Coalitions (HCC) in routine detection and reporting of communicable diseases varies among the regions. HCCs are valuable partners for public health and the healthcare system in sharing situational awareness, facilitating readiness activities, communicating among partner entities, and obtaining needed resources and guidance.

Tribal Nations

- Tribal nations, tribal healthcare facilities, and tribal healthcare providers in Washington State are not required to report communicable disease to DOH, but often do so voluntarily. Tribal nations may also provide notification to the CDC for communicable disease when requested or required.

Diagnostic Laboratories

- Under WAC 246-101-201, laboratories must notify the LHJ and/or DOH of positive preliminary test results and positive final test results for specific diseases listed in that section. Local Health Officers (LHOs) may require notifications for additional conditions within their jurisdiction.

Schools

- Under WAC 246-101-420, Schools are required to notify the LHJ of cases, suspected cases, outbreaks, or suspected outbreaks of disease that may be associated with the school.
- Schools must also cooperate with the LHJ in the monitoring of influenza and in the investigation of cases, suspected cases, outbreaks, or suspected outbreaks of disease that may be associated with the school.
- Schools must consult with a healthcare provider or the LHJ for information about the control and prevention of communicable disease as necessary.

Routine Investigation of Communicable Disease

Once a suspected or confirmed case of communicable disease of public health significance has been detected and reported to the appropriate authority, actions are taken to investigate the source of disease and to identify individuals or groups who may have been exposed.

- Healthcare providers care for and treat the patient, and obtain relevant information to inform the investigation. This information is provided to the LHJ where the healthcare facility is located, except in certain cases where investigation is conducted by DOH.
- The LHJ (or DOH, in certain cases) may also interview the patient and his or her family members for information relevant to the investigation. The LHJ has primary responsibility for conducting epidemiological investigation, and is responsible for notifying other LHJs for the county or counties where the case or case contacts reside.
- For cases of communicable disease occurring on tribal lands, the tribal government has authority and responsibility for conducting epidemiological investigation according to the laws, rules, and regulations of the tribal nation.
- DOH provides assistance, support, and coordination for epidemiological investigations undertaken by LHJs and tribal governments. DOH has primary authority for coordinating the investigation among the affected LHJs and tribal governments when more than one public health jurisdiction is affected.

Routine Control of Communicable Diseases

Communicable diseases are addressed by the healthcare and public health systems on a day-to-day basis. Disease control measures vary based on the nature of the disease and the exposure risk for each contact. Roles and responsibilities for controlling communicable disease in the absence of an emergency are listed here.

Healthcare System

- First responder agencies including EMS agencies, fire departments, and law enforcement agencies are responsible for training and equipping their personnel to implement appropriate infection control measures to prevent the spread of communicable disease. First responder agencies maintain the capability to identify personnel who may have been exposed to communicable disease, monitor these personnel, and provide appropriate post-exposure instructions and care for these personnel.
- First responders including EMS personnel, fire department personnel, and law enforcement officers are expected to identify the need for and implement the appropriate infection control measures. This includes the use of the appropriate level of personal protective equipment (PPE) and appropriate decontamination of vehicles and durable medical equipment.
- Healthcare facilities are responsible for training and equipping their personnel to implement appropriate infection control measures to prevent the spread of communicable disease within the facility. Healthcare facilities are also responsible for providing safe infrastructure including appropriately equipped negative-pressure rooms and other appropriate facilities and equipment to control the spread of disease. Healthcare facilities also maintain the capability to identify personnel who may have been exposed to communicable disease, to monitor these personnel, and to provide appropriate post-exposure instructions and care.

- Healthcare providers are responsible for identifying the need for and implementing isolation in the environment of care. This includes the use of the appropriate level of PPE and appropriate decontamination of durable medical equipment.

Local Health Jurisdictions and Local Health Officers

- The LHO has the authority to control communicable disease within the county. Pursuant to WAC 246-100-036, the LHO is authorized to carry out such "measures he or she deems necessary based on his or her professional judgment, current standards of practice and the best available medical and scientific information" to control communicable disease.
- LHO orders "must be enforced by all police officers, sheriffs, constables, and all other officers and employees of any political subdivisions within the jurisdiction of the health department in accordance with RCW 43.20.050"
- In counties where no LHO has been appointed, the local board of health (LBH) exercises the authority of the LHO.

Tribal Nations

- Tribal governments have the authority and responsibility to control communicable disease on tribal lands and are expected to do so according to the laws, rules, and regulations of the tribal government.

State Agencies

- DOH and other state agencies routinely provide technical assistance and support to effectively inform the public and assist other jurisdictions in controlling communicable disease.
- The Washington Department of Social and Health Services (DSHS) routinely monitors and controls communicable disease in refugee populations within Washington State. DSHS also manages disease detection and control efforts at state-operated psychiatric facilities including Eastern State Hospital and Western State Hospital.
- WSDA routinely controls communicable disease in animal populations and in federally-licensed food processing facilities in Washington.

Federal Agencies

- CDC Division of Global Migration and Quarantine (DGMQ) routinely controls communicable disease at ports of entry.

B. Levels of Communicable Disease Incident

When certain conditions exist, it is necessary to shift from the routine actions identified above to an enhanced mode of coordination. The need for this shift to occur is based primarily on the geographical distribution of the incident within or across jurisdictional boundaries. A shift in operations is also necessary if resources are or may be overwhelmed, if the pathogen poses or may pose an extreme threat to public health, if special technical assistance is required, or if public or political perception of the threat is significantly inconsistent with the true severity of the threat.

The levels of communicable disease incident are listed in Table 1 (below) alongside potential characteristics of the incident and the nature of response that occurs at each level. This table applies only to communicable diseases of public health significance.

Refer to Attachment A for a Communicable Disease Emergency Severity Assessment Matrix, a tool for quantitative and qualitative analysis of an ongoing incident to assist in identifying the level of communicable disease incident and appropriate nature of response.

These levels of severity are cross-sectional, in that severity is estimated at one point in time. It is important to, through the course of a communicable disease incident, continuously reevaluate the complexity and severity of the incident to guide response activities.

Table 1. Nature of Response at Each Level of Communicable Disease Incident

Level	Incident Characteristics	Nature of Response
5	The disease is limited in impact and available treatments generally produce positive outcomes in those who are ill. Cases and contacts are limited to a single county or tribal jurisdiction. Disease does not spread very easily and if treatment is needed, nearly any medical facility is capable of treating the disease.	Affected LHJ or tribal government leads the response to the incident
4	The disease is minor but may be easily transmissible. The disease is well understood and treatment is widely available. The incident affects or occurs across more than one county or tribal jurisdiction.	Affected LHJs or tribal governments lead the response and receive support and coordination from DOH
3	The disease is moderately severe and threatens to produce significant morbidity or mortality in some populations. Cases and contacts are present in several jurisdictions. Most healthcare providers can safely treat suspected or confirmed cases. Public concern is significant but consistent with the severity of the threat.	DOH leads the response in coordination with affected LHJs and tribal governments
2	The disease is severe and has limited or no specific treatment options. The disease is highly infectious and requires special training and equipment to manage safely. Public concern is significant and may not be consistent with the severity of the threat. .	DOH leads the statewide response, coordinating with all LHJs and tribal governments in collaboration with the CDC
1	The disease is novel with severe morbidity and mortality in the general population and has severe or catastrophic effects on social function. Response requires the full efforts and resources of all government agencies at the local, state, and federal levels.	DOH leads the statewide response in close partnership with the CDC, which leads the national response. DOH leads coordination with all disciplines and levels of government

C. Communicable Disease Emergencies

Though communicable disease incidents have varying nature and scope there are three primary factors that, when one or more is present, trigger response to communicable disease as an emergency. These factors are:

- The incident affects more than one jurisdiction (county/tribe),
- The incident might overwhelm the resources of any facility or jurisdiction,
- Response to the incident requires cross-jurisdictional coordination beyond the scope of normal operations.

When one or more of these factors is present in Washington State, a communicable disease emergency exists. It is important to note that it is possible for a communicable disease emergency to exist in Washington State even when there are zero cases of the disease within the state.

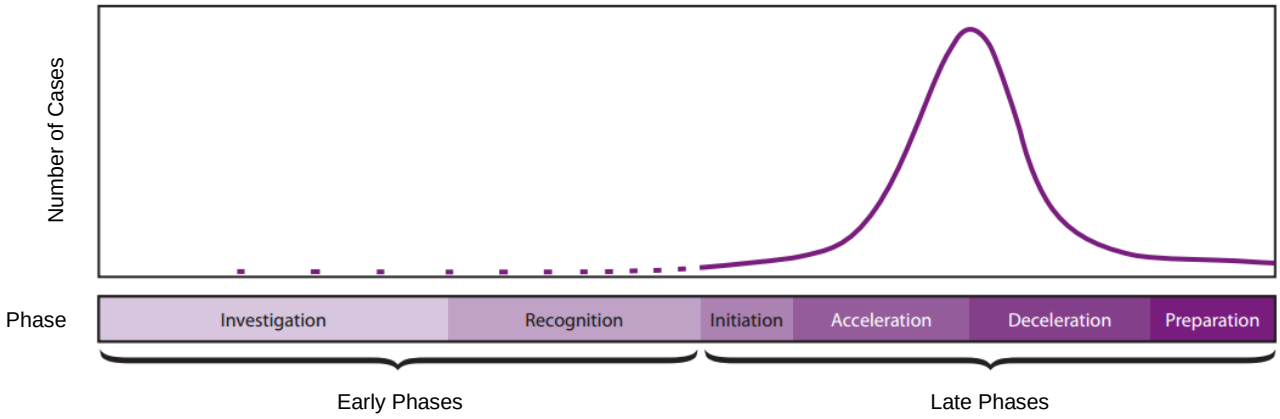
D. Phases of a Communicable Disease Emergency and Expected Response Actions

The phases of a communicable disease emergency, listed below along with expected response actions during each phase, is based on the CDC's preparedness and response framework for influenza pandemics.

The levels of severity discussed above in Table 1 are distinct from the phases of a communicable disease emergency. Incident severity is what determines the response framework. The phases indicated in Figure 1 are chronological rather than cross-sectional and are designed to guide response activities at the levels of local and state government during each phase, regardless of incident severity.

It is important to note that the below tables of expected response actions may not be applicable to all jurisdictions and all communicable disease emergencies. Furthermore, many communicable disease incidents or emergencies will skip certain phases. Helper text is included at the top of each table to provide assistance in identifying the current phase of a CD incident/emergency. This tool is designed to provide a list of considerations for local/tribal and state jurisdictions for the purposes of planning, preparedness, and response.

Figure 1 – Phases of Communicable Disease Emergency (CDC)



Investigation Phase

The investigation phase begins when an emerging communicable disease threat is identified that *may* constitute a hazard to the people of Washington. During this phase, the threat is not imminent and the exact nature of the threat may be unclear. Data regarding the threat may be limited in availability and guidance may be limited or nonexistent.

Table 2 – Investigation Phase – Expected Response Actions

Domain	Local/Tribal Level	State Level
Incident management and operational coordination	• Review (and enhance if needed) local/tribal response plans to ensure readiness • Utilize the Communicable Disease Emergency Severity Assessment Matrix to assess severity of the incident (Attachment A) • Coordinate activities and share information with partner entities within the jurisdiction and in neighboring jurisdictions • Develop "triggers" for escalation of incident management efforts and Incident Command System (ICS) activation • Review statutory authorities and legal framework for disease control and emergency response	• Prepare to provide technical and resource assistance to the affected jurisdiction(s) if requested • Utilize the Communicable Disease Emergency Severity Assessment Matrix to assess risk and potential impact of the incident • Assess the need for state-facilitated coordination efforts and prepare to meet this need • Develop "triggers" for escalation of incident management efforts and Incident Management Team (IMT) activation. • Inform state agency leadership and the governor's office if needed • Review statutory authorities and legal framework for control of communicable disease
Surveillance and epidemiology	• Maintain and enhance active and passive surveillance systems • Implement case and contact investigation of suspected or confirmed infections in humans (and animals if applicable) • Work to identify risk factors for and modes of transmission • Report suspected and confirmed cases as requested • If only animal cases are identified, assess human exposures and risks for infection • Identify whether state assistance is required to support surveillance systems and field investigation	• Maintain and enhance active and passive surveillance systems • Work to identify risk factors for and modes of transmission • Facilitate information sharing and provide guidance as needed • Coordinate activities with animal health officials • Report cases to the CDC as needed • Seek and distribute updated guidance and technical assistance as available • Provide resource assistance to partner entities as requested • Participate in national conversations to share information
Laboratory	• Work with healthcare providers and entities to facilitate appropriate sample collection and shipping • Coordinate with the State Public Health Laboratory (WAPHL) to support sample accessioning and communication of results as needed • For jurisdictions/entities with laboratory capability, assess and optimize laboratory capacity to detect and characterize cases. Report results as requested	• Assess and optimize laboratory capacity to detect cases • For diseases where testing is not available at the WAPHL, assess feasibility of developing testing capability • Coordinate activities with diagnostic laboratories (if appropriate) • If needed, ship samples to the CDC or other reference labs, receive results, and communicate results to appropriate stakeholders • Identify whether federal assistance is required to support laboratory activities

Non-Pharmaceutical Interventions (NPIs)	• Implement appropriate Indirect Non-Pharmaceutical Interventions (see Attachment C) to limit spread of the disease should it occur within the jurisdiction • If human-to-human transmission is suspected, consider implementing Direct Non-Pharmaceutical Interventions (see Attachment C) for suspected and confirmed cases and case contacts (if appropriate) • Enhance all usual emergency preparedness and public health activities with schools and businesses	• Promote Indirect Non-Pharmaceutical Interventions throughout the state. Coordinate messaging with LHJs and Tribal Governments • Review relevant guidance documents and update as needed for the situation • Provide guidance for border health and travelers' health activities as appropriate for the situation
Medical care and countermeasures	• Engage Healthcare Coalitions to support and coordinate healthcare system preparation • Advise healthcare providers within the jurisdiction to promptly identify suspected cases, diagnose confirmed cases, and promptly provide appropriate treatment to ill persons • Based on current recommendations, implement infection-control practices • If human-to-human transmission is suspected, monitor and assist with early access to post-exposure chemoprophylaxis for case contacts per current recommendations (if applicable) • Review all guidance documents, update as needed for the situation, and communicate with key stakeholders • Enhance all usual emergency preparedness and public health activities with healthcare facilities and providers	• Advise healthcare providers statewide to promptly identify suspected cases, diagnose confirmed cases, and promptly provide appropriate treatment to ill persons • Review all guidance documents and update as needed for the situation. Disseminate guidance for diagnosis and treatment of ill persons and infection-control measures to partner agencies. • Consider which immediate steps are needed to facilitate seamless implementation of medical countermeasures plans • Distribute health advisory notices with information on case definitions and infection-control measures to hospitals and outpatient care centers
Vaccine (if applicable)	• Identify the quantity of vaccine locally available for distribution if needed. This may be done in collaboration with healthcare coalitions as appropriate • Evaluate all communicable disease preparedness activities, including a review of vaccine distribution plans, identify priority groups for vaccination, and review plans and staffing for mass vaccination clinics and points of dispensing • Review processes for vaccine accountability	• Evaluate all usual communicable disease preparedness activities, including a review and update of vaccine distribution plans, identify priority groups for vaccination, and review plans and staffing for mass vaccination clinics and points of dispensing • Establish the decision framework for initiating a vaccine campaign • Review all guidance documents, update as needed for the situation, and communicate to key stakeholders • Identify the quantity of vaccine available for distribution if needed • Review processes for vaccine accountability
Risk communication	• Frequently update clinicians (and veterinarians, if appropriate) in the jurisdiction • Share information with key partners, such as animal and human health public affairs officers and other agencies • Disseminate timely, relevant, and inclusive messages to the public	• Disseminate relevant and timely messages in coordination with key partners including local, tribal, state, and federal agencies • Support and coordinate messaging efforts as appropriate with other state, regional, and federal partners • Disseminate timely, relevant, and inclusive messages to the public

Recognition Phase

The recognition phase begins with the first suspected or confirmed case of the disease located in Washington State. During this phase, the threat is now present within the state and an enhanced mode of response is necessary. The exact nature of the threat may still be somewhat unclear and guidance may continue to be limited.

Table 3 – Recognition Phase – Expected Response Actions

Domain	Local/Tribal Level (includes unaffected jurisdictions)	State Level
Incident management and operational coordination	• Continue or initiate actions described for the investigation phase for all domains • Review all decisions previously made during the investigation phase to ensure they continue to be relevant to the developing situation • Repeat the Communicable Disease Emergency Severity Assessment Matrix to assess risk and potential impact of the incident • Consider activation of the local/tribal emergency operations center • Forecast future resource needs for a potential response or escalation of response	• Continue or initiate actions described for the investigation phase for all domains • Review all decisions previously made during the investigation phase to ensure they continue to be relevant to the developing situation • Repeat the Communicable Disease Emergency Severity Assessment Matrix to assess risk and potential impact of the incident • Forecast future resource needs for a potential response or escalation of response • Convene a group of public health and healthcare system leaders to address policy issues and make statewide policy decisions; expand interagency and intergovernmental coordination • Consider requesting a Governor's emergency proclamation • Consider activation of emergency operations and coordination centers at the state level
Surveillance and epidemiology	• Conduct enhanced surveillance • Continue case and contact investigation using recommended methods • Enhance surveillance efforts with other local and tribal partners. • Conduct surveillance for hospitalizations and deaths • Report suspected and confirmed cases to DOH • If animal cases are identified, consider conducting joint investigations with animal health officials	• Conduct enhanced surveillance statewide • Gather and distribute critical medical and public health intelligence • Refine criteria for reporting and investigating cases and contacts • Provide technical assistance as needed • Evaluate the need for border controls for animals or products if appropriate, in collaboration with the CDC • Share intelligence with federal agency partners
Laboratory	• Facilitate confirmation of all suspected cases at an appropriate public health laboratory. Report results to DOH if testing is done at a local laboratory • Facilitate timely notification of results to patients, providers, and public health officials	• Prepare specimen triage plans and implement surge plans if needed • Stockpile diagnostic test kits and ancillary reagents if possible and appropriate • Implement new testing methods at WAPHL if possible and necessary • Coordinate sample testing with reference labs or CDC as needed

Non-Pharmaceutical Interventions (NPIs)	• Continue implementation of appropriate Indirect NPIs (see Attachment C) to limit spread of the disease should it occur within the jurisdiction • Implement appropriate Direct Individual-Level NPIs (see Attachment C) as needed to prevent spread of disease • Prepare to implement appropriate Direct Community-Level NPIs (see Attachment C) in the event that disease spread continues	• Review all guidance documents and update as needed for the situation • Issue policy guidance and recommendations for NPIs for this specific incident • Identify resources to support local planning for and implementation of NPIs • Evaluate and implement required border control measures (entry, exit, or both) as appropriate for the situation
Medical care and countermeasures	• Consider implementation of voluntary contact chemoprophylaxis based on current recommendations • Provide guidance to clinicians about recommended treatment, prophylaxis, and infection-control guidelines • Partnering with Healthcare Coalitions, assess impact on medical care facilities; identify whether medical resources are sufficient to manage ill persons and conduct case-based control efforts; determine if state or other outside assistance is required • Partner with Healthcare Coalitions to share healthcare system resources and situational awareness	• Update and release guidance documents as needed for the situation • Review options and develop policy guidance for provision of mass health care with scarce resources • Consider development of prioritization procedures for materials that could be in short supply • Conduct regulatory readiness steps including preparing to request and to authorize regulatory waivers for healthcare systems and facilities • Evaluate whether transmission and severity assessments merit requests for Strategic National Stockpile (SNS) countermeasures or other therapeutics • Contact coordinators of the local and/or regional SNS regarding the potential distribution of SNS countermeasures, as appropriate
Vaccine (if applicable)	• Coordinate with local, tribal, and state partners to prepare for a vaccine campaign as appropriate • Prepare for a vaccine campaign; refine vaccine distribution and administration plans if a campaign will be initiated, including mass vaccination initiatives and coordination with pharmacies and other groups as appropriate, as well as vaccine accountability processes	• Develop and provide technical support and guidance to local, tribal, and private sector partners in preparation for and during a potential campaign • Prepare for a vaccine campaign; refine vaccine distribution and administration plans if a campaign will be initiated, including mass vaccination initiatives and coordination with pharmacies and other groups as appropriate, as well as vaccine accountability processes
Risk communication	• Develop or update and implement a comprehensive media relations and outreach plan in close collaboration with local, tribal, and state partners • Disseminate risk communication messages, including what is known, what is not known, and what is being done by public health officials • Disseminate messages for travelers, as well as community mitigation (NPI) messages, when to seek care, and how to care for ill persons at home as appropriate.	• Develop or update a media relations and outreach plan; disseminate inclusive risk communication messages • Collaborate, coordinate, and engage with partners and stakeholders • Conduct inclusive briefings with local, regional, and state response partners, businesses, tribes, and health-care facilities on the potential for escalation, response actions underway, and preparedness steps that partners should consider • As requested, develop and share inclusive and accessible risk communication tools

Initiation Phase

Once cases are present in Washington State, the initiation phase begins with the presence of evidence that the disease poses a serious threat to public health. Such evidence might include emerging data from other parts of the nation/world that indicate sustained human-to-human transmission, evidence of human-to-human transmission within Washington, or other scientific evidence indicating that the disease carries outbreak potential with or without effective public health intervention.

Table 4 – Initiation Phase – Expected Response Actions

Domain	Local/Tribal Level (includes unaffected jurisdictions)	State Level
Incident management and operational coordination	• Continue or initiate actions described for the recognition phase (Table 3 above) • Consider activation of local and/or tribal emergency operations center • Consider declaring a state of emergency	• Continue or initiate actions described for the recognition phase • Consider activation of state emergency operations center and/or state agency department operations centers • Consider Governor's proclamation of emergency
Surveillance and epidemiology	• If affected, continue enhanced surveillance; conduct case investigation and response • If unaffected, prepare for investigation and response • Enhance surveillance efforts with other local and tribal partners • Conduct surveillance for hospitalizations and deaths	• Deploy state agency resources to assist affected jurisdictions as requested • Conduct enhanced surveillance statewide • Gather and distribute critical medical and public health intelligence • Share intelligence with federal agency partners
Laboratory	• Continue to facilitate confirmation of all suspected cases at an appropriate public health laboratory and facilitate timely notification of results to patients, providers, and public health officials	• Implement surge plans and facilitate rapid testing and notification of laboratory results
Non-Pharmaceutical Interventions (NPIs)	• Implement Direct Individual-Level NPIs (see Attachment C) for cases and contacts • Implementation of appropriate Direct Community-Level NPIs (see Attachment C) to prevent further spread of the disease • Assess whether certain populations may be disproportionately impacted by the disease, or by response efforts and if so, engage with these communities to mitigate impacts	• Obtain and deploy resources to support local planning for and implementation of NPIs • Evaluate and implement required border control measures (entry, exit, or both) as appropriate for the situation including at air and sea ports as indicated, in close collaboration with the CDC
Medical care and countermeasures	• Monitor the demand for healthcare services and assess whether assistance is needed to implement medical surge • Review and prepare to deploy a mortuary surge (mass fatality) plan	• Monitor the healthcare surge and stress on the healthcare system, including provision of key medical resources and tools, as needed • Consider requesting SNS antiviral drugs and other materiel reserves if needed

	• Consider deployment of local caches and/or requesting state/federal resources to support the healthcare system • Consider implementation of chemoprophylaxis of exposed persons based on current recommendations if applicable	• Conduct advanced planning to anticipate resource needs into the future; begin to acquire resources to meet anticipated needs
Vaccine	• Implement vaccination campaign if a vaccine is available, appropriate for the disease, and the state and federal governments support the decision to do so • Assure accountability for vaccines throughout the distribution processes	• Implement vaccination campaign if a vaccine is available, appropriate for the disease, and the state and federal governments support the decision to do so • Update the state distribution plan based on CDC prioritization guidelines, estimated state allocation of vaccine, and epidemiology of the disease within the state • Assure accountability for vaccines throughout the distribution processes
Risk communication	• Disseminate updated risk messages, including providing anticipatory guidance or information on what might be expected • Share information regarding antivirals and the possible implementation of NPIs as appropriate • Continue to provide regular updates to key partners, stakeholders, elected officials, and the media	• Disseminate updated risk messages, including providing anticipatory guidance or information on what might be expected • Share information regarding antivirals and the possible implementation of NPIs as appropriate • Continue to provide regular inclusive updates to key partners, stakeholders, elected officials, and the media

Acceleration Phase

The acceleration phase of a communicable disease emergency includes a consistently increasing number of cases of the disease despite previous public health and healthcare interventions.

Table 5 – Acceleration Phase – Expected Response Actions

Domain	Local/Tribal Level (includes unaffected jurisdictions)	State Level
Incident management and operational coordination	• Continue actions described for the initiation phase (Table 4 above) • Activate local and/or tribal emergency operations centers, even in unaffected jurisdictions • Proclaim a local state of emergency • Implement and maintain processes to track the effectiveness of public health interventions	• Continue actions described for the initiation phase (Table 4 above) • Request activation of the state emergency operations center and DOH Incident Management Team (IMT) • Request Governor's proclamation of emergency • Implement and maintain processes to track the effectiveness of public health interventions
Surveillance and epidemiology	• If affected, transition surveillance from individual case confirmation to severe disease and RHINO surveillance as appropriate • If unaffected, continue individual case confirmation if possible • Monitor for changes in epidemiology • Continue enhanced surveillance for deaths	• Deploy state agency resources to assist affected jurisdictions as requested • Conduct enhanced surveillance statewide • Gather and distribute critical medical and public health intelligence • Share intelligence with federal agency partners
Laboratory	• Facilitate laboratory confirmation a sample of cases or all cases as requested • Implement revised specimen submission protocol per CDC and DOH guidance as appropriate	• Provide laboratory confirmation all cases or a sample of cases as resources allow and as required for virologic surveillance • Implement revised specimen submission protocol per CDC guidance as appropriate
Non-Pharmaceutical Interventions (NPIs)	• Implement widespread NPIs (all types as appropriate) including Direct Community-Level NPIs • Monitor the effectiveness of NPIs • Monitor for adverse impacts of NPIs on society and coordinate with emergency management and other partners to mitigate adverse effects as possible	• Obtain and deploy resources to support local implementation of NPIs • Forecast adverse effects of NPIs on society and leverage state agency and federal resources to mitigate these effects
Medical care and countermeasures	• Monitor the demand for healthcare services and provide assistance to implement medical surge including establishing alternate care facilities (ACFs) • Deploy a mortuary surge (mass fatality) plan if needed • Deploy local caches and request state/federal resources to support the healthcare system as needed	• Monitor the healthcare surge and stress on the healthcare system, including provision of key medical resources and tools, as needed. • Provide policy guidance to support medical surge including use of ACFs, implementation of Crisis Standards of Care, and rationing of critical medical resources • Continue advanced planning to anticipate resource needs into the future; begin to acquire resources to meet anticipated needs

Vaccine	• Implement vaccination campaign if a vaccine is available, appropriate for the disease, and the state and federal governments support the decision to do so • Assure accountability for vaccines throughout the distribution processes	• Implement vaccination campaign if a vaccine is available, appropriate for the disease, and the state and federal governments support the decision to do so • Continue to update the state distribution plan based on CDC prioritization guidelines, estimated state allocation of vaccine, and epidemiology of the disease within the state. • Assure accountability for vaccines throughout the distribution processes
Risk communication	• Disseminate updated risk messages, including providing anticipatory guidance or information on what might be expected • Share information regarding antivirals and the possible implementation of NPIs as appropriate • Continue to provide regular updates to key partners, stakeholders, elected officials, and the media	• Activate statewide ESF 8 Joint Information System (JIS)/Joint Information Center (JIC) • Disseminate updated inclusive risk messages in collaboration with state, regional, and federal partners, including providing anticipatory guidance or information on what might be expected • Share information regarding antivirals and the possible implementation of NPIs as appropriate • Continue to provide regular inclusive updates to key partners, stakeholders, elected officials, and the media

Deceleration Phase

The deceleration phase of a communicable disease emergency includes a consistently decreasing number of cases of the disease in Washington State.

