Emergency Preparedness and Response Base Plan
Plan Structure, Authorities, Incident Command and Emergency Operations
North Dakota Department of Health

Scope of Plan
This plan covers the concepts and structure of NDDoH response plan, incident command, and procedures for emergency operations for the North Dakota Department of Health (NDDoH), including Case Manager System and Department Operations Center management.

I. PLAN CONCEPTS AND STRUCTURE

Because the NDDoH response structure is subordinate to the Department of Emergency Services, all plans can be considered subsidiaries of DES plans. However, these plans can function independently of DES, particularly when the NDDoH DOC is responding to an incident but the SEOC has not been activated.

Plan Repository
The most recent version of any plan can be found in the NDDoH document library, a SharePoint site. Versioning is turned on so outdated versions can be pulled up if needed. Permissions are given to some state staff and some local staff to modify the contents of the document library. The site is backed up regularly by ITD. Plans usually are updated rather than deleted. When they are no longer useful, they are placed in an archive folder. Occasionally a document may be deleted if it does not belong. It will go to a deleted item folder. The backup, versioning, archiving and deleted item folder act as barriers to documents be inadvertently lost.

Response Modules
When NDDoH responds to a disaster, it activates a set of response "modules" appropriate for that particular disaster. Some modules would be activated for every event (incident command, public communications, tactical communications, and responder safety). Others would only be activated if appropriate, for example, a flood would activate health care infrastructure support, health facility evacuation, sheltering in place, environmental management. These modules cover most of the needs of any particular event. This does not preclude event specific planning and exercising since some events have unique features.

Plan Structure
Plan structure does not tend to be organized around modules. This is primarily a function of funding. For instance, the pandemic influenza plan contains many different modules that are not documented elsewhere, but would nonetheless be used in other types of events (e.g., community containment). This is also true for SNS which contains the tactical communication plan. Because of the need to submit these two plans in particular as single entities to federal reviewers, the plans have not been broken into modules. This is not a problem except that it may be difficult for someone not familiar with the plans to know where to find specific modules.

Annexes and Attachments
This plan is considered the base plan. All other plans are considered to be annexes of this plan. Some may be base plan annexes, some are event specific annexes and some are support annexes. Many annexes have multiple attachments. Although they may exist as separate files in the document library, they are considered to be part of the annex. Usually attachments contain reference material. Sometimes the word Appendix is used to represent a major annex sub-section (e.g., chapter) formatted as a separate file; it is not a typical attachment because it is part of core of the annex; however, the term tends to be non-specific and mostly retained as part of the SNS plan.

Summary Plans
Some summary plans have been created for specific users. In particular, summary plans have been created for DES which has made the summary part of one of their multi-agency plans.

Assistive Documents
A variety of document exist for the facilitation of planning by others. For example, several planning templates exist which create improved uniformity among plans from multiple regions.

T**raining Materials**
Some of the documents in the library are specifically for training. These may take many forms including PowerPoint presentations, links to videos or written instructional material (e.g., safe use of a pallet jack).

II. INCIDENT COMMAND

Activation Criteria

Criteria for activation of the NDDoH emergency response plans is as follows:

- A single division of NDDoH or a single local public health unit lacks sufficient resource to respond or is likely to lack adequate resource.
- Multiple NDDoH divisions or multiple local public health units are involved in the response.
- At the discretion of the case manager (e.g., supportive role to SEOC, exercise staff in real event, complex or prolonged response even if response is narrow in scope.

If these criteria are met, NDDoH Department Operations Center is activated and the emergency response plans are implemented.

If events occur that do not meet these criteria, then normal daily operations occur as outlined with memorandums of agreement and contracts between NDDoH and local public health units.

Integration with State, Local and Federal Emergency Management

NDDoH is assigned specific disaster response responsibilities by the North Dakota Department of Emergency Services (NDDES). Expectation of NDDoH include the following:

State Emergency Response Roles

- Operate the DOC as a subsidiary of the SEOC or in communication with DES if the SEOC has not been stood up.
- Develop plans to meet expected responsibilities for NDDoH during any disaster that impacts health, and modify those plans from exercise and real events.
- Develop the physical environment, personnel, medical materiel, pharmaceuticals, hardware, software and administrative and relational infrastructure needed to respond to health and medical issues during all types of disasters.
- Participate in federal, state, local and NDDoH specific exercises as they relate to agency preparedness.
- Work through DES to obtain non-medical resources to support medical response
- Participate in shared agency responsibilities
- Develop systems for fiscal responsibility and documentation of expenditures related to disaster.
- Advise DES and the Office of the Governor on disaster declarations needed to manage health during a disaster.
- Work with law enforcement as needed related to investigation of terrorist health threats

- Act in support role to other agencies for general population sheltering, meeting social needs of population, meeting mental health needs of population, communications and transportation.

