

Oklahoma State Department of Health

Oklahoma Public Health & Medical System Emergency Response Plan




Oklahoma State
Department of Health
Creating a State of Health

Version 11.0
2019

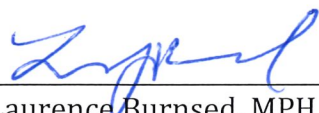
Plan Approval and Authorization

The undersigned concur with the jurisdictional and departmental features of the following
OSDH Public Health and Medical System Emergency Response Plan (ERP).



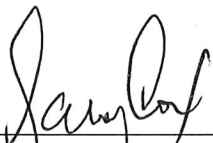
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10/17/19
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Record of Review & Changes

Description: Record of Significant Additions, Deletions, and Changes	Date/Initials
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Overview, Population - Statistics Updated • Overview, Hazards - 2011 Responses Added • Medical Response Strategy - MAC Added • Incident Management & Authority - Additional Detail on Activation Added • Notifications, Alerts, and Recalls (section renamed – previously Notifications and Alerts) - Staff Recall Information and Technical Experts Added • Response Capabilities, Public Health Emergency Operations Center/Situation Room - Updated based on AAR Feedback • Annex O, Communications SOG - Revised to Better Identify Priority of Technology Use based on AAR Feedback • Annex U - Contacts Updated • Appendix C - Updated • Appendix D - Updated <p>NEW/INCORPORATED:</p> <ul style="list-style-type: none"> • Infection Control Manual (Annex J) Added • Chemical Response (Annex M) Added 	<p>6/28-7/15/2011 (L. Jordan)</p>
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • ERP Structure Chart – Updated to Reflect New Annexes • Medical Response Strategy – Revised and Consolidated • Incident Management - Section Renamed (previously Incident Management and Authority), Language on ERP Activation Updated • Activation - Section Renamed (previously Implementation), Clarification Between ERP and Public Health Emergency Operations Center/Situation Room Activation Added <p>NEW/INCORPORATED:</p> <ul style="list-style-type: none"> • County Health Department ERPs (Annex B) Added • MERC ERPs (Annex C) Added 	<p>8/1-8/5/2011 (S. Sproat)</p>
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Scope - Modified language related to applicability. • Medical Response Strategy – Revised to better clarify the roles of MMRS, RMRS, RMPG and OSDH in medical system response. <p>NEW/INCORPORATED:</p> <ul style="list-style-type: none"> • Situation Updates and Reports Added • After Action Report Development Added 	<p>6/18-7/5/2012 (S. Sproat, S. Ames, M. Shultz)</p>

<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Communications Interoperability – Modified 800 MHz and SATCOM capability • Cover Graphics 	<p>7/6/2012 (S. Cannella)</p>
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Appendix B – updated org structure • Appendix D – updated map • Situation Updates and Reports – incorporated medical system into updates/reports (comments received from R/MMRS partners) 	<p>8/16/2012 (L. Jordan)</p>
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Situation Room Activation Levels – Modified Level 2 activation to include reference to SEOC activation at Level 2 	<p>8/16/2012 (S. Sproat)</p>
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Overview – Updated statistics • Medical Response Strategy – Updated to reflect current status of Region 2 and 4 Medical Emergency Response Centers • Communications Interoperability – Modified SATCOM capability; modified Spirit Phone capability 	<p>7/26/2013 (S.C. Cannella)</p>
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Activation – Included reference to local health department ERP activation 	<p>8/8/2013 (S. Sproat)</p>
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Appendix A – Added new acronyms 	<p>8/29/13 (S.C. Cannella)</p>
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Situation Room Activation Levels – Added the Deputy Commissioner of Prevention and Preparedness Services to the list of positions with authority to activate the OSDH EOC 	<p>12/03/13 (T. Frioux)</p>
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Situation Room Activation Levels – modified levels to align with Emergency Management and also provided a clear description for the purpose of each level and the differences between them 	<p>5/18/14 (S.C. Cannella)</p>
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Added Administrative Preparedness • ERP Structure Chart; changed Chemical to CBRNE <p>Updated OSDH Responsibilities to include initiatives assigned by the Oklahoma Department of Emergency Management in the State of Oklahoma Emergency Operations Plan</p>	<p>1/27/2015 (S. Sproat)</p>

<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Updated ICS Organizational Chart • Updated OSDH Organizational Chart • Updated County Health Districts & Homeland Security Regions Map • Changed cover page • Updated population percentages • Changed Chief Operating Officer position title to Senior Deputy Commissioner 	<p>1/27/2015 (A. Mangham)</p>
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Updated 2016 Dates • Updated ICS Organizational Chart • Updated OSDH Organizational Chart • Updated County Health Districts & Homeland Security Regions Map • Added “Deputy Secretary of Health & Human Services” title to Senior Deputy Commissioner position • Updated population percentages (pg. 5) • Updated the Communications Interoperability section (pg. 19) • Changed footer format to be consistent with other plans, SOGs, and SOPs 	<p>02/02/2016 (A. Mangham)</p>
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Changed identifying year to “version” on cover • Removed Toni Frioux and added Kristy Bradley on authorization page • Changed Deputy Commissioner to State Epidemiologist where appropriate • Changed Executive Team to Senior Leadership Team and included Chief Operating Officer and Director of State and Federal Policy (pg. 17) • Changed a sentence about the Spirit Phone system (pg. 19) • Updated OSDH ICS Organizational Chart • Updated OSDH Organizational Chart • Updated County Health Districts & Homeland Security Regions Map • Added Ebola Concept of Operations and updated the Structure Chart(pg. 3) 	<p>07/06/2016 (A. Mangham)</p>
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Updated OSDH ICS Organizational Chart • Updated OSDH Organizational Chart • Updated County Health Districts & Homeland Security Regions Map 	<p>01/30/2017 (A. Mangham)</p>

<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Added Access and Functional Needs (AFN) demographic information under the Population Section. (p. 5) • Changed Medical Response Strategy language. (p. 7) • Renamed the After Action Report Development section to After Action Report Development Protocol and changed some language. (p. 21, 22, and TOC) 	<p>05/17/2017 (S. Sproat)</p>
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Updated OSDH ICS Organizational Chart • Updated OSDH Organizational Chart • Updated County Health Districts & Homeland Security Regions Map • Added the All Hazards Disaster Behavioral Health Plan from ODMHSA to the Annex list. • Adjusted the Annex list as necessary. (p. iv) 	<p>06/19/2017 (A. Mangham)</p>
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Updated suggested corrections from Dr. Bradley. 	<p>07/05/2017 (A. Mangham)</p>
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Added information about earthquakes under Geography. (p.4) • Added a bullet under Assumptions. (p.9) • Added Office of Tribal Liaisons and Office of Minority Health to the Technical Experts and Subject Mater Experts list. (p. 18) • Added a sentence about translation services under Risk Communications. (p.21) 	<p>08/22/2017 (A. Mangham)</p>
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Corrected manmade to man-made. (p.1, 6, & 7) • Updated identified hazards list from 2016 state EOP. (p. 6 & 7) • Corrected medical and health to read health and medical. (p.7) • Added earthquakes to list of potential major disasters. (p.11) • Added “Regional” to County Health Department “Regional” Directors. (p. 13 & 14) • Corrected Command & General to Command and General. (p.14, 17, & 19) • Corrected public health & medical to public health and medical. (p.16 & 17) • Update After Action Report Development Protocol. (p.23) • Updated OSDH ICS Organizational Chart • Updated OSDH Organizational Chart • Updated County Health Districts & Homeland Security Regions Map 	<p>01/31/2018 (A. Mangham)</p>

<ul style="list-style-type: none"> • Corrected page numbers and formatting due to adding a new Record of Review & Change page. 	
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Added Tom Bates as Interim Commissioner (p. i) • Added Administrative Preparedness Plan to Table of contents and the Structure Map (p. iv & 3) • Added Medical Reserve Corp Section (p. 8) • Removed Senior Deputy Commissioner from PHEOC Activations Levels section (p.16) • Added EMAC and OKMRC activation information under the Director of EPRS section (p.18) • Removed Senior Deputy Commissioner and added State Epidemiologist under Senior Leadership Team (p.18) • Added Incident Management Team under Key Responders (p.19) • Updated OSDH ICS Organizational Chart (p.28) • Updated OSDH Organizational Chart (p.30) • Updated County Health Districts & Homeland Security Regions Map (p.32) 	<p>06/04/2018 (S. Sproat/A. Mangham)</p>
<p>MODIFIED SECTIONS:</p> <ul style="list-style-type: none"> • Added recognition of National Preparedness Goal and 32 capabilities to the Purpose (p. 1) • Added annually to the Development and Maintenance section (p. 4) • Added medical infrastructure to Infrastructure (p. 5) • Added Political Geography section (p. 5) • Updated all statistics (p.4-9) • Added summary of tribal coordination in Oklahoma Tribal Nations section (p. 10) • Updated Situation Updates and Reports (p. 16) • Updated IMT to refer to the OSDH IST (p. 21) • Updated Technical Experts and Subject Matter Experts (p. 21) • Updated Communications Operability (p. 23) 	<p>08/2019 (R. Cook, L. Jordan, J. Krawic)</p>

Note: As items are added/deleted, page numbers listed at time of modification may be slightly different over time.

