State of Delaware
Department of Health and Social Services
Division of Public Health
Standard Operating Guideline (*Delete if plan*)

Planning Tool for the Development of a Plan or SOG

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1.0 Purpose

1.1 The purpose contains general statements of what the plan/SOG is meant to do.

1.2 *Use the following phrases or words*; to describe, to define, to provide guidance and establish procedures and to define roles and responsibilities.

1.3 This standard operating guideline is intended to be used as a guide and does not replace sound judgment nor anticipates all situations and contingencies.

2.0 Planning Assumptions

2.1 Assumptions are simply that: what, in developing the Plan/SOG, has been treated as true for the Plan/SOG execution. These should be included to show the limitations of the Plan/SOG, allowing Plan/SOG users (and others) to foresee that some improvisation or modification may become necessary. It is valid to include even "obvious" assumptions: that identified hazards will occur (scenarios, if used, can be outlined), that individuals and organizations are familiar with the Plan/SOG and will execute their assigned responsibilities, that assistance may be needed, and that--if so--assistance will be available.

2.2 The planning assumption should indicate the legal basis for the plan/SOG. Laws, statutes, ordinances, executive orders, regulations, and formal agreements relevant to emergencies should be listed in the Tabs.

2.3 **Example Planning Assumptions**

2.4 A natural or technological disaster or catastrophic incident may cause significant health and medical issues such as disease, injuries, or fatalities that may overwhelm the health care system.

2.5 Large numbers of casualties from a catastrophic or large-scale incident will necessitate the activation of the Division of Public Health (DPH) Modular Medical Expansion System (MMES).

2.6 In some instances, victims will require isolation resulting from a release of a contagious biological agent. Specific authorities and responsibilities are contained in the Emergency Health Powers Act. Isolation or shielding of patients or victims may also be necessary in the incident of dispersal of a highly energetic radiological agent resulting in internal contamination, in order to protect medical or emergency personnel from significant radiation dose (patients may become sources of radiation dose).

3.0 Concept of Operations

3.1 General

The audience for the Basic Plan/SOG needs to picture the sequence and scope of the planned emergency response or procedure. The concept of operations section explains the DPH's overall approach to an emergency situation, response or procedure, i.e., what should happen, when, and at whose direction. The concept of operations should broadly explain operations and procedures. The Tabs should incorporate more of the details of the Basic Plan/SOG. Topics in the Basic Plan should include concept of operations, notification, activation, deployment, command and control, roles and responsibility, plan maintenance and training, exercise and evaluation. The general statement should be 1 to 2 pages to broadly outline the details of the Plan/SOG.

Plans/SOGs should utilize common language and stay away from using command words i.e. will and shall. See *Tab C Plan Common Language Guide*.

3.2 Topic 1

3.2.1 Topics outlined in your general statement should be broadly explained in your concept of operations. Each topic should have its own header or title.

3.3 Topic 2

3.3.1

3.4 Topic 3

3.4.1

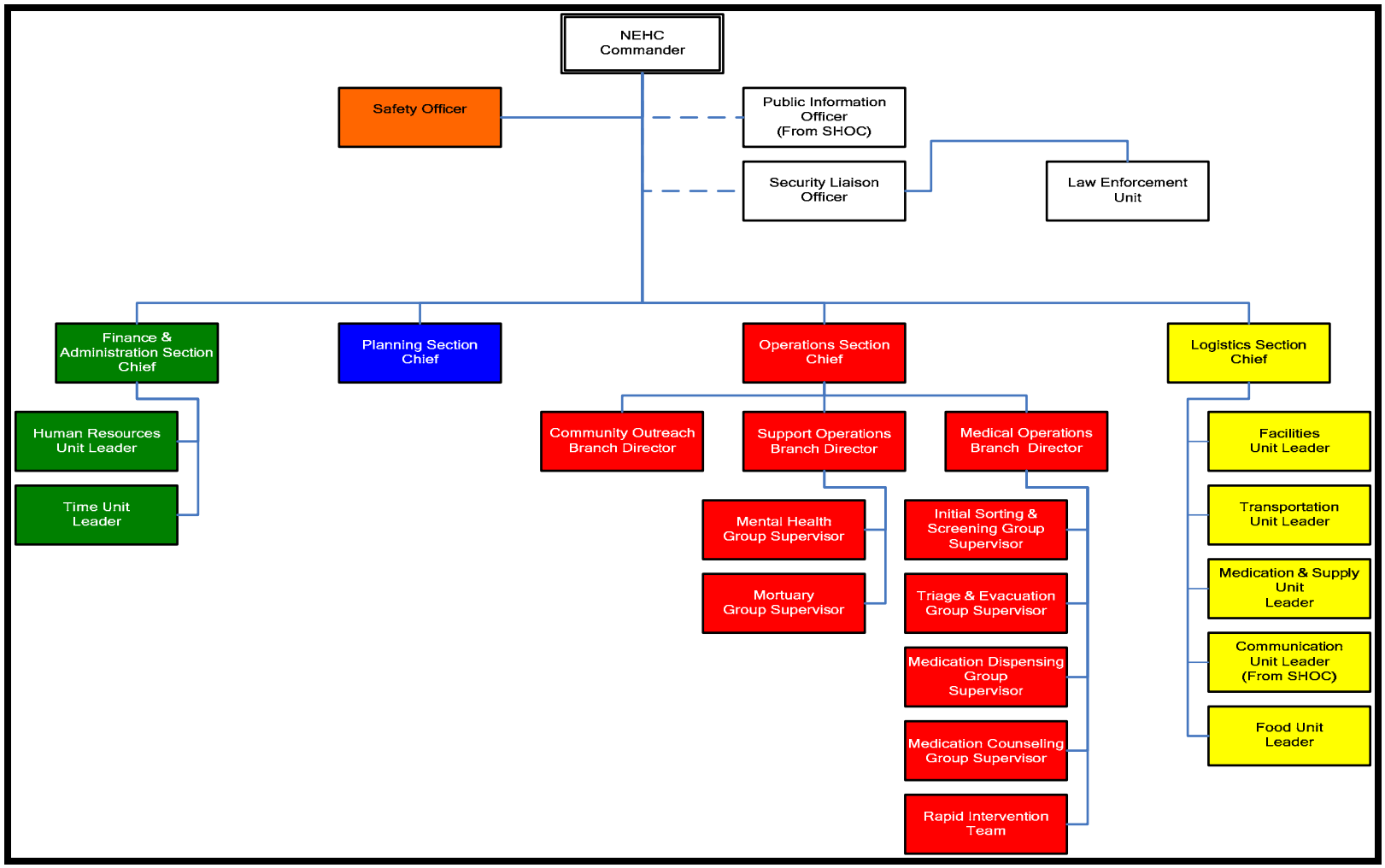
3.5 Topic 4

3.6 Figures

3.6.1 Figures i.e. graphs and organizational charts should be labeled as "Figure 2-1 SHOC Organization Chart". The 2 represents the section and the one represents that it is the first figure in that section. *Titles of the figure should be level 2 so that they show up in the table of contents.*