Table 6 – Deceleration Phase – Expected Response Actions

Domain	Local/Tribal Level (includes unaffected jurisdictions)	State Level
Incident management and operational coordination	• Continue actions described for the acceleration phase (Table 5 above) • Evaluate proportionality of response activities and ensure that activities remain appropriate to the current situation • Continue to track the effectiveness of interventions.	• Continue actions described for the acceleration phase (Table 5 above) • Evaluate proportionality of response activities and ensure that activities remain appropriate to the current situation • Continue to track the effectiveness of public health interventions
Surveillance and epidemiology	• Continue severe disease and RHINO surveillance • Monitor for changes in epidemiology	• Continue severe disease and RHINO surveillance • Monitor for changes in epidemiology • Continue enhanced surveillance statewide • Gather and distribute critical medical and public health intelligence
Laboratory	• Continue to facilitate confirmation of all suspected cases at an appropriate public health laboratory and facilitate timely notification of results to patients, providers, and public health officials	• Continue to facilitate confirmation of all suspected cases • Coordinate sample testing with reference labs or CDC as needed
Non-Pharmaceutical Interventions (NPIs)	• Assess, plan for, and implement phased and targeted cessation of NPIs if appropriate	• Continue to assist with monitoring the effectiveness of and assessing adverse effects of NPIs on society
Medical care and countermeasures	• Maintain infection control strategies in the community • Initiated targeted and phased cessation of medical surge strategies as appropriate	• Provide planning and policy support to guide infection control strategies and cessation of medical surge measures
Vaccine	• Continue vaccination response as appropriate and sustain vaccine accountability processes	• Continue vaccination response as appropriate and sustain vaccine accountability processes
Risk communication	• Disseminate updated risk messages • Provide information on measures to prepare for and respond to possible additional waves of disease • Continue to provide regular updates to key partners, stakeholders, elected officials, and the media	• Disseminate updated inclusive risk messages • Provide inclusive information on measures to prepare for and respond to possible additional waves of disease • Continue to provide regular inclusive updates to key partners, stakeholders, elected officials, and the media

Preparation Phase

The preparation phase of a communicable disease emergency is characterized by low outbreak activity in Washington State with possible continued transmission in other states or other parts of the world. The purpose of this phase is to facilitate preparation for future waves of disease that may occur.

Table 7 – Preparation Phase – Expected Response Actions

Domain	Local/Tribal Level (includes unaffected jurisdictions)	State Level
Incident management and operational coordination	• Continue actions described for the deceleration phase (Table 6 above) as appropriate • Consider deactivation of local/tribal emergency operations centers • Prepare for subsequent waves • Develop an after-action report and improvement plan to document lessons learned • Consider suspending emergency declarations	• Continue actions described for the deceleration phase (Table 6 above) as appropriate • Consider deactivation of state emergency operations center and state agency emergency coordination centers • Prepare for subsequent waves and develop triggers for reactivation of emergency operations centers • Develop an after-action report and improvement plan to document lessons learned • Consider suspending emergency declarations
Surveillance and epidemiology	• Continue severe disease and RHINO surveillance to detect acceleration to the next wave • Resume conducting routine non-emergency surveillance	• Continue severe disease and RHINO surveillance to monitor progress of the incident and detect acceleration to the next wave • Resume conducting routine non-emergency surveillance
Laboratory	• Return to routine surveillance and testing methodologies	• Return to routine surveillance and testing methodologies
Non-Pharmaceutical Interventions (NPIs)	• Modify NPIs as needed and as appropriate • Continue to promote Indirect NPIs as appropriate	• Provide assistance with NPI modification as needed
Medical care and countermeasures	• Monitor medical surge trends • Replenish stockpiles and caches as possible • Monitor medical countermeasure usage trends	• Monitor medical surge trends • Replenish stockpiles and caches as possible • Monitor medical countermeasure dispensing and usage trends
Vaccine	• Continue vaccination response using epidemiological data to support vaccination prioritization in anticipation of a subsequent wave	• Continue vaccination response using epidemiological data to support vaccination prioritization in anticipation of a subsequent wave
Risk communication	• Disseminate updated risk messages including information on measures to prepare for and respond to possible additional waves of disease	• Disseminate updated risk messages including information on measures to prepare for and respond to possible additional waves of disease

E. Additional Roles and Responsibilities during Communicable Disease Emergencies

When a communicable disease emergency exists, enhanced support and coordination among the healthcare and public health systems across all jurisdictions statewide is needed. The following describes the roles and responsibilities of each entity during a communicable disease emergency, and must be carried out in addition to the non-emergency roles and responsibilities of each entity.

The responsibilities listed below are general, and expectations may differ based upon the specific demands of a given communicable disease emergency. This is not an exhaustive list of expected response actions, roles, and responsibilities. Generally, the listed roles and responsibilities will be performed in each of the jurisdictions impacted by any communicable disease emergency.

Hospitals and other healthcare facilities

The core functions of hospitals, healthcare systems, and other healthcare facilities in a communicable disease emergency are to screen, diagnose, and treat patients known or suspected to have the infection, to take actions within the facility to control the spread of the disease, and to maintain continuity of critical healthcare services. To execute these core functions, such entities must:

- Maintain the capability to surge in order to care for a greater number of patients with greater severity of illness than in non-emergency conditions.
- Provide information to the HCCs, LHJs, and DOH for situational awareness including: facility operating status, capabilities, resources on hand, resource needs, case counts, exposed healthcare workers, and other important matters.
- Use existing communications and information sharing tools such as WATrac to share information and communicate with response partners.
- Provide resource and technical assistance to other healthcare facilities as able when requested.
- Request resources through established processes when needed.
- Support epidemiological investigation and public health interventions as requested.
- Identify staff persons who have or may have been exposed to communicable disease, notify the LHJ, and conduct follow-up monitoring and post-exposure therapy as appropriate.
- Take actions to protect healthcare workers following the most up-to-date guidance from the CDC and DOH including establishing process and procedures, training staff, providing appropriate PPE, and other protective actions.

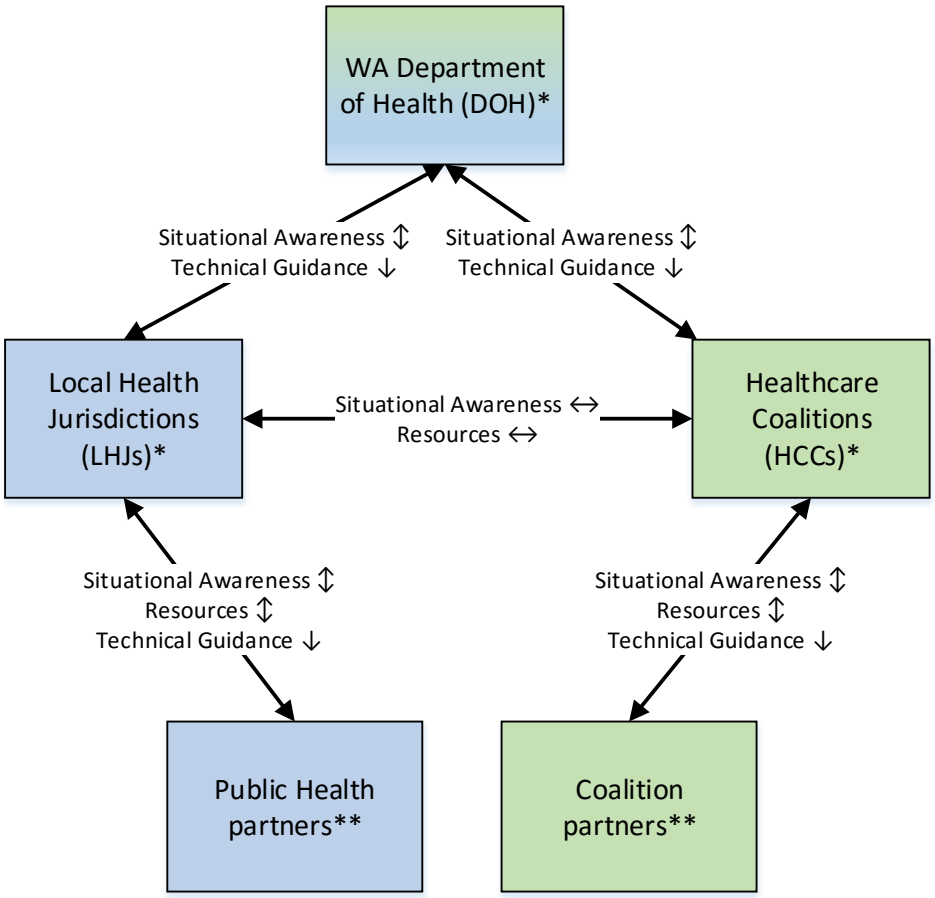
Healthcare Coalitions (HCCs)

The function of the Healthcare Coalitions (HCCs) during a communicable disease emergency will vary by jurisdiction and HCC capability, however HCCs are generally expected to:

- Facilitate situational awareness gathering and information sharing among healthcare system partners in the region including hospitals, urgent care centers, long term care facilities (LTCs), EMS agencies, public health agencies, and emergency management agencies.

- As possible, facilitate resource sharing among healthcare partners within the region, including material resources, technical knowledge, and training.
- Serve as a channel for bidirectional information sharing from DOH and LHJs to coalition partners and from coalition partners to DOH and LHJs. (Refer to Figure 2 below)

Figure 2 – General Support and Coordination Framework



*This graphic does not reflect relationships with Local and State Emergency Management agencies that are necessary for information sharing and resource requesting. Please refer to Figures 3 and 4 for a more detailed description of these relationships.

**There is overlap among local health and healthcare coalition partners. This underscores the need for close coordination among LHJs and HCCs to develop and maintain Common Operating Picture.

Emergency Medical Services (EMS) and other first response agencies

During a communicable disease emergency, EMS and other first responder agencies are expected to continue to respond to emergency calls, provide emergency medical care in the prehospital environment, and to transport ill and injured persons to appropriate healthcare facilities. To do this, EMS and other first responder agencies are expected to:

- Assure availability of staffing and resources to meet an increased demand for services.
- Request resources through established processes when needed.
- Support epidemiological investigation and public health interventions as requested.
- Identify staff persons who have or may have been exposed to communicable disease, notify the LHJ, and conduct follow-up monitoring and post-exposure therapy as appropriate.
- Take actions to protect healthcare workers following the most up-to-date guidance from the CDC, DOH, and LHJs including establishing process and procedures, training staff, providing appropriate PPE, and other protective actions.
- Provide resources to assist other EMS/first responder agencies and jurisdictions as possible when requested.

Public Safety Answering Points (PSAPs) and Dispatch Centers

During a communicable disease emergency, PSAPs and dispatch centers are expected to continue to answer emergency calls, dispatch appropriate resources to emergencies, and to obtain and transmit critical information to EMS and other first responders. To do this, PSAPs and dispatch centers are expected to:

- Assure availability of staffing and resources to meet an increased demand for services.
- Request resources through established processes when needed.
- Be aware of and follow the most up-to-date guidance from the CDC, DOH, LHJs, and the Washington Emergency Management Division (EMD) regarding screening for communicable disease.
- Assess risk of each emergency call and notify responders of the level of risk of communicable disease exposure posed by the patient if applicable.

Local Health Jurisdictions (LHJs) and Tribal Governments

Local Health Jurisdictions (LHJs) and Tribal Governments are generally responsible for developing and implementing activities in order to protect the health of the public within their jurisdiction. During a communicable disease emergency this mission remains the same but also includes other activities to promote information sharing and operational coordination:

- Carry out health officer recommendations and orders to control the spread of the disease within the jurisdiction including the implementation of non-pharmaceutical interventions such as isolation, quarantine, and social distancing, or as appropriate, medical countermeasures including vaccination and prophylaxis.
- Coordinate with neighboring jurisdictions to aid in the implementation of disease control measures.
- Investigate the source of the disease, suspected cases, contacts, and possible environmental sources of disease as appropriate.

- Conduct monitoring of exposed and possibly exposed individuals to identify onset of illness and refer to appropriate treatment.
- Facilitate laboratory testing and case confirmation for suspected cases of disease.
- Gather relevant information from healthcare entities, other government agencies, schools, childcare facilities, and major employers as appropriate.
- Provide relevant situational awareness and other information to DOH and other assisting and cooperating agencies as appropriate.
- Assess available resources to carry out public health interventions, identify the need for assistance, and request additional resources as needed through established channels.
- Maintain processes through which to accept aid arriving from outside of the jurisdiction
- Coordinate with HCCs to support the healthcare system and share information among healthcare system entities.
- Support distribution and administration of medical countermeasures as appropriate
- Provide resources as possible to support requests for mutual aid from outside jurisdictions.

Local Health Officers (LHOs) and Tribal Health Officers

The core responsibility of Local and Tribal Health Officers during a communicable disease emergency is to order all necessary and effective measures to control spread of the disease within their jurisdiction. To control the spread of communicable disease in the most effective manner possible, health officers must:

- Obtain information and intelligence about the nature, scope, and scale of the communicable disease emergency in collaboration with the LHJ and neighboring jurisdictions.
- Have a clear understanding of the nature of the pathogen including its transmission modalities, treatment options, at-risk populations, and other key considerations.
- Decide upon and recommend or order implementation of interventions that, according to the available evidence and best judgment of the LHO, are necessary and effective in controlling the spread of the disease.
- Monitor the effect of disease control measures. Adjust recommendations/orders based upon the effect of enacted measures.
- Cooperate with law enforcement officials, particularly county sheriffs, to appropriately enforce the ordered interventions.
- Coordinate and share all pertinent information with neighboring jurisdictions, other LHOs, and DOH in a timely manner.

Washington State Department of Health (DOH)

DOH acts on the order and instruction of the Secretary of Health to protect the health of the public and control the spread of disease throughout the state. The Secretary of Health has the same authority as the LHO, but he or she shall not exercise this authority except under specific circumstances identified in RCW 43.70.130 (7). In a communicable disease emergency, DOH will:

- Coordinate the healthcare and public health system response including gathering and sharing information and relevant situational awareness, which may include

facility operating status, hospital bed capacity, case counts, laboratory testing results, availability of vaccine and medication, and other critical elements of information.

- Conduct and provide access to laboratory testing including receiving and accessioning specimens, shipping to outside laboratories as needed, and receiving and communicating results of laboratory tests.
- Support requests for material or technical assistance from healthcare and public health entities. This may include seeking resources through intrastate mutual aid, interstate mutual aid, or federal agency resources. This may also include providing resources such as incident management teams, isolation and quarantine facilities and support teams, epidemiology task forces, and other resources from DOH or other state agencies.
- Identify needs for, allocate, and acquire vaccine as needed and as appropriate for the incident. Conduct public and provider outreach and education efforts regarding vaccines and other disease prevention measures. Conduct vaccine accountability efforts and support local and tribal health jurisdictions in assuring vaccine accountability.
- Support collaboration and coordination among LHJs/LHOs, tribal governments, tribal health officers, HCCs, and other healthcare entities to reduce duplication of effort and support common approaches to controlling disease across the state.
- Provide policy support to authorities having jurisdiction throughout the state, including the Governor's office, to address ethical concerns and support decision making at all levels of government.
- Provide guidance and recommendations to healthcare providers regarding clinical management of patients as needed.
- Facilitate discussions among LHOs and LHJs to promote consistency in message, public health interventions, and disease reporting requirements.
- Coordinate public information and risk communication efforts for multi-county incidents or DOH-led responses to provide inclusive, consistent, timely, and accurate information to the public.
- Request, receive, and distribute medical countermeasures as appropriate
- Serve as a conduit of communications and information sharing to and from EMD, CDC, the US Department of Health and Human Services (HHS), and other assisting and cooperating agencies.

Law Enforcement Agencies and Officers

Law Enforcement Agencies (LEAs) and Officers (LEOs) play critical roles in enforcing public health interventions, supporting responder health and safety, and maintaining social function during a communicable disease emergency. LEAs and LEOs are expected to:

- Enforce lawful orders issued by the Local Health Officer (LHO)
- Collaborate with public health, emergency management, and other disciplines at all levels to protect responder health and safety
- As requested, supply personnel and technical guidance to secure critical resources and provide site security for healthcare facilities, points of distribution, and other sites as needed.

County Superior Courts

County Superior Courts serve as the venues for petitioning judicial orders that may be necessary or desirable in order to effectively implement and/or enforce LHO orders. As such, County Superior Courts are expected to:

- Collaborate with local health officers, other public health authorities, and law enforcement in advance of an emergency to promote mutual understanding of public health interventions and judicial processes.
- Hear petitions from local health officers regarding public health interventions and issue rulings according to the opinion of the court.

Washington State Department of Agriculture (WSDA)

WSDA is the lead state agency for veterinary and animal health issues. WSDA is an essential partner to provide technical guidance and expertise when a communicable disease may impact or originate in animal populations, and is a key partner during any zoonotic disease (ZD) incident. When appropriate, WSDA will:

- Assist in providing veterinary services for living and deceased animals including service animals, pets, livestock, and wild or captive animals.
- Coordinate and provide information on animal disease surveillance
- Provide or obtain access to resources and assets to support veterinary response needs
- Provide technical guidance on animal destruction and disposal efforts as needed
- Provide epidemiological support as needed

Local and Tribal Emergency Management Agencies (EMAs) and Tribal Governments

Local emergency management agencies (EMAs) are responsible for providing support to the LHJs, healthcare system, PSAPs, and EMS and other first responder agencies. During a communicable disease emergency, EMAs will:

- Receive resource requests from cities and towns, LHJs, healthcare entities, EMS and other first responder agencies, and other assisting and cooperating agencies within the jurisdiction and neighboring tribal governments.
- Communicate resources requests to the State Emergency Operations Center (SEOC) for fulfillment.
- Obtain critical information from all jurisdictional partners, the SEOC, DOH, and other assisting and cooperating agencies, to build and communicate situational awareness to the SEOC, LHJ, and DOH.
- Support the LHJ and/or tribal community in carrying out LHO or tribal health officer orders to prevent the spread of disease.
- Maintain continuity of government and critical community services. Take measures to maintain the orderly function of society within the jurisdiction throughout the course of the emergency.

Northwest Portland Area Indian Health Board

The Northwest Portland Area Indian Health Board (NPAIHB) is a trusted partner organization representing the 29 federally-recognized tribes in Washington as well as tribal nations in Oregon and Idaho. As an important coordinating entity, NPAIHB has the ability to:

- Coordinate and share information among the tribes located in Washington, and with DOH and other partners as needed.

- Identify resource needs among Washington tribes and work to connect resources with the needs.

Washington State Military Department, Emergency Management Division (EMD)

During a communicable disease emergency, EMD is chiefly responsible for operating the SEOC which serves as the purveyor of information and situational awareness, resource ordering point, and forum for statewide operational coordination including among state agencies and between the state and local levels. To assure effective statewide response to communicable disease emergencies, EMD will:

- Provide communications and information sharing capability support for all Emergency Support Functions (ESFs) at the state level.
- Receive, process, and fulfill requests for resources from EMAs and state agencies through intrastate mutual aid, interstate mutual aid, and federal agency assistance.
- Provide access to Washington National Guard resources as needed.
- Facilitate obtaining a Governor's proclamation of emergency or disaster if appropriate.
- Provide central cost-tracking capability and maintain documentation to support reimbursement claims.
- Support information sharing and public information that is inclusive for the whole community.
- Maintain continuity of government and critical community services. Take measures to maintain the orderly function of society within the jurisdiction throughout the course of the emergency.

Federal Agencies

Federal partners including but not limited the CDC, HHS, Department of Defense, Federal Emergency Management Agency (FEMA), Indian Health Service (IHS), and the Food and Drug Administration (FDA) will support response with guidance, support, and coordination as requested and required. Federal agencies might be requested to:

- Promote coordination with other states, tribal nations, and foreign countries responding to a widespread communicable disease emergency.
- Provide assistance in obtaining resources through interstate or international mutual aid.
- Fulfill requests for federal agency resources including personnel, equipment, medical supplies, vaccines, and medications including the Strategic National Stockpile (SNS).
- Provide technical assistance and guidance to support disease control measures including case study data and recommendations for public health interventions.
- Coordinate border control and broad travel restriction issues through the CDC Division of Global Migration and Quarantine (DGMQ)
- Lead clinical and epidemiological research efforts nationwide and provide funding to support such efforts.
- Provide financial support for research, response, and/or recovery in relation to the communicable disease emergency.

F. Support and Coordination Frameworks for Communicable Disease Emergency Response

The below graphics are intended to clarify the flow of information and resource requests during a communicable disease emergency.

Figure 3 - Minimum Required Information Sharing

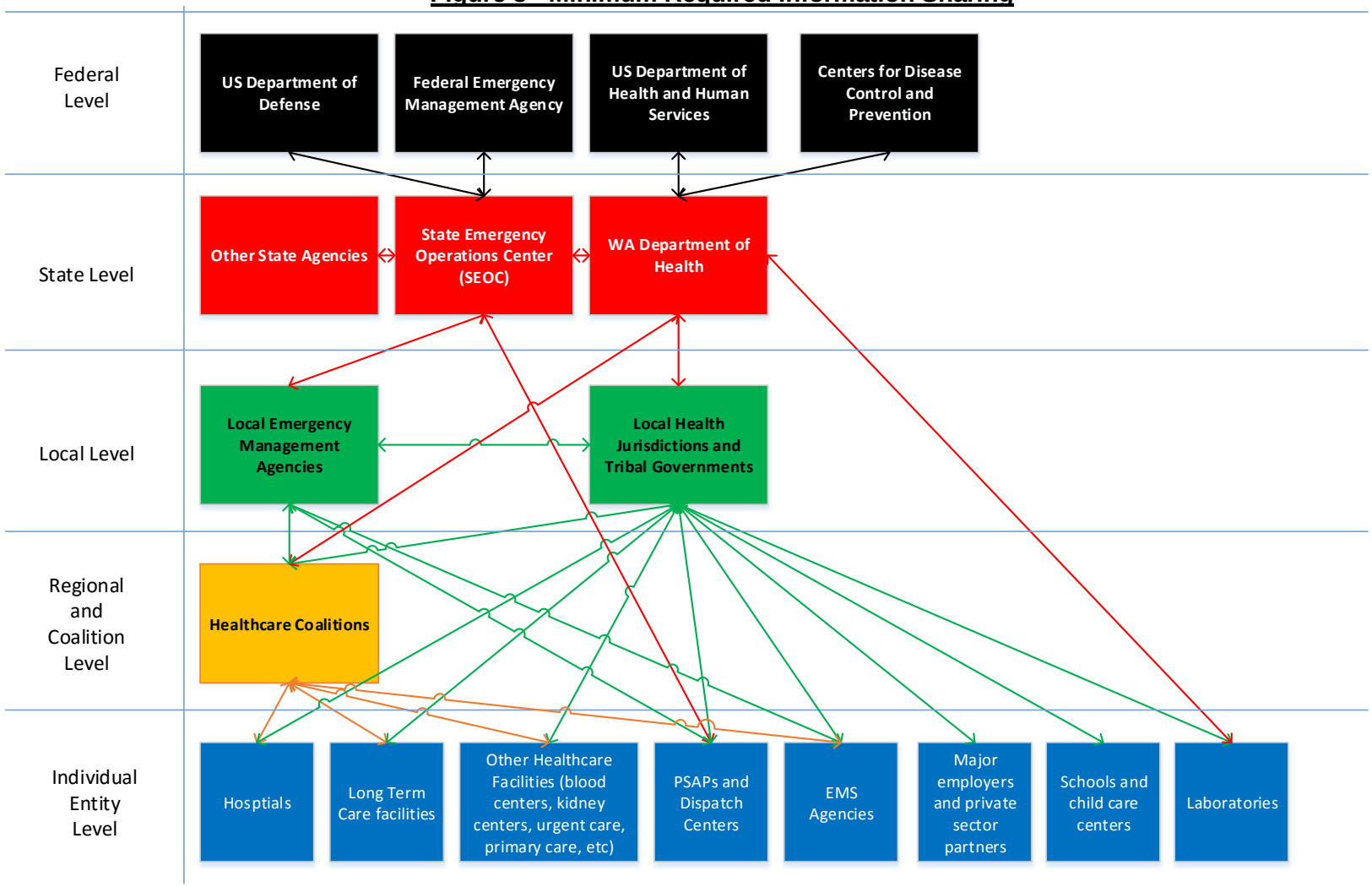
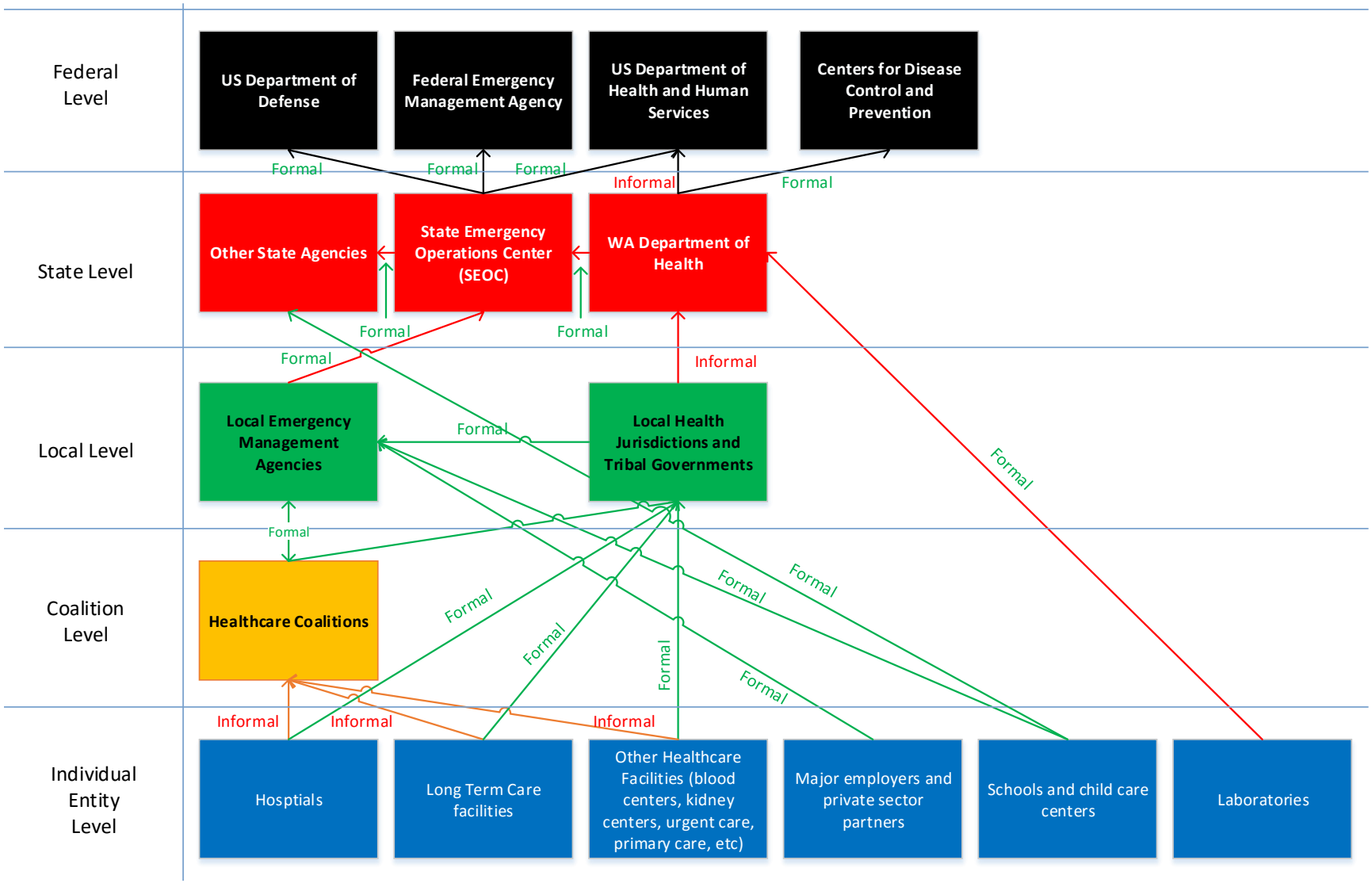


Figure 4 - Formal and Informal Resource Requests



III. ATTACHMENTS

Attachment A	Communicable Disease Emergency Severity Assessment Matrix
Attachment B	Framework for Ethical Response to Communicable Disease
Attachment C	Non-Pharmaceutical Interventions (NPI) Policy and Implementation Playbook
Attachment D	Pandemic Influenza and Acute Viral Respiratory Infection (AVRI) Response Considerations
Attachment E	Ebola Virus Disease (EVD) and Other Special Pathogen Disease (OSPD) Statewide Response Framework
Attachment F	Health and Human Services (HHS) Region X Ebola Virus Disease (EVD) and Other Special Pathogen Disease (OSPD) Regional Coordination Concept of Operations
Attachment G	Bioterrorism Response Considerations
Attachment H	Zoonotic (ZD) and Vector Borne Disease (VBD) Response Concept of Operations
Attachment I	Authorities and Relevant Legal Framework

A. Communicable Disease Emergency Severity Assessment Matrix

This is a hybrid qualitative and quantitative assessment tool to assist in describing the severity and complexity of an anticipated or ongoing communicable disease emergency. The aggregate score obtained through the use of this matrix can be used to estimate the most appropriate type of response to the communicable disease emergency as described below.