Introduction

Authority

The Oklahoma State Department of Health (OSDH) is the lead agency for public health initiatives, including public health and medical systems emergency preparedness and response activities. Oklahoma statutes grant the Commissioner of Health broad authority to maintain, protect, and improve public health. Per state statute (63 O.S. 2001, Section 683.2 D), OSDH shall have written plans and procedures in place to support their responsibilities in the State Emergency Operations Plan (EOP). This Emergency Response Plan (ERP) identifies these OSDH responsibilities and supports the public health and medical care component, Emergency Support Function (ESF) #8, as required in the State EOP.

Purpose

The purpose of this ERP is to provide an effective system to mitigate against, prepare for, respond to, and recover from the effects of national security incidents, natural disasters, catastrophic health emergencies, and man-made hazards affecting Oklahoma. Such hazards could potentially cause severe illness, injury, and/or fatalities on a scale sufficient to overwhelm local public health or medical service capabilities. Cooperation with local and federal government, tribes, private entities, and volunteer service organizations is vital to execute portions of this plan. This ERP also supports the following objectives from the State EOP:

- Assign responsibility to identified state agencies/departments and volunteer service organizations.
- Define the roles of federal, state, regional, and local government entities in providing disaster relief and assistance.
- Accept guidance from the Department of Homeland Security/Emergency Preparedness and Response/Federal Emergency Management Agency (DHS/EPR/FEMA), Region VI, Denton, Texas.
- Assist other ESF's according to Appendix 2 in the State EOP.

The Oklahoma Public Health & Medical System Emergency Response Plan includes response strategies that support the public health and medical components of the 32 core capabilities specified in the National Preparedness Goal. This plan also establishes the organizational framework for the activation and management system for key OSDH activities implemented in response to hazards as described above. It is compatible with federal and state emergency response plans, promotes the coordination of an efficient and effective statewide response, utilizes the National Incident Management System (NIMS), and establishes common goals, strategies, and terminology with regional and local plans. Further, this ERP also describes the major capabilities and resources available to OSDH to address various health hazards.

Scope

This ERP applies broadly to all OSDH services, program areas, response partners and staff that may be involved in Oklahoma response and recovery activities. Key OSDH responders are expected to have a basic understanding of the following items:

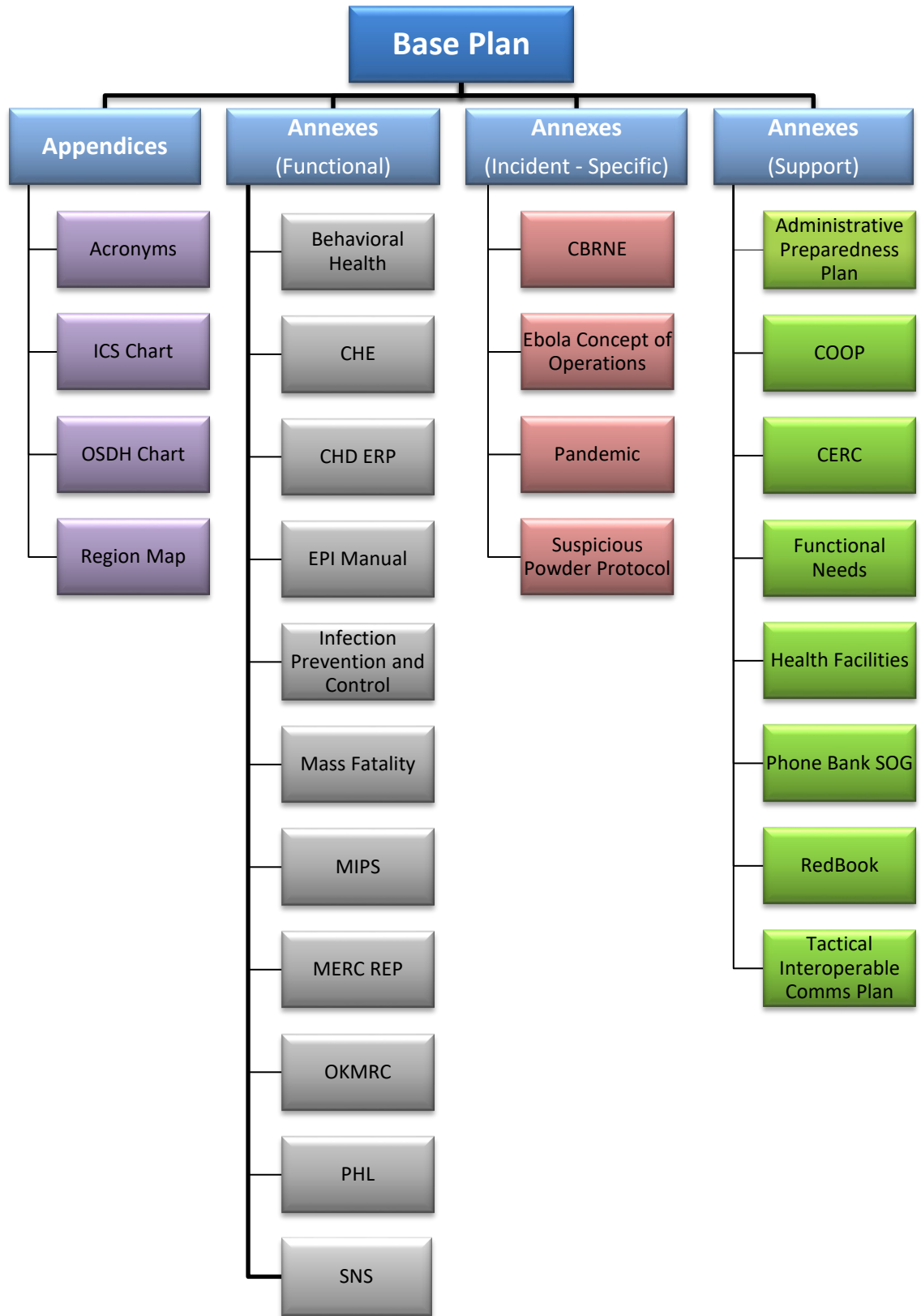
- OSDH roles and responsibilities in, and resulting from, an incident or disaster;
- The decision-making process used to activate this ERP and the State Public Health Emergency Operations Center (PHEOC) also known as the Situation Room;
- The incident management structure used by OSDH; and,
- The alert and notification process used to provide situational awareness, give instructions, and recall staff.

Structure

This ERP consists of five major sections:

1. **ERP Appendices** contain additional specific resource information (such as organizational charts and contact information.)
2. **ERP Base Plan** is an overview of agency response systems and policies. It cites the authority for emergency operations, explains the general concept of operations, and assigns roles and responsibilities for OSDH.
3. **ERP Functional Annexes** provide detailed information organized around the performance of a broad function. Each annex focuses on one critical emergency function that OSDH may perform in response to an incident.
4. **ERP Incident-Specific Annexes** provide hazard-specific information containing details applicable to a particular type of response (such as Pandemic Influenza and Suspicious Powder Protocol.)
5. **ERP Support Annexes** are procedural documents and plans that enhance this ERP and may be used when responding to different types of hazards, (such as the OSDH Phone Bank Standard Operating Guide [SOG]).

