

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
ACRONYMS AND ABBREVIATIONS**

ACP	Access Control Point
ALERT	Automated Local Evaluation in Real Time
ANS	Alert and Notification System
ANAD	Anniston Army Depot
APG	Aberdeen Proving Ground
ARC	American Red Cross
ARES	Amateur Radio Emergency Services
BGAD	Blue Grass Army Depot
CB	Citizens Band
CCA	Comprehensive Cooperative Agreement
CCF	Congregate Care Facility
CCPS	Crime Control & Public Safety (NC Dept of)
CDC	Centers for Disease Control and Prevention
CEM	Comprehensive Emergency Management
“CEO”	Chief Executive Official
CERCLA	Comprehensive Environmental Response, Compensation and Liability Act
CFR	Code of Federal Regulations
CHEMTREC	Chemical Manufacturers’ Association Chemical Transportation Emergency Center
COG	Continuity of Government; also Council of Governments
CPG	Civil Preparedness Guide
CSEPP	Chemical Stockpile Emergency Preparedness Program
DAC	
DAO	Damage Assessment Officer

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DCI	Division of Criminal Information (formerly Police Information Network)
DEHNR	Department of Environment, Health & Natural Resources
DFO	Disaster Field Office
DHR	Department of Human Resources
DMAT	Disaster Medical Assistance Team
DOD	Department of Defense
DOE	Department of Energy
DOJ	Department of Justice
DOT	Department of Transportation
DRC	Disaster Recovery Center
DSS	Department of Social Services
DWI	Disaster Welfare Information
EAS	Emergency Action System (formerly EBS-Emergency Broadcast System)
EBS	Emergency Broadcast System
ECL	Emergency Classification Level
EHS	Extremely Hazardous Substances
EM	Emergency Management
EMA	Emergency Management Assistance (Federal Program)
EMC	Emergency Management Coordinator
EMI	Emergency Management Institute
EMP	Electromagnetic Pulse
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EOC	Emergency Operations Center

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EOP	Emergency Operations Plan
EOPC	Emergency Operation Plan Committee
EPA	U.S. Environmental Protection Agency
EPCRA	Emergency Planning and Community Right-to-Know Act
EPG	Emergency Planning Guide
EPI	Emergency Public Information
EPZ	Emergency Planning Zone
ERT	Emergency Response Team
ERT-A	Emergency Response Team Advance Element
ERT-N	Emergency Response Team National
ESF	Emergency Support Function
EST	Emergency Support Team
FasT	Field Assessment Team
FCC	Federal Communications Commission
FCO	Federal Coordinating Officer
FEMA	Federal Emergency Management Agency
FHBM	Flood Hazard Boundary Map
FIA	Federal Insurance Administration
FIRMS	Flood Insurance Rate Maps
FIS	Flood Insurance Study
FPEIS	Final Programmatic Environmental Impact Statement
FRC	FEMA Regional Coordinator
FRP	Federal Response Plan
GAR	Governor's Authorized Representative

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GIS	Geographic Information System
GS	General Statute
HAZMAT	Hazardous Materials
HICA/MYDP	Hazard Identification, Capability Assessment/Multi-Year Development Plan
HRCQ	Highway Route Controlled Quantity
IC	Incident Commander
ICP	Incident Command Post
ICS	Incident Command System
IEMS	Integrated Emergency Management System
IRZ	Immediate Response Zone
JIC	Joint Information Center
JIS	Joint Information System
JNACC	Joint Nuclear Accident Coordinating Center
LEPC	Local Emergency Planning Committee
MOU	Memorandum of Understanding
mph	miles per hour
mR	milliroentgen
MSDS	Material Safety Data Sheet
NAAP	Newport Army Ammunition Plant
NAWAS	National Warning System
NCDSS	North Carolina Division of Social Services
NCEM	North Carolina Division of Emergency Management
NCERC	North Carolina Emergency Response Commission
NCGS	North Carolina General Statutes