3.6.2 Example below:

Figure 3-1—NEHC Organizational Chart 'Example'



3.7 Tables

3.7.1 Word tables and excel spreadsheets should be label as “Table 3-1 Pandemic Influenza Priority Vaccination”. The 3 represents the section and the 1 represents that it is the first table in the section. *Titles of the table should be level 2 so that they show up in the table of contents.*

3.7.2 Example below:

Table 3-1 Stages of a Pandemic 'Example'

PHASE	INTERPANDEMIC PERIOD	RATIONALE
Phase 1	No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human infection or disease is considered to be low.	It is likely that influenza subtypes that have caused human infection and/or disease will always be present in wild birds or other animal species. Lack of recognized animal or human infections does not mean that no action is needed. Preparedness requires planning and action in advance.
Phase 2	No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.	The presence of animal infection caused by a virus of known human pathogenicity may pose a substantial risk to human health and justify public health measures to protect persons at risk.
	PANDEMIC ALERT PERIOD	
Phase 3	Human infection(s) with a new subtype but no human-to-human spread, or at most rare instances of spread to a close contact.	The occurrence of cases of human disease increases the chance that the virus may adapt or reassort to become transmissible from human to human, especially if coinciding with a seasonal outbreak of influenza. Measures are needed to detect and prevent spread of disease. Rare instances of transmission to a close contact – for example, in a household or health-care setting – may occur, but do not alter the main attribute of this phase, i.e. that the virus is essentially not transmissible from human to human. Example-One or more unlinked human cases with a clear history of exposure to an animal source/non-human source (with laboratory confirmation in a WHO-designated reference laboratory).
Phase 4	Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.	Virus has increased human-to-human transmissibility but is not well adapted to humans and remains highly localized, so that its spread may possibly be delayed or contained. Example- One or more clusters1 involving a small number of human cases, e.g. a cluster of <25 cases lasting <2 weeks.
Phase 5	Larger cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans but may not yet be fully transmissible (substantial pandemic risk).	Virus is more adapted to humans, and therefore more easily transmissible among humans. It spreads in larger clusters, but spread is localized. This is likely to be the last chance for massive coordinated global intervention, targeted to one or more foci, to delay or contain spread. In view of possible delays in documenting spread of infection during pandemic *phase 4*, it is anticipated that there would be a low threshold for progressing to *phase 5*. Example-Ongoing cluster-related transmission, but total number of cases is not rapidly increasing, e.g. a cluster of 25–50 cases and lasting from 2 to 4 weeks.
	PANDEMIC PERIOD	
Phase 6	Pandemic: increased and sustained transmission in general population.	Major change in global surveillance and response strategy, since pandemic risk is imminent for all countries. The national response is determined primarily by the disease impact within the country.
	POST PANDEMIC PERIOD	
Post	Return to the Interpandemic Period (Phase 1)	

3.8 **Notification and Activation**

3.8.1 How are personnel notified and activated and by whom. Through DENS, call down rosters, phone calls, etc?

3.9 **Deployment**

3.9.1 This section should include the following topics:

3.9.1.1 Staging area

3.9.1.2 Equipment

3.9.1.3 Transportation requirements, if needed

4.0 Agencies Roles and Responsibilities

4.1 This section establishes the emergency organization that will be relied on to respond to or responsible for the emergency situation, response, or procedure. It includes a listing by organization of what kinds of tasks are to be performed. This listing permits a quick grasp of who does what, without some of the procedural details included in the tabs. When two or more organizations perform the same kind of task, one should be given primary responsibility and the other(s) should be given a supporting role. A matrix of organizations or organizational chart and areas of responsibility (including functions) should be included to show at a glance the primary and supporting roles. The listing by organizations might also include organizations not under jurisdictional control, if they have defined responsibilities for responding to situation and/or responsibility for the procedure. *The following are examples*:

4.2 **State Agencies**

4.2.1 **The Office of the Governor**

4.2.1.1 Inter-pandemic and Pandemic Alert Responsibilities

- Provide oversight for pandemic influenza planning through the Public Health Emergency Planning Commission.

4.2.1.2 Pandemic Responsibilities

- Consider declaring a State of Emergency.

- Request the Strategic National Stockpile (SNS) from the Centers for Disease Control and Prevention (CDC).

- Coordinate and/or delegate public information efforts. Establish a Joint Information Center (JIC) in conjunction with DEMA and other state agencies, when necessary.

4.2.2 **Department of Health and Social Services (DHSS)**

4.2.2.1 Inter-pandemic and Pandemic Alert Responsibilities

- Provide support and personnel for DPH pandemic influenza preparations.

4.2.2.2 Pandemic Responsibilities

- Provide assistance, as required, to support response operations.
- Provide personnel to support NEHCs.

4.2.3 **Division of Public Health**

4.2.3.1 Inter-pandemic and Pandemic Alert Responsibilities

- Provide oversight for pandemic influenza, disease surveillance, laboratory assessment, vaccine management, immunization, medical surge, mass fatality, influenza public education, and health and risk communication planning.
- Coordinate with other state agencies and partners on pandemic influenza planning and preparedness (i.e. Department of Corrections (DOC), county governments, local municipalities, etc).

5.0 Command and Control

5.1 This section details 'who' is responsible for the emergency situation and lays out the reporting structure. Organization charts should be included in the plan for a transparent chain of command. The National Incident Management System (NIMS) should be utilized in constructing a command structure.