Emergency Response Plan Structure Chart



Development and Maintenance

The Director of the Emergency Preparedness and Response Service (EPRS) serves as the OSDH Emergency Response Coordinator, and is responsible for reviewing and updating this base plan annually, or as necessary, and for compiling its annexes and appendices. This ERP along with associated annexes and appendices will be maintained for purposes of correcting deficiencies identified through actual emergency response operations, exercises, and changes in structure and technology. Changes to this plan may also stem from information received from the NIMS, Oklahoma Office of Homeland Security (OKOHS), or Oklahoma Department of Emergency Management (OEM). OSDH response partners will be notified of important ERP updates and changes. An updated ERP is released every year with input from several stakeholders throughout the agency; revisions are captured in the Record of Changes table. Planning meetings are documented and documentation is available upon request.

Overview

Physical Geography

Oklahoma is a large and climatically diverse state that spans 69,903 square miles and ranks 19th largest in the nation in terms of geographic size. Its terrain is predominately plains that range from nearly flat in the west to rolling hills in the central and near east. Various hilly regions include the Wichita Mountains in the southwest, the Arbuckle Mountains in the south central, and the Ouachita Mountains in the southeast. Elevations range from 287 feet above sea level where the Little River exits in southeastern Oklahoma to 4,973 feet on Black Mesa near the New Mexico border.

The average relative humidity ranges from about 60% in the panhandle to just over 70% in the east and southeast. Prevailing winds are southerly throughout most of the state during the spring and autumn with March and April being the windiest months. The mean annual temperature over the state ranges from 62° F along the Red River to 58° F along the northern border. Temperatures of 32° F or less occur, on average, about 60 days per year in the southeast. Temperatures of 90° F or greater occur, on average, about 60-65 days per year in the western panhandle and the northeast corner of the state. Precipitation is quite variable on a year-to-year basis. The average annual precipitation ranges from approximately 17" in the panhandle to approximately 56" in the southeast.

Snowfall remaining on the ground more than a few days is an uncommon occurrence, but freezing rain is a distinct wintertime hazard in Oklahoma. Floods of major rivers and tributaries occur with greatest frequency during spring and autumn months associated with greatest rainfall. Flash flooding of creeks and minor streams remains a serious threat, especially in urban and suburban areas, where development and removal of vegetation have increased runoff. Thunderstorms occur about 55 days per year in the east, decreasing to about 45 days per year in the southwest. Tornadoes are a particular hazard as the frequency of occurrence is among the greatest in the world. Tornadoes can occur at any time of year, but are the most frequent during springtime (April – May). Oklahoma is at moderate risk for an earthquake. The Oklahoma Geological Survey Observatory records, identifies, and locates 30 to 167 earthquakes each year. (*Source: 2019 State Hazard Mitigation Plan*)

Political Geography

Oklahoma has 77 Counties, over 590 incorporated municipalities consisting of cities and towns and 38 Federally Recognized Tribal Jurisdictions.

The state government of Oklahoma is divided into an executive, a legislative and a judicial branch. The governor, the state's chief executive, has a degree of direct executive power but must share executive power with other statewide elected officers. The lieutenant governor serves as the first-in-line successor to the governorship should a vacancy occur.

In traditional Midwest fashion, counties in Oklahoma possess a moderate scope of power. As extensions of the state government, counties are primarily administrative bodies which possess executive and limited judicial powers, but not legislative powers. Their primary responsibilities are related to managing, planning and governing unincorporated land within their borders. The counties keep records of deaths, births, marriages, divorces, property ownership, and court activities within the county. The counties must also maintain a court system, law enforcement, road and bridge construction, and voter registration. Each county is divided into three districts drawn based on equal population. From each of the three districts, a county commissioner is elected independently from the other two commissioners. The three commissioners serve collegiately, with each having equal voting powers and a yearly rotating chairmanship.

Within Oklahoma there are two types of municipal governments: cities and towns. To be a city, a community must have a population of at least 1,000. Both are municipal corporations in that they can both sue and be sued, may own and sell property, create debt, and may levy and collect taxes. They are the most basic level of government in Oklahoma and are also the most accessible.

Tribal governments are an important and unique member of the family of American governments. The US Constitution recognizes that tribal nations are sovereign governments.

Sovereignty is a legal word for an ordinary concept—the authority to self-govern. Hundreds of treaties, along with the Supreme Court, the President, and Congress, have repeatedly affirmed that tribal nations retain their inherent powers of self-government. These treaties, executive orders, and laws have created a fundamental contract between tribes and the United States. Today, tribal governments maintain the power to determine their own governance structures, pass laws, and enforce laws through police departments and tribal courts.

State governments and tribal governments have a great deal in common, and established best practices in Tribal-State relationships result in there being far more cooperation at the local level than there is conflict (*see page 10 for more information on this*).

Population

Oklahoma's primary population centers include Oklahoma City, Tulsa, Lawton and Enid. Oklahoma has the second largest population of American Indian and Alaska Native people (alone or in combination with one or more other races) in the United States - estimated at 523,396. Oklahoma's population is approximately 4,035,516 and is expected to grow to 4,198,113 (4.03% increase) by 2023. Approximately 33% of the population are minorities. The percent of the population aged 65 years or older is estimated to be 14.5% and 24.6% being Age 17 or younger. The estimated number of Oklahomans with Access and Functional Needs (AFN) is 594,454 (15.34%).

(Source: 2016 CDC SVI Data, U.S. Census Bureau, Esri Population Demographics)

Infrastructure

Of Oklahoma's 77 counties, 70 counties have at least one county health department. Oklahoma and Tulsa counties are autonomous county health departments and have multiple locations within their jurisdiction while the remaining counties are covered by OSDH. There are 81 local Health Departments; other critical medical infrastructure includes 163 Hospitals, 668 Long Term Care facilities, 234 Home Health agencies, 10 Veteran Affairs Healthcare facilities, 85 Dialysis centers, 98 Primary Care facilities and 972 Pharmacies.

There are over 3,240 miles of railroad track in the state and 12,867 miles of highway (including 933 miles of the Federal interstate highway system). Interstates 40 and 44 are the principal east-west routes and Interstate 35 bisects the state going north-south. Two primary commercial airports are located in Oklahoma City and Tulsa and there are 3 ports located along the 445-mile long McClellan-Kerr Arkansas River Navigation System. Many large dams use the Arkansas and Red River systems as a source of energy. Almost all of the state's electricity is generated in plants burning coal or natural gas and the remainder comes from hydroelectric facilities. *(Sources: 2019 State Hazard Mitigation Plan.)*

Oklahoma is also home to five U.S. military installations including: Fort Sill (Lawton), Tinker Airforce Base (AFB) (Oklahoma City), Altus AFB (Altus), Vance AFB (Enid), and the McAlester Army Ammunition Depot (McAlester).

Economy

Oklahoma's Gross Domestic Product (GDP) totaled nearly \$197.5 billion in 2019. Oklahoma City, Tulsa, Lawton and Enid account for roughly 74.4% of the total state GDP. The Mining, Trade, Transportation, and Utilities sectors make up the largest portion of Oklahoma's economic output, followed by government, financial activities, and manufacturing.