Assessment

- Define the nature of the threat to health using the assistance of other agencies and partners as needed.
- Define scope and anticipated course of health and medical impact of a disaster.
- Compile and report statewide number of incident-related injuries and deaths
- Track the long term health effects of disasters on the population after the event.
- Coordinate with Animal Health to evaluate and mitigate animal threats to human health
- Provide disaster data to the public, federal government and policymakers

Activation and Response

- Support communications systems needed to provide situational awareness and guidance to the health response system.
- Activate the health and medical disaster response
- Provide community preventive actions and education for disaster response
- Establish public health policy related to disaster and apply national policy to disaster response in North Dakota
- Lead mass fatality response for the state and support local mass fatality response, including support of mortuary system.
- Ensure the safe movement of patients and other vulnerable populations assigned to NDDoH from areas of risk
- Place evacuated health care personnel in alternate institutions
- Provide technical assistance to communities for disaster response
- Provide guidance to health care re: diagnosis and treatment of disaster related illness.
- Provide specialized clinical laboratory services
- Monitor persons at risk for disease
- Provide for community containment for disease, including legal confinement and provision of alternate I&Q locations
- Pre-position health and medical equipment, supplies and communications assets in regions throughout the state for use in disaster.
- Coordinate the provision of supplemental medical personal through the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VP) system
- Coordinate the delivery of emergency medical services, medical services, public health services, and hospital services
- Coordinate the sheltering of patients with medical needs
- Provide health and medical assets to local and state responders from the state and federal medical cache systems
- Process necessary emergency response waivers for medical and facility licensure and regulations
- Take lead responsibility for preventing the spread of infectious diseases
- Manage the replacement of critical local public health services lost due to disaster until they can be restored.
- Ensure population access to health care when normal health care delivery has been interrupted.
- Track movement of displaced patients
- Communicate security needs to DES required to maintain health and medical response and ensure personnel and material safety.
- Provide just-in-time training to all state health and medical responders.
- Respond with other states for shared risk
- Ensure health messages reach all segments of the population.

Environment

- Evaluate disaster risks to the environment pre-disaster
- Evaluate risk of environmental hazards spreading to new areas and impacting new populations

- Provide technical assistance to ensure safe drinking water and safe food in the event of an emergency or disaster which may have resulted in bacteriological or chemical contamination.
- Provide technical assistance to assure safe and sanitary disposal of household refuse and wastewater in the event of a flood, and procedures for utility shut-offs and prevention of wastewater backup.
- Provide assistance to health care for disposal of highly infectious medical waste
- Oversee environmental remediation response and ensure adequate clean-up to restore area to a reasonable pre-disaster condition
- Provide environmental laboratory services

Liaison

- Serve as a liaison with health care providers and local public health units and provide technical assistance to local emergency medical responders.
- Serve as liaison to national health partners (e.g., CDC).
- Severe as liaison to the public health infrastructure of other states.

Partner Roles in Support of NDDoH Disaster Response

DES – The Department of Emergency Services is the lead agency for disaster response and coordinates activity of all other agencies, allocating resources according to priority. DES operates the State Emergency Operations Center (SEOC).

DOT – Although NDDoH uses contract carriers and its own transportation resources for a large percentage of the transportation, DOT is called on in many disasters for large number of vehicles and drivers, CDL drivers for semis, state vehicle recovery and local storage of trailers with disaster medical equipment.

NDHP – Highway Patrol is the lead coordinating agency for disaster security. It is accessed through a coordinating center in the SEOC and uses the statewide resources it needs to meet specific disaster security requirements.

NDDHS – The state social service agency is responsible for joint triage of shelter patients and providing sheltering services for the general population. It is also the primary agency for meeting social and mental health needs.

A variety of other state agencies may be engaged in specific events in support of NDDoH such as Department of Agriculture (Animal Health), National Guard (CST team, critical transport), Attorney General (legal opinion), individual state universities (expert technical assistance and use of university facilities), Civil Air Patrol (air transport), Department of Public Instruction (school policy), Department of Information Technology (data systems and servers), Indian Affairs (tribal liaison), Industrial Commission Oil and Gas Division (environmental response to oil and gas) and Water Commission (flood control).

During a disaster response, NDDoH Department Operations Center (DOC) works within a framework of dynamic cooperation with the North Dakota Department of Emergency Services (DES) such that additional tasks may be assigned to the DOC by DES, or as issues are anticipated for which NDDoH does not have management responsibility, the issue may be passed up to DES for action. However, most tasks which NDDoH executes during an event will to be represented under one of the DES assigned responsibilities listed above. An alternate source of tasks to which the DOC needs to respond may arise out of NDDoH relationships with key partners statewide (e.g., health care, professional associations, non-profits) or out of specific problems that have been brought to the attention of the DOC by local, federal or state agencies. NDDoH will keep DES and planning partners apprised of significant activities regardless of source.

In some cases, the DOC may share responsibility for a particular task with another state agency, may be unable to complete an assigned task without the support of another agency, or may be acting entirely in a support role to another agency, contributing to the mission of the other agency as requested. Multi-agency cooperation is managed through DES unless the task falls under pre-existing MOUs with a sister

agency. In addition, some DOC personnel may be assigned to special organization units spanning multiple agencies; the most common examples are staffing the Joint Information Center (JIC) and assignment of an NDDoH liaison to the SEOC.

Although closely integrated with the local public health response, the specific roles for which NDDoH is responsible may not fully coincide with local public health assigned responsibilities. For example, NDDoH is assigned responsibility for mass fatality at the state level, but mass fatality may or may not be assigned to local public health within any particular local jurisdiction. Nonetheless, NDDoH will call upon local public health to help NDDoH meets its state obligations, even if local assistance comes through the help of another local entity gained through the facilitation of local public health. Similarly, a local public health agency may receive an assignment which is outside the usual scope of NDDoH (e.g., a social service task). If local public health requests NDDoH assistance with a task outside the usual responsibilities of NDDoH, NDDoH will either directly assist the local public health entity or help it secure assistance from an alternative source.