5.2 For public health emergencies and other emergency situations, DPH utilizes the State Health Operations Center (SHOC) to oversee the emergency at hand. See the *State Health Operations Center (SHOC) Plan* for further details.

5.3 Not all SOGs should have a 'Command and Control' section.

6.0 Communications

6.1 The communications section provides information on establishing, using, maintaining, augmenting, and providing backup for all of the types of communications devices needed during emergency response operations.

7.0 Staffing Guidelines

7.1 This section should detail staffing requirements to operate command structure and public health response facilities which are part of the Modular Medical Expansion System (MMES).

8.0 Plan Development and Maintenance

Example language:

8.1 DPH is responsible for the SNS plan development and maintenance.

8.2 The SNS Planning Committee advises DPH in the development and maintenance of the SNS plan.

8.3 DPH attempts to secure funding for the SNS Program continued operation.

8.4 All participants are to review the plan annually and submit suggested changes to DPH.

8.5 Contact numbers are updated quarterly by DPH.

8.6 Memorandums of Agreement are reviewed annually.

9.0 Training and Exercise

Example language:

9.1 The Public Health Preparedness Section (PHPS) is responsible for providing education and training on the SNS plan to DPH employees and DPH's partner organizations.

9.2 Individuals selected to serve on the RCT will attend CDC sponsored SNS training programs as offered within six months of appointment.

9.3 Required training will be offered after the plan has been revised.

9.4 The SNS plan will be exercised annually. This may be accomplished through a tabletop, functional or full-scale exercise.

9.5 Whenever possible, the SNS programs' Training and Exercise Device (TED) will be requested to support a functional or full-scale exercise.

9.6 Just-In-Time Training

9.6.1 Definition – Just-in-Time Training is a concise, specific training provided just prior to its usage.

9.6.2 Situation – JIT is most typically used to orient new staff to their role. Pro-longed events, events that cause workforce shortages, changes in procedures, new staff, are some reasons why JIT may be needed.

9.6.3 Delivery - JIT will most likely be delivered on site by Supervisors who have received Train-the –Trainer classes. The SHOC Logistics may deploy the JIT Team to the site. JIT may also be available via videoconference, pre-deployed materials and distance learning (DeTRAIN).

9.6.4 Content – JIT Content for the RSS includes

9.6.4.1 Incident Command Structure

9.6.4.2 Sequence of Events

9.6.4.3 Description of RSS Operations and Facility Orientation

9.6.4.4 Review of Job Action Sheets and Responsibilities

9.6.4.5 RSS Forms and Brief Overview of SNS Inventory Management System

9.6.4.6 Safety

10.0 Evaluation and Quality Improvement

10.1 PHPS will require After Action Reports (AARs) for each exercise conducted.

10.2 PHPS will review AAR and consider recommendations for improvement and will follow HSEEP guidelines.

10.3 Quality assurance and improvement activities including reviews of policy, procedures, protocols and processes are incorporated as part of the annual plan review.

11.0 Tabs

Tab A References

Note: Review and follow *PHPS Internal Procedures "Planning"*, pages 92 to 100, in developing plans and SOGs.

Example

1.0 *PHPS Internal Procedures*, pages 92-100

2.0 SLG 101: *Guide for All-Hazard Emergency Operations Planning*

Tab B Glossary

Example (includes all acronyms and definitions)

A

AAR—After Action Report

ACC—Acute Care Center

ACLS—Advanced Cardiac Life Support

ALS—Advanced Life Support

APN—Advanced Practical Nurse

B

C

CBRNE—Chemical, Biological, Radiation, Nuclear, or Explosive

CDC—Center for Disease Control and Prevention

CHA—County Health Administrator

Channel—A radio frequency used for two-way communications. See "talk group."

COPN—Community Outreach Provider Network

COS—Community Outreach Section

CTS—Casualty Transport System

D

"Deceased" Patient—Patient who has died as the result of exposure to chemical, biological, radiological, nuclear, or explosive agent.

Delaware Emergency Notification System (DENS)—A system that can call telephone numbers and alert pagers. A prerecorded message is played to all telephone numbers. Pagers may be numeric or alpha-numeric.

"Delayed" Patient—Patient who has become ill and should be evacuated within two hours to prevent their condition from deteriorating.

DelDOT—Delaware Department of Transportation

DEMA—Delaware Emergency Management Agency

DENS—Delaware Emergency Notification System

DHAN—Delaware Health Alert Network

DHSS—Delaware Health and Social Services

DOE—Department of Education

DPC—Disease Prevention and Control

DPH—Division of Public Health

DPS—Delaware Pharmacists Society

DSAMH—Division of Substance Abuse and Mental Health

DSFS—Delaware State Fire School

DSP—Delaware State Police

E

ED—Emergency Departments

EOC—Emergency Operations Center

EMT-B—Emergency Medical Technician-Basic

EMS—Emergency Medical Services

"**Expectant/Deceased" Patient**—Patient who is expected to die despite the best medical care available

F

FAC—Facility Administrator Center

G

H

Head of Household Process—A method of dispensing prophylactic medication to a family by having the head of the household pick up the medications.

HR—Human Resources

HRSA—Health Resources and Services Administration

I

ICS—Incident Command System

"Immediate" Patient—Patient who should be evacuated as soon as possible, not exceeding one hour, in order to save life or limb.

ISS—In-state Stockpile

J

K

L

M

MCI—Mass Casualty Incident

ME—Medical Examiner

"Minor" Patient—Patient whose condition is not expected to worsen significantly while awaiting evacuation.

N

NEHC—Neighborhood Emergency Help Center

Neighborhood Emergency Help Center (NEHC)—A facility operated by the Division of Public Health to provide prophylaxis, medical triage and sheltering, and serve as a gateway into the healthcare system in the event of a disaster or public health event.

NHS—Northern Health Services

NIMS—National Incident Management System

"Not Sick" Client—Client who is able to walk on their own, follow simple commands, and are free of fever, active coughing or are otherwise asymptomatic and are not suffering from incident-related trauma.

O

OCME—Office of the Chief Medical Examiner

P

PA—Physician Assistant

PAO—Public Affairs Officer

PHPS—Public Health Preparedness Section

PIO—Public Information Officer

POD—Points of Dispensing

PPE—Personal Protective Equipment

Q

R

RPM—Respiratory, Perfusion, and Mental Status

S

SHO—State Health Officer

SHOC—State Health Operations Center

SHS—Southern Health Services

Sick Patient—Patient who has a fever, respiratory distress, other symptoms, or has an obvious life threatening condition.