Oklahoma produces a substantial amount of oil. Excluding federal offshore areas, Oklahoma was the nation's 6th-largest crude oil producing state in 2017 (at 165,920,000 barrels). Crude oil wells and gathering pipeline systems are concentrated in central Oklahoma. Two of the 100 largest oil fields in the United States are found in Oklahoma. *(Sources: Oklahoma Economic Indicators 2019)*

Hazards

The State's geography and economy, alone as described above, provide a catalyst for both natural and man-made disasters. Oklahomans experience disasters on a regular basis that test the response capabilities at the local, regional, and state level. In 2006 Oklahoma suffered through months of destructive and deadly wildfires resulting in more than 450,000 acres burned and 872 homes damaged. In 2007 alone, there were nine Presidential disaster declarations for Oklahoma, more than any other state that year. In January and December of that year, the state was impacted by ice culminating in the worst power outage in state history. In August 2008 several hundred people became ill, and one died, from E. coli O111 after eating at a restaurant in a rural area of northeastern Oklahoma. In May 2009 a novel swine-origin H1N1 virus was identified in Oklahoma resulting in a year long, statewide response to that pandemic. In December 2009, on Christmas Eve, central Oklahoma was visited with one of the largest snowfalls on record for the state, a blizzard that virtually shut down Oklahoma City and froze much of the emergency response community in place. In January 2010 a major ice storm blanketed most of Oklahoma's Region 3 and parts of Region 6/8 causing widespread power outages, damage and injury. In February 2011, central and northeastern Oklahoma were hit with two major winter storms resulting in numerous transportation challenges affecting medical system staff and patients. In 2012, Oklahoma was impacted by drought and numerous wildfires impacting several communities across the state. Oklahoma continues to have the distinction of being the site of more tornado events than any other place in the world. In May 2013, central Oklahoma was ravaged by two EF-5 tornadoes resulting in a large number of deaths and injuries. The second EF-5 set a record for the widest tornado ever recorded. May 2019 was the most active tornado month in Oklahoma to date, with 103 confirmed tornadoes. On top of the tornadoes, historic ravine and flash flooding occurred throughout the state; every county in the state was under a state of emergency. This significantly affected the health and medical system with several injuries, evacuations and closures occurring.

Oklahoma is also not a stranger to terrorist attacks. On April 19, 1995 Oklahoma, and the country as a whole, changed forever when the Alfred P. Murrah Federal Building in downtown Oklahoma City was destroyed by a truck bomb that took the lives of 168 people. In 2005, though the exact intent may never be known, a college student was killed when an Improvised Explosive Device (IED) detonated only steps away from a college football stadium filled with more than 85,000 people. Federal, state, and local authorities remain concerned about a number of groups located and doing business in Oklahoma that include extremist fringe groups fighting in the name of Islam, eco-terrorists, white supremacists, and militias.

OEM maintains a state-level Hazard Analysis as Appendix 1 to the state EOP. This analysis lists natural disasters associated with severe thunderstorms (tornadoes, floods, hail, and strong winds) as having the greatest damage potential and highest probability of occurrence. The other hazards identified in the analysis include:

- Acts of Terrorism
- Air Transport Accidents

- Civil Disorders
- Dam Failures
- Droughts
- Earthquakes
- Expansive Soils
- Extreme Heat
- Flooding
- Gas and Oil Well Blowouts
- Hail
- High Winds
- Highway Hazardous Material Incidents
- Landslide
- Levee Failure
- Lightning
- Medical Emergencies/Epidemics
- Pipeline Hazardous Material Incidents
- Power Outages
- Radioactive Fallout
- Railway Hazardous Material Incidents
- River Hazardous Material Incidents
- Severe Winter Storms/Ice/Freezing Rain
- Special Event
- Stationary Hazardous Material Incidents
- Subsidences/Sink Holes
- Tornado
- Water Shortage
- Wildfires

(Source: 2019 State of Oklahoma Emergency Operations Plan)

Medical System Response Strategy

The Commissioner of Health is responsible for coordination of all state health and medical services in response to man-made or natural emergencies. The Governor, the Director of Emergency Management, and the Director of the Oklahoma Office of Homeland Security are kept informed of the status of health and medical services during emergency operations. Local health department directors are responsible for monitoring and supporting medical system response activities within their assigned jurisdiction. The philosophy adopted by Oklahoma is that each community, regardless of size, should have a basic capability to respond to any type of disaster. To facilitate public health and medical system planning and coordination, Oklahoma is divided into eight public health and medical systems regions. Each region is represented by its own regional healthcare coalition (HCC). The HCC is empowered to develop medical system response plans and protocols, as needed, supporting the Medical Surge Capacity and Capability (MSCC) concept, and serves as the principal planning group for the Regional Medical Response System (RMRS). The MSCC methodology is based on valid principles of emergency management according to the NIMS

and serves as the basis for all public health and medical response for Oklahoma. The MSCC provides a management system that maximizes the ability to provide medical evaluation and care during incidents that exceed the normal medical capacity and capability of an affected community. The ability to provide adequate medical care under such circumstances is called medical surge. Medical surge is largely determined by the medical system's surge capacity (the ability to respond to a markedly increased number of patients) and surge capability (the ability to address unusual or very specialized medical needs). Oklahoma strategies to enhance medical surge are rooted in interdisciplinary coordination and based at the local level. OSDH assigns primary responsibility for medical system emergency response coordination to the RMRS during times of disaster. The RMRS was created by OSDH starting in 2005 to develop and coordinate HCCs in each sub-state region of Oklahoma. RMRS operates a Medical Emergency Response Center (MERC) designed to serve as the medical system emergency operations center for the region during times of crisis. The MERC functions as a component of the regional Multi-Agency Coordinating (MAC) system during emergencies that necessitate response coordination across multiple jurisdictions or counties within a sub-state region. The OSDH PHEOC/Situation Room monitors and supports medical system response activities in all regions of the state.

Oklahoma Medical Reserve Corps

The Oklahoma Medical Reserve Corps (OKMRC) was created as a component of the National Medical Reserve Corps (MRC) Program which was launched in July 2002 by the Office of the U.S. Surgeon General in response to President George W. Bush's call for Americans to offer volunteer services in their community. The objective of the MRC program is to create a national network of local, community based groups of medical, public health, and other volunteers who are organized and utilized to prepare for and respond to all-hazards, as well as to provide public health support throughout the year. At the national level, the MRC Program Office facilitates efforts to establish and implement local MRC units across the country (Public Law (PL) 107-188, the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Section 107).

The OKMRC is a statewide program managed by the OSDH with collaborative assistance from the Tulsa Health Department (THD); the Oklahoma City/County Health Department (OCCHD); the University of Oklahoma, College of Nursing (OUCN); and the Choctaw Nation of Oklahoma. The vision of the OKMRC is to enhance emergency preparedness and response capabilities by supplementing existing response infrastructures in local communities across the State of Oklahoma. The MRC mission is to engage volunteers, strengthen public health, emergency response, and community resiliency.

The OKMRC provides support for incident response by augmenting medical and public health personnel when local resources are overwhelmed or exhausted. The OKMRC is comprised of specialty teams and county units operating under the authority of local county health departments. The Choctaw Nation MRC Unit operates under the sovereignty of the Choctaw Nation, and as an affiliate of the OKMRC. Activation of the OKMRC is driven by a request from a collaborative partner and depends upon the size, scope, and nature of an incident or event. OKMRC volunteers are utilized according to their training and capabilities.

The OKMRC does not act as a freestanding medical resource and must be integrated into an established incident command systems (ICS). Self-deployment and the contacting of individual members by outside agencies are strictly prohibited and can negatively impact overall response.

Tribal Nations

OSDH continues to strengthen relationships with the tribal nations in the state, many of whom have very robust health and response systems. Agreements for coordinated responses to disease outbreaks have been created with the Chickasaw and Cherokee Nations. Depending on the location of the suspect case, resources may be shared for investigation and testing. Further, a Joint Information System will be established to ensure a coordinated message is provided.

Situation

This ERP highlights the pivotal role of the public health and medical systems in emergency preparedness and response. A major statewide emergency that may cause numerous fatalities, severe illness, and/or injuries, disruption of normal life systems and possibly property loss will have a powerful impact on Oklahoma's economic, physical, and social infrastructures. To prepare for and respond to an emergency of great severity and magnitude will require rapid response surveillance, dependable communication systems, a trained and available workforce, and volunteers to help perform essential tasks. All these efforts must be anticipated and coordinated according to NIMS protocols.

Oklahoma recognizes a Catastrophic Health Emergency (CHE) as an occurrence of imminent threat of an illness or health condition that:

- 1) Is believed to be caused by any of the following:
 - Nuclear attack,
 - Bioterrorism,
 - Chemical attack, or
 - Novel or previously controlled or eradicated infectious agents or biological toxins, and

- 2) Poses a high probability of any of the following harms:
 - Large numbers of deaths in the affected population,
 - Large numbers of serious or long-term disabilities in the affected population, or
 - Widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people in the affected population.