For any large disaster which involves NDDoH, the US Department of Health and Human Services (DHHS) has a stake in timely and effective response. A failure at the state or local level which results in substantial morbidity, mortality or cost may result in the federal government bearing substantial blame for the outcome. Generally, DHHS will assume a standby response posture as long it is kept informed of the situation, and be prepared to assist with any need for particular resources which may be supplied from the federal government. In any substantial disaster response affecting North Dakota public health specifically (as opposed to affecting public health in all states), DHHS will embed one or more federal officers with the state response. These embedded representatives are fully connected to the DOC electronically (networks, video conferencing, telephone) and are located within the same building making their physical participation in the DOC readily accessible. In addition, the Incident Commander holds meetings with these federal representatives which may include other federal officials through a distance connection. In some instances, other US agency representatives may be included on-site or via distance connections.

Command and Control Structure for State Public Health

The NDDoH Department Operations Center (DOC) is only activated during an emergency response. When the DOC is not activated, urgent issues are dealt with by the Case Manager (who is one of four Emergency Preparedness and Response Section employees trained for that position). The Case Manager position is staffed 24/7 (unless the DOC has assumed that role) and may deal with a response alone, or may engage other parts of the agency. A backup case manager is also on duty in the event the Case Manager is not available. Backup case manager responsibilities are rotated among Disease Control staff. The Case Manager works within the existing structure of the agency following chain of command; however, at any time, the Case Manager can transition to incident management if that structure is better able to deal with the situation. Transition to incident management presumes activation of the DOC but does not automatically determine the depth of resource or staff activation needed in the DOC.

Once the DOC has been activated, the DOC Incident Commander on duty has primary decision making authority for all aspects of the response. It is not necessary for this person to work through NDDoH administrative channels to respond to the disaster. However, the Incident Commander does not work in a vacuum separated from other parts of the agency, including agency administration, or from partners outside the agency. When consultation is advisable and the time scale for response makes it possible, decisions are made by involving other decision makers, albeit the final NDDoH decision lies with the Incident Commander. Because the incident commander for the agency works under the authority of the incident commander for the entire event (if the SEOC has been activated), the Incident Commander's response may be modified by the SEOC, particularly where DOC action interfaces with local, state and federal partners.

The DOC Incident Commander will determine the extent to which he or she wishes to activate personnel staffing in the DOC. Any or all command staff positions may be activated and special components within each of the command sections may be activated. (See diagram of expanded DOC operations). If any particular DOC section needs to staff an organizational branch, usually that branch will be activated to work in their usual work location or in some alternate congregate location physically outside the DOC. Alternate group work sites wired for video conferencing may preferentially be used for this. Although the staffing diagram gives a likely structure to DOC operations, the Incident Commander is not restricted from using an alternate structure which he or she feels best meets the contingencies of the response.

Although the DOC site is setup for 16 persons and can be expanded to accommodate more, full staffing for the DOC is usually limited to the following 11 positions:

- Incident Commander
- Deputy Incident Commander (if Incident Commander at SEOC);
- Operations Section Chief;
- Logistics Section Chief ;
- Planning Section Chief;
- Liaison
- PIO

The Incident Commander may act in the role of Safety Officer or may assign that role to another individual. The DOC may be staffed with as little as one or two persons in small events.

Persons normally responsible for filling primary command staff roles are professional EPR staff; usual roles as designated below.
Emergency Preparedness Director – Incident Commander
PHEP Director – Deputy Incident Commander
HPP Director – Operations Chief
Career Epidemiology Field Officer – Planning Chief
PHEP or HPP Program Representative - Liaison
While specific person usually fill specific roles, any of the roles might be filled by any staff person. If demands of staffing the primary command roles exceed availability of professional staff, NDDoH employees from outside the Emergency Preparedness and Response Section are mobilized from a designated team of trained persons.

Branches are normally activated as part of ICS but physically located outside the DOC. The organizational head of that branch may use a variety of staffing mechanisms, including the use of many different staff to complete specific assignments rather than assigning a few staff to disaster response for an entire shift. Parts of the agency which may function as an ICS unit physically outside the DOC include the following:

- Disease Control;
- Health Facilities;
- SNS/Medical Supply;
- Environment;
- Administration;
- Hotline;
- Shelter;
- EMS.

If the SEOC has been activated, the DOC Incident Commander may relocate to the SEOC where he or she will act as the NDDoH liaison to the SEOC as well as Incident Commander of the NDDoH DOC. In this case, the Deputy Incident Commander will orchestrate DOC activity and act as the sole information conduit to the Incident Commander from the DOC. In an event which is primarily a public health response, the Incident Commander may remain in the DOC even if the SEOC has been activated.

Command and Control Structure for Local Public Health

Although local public health incident command structures generally parallel those of the state, some local variation exists. During a disaster response, local public health works under the authority of local emergency management. The local public health operations center may exist in a separate location from the local emergency operations center or may function as part of the local EOC operations section, physically co-located with the local EOC. A local public health agency may be covering one or more than one county, and one, some, or all of the counties may have activated their operations center. Not all counties covered by a single local public health unit may be affected by any single disaster. In addition, each local public health preparedness region will have a lead public health agency which may use its staff to assist public health response over the entire region or within a single county within that region. Regional public health preparedness staff hired with state preparedness funds but supervised by a local public health agency may act in any of the following assignments:

- Role within single local operations center;
- Liaison role outside of any particular operations center;
- Assist role in another region;
- Assist role to the NDDoH DOC (i.e., local public health liaison); or,
- Assigned a special operational role such as commander of a state medical shelter.

