Infectious disease emergency response (IDER) plan
2024

Utah Department of
Health & Human
Services

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Acknowledgement

The Utah Department of Health and Human Services (DHHS) would like to thank the emergency response coordinators and the other staff from each of the local health departments for reviewing and improving the Infectious disease emergency response plan.

We also acknowledge the contributions to the plan by the Utah Department of Health and Human Services Office of Emergency Medical Services and Preparedness.

Infectious disease response plan (IDER) approval

Michelle Hofmann (Apr 23, 2024 22:59 MDT)

Chief Medical Officer, **Michelle Hofmann**
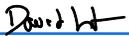
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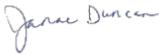
Division of Population Health director, **Janae Duncan**

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Preparedness & Response Program director, **Michelle Hale**

Record of changes

Date	Description of change	Affected section(s)
2/2024	Finalizations and approvals	All
6/2023	Complete overhaul of plan	All
1/2023	Merger of UDOH and DHS	All

Record of distribution

Date	Title, name	Agency
9/27/2023	Preparedness epidemiologist, Jade Murray	DHHS

I. IDER overview

A. Background

Infectious diseases that have epidemic, pandemic, or bioterrorism potential and spread rapidly through a population within a short time are an ongoing public health concern. Frequent exposure to infectious sources (e.g., food, infected animals, and vectors) or a high rate of person-to-person spread facilitates transmission of these diseases. Infectious disease emergencies range from naturally occurring outbreaks of illness (e.g., measles, pertussis, hepatitis A, meningococcal disease) to emerging infectious diseases (e.g., COVID-19, Middle Eastern Respiratory Syndrome (MERS_CoV), Avian influenza, Ebola Virus Disease, etc.), or intentional acts of bioterrorism (e.g., anthrax or smallpox). The circumstances of infectious disease emergencies vary by many factors, including type of agent, scale of exposure, and mode of transmission. Planning and preparing in advance of an infectious disease emergency is critical for an effective response.

Over time, as laboratory detection and surveillance of infectious diseases has improved, and outbreak investigations have become more numerous and complex, the need for a coordinated response by public health and its partners has increased. At the same time, globalization and political issues have created an environment where biological agents may also become terrorist threats.

In response to these issues, the Utah Department of Health and Human Services (DHHS) created the Infectious Disease Emergency Response (IDER) Plan as a framework with the flexibility to respond to any infectious disease incident.

B. Purpose

The purpose of the IDER Plan is to provide guidance for how DHHS will contain an outbreak of disease caused by an infectious organism or a biological toxin, or respond to other infectious disease emergencies. This is consistent with DHHS's mission to advocate for, support, and serve all individuals and communities in Utah. In the past, DHHS drafted disease-specific plans to address various infectious disease emergencies. But, as it is apparent that there are many infectious disease threats and events that may require a coordinated response, this plan has been organized as an all-inclusive plan for any infectious disease emergency. The plan has also been organized to fit into the state's general disaster and emergency response planning systems because it is important for any infectious disease emergency response to be well-integrated into these systems. Many of the basic response activities for infectious diseases are similar, and this approach to planning also helps avoid duplication.

The goals of this plan are to minimize serious illness and death, and limit societal disruption and economic losses. The plan is also intended to coordinate well with response plans at the local, national, and global levels. This plan is consistent with plans developed by the World Health Organization and the U.S. Department of Health and Human Services.

The IDER plan is modeled after a toolkit developed by the San Francisco Bay Area Advanced Practice Center and endorsed by the National Association of City and County Health Officers (NACCHO). As such, the way the plan is organized follows the Incident Command System (ICS) and addresses planning and policies, roles and responsibilities, operations, logistics and finance for an infectious disease outbreak/incident. The planning process has been fully integrated with and is part of the state's all-hazards emergency planning process.

Activities that may be implemented during an infectious disease emergency response include:

- Coordination with other local, tribal, regional, state, and federal agencies and other organizations to respond to the emergency
- Develop and disseminate information and guidance for the medical community, responders, general public, and special populations and settings
- Work with partners to implement public health disease containment measures such as infection control, mass prophylaxis (e.g., vaccines, immunoglobulin), isolation and quarantine, or restriction and clearance
- Work with partners who coordinate medical care systems (including long-term care and skilled nursing) and manage alternate care and/or shelter sites
- Conduct epidemiological surveillance and investigation activities, such as surveillance, data collection, outbreak investigation, and laboratory testing
- Collect and analyze data to support the development of objectives, strategies, and policies
- Implement the DHHS All hazards response plan—if potential impact and circumstances warrant this

C. Scope

This plan is primarily focused on the activities and responsibilities of DHHS in response to infectious disease emergencies. The communicable disease teams in the Office of Communicable Diseases (OCD) within the Division of Population Health routinely receive reports of cases of reportable infectious disease, and assist LHDs and tribal areas to conduct investigations and implement disease containment measures.

Using the IDER plan in this setting creates a decision-making and coordination infrastructure that allows the organization to leverage staff and resources in an efficient and seamless way. It also ensures that everyone involved in the response is aware of policy and operational decisions, which enables them to stay focused on their assigned tasks.

D. Plan activation

The IDER plan is intended to be used for any infectious disease emergency that requires a response that exceeds the OCD's normal disease control capacity, or that requires an increased level of

communication between agencies. Some outbreaks or situations will require limited response activities; other situations will require large-scale response efforts that involve many divisions within the DHHS and the cooperation and coordination of the LHDs, tribal areas, and other partners. In the case where additional non-infectious disease threats arise during a response, or if the scope and response warrants additional resources, the Executive Leadership Team (ELT) may authorize implementation of the broader All hazards response plan, or the Governor's office may authorize implementation of a Unified Command or other similar structure.

The DHHS IDER plan is structured according to the DHHS ICS. The IDER plan focuses on activities specifically related to infectious disease emergency response; otherwise, the plan will refer to the all-hazards DHHS Emergency operations plan when activities are not significantly different.

Levels of ICS response described in the IDER plan are graduated based on need: initial (baseline or routine), partial, and full activation. There are many situations in which staff must be pulled away from their routine tasks to respond to outbreaks that affect more than one local jurisdiction. By organizing the IDER plan in levels of activation, we can structure our response to routine outbreaks using the plan, and thus be better prepared to implement the plan to respond to larger emergencies.

Potential triggers to activate the IDER plan include:

- Public health response to a new/novel communicable disease
- Multi-agency joint investigation to a public health threat
- Public health response involving multiple local jurisdictions that requires DHHS coordination
- Response to a more routine public health event (e.g., small outbreak) that will:
  - benefit from use of ICS to organize the response
  - provide an opportunity to exercise implementation of ICS

DHHS staff authorized to initiate activation and deactivation of the IDER Plan include:

- Division of Population Health director or designee (ex: assistant division director)
- State epidemiologist
- Office of Communicable Diseases director
- Disease Response, Evaluation, Analysis, and Monitoring program manager

Approval to activate the IDER plan should be obtained through the chain of command, up to the Division of Population Health director, or their designee, with notification to and approval from section leadership/EDO, unless they are unavailable and the situation warrants urgent plan implementation. In this instance, any of the authorized staff noted above may activate the IDER plan, with notification to those in the chain of command as soon as possible.

Only authorized DHHS staff may activate and deactivate the IDER plan. The steps to IDER activation and deactivation can be used during an infectious disease outbreak (Figure 1).

Figure 1: IDER activation/deactivation

Figure 1: IDER activation/deactivation

Flowchart content:

"Incident Occurs"

Workload exceeds normal or communication increases

- **Yes →** Notify DHHS staff authorized to activate IDER → Leadership will activate IDER; send notification to all DHHS key ICS staff via UNIS → Determine and notify potential key/core IDER positions to meet at DHHS DOC → Initial briefing and role assignment

- **No ↓** Informal IDER activation/IDER practice
  - **Yes →** Notify Office Director or Program Manager for informal IDER activation → IDER informally activated for OCD or DREAM Program → Determine and notify potential key/core IDER positions to meet in EPI Emergency response room
  - **No ↓** No IDER activation

Initial briefing and role assignment → Meet every operational period to report/update on the current situation → Activate the DHHS All Hazards Response Plan as needed → Command Staff decides to deactivate IDER → Send out notifications to all IDER positions via UNIS → After action meeting and revise current IDER Plan as needed

E. Roles and responsibilities

DHHS is the lead agency for coordination of any state-level health or medical emergency response. Under the Utah Communicable Disease Control Act, DHHS has the authority to investigate and control the causes of epidemic infections and communicable disease within the state. DHHS shall provide for the statewide detection, reporting, prevention, and control of communicable diseases, epidemic infections, or any other health hazard which may affect public health.