This tool was developed by WA DOH after a careful review of the literature and in consideration of the CDC Pandemic Severity Index (PSI) and the WHO processes for characterizing influenza pandemic severity. The tool was developed to assess key criteria for communicable disease severity laid out by the WHO, and was validated using historical outbreak data.

To use this tool, identify the factor in each row of Table 9 that best describes the emergency and find its corresponding score in the column header. Write that number in the box in the same row of the right hand column. Once complete, total the score to obtain the total matrix score and identify the appropriate category in the table below. Table 8 directly correlates to Table 1 (Page 11) based on the Levels of Communicable Disease Incident in the right hand column of Table 8.

Table 8 – Response Type by Matrix Score and Level of Communicable Disease Emergency

Total Matrix Score	Probable Characteristics and Type of Response	Corresponding Level (Table 1)
17-25	The disease is limited in impact and available treatments generally produce positive outcomes in those who are ill. Disease does not spread very easily and if treatment is needed, nearly any medical facility is capable of treating the disease. Response is led by the local health jurisdiction with basic assistance from neighboring jurisdictions or state agencies as needed.	5
26-40	The disease is usually minor but may be easily transmissible. The disease is well understood and treatment is widely available. Affected LHJs lead response. LHJs may have sufficient resources to manage this incident but may require a moderate degree of support from intrastate mutual aid or state agency resources. DOH provides support and coordination among responding jurisdictions as needed.	4
41-55	The disease is moderately severe and threatens to produce significant morbidity or mortality in some populations. Cases and contacts are distributed throughout the state. Most healthcare providers can safely treat suspected or confirmed cases. Public concern is significant but consistent with the severity of the threat. Response is led by DOH but is primarily carried out by LHJs, receiving close coordination and support from DOH.	3
56-70	The disease is severe and has limited or no specific treatment options. The disease is highly infectious and requires special training and equipment to manage safely. Public concern is severe. Response is led by DOH in close collaboration with all political subdivisions within the state and all state agencies, in order to consistently control the spread of the disease throughout the state, rapidly share information, manage resources effectively, and facilitate requests for interstate and federal aid.	2
70-85	The disease is novel with severe morbidity and mortality in the general population and has severe or catastrophic effects on social function. Response requires the full efforts and resources of all government agencies at the local, state, and federal level to contain the disease, treat the infected population, research and develop treatments, maintain continuity of government, and restore social function.	1

Table 9.1 - Communicable Disease Emergency Severity Assessment Matrix (Page 1)

Categories	1	2	3	4	5	Score
Characteristics of the Pathogen						
Pre-Incident Pathogen Prevalence	Very Common – endemic in Washington with frequent cases	Common –endemic in Washington with occasional cases	Uncommon – known pathogen not endemic in Washington State	Rare – known pathogen not endemic in the United States	Extremely Rare – pathogen is novel or emerging and may not be well understood	
Modes of Transmission	Direct fluid contact only (or food-borne only)	Direct and Indirect contact	Contact and Droplet (or Vector)	Airborne (with or without contact)	Multiple modes or unknown transmission	
Precautions Required	Standard only	Contact precautions	Contact and droplet precautions	Airborne precautions ± contact (N95 or PAPR)	Special precautions (DOT Category A or BSL 4 type)	
Ease of Transmission (R_0 if available)	Transmission is rare (R_0 0-0.5)	Transmission is difficult (R_0 0.5-1)	Moderately Transmissible (R_0 1.0-2.0)	Easily transmissible (R_0 2.5-4)	Highly infectious (R_0 >4)	
Known Effective Treatment	Known specific treatment widely available	Known specific treatment with limited availability	No known specific treatment, however supportive care often produces positive outcomes	No known specific treatment, morbidity and mortality remain high with supportive care	No known specific treatment or effective supportive care	
Available vaccine/ prophylaxis	Vaccine/prophylaxis widely available	Vaccine/prophylaxis available in region	Vaccine/prophylaxis with limited availability	Known vaccine/prophylaxis is unavailable	No known vaccine/prophylaxis	
Morbidity	Sequelae are rare (<10% of cases) and often minor in severity	Sequelae are rare (<10% of cases) and may produce significant disability	Sequelae are uncommon (10-20% of cases) and may produce significant disability	Sequelae are common (20-30% of cases) and may produce significant disability	Severe sequelae resulting in disability are common (>30% of cases)	
Mortality (CFR if known)	Fatalities are rare (CFR <0.5%)	Infrequent fatalities in patients with comorbidities (CFR <1%)	Occasional fatalities in the general population (CFR <1%)	Substantial fatalities in at-risk groups and frequent fatalities in the general population (CFR 1-10%)	Substantial fatalities in the general population (CFR >10%)	
					Page 1 Total =	

Table 9.2 - Communicable Disease Emergency Severity Assessment Matrix (Page 2)

Categories	1	2	3	4	5	Score
Characteristics of Incident Impact						
Jurisdiction(s) affected	Single county	More than one county	Widespread throughout the state	Throughout the state and also in neighboring state(s)/province(s)	Widespread throughout WA and the United States or worldwide.	
Available resources	Existing local resources are sufficient	Statewide resources are sufficient	Interstate or federal aid is needed	Federal and international aid are needed	Worldwide resources are not sufficient	
Public Concern	Minor media attention, minor or absent public concern	Moderate public concern easily managed with effective messaging	Significant media attention and public concern, susceptible to effective messaging	Significant public concern not susceptible to effective messaging	Public panic that threatens or produces failure of law and order	
Population at risk	Small, limited population at risk	Large but limited population at risk	Some age groups at significantly increased risk	Significant portion of the general population at risk	Whole general population at near equal risk	
Social Function	Society is functioning normally	Society functions with occasional gaps in private-sector services	Major services are intact but peripheral services have failed	Major public services are at risk or experience periodic failures	Social collapse is possible or imminent	
Healthcare System Function	Systems function normally	Systems are stretched but consistently meet all community needs	Systems mostly meet community needs with difficulty	Systems meet some but not most community needs	Systems fail to meet community needs	
School/Daycare Absentee Rates	Not significantly increased	Minor increase (<3% above average)	Moderate Increase (3-15% above average)	Significant absenteeism (15-30% above average)	Widespread absenteeism (>30% above average)	
Major Employer Absentee Rates	Not significantly increased	Minor increase (<3% above average)	Moderate Increase (3-15% above average)	Significant absenteeism (15-30% above average)	Widespread absenteeism (>30% above average)	
Washington Case Counts (confirmed and probable)	Single case or small cluster (<10 cases)	10-100 cases	100-1,000 cases	1,000-10,000 cases	>10,000 cases in WA	
					Page 2 Total =	
					Page 1 Total =	
					TOTAL =	

B. Framework for Ethical Response to Communicable Disease

(This ethical framework is adapted from the Alberta Health Ethical Framework for Responding to Pandemic Influenza *and the WHO discussion paper:* Addressing ethical issues in pandemic influenza planning).

This framework is based on a set of well-recognized ethical principles and outlines a transparent process by which to assess potential actions during a communicable disease emergency. The purpose of this framework is to provide guiding principles to support decision making during a communicable disease emergency across the state.

Recognizing that each health officer and other individual having jurisdiction has the authority and may choose to employ divergent methods to control disease and conduct emergency response within that jurisdiction, it is expected that all decisions be made with the primary intention of protecting the health, well-being, and life safety of the general public. Severe or widespread communicable disease emergencies may pose significant ethical challenges and this tool should be used to support ethical policy decisions in such an incident.

Ethical Tensions in a Communicable Disease Emergency

Healthcare and public health systems experience tension among three primary responsibilities on a daily basis:

- Responsibility to each individual
- Responsibility to society at large
- Responsibility to healthcare providers

In the absence of an emergency, this tension is held in balance which allows hospitals and healthcare systems to focus primarily on serving each individual patient. Healthcare and public health resources are generally sufficient to meet the responsibility to society at large, and through advances in infection prevention and control and occupational health and safety, the responsibility to protect healthcare workers is usually managed effectively.

When a communicable disease emergency occurs, this careful balance must shift. Healthcare and public health resources may be limited and the risk to workers may be substantial. When risk to healthcare and public health workers increases, the ability to protect them from harm may be compromised and yet the responsibility to society and to the individual remains. As resources are consumed and demand for limited resources exceed the capability to meet the need, excess tension is created which must be resolved through ethical decision making in order to hold in balance these three responsibilities in a new environment. In cases where responsibilities to individuals and groups are held in tension, decision-makers can use the ethical principles below to find the best possible solution.

Ethical Principles

This ethical framework is based on equal concern and respect for all. This means that:

- Everyone matters
- Everyone matters equally – but this does not mean that everyone is treated the same
- The interests of each person are the concern of all of us, and of society
- The harm that might be suffered by every person matters, and so minimizing the harm that a communicable disease might cause is a central concern

The principles of equal concern and respect include a number of different ethical principles, which are discussed below. When a particular decision has to be made, using the list of principles can help in considering a range of ethical issues. It is not, however, a checklist for the one right answer.

Decision-makers will need to use the best information that is available to them at that time. Whether or not a decision was ethically sound will be judged in the context of the situation that existed at the time, rather than a normal situation. Often, there will be tension both within and between these principles - for example, in weighing different sorts of harm, and in trying to both minimize harm and to be fair. There are often no absolute right answers.

1. Respect

This principle means that:

- The Whole Community should be kept as informed as possible.
- When possible, people's personal choices about their treatment and care should be considered to the extent possible.
- When people are unable to make their own health care decisions and have not provided any written expressed wishes regarding their care, those who must decide for them should do so in consideration of what the person may have wanted, supported by the standards and duties of the health care providers involved in the decision at the time.

Respect applies to all individuals including patients, health care workers and the general public. There should be the widest possible involvement of people in planning for a communicable disease emergency. The urgency of the situation may mean that it is not possible to consult widely (or at all); however, treating people with respect means keeping them informed of the situation as much as possible. Respect means balancing people's personal choices with the reality of the situation.

2. Minimizing Harm Caused by the Disease

During a communicable disease emergency, some harm may be unavoidable. This principle means that there is a need to:

- Attempt to minimize the spread of the disease.
- Minimize the risk of complications for the ill.
- Utilize experience and existing evidence to fight the disease and to treat people who are ill.
- Avoid causing further harm (non-maleficence), including avoiding therapies or interventions where the potential risks outweigh the potential benefits
- Minimize the disruption to society caused by the disease.

This principle is intended to cover the physical, psychological, social, and economic harm that might result from a communicable disease emergency. Actions relevant to minimizing harm include those that prevent the spread of the disease, save lives, support the healthcare system in saving lives, and are designed to help society cope with and recover from the emergency.

3. Fairness

The principle of fairness means that:

- Everyone matters equally but may not be treated the same.
- People with an equal need for and chance of benefiting from health resources should have an equal chance of receiving them regardless of other factors.

The implications of the principles of fairness and minimizing harm often arise together in planning and policy decisions. In considering a particular decision, a useful first question might be: How could harm be minimized? Then it is necessary to ask: Would it be fair to do this? Could the same outcome be achieved in a fairer way? This involves thinking about the interests of everyone who may be affected by the decision. There need to be good reasons to treat some people differently from others, which the decision-makers must be prepared to explain. The decision-making *process* also needs to be fair, which is considered part of the principle of good decision making below.

4. Working together

This principle means:

- Working together to plan for, respond to, and recover from disease outbreaks
- Helping one another
- Being prepared to share information that will help others, without compromising the privacy and dignity of the individuals involved

Communicable disease emergencies affect all parts of society, and it is crucial that different agencies collaborate and coordinate at local, regional, state, levels. Working together also implies strong links at the interstate, federal and international, levels. This includes both providing and seeking timely information from partners across the Pacific Northwest and the United States.

5. Reciprocity

The principle of reciprocity is based on the concept of mutual exchange. Therefore:

- If people are asked to take increased risks, or face increased burdens during a communicable disease emergency, they should be supported in doing so, and the risks and burdens should be minimized as far as possible.

Some people, such as healthcare workers, may face heavy burdens in carrying out their duties during a communicable disease emergency. It is important to think about how to minimize those burdens while providing care and support to those heavily burdened while serving society during a communicable disease emergency.

6. Proportionality

This principle means that:

- Those responsible for providing information should give people the most accurate information available.
- Decisions on actions that may affect people's daily lives should be proportionate to the risk and benefits that may result from the proposed action. Proportionality requires that the least restrictive means possible is used when limiting liberty and freedom in the face of a communicable disease emergency.

7. Flexibility

This principle means that:

- Plans and response activities should be adapted to take into account new information and changing circumstances.
- People should have as much opportunity as possible to express concerns about or disagreement with decisions that affect them.

8. Good decision making

Respect for this principle involves the following components:

Openness and transparency:

- This means that those making decisions should:
  - Consult those concerned as much as possible in the time available.
  - Be open about what decisions need to be made and who is responsible for making them.
  - Be as open as possible about what decisions have been made and why they were made.

Inclusiveness

- This means that those making decisions should:
  - Involve people to the greatest extent possible in aspects of planning that affect them.
  - Take into account all relevant views expressed.
  - Work to make sure that particular groups are not excluded. Some people may find it harder to access communications or services than others, and decision-makers should consider how they can express their views and have a fair opportunity to get their needs for treatment or care met.

Accountability

- This means that those responsible for making decisions may have to justify the decisions that they do or do not make.

Reasonableness

- This means that decisions should be:
  - Rational, practical, and evidence-based
  - Not arbitrary
  - The result of an appropriate process, taking into account how quickly a decision has to be made and the circumstances in which a decision is made.

Ethical Decision Assessment Worksheet

The worksheet on the following page is intended to help a decision maker weigh potential options against the ethical principles identified above. This tool is intended to be used to help inform a decision in conjunction with appropriate legal, scientific, policy, and programmatic guidance.

Example: You witness a coworker who has worked with the organization for a long time taking some basic supplies out of the office copy room.

Table 10 – EXAMPLE Ethical Decision Assessment Worksheet

Ethical Principles	**Option 1:** Report this to your supervisor immediately.	**Option 2:** Confront the coworker about what you saw.	**Option 3:** Do nothing.
Respect	This respects the workplace and your supervisor, as they will be informed of the incident. It doesn't necessarily respect the employee as he was not informed before the report.	This option incorporates respect, as it addresses the issue but gives the employee a chance to express their side of the story. Your supervisor may not be informed, but since inappropriate actions may be corrected, it may not be necessary.	This option does not reflect respect, as you have made no effort to understand what you saw or let your supervisor know if there is in fact an issue.
Proportionality	This option seems out of proportion. Without taking the time to understand the situation, one might actually report inaccurate information that could jeopardize the reputation of the employee.	This option is in proportion. It addresses the issue, but allows the employee to share their side of the story and possibly correct the inappropriate actions without losing face, especially since the supplies are not worth much money.	It could be argued that this option is proportional as the supplies are not worth much, and their loss won't greatly affect the business. Not reporting it will ensure that the employee's reputation is not duly or unduly affected.

Table 11 - Ethical Decision Assessment Worksheet)

Ethical Principles	***Option 1***	***Option 2***	***Option 3***
Respect			
Minimizing the Harm			
Fairness			
Working Together			
Reciprocity			
Proportionality			
Flexibility			
Good Decision Making			

Summary of Decision

For the question:	
We recommend that:	
This allows us to:	
This solution does not:	
We argue that this is justified because:	

C. Non-Pharmaceutical Interventions (NPI) Policy and Implementation Playbook

Non-Pharmaceutical Interventions (NPIs) are among the most effective methods to control the spread of communicable disease. While vaccines are available to protect against many pathogens and other medical countermeasures are available for some pathogens of concern, there are many pathogens with outbreak potential for which no effective vaccine or medical countermeasure exists.

When implemented early and effectively, evidence indicates that NPIs can be *at least* as effective as antiviral drugs. The key to successful NPI implementation is to implement each intervention based on pre-established triggers based on early case detection and emerging epidemiological data.

The following policy "playbook" provides a brief analysis of possible Non-Pharmaceutical Interventions (NPIs) that might be implemented by state, local, or tribal health officers and briefly discusses some potential costs and benefits of each along with recommendations for when the use of each intervention *may* be appropriate. This is not a comprehensive list of all possible NPIs.

When ordering interventions, the individual having authority must consider the practicability of implementation and be confident that implementation of the ordered interventions is not only feasible, but also ethically sound, the least restrictive effective intervention, and scientifically sound.

It is critical to consider that virtually any NPI will be accompanied by significant equity concerns. Each intervention has the potential to disproportionately impact certain people or groups of people, and therefore implementation should be planned and conducted carefully.

Effective risk communications and public information are critical aspects of the successful implementation of NPIs. All jurisdictions are strongly encouraged to involve public information personnel in all phases of planning for, implementing, and evaluating NPIs.

The contents of this document are based on sound scientific evidence and were developed and vetted by a diverse group of epidemiologists, health officers, and emergency planners. This policy playbook is NOT a substitute for effective planning, ethical decision-making, sound scientific judgment, or legal counsel and should not be interpreted as binding or comprehensive guidance for response to any specific hazard. This document must not be the sole source of information when considering the most appropriate methods with which to control a communicable disease. The contents of this document are derived from the CDC's NPI guidance (www.cdc.gov/nonpharmaceutical-interventions) and the peer-reviewed evidence base.

Table 12 below is organized to analyze specific interventions. Table 13 is designed to list interventions that may be effective for pathogens organized by route of transmission. Table 14 provides example decision packages for common categories of communicable disease threat, organized by outbreak level (See Table 1, Page 11).

Table 12 – Analysis of Potential NPI options

Non-Pharmaceutical Intervention Option	Success Factors	Possible Drawbacks	Possible Benefits	Appropriate Use Scenario	Possible Implementation Methods
Indirect Interventions The following interventions rely heavily upon effective public messaging to encourage behaviors that will help to reduce the spread of the disease. These may or may not be focused to specifically target high-risk groups, such as international travelers when disease transmission is occurring abroad. These interventions are the least restrictive of all NPIs, quick to implement, inexpensive, and effective. These interventions are listed in no specific order.					
Increase hand washing and use of alcohol-based hand sanitizer	Success depends on public education effectiveness, public compliance, and access to hand washing/sanitizing stations	None anticipated	Quick and easy to implement; effective at reducing illness due to direct/indirect contact	Diseases transmitted by direct contact, indirect contact, and/or droplet routes	Inclusive public messaging campaign, flyers in public locations, hand sanitizer stations in accessible areas
Cover coughs and sneezes	Success depends on public education effectiveness and public compliance	None anticipated	Quick and easy to implement; effective at reducing illness due to droplet transmission	Diseases transmitted by droplet or airborne routes	Inclusive public messaging campaign, flyers in public locations, provide tissues in accessible areas
Use a mask in public if you are sick	Success depends on public education effectiveness, public compliance, and access to masks	Evidence base for effectiveness of mask use by the public is not conclusive. May degrade compliance with other NPIs	If used correctly and consistently, masks *may* reduce transmission via droplet	Diseases transmitted by droplet	Inclusive public messaging, flyers in public locations, provide masks in public locations, provide list of locations to purchase
Abstain from sex or use condoms when having sex	Success depends on public education effectiveness, public compliance, and access to condoms	Some religious and cultural groups do not support the use of condoms. Messaging may alienate some members of the public	If used correctly and consistently, condoms offer protection against sexually-transmitted diseases. Abstinence from sex is completely effective.	Diseases transmitted by direct fluid contact; diseases with known or suspected potential for sexual transmission	Inclusive public messaging campaign, flyers in public locations, provide condoms to high-risk groups, provide list of locations from which condoms may be purchased
Use EPA-registered insect repellent when outdoors	Success depends on public education effectiveness, public compliance, access to repellent	Some individuals do not support the use of chemical insect repellent and may not comply	EPA-registered insect repellents reduce the risk of insect bites	Vector-borne diseases transmitted by mosquitos, ticks, flies, and other insects	Inclusive public messaging, flyers in public locations, provide insect repellent to high-risk groups, provide list of locations to purchase
Cover exposed skin when outdoors and avoid outdoor activities at night	Success depends on public education effectiveness and public compliance	None anticipated	Covering exposed skin and remaining indoors after dark reduce the risk of insect bites	Vector-borne diseases transmitted by mosquitos, ticks, flies, and other insects	Inclusive public messaging campaign, flyers in accessible locations

Non-Pharmaceutical Intervention Option	Success Factors	Possible Drawbacks	Possible Benefits	Appropriate Use Scenario	Possible Implementation Methods
Eliminate standing water in your environment	Success depends on public education effectiveness and public compliance	None anticipated	Eliminating standing water may reduce insect habitat	Vector-borne diseases transmitted by mosquitos, ticks, flies, and other insects	Public messaging campaign, flyers in accessible locations
Avoid insects when sleeping: use permethrin-treated nets, window screens, air conditioning (A/C)	Success depends on public education effectiveness, public compliance, and access to nets, screens, and A/C	Many individuals will be unable to comply with this recommendation due to lack of A/C and inadequate resources to purchase nets and window screens	Many insects are more active during twilight and night hours, so use of these interventions reduces the risk of bites	Vector-borne diseases transmitted by mosquitos, ticks, flies, and other insects	Inclusive public messaging campaign, flyers in accessible locations, provide nets to high-risk groups, provide list of locations from which insect repellent may be purchased
Seal your home to prevent rodent infestations	Success depends on public education effectiveness, technical aptitude, and financial resources	Many individuals will be unable to comply with this recommendation due to lack of A/C and inadequate	Sealing the home can prevent rodent access and reduce risk of transmission of vector-borne diseases	Vector-borne diseases transmitted by rodents	Inclusive public messaging campaign, provide free inspection and referral for service to high-risk groups, instructions on DIY assessments
Eliminate rodent food sources	Success depends on public education effectiveness, compliance, and ability to dispose of clutter	None anticipated	Maintaining a clean home and sealing all food containers among other actions eliminate habitat for vector species	Vector-borne diseases transmitted by rodents	Inclusive public messaging campaign, flyers in accessible locations
Trap rodents around the home	Success depends on public education effectiveness, public compliance, and access traps	Trapping indoors without sealing the home may cause additional rodents to enter the structure	Trapping can eliminate rodents from a structure if the structure is sealed which reduces risk of transmission of vector-borne diseases	Vector-borne diseases transmitted by rodents	Inclusive public messaging campaign, flyers in accessible locations
Clean up after a rodent infestation	Success depends on public education effectiveness, adherence to guidance, and access to cleaning and protective equipment	Improper cleaning of rodent urine/droppings and doing so without the gloves or proper cleaning supplies can increase risk of exposure to pathogens	Thorough cleaning of an area previously infested by rodents reduces the risk of disease transmission	Vector-borne diseases transmitted by rodents	Inclusive public messaging campaign, provide free inspection and referral for service to high-risk groups, instructions on DIY cleanup
Keep distance from others (>3 feet)	Success depends on public education effectiveness and public compliance	Certain cultural and religious groups may be unwilling or unable to comply due to conflict with cultural/religious norms or practices	Quick and easy to implement; effective at reducing illness due to direct/indirect contact, droplet, and airborne routes	Diseases transmitted by direct contact, indirect contact, droplet, and/or airborne routes	Inclusive public messaging campaign, flyers in accessible locations

Non-Pharmaceutical Intervention Option	Success Factors	Possible Drawbacks	Possible Benefits	Appropriate Use Scenario	Possible Implementation Methods
Encourage frequent environmental disinfection in personal areas	Success depends on public education effectiveness, public compliance, and access to appropriate disinfectants at home	None anticipated	Environmental disinfection is effective at reducing illness due to indirect contact (fomites)	Pathogens that are durable on dry surfaces and when significant risk for indirect contact transmission exists	Inclusive public messaging campaign, flyers in accessible locations, distribute disinfectant in accessible locations
Encourage frequent environmental disinfection in common and public areas	Success depends on messaging reach, organizational willingness and compliance, and access to appropriate disinfectants and workforce	None anticipated	Environmental disinfection is effective at reducing illness due to indirect contact (fomites), particularly on high-touch surfaces	Pathogens that are durable on dry surfaces and when significant risk for indirect contact transmission exists	Messaging to government agencies, major employers, transportation providers, private sector partners, CBOs, and FBOs
Remain home through the duration of your illness if you are sick	Success depends upon individual willingness and ability to stay home from work/school/events including access to paid sick leave	Many members of the public will be reluctant to stay home due to risk of lost wages and limited or no access to paid sick leave	This is a form of voluntary isolation which is extremely effective in reducing the spread of illness if ill persons comply consistently	Diseases transmitted by direct contact, indirect contact, droplet, and/or airborne routes	Inclusive public messaging campaign, flyers in accessible locations
Encourage employers to extend paid sick leave for ill employees	Success depends on messaging reach, employer willingness, and employer compliance	The decision to extend paid sick leave benefits has significant economic ramifications for employers and may threaten the viability of their business	Extending paid sick leave benefits to ill workers could be expected to facilitate compliance with requests for voluntary isolation	Diseases transmitted by direct contact, indirect contact, droplet, and/or airborne routes	Messaging to government agencies, major employers, transportation providers, private sector partners, CBOs, and FBOs
Encourage employers to allow ill employees to work from home if possible	Success depends on messaging reach, employer willingness, and access to technologies that facilitate telecommuting	Many industries are not conducive to “work from home” or telecommuting	Allowing ill workers to work from home could be expected to facilitate compliance with requests for voluntary isolation	Diseases transmitted by direct contact, indirect contact, droplet, and/or airborne routes	Messaging to government agencies, major employers, transportation providers, private sector partners, CBOs, and FBOs

Direct Individual-Level Interventions The following interventions used to prevent the spread of disease when few ill persons have been identified and individual-level intervention is possible to prevent a broader outbreak. These are characterized as direct because they are implemented via a direct request or order given to a specific individual or small group and can be enforced by law, as opposed to the above Indirect NPIs which are broad-sweeping appeals for public assistance presented to the community at large without direct ordering or enforcement.					
Non-Pharmaceutical Intervention Option	**Success Factors**	**Possible Drawbacks**	**Possible Benefits**	**Appropriate Use Scenario**	**Possible Implementation Methods**
Voluntary isolation of sick persons	Effective education and ability to comply with request. Material support with “wrap-around” services and working with the employer may help compliance	Non-compliance with voluntary isolation increases risk of disease transmission, is difficult to enforce	Isolation is extremely effective in reducing the spread of illness consistent. Voluntary isolation is “less-restrictive” and is more acceptable to the public	Diseases transmitted by direct contact, indirect contact, droplet, and/or airborne routes	Instructing healthcare providers to educate patients, health officer request for patient to self-isolate, engage community and faith-based organizations to support
Involuntary isolation of sick persons	Success depends on healthcare facility and/or public health system ability to implement	Involuntary isolation is extremely restrictive and resource intensive	Isolation is extremely effective in reducing the spread of illness. Non-compliant persons can be prevented from spreading disease	Diseases transmitted by direct contact, indirect contact, droplet, and/or airborne routes. Only recommended when individual is not reliable or compliant	Health officer order for emergency detention, court order, physician order within a hospital
Voluntary quarantine of contacts of ill persons	Success depends on effective contact tracing and individual ability to comply with request. Material support with “wrap-around” services and working with the employer may help to encourage compliance	Non-compliance with voluntary quarantine increases risk of disease transmission	Quarantine may allow quick identification of a suspect case and helps to prevent exposures early in the course of illness	Diseases transmitted human-to-human where ill individuals may become contagious before showing symptoms.	Health officer request for contact to self-isolate, engage community and faith-based organizations to support. Work with employers.
Involuntary quarantine of contacts of ill persons	Success depends on effective contact tracing as well as public health system ability to implement and enforce quarantine which is costly and resource intensive	Involuntary quarantine is extremely restrictive and resource intensive	Quarantine allows quick identification of possible cases and can help to prevent exposures. Non-compliant persons can be prevented from spreading disease	Diseases transmitted human-to-human where ill individuals may become contagious before showing symptoms. Only recommended when individual is not reliable or compliant	Health officer order for emergency detention or court order. Quarantine at home, in a community-based facility, or in a government owned facility.
Individual travel restrictions (avoid mass transit, do not leave the county, etc.)	Success depends on effective education and individual ability to comply with request.	Some individuals will be unable or unwilling to comply with travel restrictions	Travel restriction is less restrictive than isolation or quarantine but may reduce likelihood of disease transmission by reducing interpersonal contacts	Diseases transmitted by direct contact, indirect contact, droplet, and/or airborne routes	Health officer request for individual to restrict travel, engage community and faith-based organizations to support. Work with employers.