Staffing and Personnel Rosters

The scheduling of DOC hours is highly flexible, but will usually follow one these patterns:

- Serial point in time – Designated staff meet at the DOC to update response and formulate new action steps within a brief period, then disperse to work on specific assignments until the time the DOC is scheduled to meet again. Operational periods may be one to several days.
- Work day schedule – The DOC is activated from 8:00am until 5:00pm Monday through Friday, with round the clock on-call DOC staff available as needed. Usually the operational period is a day or a weekend;
- 12 day schedule – The DOC is activated from 7:00am until 7:00pm, seven days a week; DOC hours and staff density on weekends may be lower if that is consistent with workload requirements. Operational period is usually 24 hours.
- 24 hour schedule - The DOC is staffed in two 12 hour shifts, 7:00 until 7:00, seven days a week. Operational period is usually 12 or 24 hours.

The Emergency Preparedness and Response (EPR) Section of NDDoH has staff assigned full time to emergency preparedness. EPRS staff will maintain a presence in the DOC throughout any period of DOC activation, usually in command staff roles. When the DOC is staffed for periods during usual work hours, five days a week, the EPR Section will usually supply the entire staff located in the DOC. All EPR staff may be involved in the response. Some will be assigned duty in the DOC; some will have duties in the warehouse and some will work in support roles from outside the DOC, including administrative support staff and IT support staff.

Once DOC activation moves to seven days per week, other staff from the agency will be used to supplement the EPRS staff to the extent necessary. During periods of 24 hour operations, it is likely that many sections, including those physically inside the DOC and those assigned to other stations, will have been activated. Day shift and night shift are usually not staffed at the same strength, and during transition

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periods (event ramp up or ramp down), some night staff may be allowed to sleep in the building. The decision regarding which sections to staff is situation dependent. How broadly to staff and at what times the DOC will be staffed is made by the daytime Incident Commander but can be altered at any time by the Incident Commander on duty.

Selection of non-EPRS staff to work in incident command draws from a set of five rosters – incident command, hotline, SNS, transportation and general. The incident command roster includes persons with training and experience working in the DOC or its operational divisions. The hotline roster contains persons trained to answer calls incoming to the hotline while physically located at their usual workstation. The SNS roster is activated to work in the warehouse when need for mass prophylaxis or material distribution from the warehouse exists. The transportation roster includes persons who drive materials across the state and who may stay to regulate the allocation or local utilization of the material (e.g., material setup). Most are persons having some experience driving a small truck and hauling a trailer. The general team includes all other persons not assigned to one of the other teams. Special teams may be created in any of the rosters by drawing from the general roster. The ICS roster is the usual host to special teams. Examples include shelter staffers and volunteer management staff.

An additional potential source of staffing for the DOC is non-governmental agency partners. In the past, this has been limited to health care professional organizations which bring special skills and relationships to assist the DOC to complete tasks requiring coordinated action among a large number of private health care entities (e.g., evacuation of nursing homes to other nursing homes). When these staff are activated, they are physically and organizationally imbedded within the medical services branch of the operations section.

Staff Expectations and Care of Staff

Staff sign in and out of the DOC; staff off-site sign in over the web. Staff are expected to be in the DOC on time. When the DOC is active during the day (no second shift is coming on) and urgent, unresolved issues remain at usual quitting time, necessary staff are expected to stay and complete those tasks. When the shift is dismissed, the Incident Commander or his designee will be on call to respond and may call one or more team members back in if necessary. Likewise if the DOC is staffed for 12 hours and tasks are completed early, some or all staff may be released early. When a second shift is coming on duty, staff should plan to report early to get a briefing from those going off shift. This may need to be as long as 30 minutes depending on the section and the level of activity.

If duty is light and the DOC is only on 8 hour per day staffing, some staff may be released to find lunch; however, under normal operating conditions, food for staff will be supplied by the EPR Section. Those needing special dietary considerations can arrange that with those obtaining the food or bring alterative food to eat.

Impact of DOC Activation on Agency

All NDDoH staff have a potential role in disaster response. For an evolving disaster (flood, contagious illness), DOC responders in the DOC will provide information to the entire agency related to progress of the event, anticipated future impact on the agency and likely timeline for needing to activate more responders. This usually occurs using several venues – web site, webcast updates and HAN alerts. For point-in-time disasters (tornado, explosion) which decline in intensity after an initial peak, no advance warning can be given, but sustained response over prolonged periods by a large number of staff are not usually needed. After the initial containment, EPR Section staff and selected subject matter experts can typically manage the response without further draw down of agency personnel. However, some point-in-time events may have sudden onset and slow resolution which may require sustained agency-wide response (e.g., severe ice storm with infrastructure damage).

Few non-EPR Section staff will be on disaster response duty for prolonged periods. Deployment to disaster response for non-EPR Section staff will typically be limited to one to two weeks and most non-EPR Section staff will only work a few days. During a disaster response, dealing with the disaster is highest priority, and that part of the agency which is not actively engaged in response, may be asked to curtail non-critical activity which may limit disaster response access to employees. The degree to which disaster response interferes with usual duties depends on the severity of the disaster.