This plan is focused on DHHS's responsibilities and activities regarding infectious disease emergencies. An infectious disease emergency that is multi-jurisdictional, the entire state, or the nation would require significant coordination, consistency, and standards to ensure that all citizens of Utah are informed and protected, and receive appropriate care. A situation such as this would require the DHHS to lead a coordinated response with LHDs, tribal areas, and partnering response agencies. Thus, the plan includes guidance for best practices and coordination of activities across the state. However, the plan does not presume to instruct LHDs and tribal areas on their local responses to an event. Disaster response is inherently local, and LHDs and tribal areas have developed their own plans for response based on their needs and capabilities. This plan seeks to complement, rather than replace, local health planning. Throughout the planning process, LHDs and tribal areas have been informed of the state's planning process and invited to provide input in areas where their local responses and activities may be impacted.

DHHS staff

The OCD within the Division of Population Health is the lead section for an infectious disease emergency response and will provide leadership for DHHS Department Operations Center (DOC) staff for the duration of an infectious disease emergency response. DHHS executive leadership will serve as the Policy group, with the role of advising response leadership and making policy decisions. DHHS executive leadership will authorize implementation of the all-inclusive All Hazards Response Plan when circumstances warrant this. Other DHHS ICS positions will be staffed by DHHS Epidemiology, DPH, UPHL and surge personnel, as determined by the incident manager.

IDER organizational chart
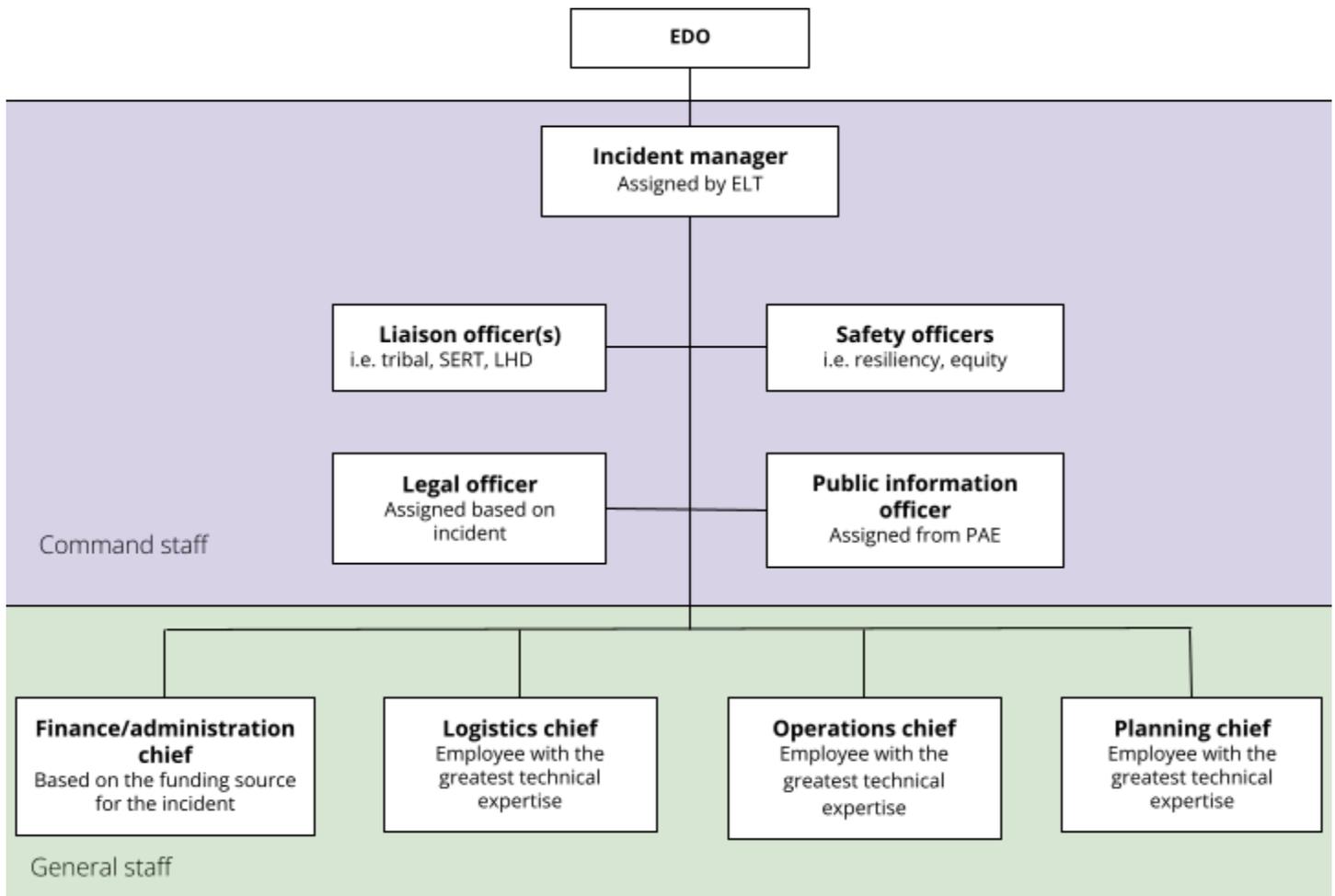
Organization

In a major incident, department communication, coordination, and response is managed through ICS in order to organize, monitor, and mobilize appropriate resources efficiently. Response staff will be organized by function within the ICS structure. The responsibilities of a role may expand or contract, new roles may be created to address unique needs, and some roles may not be activated at all depending on the requirements of the response.

Executive Director's Office (EDO)
- Assess potential department, system, and community impact of the incident.

- Designate the DHHS incident manager
- Approve response priorities
- Develop policy necessary to facilitate response or mitigate incident
- Makes sure governor and legislature are informed of DHHS role, capabilities, and objectives

Incident manager
- Typically, the incident manager is assigned from the OU with primary responsibility for the incident type
- Provide overall leadership for incident response
- Establish and adjust the ICS organization and scale based on incident demands
- Sets operational period and incident objectives approved by the EDO
- Approve the incident action plan
- Authorize resource requests and surge staffing

Public information officer
- Respond to media and public inquiries
- Develop materials and coordinates media briefings
- Provide information to the public
- Monitor, control, and respond to rumors when necessary

Safety officer
- Identify hazards associated with the response and assesses risk
- Communicate instances of injury, illness, or exposure to the incident manager
- Review the incident action plan (IAP) for safety implications for response personnel

Resiliency officer
- Maintain psychological safety and advocate for mental health resources for response operations
- Hold regular check-ins of response staff to determine mental health wellness

Equity officer
- Ensure adequate identification of at-risk populations, specific risks, and response plans account for access, trust, and equity
- Broadly support the incident and applies a health equity lens to command, operations, public information, liaisons, and planning to assure the needs of all affected communities and persons are considered and adequately reflected in response and recovery
- Devise short-term and long-term approaches to ensure equity throughout the emergency
- Coordinate with and support trusted community agencies that serve populations most impacted by gaps
- Depending on the scope and scale, coordinate and facilitate an equity task force with representatives from community, faith, and private sector organizations to inform policies and resource allocation, and tailor community engagement

Legal officer
- Advise on scope of state and DHHS legal authority

- Draft public health orders of constraint and public health emergency declarations
- Advise on policy decisions for potential liability

State emergency response team (SERT) liaison officers
- SERT members assigned to the State Emergency Operations Center Emergency Support Function (ESF) #6 and #8 desks to DEM
- Responsible for WebEOC coordination from DHHS to DEM
- Liaison with other ESFs at SEOC