[As defined in O.S. § 63.6104]

Assumptions

- A major statewide emergency that may cause numerous fatalities, debilitating illnesses or injuries, property loss, and disruption of normal life support systems and possible health care property loss will have a large negative impact on the statewide economic, physical, and social infrastructures.

- The all-hazards approach to planning and implementing response efforts has the greatest chance of providing a successful outcome.
- Release of a biological, chemical, nuclear, radiological, or incendiary agent will result in public health hazards.
- Resources in a local or regional affected area will be inadequate to respond to a large-scale emergency; state assistance will be required.
- OSDH has planned, prepared for, and will respond to any emergency adversely impacting the public's health in any part of Oklahoma.
- Disruption of sanitation services, loss of power, and amassing of people in shelters will increase risk of disease and injury.
- Primary medical treatment facilities may be damaged or inoperable; statewide coordination will be required.
- An intentional release/attack using infectious or chemical agents may not be recognized as a Weapons of Mass Destruction (WMD) or terrorist event. The first indications of such an attack may be upon manifestation and recognition of the first medical symptoms occurring hours to days later.
- A natural emergence and spread of a virulent infectious disease agent would create a public health emergency similar in impact to that caused by a WMD.
- It is of the utmost importance to ensure the healthcare system is alerted to potential or realized threats in a rapid and timely manner. Only then can providers take appropriate action to promptly recognize and treat exposed and ill individuals and limit the potential for others to be affected. Required actions may include decontamination, medical treatment, medical countermeasure prophylaxis (antibiotics, antivirals, vaccines, antidotes, or chelating agents), and isolation.
- Terrorist incidents may involve damage or disruption to computer networks, telecommunication systems, or internet systems. In addition, disruption of vital community networks for utilities, transportation, and/or communication could endanger the health and safety of the population.
- Extensive media interest in a terrorist event will necessitate media management operations and resources beyond those needed for most other emergency management operations.
- Medical standards of care may be adjusted in a major incident or catastrophe.
- OSDH may make recommendations regarding prioritizing who receives prophylaxis or treatment, and will look to the federal government for guidance on such matters.
- The degree of OSDH involvement in a response to a given incident will depend largely upon the applicability of specific OSDH authorities and its jurisdiction.
- Public health officials who are prepared to address the cultural needs of communities affected by adverse events can be instrumental in reducing people's psychological distress and meeting the community's needs to recovery effectively. OSDH is committed to exercising an inclusive and integrated approach to disaster and emergency preparedness, response, and recovery activities that ensures that culturally and linguistically diverse populations are not overlooked or misunderstood. Cultivating a working knowledge of different health and illness related beliefs, customs, and treatments of cultural groups can better equip public

health responders with the information necessary to provide timely and appropriate services. Additionally, it is important to maintain the ability to adapt and as appropriate, to modify, the services offered to fit the cultural context of the patients and communities that we are serving.

Concept of Operations

Activation

In the event of a statewide or local emergency affecting the public's health, OEM, acting on behalf of the Governor, may order the Commissioner of Health to implement all or a portion of this ERP. When the Governor declares a "State of Emergency," the State Emergency Operations Center (SEOC) is typically activated and all needed ESF Liaison Officers and appropriate personnel quickly report to the SEOC. If the emergency threatens Oklahoma's Health and Medical Community Lifeline, then OSDH will activate the PHEOC/Situation Room and initiate this ERP to coordinate public health and medical system response actions in order to stabilize the Health and Medical Community Lifeline. When this ERP is activated at the state level, the impacted local health department staff and local health department ERP are automatically activated.

In addition to a declared state of emergency involving health, the Commissioner of Health may determine, based on information from a variety of possible sources, that it is necessary for OSDH to initiate this ERP.

The following items are possible intelligence sources:

- Suspicious results from Public Health Lab (PHL) sample analyses;
- Results from surveillance systems;
- Alerts or requests for assistance from local agencies or other external sources;
- OSDH staff observations;
- Media reports;
- EPRS Duty Officer;
- Centers for Disease Control and Prevention (CDC);
- Office of Homeland Security; and
- Oklahoma OEM

This ERP is initiated by written or electronic notification at the discretion of the Commissioner of Health. In addition to a declared state of emergency, the Commissioner of Health can initiate this ERP in response to an event significantly impacting, or with the potential to significantly impact, the public's health. Thresholds for activation of this ERP may include:

- A public health threat that exceeds, or is predicted to exceed, the capacity of an individual OSDH service;
- A public health threat that requires the engagement and coordination of multiple services from across the agency;
- A public health threat that requires the engagement and coordination of other state agencies and/or non-governmental entities;
- A mass casualty incident that exceeds local capacity;

- A major disaster such as a tornado, winter storm, wildfire, earthquake, or flood that damages community infrastructure (hospitals, transportation system, utilities, etc.) causing major public health impacts, environmental disease, or injury;
- A bioterrorism incident – suspicion, alert or actual occurrence of any size;
- An event that has a worsening prognosis, potential for rapid growth, and/or major impact on the public’s health and safety; or
- An event that has, or has the potential to have high public, media or political interest.

Administrative Preparedness

Administrative preparedness is the process of ensuring that fiscal and administrative authorities and practices that govern funding, procurement, contracting, hiring, and legal capabilities necessary to mitigate, respond, and recover from public health threats and emergencies can be accelerated, modified, streamlined, and accountably managed. The goal of administrative preparedness is advance planning to remove administrative barriers that prevent timely distribution and utilization of funds during a public health emergency for the purpose for which they are intended, that being to save lives, reduce morbidity and minimize disruption of the public health and medical system. These processes include emergency procurement, contracting, and hiring processes.

OSDH has implemented an administrative preparedness plan (Annex P) that employs a number of authorities and mechanisms that enable the agency to expedite operational, logistical and fiscal processes in order to effectively respond to public health threats. Under existing authorities, OSDH is able to receive and distribute federal emergency funds and can implement expedited processes to meet shortened application timelines with or without an official emergency declaration. OSDH has established processes that allow for authorization of emergency funds to local health departments, as well as reporting and monitoring methods to ensure accountability.

In addition, Oklahoma has the ability to reduce the standard time cycle to award contracts and purchase goods and services during times of emergency. OSDH also has a process in place designed to reduce the time cycle for hiring and/or immediate reassignment of existing staff in order to effectively deal with emergency situations.

OSDH works with the Oklahoma State Board of Pharmacy to minimize potential conflicts between emergency use authorizations (EUA) and state-based pharmaceutical, prescribing, labeling, and other drug-related laws.

Incident Management

All agencies, departments, and organizations having responsibilities delineated in this ERP will use the NIMS as a systematic, proactive approach to work together seamlessly to prevent, protect against, respond to, recover from, and mitigate the effects of incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life and property and harm to the environment. NIMS works with the National Response Framework

(NRF) which provides the structure and mechanisms for national-level incident management.

The ICS serves as the operating protocol for all OSDH responses. In order to effectively carry out this ERP and the related plans noted in its annexes, OSDH staff will maintain ICS proficiency as directed by the Commissioner of Health. The agency ICS organizational structure, when implemented (refer to Appendix B), is scaled appropriately to meet the needs of an incident. 'Scaling' refers to the notion that as an incident evolves, the level of activation, the type and number of staff, and the type and number of resources will be appropriately adjusted in order to effectively manage the incident.

An authority memo and/or delegation of authority, if applicable, will be posted by the PHEOC/Situation Room and shall include the following elements:

- Who initiated the activation/recall;
- The initial level of activation;
- The time of activation;
- Brief description for activation;
- Identify initial ICS elements to fill; and
- Identify subject matter experts (SMEs) required, if known.

Upon activation, OSDH makes appropriate notifications for a potential or realized public health threat, implements an ICS structure, and stands-up the PHEOC/Situation Room according to standardized activation levels.

Situation Updates and Reports

Defining the public health impact of an incident or event is a core Public Health and Healthcare Preparedness Capability and is critical to establishing situational awareness at the local, regional, state and federal level.