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NCNG	North Carolina National Guard
NCP	National Contingency Plan
NDA	National Defense Area
NDMS	National Disaster Medical System
NFA	National Fire Academy
NFIP	National Flood Insurance Program
NFPA	National Fire Protection Association
NHFC	National Hurricane Forecast Center
NOAA	National Oceanic and Atmospheric Administration
NOI	Notice of Interest (FEMA Form 90-49)
NRC	Nuclear Regulatory Commission; National Response Center
NRT	National Response Team
NUREG	Nuclear Regulation
NWS	National Weather Service
OEM	Office of Emergency Management
OPA	Oil Pollution Act
OSC	On Scene Coordinator
OSHA	Occupational Safety and Health Act
PA	Public Address
PAZ	Protective Action Zone
PBA	Pine Bluff Arsenal
PDA	Preliminary Damage Assessment
PIO	Public Information Officer
PL	Public Law

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
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PPA	Performance Partnership Agreement
PUDA	Pueblo Depot Activity
PZ	Precautionary Zone
RACES	Radio Amateur Civil Emergency Services
RADPRO	Radiation Protection
RAP	Radiological Assistance Program
REACT	Radio Emergency Associated Communications Teams
REP	Radiological Emergency Preparedness Program
RO	Radiological Officer
ROC	Regional Operating Center
ROD	Record of Decision
RRP	Regional Response Plan
SAME	Specific Area Message Encoder
SAR	Search and Rescue
SARA	Superfund Amendments and Reauthorizations Act
SBI	State Bureau of Investigations
SCO	State Coordinating Officer
SEMA	State Emergency Management Agency
SERC	State Emergency Response Commission (See NCERC also)
SERT	State Emergency Response Team
SLG	State and Local Guide
SOG	Standard Operating Guideline
SOP	Standard Operating Procedure
SPCA	Society for the Prevention of Cruelty to Animals

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
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SWP	State Warning Point
TDD	Telecommunications Device for the Deaf
TEAD	Tooele Army Depot
UMDA	Umatilla Depot Activity
USCG	United States Coast Guard
USDA	U.S. Department of Agriculture
USGS	U.S. Geological Survey
US&R	Urban Search and Rescue

GREENE COUNTY EMERGENCY OPERATIONS PLAN BASIC PLAN

I. PURPOSE

This plan predetermines actions to be taken by government agencies and designated private organizations within Greene County (which are in addition to their day to day responsibilities) to reduce the vulnerabilities of people and property to disaster and establish capabilities to respond effectively to the actual occurrence of a disaster or threat of a disaster.

II. SITUATION AND ASSUMPTIONS

A. Situation

1. Greene County is located in the East Central section of the state. It is bound on the east by Pitt County, on the south by Lenoir County, on the north by Wilson County and on the west by Wayne County.
2. There are 3 municipalities within the county as shown below: (estimated 2006 population – 20,157.) These municipalities utilize the forms of government as shown below:

<u>Municipality</u>	<u>Form of Government</u>
Hookerton	Mayor/Council
Snow Hill	Mayor/Council
Walstonburg	Mayor/Council

3. Three state correctional facilities are located in Maury. Eastern Correctional houses approximately 550 medium security prisoners. Greene Correctional houses approximately 650 minimum security prisoners. Maury Correctional houses approximately 1000 closed prisoners.
4. The major traffic arteries in the county are; US 264, US 13 & 258 and NC 58, 903 and 91.
5. One Railroad serves the county: Norfolk Southern Railway. The railway enters on Wilson/Greene county line and runs through Walstonburg and exits on Greene/Pitt county line. There is approximately 3 miles of track in the county.

6. Several bridges throughout the county are crucial for timely evacuations to occur these are:

C-2	258	C-17	258	C-37	258/13	C-44	58
C-4	258	C-20	258/13 Bypass	C-41	13	C-45	903
C-6	258	C-24	264 Alt	C-42	58	C-50	903
C-12	91	C-28	58				

NOTE: These bridges are located on the DOT bridge map located in the Emergency Management Office.

7. National Flood Insurance Program Administrator for Greene County is the County Building Inspectors. Maps indicating low lying flood areas are located in the county inspection office.
8. Greene County is exposed to many hazards, all of which have the potential to disrupt the community, cause damage and create casualties. Potential hazards are:
1. Hurricanes
 2. Major Fire
 3. Tornadoes
 4. Floods
 5. Hazardous Materials
 6. Drought
 7. Forest Fires
 8. Severe Bridge Damage
 9. Civil Disorders
 10. National Security Emergency
 11. Dam Failures
 12. Hazardous Materials Events
9. There are no airports located in Greene County.
10. Greene County receives weather warnings from the National Weather Service office in Newport.