Tribal health liaison
- Activated when the incident is multi-jurisdictional or involves tribal partners
- Primary point of contact and coordination for tribal health departments and other related partners
- Coordinate responses to questions, resource requests, and other needs
- Report on partner capabilities, resources, and needs

Local health department (LHD) liaison
- Activated when the incident is multi-jurisdictional
- Primary point of contact between DHHS and all LHDs
- Maintain a list of partners and representatives
- Coordinate responses to questions, resource requests, and other needs
- Report on partner capabilities, resources, and needs

Medical officer
- Advise the incident commander or section chief, as assigned, on issues related to biological or infectious disease emergency response

Planning section chief
- Typically, the planning section chief is assigned from EMSP. Roles include:
  - Collect, evaluate, and display incident intelligence and information
  - Prepare and document IAPs
  - Track resources assigned to the incident
  - Maintain incident documentation
  - Develop plans for demobilization

Operations section chief
- Direct and coordinate all incident operations
- Typically, the operations section chief is the person who has the greatest technical and tactical expertise to deal with the problem at hand

Logistics section chief
- Typically, the logistics section chief is assigned from EMSP
- Responsible for all services and support needs, which includes:
  - Order, acquire, maintain, and account for equipment and supplies

- Acquire and account for essential personnel
- Provide communication planning and resources
- Set up food services for responders
- Set up and maintain incident facilities
- Provide support transportation

Finance section chief
- Responsible for:
  - Expedited resource procurement
  - Contract initiation and monitoring
  - Timekeeping
  - Cost analysis
  - Compensation for injury or damage to property
  - Documentation for reimbursement
- Typically, the finance section chief is assigned based on the funding source for the incident. In all situations, the DHHS Division of Finance and Administration works in coordination with the finance section.

F. Notification

The following DHHS leaders must be notified when the IDER plan is activated:

- Executive director
- Deputy director
- Division of Population Health director and assistant director
- State epidemiologist
- Office of Communicable Diseases director
- Disease Response, Evaluation, Analysis, and Monitoring program manager
- Office of Emergency Medical Services and Preparedness director
- Office of Public Affairs and Education
- Utah Public Health Laboratory director

Other internal and external partners will be notified of the IDER plan activation, including liaisons and representatives from LHDs and tribal areas if the local health jurisdiction is involved in the incident.

G. IDER communications

The IDER plan assumes that all communications and requests follow incident command guidelines (vertical communication to supervisees or supervisor). During each operational period, there should be a minimum of one briefing for all response staff.

H. Operational period

The length of the operational period (8 hours, 12 hours, 24 hours, 1 week) is determined by the needs of

the incident and set by the command and general staff. In rapidly escalating or very complex incidents, the operational periods should be shorter to allow for rapid response to changing events.

I. Training

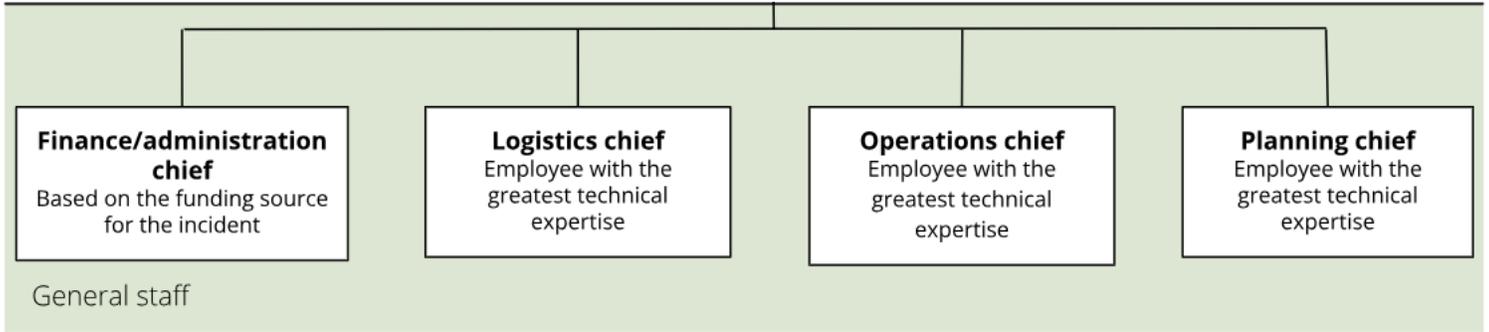DHHS provides ongoing training opportunities for DHHS and community partner staff to maintain the necessary skills and knowledge to appropriately respond to an emergency.
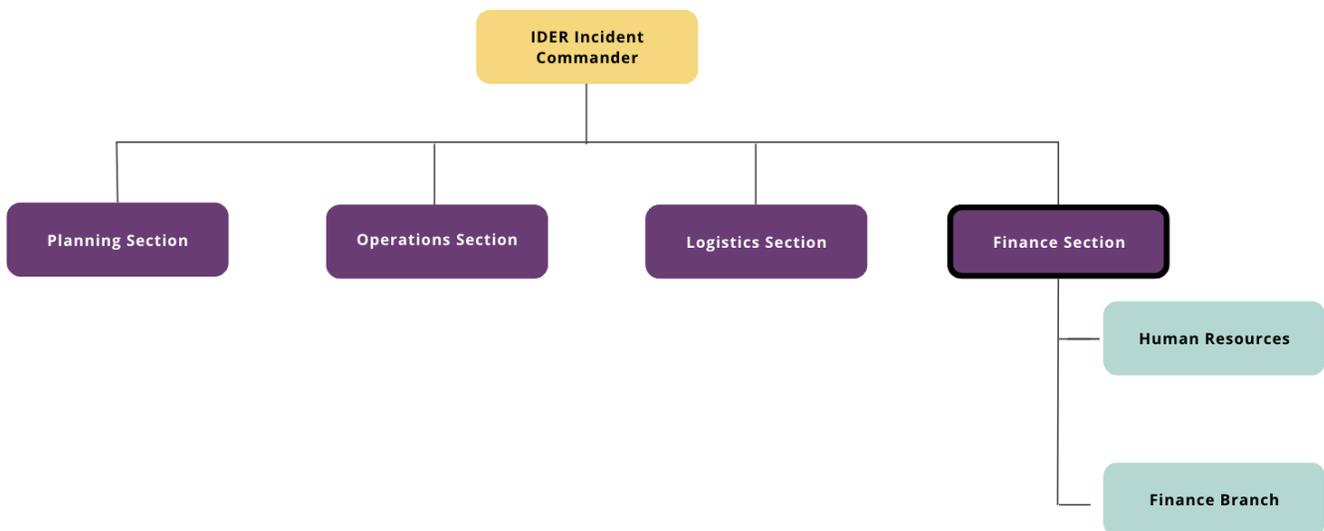These include, but are not limited to:
- Communication drills
- Baseline preparedness and response training
- Notification drills
- IDER plan trainings, drills, and exercises
- DHHS-led workshops, drills and exercises
- ICS FEMA training courses

General staff section

Finance/administration chief	Logistics chief	Operations chief	Planning chief
Based on the funding source for the incident	Employee with the greatest technical expertise	Employee with the greatest technical expertise	Employee with the greatest technical expertise

General staff

Financial/administration

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                        IDER Incident
                         Commander
    ┌───────────────┬───────────────┬───────────────┐
Planning Section  Operations    Logistics      Finance Section
                   Section       Section            │
                                              ┌─ Human Resources
                                              │
                                              └─ Finance Branch
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Description

The IDER plan contains brief summary information for the finance section. The finance/administration section functions in any response, and its basic job duties don't change dramatically from one disaster to another. In order to minimize redundancies, job duties are summarized here.

A. Purpose and objectives

The purpose of the finance section is to facilitate the purchase and reimbursement of resources utilized

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in an infectious disease emergency response. Finance section objectives include:
- Track hours worked by response staff for local, state, and/or federal reimbursement
- Facilitate purchase of supplies necessary for the emergency response
- Monitor multiple sources of funds
- Track and report the financial cost of the response to the incident manager

B. Methods

The finance section uses the following methods to achieve objectives:

Procurement: All financial matters related to the purchase of supplies and services for the emergency event are managed by the procurement unit. The unit makes sure proper purchasing protocols are used throughout the response. The unit generates purchase requisitions, obtains purchase order approvals, manages vendor contracts, and conducts all financial transactions with vendors.