Direct Community-Level Interventions The following interventions may be used at the community level, particularly when individual-level interventions have failed and/or when cases are widespread and effective case identification and/or contact tracing is difficult or impossible. These interventions are among the most restrictive interventions, are difficult to implement, and each carry significant drawbacks if implemented.					
Non-Pharmaceutical Intervention Option	**Success Factors**	**Possible Drawbacks**	**Possible Benefits**	**Appropriate Use Scenario**	**Possible Implementation Methods**
Ordering cancellation of major public events (festivals, public markets, etc.)	Success depends upon event sponsor compliance and authorities' ability to enforce effectively	May result in revenue loss, public outrage, political backlash, and may disproportionately impact certain cultural or community groups	Reduces opportunities for widespread disease transmission by reducing interpersonal contacts and increasing social distance	Diseases easily transmitted human-to-human via by contact, droplet, and/or airborne routes, when less-restrictive interventions have failed	Health officer order or request that major government-sponsored events/gatherings be cancelled or postponed.
Ordering cancellation of large private gatherings (i.e. movie theaters, shopping malls, religious gatherings, concerts)	Success depends upon public and event sponsor compliance and authorities' ability to enforce effectively	May result in revenue loss, public outrage, political backlash, and may disproportionately impact certain cultural or religious groups	Reduces opportunities for widespread disease transmission by reducing interpersonal contacts and increasing social distance	Diseases easily transmitted human-to-human via by contact, droplet, and/or airborne routes, when less-restrictive interventions have failed	Health officer order or request that large private gatherings be cancelled or postponed.
Ordering closure of schools and childcare facilities	Success depends upon authorities' ability to enforce effectively and may be supported by closure of workplaces so that need for childcare is reduced	Will disproportionately impact families with young or school-age children and likely cause an increase in non-outbreak associated workplace absenteeism	Reduces opportunities for widespread disease transmission by reducing interpersonal contacts and increasing social distance among those least likely to comply with less-restrictive NPIs	Diseases easily transmitted human-to-human via by contact, droplet, and/or airborne routes, when less-restrictive interventions have failed or when children are at particular risk	Health officer order to cease operation of school(s) and childcare facility(ies). May be limited to certain at-risk age groups if applicable
Ordering suspension of public transportation	Success may be supported by closure of workplaces and supporting alternative transportation for people without private transportation	Will disproportionately impact those without access to private transportation and will cause adverse economic impact to those who must travel	Reduces opportunities for direct or indirect disease spread, and may prevent a disease from entering new geographical regions	Diseases easily transmitted human-to-human via by contact, droplet, and/or airborne routes, when less-restrictive interventions have failed or to prevent introduction in new areas	Health officer collaboration with public transportation providers to limit or cancel service as appropriate. Health officer order as needed
Preventing non-emergency travel outside of the home	Success depends upon public compliance and authorities' ability to enforce effectively	Will prevent the operation of private business, the effect of which will be felt by employees as loss of income, and the public as lack of commodity availability	Reduces opportunities for direct or indirect disease spread, and may prevent a disease from entering new geographical regions	Diseases easily transmitted human-to-human via by contact, droplet, and/or airborne routes, when less-restrictive interventions have failed or to prevent introduction in new areas	Health officer order to the public to cease all non-essential travel. Essential must be defined. Work with law enforcement agencies to enforce

Non-Pharmaceutical Intervention Option	Success Factors	Possible Drawbacks	Possible Benefits	Appropriate Use Scenario	Possible Implementation Methods
Closing ports of entry	Success depends upon authorities' ability to enforce effectively	Will result in broad-reaching economic consequences for businesses that depend upon ports of entry for commerce. Costs may be assumed by the public in the form of increased commodity cost or lack of availability	Reduces opportunities for direct or indirect disease spread, and may prevent a disease from entering new geographical regions	Diseases easily transmitted human-to-human via by contact, droplet, and/or airborne routes, when less-restrictive interventions have failed or when there is concern for transplantation into new areas	Health officer order to close ports of entry. Requires substantial coordination with federal government and private sector
Preventing access to or egress from a specific geographic area (cordon sanitaire)	Success depends upon authorities' ability to enforce effectively	Results in the effective "cutting-off" of an entire community. People not residing in the area will be stranded without support. Commerce will be heavily compromised.	May contain a disease within the boundaries of the cordon.	Diseases easily transmitted human-to-human via by contact, droplet, and/or airborne routes, when less-restrictive interventions have failed and when a disease is largely confined to one geographical area	Health officer order to cordon a specific geographic area. Work with law enforcement agencies to enforce

Table 13 – Appropriate NPIs organized by Route of Transmission

The purpose of this matrix is to provide decision support to LHOs by indicating which NPIs *may* be effective to control a communicable disease based on its route(s) of transmission. It is important to note that, despite the potential efficacy of a given intervention, each intervention may not be appropriate to implement in a given situation. The decision to implement an NPI should be made based not only upon the expected efficacy of an intervention, but also the appropriateness of the intervention in each situation and its possible consequences. This does not constitute an exhaustive list of all possible NPIs that may be effective in controlling the spread of a particular disease or condition. This document is derived from the CDC's NPI guidance (www.cdc.gov/nonpharmaceutical-interventions).

Potential NPIs	Modes of Transmission					
	Direct contact	Indirect contact (fomites)	Respiratory droplet	Airborne	Vector (Insect)	Vector (rodent)
Increase hand washing and use of hand sanitizer	X	X	X	X		
Cover coughs and sneezes	X	X	X	X		
Use masks in public when sick			X	X		
Use EPA-registered insect repellent when outdoors					X	
Cover skin when outdoors					X	
Avoid insects when sleeping					X	
Seal your home to prevent rodent infestations						X
Eliminate rodent food sources						X
Trap rodents around the home						X
Clean up after a rodent infestation						X
Keep distance from others when you are sick	X	X	X	X		
Encourage frequent environmental disinfection in personal areas	X	X	X			
Encourage frequent environmental disinfection in common and public areas	X	X	X			
Remain home through the duration of your illness if you are sick	X	X	X	X		

Potential NPIs	Direct contact	Indirect contact (fomites)	Respiratory droplet	Airborne	Vector (Insect)	Vector (rodent)
Encourage employers to extend paid sick leave for ill employees	X	X	X	X		
Encourage employers to allow ill employees to work from home if possible	X	X	X	X		
Voluntary isolation of sick persons	X	X	X	X		
Involuntary isolation of sick persons	X	X	X	X		
Voluntary quarantine of contacts of ill persons	?	?	?	?		
Involuntary quarantine of contacts of ill persons	?	?	?	?		
Individual travel restrictions (avoid mass transit, do not leave the county, etc.)	X	X	X	X		
Ordering cancellation of major public events	X	X	X	X		
Ordering cancellation of large private gatherings	X	X	X	X		
Ordering closure of schools and childcare facilities	X	X	X	X		
Ordering suspension of public transportation	X	X	X	X		
Ordering closure of workplaces, businesses, and public buildings	X	X	X	X		
Preventing non-emergency travel outside of the home	X	X	X	X		
Closing ports of entry	X	X	X	X		
Preventing access to or egress from a specific geographic area (cordon sanitaire)	X	X	X	X		

? – denotes situations in which an intervention may be appropriate depending on disease characteristics. Quarantine may be appropriate for diseases that are transmissible when the infected person is asymptomatic.

Table 14 – Example NPI Decision Package Organized by Incident Severity Level – Viral Respiratory Illness

The purpose of this table is to provide an example decision package for Non-Pharmaceutical Interventions (NPIs) in the context of a communicable disease emergency caused by a viral respiratory illness such as influenza, measles, Severe Acute Respiratory Syndrome (SARS), Middle East Respiratory Syndrome (MERS), or similar illness. This document is derived from the CDC's NPI guidance (www.cdc.gov/nonpharmaceutical-interventions).

Viral respiratory illness may be transmitted via large and small respiratory droplet/aerosol, direct contact, and indirect contact (fomites). The decision to implement this package or parts thereof must be based on the characteristics of the exact pathogen, the degree of transmissibility, and the severity of illness caused by the pathogen.

Begin at Level*	Intervention	Expected Result	Example Implementation
5	Increase hand washing and use of alcohol-based hand sanitizer	Reduce probability of direct and indirect transmission of the disease by disinfecting hands	Conduct public messaging and media campaigns to encourage educate the public and to promote enhanced hygiene and social distancing measures. Targeted messaging to major employers may be beneficial in encouraging these behaviors in the workplace
5	Cover coughs and sneezes	Reduce probability of droplet transmission of the disease by reducing the range of respiratory droplets and aerosols	
5	Keep distance from others (>3 feet)	Reduce probability of direct and droplet transmission by reducing the number of interpersonal contacts	
5	Frequently disinfect personal surfaces (doorknobs, phones, keyboards, etc.)	Reduce probability of indirect transmission by disinfecting fomites	
5	Remain home through the duration of your illness if you are sick	Reduce probability of transmission by preventing contacts between well and sick people	
4	Voluntary isolation of sick persons	Reduce probability of transmission by preventing contacts between well and sick people	Health officers, medical providers, and public health personnel provide direct education to cases and contacts asking that they remain home for an established period of time
4	Voluntary quarantine of contacts of sick persons	Reduce probability of transmission in the event that the contact becomes contagious before symptoms develop	
3	Involuntary isolation of sick persons	Reduce probability of transmission by preventing contacts between well and sick people	Health officers issue emergency detention orders or seek court orders for involuntary detention in order to involuntarily isolate or quarantine those who are uncooperative
3	Involuntary quarantine of contacts of sick persons	Reduce probability of transmission in the event that the contact becomes contagious before symptoms develop	
2	Order cancellation of major public events and large private gatherings	Reduce probability of transmission by reducing the number of interpersonal contacts	Health officer orders to suspend all gatherings above a certain size with the intention to reduce risk of disease transmission if a subset of that population may be sick
2	Order closure of schools, childcare facilities, workplaces, and public buildings	Reduce probability of transmission by reducing the number of interpersonal contacts	
1	Prevent non-emergency travel outside of the home	Reduce probability of transmission by reducing the number of interpersonal contacts	Health officer orders to halt non-emergency travel and remain indoors in order to protect those not yet sick and isolate those who are
1	Establish *cordon sanitaire*	Contain the disease within specific geographical boundaries	

**Refer to Tables 1 and 8 for level definitions. Levels range from 1 to 5. In general, level 5 represents a limited outbreak and level 1 is a widespread emergency with high morbidity and mortality.*

Table 15– Example NPI Decision Package Organized by Incident Severity Level – Contact Diseases

The purpose of this table is to provide an example decision package for Non-Pharmaceutical Interventions (NPIs) in the context of a communicable disease emergency caused by a disease primarily transmitted by direct or indirect contact such as Methicillin-resistant Staphylococcus Aureus (MRSA), Carbapenem-resistant Enterobacteriaceae (CRE), and similar illnesses. This document is derived from the CDC's NPI guidance (www.cdc.gov/nonpharmaceutical-interventions).

Contact Diseases are transmitted when an infected person has direct bodily contact with an uninfected person and the microbe is passed from one to the other. Contact diseases can also be spread by indirect contact with an infected person's environment or personal items. The presence of wound drainage or other discharges from the body suggest an increased potential for risk of transmission and environmental contamination. Precautions that create a barrier and procedures that decrease or eliminate the microbe in the environment or on personal belongings, form the basis of interrupting transmission of direct contact diseases.

Begin at Level*	Intervention	Expected Result	Example Implementation
5	Increase hand washing and use of alcohol-based hand sanitizer	Reduce probability of direct and indirect transmission of the disease by disinfecting hands	Conduct inclusive public messaging and media campaigns to encourage educate the public and to promote enhanced hygiene and social distancing measures. Targeted messaging to major employers and government agencies may be beneficial in encouraging these behaviors in the workplace
5	Keep distance from others (>3 feet)	Reduce probability of direct and droplet transmission by reducing the number of interpersonal contacts	
5	Frequently disinfect personal surfaces (doorknobs, phones, keyboards, etc.)	Reduce probability of indirect transmission by disinfecting fomites	
5	Remain home through the duration of your illness if you are sick	Reduce probability of transmission by preventing contacts between well and sick people	
4	Voluntary isolation of sick persons	Reduce probability of transmission by preventing contacts between well and sick people	Health officers, medical providers, and public health personnel provide direct education to cases asking that they remain home for an established period of time
4	Involuntary isolation of sick persons	Reduce probability of transmission by preventing contacts between well and sick people	Health officers issue emergency detention orders or seek court orders for involuntary detention in order to involuntarily isolate those who are uncooperative or unreliable
3	Order targeted cancellation of select major public events and large private gatherings	Reduce probability of transmission by reducing the number of interpersonal contacts	If a specific population is recognized to be at increased risk for transmission, consider suspending gatherings until disease transmission subsides
3	Order targeted closure of impacted schools, childcare facilities, workplaces, and/or public buildings	Reduce probability of transmission by reducing the number of interpersonal contacts	

**Refer to Tables 1 and 8 for level definitions. Levels range from 1 to 5. In general, level 5 represents a limited outbreak and level 1 is a widespread emergency with high morbidity and mortality.*

Table 16– Example NPI Decision Package Organized by Incident Severity Level – Fecal-Oral Diseases

The purpose of this table is to provide an example decision package for Non-Pharmaceutical Interventions (NPIs) in the context of a communicable disease emergency caused by a disease primarily transmitted by fecal-oral transmission such as E. coli, adenovirus, campylobacter, salmonella, and similar illnesses. This document is derived from the CDC's NPI guidance (www.cdc.gov/nonpharmaceutical-interventions).

Fecal-oral transmission occurs when a person touches the stool of an infected person or an object contaminated with the stool of an infected person and ingests the germs. A disease that is spread by the fecal-oral route can be transmitted from person to person, or in food or water. This can happen when a person fails to wash their hands properly after using the bathroom, and then handles food that is eaten by others, or when feces contaminate a water supply. Hand hygiene is one of the best ways to prevent the spread of disease.

Begin at Level*	Intervention	Expected Result	Example Implementation
5	Increase hand washing and use of alcohol-based hand sanitizer	Reduce probability of direct and indirect transmission of the disease by disinfecting hands	Conduct inclusive public messaging and media campaigns to encourage educate the public and to promote disease prevention measures. Targeted messaging to major employers and government agencies may be beneficial in encouraging these behaviors in the workplace
5	Frequently disinfect personal surfaces (doorknobs, phones, keyboards, etc.)	Reduce probability of indirect transmission by disinfecting fomites	
5	Remain home through the duration of your illness if you are sick, particularly for food service workers	Reduce probability of transmission by preventing contacts between well and sick people, particularly in high-risk settings	
5	Peel and wash food produce to remove potentially infectious material; store and cook all food carefully	Reduce probability of transmitting the disease through food products	
5	Order targeted closing of impacted facilities (restaurants, daycares, etc.) to inspect and perform through disinfection	Identify sources of infection and eliminate contamination	Health officers order closure of certain facilities until deemed safe

**Refer to Tables 1 and 8 for level definitions. Levels range from 1 to 5. In general, level 5 represents a limited outbreak and level 1 is a widespread emergency with high morbidity and mortality.*

Table 17– Example NPI Decision Package Organized by Incident Severity Level – Bloodborne Diseases

The purpose of this table is to provide an example decision package for Non-Pharmaceutical Interventions (NPIs) in the context of a communicable disease emergency caused by a disease primarily transmitted by bloodborne transmission such as Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), and similar illnesses. This document is derived from the CDC's NPI guidance (www.cdc.gov/nonpharmaceutical-interventions).

Bloodborne diseases can be transmitted through contact with infected blood and other potentially infectious body fluids including but not limited to semen, vaginal secretions, cerebrospinal fluid, and saliva. The best methods to prevent transmission of bloodborne pathogens are to avoid exposure to potentially infectious fluids.

Begin at Level*	Intervention	Expected Result	Example Implementation
5	Abstain from sex or use barrier devices correctly and consistently when having sex	Reduce the likelihood of fluid-to-fluid contact	Conduct inclusive public messaging and media campaigns to encourage educate the public and to promote disease prevention measures. Other effective approaches may include distributing condoms and other barrier devices and conducting needle-exchange. Targeted messaging to at-risk populations may also reduce risk for those at highest risk.
5	Avoid sharing personal items such as razors, toothbrushes, etc.	Reduce the likelihood of fluid-to-fluid contact	
5	Avoid sharing needles, syringes, or other equipment used to inject drugs	Reduce the likelihood of fluid-to-fluid contact	
5	Avoid contact with blood and other body fluids	Reduce the likelihood of fluid-to-fluid contact	
5	Keep wounds covered	Reduce the likelihood of fluid-to-fluid contact	
5	Avoid getting tattoos or body piercings in unlicensed settings or with non-sterile equipment	Reduce the likelihood of fluid-to-fluid contact	

**Refer to Tables 1 and 8 for level definitions. Levels range from 1 to 5. In general, level 5 represents a limited outbreak and level 1 is a widespread emergency with high morbidity and mortality.*

D. Pandemic Influenza and Acute Viral Respiratory Infection (AVRI) Response Considerations

Purpose

The purpose of this attachment is to describe specific response considerations for pandemic influenza and other acute viral respiratory infection (AVRI) that are different from the core text of the *Statewide Communicable Disease and Pandemic Response Concept of Operations*. The purpose of this section is to elaborate on these differences rather than to restate the common framework for response to all communicable disease emergencies and pandemics.

Background

Pandemic influenza struck three times in the 20th century causing varying degrees of increased illness and death. Of particular note is the 1918 pandemic where more than 50 million people died around the world and 500 million people became ill causing a catastrophic social disruption.

Influenza causes upper respiratory tract infections with fever, muscle aches, headache, fatigue, dry cough and runny nose. Complications of influenza may be life-threatening and include viral and bacterial pneumonia which are more likely to occur in the very young, the elderly, and in those with certain medical conditions, including pregnancy. The virus is spread through close contact and by respiratory droplets.

According to the World Health Organization (WHO), —A pandemic influenza (or global pandemic) occurs when a new influenza virus subtype appears to which few or none are immune. In past pandemics, influenza has spread worldwide within months. Influenza is now expected to spread even more quickly due to modern global travel patterns. While it was generally assumed that there may be between one to six months warning before outbreaks begin in the United States, Washington State experienced an outbreak within days of the first confirmed cases of H1N1 in Mexico in 2009. Existing scientific evidence and historical experience indicate that:

- Pandemic influenza or other AVRI will reemerge in the future.
- New subtypes are most likely to emerge in a country other than the United States, although a novel strain could first emerge in the United States.
- An influenza or AVRI pandemic will probably occur in waves over an extended period of time. At least two waves can be expected.
- In Washington, an influenza pandemic would result in substantial impact to the population. Figure 8 below, shows the assumed impact of a pandemic, based on a range of 15–35% of the population becoming ill. Estimates in the ‘moderate‘ column represent a range with a lower hospitalization and fatality rate as occurred in pandemic influenza outbreaks in 1957 and 1968, while estimates in the ‘severe‘ column are based on a 1918-like pandemic with increased hospitalizations and death.

Figure 8 – Potential Impact of Pandemic Influenza in Washington State
(calculated using the CDC's FluAid 2.0 and Washington State 2003 Census)

Severity	Moderate (1957/68-like)		Severe (1918-like)	
	United States	Washington	United States	Washington
Illness	90 million	1.9 million	90 million	1.9 million
Outpatient medical care	23,297,882 – 54,361,724	479,685 – 1,119,265	45 million	943,000
Hospitalization	513,617 – 1,198,443	10,399 – 24,255	9,900,000	210,009
Will require intensive/critical care	77,043 – 179,703	1,560 – 3,638	1,485,000	31,501
Deaths	116,962 – 272,911	2,303 – 5,373	1,903,000	40,368

Planning Assumptions

This attachment is based on the following assumptions in addition to the assumptions of the *Statewide Communicable Disease and Pandemic Response Concept of Operations*:

- The extent to which a pandemic will affect the general population will depend on the severity and spread of the disease.
- Each intervention used to control disease spread has the potential to disproportionately impact certain people or groups of people, and therefore implementation should be planned and conducted carefully
- Priority groups for vaccine and other medical countermeasures will be determined as the outbreak unfolds
- Although there may be isolated pockets, an influenza or AVRI pandemic will likely affect all geographic areas of the state
- An intense public reaction is likely and will require communication and public safety measures
- Support for medical surge including alternate care sites ad crisis standards of care will be needed
- Support for mass fatality management will be needed

Pandemic Influenza and AVRI Response Considerations

Response activities will be carried out in collaboration with the Washington Emergency Management Division (EMD), LHJs, Tribes, and other local, state and federal agencies and community organizations as described in the *Statewide Communicable Disease and Pandemic Response Concept of Operations.* Specific considerations for response to pandemic influenza and AVRI include:

Surveillance and Epidemiology

Washington's influenza surveillance system (ILI Net) monitors influenza activity in the state and will provide surveillance data needed to guide response efforts during an influenza pandemic.

Laboratory Diagnostics

The Washington State Public Health Laboratory (WAPHL) is capable of differentiating seasonal influenza from non-typable influenza. Non-typable influenza is tested at the CDC and all non-typable strains are evaluated to determine if they are novel or potentially a pandemic strain. The WAPHL provides protocols for the rapid identification of public health threat agents including routine testing for novel viruses and enhanced testing during a pandemic.

Healthcare Systems Planning

The healthcare system in Washington coordinates planning and actions by healthcare and non-healthcare emergency response partners that will be necessary for the provision of care in hospitals and other healthcare settings, including surge capacity and mortuary issues. Refer to the *Medical Surge Appendix* to the ESF 8 Annex for further information on healthcare system planning and response considerations for all-hazard medical surge.

Vaccine Distribution and Use

DOH, along with many LHJs, maintains plans and processes for the distribution and use of vaccines during communicable disease emergencies including an influenza or AVRI pandemic. Vaccination of at-risk individuals, healthcare workers, and the general public are effective measures to reduce transmission of disease and limit morbidity and mortality due to the disease.

Vaccine may decrease transmission of influenza and its complications. Educating the public about vaccines can increase the general public‘s familiarity and confidence in vaccine efficacy and safety.

- Seasonal influenza vaccine will aid to reduce illness from those strains, and may minimize the chance of avian or animal influenza combining with a human influenza virus to create a potential pandemic influenza strain.
- Among those at risk for pneumococcal disease, pneumococcal polysaccharide vaccine will reduce illness and death associated with secondary pneumococcal pneumonia that can follow influenza infection.
- If available, a vaccine effective against a pandemic influenza or AVRI strain may minimize influenza transmission, severity of illness, and mortality.
- If available, vaccine may be distributed in the early phases of a potential pandemic.

Antiviral Drug (AVD) Distribution and Use

Antiviral Drugs (AVDs) can serve as a medical countermeasure to save lives and provide the pharmaceutical industry time to produce an effective vaccine. Key goals for AVDs include:

- Limit mortality and morbidity due to the pandemic

- Minimize social disruption and economic impact resulting from the pandemic

Appropriate use and distribution of antivirals during a pandemic may reduce morbidity and mortality and diminish the overwhelming demands that will be placed on the health care system. DOH, along with many LHJs maintains plans and processes for the distribution and use of antiviral drugs during an influenza or AVRI pandemic.

Community Disease Control and Prevention

Comprehensive community mitigation strategies for a pandemic include both pharmaceutical (vaccine and antivirals) and non- pharmaceutical interventions (NPIs). Please refer to the *NPI Policy and Implementation Playbook* for further recommendations around the use of NPIs.

Managing Travel-Related Risk of Disease Transmission

In a world of modern air travel and a relatively short incubation period of the influenza and AVRI pathogens, disease spread will likely be rapid during a pandemic. Specific measures may be needed to manage the risk of travel-associated disease transmission. Such measures will be coordinated with the CDC DGMQ Seattle Quarantine Station including all foreign transport issues and communicable diseases entering the U.S. and Washington through major ports of entry.

Public Information and Risk Communications

The use of proven risk communication methods is essential to inform the public during a pandemic. The overarching goal of the communications strategy is to provide timely, accurate and pertinent information to the public and other stakeholders. DOH is committed to providing reasonable accommodations to populations to assure individuals have equal access to effective communications in alignment with ADA and the Rehabilitation Act.

Key public information objectives include:

- Build and maintain public confidence in the public health and healthcare system and its ability to respond to and effectively manage an emergency.
- Provide accurate, rapid and complete information including addressing rumors and inaccuracies.
- Rapidly provide the public, health care providers, policy-makers and the media access to accurate, consistent, and comprehensive information and details about the pandemic.
- Provide accurate, consistent and highly accessible information and materials to internal staff to ensure clarity of roles and responsibilities.
- Provide accessible and culturally appropriate information for People with Limited English Proficiency (LEP), People with Access and Functional Needs (PAFN), and diverse cultural audiences.

E. Ebola Virus Disease (EVD) and Other Special Pathogen Disease (OSPD) Statewide Response Framework

Purpose

The purpose of this attachment is to communicate the Washington State framework for response to Ebola Virus Disease (EVD) and Other Special Pathogen Disease (OSPD) to relevant agencies, organizations, and stakeholders while expressing the unique considerations for managing pathogens that may be highly infectious and/or high consequence in nature.

This concept and corresponding frameworks are intended to be consistent with the full content of the Washington Statewide Communicable Disease Response Concept of Operations and the responsibilities established therein.