DOC duty replaces regular duty, but staff may occasionally need to deal with an urgent non-disaster issue either while on duty in the DOC or on a day when they can be replaced. Staff can access their regular email through webmail to deal with those issues as time permits. Schedules are made in advance and staff can arrange to be gone from the DOC if needed for alternate duty. Supervisors are asked to work with the EPR Section to ensure that staff fulfilling critical functions are not diverted away from usual duties to the point that those critical functions are damaged.

When non-EPR Section staff are needed for disaster response, disaster response funds purchase their work hours. To the degree possible, scheduling will attempt to avoid overtime, but this becomes a secondary consideration during periods of high urgency when non-EPR Section staff are most likely to be required.

EPR Section staff assume disaster response duties as part of their job description and will generally be assigned to disaster response roles daily. During intense response, long hours and daily duty can stress staff and degrade performance. This is particularly likely to affect EPR Section staff who may sustain disaster response for several weeks. Consequently, all staff in sustained, high demand roles are subject to being rotated out for a day of rest.

Relationship of Agency Administration to Incident Command

The activation of incident command dictates that all aspects of disaster management are turned over to the Incident Commander. The State Health Officer or Deputy State Health Officer may serve as Incident Commander or may act in their usual roles related to non-disaster functions and in support roles to incident command for disaster issues which interface policy and communication. These tasks may include consultation, political liaison or public spokesperson for the agency.

DOC Activation Sequence

Sequence for activation of the DOC is in part dependent on whether the event is predictable (e.g., spring flooding) or unpredictable (e.g., tornado). In an unpredictable event, the case manager transitions the department from the case manager system to the incident command system without advance notice. The State Health Officer and DES are notified that the DOC has been stood up and the case manager becomes the incident commander, but may choose to transition that role to another person at some point in the first operational period. The Incident Commander decides the parameters of DOC activation (personnel number and assignments) including whether DOC staff will come entirely from the EPR Section or draw Department-wide. The Incident Commander may send out a Health Alert message notifying all persons on the ICS roster to report to the DOC immediately. Not all notified may be immediately available and not all that report may need to remain to staff the DOC that shift. Alternately, the Incident Commander may decide to active the DOC entirely with EPR Section staff or may assign individuals outside the EPRS to activate a specific division (e.g., Medical Services Section may be asked to activate the ICS Disease Control Branch).

During the first hour, the Incident Commander will provide what information is available regarding the incident to the staff reporting to the DOC. He or she then may set the operational period length and use

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the staff on duty to jointly create incident objectives, or he/she may make short term assignments for immediate response including one to the planning section to collect additional situational update information, formulate draft incident objectives for the initial operational period and prepare a situational briefing. Flexibility is critical since the Incident Commander may have to balance immediate response activities with the need to further develop the organizational structure of the DOC (including setting a DOC Clock (battle rhythm)and developing staffing rosters for future shifts) and ensuring all staff as well as response partners have a common operating picture.

DOC Clock

Each day that the DOC is activated for eight or more hours per day, the DOC will follow a clock which coordinates the timing of information exchange. The exact time and content will vary from event to event but must take into account briefings at DES and at critical local response partners. The clock will have a daily core of activity with additional activities on specific days. The clock is likely to include the following:

- DOC planning meeting – this will usually occur in the DOC at the beginning and possibly again near the end of each daily shift. This meeting briefing lays out the key objectives and tasks for the day and follows up to ensure completion of objectives at the end of the day.
- DES briefing – this is in the morning and typically attended by the Incident Commander. If only the Incident Commander participates, then he or she will brief DOC staff on return. This briefing presents situational information across all support functions including health and medical. In some events it may be advisable to connect the DOC to the DES briefing so all staff are aware of information which is presented.
- Partner briefing – this originates from the adjacent to the DOC via video conference to all NDDoH partners involved in response, primarily health care and public health. It may occur twice per day, once per day or one or more times per week. The schedule will vary according to the changing intensity of the event. Although this briefing sometimes may conflict with local schedules, a consistent time is set which will accommodate most participants.
- Daily document schedule – specific documents may be due at certain times of day, in particular a situation report may need to go to DES and preparation of data summaries for the partner briefing may be needed.
- Press conference – this occurs on no set schedule and is likely to involve some DOC staff. It does not occur in the DOC.

Communication Pathways

The briefings described in the DOC Clock are intend to provide NDDoH responders and its partners with a common operation picture, but individual-to-individual and operation center-to-operation center communications will also need to occur as needed.

In the DOC, Section Chiefs will have control over their own phone number, releasing it to individuals from whom they are willing to receive a direct call back. Likewise the Incident Commander and Deputy will provide their direct contact information to those persons to whom they are likely to need to speak to frequently. Otherwise, all incoming calls will go to the Liaison. The Liaison will screen calls and use rules provided by the Incident Commander or Deputy Incident Commander regarding how to direct those calls. The Liaison will need to be aware of which section, and if possible, which person is working particular issues and direct calls accordingly. Many calls may come in requesting the Incident Commander. Rules provided by the Incident Commander will determine if he or she will take the call or divert it to one of the sections. If the Incident Commander is not located in the DOC, the Deputy will receive calls intended for the Incident Commander and determine whether they should be passed on.

In receiving a call, the Liaison will generally attempt to obtain enough information to know where to direct the call or which section needs to return the call. The Liaison will generally not attempt to obtain a full description of the problem since it can become garbled by being second hand. The preference is for the designated person to take the call in transfer or to call the person back for specific details of the caller's need.