Cost tracking: All financial tracking and reporting for the response is managed by the cost unit. The unit makes sure all incident-associated costs are captured using existing, standard DHHS methodologies, as well as alternate response-specific mechanisms. The unit produces cost reports and projections to decision makers in the ICS organization to help inform and shape the response objectives and strategies.

Time tracking: The time tracking unit makes sure personnel time is accurately recorded and is in compliance with agency and donor reporting policies. The time tracking unit maintains time records for all personnel assigned to the incident in preparation for cost recovery reporting after the response. The unit coordinates with payroll departments to ensure payroll processing for response staff occurs in a timely fashion.

C. Implementation

Activate the finance section chief anytime the IDER plan is activated. The finance section chief manages the direct financial needs of the incident. In an incident that requires DOC activation, some or all finance functions may be performed at the DOC. The finance section chief determines which units are required for the response and activates the appropriate units, after approval by the incident manager. Functions of the finance section include:
- Manage all financial functions for the response
- Regularly provide updated financial information on the cost of the response, cost analysis information, and projected expenditures at command staff meetings and as needed
- Maintain daily contact with the DOC on finance matters. This is particularly critical in proclaimed disasters where state and/or federal reimbursement is likely
- Make sure all personnel time records are accurately completed, according to DHHS policy
- Provide financial input to demobilization planning
- Make sure all claims, invoices, and purchase orders are properly executed
- The finance section chief reports to the incident manager

D. Deliverables

The finance section produces the following:
- Summary of costs
- Time tracking report
- Module objectives and update, ICS Form 202b (for each operational period
- Summary of purchase orders
- Expenditure report
- Cost projection report
- Personnel time tracking report

Logistics
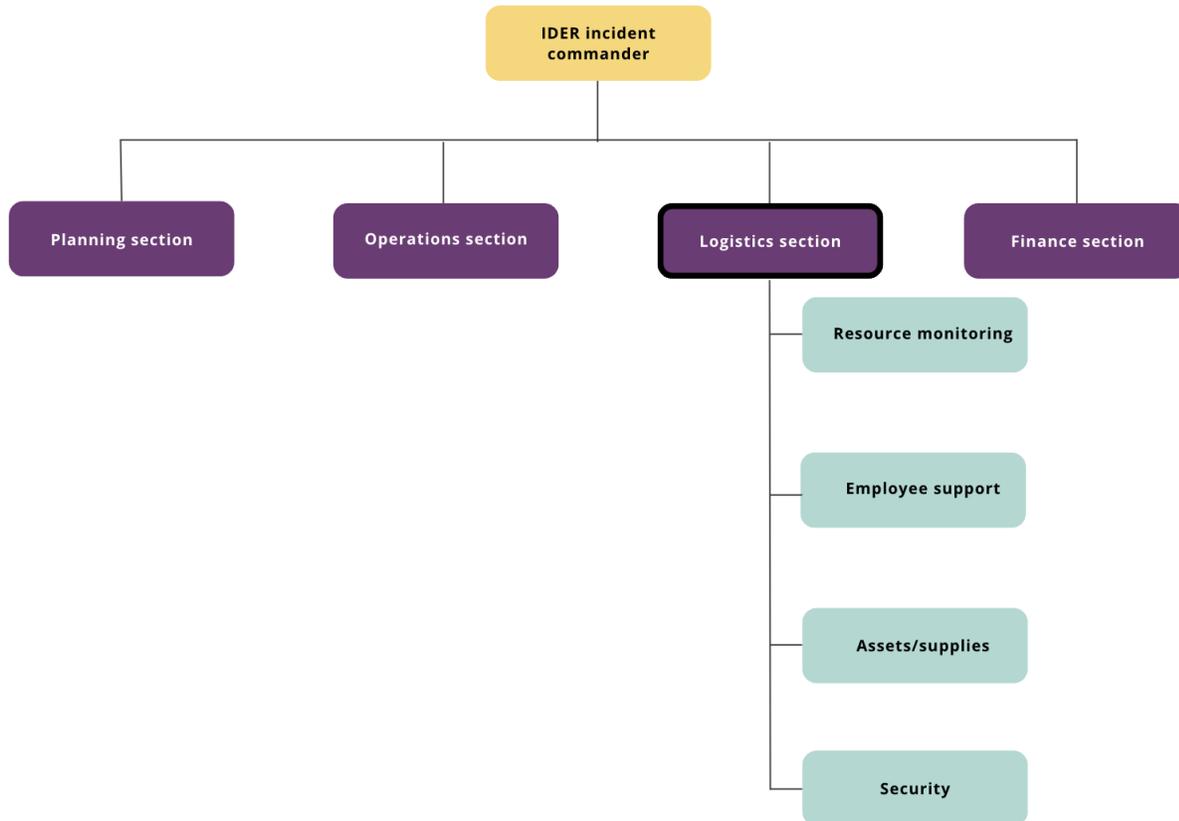
Description

The IDER plan contains brief summary information for the logistics section. More detailed information on this group and its functions can be found in the DHHS emergency operations plan (EOP), including the job action sheets (JAS) and standard operating procedures (SOPs). The logistics section functions in any response, and its basic job duties don't change dramatically from one disaster to another. In order to minimize redundancies, job duties are summarized here.

A. Purpose and objectives

The logistics section locates or requests the supplies and personnel needed to support the response and responders, and directs these resources to the appropriate location. The section also makes sure communications and information technology infrastructure is functional and interoperable. Logistics section objectives include:
- Receive and fulfill personnel requests

- Receive and fulfill supplies
- Track inventory of supplies and personnel, including donations
- Set up, maintain, troubleshoot, and repair communications and information technology equipment for the response
- Set up conference rooms for use by responders who work outside the DHHS DOC
- Ensure security of response activities
- Arrange for food, water, and medical services as needed to ensure responder well-being
- Demobilize resources
- Make sure all DHHS resources and assets, including response teams and equipment, are available and ready to be deployed should the response require it
- Collect, track, and respond to all resource requests from local health departments, healthcare facilities, and other partners
- Make sure appropriate personal protective equipment (PPE) for DHHS responders is available and worn as necessary and recommended by the safety officer, medical officer, and/or incident manager
- Order requested equipment and supplies required for the event, as approved by the incident manager

B. Methods

Additional logistics methods that may be utilized:

Personnel recruitment: The volunteer unit works with human resources and/or health department managers to identify and assign staff to the response. For activations requiring additional personnel, the volunteer unit coordinates with the DHHS DOC and state EOC.

Communications and information technology systems: These units ensure redundant communications and information technology systems are set up and function as outlined in the resource needs section of each activated IDER plan module.

C. Implementation

Activate the logistics section as needed. The logistics section oversees all response-related requests for personnel and equipment, and communications and computer equipment set-up for the response. In the case of an in-person response, an employee support set-up crew may start setting up rooms for the ICS activation at the beginning of an infectious disease emergency response.

The logistics section chief oversees all section activities and receives and fulfills logistics requests. The logistics section chief determines which resources require incident manager, section chief, or branch director approval, and makes sure responders are aware of the requirements. They track the status of human and physical resources that are in use or available for use during the response, makes certain all assigned personnel and other resources check in for the incident response period, and keeps track of the current location and status of all resources. Functions of the Logistics section include:
- Oversee all section activities
- Attend command/general staff meetings

- Provide logistical input to the incident manager and plans section in preparing the incident action plan
- Brief unit leaders on the situation and their roles and responsibilities for the operational period
- Provide oversight and guidance to unit leaders (answer questions, address problems, make decisions in keeping with the section's operational objectives, and determine which problems, requests or questions need further approval)
- Provide updates for the incident action plans
- Anticipate logistics requirements
- Request and coordinate with the state EOC liaison (SERT member) for additional resources

D. Reporting

The logistics section chief reports to the incident manager. The resource monitoring branch director and employee support branch director report to the logistics section chief. The assets/supplies, volunteers, and emergency systems units report to the resource monitoring branch director. The technology, food/basic needs, and security units report to the employee support branch director.