Scope

The scope of this framework is limited to EVD and OSPD within Washington State. For patients with EVD/OSP being transferred from locations outside Washington State, please refer to the *HHS Region X EVD/OSPD Regional Coordination Concept of Operations.*

A list of Special Pathogens is included in Table 16 below. This list was developed by the Centers for Disease Control and Prevention (CDC) and the United States Army Research Institute for Infectious Diseases (USAMRIID), and has been adopted by Washington State. It is important to note that the list of pathogens below is considered minimum and not an all-inclusive list of Special Pathogens

Characteristics of Special Pathogen Disease may include any one or more of the following:

- High risk of mortality
- High risk of secondary cases
- Absence of effective vaccine, prophylaxis, or specific treatment
- Clinical or public assuredness concerns that can be mitigated by treating patients in a Special Pathogens Unit (SPU)
- Optimally safe clinical care requires the use of Personal Protective Equipment (PPE) beyond what is in daily use
- Optimally safe clinical care requires facilities or facility functionality that is different from standard hospital facilities
- Waste and laboratory samples generated in the course of clinical management requires special handling (DOT Category A or similar)

Table 16 – Special Pathogens

Arenaviruses	**Bunyaviruses**	**Henipiviruses**	**Other pathogens:**
• Lassa	• CCHF	• Hendra	• Hantaan
• Guanarito	**Orthopoxviruses**	• Nipah	• Novel influenza
• Junin	• Variola	**Filoviruses**	• Pneumonic Plague
• Machupo	• Monkeypox	• Ebola	• XDR Tuberculosis
• Sabia	**Coronaviruses**	• Marburg	• Rift Valley Fever
• Lujo Virus	• SARS		
	• MERS		

Assumptions

This framework is based on the following planning assumptions:

- All healthcare facilities in Washington State maintain the capability to identify and isolate patients with significant index of suspicion for EVD/OSPD and notify the relevant LHJ.
- All LHJs and Tribal Governments in Washington State have access to the capability to respond to a suspected case of EVD/OSPD in a private residence or a healthcare facility in their jurisdiction including performing Active Monitoring and Direct Active Monitoring (AM/DAM) of individuals at risk for developing EVD/OSPD
- All LHJs and Tribal Governments have access to the capability to arrange transportation for a patient with suspected EVD/OSPD to an appropriate hospital

Activation of this Framework

The decision to activate this framework statewide in response to a special pathogen is made by the Secretary of Health and is guided by CDC recommendations regarding the specific pathogen of concern.

All physicians in Washington are expected to activate this framework for a specific patient suspected to have EVD/OSPD, based on concerning clinical findings and exposure risk (e.g., history of recent travel to an area affected by an outbreak of such a pathogen). In response to a single patient with suspected or confirmed EVD/OSPD, medical providers must notify the appropriate Local Health Jurisdiction (LHJ) who must in turn notify DOH. This is the day-to-day process for notifiable conditions and will remain the process for activating this framework for single patients.

Framework

Public Health Responsibilities

When this framework is activated, LHJs and Tribal Health Jurisdictions are expected to fulfill their responsibilities as described in the Washington Statewide Communicable Disease and Pandemic Response Concept of Operations including notifications, epidemiological investigation, and monitoring of those at-risk for developing illness.

When processes are in place to identify returning travelers with some level of risk for EVD/OSPD at airports or other points of entry, each LHJ is expected to arrange for AM/DAM as appropriate for each returning traveler with the intent of identifying a suspected case of EVD/OSPD at the earliest possible opportunity.

Essential Elements of Information

The below Essential Elements of Information (EEI) are examples of critical considerations that must be communicated among and within jurisdictions under this framework. Many of the below elements of information constitute confidential, protected data and must be managed as such.

- When returning travelers are being monitored, the identities and locations of all people identified as having any level of risk for exposure to EVD/OSP must be shared with the LHJ in the patient's area of (temporary or permanent) residence
- The location and identity of any people suspected or confirmed to have EVD/OSP

- The death of any person suspected or confirmed to have EVD/OSP
- Incidents where first responders, healthcare workers, or members of the public have known or suspected exposure to a person suspected or confirmed to have EVD/OSP
- Travel routes and plans for cross-jurisdictional movement of a patient with suspected or confirmed EVD/OSP
- Any equipment, supply, or medication shortages or needs that may compromise response at any time

Healthcare System Responsibilities and Tiered Hospital Network

As a result of the 2014 Ebola Virus Disease (EVD) Epidemic, a tiered hospital system was developed nationwide and in Washington State to assure availability of safe and effective medical care for high-risk patients. The resulting system allows preparedness and response efforts to be focused around a relatively small number of facilities, which have built and continue to build enhanced capability to manage patients with EVD/OSPD.

This tiered system is activated as a cornerstone of effective public health and healthcare system response to EVD/OSPD. Activation of this system assures that each patient receives medical care from those who are *most* prepared to provide it and have strong, proven capability to do so. Responder health and safety is paramount in any incident, and use of the tiered hospital network assures the greatest degree of protection for clinical providers.

All hospitals regardless of tier must collaborate closely with the appropriate LHJ on an ongoing basis in preparedness, response, and recovery activities.

The tiered hospital network includes the following capabilities in Washington State:

- *Frontline Hospitals* – There are 87 frontline hospitals in Washington State, and each is expected to have the capability to:
    - Identify a patient with concern for EVD/OSPD,
    - Isolate that patient to prevent unprotected exposure to healthcare workers and other patients
    - Inform the appropriate LHJ and, if transferring the patient, inform the EMS agency of the patients infectious status
    - Arrange for safe transfer of the patient to an Assessment or Treatment facility
    - Have sufficient supplies of PPE on hand to manage an EVD/OSPD patient for at least 24 hours if needed

- *Assessment Hospitals* – There are 6 state-designated Assessment Hospitals in Washington that stand ready to:
    - Receive a patient who is suspected to have EVD/OSPD
    - Interface with EMS personnel to assure safe waste disposal and doffing of EMS personnel PPE
    - Isolate the patient in a private room
    - Obtain laboratory samples as needed to confirm the diagnosis as advised by the LHJ and DOH, and send samples to the WA PHL in coordination with the LHJ and DOH
    - Care for the patient until the diagnosis can be confirmed or ruled out and until discharge or safe transfer of the patient (up to 96 hours)

  - In consultation with the LHJ and DOH, arrange patient transfer to a designated Treatment Center
  - Have sufficient supplies of PPE on hand to manage an EVD/OSPD patient for at least 96 hours
  - Safely manage DOT Category A hazardous waste

- *Treatment Centers* – There are 2 state-designated Treatment Centers in Washington that maintain the capability to:
  - Receive a patient who is suspected or confirmed to have EVD/OSPD within 8 hours of notification
  - Carry out all capabilities of an Assessment Hospital
  - Provide comprehensive care for the patient through the full duration of their illness
  - Arrange safe discharge and appropriate follow up care

- *Regional Treatment Centers* – There are 10 federally designated Regional Treatment Centers in the United States including 1 located in Washington State. Each RTC maintains the same capability as state-designated Treatment Centers and:
  - The capability to manage at least 2 EVD/OSPD patients concurrently
  - The capability to provide or arrange pediatric care
  - At least 10 negative-pressure isolation rooms

Table 17 – Assessment Hospitals and Treatment Centers in Washington State

Category	Hospitals (in alphabetical order)	Location
Assessment Hospitals	Evergreen Health	Kirkland, WA
	Harrison Medical Center	Bremerton, WA
	PeaceHealth St. Joseph	Bellingham, WA
	Providence Regional Medical Center Everett	Everett, WA
	Providence St. Mary Medical Center	Walla Walla, WA
	Swedish Hospital Issaquah	Issaquah, WA
Treatment Centers	Harborview Medical Center (adult and pediatric)	Seattle, WA
	Seattle Children's Hospital (pediatric only)	Seattle, WA
Regional Treatment Center	Providence Sacred Heart Medical Center and Children's Hospital (adult and pediatric)	Spokane, WA

Each facility regardless of tier is expected to maintain plans and procedures, train their staff, and validate plans through exercise to assure that the necessary capability is sustained across the state.

Emergency Medical Services (EMS)

All licensed Emergency Medical Services (EMS) agencies and other first responder agencies are expected to identify patients with concerning clinical findings and potential exposure history in the prehospital environment, and to communicate this information to the receiving hospital prior to arrival.

EMS personnel are trained in basic infection control and highly infectious diseases through initial and ongoing training required to maintain certification, and are adequately equipped with appropriate PPE to protect them from most communicable diseases including patients with viral respiratory illness and those with “dry” EVD signs and symptoms. County EMS Medical Program Directors (MPDs) have received guidance from DOH and have established protocol for the appropriate clinical management of a patient with EVD/OSPD.

EMS Interfacility Transfer (IFT) Agencies

Interfacility transfer of a patient with EVD/OSPD carries many unique considerations. In patients with EVD, the severity of clinical condition directly correlates to viral load in the patient’s bloodstream; thus, the more critically ill a patient is, the more contagious the patient becomes. As a result, additional protective measures are needed to protect EMS and other personnel from exposure to the disease when conducting interfacility transfer.

DOH maintains a list of identified EMS agencies that maintain the capability to conduct interfacility transfer of EVD patients with “wet” signs and symptoms, and those with OSPD. Those agencies are listed in Table 18 below. Other agencies who have developed capability but are not included on this list may transport EVD/OSPD patients for interfacility transfer at the judgment of the agency, hospital, and LHJ.

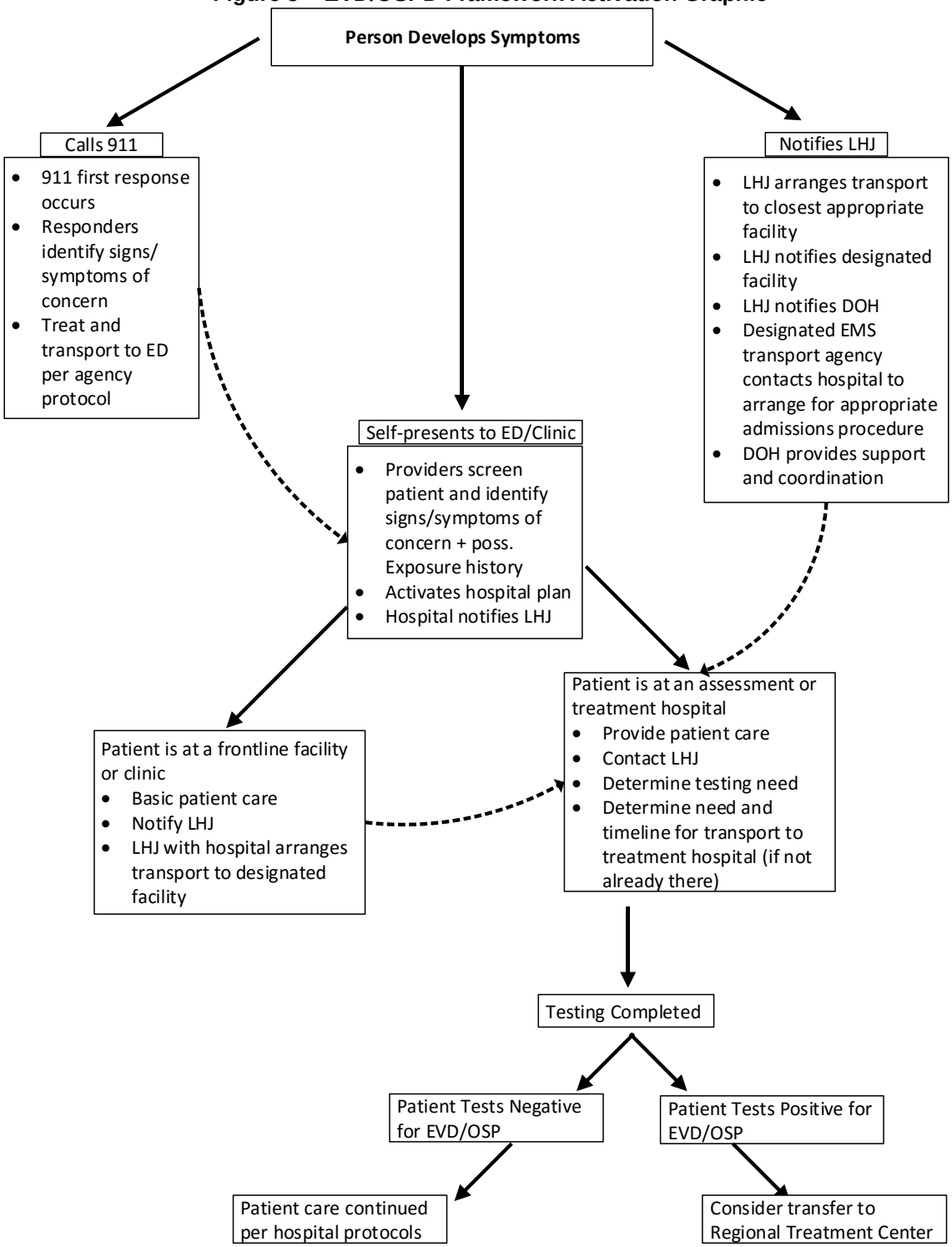
Table 18 – WA Designated EVD/OSPD Interfacility Transfer Agencies

EMS Agency (alphabetical order)	Location	Areas Served
Advanced Life Systems, Inc.	Yakima, WA	Yakima County, Confederated Tribes of the Yakima Nation
American Medical Response	Portland, OR	Grays Harbor, Lewis, Mason, Thurston Counties; Quinault Tribe
American Medical Response	Spokane, WA	Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens, Whitman, Chelan, Douglas, Grant, Okanagan Counties, Confederated Tribes of the Colville Reservation, Kalispell Tribe, Spokane Tribe
American Medical Response	Vancouver, WA	Clark, Cowlitz, Skamania, Klickitat Counties
American Medical Response	Yakima, WA	Benton, Franklin, Kittitas, Walla Walla, Yakima Counties; Confederated Tribes of the Yakima Nation
Central Kitsap Fire and Rescue	Bremerton, WA	Kitsap County
King County Medic One	Kent, WA	King County
Lake Chelan Community Hospital EMS	Chelan, WA	Chelan County
Metro West Ambulance	Hillsboro, OR	Pacific County, Wahkiakum County
Rural Metro Ambulance	Fife, WA	Clallam, Jefferson, Pierce, Skagit, Snohomish, Whatcom Counties; Makah Tribe
San Juan County EMS	Friday Harbor, WA	San Juan County
Whidbey General Hospital EMS	Coupeville, WA	Island County

Framework Activation Diagram

The following diagram describes the general processes for management of a patient with suspected EVD/OSPD beginning at the time of symptom development.

Figure 5 – EVD/OSPD Framework Activation Graphic



Patient Movement Considerations

Moving a patient with suspected EVD/OSPD is challenging due to the need for enhanced PPE for all providers involved, and the degree of preparation necessary to carry out the mission safely. Each EMS agency has slightly different operational procedures however most share several common characteristics:

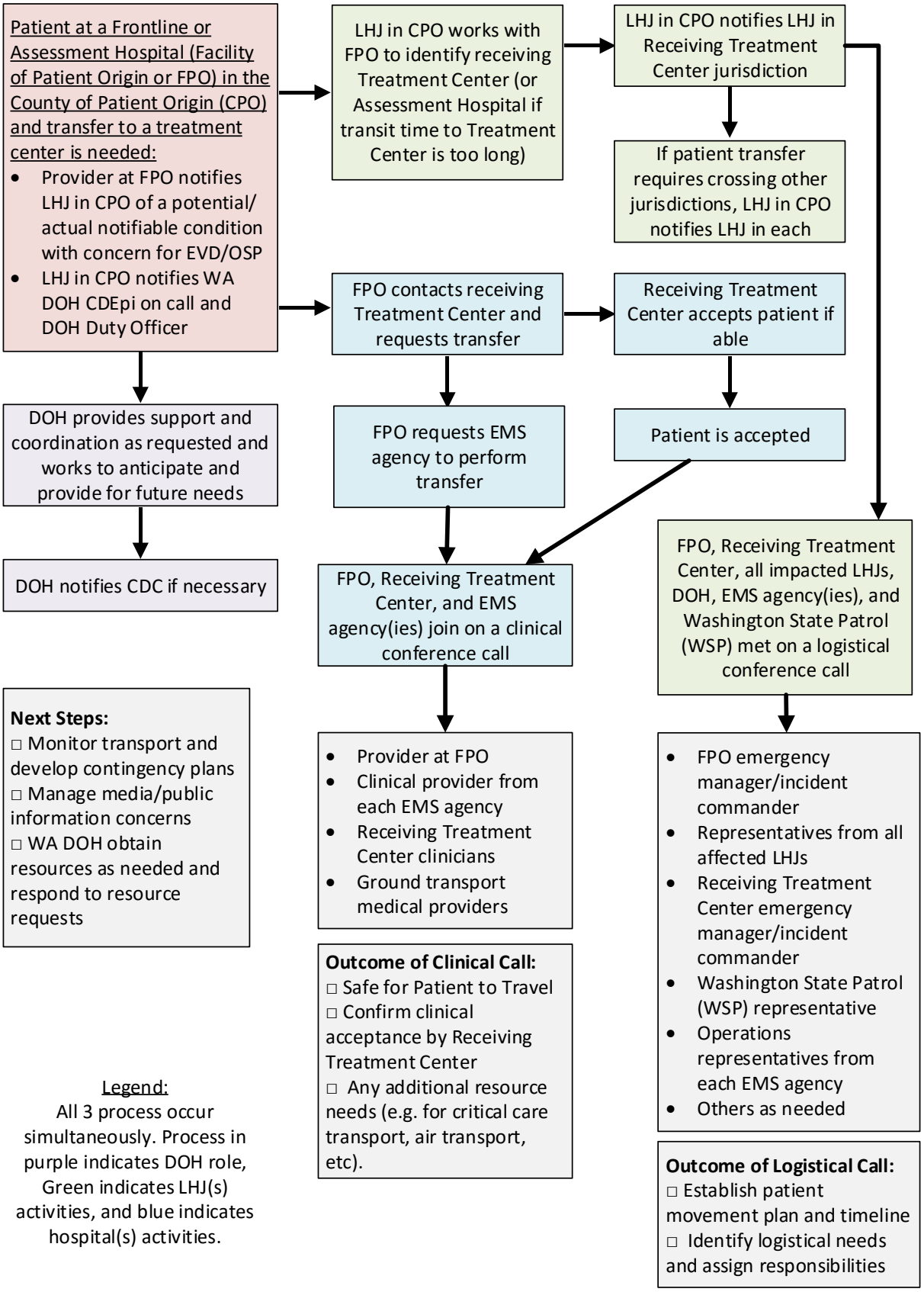
- Removing some or all of the equipment and supplies from the patient compartment of the ambulance
- Donning Level A, B, or C hazardous Materials (HAZMAT) Personal Protective Equipment (PPE), including the use of Powered Air Purifying Respirators (PAPRs) and some with Self-Contained Breathing Apparatus (SCBA)
- Placing some type of protective barrier on the inside of the ambulance to aid in decontamination

These actions, among others, are important to protect the health and safety of EMS personnel involved in this transfer. Unfortunately, EMS providers can only wear high levels of PPE for a limited amount of time, so ground transports must be limited in distance or involve multiple teams. Furthermore, some EMS agencies and hospitals have collaborated in planning to use “proceed out” teams of hospital staff to provide care for the patient during transport. Alternative solutions like this are permissible under this framework, but will require additional policy, procedure, training, and exercise in order to implement effectively. It is encouraged that written agreements be developed for cases like this to specifically delineate respective roles and responsibilities of each agency involved.

Similar complexities exist in conducting air transport for patients with EVD/OSPD. It is difficult to sufficiently protect providers from exposure to the disease in a rotor-wing aircraft (helicopter), so helicopter transport of such patients is likely not possible. It is also difficult to isolate the patient while on board a fixed-wind medical aircraft (except those specifically designed for isolation) due to the close quarters. If air transportation of a patient with suspected or confirmed EVD/OSPD is necessary and a Washington State licensed Air Ambulance service is unable to safely transport the patient, the federally-contracted air ambulance service for EVD/OSPD will be requested.

The modes and methods of transportation for each individual case will be different, and all will require a significant amount of time to plan, prepare for, and execute. One approach for a long-distance ground transport may be to activate several EMS agencies and exchange personnel (and possibly vehicles) at pre-identified intervals along the transport route, which is logistically demanding. All movement of a suspected or confirmed EVD/OSPD patient requires significant coordination to assure that the transfer is safe for the patient, EMS personnel, and the public. The framework for tactical planning for patient movement is shown in Figure 5.

Figure 6 – Tactical Planning Process for EVD/OSPD Patient Movement



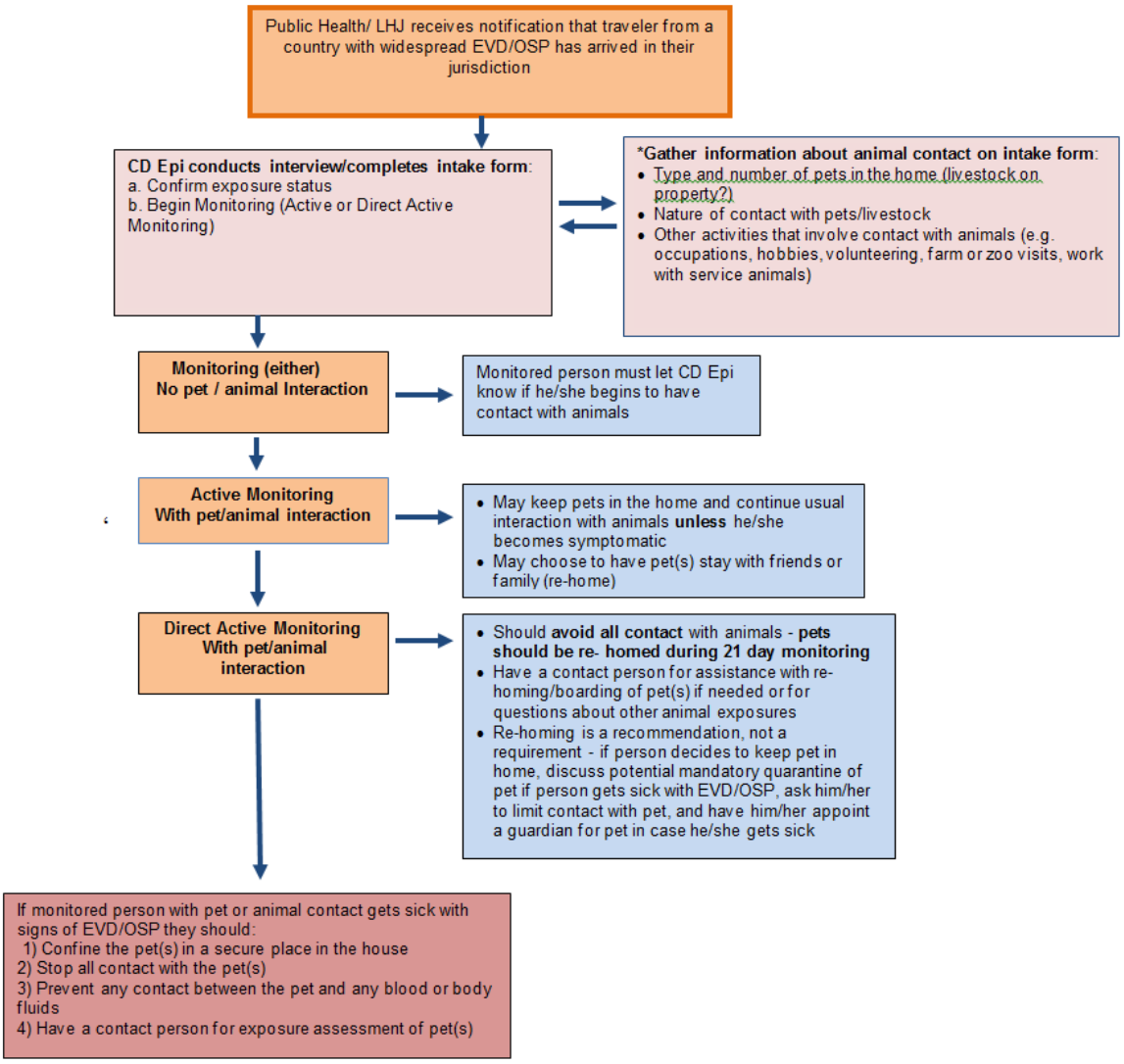
Care of Service Animals and Pets

Some animal species may be susceptible to EVD/OSPD such that, if an animal is exposed to a human case, the animal may contract and/or transmit the disease. Each pathogen will be different in regards to the animal species (if any) that are susceptible to the illness. Whenever an animal was or may have been exposed to EVD/OSPD, it is important that public health and veterinary officials evaluate each case with regard to the level of risk posed by the potential exposure, the pathogen, and the animal species, and intervene based on the existing scientific evidence and their best professional judgment. This applies to all non-human animals that may have been exposed to EVD/OSPD.

The process depicted in Figure 6 below was developed to support LHJs in identifying animals in the home of PUIs and deliver appropriate recommendations based on the level of risk.

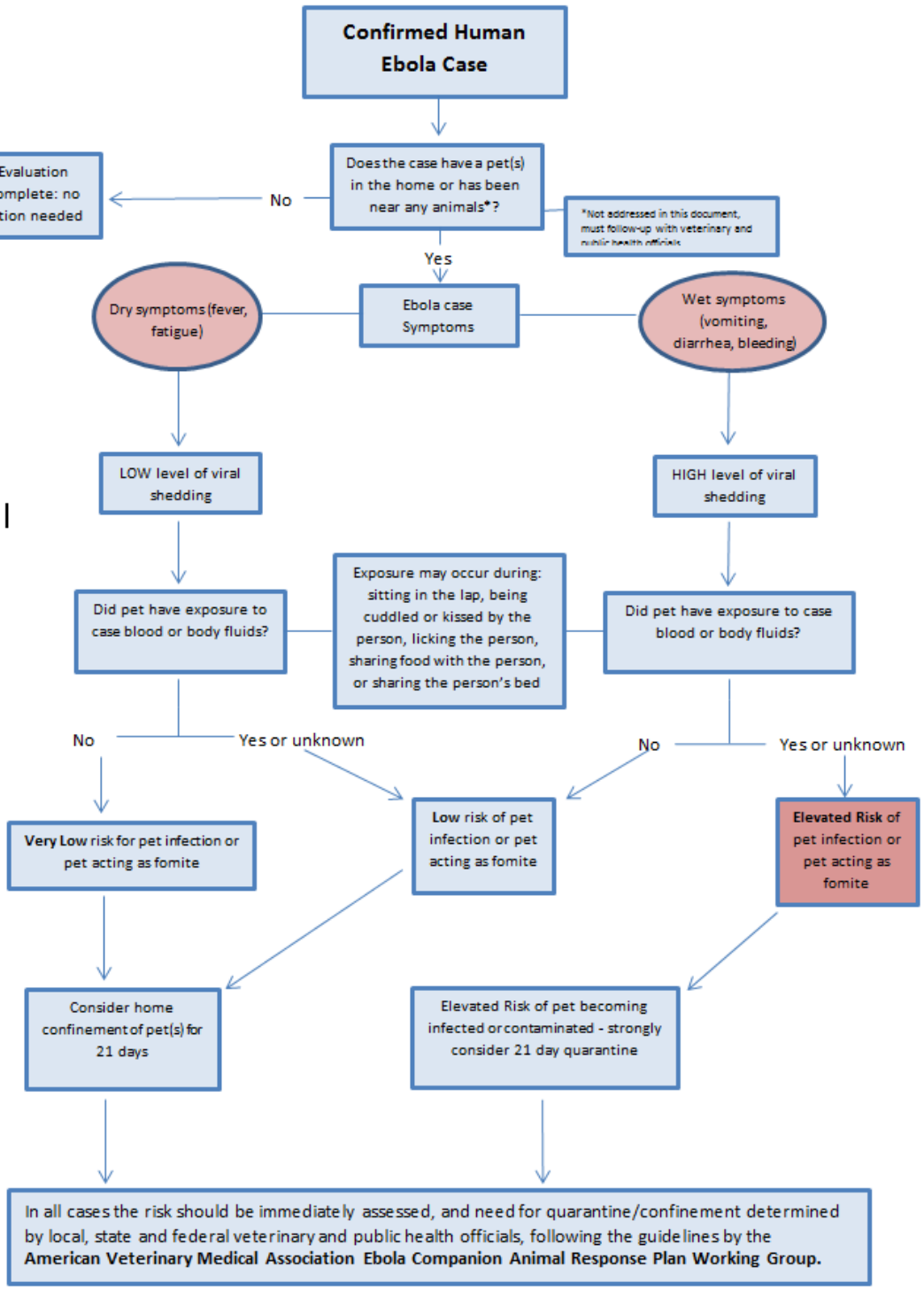
For further guidance on the management of a service animal, pet, or other animal please reference the American Veterinary Medical Association (AVMA) recommendations.