Section staff who need to communicate to the Incident Commander when located outside the DOC (e.g. SEOC) will go through the chain of command to the Deputy Incident Commander. The Deputy Incident Commander will be in frequent communication with the Incident Commander, maintaining his or her awareness of DOC progress and new issues.

Except where direct numbers have been provided, local public health and health care facilities will call the DOC Liaison and be directed toward that section most likely to be able to help him or her. Communications to and from local emergency management will pass through local public health or through DES. Requests coming from local public health or health care facilities which cannot be dealt with by the DOC will be passed up to the Incident Commander in the SEOC, who will communicate the need to a SEOC representative according to that command center's protocols. DOC members needing to speak to someone in the SEOC will direct their call through the SEOC Liaison. If a need arises for speaking to the SEOC Incident Commander, that will pass through the DOC Incident Commander unless specific directions otherwise have been given. DOC staff may in some instances make calls directly to SEOC staff without going through the Liaison, generally at a parallel level (e.g., Planning Chief to Planning Chief).

Communication and Information Systems

A variety of communication systems are available and described in detail elsewhere. This document summaries the role of each in incident management.

Face-to-Face – This is the preferred method for persons in the DOC to communicate with each other.

Landline – This is likely to be the first line of communication from the DOC to persons outside the DOC. Protocols for call management are described above.

Cell phone – All DOC members will carry a cell phone which they may use to make sure specific calls come back to them directly whether or not they are in the DOC.

Push-to-Talk phones – Although somewhat faster to use, the advantage is primarily that participation is limited to those on the push-to-talk system, so they represent a channel which is usually available. These are used particularly for communications between the Section Chief and an off-site subsection or from Incident Commander off-site into DOC sections.

Email – A DOC responder may receive disaster response information either to the email address for their particular section in the DOC or to their personal email address. Email is preferred for moving most types of electronic documentation person-to-person. Because it is not an "immediate" form of communication, it is not a routine tool for person to person communication.

Fax – The DOC has fax capabilities for paper-based document transfer. The EPRS has secure fax capabilities if needed, although that is not located in the DOC.

WebEOC – A software package which provides all users with key information needed for a common operating period is available to a controlled list of recipients. For information originating in the DOC,

primary recipients are those in DOC. Some of the entries may be passed up to the SEOC (managed by the Controller). WebEOC also provides access to key documents such as sitreps and a mechanism for attaching relevant electronic documents to information entries. WebEOC is primarily used for complex events involving multiple agencies. The Incident Commander will direct staff re: whether they should be using WebEOC.

HCStandard and Patient tracking –A software package which is primarily a data collection and data sharing tool used particularly for tracking resources at local health care institutions (e.g., bed availability), and information about the status and location of specific patients entered into the system.

Consilience Volunteer Management Software – This is a management tool used by the Volunteer Branch to credential and mobilize volunteers.

CityWatch – this communications software is used for rapid mass communication and mobilization of staff at the state and local level, including call down[1] capability when needed.

Vehicle Tracking – A software package which provides location tracking and assignment of rescue vehicles.

Field Force – This software provides real-time GIS tracking of personnel carrying GIS enabled cell phones.

Mapping software – Mapping software is a complex problem since the level of GIS skill responsible for complex response is beyond DOC skill. A single computer has access to ArcGIS (primary planning computer). Alternative software may be ArcGIS online and IMPACT. MedMap is potentially available as federal software but because of the tight control which DHHS maintains over the software it is not very flexible.

In addition, the DOC may deploy field communications equipment. These include:

- Communications kits – these contain a Begin Unit for accessing satellite communications, satellite compatible cell phone, computer, and P25 radio.
- Communications trailer – this supports a P25 radio bay station, cell phone signal amplifier and satellite connectivity
- AM radio transmitter

Additional software for data and specialty communication applications are used within operational branches related to the specific discipline being managed.

DOC Document Management

- Shared Drives – A shared drive is designated for use during an event where electronic documents and data related to the response can be stored. This will includes access to a master phone directory for disaster contacts.
- Paper documents – a filing case is provided for each section on the floor under the station table
- Office supplies are available in the kitchen area of the DOC

Other usual ICS document which may be needed is the IAP. The Incident Commander will determine which of these documents he wants to be used and how often. For incidents restricted to the DOC, particularly in the long preparatory phase before river flooding, the daily planning meeting document may be the only document required. Finance and administration is sometimes mobilized to the DOC but more

[1] Call down initiates contact which continues until a response is returned that the message has been received.

commonly is used in situ. Documentation will be managed by this unit. If finance/administration has not been activated, the Incident Commander may temporarily assign documentation to someone else in the DOC such as the Deputy IC or the Liaison. Usually this will only be during night time disasters which finance/admin is not routinely available or when that aspect of the operation is very light or very specific to administrative tasks for which EPR staff are the most knowledgeable.