E. Deliverables

The logistics section produces the following:

- Module objectives and update, ICS Form 202b (for each operational period) [Appendix B]
- Facility assessment prior to use, if required
- Logistics resource status reports
- Equipment and technology service logs
- Supplies inventory list
- Technology inventory list

Operations
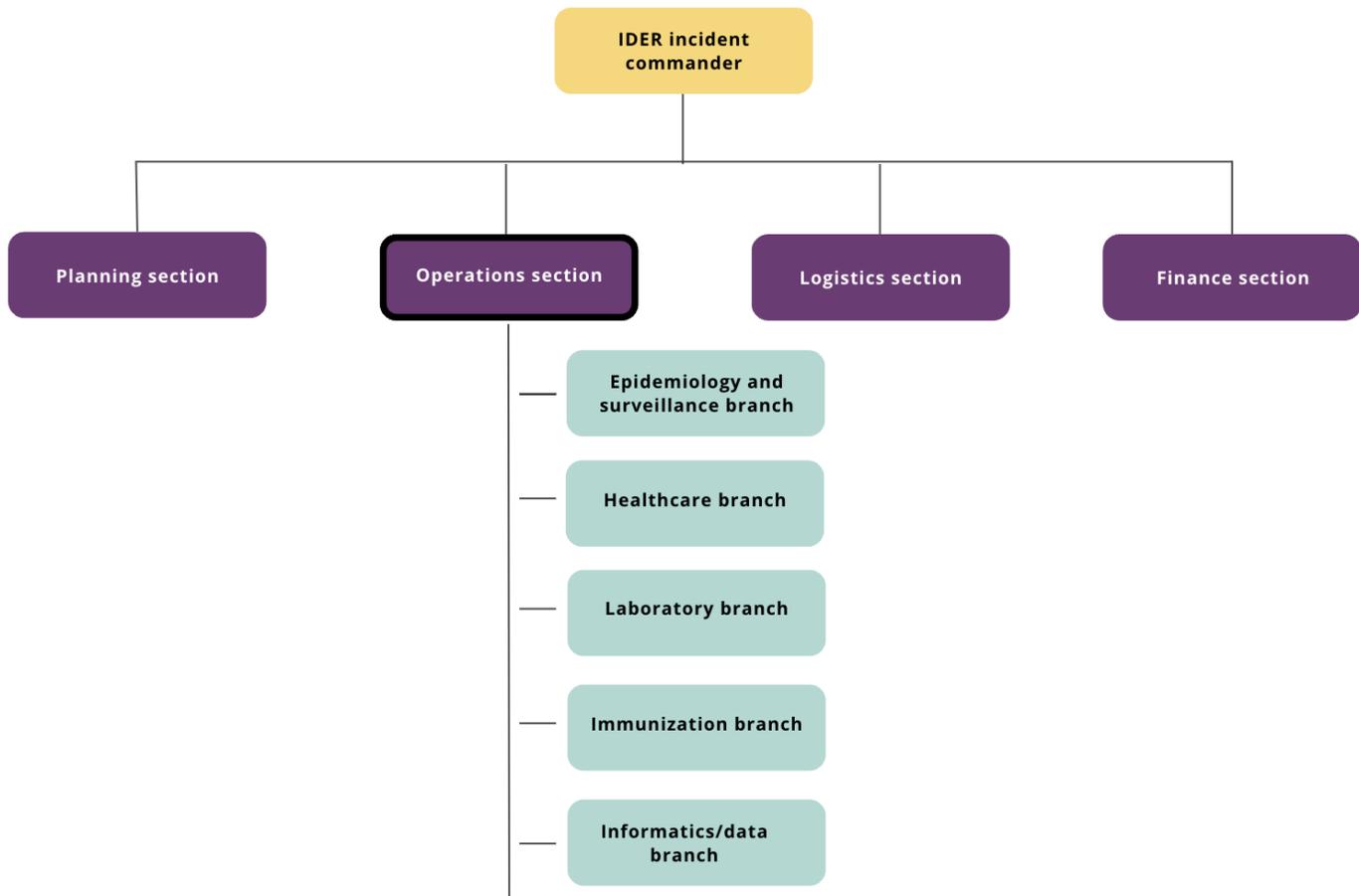
Description

The operations section commands objectives through directed strategies and execution of tactics. The IDER plan contains brief summary information for the operations section. More detailed information can be found in the DHHS Emergency operations plan and job action sheets. The operations section functions may differ for different infectious diseases. Selected disease specific information can be found under section D of the Appendix.

A. Purpose and objectives

The operations section carries out the response activities described in the incident action plan. Operations section objectives include:
- Coordinate with emergency medical services and medical treatment systems
- Provide technical consultation and guidance on appropriate specimens and lab testing
- Provide infectious disease information to responders, clinicians, and the public

- Implement surveillance strategies to identify cases, contacts, and the source and magnitude of the infectious disease emergency
- Determine risk factors for the disease and identify susceptible populations
- Determine and implement effective strategies to contain the infectious disease
- Manage and analyze data related to the infectious disease emergency, and inform the response
- Provide vaccine and immune globulin to at risk populations, if available

B. Methods

Operations strategies and activities that may be used to achieve objectives include:

Infectious disease information and guidance: This includes the development and provision of disease and event-specific guidance to various population groups. Requests for information will be screened and triaged so critical questions can be answered appropriately.
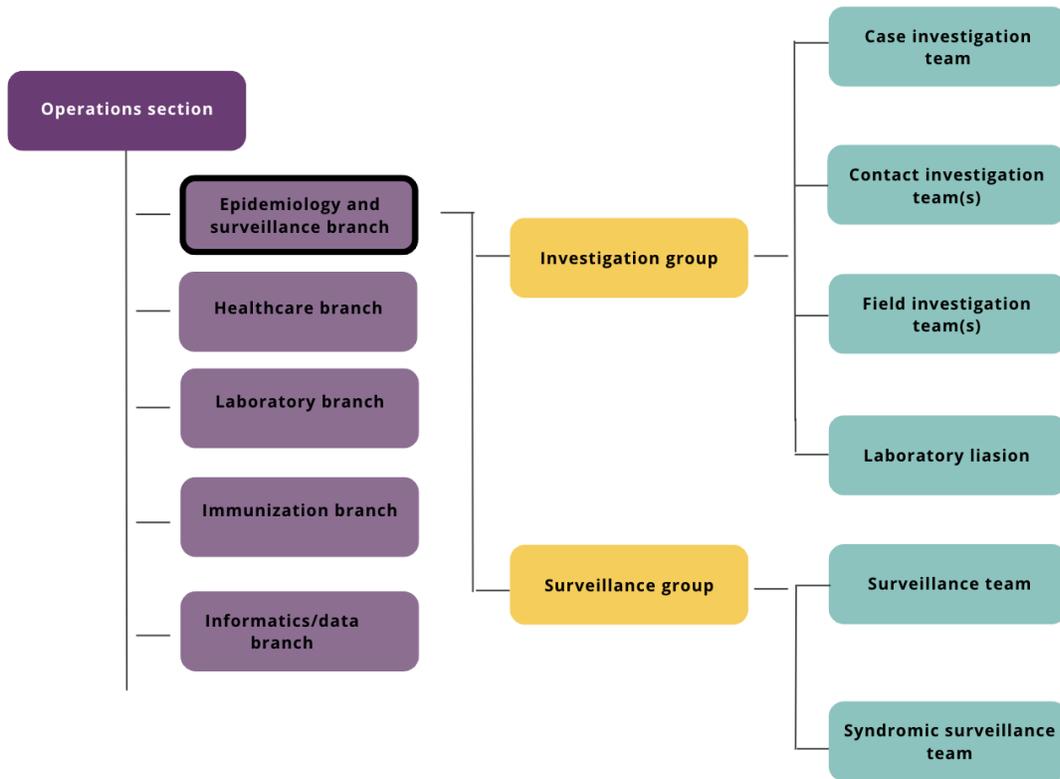
Immunization branch: Disease containment encompasses public health strategies actively performed by emergency responders and/or strategies performed by others. Activities may address community mitigation, restriction, exclusion, clearance, mass prophylaxis, isolation, and/or quarantine.
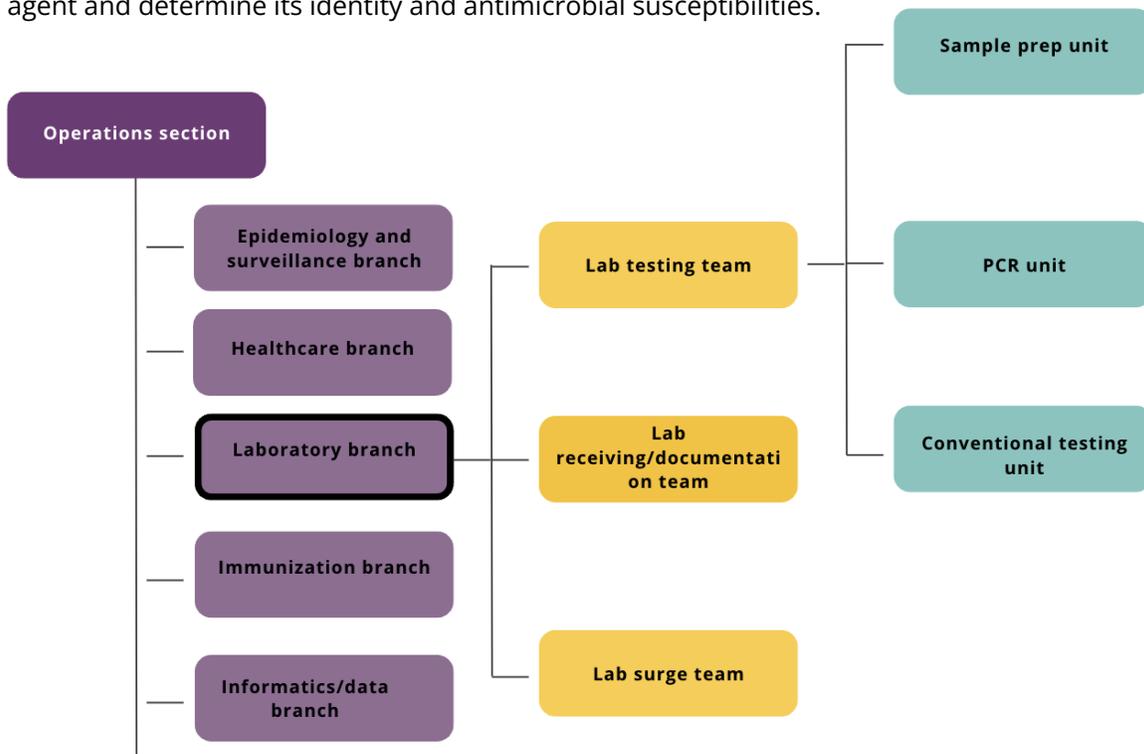
Informatics
The data branch manages and oversees the systems, applications, and databases that receive, standardize, process, manage, store, and make available data for analysis about the infectious disease emergency used by the operations section to guide the selection of strategies used to contain the event.