Simple Triage and Rapid Treatment (START)—Process used to categorize patients based on the presence or absence of ventilation, capillary perfusion, and mental status.

SNS—Strategic National Stockpile

Special Needs Client—Client including non-English speaking, pediatric, medication allergies, and others who need some form of specialized assistance.

START—Simple Triage and Rapid Treatment

State Health Operations Center (SHOC)—Center with the overall responsibility of managing public health's response to an event.

T

Talk Group—Term used for channel in the 800 MHz radio system.

U

V

W

X

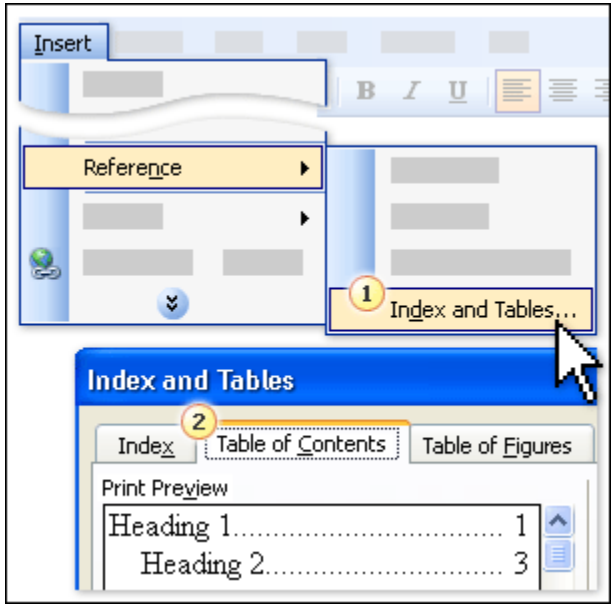
Y

Z

Tab C Detail Procedures

C-1 Table of Content Procedures

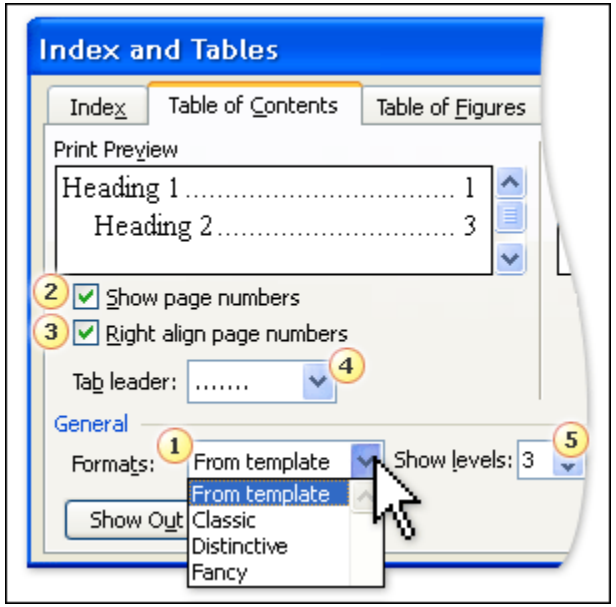
Table of Content Procedures:



1. On the **Insert** menu, point to **Reference**, then click **Index and Tables**.
2. Click the **Table of Contents** tab. If you want a TOC in the default style, just click **OK**.

COURSE TEXT

3. Once the text is marked, it's time to collect it all together in the TOC. This is where Word does the work for you.
4. First place the insertion point where you want the TOC to appear, usually at the beginning of the document. Then, on the **Insert** menu, point to **Reference** and click **Index and Tables**, then click the **Table of Contents** tab.
5. If you want to use the default options, click **OK** to create the TOC



1. Change the format of your TOC.
2. Show or hide page numbers.
3. Align page numbers.
4. Choose a tab leader.
5. Choose the number of levels required.
6.

COURSE TEXT

7. Changing the appearance of your TOC is simple. You can do it as you create the TOC or after it's built.
8. In the **Index and Tables** dialog box you can choose from a variety of built-in formats, such as Modern, Formal, or Simple. Simply click the arrow in the **Formats** box and choose whichever one you like. See the picture on the left for other options. (Not every built-in format offers all of the options shown in the picture.)

9. The **From template** option is a format that refers to an existing TOC style in the document you're working in. This means that instead of applying a new format, you could make changes to the existing TOC's format; so if you had chosen the **Classic** format you could then go back and make amendments to it. (If there is no existing TOC style in the document you're working in, then it will be a plain TOC with only the formatting you choose to apply in the dialog box.)
10. After redesigning an existing TOC in the dialog box, you'll be asked if you want to replace the old one. Just click **OK**: You'll replace the old TOC with the one including your new format.

Notes

- There's nothing stopping you from editing the TOC by hand and changing the appearance of each entry individually; just remember to make this the very last thing you do, and don't update the TOC afterwards because you'll lose all the changes.
- It's also possible to design your own TOC format. See the Quick Reference Card at the end of the course for details

C-2 Font Size, Outline Numbering & Creating Charts

1.0 Font Size & Style

1.1 All font is Times New Roman

1.2 Department and Division Header is 14 Font Bold

1.3 Title of plan and SOG is 20 Font Bold

1.4 Table of contents 12 Font Bold

1.5 Body of plan/SOG is 12 Font

1.6 Headings 1.0, 2.0 etc 12 Font Bold

1.7 Heading emphasize 12 Font Bold. Utilize to emphasis a subject and in writing the concept of operations.

1.8 Tab Headings is 16 Font Bold

1.9 Tab Sub Headings is 14 Font Bold

1.10 Title of plans or SOGs referred in the text is 12 Font Italics

2.0 Outline Numbering

2.1 The main body of the plan must utilize outline number format.

2.2 The main headings will be numbered sequentially followed by a decimal and a "0" ("1.0", "2.0", "3.0", etc).

2.3 The first subheadings will be indented from the main heading and have one decimal and will be numbered sequentially ("1.1", "1.2", "1.3", etc.). Align the number with the words on the text in previous statements. This procedure is followed throughout the entire plan.