B. Assumptions

1. One or more of the above listed emergency/disaster event occurring could impact Greene County severely with any one of the following events;
 - Loss of Electrical Power
 - Loss of water distribution, waste water and water treatment capabilities
 - Road networks becoming impassable
 - Need for mass care and/or feeding operations

- Damage or destruction of telephone and communication networks
 - Dramatic increase in media attention necessitating public information/rumor control
 - Need for federal/state assistance
 - Re-entry for public into damaged areas
 - Need for damage assessment
 - Auxiliary power for essential facilities
 - Problem of donated goods
 - Contamination of public and private wells
 - Depletion of resources
 - Damage or destruction of vital facilities
 - Reconstruction management program
 - Isolated citizens
 - Severe economic impact
 - Environmental impact on wildlife and the natural environment
 - Need for debris clearance and removal
 - Need for temporary debris burning sites
 - Increased number of vectors (animals that transmit a disease)
 - Damage or destruction of vital records
 - Presidential declared emergency or disaster
 - County and local government resources could be overwhelmed
2. The occurrence of more than one of the above listed emergency/disaster events could result in a catastrophic disaster situation, which would overwhelm local and state resources.
 3. It is necessary for the county and the municipalities to plan for and to carry out disaster response and short-term recovery operations utilizing NIMS, ICS and local resources; however, it is likely that outside assistance would be available in most major disaster situations affecting the county.
 4. Due to the threat of disruption of local government functions, all levels of government must develop standard operating procedures or guidelines (encompassing staffing, lines of succession and mode of operations) to ensure continuity of government.
 5. Officials of the county are aware of the possible occurrence of an emergency or major disaster along with their responsibilities in the execution of this plan and will fill these responsibilities as needed.

III. CONCEPT OF OPERATIONS

- A. General Statutes 166 A-2 requires County/City governments to organize and plan for the protection of life and property from the effects of hazardous events within its borders.
- B. In significant emergencies or disasters, direction and control will be carried out for the commissioners by the Emergency Services Director, the County Manager, or his designee.
- C. The County EOC will be staffed and operated as the situation dictates. When activated, operations area supported by ranking representatives from local government, state government (if representatives are provided), private sector and volunteer organizations to provide information, data, resources and recommendations as to actions needed to cope with the situation.
- D. The senior elected official or the designee of the jurisdiction (as defined in GS 14-288.1) may declare a State of Emergency to exist within the jurisdiction of any part thereof and begin implementing emergency procedures (Reference Authorities Section).
- E. Termination of a State of Emergency shall be declared by the authority whom it was issued.
- F. Facilities that have been identified as vital to operation of the county and local government functions have been identified (reference Vital Facility Information in the support manual).
- G. The County Manager and Emergency Services Director will coordinate and control resources of the county. Mayors of the municipalities will control their own resources.
- H. Emergency public information will be disseminated by all available media outlets through the public information officer (County Manager).
- I. Prior planning and training of personnel are prerequisites to effective emergency operations and must be considered as integral parts of disaster preparations.
- J. Coordination with surrounding jurisdictions is essential when events occur that impact beyond jurisdictional borders.
- K. All legal documents of either a public or private nature recorded by designate officials must be protected and preserved in accordance with existing law, statutes and ordinances.