Healthcare branch: Activities focus on coordinating the infectious disease emergency response with local medical care systems to make sure the needs of healthcare sites and patients are met. This may involve monitoring and coordinating resource requests from healthcare sites; forecasting trends in supply and demand for healthcare services and resource needs; ensuring there is support for casualty management including triage, treatment, and transportation; designating and managing alternate care and/or shelter sites; and coordinating with the medical examiner to manage mass fatalities.

Epidemiology and surveillance: Epidemiology activities primarily focus on establishing a case definition and identifying cases, contacts of cases, the population at risk, the sources of infectious disease emergency, and the magnitude of the event. Surveillance activities focus on completing and coordinating case reporting and data collection, review syndromic surveillance data, and provide assistance on disease reporting and surveillance. The information obtained by epidemiology and surveillance activities will be used to guide containment activities and situational awareness.

```
Operations section
 ├── Epidemiology and          ┌── Investigation group ──┬── Case investigation team
 │    surveillance branch ─────┤                          ├── Contact investigation team(s)
 ├── Healthcare branch         │                          ├── Field investigation team(s)
 ├── Laboratory branch         │                          └── Laboratory liasion
 ├── Immunization branch       └── Surveillance group ────┬── Surveillance team
 └── Informatics/data branch                               └── Syndromic surveillance team
```

Laboratory: Laboratory activities include recommendations for laboratory testing and facilitating specimen collection and transport to UPHL or to the CDC. Laboratory testing helps confirm the presence of an infectious disease agent and determine its identity and antimicrobial susceptibilities.