2.4 The second subheadings will be indented from the first subheading and have two decimals and numbered sequentially ("1.1.1", "1.1.2", "1.1.3", etc.).

2.5 The third subheadings will be indented from the second subheading and have three decimals and w numbered sequentially ("1.1.1.1", "1.1.1.2", "1.1.1.3", etc.).

2.6 Fourth subheadings will not be numbered; they will be indented from the third subheading and be separated by bullets ("•").

2.7 Number & Text Position

2.7.1 1.0 – 0" to .5"

2.7.2 1.1 - .5" to 1.0"

2.7.3 1.1.1 – 1.0" to 1.5"

2.7.4 1.1.1.1 – 1.5" to 2.0"

2.7.5 • - 2.0" to 2.2"

2.7.6 Set up number and text positions prior to writing plan. Go to bullets and number and utilize outline numbering. Click on to customize at the lower right hand corner and create the above positions.

2.7.7 Tabs

2.7.7.1 For Tab Heading Outlining utilize A, B, C, D, etc. Use similar set-up and examples in this document.

2.7.7.2 Tab Sub-Heading Outlining utilize A-1, A-2, etc. Center the sub-heading in the middle of the page.

3.0 Creating Charts

3.1 Organization charts, flow charts, or other diagrams are created using Microsoft Visio. Save a copy of the chart or diagram in Microsoft PowerPoint or Microsoft Word to allow users without Visio software to read the drawings

3.2 Figures and tables appearing in a plan need to be labeled with the plan heading or subheading number and a sequential number as they appear. For example, figures found in Appendix A of a plan would be labeled, “Figure A-1” and “Figure A-2”, etc. or tables within the third section of a plan would be labeled, “Table 3-1” and “Table 3-2”, etc.

C-3 Writing Concerns and Helpful Hints

1.0 Utilization of common language, correct tense, and/or active or passive voice in planning documents is difficult.

2.0 For the most part a plan or SOG or nonscientific writing situations, active voice is preferable to passive for the majority of your sentences. Even in scientific writing, overuse of passive voice or use of passive voice in long and complicated sentences can cause readers to lose interest or to become confused. Sentences in active voice are generally--though not always-- clearer and more direct than those in passive voice.

2.1 **Example**

2.1.1 **Passive – Margaret Anderson was chosen "Employee of the Year" by Governor Minner.**

2.1.2 **Active (Correct) – Governor Minner chose Margaret Anderson as "Employee of the Year."**

3.0 There are times to use the passive voice.

3.1 To emphasize the receiver – "Alicia Brown has been elected our new Director."

3.2 To Soften a message – "The photocopier has been broke."

4.0 Writing professionals say that your document should be between 25 to 40% passive. In Microsoft Word under tools the options, select the Spelling and Grammar folder and check the "show readability statistics". This option feedback shows you the % of passive voice and the education level of your document.

5.0 In planning documents try to stay away from utilizing *will or shall* except for referring to laws, regulations, policies, or a promise and utilize words such as *may, would, and should*.

6.0 Other Helpful Hints:

6.1 Rely on past tense to narrate events and to refer to an author or an author's ideas as historical entities (biographical information about a historical figure or narration of developments in an author's ideas over time).

6.2 Use present tense to state facts, to refer to perpetual or habitual actions, and to discuss your own ideas or those expressed by an author in a particular work. Also use present tense to describe action in a literary work, movie, or other fictional narrative. Occasionally, for dramatic effect, you may wish to narrate an event in present tense as though it were happening now. If you do, use present tense consistently throughout the narrative, making shifts only where appropriate.

6.3 Future action may be expressed in a variety of ways, including the use of *will*, *shall*, *is going to*, *are about to*, *tomorrow* and other adverbs of time, and a wide range of contextual cues.

7.0 Applying Parallel Structure

7.1 Parallel structure means using the same pattern of words to show that two or more ideas have the same level of importance. The use of parallel structure happens in plans or SOGs frequently.

7.2 Example

7.2.1 Examples of aggressive driving violations are as follows:

7.2.1.1 Disregarding a traffic control device.

7.2.1.2 Passing on the shoulder.

7.2.1.3 Making an unsafe lane change.

7.2.1.4 Speeding.

7.2.1.5 Failing to yield when turning left.

7.3 A parallel structure that begins with clauses must keep on with clauses. Changing to another pattern or changing the voice of the verb (from active to passive or vice versa) will break the parallelism.