Figure 7 – Decision Tree: Management of Animals belonging to a PUI for EVD/OSPD



The process depicted in Figure 7 below was developed to guide assessment of exposure risk in animals with potential exposure to EVD. A similar risk assessment process will guide decision making for any potential animal exposure to EVD/OSPD.

Figure 8 – Animal Risk Assessment Algorithm for EVD Exposure



Laboratory Testing

Laboratory testing and shipping of specimens that are suspected or confirmed to contain EVD/OSP require significant planning. It is important to note that guidelines and regulatory requirements may differ by pathogen type, but most if not all pathogens listed above as OSP will require packaging and shipping as DOT Category A material.

DOT Category A regulations do not apply to federal, state, or local government employees transporting materials for noncommercial purposes. Therefore, if packaged appropriately according to Category A regulations, a sample may be transported to WAPHL by any government official.

For more specific guidance on laboratory sample submission to WAPHL please see: http://www.doh.wa.gov/Portals/1/Documents/5100/420-130-Ebola-PHL-Testing.pdf.

Solid Waste Management

Waste produced by a person with EVD must be treated as Category A hazardous waste. OSP depending on their modes of transmission may not pose such a significant hazard. However, waste management remains an important consideration, and jurisdictions must adhere to relevant laws and regulations including CDC guidance for waste management for each specific pathogen. Please reference CDC guidance for solid waste management: http://www.cdc.gov/vhf/ebola/healthcare-us/cleaning/waste-management.html

Wastewater Management

Unique precautions must be taken for wastewater that may contain material contaminated with EVD/OSP. Precautions must follow the CDC recommendations for the specific pathogen of concern.

Please see:

http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/EmergencyPreparedness/IsolationandQuarantine
http://www.cdc.gov/vhf/ebola/prevention/handling-sewage.html

Mortuary Affairs and Human Remains Management

Human remains contaminated with EVD/OSP must be managed according to the most up-to-date CDC guidance for the pathogen of concern. It is the responsibility of each Assessment Hospital and Treatment Center to coordinate with funeral homes in their area to plan for the management of human remains contaminated with EVD/OSP. LHJs should maintain plans to support and coordinate management of human remains as needed, and should know which funeral homes in each jurisdiction have the capability to safely manage such remains.

Human remains contaminated with EVD/OSP are exempt from the U.S. Department of Transportation (DOT) Hazardous Materials Regulations (HMR; 49 CFR, Parts 171-180) regulating transportation of hazardous waste. Transportation of such remains must be coordinated through the LHJ of all jurisdictions affected by the transportation.

It is recommended that tribal governments and LHJs maintain plans to support the sociocultural aspects of fatality management and family assistance, and coordinate management of human remains accordingly.

F. Health and Human Services (HHS) Region X Ebola and Other Special Pathogens Regional Coordination Concept of Operations

(Signature page is retained under separate cover)

G. Bioterrorism Response Considerations

Purpose

The purpose of this attachment is to describe specific response considerations for bioterrorism incidents that are different from the core text of the *Statewide Communicable Disease and Pandemic Response Concept of Operations*. The purpose of this section is to elaborate on these differences rather than to restate the common framework for response to all communicable disease emergencies and pandemics.

Background

Bioterrorism is defined as the intentional or threatened use of viruses, bacteria, fungi, or biotoxins to produce death or disease in humans, animals, or plants. In the wake of bioterrorism incidents including intentional distribution of Salmonella in Oregon (1984) and the Anthrax mailings in 2001, bioterrorism remains a nationwide preparedness scenario.

We cannot know how likely it is that biological weapons will be used, however, we do know that the technology to produce and use dangerous biological agents is potentially available to people who might be willing to use them. Because the consequences of such an attack could be severe, response must be as quick and effective as possible

Recognition of a Bioterrorism Incident

Indicators of a potential bioterrorism incident may include:

- Unusual disease transmission or presentation in humans
    - Unusual season or geography
    - Incidence above baseline
    - “Atypical cases” including rare clinical forms of disease, abnormal age groups affected, high mortality, affects previously healthy or those with low risk factors for infection
    - Unusual antimicrobial resistance pattern
    - Simultaneous clusters of illness in non-contiguous areas
- Animal indicators
    - Simultaneous human and animal illness
    - Large numbers of unexplained illnesses or deaths
    - Incidence above baseline
    - Unusual clinical presentation
    - Unusual season or geography
    - High mortality

It is important to note that animal illness may precede human illness in a bioterrorism incident.

Bioterrorism Response Considerations

Public health and healthcare system response to a bioterrorism incident is not substantially different from response to a non-intentional communicable disease

emergency. It is important to note than many potential bioterror agents are considered Special Pathogens, and medical response to these will proceed pursuant to the *Statewide EVD/OSP Response Framework*. The unique considerations for public health and healthcare response to bioterrorism are as follows:

Detection

- Bioterrorism may be covert or overt. In a covert bioterrorism incident, unusual illness may be the first sign that an attack has occurred.
- Early detection is important during all communicable disease emergencies, but is particularly critical during a potential bioterrorism incident. Early identification of such an incident may allow public health officials to contain or limit the spread of disease beyond those already exposed. Early chemoprophylaxis of those potentially exposed can prevent or reduce the severity of illness due to a number of potential bioterror agents.
- The BioWatch system is a federal government program designed to detect certain pathogens in the air. Sensors are located in select sites in major cities throughout the United States and in Washington State. BioWatch may provide early notification of a potential bioterrorism incident, and combined with other surveillance data may prompt public health response.

Investigation and Response

- Bioterrorism is a criminal activity and as a result, public health and medical response and epidemiological investigation during such an incident will be conducted in close collaboration with local, state, and federal law enforcement officials.
- The Federal Bureau of Investigation (FBI) is the lead federal law enforcement agency charged with counterterrorism investigations. The FBI maintains numerous Joint Terrorism Task Forces (JTTFs), each of which includes representatives from multiple federal, state, and local law enforcement officials. JTTFs have significant responsibility for intelligence gathering and are a valuable partner for public health in investigating a bioterrorism incident.
- Any area, building, or property impacted by a bioterrorism incident is a crime scene and must be secured appropriately.
- The CDC is a key partner when responding to a bioterrorism incident and, by request, will provide resources to support investigation, laboratory testing, and disease control interventions.
- The Washington State Army National Guard (WAARNG) maintains a Homeland Response Force (HRF) including a Civil Support Team (CST) and numerous other resources that may be made available by the Governor to support investigation and response during a bioterrorism incident. HRF units can provide resources and personnel to provide triage, medical stabilization, and decontamination. CSTs maintain mobile laboratory capabilities to characterize threat agents, among other capabilities.

- The Washington State Fusion Center (WSFC) supports homeland security and public safety missions of state, local, tribal, and private sector entities. Its objectives are to detect, deter, and prevent terrorist activities through intelligence collection and threat assessment. In the event of a bioterrorism incident, WSFC will be a critical forum for information sharing to support response.
- External decontamination may be warranted if gross contamination is present on those exposed to a suspected or known bioterrorism agent. If gross contamination is not present, external decontamination is not likely to be beneficial.
- Many biological agents persist in the environment for only a short time and are highly sensitive to heat and light. Once the agent is identified, the need for environmental decontamination will become apparent. Environmental decontamination is most appropriate for sporeforming agents such as anthrax, which persist in the environment for longer periods of time. However, some level of decontamination or disinfection, even if not strictly necessary, may help to ease public concern.

Public Information and Risk Communications

- Bioterrorism incidents tend to produce a greater degree of fear among the general public than an equivalent non-intentional communicable disease emergency. For this reason, it is of the utmost importance that accurate, timely, and comprehensive and inclusive public information is provided on an ongoing basis and in a well-coordinated manner.
- During a bioterrorism incident, it is likely that the healthcare system will be overwhelmed not only by those who may be ill or may have been exposed, but also those “worried well” or citizens who believe themselves to be at risk. Effective risk communication can mitigate this impact to the healthcare system.

Laboratory Testing

- All environmental samples, human samples, and other materials obtained through epidemiological investigation are considered evidence in the context of a bioterrorism incident and must be handled as such. This includes maintaining chain of custody documentation for each sample.
- The Washington State Public Health Laboratory (WAPHL) is part of the Laboratory Response Network (LRN) along with state laboratories in every other state and numerous other laboratories. The LRN facilitates nationwide sample collection, transport, testing, surge capacity, and training to identify critical biological agents.
- Laboratory testing for some high-risk pathogens must be conducted only at the few Biosafety Level (BSL) 4 laboratories in the United States. The CDC and FBI will cooperate with state officials to arrange sample collection and shipping to appropriate CDC and Department of Defense (DoD) laboratories.

H. Zoonotic Disease (ZD) and Vector-Borne Disease (VBD) Response Concept of Operations

Background

Zoonotic and vector-borne diseases are those transmittable from animals to people, sometimes through a disease vector such as a mosquito. Zoonotic and vector-borne diseases can affect both animals and people, and public health actions in partnership with veterinary services are usually warranted. Even in outbreaks of animal diseases that are not transmissible to humans, there may be the need for public health activities to identify possible human health risk.

New infectious diseases continue to emerge around the world. According to the CDC, of the 1,415 pathogens currently known to cause disease in humans, 868 (61%) are zoonotic in origin. Of the 175 pathogens defined as emerging infections, 131 (75%) are zoonotic in origin. Many zoonotic and vector-borne diseases cause serious and sometimes life threatening illness.

Many zoonotic and vector-borne pathogens are already endemic in Washington, and some have the potential to periodically surface and cause large-scale outbreaks of human and/or animal disease. A significant outbreak of a zoonotic and vector-borne disease may result in substantial morbidity and mortality for humans and other animals, and may exhaust local and regional health and veterinary resources and other supporting services.

DOH is the lead state agency coordinating and integrating state efforts that provide public health assistance during zoonotic and vector-borne disease incidents.

Assumptions

The assumptions underlying these considerations for ZD and VBD response include:

- Local health jurisdictions have authority over the investigation and control of disease outbreaks in their jurisdictions and may request DOH assistance at their discretion.
- Zoonotic and vector-borne disease outbreaks may occur without warning. Lag times exist between exposure, diagnosis, and reporting. This lag time provides opportunity for a disease to spread to a substantial number of individuals or animals before preventive actions can be taken.
- Intentional incidents fall under the jurisdiction of law enforcement authorities. Zoonotic and vector-borne disease outbreak investigations occurring under these circumstances will require collaboration between public health and law enforcement agencies. Additional organizations including WSDA, WDFW, and/or USDA may participate in response and investigation as needed.
- LHJs may not have a ZD/VBD emergency response plan. As with routine investigations, DOH will provide technical and material assistance as requested.

Specific Authorities for ZD and VBD Response

The authority and responsibility for responding to an emergency rests with the LHJ impacted by the emergency (RCW 38.52). DOH will play a supportive or lead role as requested, coordinating with affected LHJs and other local, state, and federal agencies in the incident of a zoonotic or vector-borne disease incident that overwhelms local resources.

In accordance with Chapter 246-101 WAC, DOH will monitor, detect and report on the occurrence of human cases of zoonotic and vector-borne diseases of public health significance among Washington residents.

In accordance with WAC 246-101-405 Responsibilities of Veterinarians, veterinarians notify the state veterinarian at WSDA of notifiable conditions listed in Table V-1 of WAC 246-101-405. Per interagency agreement, WSDA then notifies the DOH Public Health Veterinarian who subsequently notifies the Zoonotic and vector-borne disease Epidemiologist or other available epidemiologist at DOH. If reporting veterinarians suspect that the animal may be associated with a human case or exposure, the veterinarian notifies the local health officer (per WAC 246-101-405).

Zoonotic Disease (ZD) and Vector Borne Disease (VBD) Response Considerations

In addition to the activities described in the *Statewide Communicable Disease and Pandemic Response Concept of Operations,* the following considerations must be made for ZD and VBD. The public health activities that DOH will lead in response to ZD/VBD outbreaks include:

Investigation and Surveillance

- Assessing the risk of human infection and illness among persons potentially exposed to a zoonotic and vector-borne disease pathogen, advising on disease control, as well as leading or supporting (depending on circumstances) the epidemiological investigations of human cases
- Conducting surveillance and investigations related to human infections including the collection of biological samples for pathogen analysis
- Collecting and analyzing environmental samples including soil, air, water, or other potential media pathways of exposure to humans

Technical and Resource Assistance

- Providing Washington State Departments of Agriculture (WSDA), Fish and Wildlife (WDFW), and other agencies with recommendations and guidance on the use of proper personal protection equipment (PPE) and other safety measures for personnel involved in responding to an outbreak.
- In consultation with WSDA Animal Health Staff, provide recommendations for animal prophylaxis, infection control in veterinary care centers, isolation, and quarantine of animals during zoonotic and vector-borne disease emergencies.

- Providing guidance to other state, tribal, and local public health agencies regarding the diagnosis and management of potential human infections and illnesses caused by zoonotic and vector-borne disease pathogens
- Provide zoonotic and vector-borne disease reservoir and vector control recommendations and resources to local health jurisdictions to support zoonotic and vector-borne disease investigation activities.

Coordination and Information Sharing

- Performing the primary and coordination roles in ESF 8 and support role in ESF 11
- Collaborating with other agencies to address public health concerns related to multi-jurisdictional investigations of animal cases of zoonotic and vector-borne disease within the state and those that extend beyond state boundaries.
- Providing updates on human and environmental surveillance/outbreak data to LHJs, DOH, other state, and federal agencies as needed.

Cases of animal disease are reportable to WSDA per RCW 16.70 Control of Pet Animals Infected with Diseases Communicable to Humans, and should be shared with DOH per an informal agreement.

Agency Responsibilities in ZD/VBD Response

Agencies involved in response to a zoonotic and vector-borne disease incident will vary depending on the circumstances, and may include any or all of the following. Each agency is listed below along with its possible roles and responsibilities:

Mosquito Control Districts

RCW 17.28 provides for the creation of mosquito control districts, and provides the districts with the power to exterminate mosquitos, a method of financing mosquito control, and the power to abate breeding places for mosquitos as needed to protect public health.

RCW 70.22 establishes a statewide program for the control or elimination of mosquitoes as a health hazard. The Secretary of Health coordinates plans for mosquito control work which may be projected by any county, city or town, municipal corporation, taxing district, state department or agency, federal government agency, or any person, group or organization, and arranges for cooperation between any such districts, departments, agencies, persons, groups or organizations.

Eighteen mosquito control districts exist in Washington State and each has the authority to conduct mosquito trapping, testing, extermination, and abatement within its jurisdiction.

Washington State Department of Agriculture

- Lead animal disease surveillance efforts and share information associated with potential human exposure to communicable disease
- Assign appropriate staff to affected area or region, local and state EOCs, or field offices as needed.

- If testing of agricultural animals is necessary, may need to assign field staff to participate in collecting specimens and working with producers.
- Lead herd depopulation actions if the need for this is determined. When local jurisdiction(s) identify a need for assistance with the disposal of a large number of animal carcasses, this effort will involve representatives from the Department of Ecology, WSDA, and DOH, to develop and implement a method to dispose of animal remains connected to the incident.

Washington State Department of Ecology

- In consultation with DOH and WSDA, support LHJs with issues pertaining to the disposal of solid waste. This would include potentially contaminated animal carcasses and feed products.

Washington State Department of Fish and Wildlife

- Assign appropriate staff to affected area or region, local and state EOCs, or field offices as needed.
- Implement wildlife control efforts as appropriate.
- Coordinate with USDA wildlife services, WSDA, and DOH.

Washington Animal Disease Diagnostic Laboratory (WADDL)

WADDL serves as the State Animal Health Laboratory for testing of animal samples, including for zoonotic pathogens. WADDL also tests environmental samples from production facilities, and food matrices as part of the Hazard Analysis Critical Control Point (HACCP) programs for food producers and processers.

Through contract with DOH, WADDL provides surveillance and outbreak testing through active surveillance programs and is a reference laboratory for animal and low risk environmental samples in the Laboratory Response Network (LRN) for bioterrorism.

WADDL is a core reference laboratory in the National Animal Health Laboratory Network and regularly provides surveillance and potential outbreak testing for foreign animal diseases, including zoonotic pathogens such as highly pathogenic avian influenza, that could impact public health, whether zoonotic or not.

WADDL is a member of the Veterinary Laboratory Investigation and Response Network (Vet-LIRN), a network of animal health laboratories that conduct surveillance and perform targeted testing of animal samples, foods and feeds for the Food and Drug Administration.

The primary duties of WADDL during a zoonotic and vector-borne disease outbreak include:

- Providing appropriate laboratory testing for zoonotic and vector-borne disease agents for animal case specimens. Facilitate submission specimens to other laboratories for diagnostic and confirmatory testing if not available at WADDL.
- Providing technical consultation to the LHJs and clinical laboratories, DOH, and external partners regarding specimen submission.

United States Department of Agriculture (USDA)

USDA Animal and Plant Health Inspection Service (APHIS) Wildlife Services maintains authority over and provides federal leadership and expertise to resolve wildlife conflicts including disease outbreaks that may affect human and domestic animal populations.

USDA-APHIS Veterinary Services: Contributes expertise, infrastructure, networks, and systems to operate effectively with multiple partners (local, state, national and international) across disciplines to collaboratively promote healthy animals, people, ecosystems, and society. USDA provides federal leadership and expertise in the prevention, control and/or elimination of diseases of US livestock and poultry; and in animal health emergency response coordination.

I. Relevant Legal Authorities

Key state authorities that govern response to communicable disease are described in the ESF 8 Annex to the State Comprehensive Emergency Management Plan (CEMP) and are discussed in specific detail here. For the full text of each authority, visit: https://apps.leg.wa.gov.

Revised Code of Washington (RCW) Chapters and Sections

RCW 43.70.020(3) – State Department of Health (excerpted)

"(3) The department shall provide leadership and coordination in identifying and resolving threats to the public health by:

(a) Working with local health departments and local governments to strengthen the state and local governmental partnership in providing public protection;
(b) Developing intervention strategies;
(c) Providing expert advice to the executive and legislative branches of state government;
(d) Providing active and fair enforcement of rules;
(e) Working with other federal, state, and local agencies and facilitating their involvement in planning and implementing health preservation measures;
(f) Providing information to the public; and
(g) Carrying out such other related actions as may be appropriate to this purpose"

RCW 43.70.130 – Powers and duties of the Secretary of Health (excerpted)

"The secretary of health shall:

(1) Exercise all the powers and perform all the duties prescribed by law with respect to public health and vital statistics;
(2) Investigate and study factors relating to the preservation, promotion, and improvement of the health of the people, the causes of morbidity and mortality, and the effects of the environment and other conditions upon the public health. . .
(3) Strictly enforce all laws for the protection of the public health and the improvement of sanitary conditions in the state, and all rules, regulations, and orders of the state board of health;
(4) Enforce the public health laws of the state and the rules and regulations promulgated by the department or the board of health in local matters, when in its opinion an emergency exists and the local board of health has failed to act with sufficient promptness or efficiency, or is unable for reasons beyond its control to act, or when no local board has been established. . .
(5) Investigate outbreaks and epidemics of disease that may occur and advise local health officers as to measures to be taken to prevent and control the same;
(6) Exercise general supervision over the work of all local health departments and establish uniform reporting systems by local health officers to the state department of health;

(7) Have the same authority as local health officers, except that the secretary shall not exercise such authority unless the local health officer fails or is unable to do so, or when in an emergency the safety of the public health demands it, or by agreement with the local health officer or local board of health;
(10) Take such measures as the secretary deems necessary in order to promote the public health. . . and
(11) Establish and maintain laboratory facilities and services as are necessary to carry out the responsibilities of the department."

RCW 70.05.070 – Local health officer – powers and duties (excerpted)

"The local health officer . . . if any, shall:

(1) Enforce the public health statutes of the state, rules of the state board of health and the secretary of health, and all local health rules, regulations and ordinances within his or her jurisdiction including imposition of penalties. . .
(2) Take such action as is necessary to maintain health and sanitation supervision over the territory within his or her jurisdiction;
(3) Control and prevent the spread of any dangerous, contagious or infectious diseases that may occur within his or her jurisdiction;
(4) Inform the public as to the causes, nature, and prevention of disease and disability and the preservation, promotion and improvement of health within his or her jurisdiction;
(5) Prevent, control or abate nuisances which are detrimental to the public health;
(9) Take such measures as he or she deems necessary in order to promote the public health. . ."

RCW 70.05.060 – Powers and duties of local board of health (excerpted)

"Each local board of health shall have supervision over all matters pertaining to the preservation of the life and health of the people within its jurisdiction and shall:

(1) Enforce through the local health officer or the administrative officer . . . if any, the public health statutes of the state and rules promulgated by the state board of health and the secretary of health;
(2) Supervise the maintenance of all health and sanitary measures for the protection of the public health within its jurisdiction;
(3) Enact such local rules and regulations as are necessary in order to preserve, promote and improve the public health and provide for the enforcement thereof;
(4) Provide for the control and prevention of any dangerous, contagious or infectious disease within the jurisdiction of the local health department;
(6) Make such reports to the state board of health through the local health officer or the administrative officer as the state board of health may require. . ."

RCW 49.60.218 – Use of dog guide or service animal (excerpted)

(3)(a) "Service animal" means any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. Except as provided in subsection (2) of this section, other species of animals, whether wild or domestic, trained or untrained, are not service animals. The work or tasks performed by a service animal must be directly related to the individual's disability. Examples of work or tasks include, but are not limited to, assisting individuals who are blind or have low vision with navigation and other tasks, alerting individuals who are deaf or hard of hearing to the presence of people or sounds, providing nonviolent protection or rescue work, pulling a wheelchair, assisting an individual during a seizure, alerting individuals to the presence of allergens, retrieving items such as medicine or the telephone, providing physical support and assistance with balance and stability to individuals with mobility disabilities, and helping persons with psychiatric and neurological disabilities by preventing or interrupting impulsive or destructive behaviors. The crime deterrent effects of an animal's presence and the provision of emotional support, well-being, comfort, or companionship do not constitute work or tasks.

RCW 71A.10.040 – Protection from discrimination

Persons are protected from discrimination because of a developmental disability as well as other mental or physical handicaps by the law against discrimination, chapter **49.60** RCW, by other state and federal statutes, rules, and regulations, and by local ordinances, when the persons qualify as handicapped under those statutes, rules, regulations, and ordinances.

Washington Administrative Code (WAC) Chapters and Sections

WAC 246-100-021 – Responsibilities and duties – Health care providers (excerpted)

Every health care provider, as defined in chapter 246-100 WAC, shall:

(1) Provide adequate, understandable instruction in control measures designed to prevent the spread of disease to:
  (a) Each patient with a communicable disease under his or her care; and
  (b) Others as appropriate to prevent spread of disease.

(2) Cooperate with public health authorities during investigation of:
  (a) Circumstances of a case or suspected case of a notifiable condition or other communicable disease; and
  (b) An outbreak or suspected outbreak of illness.

WAC 246-100-036 – Responsibilities and duties – Local health officers (excerpted)

(1) The local health officer shall establish, in consultation with local health care providers, health facilities, emergency management personnel, law enforcement agencies, and any other entity he or she deems necessary, plans, policies, and procedures for instituting emergency measures necessary to prevent the spread of communicable disease or contamination.

(3) Local health officers shall, when necessary, conduct investigations and institute disease control and contamination control measures, including medical examination, testing, counseling, treatment, vaccination, decontamination of persons or animals, isolation, quarantine, vector control, condemnation of food supplies, and inspection and closure of facilities, consistent with those indicated in the *Control of Communicable Diseases Manual*, 20th edition, published by the American Public Health Association, or other measures he or she deems necessary based on his or her professional judgment, current standards of practice and the best available medical and scientific information.

(4) A local health department should seek agreements as necessary with tribal governments, with federal authorities or with state agencies or institutions of higher education that empower the local health officer to conduct investigations and institute control measures in accordance with WAC 246-100-040 on tribal lands, federal enclaves and military bases, and the campuses of state institutions. State institutions include, but are not limited to, state-operated colleges and universities, schools, hospitals, prisons, group homes, juvenile detention centers, institutions for juvenile delinquents, and residential habilitation centers.

WAC 246-100-070- – Enforcement of local health officer orders (excerpted)

(1) An order issued by a local health officer in accordance with this chapter shall constitute the duly authorized application of lawful rules adopted by the state board of health and must be enforced by all police officers, sheriffs, constables,

and all other officers and employees of any political subdivisions within the jurisdiction of the health department in accordance with RCW 43.20.050.

(2) Any person who shall violate any of the provisions of this chapter or any lawful rule adopted by the board shall be deemed guilty of a misdemeanor punishable as provided under RCW 43.20.050.

(3) Any person who shall fail or refuse to obey any lawful order issued by any local health officer shall be deemed guilty of a misdemeanor punishable as provided under RCW 70.05.120.

WAC 246-101-101- – Notifiable conditions and the healthcare provider (excerpted)

This section describes the conditions that Washington's health care providers must notify public health authorities of on a statewide basis. The board finds that the conditions in Table HC-1 (see https://apps.leg.wa.gov) of this section are notifiable for the prevention and control of communicable and noninfectious diseases and conditions in Washington.

(1) Principal health care providers shall notify public health authorities of the conditions identified in Table HC-1 of this section as individual case reports following the requirements in WAC 246-101-105, 246-101-110, 246-101-115, and 246-101-120.

(2) Other health care providers in attendance, other than the principal health care provider, shall notify public health authorities of the conditions identified in Table HC-1 of this section unless the condition notification has already been made.

(3) Local health officers may require additional conditions to be notifiable within the local health officer's jurisdiction

WAC 246-101-105- – Duties of the healthcare provider (excerpted)

Health care providers shall:

(1) Notify the local health department where the patient resides, or, in the event that patient residence cannot be determined, the local health department in which the health care providers practice, regarding:

(a) Cases or suspected cases of notifiable conditions specified as notifiable to local health departments in Table HC-1 of WAC 246-101-101;

(b) Cases of conditions designated as notifiable by the local health officer within that health officer's jurisdiction;

(c) Outbreaks or suspected outbreaks of disease including, but not limited to, suspected or confirmed outbreaks of varicella, influenza, viral meningitis,

health care-associated infection suspected due to contaminated food products or devices, or environmentally related disease;

(d) Known barriers which might impede or prevent compliance with orders for infection control or quarantine; and

(e) Name, address, and other pertinent information for any case, suspected case or carrier refusing to comply with prescribed infection control measures.

(2) Notify the department of conditions designated as notifiable to the local health department when:

(a) A local health department is closed or representatives of the local health department are unavailable at the time a case or suspected case of an immediately notifiable condition occurs;

(b) A local health department is closed or representatives of the local health department are unavailable at the time an outbreak or suspected outbreak of communicable disease occurs.

(4) Notify the department regarding cases of notifiable conditions specified as notifiable to the department in Table HC-1 of WAC 246-101-101.

(5) Assure that positive preliminary test results and positive final test results for notifiable conditions of specimens referred to laboratories outside of Washington for testing are correctly notified to the local health department of the patient's residence or the department as specified in Table Lab-1 of WAC 246-101-201. This requirement can be satisfied by:

(a) Arranging for the referral laboratory to notify either the local health department, the department, or both; or

(b) Forwarding the notification of the test result from the referral laboratory to the local health department, the department, or both.

(6) Cooperate with public health authorities during investigation of:

(a) Circumstances of a case or suspected case of a notifiable condition or other communicable disease; and

(b) An outbreak or suspected outbreak of disease.

(7) Provide adequate and understandable instruction in disease control measures to each patient who has been diagnosed with a case of a communicable disease, and to contacts who may have been exposed to the disease.

(8) Maintain responsibility for deciding date of discharge for hospitalized tuberculosis patients.