Task Assignments to DOC Staff

Those working in the DOC may receive assignments in several ways:

- Each section may have routine tasks which occur each day specific to the section. These may include logistical tasks, personnel tasks, documentation tasks, data tasks or administrative tasks.
- Morning planning meetings will be used in most events which extent beyond a few hours. These will attempt to identify all new tasks which need to be accomplished and review the status of previously identified tasks. Each task will have one or more persons assigned to complete it.
- The Incident Commander or Deputy Incident Commander may become aware of an issue and assign response to a particular section. This may be identified through a communication from the SEOC, from an individual or organization outside the DOC (e.g., local public health or health care institution)..
- Incoming phone calls or other communications may alert DOC section staff that an issue needs to be addressed. Usually an incoming communication is directed toward the correct section at the time it arrives (and the Incident Commander or Deputy Incident is simply made aware of it if it represents a new issue or complication). If the issue is picked up by a section without the lead response role for that issue, it may be referred to the correct section or communicated to the Incident Commander or Deputy Incident Commander to assign it to the appropriate section.

During the usual response in which DOC staff are few, each person in the DOC will have an assigned role, but staff will also assist with specific tasks in other sections as need and urgency arise. This allows the DOC staff to be lean and responsive.

In an urgent event, the DOC may function in rapid response mode during which the Incident Commander will delegate individual tasks to whoever is available. For instance, rapid operational and logistical response may be the overwhelming need, so all staff are focused on achieving that outcome under the direct guidance of the Incident Commander. The use of this rapid response mode is only possible because the DOC is staffed by just a few, experienced responders. Normally this operational mode would not persist beyond a few hours in which rapid critical response is needed. Even in the middle of an event, urgent need to save life and health may cause the DOC to enter this intense operational mode.

Public Information Management

During an emergency response, all public information flows through the PIO[2]. The PIO is located in the JIC where information messages are coordinated across all agencies. A PIO will not be routinely located in DOC. A single lead agency spokesperson will be the visible public representative for the agency. NDDoH employees, including DOC personnel not assigned to public information, are not to talk to media; media inquiries will go the JIC. Inquiries from the public are not expected to come to the DOC, but should that happen they may be directed to the hotline if active[3]. Issues which may need public information release should be coordinated through the chain of command.

[2] Occasionally at the beginning of an event, the PIO position will not be activated and the Incident Commander will choose to retain that role. Usually this will occur when the DOC is in rapid response mode at the beginning of an event.

[3] The contact for the DOC is not usually published; however, the process of sharing the DOC contact with partners occasionally results in a private individual calling the DOC.

The PIO will also be responsible for coordinating communication with the regional PIOs. This is intended to keep messages as consistent as possible statewide as well as minimize duplication of work.

The PIO may need data to support public responses including health care system status and adverse health outcomes. If the data does not already exist, the request will be referred to the Planning Section for collection and report preparation.

State Field Staff

Employees of NDDoH may be permanently placed in the field (e.g., at a local public health department) or may be mobilized into the field in response to disaster. Field staff permanently assigned to the local level (field epidemiologists, environmental staff) may function as part of local response system or may be called upon to serve in liaison roles for NDDoH with local public health. Field staff for areas not affected by the disaster may be mobilized to the affected area.

Additional state staff are likely to move into the field in the following circumstances:

- Epidemiologists may be used to supplement field staff for investigation and control measures. These individuals could also become part of a team with local staff;
- Environmental staff may be mobilized to the field in response to an environmental disaster, either operational staff or SMEs ;
- Shelter staff will move on-site to a state medical shelter to manage the shelter and supervise volunteers assisting with sheltering.
- Transport and equipment support staff may move equipment to the local level, set up equipment of use and regulate release of equipment for local use.

Staff mobilized to the field will be supervised from the Operations Section of the DOC and work alongside, but not integrate with, local public health staff. Joint tasks for state and local staff would be managed between the two operations centers. Often these staff will belong to an section of the agency which has been assigned to work as part of the incident command system (almost always operations), but have remained in situ. When these staff are in the field they will normally be supervised through their usual section, with tasking coming down to these staff through the chain of command.

Outside Resources

A wide range of potential resources not routinely available to ND state and local government are available for disaster assistance from North Dakota private entities, other states, the federal government and Canadian neighbors. All such resources are likely to incur substantial costs[4].

The Incident Commander will work directly with Federal partners to anticipate Federal resources that may be needed. Federal partners assist the Incident Commander to understand the nature of available resources, the response time for arrival, capability limitations, logistical requirements and anticipated cost to the state. Because mobilizable Federal assets are costly, the Incident Commander will not request to mobilize federal assets unless they are very likely to be needed. Mobilizable Federal health and medical assets include:

- NDMS teams (DMAT, VMAT, DMORT) for acute care assistance
- Federal medical station (medical sheltering)
- Field medical hospital (DOD)
- Contract ambulance services
- Public health and mental health teams

[4] National Guard resources are considered to be routinely available to support North Dakota disaster response and can be access through DES.

- Equipment for sheltering or health care provision

A variety of other mobilizable Federal assets are available for disaster response which are not specifically health and medical but may be used for health and medical applications such as helicopter rescue vehicles for evacuation of flooded health care facilities should that be necessary. In addition to mobilizable resources, a variety of other Federal resources are available to assist the state (e.g., subject matter expertise, mapping assistance, SNS resources, pharmacy assistance program) which can be accessed by a request to Federal liaisons.

An alternative to federal resources is state resources obtained through the Emergency Medical Assistance Compact (EMAC). This may include a wide range of public and private resources for health care and public health, including equipment, public health personnel, health care personnel and vehicles (e.g., ambulances). Most often these are obtained from population centers in neighboring states (MN and South Dakota). Resource sharing is also available from the province of Manitoba, although not through EMAC.