7.4 Parallel structure can start with “ing form of words” or with infinitive phrases i.e. to hike, to pass, to speed.

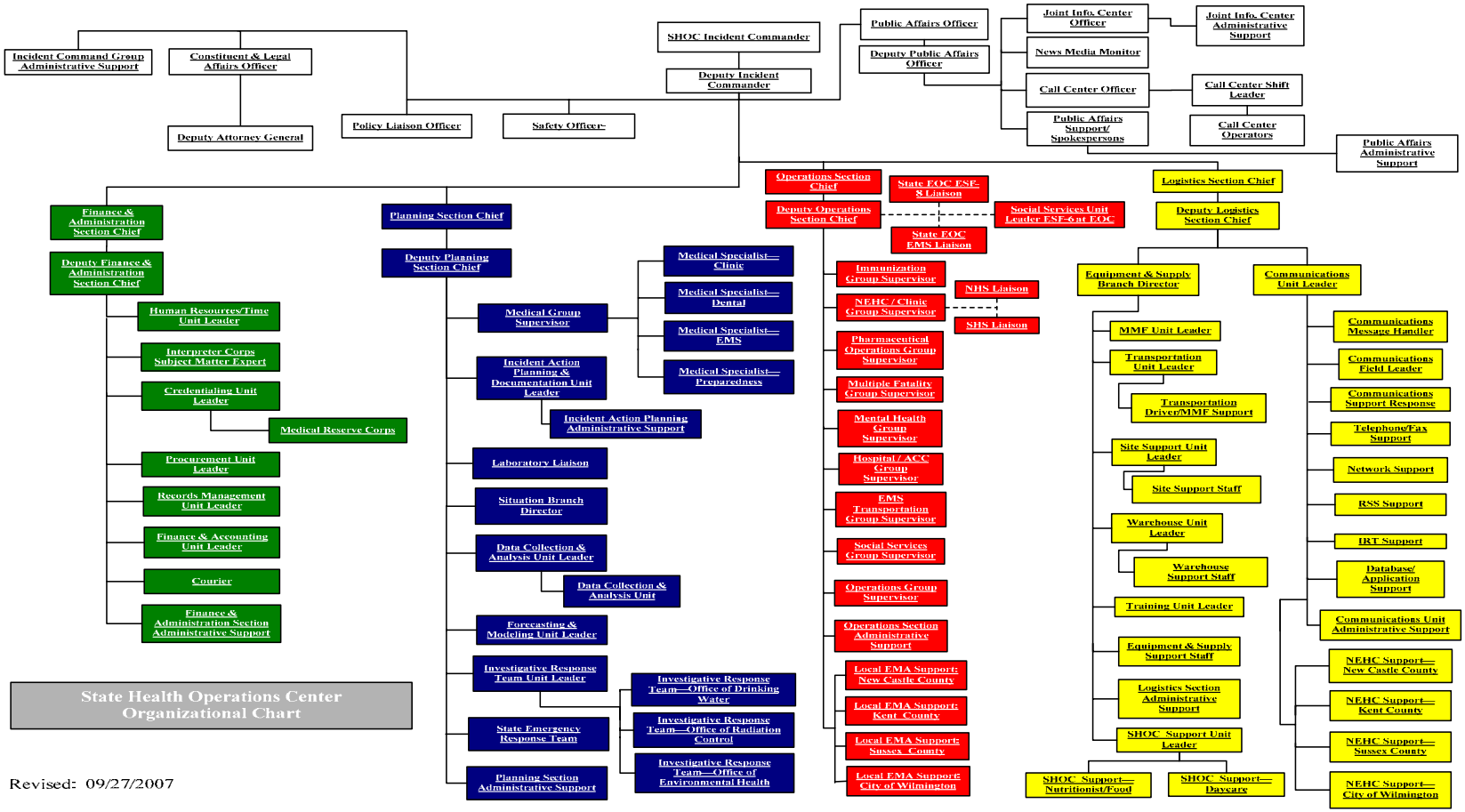
8.0 Writing online resources:

8.1 http://owl.english.purdue.edu/handouts/index.html

Tab D Example Organization Charts

1.0 Create organization charts in Microsoft Visio and cut and past into your plan or SOG.

2.0 Example Org Chart


Incident Command Group Administrative Support
Constituent & Legal Affairs Officer
Deputy Attorney General
Policy Liaison Officer
Safety Officer
SHOC Incident Commander
Deputy Incident Commander
Public Affairs Officer
Deputy Public Affairs Officer
Joint Info. Center Officer
Joint Info. Center Administrative Support
News Media Monitor
Call Center Officer
Call Center Shift Leader
Public Affairs Support/ Spokespersons
Call Center Operators
Public Affairs Administrative Support
Finance & Administration Section Chief
Deputy Finance & Administration Section Chief
Human Resources/Time Unit Leader
Interpreter Corps Subject Matter Expert
Credentialing Unit Leader
Medical Reserve Corps
Procurement Unit Leader
Records Management Unit Leader
Finance & Accounting Unit Leader
Courier
Finance & Administration Section Administrative Support
Planning Section Chief
Deputy Planning Section Chief
Medical Group Supervisor
Medical Specialist—Clinic
Medical Specialist—Dental
Medical Specialist—EMS
Medical Specialist—Preparedness
Incident Action Planning & Documentation Unit Leader
Incident Action Planning Administrative Support
Laboratory Liaison
Situation Branch Director
Data Collection & Analysis Unit Leader
Data Collection & Analysis Unit
Forecasting & Modeling Unit Leader
Investigative Response Team Unit Leader
Investigative Response Team—Office of Drinking Water
Investigative Response Team—Office of Radiation Control
Investigative Response Team—Office of Environmental Health
State Emergency Response Team
Planning Section Administrative Support
Operations Section Chief
Deputy Operations Section Chief
State EOC ESF-8 Liaison
Social Services Unit Leader ESF-6 at EOC
State EOC EMS Liaison
Immunization Group Supervisor
NEHC / Clinic Group Supervisor
NHS Liaison
SHS Liaison
Pharmaceutical Operations Group Supervisor
Multiple Fatality Group Supervisor
Mental Health Group Supervisor
Hospital / ACC Group Supervisor
EMS Transportation Group Supervisor
Social Services Group Supervisor
Operations Group Supervisor
Operations Section Administrative Support
Local EMA Support: New Castle County
Local EMA Support: Kent County
Local EMA Support: Sussex County
Local EMA Support: City of Wilmington
Logistics Section Chief
Deputy Logistics Section Chief
Equipment & Supply Branch Director
MMF Unit Leader
Transportation Unit Leader
Transportation Driver/MMF Support
Site Support Unit Leader
Site Support Staff
Warehouse Unit Leader
Warehouse Support Staff
Training Unit Leader
Equipment & Supply Support Staff
Logistics Section Administrative Support
SHOC Support Unit Leader
SHOC Support—Nutritionist/Food
SHOC Support—Daycare
Communications Unit Leader
Communications Message Handler
Communications Field Leader
Communications Support Response
Telephone/Fax Support
Network Support
RSS Support
IRT Support
Database/ Application Support
Communications Unit Administrative Support
NEHC Support—New Castle County
NEHC Support—Kent County
NEHC Support—Sussex County
NEHC Support—City of Wilmington
State Health Operations Center Organizational Chart
Revised: 09/27/2007

Tab E Laws, Regulations, MOU or Formal Agreement

1.0 Copies of the laws, MOUs, or Formal Agreements should be place in the tab.

2.0 Example MOU

MEMORANDUM OF AGREEMENT

BETWEEN

STATE OF DELAWARE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

AND

ASTRAZENECA PHARMACEUTICALS LP FOR

RECEIPT, STAGING, STORAGE AND DISTRIBUTION

OF THE

STRATEGIC NATIONAL STOCKPILE

WHEREAS the Delaware Department of Health and Social Services and AstraZeneca Pharmaceuticals LP ("AstraZeneca") wish to enter into an agreement pursuant to which AstraZeneca would allow a portion of its warehouse and distribution facility located at 587 Baltimore Pike, Newark, Delaware (the "Facility") to be used as a Strategic National Stockpile Program (SNS) "receipt, staging and storage" (RSS) site, and