(9) Notify the local health officer of intended discharge of tuberculosis patients in order to assure appropriate outpatient arrangements are arranged.

(10) By July 1, 2011, when ordering a laboratory test for a notifiable condition as identified in Table HC-1 of WAC 246-101-101, providers must provide the laboratory with the following information for each test order:

(a) Patient name;

(b) Patient address including zip code;

(c) Patient date of birth;

(d) Patient sex;

(e) Name of the principal health care provider;

(f) Telephone number of the principal health care provider;

(g) Type of test requested;

(h) Type of specimen;

(i) Date of ordering specimen collection.

WAC 246-101-505- – Duties of the local health officer or the local health department (excerpted)

(1) Local health officers or the local health department shall:

(a) Review and determine appropriate action for:

(i) Each reported case or suspected case of a notifiable condition;

(ii) Any disease or condition considered a threat to public health; and

(iii) Each reported outbreak or suspected outbreak of disease, requesting assistance from the department in carrying out investigations when necessary.

(b) Establish a system at the local health department for maintaining confidentiality of written records and written and telephoned notifiable conditions case reports;

(c) Notify health care providers, laboratories, and health care facilities within the jurisdiction of the health department of requirements in this chapter;

(d) Notify the department of cases of any condition notifiable to the local health department (except animal bites) upon completion of the case investigation;

(e) Distribute appropriate notification forms to persons responsible for reporting;

(f) Notify the principal health care provider, if possible, prior to initiating a case investigation by the local health department;

(g) Carry out the HIV partner notification requirements of WAC 246-100-072;

(h) Allow laboratories to contact the health care provider ordering the diagnostic test before initiating patient contact if requested and the delay is unlikely to jeopardize public health;

(i) Conduct investigations and institute control measures in accordance with chapter 246-100 WAC.

(2) The local health department may adopt alternate arrangements for meeting the reporting requirements under this chapter through cooperative agreement between the local health department and any health care provider, laboratory or health care facility;

(3) Each local health officer has the authority to:

(a) Carry out additional steps determined to be necessary to verify a diagnosis reported by a health care provider;

(b) Require any person suspected of having a notifiable condition to submit to examinations required to determine the presence of the condition;

(c) Investigate any case or suspected case of a reportable disease or condition or other illness, communicable or otherwise, if deemed necessary;

(d) Require the notification of additional conditions of public health importance occurring within the jurisdiction of the local health officer.

WAC 246-101-605- – Duties of the local health officer or the local health department (excerpted)

(1) The department shall:

(a) Provide consultation and technical assistance to local health departments and the department of labor and industries investigating notifiable conditions reports upon request.

(b) Provide consultation and technical assistance to health care providers, laboratories, health care facilities, and others required to make notifications to public health authorities of notifiable conditions upon request.

(c) Develop, maintain, and make available for local health departments guidance on investigation and control measures for notifiable communicable disease conditions.

(d) Develop and make available forms for the submission of notifiable conditions data to local health departments, health care providers, laboratories, health care facilities, and others required to make notifications to public health authorities of notifiable conditions.

(e) Maintain a twenty-four hour telephone number for reporting notifiable conditions.

(f) Develop routine data dissemination mechanisms that describe and analyze notifiable conditions case investigations and data. These may include annual and monthly reports and other mechanisms for data dissemination as developed by the department.

(g) Conduct investigations and institute control measures as necessary.

(2) The department may:

(a) Negotiate alternate arrangements for meeting reporting requirements under this chapter through cooperative agreement between the department and any health care provider, laboratory, or health care facility.

(b) Consolidate reporting for notifiable conditions from any health care provider, laboratory, or health care facility, and relieve that health care provider, laboratory, or health care facility from reporting directly to each local health department, if the department can provide the report to the local health department within the same time as the local health department would have otherwise received it.

Relevant Federal Laws and Regulations

H.R. 307 – Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA) (excerpted)

(Refer to 42 USC Chapter 6A (excerpted below) for amended language of the Public Health Service Act)

Sec. 202 - (a) COOPERATIVE AGREEMENTS.—Section 319C–1 of the Public Health Service Act (42 U.S.C. 247d–3a) is amended—

(1) in subsection (b)(1)(C), by striking ''consortium of entities described in subparagraph (A)'' and inserting ''consortium of States''; (2) in subsection (b)(2)— (A) in subparagraph (A)— (i) by striking clauses (i) and (ii) and inserting the following:

''(i) a description of the activities such entity will carry out under the agreement to meet the goals identified under section 2802, including with respect to chemical, biological, radiological, or nuclear threats, whether naturally occurring, unintentional, or deliberate;

''(ii) a description of the activities such entity will carry out with respect to pandemic influenza, as a component of the activities carried out under clause (i), and consistent with the requirements of paragraphs (2) and (5) of subsection (g);''; (ii) in clause (iv), by striking ''and'' at the end; and

(iii) by adding at the end the following:

''(vi) a description of how, as appropriate, the entity may partner with relevant public and private stakeholders in public health emergency preparedness and response;

''(vii) a description of how the entity, as applicable and appropriate, will coordinate with State emergency preparedness and response plans in public health emergency preparedness, including State educational agencies (as defined in section 9101(41) of the Elementary and Secondary Education Act of 1965) and State child care lead agencies

(designated under section 658D of the Child Care and Development Block Grant Act of 1990);

''(viii) in the case of entities that operate on the United States-Mexico border or the United States-Canada border, a description of the activities such entity will carry out under the agreement that are specific to the border area including disease detection, identification, investigation, and preparedness and H. R. 307—14 response activities related to emerging diseases and infectious disease outbreaks whether naturally occurring or due to bioterrorism, consistent with the requirements of this section; and

''(ix) a description of any activities that such entity will use to analyze real-time clinical specimens for pathogens of public health or bioterrorism significance, including any utilization of poison control centers;''; and

(B) in subparagraph (C), by inserting '', including addressing the needs of at-risk individuals,'' after ''capabilities of such entity'';

(7) AVAILABILITY OF COOPERATIVE AGREEMENT FUNDS.—

''(A) IN GENERAL.—Amounts provided to an eligible entity under a cooperative agreement under subsection (a) for a fiscal year and remaining unobligated at the end of such year shall remain available to such entity for the next fiscal year for the purposes for which such funds were provided.

''(B) FUNDS CONTINGENT ON ACHIEVING BENCHMARKS.— The continued availability of funds under subparagraph (A) with respect to an entity shall be contingent upon such entity achieving the benchmarks and submitting the pandemic influenza plan as described in subsection (g)

42 U.S.C. § 247d–3a - Improving State and local public health security (excerpted)

(a) In general: To enhance the security of the United States with respect to public health emergencies, the Secretary shall award cooperative agreements to eligible entities to enable such entities to conduct the activities described in subsection (d).

(2) prepare and submit to the Secretary an application at such time, and in such manner, and containing such information as the Secretary may require, including—

(A) an All-Hazards Public Health Emergency Preparedness and Response Plan which shall include—

(i) a description of the activities such entity will carry out under the agreement to meet the goals identified under section 300hh–1 of this title, including with respect to chemical, biological, radiological, or nuclear threats, whether naturally occurring, unintentional, or deliberate;

(ii) a description of the activities such entity will carry out with respect to pandemic influenza, as a component of the activities carried out under clause (i), and consistent with the requirements of paragraphs (2) and (5) of subsection (g);

(iii) preparedness and response strategies and capabilities that take into account the medical and public health needs of at-risk individuals in the event of a public health emergency;

(v) a description of how the entity will include the State Unit on Aging in public health emergency preparedness;

(vi) a description of how, as appropriate, the entity may partner with relevant public and private stakeholders in public health emergency preparedness and response;

(vii) a description of how the entity, as applicable and appropriate, will coordinate with State emergency preparedness and response plans in public health emergency preparedness, including State educational agencies (as defined in section 7801(41) of title 20) and State child care lead agencies (designated under section 9858b of this title);

(viii) in the case of entities that operate on the United States-Mexico border or the United States-Canada border, a description of the activities such entity will carry out under the agreement that are specific to the border area including disease detection, identification, investigation, and preparedness and response activities related to emerging diseases and infectious disease outbreaks whether naturally occurring or due to bioterrorism, consistent with the requirements of this section; and

(ix) a description of any activities that such entity will use to analyze real-time clinical specimens for pathogens of public health or bioterrorism significance, including any utilization of poison control centers;

(E) an assurance that the entity will conduct activities to inform and educate the hospitals within the jurisdiction of such entity on the role of such hospitals in the plan required under subparagraph (A);

(G) a description of the means by which to obtain public comment and input on the plan described in subparagraph (A) and on the implementation of such plan, that shall include an advisory committee or other similar mechanism for obtaining comment from the public and from other State, local, and tribal stakeholders; and

(H) as relevant, a description of the process used by the entity to consult with local departments of public health to reach consensus, approval, or concurrence on the relative distribution of amounts received under this section.

(e)Coordination with local response capabilities

An entity shall, to the extent practicable, ensure that activities carried out under an award under subsection (a) are coordinated with activities of relevant Metropolitan Medical Response Systems, local public health departments, the Cities Readiness Initiative, and local emergency plans.

(2)Criteria for pandemic influenza plans

(A)In general: Not later than 180 days after December 19, 2006, the Secretary shall develop and disseminate to the chief executive officer of each State criteria for an effective State plan for responding to pandemic influenza. The Secretary shall periodically update, as necessary and appropriate, such pandemic influenza plan criteria and shall require the integration of such criteria into the benchmarks and standards described in paragraph (1).

(B)Rule of construction: Nothing in this section shall be construed to require the duplication of Federal efforts with respect to the development of criteria or standards, without regard to whether such efforts were carried out prior to or after December 19, 2006.

42 U.S.C. § 264 - Regulations to control communicable diseases

(a) Promulgation and enforcement by Surgeon General: The Surgeon General, with the approval of the Secretary, is authorized to make and enforce such regulations as in his judgment are necessary to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession. For purposes of carrying out and enforcing such regulations, the Surgeon General may provide for such inspection, fumigation, disinfection, sanitation, pest extermination, destruction of animals or articles found to be so infected or contaminated as to be sources of dangerous infection to human beings, and other measures, as in his judgment may be necessary.

(d)Apprehension and examination of persons reasonably believed to be infected

(1) Regulations prescribed under this section may provide for the apprehension and examination of any individual reasonably believed to be infected with a communicable disease in a qualifying stage and (A) to be moving or about to move from a State to another State; or (B) to be a probable source of infection to individuals who, while infected with such disease in a qualifying stage, will be moving from a State to another State. Such regulations may provide that if upon examination any such individual is found to be infected, he may be detained for such time and in such manner as may be reasonably necessary. For purposes of

this subsection, the term “State” includes, in addition to the several States, only the District of Columbia.

(2) For purposes of this subsection, the term “qualifying stage”, with respect to a communicable disease, means that such disease—

(A) is in a communicable stage; or

(B) is in a precommunicable stage, if the disease would be likely to cause a public health emergency if transmitted to other individuals.

28 CFR Part 35 – Nondiscrimination on the Basis of Disability in State and Local Government Services (excerpted)

§ 35.160 General.

(a)

(1) A public entity shall take appropriate steps to ensure that communications with applicants, participants, members of the public, and companions with disabilities are as effective as communications with others.

(2) For purposes of this section, “companion” means a family member, friend, or associate of an individual seeking access to a service, program, or activity of a public entity, who, along with such individual, is an appropriate person with whom the public entity should communicate.

(b)

(1) A public entity shall furnish appropriate auxiliary aids and services where necessary to afford qualified individuals with disabilities, including applicants, participants, companions, and members of the public, an equal opportunity to participate in, and enjoy the benefits of, a service, program, or activity of a public entity.

(2) The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the method of communication used by the individual; the nature, length, and complexity of the communication involved; and the context in which the communication is taking place. In determining what types of auxiliary aids and services are necessary, a public entity shall give primary consideration to the requests of individuals with disabilities. In order to be effective, auxiliary aids and services must be provided in accessible formats, in a timely manner, and in such a way as to protect the privacy and independence of the individual with a disability.

Coordinating Agency:
Department of Health (DOH)

Primary Agencies:

Department of Ecology (DOE)
Local Air Agencies (LAA)

Support Agencies:
Department of Social and Health Services (DSHS)
Department of Enterprise Services (DES)
Department of Natural Resources (DNR)
Department of Labor and Industries (L&I)
Washington Military Department (MIL)
Emergency Management Division (EMD)
American Red Cross (ARC)

INTRODUCTION

Purpose

This appendix is a supporting document to Emergency Support Function (ESF) 8 - Public Health, Medical, and Mortuary Services. It describes how state entities will support local jurisdictions or tribes when responding to an air quality incident that impacts the health of a population within Washington State.

Scope

This document provides overall guidelines and processes that can be employed or adapted to an emergency resulting in deteriorating air quality that impacts human health. Additionally, this appendix focuses on coordination and support activities to address public health and medical needs of jurisdictions responding to an air quality incident causing health issues to the public.

An air quality incident releases pollutants into the air that generates or causes health issues for the public.

Air quality incidents impacting the health of the population can include:

- Wildfires
- Dust storms
- Volcanic activities
- Cleanup activities associated with natural disasters

Over time various types of air quality incidents may be added to this appendix along with attachments that provide more information. This appendix is meant to guide the activities of the staff at the ESF 8 desk rather than to provide guidance for responders or other professionals responding to the incident.

Policies

Revised Code of Washington (RCW) 70.94.141, Air Pollution Control Authority – Powers and Duties of Activated Authority

Air quality in most areas of Washington is protected by air pollution control authorities called Local Air Agencies. RCW 70.94.141 defines the agencies' authorities to protect the air quality in their jurisdictions.

RCW 70.94.331, Powers and Duties of Department

In areas of Washington where there is no local air agency the Department of Ecology fills the role of a local clean air agency. RCW 70.94.331 grants to Ecology the same authorities as in 70.94.141 along with other specific authorities.

RCW 70.94.6534 Silvicultural Forest Burning – Reduce Statewide Emissions – Exemptions – Monitoring Program

The Department of Natural Resources (DNR) regulates silvicultural (forest) burning under the Smoke Management Plan.

RCW 76.04.750 Uncontrolled Fire a Public Nuisance – Suppression – Duties – Summary Action – Recovery of Costs

Fires on or threatening any forest land burning, uncontrolled and without proper action being taken to prevent its spread, is a public nuisance and must be suppressed.

EPA and tribal governments have authority over air quality issues on tribal reservation lands.

In accordance with Title VI of the Civil Rights Act of 1964, the Department of Health (Department) will ensure that people with limited English proficiency have meaningful access to the Department's services, and that no customer experiences discrimination on the basis of race, color or national origin.

ASSUMPTIONS

This Appendix will address support provided to local jurisdictions and tribes for air quality issues only.

Preservation of life and safety are always paramount.

Public health and medical services resources may be limited in availability or capacity during response and/or recovery.

Local jurisdictions and tribal governments will implement their emergency response plans and request additional resources from the state when their resources are, or it is anticipated their resources will soon be exhausted as outlined in the Washington State Comprehensive Emergency Management Plan (CEMP) and the ESF 8 Annex. State agencies will provide resources as available.

Assistance from federal agencies and other state, local, and tribal governments outside of Washington may be required to supplement in-state resources, though it may not be immediately available.

The Department recognizes that language and cultural factors affect health outcomes, access to services, and access to information.

The Department commits to taking reasonable steps to provide effective and understandable public information and warnings messages to Limited English Proficient (LEP) communities during a public health emergency. (For more information review DOH's Culturally and Linguistically Appropriate Services (CLAS) Plan and Public Information Annex 3 to the DOH Emergency Response Plan-Basic).

CONCEPT OF OPERATIONS

Direction and Control

Upon notification of a developing or occurring air quality incident, the State Emergency Operations Center (SEOC) Alert and Warning Center will alert the appropriate ESF 8 lead by contacting the Washington State Department of Health (DOH) Duty Officer. The ESF 8 lead will notify the Washington State Department of Ecology (Ecology) Emergency Management Contact of any air quality support needed to protect public health.

The overall state-level medical resource support will be coordinated from the SEOC. DOH will staff the ESF 8 desk if required, provide a liaison to the SEOC Multi-Agency Coordination Group, and coordinate public health and medical air quality support as necessitated by the situation.

DOH will coordinate implementation of ESF 8 as defined by the CEMP and the ESF 8 Annex.

When ESF 8 is activated, DOH as lead will coordinate with Ecology for support in the air quality response to protect public health. All state agencies will carry out their roles and responsibilities as defined by ESF 8.

DOH will implement this plan and lead the health and medical services aspects supporting an air quality response. Ecology leads the coordination of air quality conference calls between the responsible entities, if needed.

Emergency Health and Medical Resources Request

Upon plan activation, requests for health and medical resources will be assigned to ESF 8 in the SEOC.

ACTIONS

Depending on the circumstances of the air quality incident a variety of entities may provide assistance. Actions and assistance may come from:

- federal agencies
- state agencies
- tribal governments
- local governments or jurisdictions

- non-governmental organizations

The level of involvement of each entity will vary depending on their expertise, resources available, and the type and extent of the air quality incident.

ESF 8 will lead the support and coordination of all public health and medical response activities with the agencies, governments, jurisdictions, and non-governmental organizations required during air quality incidents. The level and nature of coordination will vary based on the incident and entities involved.

Please see the attachments to this appendix for more information on possible actions to take.

RESPONSIBILITIES

Primary Agencies

DOH provides supplemental assistance to local and tribal governments in identifying the public health and medical needs or guidelines during emergencies. The functional areas for this support include but are not limited to:

- Coordinate the state-level ESF 8 response when assistance is requested by one or more impacted jurisdictions or tribes;
- Provide public health and medical communication and guidance as appropriate for the situation;
- Provide scientific and technical support to other coordinating agencies;
- Assist health agencies with health messaging related to air quality; and
- Assist with public outreach and education.

DOH can coordinate virtually and is not always needed to be physically present at the SEOC.

Ecology, along with other local air and tribal agencies, monitors ambient air quality throughout the state. Ecology, LAAs, and Tribal Air Programs provide:

- Real-time air quality monitoring data from an existing monitor network and relays monitored data to the public via Ecology's website. Air quality monitoring information is also displayed on the Washington Smoke Blog at wasmoke.blogspot.com.

Ecology, LAAs, and Tribal Air Programs are not the lead agency, but upon request and if resources are available, they may:

- Provide supplemental temporary monitoring if equipment and resources are available;
- Assist health agencies with health messaging related to ambient air quality monitoring;
- Provide assistance with air quality forecasting;
- Provide technical resources/information to emergency management on regulated industrial facilities; and
- Coordinate with other agencies as needed.

Ecology Air Quality program, LAAs, and Tribal Air Programs do not maintain emergency management personnel and typically coordinate with Incident Management Teams (IMT) and other partners virtually. If air quality technical assistance is required in the SEOC, air quality resources will need to be requested through the existing Ecology Emergency Management Contact and directly to LAA and Tribal Program Directors.

Support Agencies

Department of Natural Resources (DNR)

- Primary responsibility is to deploy and manage incident management teams to focus on suppression/containment of fires on state lands as outlined in ESF 4 Firefighting in the CEMP;
- If resources are available may order and deploy air quality mobile monitoring equipment and Air Resource Advisors through incident management teams; and
- May provide wildfire status updates through IMTs.

Department of Enterprise Services (DES)

- Assist in procuring facilities and resources to respond.

Department of Social and Health Services (DSHS)

- Coordinate with American Red Cross (ARC) and Washington Volunteers Active in Disasters (WAVOAD) to secure clean air shelters and services for those impacted by air quality incidents.

Department of Labor and Industries (L&I)

- Coordinate responder and workplace health and safety issues during emergencies or disasters including air quality impacts.

Emergency Management Division (EMD)

- Coordinate response and recovery in accordance with the CEMP through the SEOC; and
- Assist local governments and others with emergency planning and related efforts which will help Washington State residents in preparing for emergencies and disasters and to minimize casualties, loss of life, and damage to infrastructure.

Washington State Patrol

- Facilitate the movement of emergency medical resources over state highways to locations identified by public health authorities.

American Red Cross (ARC)

- ARC will work closely with WAVOAD and DSHS to support state-level ESF 8 efforts in Washington State as it relates to clean air shelters and feeding of those impacted by air quality incidents.

- This document will not supersede ARC response and relief activities nor shall it require ARC to perform any services contrary to its policies and procedures. ARC relief operations will conform to the ARC Board of Governor's Disaster Services Policy Statements and will be performed in accordance with the ARC Disaster Services Regulations and Procedures.
- ARC will maintain administrative and financial and operational control over its activities and direction of its own personnel.

Please see the attachments to this appendix for more information on responsibilities specific to the type of Air Quality Response. For Wildfire Smoke Response, see Table 2 in Attachment 1, Wildfire Response-Severe Smoke Episodes, which identifies the agencies' areas of expertise and potential involvement.

INTRODUCTION

1. Purpose

Persons with pre-existing health conditions such as asthma or other chronic respiratory conditions and cardiovascular disease, or people 65 years of age or older, infants and children, pregnant women, and smokers are particularly sensitive to smoke. Particulate matter (PM) in smoke poses the greatest risk to public health. The potential health effects vary depending on the size of the particles.

This document is intended to provide guidance for the state and federal agencies in Washington who respond to severe smoke episodes caused by large or long duration wildfires located either in or outside the state of Washington. The goal of these organizations during these incidents is to provide a coordinated response to mitigate impacts on public health. This document also identifies organizations, partners, and other governmental entities (county, city, and tribal) that state and federal responders need to coordinate with during these episodes. For all parties, this document provides a general concept of operations for coordinating multi-jurisdictional response to smoke from wildfires and may be useful for other hazardous air quality incidents. This document is focused specifically on smoke/air quality impacts and not on other risks posed by the fire or other hazard. The intent is to guide resource decisions related to air quality impacts of major wildfires or other hazards and does not replace, interfere with, or limit any action taken by a public agency in the course of performing its official duties.

As mentioned in *ESF 8 Appendix 5 – Air Quality Response*, and in accordance with Title VI of the Civil Rights Act of 1964, the Department of Health (Department) will ensure that people with limited English proficiency have meaningful access to the Department's services, and that no customer experiences discrimination on the basis of race, color, or national origin.

The Department recognizes that language and cultural factors affect health outcomes, access to services, and access to information.

The Department commits to taking reasonable steps to provide effective and understandable public information and warnings messages to Limited English Proficient (LEP) communities during a public health emergency. (For more information review DOH's Culturally and Linguistically Appropriate Services (CLAS) Plan and *Annex 3-Public Information* to the DOH Emergency Response Plan-Basic).

2. Agency Areas of Expertise and Involvement

Table 1 identifies each agency that may be involved, their general area of expertise, and their anticipated level of involvement during a wildfire smoke incident or hazardous air quality incident.

Table 1

CONTACT AGENCY OR ORGANIZATION	GENERAL AREA OF EXPERTISE / ASSISTANCE	ANTICIPATED LEVEL OF INVOLVEMENT
Federal		
1. Federal Land Managers (FLM) e.g., US Forest Service (USFS) & Bureau of Land Management (BLM)	Wildfire suppression/containment, ensure Incident Management Team (IMT) is on the ground; may provide wildfire status updates, and public outreach/coordination.	Extensive – depends on size of a wildland fire, often the lead agency.
2. FEMA	Federal response agency for natural disasters.	Low, unless smoke levels and fire danger pose an extreme threat.
3. EPA Region 10 Federal Air Rules for Reservations (FARR) Program	Coordination with tribes related to air quality on tribal lands	Depends on extent wildfire smoke is impacting tribal lands.
National		
4. ARA – reports to IMT and/or the Air Resource Agency Administrator	Technical Specialist who often works as part of an IMT during major wildfires. ARAs may also work from a remote office and be assigned to a local federal agency office. Expertise in air quality mobile monitoring and modeling and addressing public health, transportation safety, and firefighter safety.	Extensive when deployed– newly created position provides assistance to incidents and facilitates state response to air quality impacts from major wildland fires.
5. Incident Management Team (IMT)	Overall management of firefighting plans, operations, logistics, and community issues when wildfires become larger and more complex than can be handled by local resources. ARAs may be ordered by and assigned to an IMT.	Extensive during wildfire incidents but primarily deals with managing the wildfire. ARAs who are integrated with IMTs deal with the smoke issues.
6. American Red Cross (ARC)	Providing aid and assistance for natural disasters. Mass Care support for shelters, feeding, and distributing relief supplies.	Depends on severity of smoke impact and risk to public health.
7. Department of Health	Coordinates the state-level ESF 8 response when assistance is requested by one or more impacted jurisdiction or tribe. Provides public health and medical communication and guidance as appropriate for the situation. Provides scientific and technical support to other coordinating agencies. Assists health agencies with health messaging related to air quality and assists with public outreach and education.	May be extensive during periods of elevated smoke levels. Depends on wildfire severity and extent to which local health officials need assistance, or where no local health authority is in place.

CONTACT AGENCY OR ORGANIZATION	GENERAL AREA OF EXPERTISE / ASSISTANCE	ANTICIPATED LEVEL OF INVOLVEMENT
State		
8. Department of Ecology	Maintains real-time air quality monitoring data from an existing monitor network and relays monitored data to the public via Ecology's website (see Section 10 of this document). Ecology is not the lead agency, but upon request and if resources are available, may assist in providing air quality forecasting and supplemental temporary monitoring. Coordinates with other agencies as needed.	May be extensive during periods of elevated smoke levels.
9. Emergency Management Division	Coordinates response and recovery with state emergency support functions and local emergency services agencies and organizations.	Depends on severity and specific requests by local emergency management agencies for state assets. High involvement if Governor proclaims state of emergency.
10. Department of Labor & Industries	Coordinates responder and workplace health and safety issues during emergencies or disasters. Can supply indoor air quality monitors for businesses and schools.	Depends on severity and specific requests for worker protection.
11. Department of Natural Resources	Wildfire suppression/containment, ensure qualified IMTs provide oversight to firefighting efforts; may provide wildfire status updates and public outreach/coordination.	Primary response to fire danger and suppression, less on smoke risk to community. Assist with providing updated fire info to forecasting and health agencies.
12. WA State Fire Marshal	Assists in response to fire danger, coordinates with local fire officials.	Primary response to fire danger and suppression, less on public smoke exposure risk.
13. Department of Enterprise Services	Assists in procuring facilities and resources to respond to the incident.	Depends on severity and specific requests for facilities or resources.
14. Washington State Patrol	Facilitate the movement of emergency medical resources over state highways to locations identified by public health authorities.	Depends on severity and specific requests for medical resource movement.
15. Governor's Office	Coordinates state-level policy issues with multiple agencies, especially if Governor proclaims a state of emergency.	Update on as-needed basis, unless state of emergency is proclaimed.

CONTACT AGENCY OR ORGANIZATION	GENERAL AREA OF EXPERTISE / ASSISTANCE	ANTICIPATED LEVEL OF INVOLVEMENT
Local		
16. Local Health Jurisdiction	Notify public and media of health risks from smoke or hazardous air quality. Coordinates with local school administration on decisions regarding school activities and school closures. Coordinates with other community organizations on decisions to cancel or limit other public events. May make recommendations on or distribute N95 particulate filter masks to populations of impacted areas. Maintain awareness of health impacts occurring in the community. Coordinate with Ecology, DOH, firefighting agencies (DNR and State Fire Marshal), and L&I.	Extensive during periods of unhealthy to hazardous smoke levels.
17. Local Air Agencies (LAA)	In coordination with Ecology maintains real-time air quality monitoring data within their jurisdiction from an existing monitor network and relays monitored data to the public via Ecology website (see section 10 of this document). LAAs are not the lead agencies, but upon request and if resources are available, may assist in providing air quality forecasting and supplemental temporary monitoring. Coordinates with other agencies as needed.	Depends on the extent wildfire smoke is impacting counties with LAAs.
18. School Districts	With assistance, determine if student health at risk, need to cancel school events, or announce school closures.	On as-needed basis during periods of unhealthy to hazardous smoke levels.
19. Healthcare Organizations	Treating patients who present with illnesses related to smoke or hazardous air. Make individual recommendations to patients regarding risk and strategies for reducing risk. Communicate situational information and impacts to local health jurisdictions.	Extensive during periods of unhealthy to hazardous smoke levels.
20. City and local government	With assistance from local health agencies, determine health risk to community, public safety, need to cancel outdoor events, notify local businesses, and alert fire and police.	On as-needed basis during periods of unhealthy to hazardous smoke levels.
Tribal		
21. Tribal Governments	Coordination with above agencies. Similar role to #16 and #20 above.	Can be extensive if wildland fire smoke impact levels are unhealthy to hazardous within tribal communities.