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Operations section
 ├── Epidemiology and          ┌── Lab testing team ──────┬── Sample prep unit
 │    surveillance branch      │                          ├── PCR unit
 ├── Healthcare branch         │                          └── Conventional testing unit
 ├── Laboratory branch ────────┼── Lab receiving/documentation team
 ├── Immunization branch       │
 └── Informatics/data branch   └── Lab surge team
```

C. Implementation

Activate the operations section immediately for all IDER activations.

The epidemiology branch, lab branch, and informatics will most likely need to be activated immediately for all infectious disease emergencies. The operations section chief provides ongoing guidance to branches and makes sure necessary approvals are obtained and information and requests are forwarded appropriately. Decisions and policies about response goals, objectives, activities, and policies are forwarded to the incident manager for approval prior to implementation. Protocols, documents, and recommendations are forwarded to the public information officer for approval prior to dissemination. Personnel and supply requests are forwarded to the logistics section and finance section. Updates on the event and response operations will be forwarded to the planning section.

Functions of the operations section include:
- Assist in the development of the incident action plan
- Implement the incident action plan
- Meet with branch directors regularly to address implementation issues
- Oversee the development and dissemination of event and disease-related information to clinicians, responders, the public, special populations, and other stakeholders
- Oversee the implementation of public health strategies to contain the infectious disease
- Oversee the implementation of case/contact investigation and surveillance
- Oversee the analysis of data related to the infectious disease emergency and response
- Request approvals from the incident manager, policy group, and public information officer prior to implementation of activities or dissemination of materials
- Forward updates and personnel and supply requests to command staff and other sections as needed.
- Manage administrative support at UPHL
- Coordinate with healthcare and EMS groups throughout the state to ensure situational awareness and guidance dissemination
- The operations section chief reports to the incident manager

D. Deliverables

The operations section produces the following:
- Response documents and/or products assigned to active modules within the operations section
- Outbreak-associated reports
- Laboratory test results and reports
- Guidelines regarding specimen collection

Planning
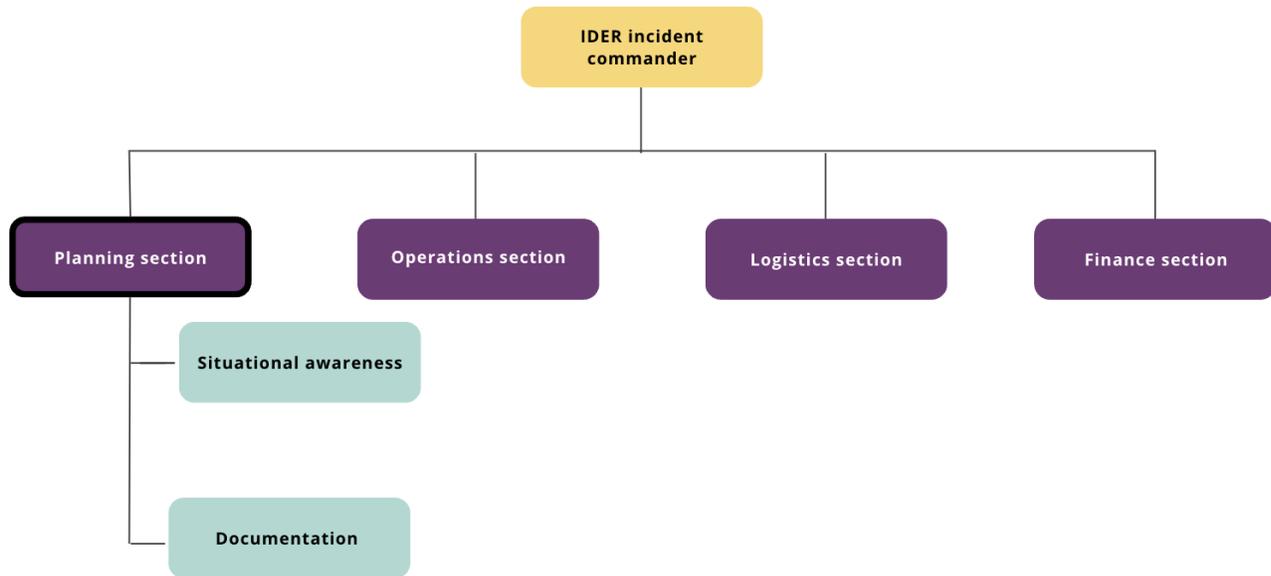
Description

The planning section collects, evaluates, and disseminates operational information pertaining to the incident. This section maintains information and intelligence on the current and forecasted situation, as well as the status of resources assigned to the incident. The planning section prepares and documents incident action plans (IAPs) and incident maps, and gathers and disseminates information and intelligence critical to the incident. The planning section has 4 primary units and may also include technical specialists to help evaluate the situation and forecast requirements for additional personnel and equipment. More detailed information may be found in the DHHS Emergency operations plan and job action sheets.

A. Purpose and objectives

The planning section provides the response with accurate and comprehensive information that enables optimal decision making about ongoing and future management.
Planning section objectives include:

- Collect, assess, and integrate incident and response information to produce an overall assessment of the incident, which includes the status of the infectious disease emergency, operational activities, and resource use
- Prepare projections of the incident, response needs, and response capabilities
- Provide recommendations for decisions and/or actions to address future response needs

- Draft an incident action plan for each operational period
- Draft situation reports weekly, or as determined by the incident manager
- Provide mapping of disease spread
- Act as liaison with the DHHS continuity of operations team to ensure prioritized essential DHHS functions continue to be carried out
- Maintain documentation of the response and store original response-related documents
- Ensure coordination between the response and ongoing health department activities
- Coordinate demobilization and after-action reporting
- Disseminate information within the response
- Coordinate access to technical specialists as needed
- Collect activity logs/ICS 214 forms from all DHHS employees involved in the response
- Make sure a department after action report is developed following the close of the incident response

B. Methods

Planning strategies include, but are not limited to:
- Incident action plan
- Situation status briefing board
- Resource tracking summaries
- Continuity of operations activities
- Documentation
- Technical specialists
- Demobilization

More detail on these methods is described in the DHHS Emergency operations plan (EOP), Standard operating procedures (SOPs) and job action sheets (JAS) for the planning section.

C. Implementations

Planning/intelligence section chief

At the beginning of a response, always consider activation of the planning section chief. Upon activation, the planning section chief is briefed by the incident manager on the situation and current operational objectives. The planning section chief makes sure all necessary functions and deliverables are accomplished in a timely and accurate manner.

Functions of the planning section

- Collect and assess information on the current situation, response activities, and available resources (e.g., module objectives and update, ICS Form 202b, inventory database)
- Provide incident status summary to command and general staff
- Identify gaps in response capacity and recommend actions to address gaps; this may include alternative future response strategies and specialized resources
- Organize and facilitate planning meetings with general and command staff

- Draft the incident action plan for each operational period and request approval from the incident commander
- Distribute all internal incident-related documents, such as federal guidance and incident action plans
- Ensure coordination between the response and ongoing health department activities
- Plan for and lead demobilization of the response

D. Reporting

The planning/intelligence section chief reports to the incident manager. Unit leaders, if activated, report to the planning/intelligence section chief.

E. Deliverables

The planning section produces the following:

- Module objectives and update, ICS Form 202b (for each operational period) [AppendixB]
- Incident action plan, ICS Form IAP, and attachments (for each operational period) [Appendix B]
- Situation status briefing board (white board, web-based, or other updatable medium)
- Resource summary report (for each operational period)
- Personnel and communications list, ICS Form #205 [Appendix B]
- Healthcare assessment summaries/reports
- Log of incident-related documents
- Demobilization plan and checkout procedure
- After-action report
- Corrective action plan
- Log of technical specialist requests
- Specific technical protocols or recommendations relevant to the situation

II.Threats/priorities/functions

Bioterrorism agents

Bioterrorism agents can be separated into 3 categories, depending on how easily they can be spread and the severity of illness or death they cause.

Category A

These high-priority agents include organisms or toxins that pose the highest risk to the public and national security because:

- They can be easily spread or transmitted from person-to-person
- They result in high death rates and have the potential for major public health impact
- They have the potential to cause public panic and social disruption
- They require special action for public health preparedness

Category A BT agents include:

Anthrax (*Bacillus anthracis*), botulism (*Clostridium botulinum* toxin), plague (*Yersinia pestis*), smallpox (variola major), tularemia (*Francisella tularensis*), and viral hemorrhagic fevers (Filoviruses (Ebola, Marburg) and arenaviruses (Lassa, Machupo))

Category B

These agents are the second highest priority because:

- They are moderately easy to spread
- They result in moderate illness rates and low death rates
- They require specific enhancements of CDC's laboratory capacity and enhanced disease monitoring

Category B BT agents include:

Brucellosis, Epsilon toxin of *Clostridium perfringens*, food safety threats, glanders, melioidosis, psittacosis, Q fever, ricin toxin from *Ricinus communis*, Staphylococcal enterotoxin B, typhus fever, viral encephalitis, and water safety threats (i.e., Vibrio cholera, Cryptosporidium parvum)

Category C

These third highest priority agents include emerging pathogens that could be engineered for mass spread in the future because:

- They are easily available
- They are easily produced and spread

- They have potential for high morbidity and mortality, and therefore, could have a major health impact

Category C BT agents include:

Emerging infectious diseases such as Nipah virus and hantavirus

III. Appendix

A. Emergency authorization and regulations

There are existing legal authorities in statute and administrative rule at the state and federal levels related to DHHS emergency operations. While not exhaustive, notable laws and rules are listed below.

State code and administrative rules
- Title 26B. Utah Health and Human Services Code
- 26A-1-114 Powers and duties of departments
- Department authority and duties, Code 26B-1-202
- Requirements for issuing, recommending, or facilitating rationing criteria, Code 26B-1-219
- Detection and Management of Chronic and Communicable Diseases and Public Health Emergencies, Code 26B-7-201
- Treatment, Isolation, and Quarantine Procedures for Communicable Diseases, Code 26B-7-301
- Local Health Emergency Assistance Program, Code 26B-7-111
- EMS Personnel Licensure Interstate Compact, Code 26B-4-137
- Powers and Duties of Local Health Departments, Code 26A-1-114
- Medical Reserve Corps, Code 26A-1-126
- Emergency Management Act, Public Safety Code 53-2a
- Interstate Local Emergency Response Act, Public Safety Code 53-2b
- COVID-19 Health and Economic Response Act, Public Safety Code, 53-2c
- Health Care Providers Immunity from Liability Act, Utah Code 58-13
- Emergency Procurement Rule, R33-8-401