- Within a reasonable timeframe of any incident or event impacting a community, an initial assessment must be reported by a local health department emergency response staff with the County Health Department Regional Director, Local Emergency Response Coordinator (LERC), Regional EPRS Team/District Coordinator, jurisdictional Medical Emergency Response Center, and the PHEOC/Situation Room. In order to rapidly communicate the scope, complexity and interdependent impacts of an incident or event, the initial situation report should include:
 - General Location and Description of the Incident or Event
 - Type of Public Health and/or Medical System Components directly and/or indirectly affected (e.g. None, Hospitals, Emergency Medical Services, Long Term Care Facilities, etc.).
 - Status of Components (e.g. stable, damaged, destroyed, communications down, no water, no power, etc.).
 - Scope of Impact (e.g. unable to treat/care for patients, understaffed, etc.).

- Actions Currently Being Taken (e.g. staff activation, moving vaccine, running of generator, closing facility early, bottled water distribution, etc.).
 - Limiting Factors (e.g. lack of resources, roadways are blocked, policies/procedures, etc.).
 - Estimated Time to Stabilization (e.g. 1 hour, 2300, unknown, etc.).
 - Impacts on other Community Lifelines (i.e. Safety & Security, Sheltering, Energy, Communications, Transportation, and Hazardous Material).
 - Resource/Support Requests
- Initial situation reports/assessments can be submitted in several ways outlined below:
 - Utilizing the ArcGIS Situation Report/Notification Application
 - Emailing the OSDH PHEOC/Situation Room (sitrm@health.ok.gov)
 - Phone Call (405-271-0900)
 - 800 MHz/VHF Radio (Channel OSDH 1)
 - Upon receipt of the initial situation report, the OSDH Emergency Manager or Duty Officer will notify the OSDH EPRS Director by phone and/or forward a copy of the report. The OSDH Emergency Manager or Duty Officer will also notify applicable agency staff in Protective Health Services if any hospitals, medical specialty facilities, nursing homes or long term care facilities are impacted. The EPRS Director is responsible for assessing the information contained in the report and notifying OSDH senior leadership and other applicable agency staff.
 - When appropriate, routine updates must be generated by local health department emergency response staff that provides a detailed update of the impact to the Health and Medical Community Lifeline in the affected community/area. Updates can be provided in several ways outlined below:
 - Replying to the existing Situation Report Email
 - Phone Call and/or Radio
 - Updating the Incident Report in the Spatial Analysis Tool (ArcGIS)
 - At all times, the County Health Department Regional Director, LERC, Regional Response Teams/District Coordinator, MERC, and the OSDH PHEOC/Situation Room must be notified on updates to ensure appropriate situational awareness and coordination.

Public Health Emergency Operations Center/Situation Room Activation Levels

In the event that the PHEOC is activated (or at the discretion of the Commissioner of Health, the State Epidemiologist or the EPRS Director), support staff and SMEs may be placed on alert and required to report to the PHEOC.

The PHEOC operates at one of four levels:

LEVEL 4: No immediate threats to the health and medical community lifeline.

Level 4 is the normal operation mode for the PHEOC. Monitoring of weather, media, and other intelligence sources for potential threats to Oklahoma's Health & Medical Community Lifeline is a standard task. Possible threats or intelligence with a potential health or medical system impact should be immediately reported to the PHEOC Duty Officer or EPRS Director who will take action if needed.

LEVEL 3: Partial Activation of the PHEOC due to a potential threat to the health and medical community lifeline.

Level 3 indicates that the PHEOC is closely monitoring a potential threat and is taking steps to prepare equipment, staff, and resources. Key personnel within EPRS and ICS staff are notified and assigned any applicable tasks. Common tasks at Level 3 include verifying inventory, checking staff availability, and performing equipment and go-bag checks. Health and medical agencies, facilities, and partners should be on alert.

LEVEL 2: Full-Scale Activation of the PHEOC due to an immediate threat to the health and medical community lifeline.

Level 2 indicates an emergency exists having a confirmed impact to the Health & Medical Community Lifeline and Command and General staff as well as key PHEOC support personnel are typically activated. A 24-hour operational period may be established and the Communications Center is staffed accordingly. An ESF-8 liaison officer will deploy to the SEOC as necessary. Health agencies, facilities, and partners that are impacted should perform communications checks and report their status to the MERC. Agencies, facilities, and partners that are not directly impacted should be ready to receive notifications and provide assistance.

LEVEL 1: Full-Scale Activation of the PHEOC due to a major impact to the health and medical community lifeline.

Level 1 indicates a major emergency exists with widespread and severe impact to Oklahoma's public health and medical community lifeline. All Command and General staff as well as key PHEOC support personnel are recalled for duty. A 24-hour operational period is established and the OSDH Communications Center is staffed accordingly. An ESF-8 liaison officer will deploy to the SEOC. All health agencies, facilities, and partners should perform communications checks and report their status to their MERC.

As an event evolves, the activation level, the type and number of ICS and PHEOC staff, and the type and number of resources will change in order to effectively manage the event.

Notifications, Alerts, and Recalls

Upon notification of a potential or realized threat, a determination on ERP activation will be made by the Commissioner of Health or designee. The designated Incident Commander (IC) will issue posting orders regarding elevations and decreases in activation levels as they occur. The ICS organization structure will also be included so agency employees have adequate situation awareness to be responsive to Command and General staff needs.

If the Commissioner of Health determines ERP activation is not necessary, informational meetings about the situation may be called by the EPRS Director or an individual monitoring the situation. If ERP activation is warranted, the Commissioner of Health, the State Epidemiologist, and the EPRS Director will assess the situation in detail and address these priority tasks:

- Determine the appropriate PHEOC operation level (1-4);
- Create and post a Delegation of Authority letter for the incident;
- Appropriately scale the basic ICS chart and send out recall notifications;
- Set time intervals for future briefings or updates for executive staff;

The Commissioner of Health, the State Epidemiologist, or the EPRS Director typically initiates a recall. All ICS staff, subject matter experts, and other key staff are subject to practice recalls to ensure the effectiveness of OSDH recall procedures and equipment. Staff will 'listen to' or 'read' recall notifications carefully since the notification may provide additional instructions such as a specific number to call, location to report (usually the PHEOC), time to report, and specific items to bring.

Transportation to and from the PHEOC, or designated duty station, is the responsibility of each individual. If inclement weather or other conditions hinder reporting to assigned duty stations, the PHEOC and ICS supervisor must be notified of delays. Options may allow the person to report by conference call or arrangements may be made for transportation to pick up the individual.

Organizational Roles

OSDH is the agency responsible to ensure and provide essential public health and medical services during times of emergency. OSDH shall identify a minimum of three (3) qualified liaison officers to the SEOC as required by the Director of OEM acting on behalf of the Governor of Oklahoma. Further, OSDH will ensure that it has sufficient trained personnel, with routine decision-making authority, to provide the SEOC with a 24-hour capability for extended periods.

OSDH Responsibilities

The Commissioner of Health is designated as the principal official responsible for leading Oklahoma's ESF-8 initiatives as assigned by the OEM in the State of Oklahoma EOP. Responsibilities include the following items:

- Consult with local officials, hospitals, and other health and medical facilities as appropriate to determine the magnitude and extent of public health/medical problems associated with a catastrophic disaster and assist local public health officials in developing appropriate strategies to address such problems;
- Define the types and amounts of public health and medical assistance required by state, local, and private health and medical organizations, developing specific requests for assistance through ESF-8, including medical personnel, equipment, and supplies;
- Determine resources needed to move patients to definitive care facilities that are part of the National Disaster Medical System (NDMS) network;
- Assist public health and environmental efforts through the use of state laboratories for micro-bacteriological and chemical analyses;
- Organize, operate, and supervise mass countermeasure distribution and dispensing to the general public or selected populations through the Oklahoma Strategic National Stockpile (SNS) plan and Mass Immunization and Prophylaxis Strategy (MIPS) plans;
- Conduct and oversee public health investigations including surveillance, epidemiologic and environmental investigations in collaboration with federal, state agency, local public health, hospitals, and medical provider partners; and
- Coordinate and ensure public health intervention including antibiotics or other medical preventive treatment, vaccination, isolation, quarantine, and advice to the public regarding personal protection in collaboration with local public health, hospital, medical provider, and federal partners.