3. Agency Actions and Desired Outcome

Table 2 describes the different actions and assistance needed during major wildfire incidents, the agency or organization expected to take such action, and the desired outcome.

Table 2

ACTION NEEDED	LEAD AGENCY AND ACTION TAKEN	DESIRED OUTCOME
1. Air Monitoring		
Measuring ambient air quality	Ecology and LAAs responsible for existing WA Air Monitoring Network. IMTs and ARA may provide additional temporary monitoring resources and equipment via local and national cache. Ecology and LAAs may assist with providing additional temporary monitoring if resources are available and requested by a Local Health Jurisdiction.	Ability to track ambient air quality levels in communities receiving the heaviest impact.
2. Air Quality Forecasting and Modeling		
Air quality forecast and modeling	ARA assigned to wildfire coordinates smoke dispersion forecasts and modeling. If no ARA assigned to wildfire, willing agencies listed in this document may coordinate available resources to help provide air quality forecast and modeling during large wildfire episodes.	Provide advance notice of possible smoke movement and impacts; improve public notification, and lower risk of public exposure to high smoke levels.
3. Issuing Health Warnings		
Providing public with frequent smoke updates on potential health risks and recommended public health actions via the web and media	Local Health Jurisdictions have primary responsibility for issuing Public Health Warnings with coordination between DOH, local government, ARA, and tribes.	Frequent coordinated updates provided to the public via Washington Smoke Blog, DOH, and local government websites, press releases, and outreach to TV and print media.
4. Website management		
Updating the Washington Smoke Blog website wasmoke.blogspot.com (see description under section 6 below)	Blog website managed by USFS and updated by WA Smoke Blog maintenance team comprised of willing members of the key agencies involved in the wildfire smoke response.	Provide the public with comprehensive “one-stop” website on wildfire status, air quality levels, health risks, press releases, and other critical info.
Updating state agency and local websites	Managed by respective agency.	Supplements the Washington Smoke Blog.

ACTION NEEDED	LEAD AGENCY AND ACTION TAKEN	DESIRED OUTCOME
5. Public Actions		
Cancel or modify public events and outdoor and business activities. Consult with schools on limited hours or closure.	Decision made at the local level by government or school authorities, after consulting with Local Health Jurisdiction, ARA, DOH, IMT, and possibly L&I with smoke forecasts provided by willing agencies. Decision made at the tribal level for events and activities on tribal land. Tribal governments may consult with the above-mentioned entities before taking this action.	Prompt action taken via notification of media and posting info on WA Smoke blog website and other relevant websites.
Identify locations within the community that may have cleaner air.	The local health jurisdiction is the lead for identifying locations that may have cleaner air in local communities.	Provide cleaner air options for the public, such as a library, mall, or community center.
Recommended evacuation/relocation of sensitive populations.	Decision made at local level by emergency management or local health jurisdiction in consultation with ARA, DOH, IMT, and possibly L&I with smoke forecasts from willing agencies. Decision made at the tribal level for evacuation/relocation on tribal land. Tribal governments may consult with the above-mentioned entities before taking this action.	Prompt action taken if dangerous smoke levels expected to persist for a prolonged period. Requires close communication with DOH, affected Local Health Jurisdictions, IMTs, and possibly EMD, ARC, and WSP.

4. Recommended Public Health Actions, Based on Level and Anticipated Duration of Exposure to Wildfire Smoke and Other Severe Smoke Episodes

Wildfire smoke is a mixture of gases and fine particles which can irritate eyes and respiratory systems and worsen chronic heart and lung diseases. The quantity and duration of smoke exposure, as well as a person's age and degree of susceptibility, play a role in determining whether someone will experience smoke-related health problems. The potential health effects vary depending on the size of the particles. Particles larger than 10 micrometers usually irritate only the eyes, nose, and throat. Particles smaller than 2.5 micrometers **($PM_{2.5}$)** can be inhaled deeply into the lungs, which increases the risk of cardiovascular and respiratory problems. When smoke levels are high, even healthy people may experience symptoms.

Table 3 is designed for use by affected Local Health Jurisdictions in consultation with DOH and other agencies that are parties to this document. The table identifies recommended public health actions to be taken. Decisions about which public health actions to recommend should be based on available monitoring data and the projected smoke or hazardous air duration.

In the absence of any $PM_{2.5}$ monitoring data, a visual evaluation can be made by using the visibility index (based on the viewing distance). This index is referred to as the "5-3-1 Visibility Index" and is a rough tool for estimating smoke levels. It can be heavily influenced by moisture in the air and angle of the sun so the Health Advisory Category Index and 5-3-1 Visibility Index are intended to be used together in identifying the public health risk and mitigation actions.

Whether or not the listed actions in Table 3 should actually be taken at various $PM_{2.5}$ levels depends on additional factors in the bulleted list below the table. As air quality worsens, recommended public health actions for better air quality categories should also be implemented. For example, if the air quality is considered “unhealthy,” then actions should be followed for "unhealthy for sensitive groups,” “moderate” and “good" air quality days.

Washington Air Quality Advisory (WAQA)
Guidance for Public Health Actions

Washington State Department of Health
DOH 334-429 July 2019

Health Advisory Category Forecasted 24-Hour Average or NowCast $PM_{2.5}$ Concentration (µg/m³)	Recommended Public Health Actions For use with Washington Air Quality Advisory $PM_{2.5}$ NowCast values and forecasted 24 hour $PM_{2.5}$ concentrations.
Good $PM_{2.5}$ 0 - 12.0	• If smoke incident is forecasted in your area, review the Washington Wildfire Response document for Severe Smoke Episodes and the Wildfire Smoke Guide for Public Health Officials. More health tips on the Department of Health Smoke From Fires website. More nformation about wildfire and air quality at WA Smoke.
Moderate $PM_{2.5}$ 12.1 – 20.4	• Distribute information to public health partners and the public. • Focus on identifying and getting information to vulnerable populations. • Refer people to the WA Smoke Blog for more information about status of wildfires. • Provide information about steps to take with health advisory categories: DOH Washington Air Quality Advisory Graphic (English).
Unhealthy for Sensitive Groups $PM_{2.5}$ 20.5 – 35.4	**Above recommendations, plus:** • Issue press release, identify sensitive groups and encourage them to reduce exposure. • For extended duration of smoke recommend spending time in a cleaner air setting in the community (air-conditioned library) or leaving the area until air quality improves. • For extended duration of smoke, open a cleaner air shelter for sensitive groups. If school is in session, refer to the DOH Air Pollution and School Activities Guide.
Unhealthy $PM_{2.5}$ 35.5 – 80.4	**Above recommendations, plus:** • Recommend cancelling children's outdoor athletic events and practices, or moving them indoors or to an outdoor space with good air quality. • Recommend the public limit strenuous outdoor activities. • Recommend that sensitive groups shelter-in-place, spend time in a cleaner air setting in the community (air-conditioned library) or leave the area until air quality improves. • For extended duration of smoke, open and publicize cleaner air shelters for sensitive groups.
Very Unhealthy $PM_{2.5}$ 80.5 – 150.4	**Above recommendations, plus:** • Consider cancelling outdoor public events and activities. • Recommend shelter-in-place for the general population. • Share information about periods of improved air quality to guide essential outdoor activity and ventilation of dwellings.
Hazardous $PM_{2.5}$: >150.4	**Above recommendations, plus:** • Cancel outdoor public events and activities. • If school is in session, discuss school closure with administrators if indoor air cannot be kept cleaner. • Recommend voluntary evacuation for sensitive groups.

For people with disabilities, this document is available in other formats.
Please call 1-800-525-0127 (TTY 711) or email civil.rights@doh.wa.gov.

-Full WA DOH and ECY guidance on cancelling events or activities, and closing schools:
https://www.doh.wa.gov/Portals/1/Documents/4300/334-428-WildfireSmokeClosureGuidance_final3.pdf
-Summary Guidance: Cancelling Outdoor Public Events and Activities:
https://www.doh.wa.gov/Portals/1/Documents/4300/334-430-WIldfireSmokeOUTDOORSummary.pdf
-Summary Guidance: School Closure, Children's Outdoor Activities Cancellation:
https://www.doh.wa.gov/Portals/1/Documents/4300/334-431-WIldfireSmokeSCHOOLSummary.pdf

Considerations that may influence implementation of the above mitigation strategies:

- Predictable fluctuations in air quality throughout the day can allow for modifications in the recommendations from the above table. For example, schools could delay recess instead of canceling it if there is a pattern of clearing in the afternoon.
- If smoke is predicted to be heavy for short durations (i.e., a few hours) the public health messaging should be to encourage people to avoid spending time outdoors.
- Indoor air quality may be poor in older dwellings. These may include schools, community centers with care centers, nursing homes, or group homes. When air quality is "Unhealthy" for an extended smoke duration, it may be worthwhile to assess indoor air quality for these and other types of facilities where people who are sensitive to smoke live or stay.

Additional Air Quality Resources-

- For more information about the air quality categories and recommended precautions, see Washington Air Quality Advisory for Smoke and Other Fine Particle Air Pollution table at https://fortress.wa.gov/ecy/enviwa/App_AQI/AQI.en-US.pdf.

- For air quality index numerical values and their health implications, see EPA's AirNow website at https://www.airnow.gov/aqi/aqi-basics/

- For information about the "Smoke Sense" study, see EPA's Smoke Sense website at https://www.epa.gov/air-research/smoke-sense-study-citizen-science-project-using-mobile-app

- For information on Washington clean air agencies and their contacts, see Washington Department of Ecology's website at https://ecology.wa.gov/About-us/Our-role-in-the-community/Partnerships-committees/Clean-air-agencies

- Washington State Department of Health Smoke From Wildfires webpage (FAQs translated into 8 languages): www.doh.wa.gov/smokefromfires

- For information about how to prepare your home and family before a wildfire, see the Washington State Department of Health Wildfire fact sheet (translated into 7 languages): https://www.doh.wa.gov/Emergencies/BePreparedBeSafe/SevereWeatherandNaturalDisasters/Wildfires

- Air Pollution and School Activities: Public Health Recommendations for Schools on Fine Particle Air Pollution: http://www.doh.wa.gov/Portals/1/Documents/Pubs/334-332.pdf

- Recommendations for Schools and Buildings with Mechanical Ventilation: Improving Ventilation and Indoor Air Quality during Wildfire Smoke Events (PDF)

- Wildfire Smoke A Guide for Public Health Officials: https://www3.epa.gov/airnow/wildfire-smoke/wildfire-smoke-guide-revised-2019.pdf

- Protect yourself from Wildfire Smoke CDC: http://www.cdc.gov/features/wildfires/

- California Air Resource Board FAQs for air cleaning devices at home: https://www.arb.ca.gov/research/indoor/acdsumm.pdf

- California Certified Air Cleaning Devices: https://www.arb.ca.gov/research/indoor/aircleaners/certified.htm

- EPA Guide to Air Cleaners in the Home, 2nd edition, August 2018: https://www.epa.gov/sites/production/files/2018-07/documents/guide_to_air_cleaners_in_the_home_2nd_edition.pdf

- EPA Residential Air Cleaners: A Technical Summary, 3rd edition, August 2018: https://www.epa.gov/sites/production/files/2018-07/documents/residential_air_cleaners_-_a_technical_summary_3rd_edition.pdf

- L & I flyer about voluntary use of face masks while working: https://lni.wa.gov/dA/ae2fa7aaea/WildfireSmokeAndDustMasksAtWork.pdf

- WA DOH flyer about mask recommendations:https://www.doh.wa.gov/Portals/1/Documents/Pubs/334-353.pdf

Information on low-cost IAQ monitors

- EPA: https://www.epa.gov/air-sensor-toolbox
- South Coast AQMD: http://www.aqmd.gov/aq-spec

5. Air Resource Advisors (ARA)

Air Resource Advisors are trained personnel who are assigned by the USFS Air Resource Division. Air Resource Advisors are ordered by the Incident Management Teams in direct control of firefighting operations. Their primary duties include smoke forecasting, smoke monitoring, and direct communications with the IMTs regarding local air quality. ARAs also focus on monitoring smoke for firefighter exposure and working directly with emergency management personnel on visibility issues associated with public roadways. ARAs work directly with IMTs and partner agencies to facilitate public information dissemination. Agencies and local jurisdictions making requests for ARA mobilization should make the request directly to the USFS contacts listed in Tab 1-WA Contact List.

6. Washington "Smoke Blog" Website

As noted in Table 2 under Website Management, a major tool for providing the public with current air quality and health information on wildfires is the Washington Smoke Blog. This blog site can provide timely "one-stop" information by including links to the various agency websites and providing critical information on wildfire status, air quality conditions and forecasts, school and activity closures, burn bans, location of shelters for those displaced by smoke, and travel restrictions due to visibility.

An important consideration when interpreting the air quality map is stated on the blog site, "The map on this website uses the national air quality reporting system called the Air Quality Index (AQI) for calculating air quality. However, Washington State uses the Washington Air Quality Advisory (WAQA) system of calculating air quality. Both use color-coded categories to show when air quality is good, moderate, or unhealthy. The difference is that the state's WAQA is based on lower levels of fine particle pollution than the federal AQI, thereby providing an earlier alert of potential air quality risks. If in doubt as to which better represents public health risk, use the more stringent of the two (i.e. the map showing worse air quality)."

This blog is managed by the USFS, and the contents are contributed and updated by a team of willing state, federal, tribal, and local agencies. The link to this blog site is: http://wasmoke.blogspot.com/.

7. Annual Pre-Wildfire Season Conference Call

Each year prior to the summer wildfire season, in May or June, USFS holds a conference call in preparation for the upcoming season with representatives from the agencies, organizations, or offices listed in this document. The purpose of this call is to review the information in this document, discuss

any specific preparation needs for the wildfire season, and update the contact list of staff expected to be using this document if major wildfires occur. This contact list is provided in Tab 1.

8. As-Needed Wildfire Conference Calls and Briefings

Similar to the above pre-season conference call, routine conference calls will be held during periods of major wildfire incidents for the purpose of briefing the parties identified in this document. These conference calls and briefings can be requested by any party. They will include updates on the status of major on-going wildfires and an opportunity to discuss current conditions related to air quality, local health impacts, smoke forecasts, recommended public actions, communications, emergency actions such as evacuation, and other issues important to the group. These briefings will include a wildfire status update from public information officers (if available) associated with Incident Command and any ARA assigned to the wildfire.

Ecology is the lead state agency for coordinating these calls, while the USFS contact listed in this document may coordinate the calls if requested. DOH may also provide assistance in coordinating these calls if needed. For major wildfires in neighboring states or provinces (Oregon, Idaho, and Canada) that are impacting Washington, the briefing will include the appropriate contacts in those states who have essential information on the smoke impact from the wildfire(s).

In situations where a smaller group conference call is needed, such as between state and local health officials to discuss specific local public health issues, or with Ecology to discuss air quality levels in areas impacted by wildfire smoke, such calls will be convened as needed. Requests for such calls should be made to either Ecology or DOH, depending on the primary topic of concern.

9. Indoor Air Monitoring Equipment

Wildfire smoke can also affect indoor air quality in private businesses and public buildings such as schools, hospitals, clinics, long-term care facilities, and offices. Research has shown that when there are heavy outdoor smoke levels, a significant amount of smoke can still infiltrate indoors, even with all of the windows and doors closed. Many commercial buildings and schools mechanically draw in the outdoor air through air filtration systems. However, standard HVAC air filters will not remove most of the ultra-fine smoke particles. More information on use of air filters, cleaners, and other ways to reduce indoor smoke levels can be found in the following documents *Wildfire Smoke: A Guide for Public Officials* https://www3.epa.gov/airnow/wildfire-smoke/wildfire-smoke-guide-revised-2019.pdf and *Recommendations for Schools and Buildings with Mechanical Ventilation* https://www.doh.wa.gov/Portals/1/Documents/Pubs/333-208.pdf.

There are different types of indoor air monitors that can be used to indicate the potential health risk when indoors. Of particular concern indoors are levels of $PM_{2.5}$ and carbon monoxide. Indoor monitoring equipment is typically less expensive than outdoor equipment, and can provide measurements in real-time data in micrograms per cubic meter ($\mu g/m^3$), via handheld or portable monitors. Accuracy varies based on temperature, humidity, and type.

For more information on lower cost air monitors, EPA and California's South Coast Air Quality Management District provide information and evaluations:

- EPA: https://www.epa.gov/air-sensor-toolbox- This website provides information for citizen scientists and others on how to select and use low-cost, portable air sensor technology and understand results from monitoring activities.

- South Coast AQMD: http://www.aqmd.gov/aq-spec- In an effort to inform the general public about the actual performance of commercially available "low-cost" air quality sensors, the SCAQMD has established the Air Quality Sensor Performance Evaluation Center (AQ-SPEC)

program. The AQ-SPEC program aims at performing a thorough characterization of currently available "low-cost" sensors under ambient (field) and controlled (laboratory) conditions.

10. Other references, resources, and links

Wildfire Smoke: A Guide for Public Officials (https://www3.epa.gov/airnow/wildfire-smoke/wildfire-smoke-guide-revised-2019.pdf**).** The smoke exposure levels listed above in Table 4 are adapted from the guidance document, *Wildfire Smoke: A Guide for Public Health Officials.* This document is currently used in many states as a reference guide for how public agencies can best protect public health during wildfire incidents. In addition to providing background information on the composition of smoke, potential health effects, and recommended actions, it contains specific strategies on how to reduce smoke exposure, such as indoor air filters and cleaners, use of masks and respirators, and examples of public service announcements for wildfire. This document is referenced here as general guidance to provide additional information, and like this document, is not intended to replace, interfere with, or limit any action taken by a public agency in the course of performing its official duties, nor does it represent a legally binding document.

Wildfire-related websites. In addition to the Washington Smoke Blog described above, these web links can provide current information on wildfire activity:

- InciWeb (Incident Information System): https://inciweb.nwcg.gov/
- Northwest Coordination Center (NWCC): https://gacc.nifc.gov/nwcc/
- DNR: https://www.dnr.wa.gov/programs-and-services/wildfire-resources
- USFS fire map: https://fsapps.nwcg.gov/afm/
- National Weather Service smoke/air quality maps: https://airquality.weather.gov/sectors/pacnorthwest.php#tabs
- Ecology: https://fortress.wa.gov/ecy/enviwa/Default.ltr.aspx
- EPA AirNow Fire and Smoke Map: https://fire.airnow.gov/National Fire Situational Awareness: https://maps.nwcg.gov/sa/#/%3F/39.8212/-95.4967/5

Washington Webcams The following are links to live webcams, which can be used to view wildfire smoke conditions around the state. However, many are designed to show only traffic and road conditions, and do not provide very good image resolution for viewing smoke. Some are much better than others.

- **Washington Department of Transportation**
  - **Traffic Cams** http://www.wsdot.wa.gov/traffic/Cameras/default.aspx
  - **Airport Cams** http://www.wsdot.wa.gov/aviation/WebCam/default.htm

- **Washington State Webcams.** The state of Washington has an extensive webcam network. Washington webcams provide views of local ski areas, Seattle, Spokane, Puget Sound, the San Juan Islands, and many other places in the state. http://www.northwestwebcams.com/washington-web-cams.shtm

Map of High Wildfire Risk Areas in Washington. A map of the areas in Washington that have a greater potential for major wildfire, prepared by DNR, and can be found at this link http://www.dnr.wa.gov/Publications/rp_burn_communitiesatrisk.pdf

Materials on Health Effects of Wildfire Smoke. DOH maintains comprehensive webpages about the health effects of wildfire smoke and strategies to minimize these effects: http://www.doh.wa.gov/smokefromfires

https://www.doh.wa.gov/CommunityandEnvironment/AirQuality/SmokeFromFires/SmokefromFiresToolkits

"Smoke from fires can be dangerous" flyers for each of the sensitive groups and for the general public:
For everyone
For babies and children
For pregnant people
For people over 65
For people with lung and heart diseases

"Know your symptoms" flyer to help the public identify the symptoms of wildfire smoke
Symptoms of wildfire smoke

Air Pollution and School Activities: http://www.doh.wa.gov/Portals/1/Documents/Pubs/334-332.pdf

11. Tabs

Current Agency Contact List. Tab 1 is a contact list of representatives from the agencies and organizations identified in this document. Annual updating of this contact list will be necessary, and should be conducted at the annual pre-wildfire season conference call, as noted in section 7.

Examples of Wildfire Smoke Public Announcements. Tab 2 provides examples of two public announcement/press releases, which can be used as a guide for future announcements.

Tab 1
Washington Wildfire Smoke and Health Contact List

CONTACT AGENCY OR ORGANIZATION	STAFF NAME and POSITION	CONTACT PHONE/EMAIL
1. US Forest Service	**Janice Peterson**, *Pacific Northwest Region, Forestry Sciences Lab, Washington Zone Coordinator* **Rick Graw**, *Pacific Northwest Region, Regional Air Resource Specialist*	jlpeterson@fs.fed.us 206-732-7845-desk 206-484-4353-cell rgraw@fs.fed.us 503-808-2918-desk 503-347-5688-cell
2. FEMA	**FEMA Region 10**	425-487-4600
3. EPA	**Mike McGown,** *Region 10, Smoke Management*	Mcgown.michael@epa.gov 208-378-5764
4. Air Resource Advisor - National Coordinator	**Pete Lahm**- USFS Smoke Program Management in WA DC (ARAs can be requested when a major smoke incident occurs)	pete.lahm@gmail.com 602-432-2614
5. American Red Cross	n/a (depends on chapter and WILDFIRE location)	n/a
6. Washington State Department of Health (DOH)	**DOH 24/7 Duty Officer** – Tumwater	hanalert@doh.wa.gov 360-888-0838
7. Washington State Dept. of Ecology Air Quality Program	**Andrew Wineke -** *Program Communications Manager, Olympia* **Sean Lundblad**- *Technical Services Manager , Olympia* **Ranil Dhammapala**-*Forecaster, Olympia* **Ferren Herron-Thorpe-***Forecaster, Olympia* **Sean M Hopkins**- *Smoke Team, Yakima* **Joye Redfield Wilder**- *Communication Manager, Yakima* **Daniel Matsche**- *Smoke Team, Spokane* **Ryan Lancaster**- *Communication Manager, Spokane*	anwi461@ecy.wa.gov 360-407-6932, 360-791-1939 slun461@ecy.wa.gov 360-407-6843 rdha461@ecy.wa.gov 360-407-6807 fher461@ecy.wa.gov 360-407-7658 seho461@ecy.wa.gov 509-575-2804 jred461@ecy.wa.gov 509-575-2610 dmat461@ecy.wa.gov 509-329-3523 Ryla461@ecy.wa.gov 360-584-3271

CONTACT AGENCY OR ORGANIZATION	STAFF NAME and POSITION	CONTACT PHONE/EMAIL
8. Washington Military Department, Office of Emergency Management (EMD)	State Emergency Operations Officers (SEOO) on Duty **EMD Duty Officer** – Camp Murray	stateemergency.operationsofficer@mil.wa.gov 24-hour emergency line 800-258-5990
9. Washington State Department of Labor and Industries (L&I)	**Scott Loerts** – Risk and Safety Manager, Olympia	scott.loerts@lni.wa.gov 360-902-5740 360-791-0816 cell
10. Washington State Department of Natural Resources (DNR)	DNR Region Office responsible for fire (Northeast, Southeast, Northwest, South Puget, Pacific Cascade, or Olympic). See Region and Districts, then Regional contact.	Region and Districts: http://www.dnr.wa.gov/about/dnr-regions-and-districts Regional Contacts: http://www.dnr.wa.gov/contact-us
11. Washington State Fire Marshal	Contact **State Fire Marshal Office**	firemarsh@wsp.wa.gov 360-596-3900
12. Washington State Local Clean Air Agencies	http://www.ecy.wa.gov/programs/air/local.html	See contacts from website links
13. Local Health Jurisdictions	Contact **DOH Duty Officer**	hanalert@doh.wa.gov 360-888-0838
14. Tribal Governments	Contact **DOH Duty Officer**	hanalert@doh.wa.gov 360-888-0838

The attached links route to agency or organization web sites. They do not provide the actual contacts for wildfire smoke and air quality issues.

Tab 2
Example 1 of Wildfire Smoke Public Announcement

Washington State Department of Health

News Release

For immediate release: Date (18-1XX)

Contact: Name, Entity/Office Phone number

Air quality degraded by wildfires across the state

OLYMPIA — Washington State Department of Health is encouraging people in areas affected by wildfire smoke to take necessary steps to protect themselves from poor air quality.

People can take the following steps to protect themselves from smoke due to wildfires:

- Visit the Washington Smoke Blog or contact your local regional clean air agency.
- Stay indoors, avoid strenuous physical activities outside, and keep indoor air clean. Close windows and doors. Use fans or an air conditioner (AC) when it is hot, and set your AC to recirculate. If you do not have AC and it is too hot to stay home, go to a place with AC such as a mall or library. Remember to stay hydrated. Do not smoke, use candles, or vacuum. Use an air cleaner with a HEPA filter.
- Contact your health care provider when you have specific health concerns, and dial 911 for emergency assistance if symptoms are serious.

Smoke from wildfires especially increases health risks for babies, children, people over 65, pregnant women, and those with health conditions, such as heart and lung diseases or diabetes.

Breathing smoky air can cause a wide range of symptoms from watery eyes and coughing to chest pain and asthma attacks. People with heart or lung diseases such as asthma are more likely to experience serious and life-threatening symptoms.

The DOH website is your source for a healthy dose of information. Find us on Facebook and follow us on Twitter. Sign-up for the DOH blog, Public Health Connection.

###

Example 2 of Wildfire Smoke Public Announcement

Washington State Department of Health

News Release

For immediate release: Date (18-XXX)

Contact: Name, Entity Phone number

Prepare now for wildfire smoke, unhealthy air quality

OLYMPIA – As wildfire season heats up, officials at the Washington State Department of Health are urging everyone in Washington to plan now for smoky days with poor air quality.

Simple steps to take now:

- Identify where to find air quality reports for your area. The Washington Smoke Blog, has a map of current fires and air quality reports statewide. EPA's Smoke Sense mobile app has location-specific information on smoke and health impacts.
- If you or a family member has heart or lung disease, including asthma, ask your doctor what precautions should be taken when air quality is impacted by smoke. Have necessary medication and recommended supplies stocked up.
- Buy a portable air cleaner with a high efficiency HEPA filter and create a "clean" room to spend time in when the air isn't healthy. Select a room with no fireplace, and few windows and/or doors.
- Information about the health impacts from smoke and more tips about how to stay healthy when smoke levels are high can be found on the department's website.

Breathing smoke isn't good for anyone, but some people are more likely to have health problems when air quality isn't good. Sensitive groups include children under 18 and adults over 65, people with heart and lung diseases, people with illnesses and colds, people who have had a stroke, pregnant women and people who smoke. These people should especially take care to reduce exposures by limiting outdoor activity and staying indoors with cleaner air when it's smoky outside.

Symptoms from exposure to smoky air can range from minor to life-threatening and include watery or dry eyes, coughing or wheezing, throat and sinus irritation, phlegm, shortness of breath, headaches, irregular heartbeat and chest pain. People experiencing serious symptoms should seek medical attention immediately.

The DOH website is your source for *a healthy dose of information*. Find us on Facebook and follow us on Twitter. Sign up for the DOH blog, Public Health Connection.

###