- Retired Volunteer Health Care Practitioner Act Rule, R156-81
- Public Health Emergency Protocols Rule, R380-65
- Communicable Disease Rule, R386-702
- Statewide Mutual Aid Act Rule, R704-2

Federal acts and orders
- Public Health Service Act, 42 USC 247d
- Robert T. Stafford Disaster Relief and Emergency Assistance Act, Stafford Act
- Federal Emergency Management and Assistance, Code of Federal Regulations Title 44
- Indian Tribal Governments Sovereignty, Executive Order 13175
- Individuals with Disabilities in Emergency Preparedness, Executive Order 13347

B. ICS forms

ICS Incident briefing form (Form 201)

Available online at https://training.fema.gov/icsresource/icsforms.aspx

Completed by IDER command staff during activation and notification; it summarizes situational

information and objectives of the first operational period.

Incident action plan
Incident action plan defines the response activities and resource utilization for an operational period. The IAP contains objectives of the overall incident strategy and specific actions for the next operational period.

C. DHHS Plans

Continuity of operations plan (COOP)

The DHHS COOP plan outlines critical functions and services that are necessary to provide vital services, exercise civil authority, maintain the safety and well-being of the general population, or sustain critical support to the Utah Department of Health and Human Services (DHHS). These services, depending on the emergency level, may be implemented within a 12-hour period and should be able to be sustained for a period of up to 30 days after a natural disaster.

The DHHS [Continuity of operations plan](#)

Emergency operations plan (EOP)

The DHHS [Emergency operations plan (EOP)](#) details the functions and responsibilities of the DHHS assets during the preparedness, response, and recovery phases of emergency/disaster operations. This plan establishes a department organizational structure for emergency/disaster response, as well as describes the concepts and policies under which the department operates during emergencies/disasters. In addition, the plan provides for coordination with other state and local agencies.

D. Communicable disease information

Anthrax

Anthrax is caused by *Bacillus anthracis*, a gram-positive, spore-forming bacillus which can cause serious acute infections in both animals and humans. *B. anthracis* can be found naturally in soil, and affects domestic and wild animals worldwide. Although it is rare, people can get sick with anthrax if they come in contact with infected animals or contaminated animal products. The incidence of anthrax has decreased in developed countries, but it remains a considerable health problem in developing countries. Anthrax occurs primarily in 3 forms: cutaneous, inhalational/respiratory, and gastrointestinal. Due to the nature of the disease, *B. anthracis* could be used as a weapon of bioterrorism.

The anthrax disease plan and the "white powder incident" investigation process can be found at:

https://epi.utah.gov/anthrax/

Ebola virus disease (EVD)

The Ebola virus causes acute and serious illness which is often fatal if left untreated. The incubation period for Ebola virus disease (EVD) is 2 to 21 days. Initial symptoms include sudden onset of fever, fatigue, muscle pain, headache, and sore throat. This is followed by vomiting, diarrhea, rash, symptoms of impaired kidney and liver function, and in severe cases, both internal and external bleeding. Fruit bats of the *Pteropodidae* family are thought to be the natural Ebola virus hosts. Person-to-person transmission of EVD occurs through direct contact with infected blood, urine, vomit, diarrhea, other infected secretions or organs, or semen. There is no proven treatment and no licensed vaccines available for Ebola virus disease. Effective outbreak control relies on case management, surveillance and contact tracing, as well as good laboratory service. The current EVD outbreak (started in March of 2014) is the largest and most complex outbreak since the Ebola virus was first discovered in 1976.

The Ebola virus disease plan can be found at:
https://epi.health.utah.gov/wp-content/uploads/2019/07/ebola_plan.pdf

The Ebola CONOPS can be found at:
https://drive.google.com/file/d/1KzCelUUJ0WlFhFz4kuFYDwA6rbUYOjag/view?usp=drive_link

Middle East respiratory syndrome (MERS)

MERS first appeared in the Middle East in 2012 and is associated with severe respiratory illness. All identified cases have occurred in, or have been associated with, people who travel to the Middle East. In 2015, an outbreak of MERS occurred in South Korea primarily among healthcare workers after the virus was introduced into a hospital by a traveler from the Middle East. MERS appears to have a high case fatality rate. There is no cure and no vaccine to prevent MERS. Correct diagnosis and early detection of cases and their contacts is crucial in preventing future cases and outbreaks.

The MERS disease plan can be found at:
https://epi.health.utah.gov/wp-content/uploads/2019/07/MERS_plan.pdf

Severe acute respiratory syndrome (SARS)

SARS was first described in February 2003. It is thought to have originated in the Guangdong Province of China, with initial infectious human cases occurring sometime around November 2002. By July 2003, multiple major international outbreaks of SARS had resulted from spread from an initial outbreak in Hong Kong to other countries, including Canada, China, Taiwan, Singapore, and Vietnam. The disease then spread to 20 other major locations following standard airline travel routes. The largest proportion of cases occurred within hospitals and

among hospital workers and their families. According to the World Health Organization (WHO), a total of 8,098 people worldwide were diagnosed with SARS during the 2003 outbreak. Of these cases, 774 died (9.6%). In the U.S., 8 people had laboratory-confirmed evidence of SARS-CoV infection. All of these cases appeared to have been imported from other countries where SARS was widespread. One case was identified in Utah. Further spread of SARS within the U.S. did not occur.

In 2004, although several cases of SARS were reported in China, there were no documented cases of human-to-human transmission. Individuals at greatest risk for SARS-CoV infection include those who recently traveled to a country where community-wide spread of SARS has been documented and those who have had direct, close contact with someone who is ill with SARS.

The SARS disease plan can be found at:
https://epi.health.utah.gov/wp-content/uploads/2019/07/SARS_plan.pdf

Measles

Measles, also known as Rubeola, is a highly contagious, acute viral illness that can lead to serious complications. The illness is characterized by a prodrome followed by a maculopapular rash. Measles is transmitted airborne by droplet spread, direct contact with nasal or throat secretions of an infected person. The period of communicability extends from 4 days before rash onset to 4 days after. Since the implementation of effective childhood immunization programs, measles cases in many developed countries have dropped dramatically and generally occur in young unimmunized children or older children, adolescents, or young adults. The case fatality rate is estimated to be less than 1% in developed countries, but can be 3-5% in developing countries. Vaccination is the primary method of prevention.

The measles disease plan can be found at:
https://epi.health.utah.gov/wp-content/uploads/Measles-Disease-Plan-Updates-to-Required-Fields.pdf

Pandemic Influenza

Influenza, caused by RNA viruses, is an acute respiratory disease characterized by abrupt onset of fever and respiratory symptoms. It is primarily transmitted via large droplets generated when infected persons cough or sneeze. Transmission may also occur through direct contact, or indirect contact, with respiratory secretions. Indirect exposure may occur, for example, when touching surfaces contaminated with influenza virus and then touching the eyes, nose, or mouth. The virus has good persistence in the environment, particularly in cold conditions with low humidity. Influenza spreads rapidly in a population because it has a short incubation period of 1-3 days, and because persons are infectious before symptoms begin and during early illness. Emerging new influenza viruses have the potential to cause pandemics since the human population has little to no immunity against them. The best way to prevent influenza and influenza related complications is to receive a

yearly influenza vaccination.

The pandemic influenza plan can be found at:
https://epi.health.utah.gov/wp-content/uploads/2019/07/novel_influenza_plan.pdf

COVID-19

In December 2019, a novel (new) coronavirus (COVID-19) was identified in Wuhan, Hubei Province, China. In January 2020, the first U.S. case of novel coronavirus was identified in Washington state. Initial cases in the U.S. were clustered; however by mid-March 2020, multiple cases in areas across the country were reported with no epidemiologic link to a confirmed case. Widespread community transmission was documented as early as July 2020. Because this was a new virus, it is assumed no humans had pre-existing immunity. The novel coronavirus quickly spread and is now in countries worldwide, and part of an ongoing pandemic.

The COVID-19 disease plan can be found at:
https://epi.health.utah.gov/wp-content/uploads/COVID-19-Disease-Plan.pdf

Disease plans

Additional disease plans for Utah reportable diseases can be found at:
https://epi.utah.gov/plans-and-reports-atozlist/

IDER acronym guide

AAR	After action report
AI/AN	American Indians/Alaskan Natives
OCD	Office of Communicable Diseases
BT	Bioterrorism
CDC	Centers for Disease Control and Prevention
COOP	Continuity of operations plan
DPH	Department of Public Health
DOC	Department Operations Center
DREAM	Disease Response, Evaluation, Analysis and Monitoring
ELT	Executive leadership team
EMS	Emergency medical services
EOC	Emergency Operations Center
EOP	Emergency operation plan
EPI	Epidemiology
EVD	Ebola virus disease
IAP	Incident action plan
ICS	Incident Command System
IDER	Infectious Disease Emergency Response
IVR	Interactive voice response
JAS	Job action sheet
JIC	Joint Information Center
LHD	Local health department
MERS	Middle East respiratory syndrome

NACCHO	National Association of County and City Health Officials
PIO	Public information officer
PPE	Personal protective equipment
SARS	Severe Acute Respiratory Syndrome
SERT	State emergency response team
SME	Subject matter expert
SOP	Standard operating procedures
DHHS	Utah Department of Health and Human Services
UNIS	Utah Notification and Information System
UPHL	Utah Public Health Laboratory