Key Responders

The following OSDH positions are those staff primarily responsible for the execution of this ERP and will perform critical functions in a public health and/or medical systems response:

Commissioner of Health: As the lead health official for Oklahoma, the Commissioner (or designee) authorizes activation of this ERP. The Commissioner of Health also serves as liaison to the Governor's Office; requests opening of the PHEOC, if necessary; acts as chief

spokesperson for OSDH, unless otherwise delegated; has ultimate responsibility for overall OSDH response and recovery goals as identified in agency Incident Action Plans (IAP), and approves out-of-state deployments of agency staff, incident management teams, and OKMRC volunteers under Emergency Management Assistance Compact (EMAC).

Director of Emergency Preparedness and Response Service: As the lead emergency response coordinator for Oklahoma public health and medical systems preparedness activities, the Director of EPRS manages six Regional Response Teams (Regions 1 - 6), coordinates agency preparedness and response activities with RMRS agencies and HCCs, activates and deploys the OKMRC at the state level, maintains and activates the PHEOC/Situation Room, coordinates and executes the SNS and MIPS plans, coordinates and manages all out-of-state EMAC deployments of agency staff, incident management teams, and OKMRC volunteers, and maintains and executes this ERP.

Senior Leadership Team: This group includes the Commissioner of Health, State Epidemiologist, Deputy Commissioners, Chief Operating Officer (COO), Chief Financial Officer (CFO), and the Director of State and Federal Policy. This team has overall responsibility of the entire health department and communicates with the Governor's Office as required. Members of this group may or may not be active within the current ICS structure.

Command and General Staff: The Command and General staff operate using the principles of the ICS to achieve the goals and objectives outlined in approved agency IAPs. Qualified individuals are pre-identified to fulfill key ICS positions three or more deep to ensure the PHEOC may be activated at any time and for any duration in order to meet any health threat. A guiding principle of ICS emphasizes when setting up an ICS structure that the correct person to fulfill an ICS position is the most qualified for the critical task on hand and not necessarily the highest ranking.

Regional Preparedness and Response Teams: Public Health and Medical System Regions (1-6) operations, coordination, planning, and exercises are the primary responsibility of Regional Preparedness and Response Teams. Regional Preparedness and Response Team members will typically comprise the primary staff of regional MACs when activated. These teams are under the supervision of the EPRS Director and are comprised of Emergency Response Planners and Nurses.

EFS-8 Liaison Officer: The Public Health and Medical Services liaison officer (ESF-8) provides the mechanism for coordinated federal assistance to supplement state, tribal, and local resources. This function considers how to best service a population whose members may have medical and/or public health needs before, during, and after an incident. An ESF-8 liaison provides coordinating assistance to state, tribal, and local governments in the following core areas:

- Agriculture safety and security
- All-hazard public health and medical consultation, technical assistance, and support
- Assessment of public health and medical needs

- Behavioral health care
- Blood and blood products
- Food safety and security
- Health surveillance
- Health/medical/veterinary equipment and supplies
- Mass fatality management, victim identification, and decontaminating remains
- Medical care personnel
- Patient care
- Patient evacuation
- Potable water/wastewater and solid waste disposal
- Public health and medical information
- Safety and security of drugs, biologics, and medical devices
- Vector control
- Veterinary medical support

OSDH Incident Support Team (IST): The OSDH IST is designed to support jurisdictional response efforts. The purpose of the IST is to assist any jurisdiction confronted with an incident beyond its capabilities in either complexity or duration. The makeup of the IST will depend upon the size, scope, and nature of an incident or event. The IST will be composed of credentialed staff, and can also include Trainee's who meet the minimum training requirements. The Director of EPRS will assemble, activate and deploy an IST at the request of the Commissioner of Health, Senior Leadership Team member, or a Regional Health Director. The IST offers the following capabilities to an incident:

- A robust management framework to support the jurisdiction in bringing an incident to conclusion
- Planning and documentation to include assistance in development of IAPs, Site Safety Plans, etc.
- Logistical support and resource management
- Liaison Support
- Operational support and expertise

Technical Experts and Subject Matter Experts: Representatives from the following areas may be designated as Technical Experts during activations and asked to report to the PHEOC in person, or when authorized, may participate in ICS meetings by conference call.

- Acute Disease Service
- Administrative Services
- Community Health Services
- Consumer Health Service
- Emergency Medical Systems
- Family Health Services
- Immunizations Service
- Informatics Division

- Injury Prevention Service
- Long Term Care
- Medical Director
- Mental Health
- RMRS
- Office of Minority Health
- State Epidemiologist
- Office of Tribal Liaisons
- Oklahoma Medical Reserve Corps
- Others as required by circumstances of the emergency
- Pharmacy
- Protective Health Services
- Public Health Laboratory
- Radiation (Dept. of Environmental Quality)
- Safety/Security
- Strategic National Stockpile

Response Capabilities

Public Health Emergency Operations Center /Situation Room

The PHEOC functions as the state Public Health and Medical System EOC during times of emergency. During an incident, Command and General staff utilize the PHEOC for gathering intelligence and information, disseminating critical health information, analyzing data and the response, and acquiring, allocating, and disseminating critical health resources. The PHEOC coordinates with the SEOC through the ESF-8 Liaison Officer, local health departments, and regional Multi-Agency Coordination (MAC) groups if activated. The PHEOC is outfitted with multiple audio, visual, and information systems to support the public health and medical system decision-making process. Critical communication is provided and available at all times through multiple redundant communications systems as described below.

Communications Interoperability

Effective communications allows for an accurate and “common operating picture” of an incident to be created and shared by collating and gathering pertinent information to support decision-making. A standardized message form and log are utilized for prioritizing and tracking resource requests and dissemination of decisions and policies affecting the execution of the IAP. Successful communication is reasonably ensured when systems are interoperable, reliable, scalable, portable, resilient, and redundant. In this endeavor, the PHEOC employs the following communication and information management/sharing systems:

- The ArcGIS Gallery is accessible 24/7 by several stakeholders throughout the state. Although not mandatory; the PHEOC/Situation Room strongly advises staff and partners to utilize the system to ensure the most accurate and updated info is shared. This is the best method to establish and maintain a common operating picture across the state.
- Email is monitored 24/7 by the PHEOC Duty Officer to ensure timely responses to any health threat.
- Cellular devices are issued to response staff and allow for both voice and email messages in the field.
- Government Emergency Telecommunications Service (GETS) is a nationwide priority telecommunications service intended for use in a crisis, disaster or other emergency when the probability of completing a landline call has significantly decreased.
- The PHEOC is setup with three priority lines through the Centrex system.
- Two fax machines provide additional support to OSDH. One fax machine directly serves the PHEOC and it is located in the OSDH Communications Center. The other fax machine is located in the OSDH Phone Bank.
- WebEOC® by Juvare, is an information management and information sharing platform that is implemented statewide.
- EMResource® is a web-based information tool that enhances medical system responses to emergencies.
- OSDH web site posts important incident information for the public.

- A dual-band (800 MHz & VHF) capable radio system serves as the primary communication system for Command and General staff. It also serves as the backup method of communication between the PHEOC/Situation Room, Regional Staff and LERCS. The OSDH Communications Center has two base stations, and 45 handheld radios issued out across the state.
- Three handheld Satellite phones are available as needed.
- National Public Health Radio Network (NPHRN) is a CDC high frequency (HF) emergency radio system that allows unsecured external voice and data communications with the CDC and other key health entities.
- OSDH maintains a Phone Bank (refer to Annex U) that can accommodate up to 15 operators to handle a large volume of public health inquiries and/or support epidemiologic investigations.
- The RedBook (Annex V) is an indexed red binder of emergency contacts provided to key responder staff. This contact book is verified, updated, and distributed by the OSDH Communications Center on a regular basis and can be found in the Gallery.
- Swift 911 is used to rapidly notify key staff on activation.
- Oklahoma Health Alert Network (OK-HAN) securely communicates critical health information to key partners, quickly recalls staff, and conducts surveys.