WHEREAS the Delaware Department of Health and Social Services has responsibility to plan for the Strategic National Stockpile Program under the Cooperative Agreement with the Centers for Disease Control and Prevention, and

WHEREAS the Delaware Department of Health and Social Services has the statutory authority under Delaware Code Title 20, Chapter 31, Subchapter V and the US Public Law 93-288, The Disaster Relief Act of 1974, to identify facilities and services necessary to appropriately plan for emergency response to a disaster situation, including plans for the receipt staging and storage and distribution of the supplies pursuant to the SNS, and

WHEREAS the Delaware Department of Health and Social Services finds it in the public interest to plan for the receipt and the efficient staging, storage and distribution of the SNS in Delaware, and

WHEREAS AstraZeneca has volunteered its Facility for use in the event of an "Emergency" in Delaware under the terms and conditions described in this Agreement, and

WHEREAS AstraZeneca has agreed that there will be no compensation from the Delaware Department of Health and Social Services to AstraZeneca for this purpose, but if eligible, AstraZeneca may seek reimbursement from local/state/federal sources for the services provided.

Page 1 of 8

Tab G Job Action Sheets (JAS)

1.0 If required, place Job Action Sheets (JAS) in a tab.

2.0 Example Job Action Sheet (JAS)

INCIDENT COMMANDER **JOB ACTION SHEET** To provide overall command and control for SHOC operations.
NAME: _____ **DATE:** _____

DATE/TIME TASK DONE	TASK DESCRIPTION	REFERENCE
Level 1—Heightened Assessment		
	Review assigned Job Action Sheet.	
	Review and revise assignments of section chiefs, back ups, and others as needed.	
	Schedule a conference call with sections chiefs and back ups.	
	Based on the conference call, decide if: A) Additional conference calls need to be scheduled. B) The SHOC activation level needs to be raised.	
	Direct all agencies and organizations to update contact information of key personnel.	
Level 2—Localized Event, Potential Statewide Impact		
	If not completed in Level 1 activation, complete review and revision of assignments for section chiefs, back ups, and others as needed.	
	Ensure appropriate functions in Finance and Administration, Operations, Planning, and Logistics Sections are activated and potentially staffed for 24 hour, 7 day operation.	
	Schedule a conference call with sections chiefs and back ups.	
	Confirm completion of updates to contact information for key personnel.	
Level 3—Statewide Emergency		

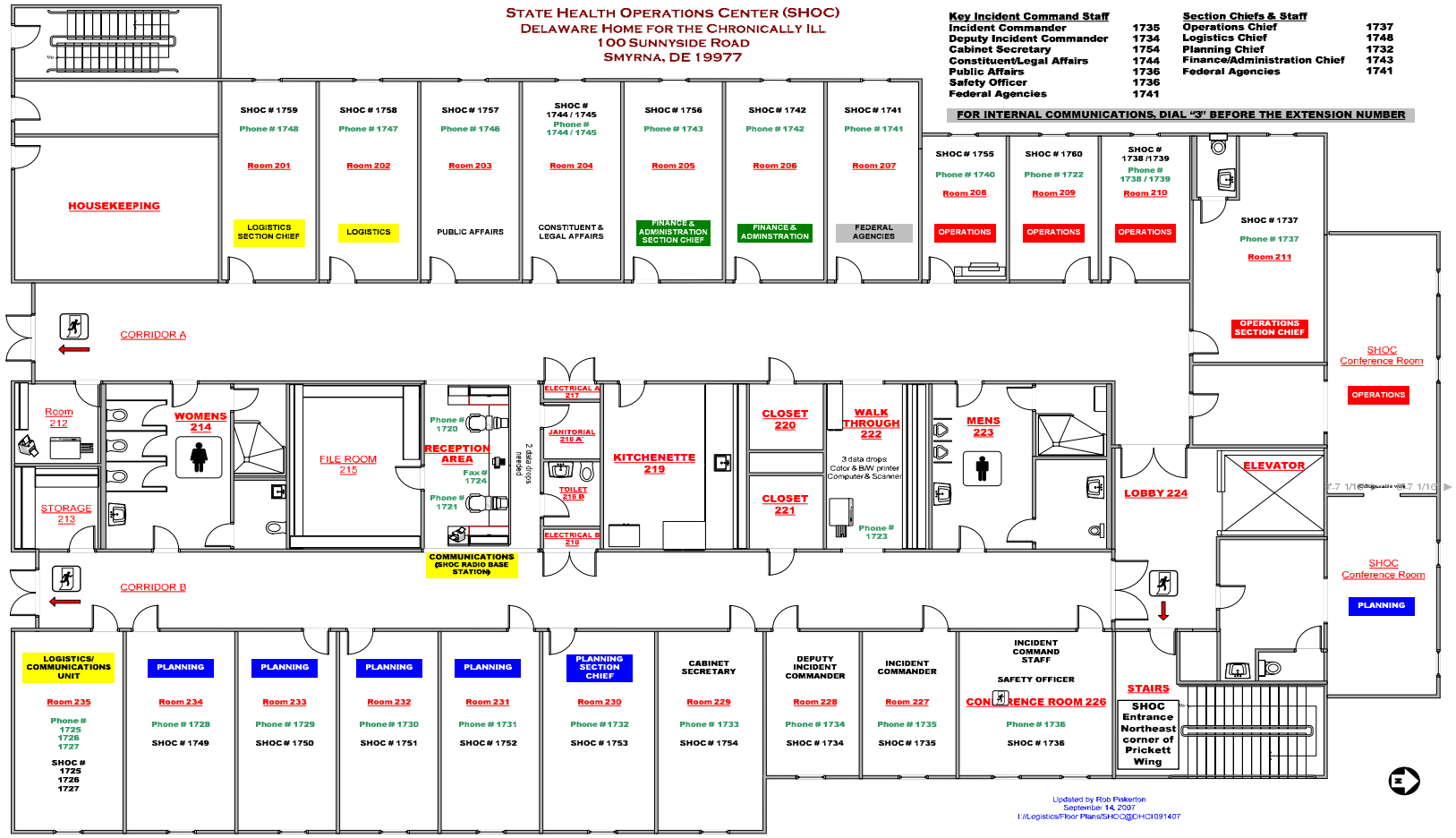
DATE/TIME TASK DONE	TASK DESCRIPTION	REFERENCE
	Put on identification vest.	
	Recall staff as required to manage the event.	
	Consider the need for staffing of Planning, Finance and Administration, Operations, and Logistics functions, as needed, on a 24 hours, 7 days a week basis.	
	Direct updating of all lists of contacts, including telephone numbers, fax numbers, and e-mail addresses of government agencies needed to support SHOC.	
	Conduct an early briefing for the Incident Command Group staff and section chiefs.	
	Direct development of an initial IAP.	
	Review and approve initial IAP.	
	Review and approve all future IAPs prior to distribution.	
	Confirm that the Communications Unit has distributed DEMA conference call information to: A) Section Chiefs B) DHSS Disaster Coordinators C) Hospitals	
	Review and approve all official documents and actions (e.g., press releases, quarantine, isolation, etc.)	
	Chair Incident Command Group staff and section chiefs' meetings on a regular basis. Frequency will be based upon type of event and its complexity.	
	Ensure continuing liaison and coordination with the Secretary of Health and Social Services.	
	Participate in joint briefings, as needed.	
	Coordinate public health actions with adjoining states.	
	Recommend declaration of a public health emergency, if required.	
	Review and approve distribution of Public Health resources when requested.	
	Review and approve plans to provide staffing for field response operations.	