Within the state, some resources exist at private entities including health care facilities not affected by the disaster. Examples include medical equipment not carried by the state cache or hospital-owned patient transport helicopters for hospital to hospital transfer. Some of these private resources are automatically integrated into local response to disaster in their area (e.g., FM ambulance and Fargo flooding). If these resources are likely to be needed for a particular type of response, a contingency contract will be in place that can be activated without delay.

DOC Security
The level of DOC security is determined by threat assessment. If a potential threat exists for the DOC, such as during a bioterrorism event, the DOC will be locked down. The DOC will be reachable by a card access controlled elevator and the ingress using the stairs will be cut off. Stairs will continue to be available for rapid evacuation. DOC staff will be assigned identification which uses a standard EPR responder card and their driver's license. DOC staff are issued key cards which can be used to operate the elevators (during security lockdown) and building doors during non-business hours. Video surveillance is conducted of the building accessing and surrounding the DOC.

Data Sharing and Clearance
Confidential Data: The DOC avoids receiving and storing confidential data unless necessary. The data which the DOC has most often captured which is confidential is data which goes into the patient tracking system for evacuation of health care facilities. To improve the response time of facilities which are prone need to consider evacuation and for which the data is relatively stable (e.g. LTCF in areas prone to flooding), some of this data may be retained continuously in HCStandard Data Tracking Module. This data is stored on a secured network with access limited to only those who need to use the data to manage the disaster (e.g., vehicle rostering). Health care facilities are only allowed to see the data related to their own patients. Some additional documents may be created during the course of the event such as bus rosters and stored on an access limited drive in the state network. These documents are destroyed after the event is over.

Some data possessed by the DOC (or by EPRS when the DOC is not active) is for official use only, but not confidential or classified. This includes data related to vulnerabilities or response plans (e.g., SNS) which cannot be made public. EPRS takes the attitude that unless there is a compelling confidentiality issue or security issue, documents related to planning should be public. Official use only documents are stored on the secure state server either on a shared administrative drive used only in EPRS or the DOC or in a sharepoint site on the server (document library). The document library is intended to have the last and final version of any plan.

As part of the incident management process, certain information may pose no security threat or confidentiality threat, but falls in the category of "sensitive but not classified." This may include data about an event which reflects on a health care provider, community or partner which that entity would not choose to be public. Although it cannot be protected from a FOIA request, it is retained on the secure server and its disposition is discussed as part of a clearance process.

Databases with confidential data may be used as part of the response, such as surveillance systems like death or passive disease reporting which require protection, but those policies are beyond the scope of this document and covered under IRB or HIPAA rules recorded elsewhere. Some of this data is transmitted using national standard (e.g., HL-7 messaging). Sometimes data may need to be received from the field which is confidential, and secure mechanisms such as secure fax are provided for their transmission to the DOC.

Demobilization

Demobilization planning is part of the mobilization process. This is needed to ensure that resources remain accounted for, in good condition and re-deployable -- whether people or things.

Personnel demobilization – As the DOC requirements decrease, the DOC will stand down to progressively shorter hours with only EPRS staff managing the DOC. Staff will be dismissed and told when to report next to the DOC. If they are needed in the interim they will be called back in. Supervisory staff, usually part of an operation section, are responsible for immediate debriefing and identification of needs which need to be met (e.g., psychological need).

Equipment demobilization requires

- All recoverable equipment must be returned to the DOC where it inventoried, prepared for storage and redeployment, and registered into the warehouse material management system. In some circumstances, material management experts will be deployed to the field to assist with material recovery and proper handling.
- Specific staff may be deployed by the DOC to manage material that has been sent to the field. Usually this is medical or sheltering material which is dispensed to users as needed and recovered when no longer needed. The person in the field is responsible for documentation until the material is returned to the warehouse for re-inventory and storage.

Safety

It is not usual for a separate safety officer to be established for the DOC; consequently, this remains the responsibility of the IC or is delegated to operations supervisors. Safety issues are addressed routinely as part of morning planning meetings. The Planning Chief in particular is responsible for identifying issues that need to be addressed that have been overlooked and ensuring that advanced planning occurs for those contingencies. Safety protocols may be very specific to the event. For example, in H1N1, CDC provided guidance for respiratory protection and application of this guidance belonged to Disease Control. In many cases, the safety procedures depend on operational expertise which is not available in the DOC, but located in the operational sections. For instance, the safe operation of a boat for water sampling or safe operation of an air monitoring station in an environmental event exist in the Environmental Health Section. In some complicated events, an SME from an operation section in situ will be mobilized to the DOC (e.g., an environmental specialists assist with staffing the planning section) who is assigned responsibility for being a liaison back to the operational section, including ensuring safety procedures are in place.

After-Action

An after action review takes place as soon as possible after the end of the event. In some instances, multiple after actions may occur. For instance, a DOC after action may occur with NDDoH response staff only. Another may include the health care sector and another may be specific to a very active operational section (e.g., Disease Control). Many issues may come up in an after action which are not actually problems that need long term tracking. That is, the after action may still be an opportunity to air a concern (e.g., a particular HCF didn't like the time of the daily briefing). However, the agency recently began a long term tracking issue log which captures problems from exercises and events that need eventual resolution. Although items may be added tentatively, the EPRS Director will determine if an item should remain on the list. Periodic program issue meetings occur as part of routine business during which the issue list is review.

For every exercise and real event, an HSEEP compatible after action report is assigned to staff trained in their development, then forward to key EPRS staff for review before they are filed for long term documentation.