Risk Communications

The tragedies of September 11, 2001 and the continuing threat of terrorism reemphasized the need for public officials to communicate effectively with the public and the media to deliver messages that inform without frightening, and educate without provoking alarm. Risk Communication addresses this issue and is defined as the exchange of information and opinion among individuals, groups, and institutions. It often involves multiple messages about the nature of risk or expressing concerns, opinions, or reactions to risk messages, or to legal and institutional arrangements for risk management (*Source: U.S. Department of Health and Human Services. Communicating in a Crisis: Risk Communication Guidelines for Public Officials, Washington, D.C., 2002*)

The Crisis and Emergency Risk Communications (CERC) Plan (refer to Annex R) details media actions for OSDH in the event of a bioterrorism, nuclear, chemical, pandemic, or other health emergency. Timely, consistent, and accurate communications positively impact how the media, general public, and clinical health care communities react to an incident. This ERP presumes that it is in the agency's best interest to take a pro-active approach to public relations in an emergency situation and the preferred strategy will be one of forthcoming disclosure of confirmed information as soon as it becomes available. By doing such, the agency will minimize speculation and inaccurate reporting, and instead foster trust and support for agency efforts. In addition, the OSDH Office of Communications has procedures in place for translation services as required based upon the situation.

Investigations

The goal of public health investigation in an emergency is to gather information to drive public health intervention and communication. Tools of public health investigation include these items: surveillance, epidemiological and laboratory investigation, environmental

investigation, and communication with other investigative partners and persons who may have been exposed (refer to Annexes D and J). Depending on the nature and extent of an incident, a number of investigative strike-teams may deploy throughout the state and coordinate with the OSDH PHEOC/Situation Room.

Interventions

The overall goal of public health intervention is to minimize morbidity and mortality during a health emergency. Medical methods (treatment, prophylaxis, and vaccination) and physical separation methods (isolation, quarantine, social distancing, and personal protection) are used to prevent disease in those exposed and/or to limit the potential for exposure in those not yet exposed. While the medical care system generally deals with ill individuals, potential illness, and prevention of exposure within medical settings, the public health system typically focuses on prevention strategies within the community and addressing the overall health needs of the affected population.

After Action Report Development Protocol

Evaluation of a response is the fundamental basis for improvement planning because it assesses an entity's performance in an exercise/event/incident and identifies strengths and areas for improvement. After Action Reports/Improvement Plans (AAR/IPs) provide concrete steps that an entity can take to remedy deficiencies or shortcomings observed. Understanding the importance of this process, OSDH completes AAR/IPs for all responses that meet one of the following triggers:

- Activation of the OSDH ERP in response to any public health emergency including disease outbreaks, environmental public health hazards, natural disasters, terrorist attacks or other public health threats including, but not limited to:
 - Disease outbreaks that require coordinated efforts of multiple OSDH service areas outside of the OSDH Acute Disease Service (ADS), or exceed the day-to-day capacity of ADS.
 - Environmental health hazards that require coordinated engagement of multiple OSDH service areas.
 - Response efforts that require activation of the OSDH Phone Bank.
 - Response efforts in support of federal, state, tribal, and/or local partners.
 - Upon issuance of a Delegation of Authority by the Commissioner of Health.
 - Upon activation request by the Director of OEM.
 - Upon issuance of a Disaster Declaration by the Governor.
- Multi-jurisdictional responses within the state, or within FEMA Region VI (Texas – Arkansas – Louisiana – Oklahoma – New Mexico).
- Events that require activation of a MERC at Level 2 or higher.
- Events that require deployment of public health emergency cache assets.

Incident Command will debrief the responders following a response. This facilitated discussion, referred to as a hotwash, will allow responders to engage in a self-assessment of their response involvement and provide a general assessment of how the entity performed. The hotwash allows staff tasked with developing the AAR the opportunity to clarify points or collect any missing information. The AAR will capture observations of an

exercise/incident and provide recommendations for post-response improvements. An Improvement Plan (IP) is developed to identify specific corrective actions, assign these actions to responsible parties, and establish target dates for action completion. The IP articulates specific corrective actions by addressing issues identified in the AAR; provides completion dates by which the corrective action should be completed, and assigns a responsible person(s) and agency(s).

Once deactivation has occurred the following post-response timeline is initiated:

- The IC and Planning Section Chief will conduct a hotwash following deactivation.
- Using the Homeland Security and Exercise Evaluation Program (HSEEP) Template, a draft AAR/IP will be submitted for review within 60 days of deactivation or end of exercise (EndEx) to the Training and Exercise Coordinator (T&E Coordinator), and the T&E Coordinator will submit the AAR/IP to appropriate personnel for review and approval.
- Comments, changes and notations will be due back to the T&E Coordinator within 10 working days.
 - For State-level responses and exercises, the T&E Coordinator will submit the AAR/IP to appropriate personnel for review and approval.
 - For regional responses and exercises (as well as the two autonomous health departments) the T&E Coordinator will provide feedback to the appropriate personnel, regional planners, and/or district coordinators.
 - For local responses and exercises, the LERC will submit the AAR/IP to Regional Planners for review and Regional Planners will forward the AAR/IP to the T&E Coordinator following their review.
- An After Action Meeting to assign responsibilities in the IP will be conducted within 60 days of deactivation or EndEx.
- Submitting personnel will accept changes, return to the T&E Coordinator who will then save as the FINAL and publish as final and send the final document, with a publication date within 90 days. The publication date will also serve as the start date for all corrective action in the IP.

This ERP, or its appropriate Annex or Appendix, will be modified as soon as practicable to include any change in response protocols or procedures that is identified as an area for improvement in a final AAR/IP.

Appendices

Acronyms

AAR/IP	After Action Report and Improvement Plan
ADS	Acute Disease Service
AFB	Air Force Base
AFN	Access and Functional Needs
ArcGIS	Architecture Geographic Information System
CBRNE	Chemical Biological Radiological Nuclear Explosive
CDC	Centers for Disease Control and Prevention
CERC	Crisis and Emergency Risk Communication
CHE	Catastrophic Health Emergency
COOP	Continuity of Operations Plan
DHS	Department of Homeland Security
EMS	Emergency Medical Services
EMAC	Emergency Management Assistance Compact
EOP	Emergency Operations Plan
EPR	Emergency Preparedness and Response (Federal)
EPRS	Emergency Preparedness and Response Service (OSDH)
ERP	Emergency Response Plan
ESF	Emergency Support Function
FEMA	Federal Emergency Management Agency
GDP	Gross Domestic Product
GETS	Government Emergency Telecommunications System
HAN	Health Alert Network
HCC	Healthcare Coalition
HF	High Frequency
IAP	Incident Action Plan
IC	Incident Commander
ICS	Incident Command System
IED	Improvised Explosive Device
IP	Improvement Plan
IST	Incident Support Team
LERC	Local Emergency Response Coordinator
MAC	Multi-Agency Coordination
MERC	Medical Emergency Response Center
MIPS	Mass Immunization and Prophylaxis Strategy
MRC	Medical Reserve Corps
MSCC	Medical Surge Capacity and Capability
NDMS	National Disaster Medical System
NIMS	National Incident Management System
NPHRN	National Public Health Radio Network
NRF	National Response Framework

OEM	Oklahoma Department of Emergency Management
OKMRC	Oklahoma Medical Reserve Corps
OKOHS	Oklahoma Office of Homeland Security
OS	Oklahoma Statute
OSDH	Oklahoma State Department of Health
PHEOC	Public Health Emergency Operations Center
PHL	Public Health Laboratory
RMRS	Regional Medical Response System
SEOC	State Emergency Operations Center
SME	Subject Matter Expert
SNS	Strategic National Stockpile
SOG	Standard Operating Guidelines
TALON	Texas, Arkansas, Louisiana, Oklahoma, New Mexico (FEMA Reg 6)
WebEOC	This is an Internet accessed 'virtual EOC' communications tool.
WMD	Weapon of Mass Destruction

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