DATE/TIME TASK DONE	TASK DESCRIPTION	REFERENCE
Demobilization		
	Review and approve the demobilization plan before it is issued.	
	Direct all SHOC sections to forward all documents to the IAP & Documentation Unit including copies of any electronic records generated as part of the emergency response. Generally, the information should be relevant to: A) Expense recovery. B) Intelligence (non-classified) or other data that supports decisions made during the event. C) Copies of all official communications generated during the event including DHAN communications. D) Purchase orders, contracts, and inventory records (pre- and post- incident).	
	Coordinate with PHPS, about the strengths of and deficiencies in the response for inclusion in the AAR. Include suggestions to correct the deficiencies, where appropriate.	
	Review and approve a summary report of the event for the Secretary of DHSS.	

Tab H Facility Layouts

1.0 If required, place Facility Layouts in a tab.

2.0 Example Facility Layout


STATE HEALTH OPERATIONS CENTER (SHOC)
DELAWARE HOME FOR THE CHRONICALLY ILL
100 SUNNYSIDE ROAD
SMYRNA, DE 19977
Key Incident Command Staff
Incident Commander 1735
Deputy Incident Commander 1734
Cabinet Secretary 1754
Constituent/Legal Affairs 1744
Public Affairs 1736
Safety Officer 1736
Federal Agencies 1741
Section Chiefs & Staff
Operations Chief 1737
Logistics Chief 1748
Planning Chief 1732
Finance/Administration Chief 1743
Federal Agencies 1741
FOR INTERNAL COMMUNICATIONS, DIAL "3" BEFORE THE EXTENSION NUMBER
HOUSEKEEPING
SHOC # 1759 Phone # 1748 Room 201 LOGISTICS SECTION CHIEF
SHOC # 1758 Phone # 1747 Room 202 LOGISTICS
SHOC # 1757 Phone # 1746 Room 203 PUBLIC AFFAIRS
SHOC # 1744 / 1745 Phone # 1744 / 1745 Room 204 CONSTITUENT & LEGAL AFFAIRS
SHOC # 1756 Phone # 1743 Room 205 FINANCE & ADMINISTRATION SECTION CHIEF
SHOC # 1742 Phone # 1742 Room 206 FINANCE & ADMINSTRATION
SHOC # 1741 Phone # 1741 Room 207 FEDERAL AGENCIES
SHOC # 1755 Phone # 1740 Room 208 OPERATIONS
SHOC # 1760 Phone # 1722 Room 209 OPERATIONS
SHOC # 1738 /1739 Phone # 1738 / 1739 Room 210 OPERATIONS
SHOC # 1737 Phone # 1737 Room 211 OPERATIONS SECTION CHIEF
CORRIDOR A
Room 212
STORAGE 213
WOMENS 214
FILE ROOM 215
Phone # 1720
RECEPTION AREA
Fax # 1724
Phone # 1721
2 data drops
COMMUNICATIONS (SHOC RADIO BASE STATION)
ELECTRICAL A 217
JANITORIAL 218 A
TOILET 218 B
ELECTRICAL B 219
KITCHENETTE 219
CLOSET 220
CLOSET 221
WALK THROUGH 222
3 data drops Color & B/W printer Computer & Scanner
Phone # 1723
MENS 223
LOBBY 224
ELEVATOR
SHOC Conference Room OPERATIONS
SHOC Conference Room PLANNING
CORRIDOR B
LOGISTICS/ COMMUNICATIONS UNIT Room 235 Phone # 1725 1726 1727 SHOC # 1725 1726 1727
PLANNING Room 234 Phone # 1728 SHOC # 1749
PLANNING Room 233 Phone # 1729 SHOC # 1750
PLANNING Room 232 Phone # 1730 SHOC # 1751
PLANNING Room 231 Phone # 1731 SHOC # 1752
PLANNING SECTION CHIEF Room 230 Phone # 1732 SHOC # 1753
CABINET SECRETARY Room 229 Phone # 1733 SHOC # 1754
DEPUTY INCIDENT COMMANDER Room 228 Phone # 1734 SHOC # 1734
INCIDENT COMMANDER Room 227 Phone # 1735 SHOC # 1735
INCIDENT COMMAND STAFF SAFETY OFFICER CONFERENCE ROOM 226 Phone # 1736 SHOC # 1736
STAIRS
SHOC Entrance Northeast corner of Prickett Wing
Updated by Rob Pinkerton
September 14, 2007
I:/Logistics/Floor Plans/SHOC@DHCI091407

Tab I Forms

1.0 If required, place forms in a tab.

2.0 Example Form – "General Message Sheet"

GENERAL MESSAGE (IMS 213)		
TO:		**POSITION:**
FROM:		**POSITION:**
SUBJECT:	**DATE:**	**TIME:**
MESSAGE:		
SIGNATURE/POSITION:		
REPLY:		
DATE:	**TIME:**	**SIGNATURE:**