- L. Departments, agencies and organizations assigned either primary or supporting responsibilities in this document must develop implementation documents in order to support this plan.
- M. When local government resources prove to be inadequate during emergency operations, request for assistance will be made to other jurisdictions, higher levels of government and other agencies in accordance with existing or emergency negotiating mutual aid agreements and understanding. Request for State or Federal resources must be made through the Greene County Emergency Services Director to the State EOC through Web EOC.
- N. When a disaster affect a relatively small portion of the county (i.e., one to the municipalities), the Emergency Services Office will respond to that municipality EOC to provide assistance and request state and local resources for the affected area. At no time will the county emergency services office assume direction and control of municipal resources.
- O. Municipalities, unaffected by the disaster may be requested to send personnel and equipment to other parts of the county to assist in mitigating the effects of the disaster on the citizens of the county.
- P. When a disaster overwhelms the capability of state and local governments, resources of federal departments and agencies may be needed.
- Q. The process for requesting and obtaining these federal resources must be understood by all parties.
- R. The Federal Response Plan (FRP) established the basis for fulfilling these federal governments role in providing response and recovery assistance to a state and its affected local governments impacted by a significant disaster of any kind, which results in a required federal response.
- S. Under this plan, departments and agencies having various authorities and resources have been assigned primary and support agency responsibilities for various Emergency Support Functions (ESF).
- T. These emergency support functions will work in concert with state agencies to provide the needed resources. All State and Federal resources will be delivered to Greene County's CRDP (County Receiving & Distribution Point). The CRDP for Greene County is the Emergency Services office and parking lot located between the Emergency Services office and Public Health.

- U. Under the provisions of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, a Federal Coordinating Officer (FCO) will be appointed as the Presidents' representative to coordinate overall delivery of federal assistance. Federal departments and agencies have been assigned missions to provide assistance directly to the state, under the overall direction of the FCO.
- V. Local governments will use their normal channel for requesting assistance and/or resources, i.e., through the County Emergency Operations Center to the State EOC. If state resources have been exhausted, the state will arrange to provide the needed resources using the ESF's as described in the Federal Response Plan.
- W. The National Weather Service Office will detect and track potentially dangerous storm systems. The Weather Service begins issuing advisories containing strategic information on any storm system that might affect Greene County and continues to issue updated advisories, watches and warnings as long as any threat exists. Such advisories are broadcast over the NWS/NOAA Weather Radio System and also local government frequencies, radio and television stations as they become aware of potential problems.
- X. The Greene County Emergency Services Office will coordinate with the National Weather Service to maintain up-to-date information concerning potential flooding, winter and tropical storm warnings and watches. As appropriate, such information will be provided to the citizens of the affected areas with the county.
- Y. The Amateur Radio Emergency Services (ARES), by agreement with the NWS, will report weather conditions that have a potential to inflict severe damages on Greene County (i.e. tornadoes).
- Z. The Greene County Emergency Services Office has identified low lying areas that are prone to flash flooding and dam failure(s) resulting in flooding and upon receipt of potential problems in these areas, will notify the down stream residents to evacuate to higher ground.
- AA. The Emergency Services Office (which is a combination of the Fire Marshals Office, the Emergency Management Office and EMS Office) will, in most instances, be the lead agency for response to natural hazards, due to the various capabilities located within this office.

IV. CONTINUITY OF GOVERNMENT

- A. Emergency and disaster occurrence could result in disruption of government functions necessitates that all levels of local government and their departments develop and maintain procedures to ensure continuity of government.
- B. The line of succession of the County Board of Commissioners proceeds from the Chairman to the members of the board in accordance with county policy.
- C. Each department is responsible for preservation of essential records and documents to ensure continued operational readiness and to comply with existing laws and ordinances.
- D. Vital Facilities
 1. Several categories of facilities have been identified as essential for an immediate response following a disaster or emergency and others have been identified as critical for long term recovery operations. These categories include:
 - Electrical distribution systems
 - Water distribution systems
 - Health and Medical Facilities
 - Transportation Resources and Facilities
 - Communication networks
 - Public Buildings
 - Emergency Services Facilities
 - Landfill and Debris Sites
 - Public/Private Supply Centers
 2. Information on specific vital facilities and resources will be maintained in the Greene County Office of Emergency Services and accessible from the County EOC.

V. PLAN DEVELOPMENT AND MAINTENANCE

- A. Government agencies charged with responsibilities are responsible for development of standard operating procedures, checklists or guidelines to support operations outlined in this plan, review of those portions of the plan actually implemented in any emergency and providing copies of agreements and standard operating procedures of checklists to the Emergency Services office for placement in the Implementation Manual.
- B. This plan shall be exercised in accordance with the Federal Emergency Management Agency four-year exercise plan.

VI. AUTHORITIES AND REFERENCES

A. Selected references that form the legal basis for actions outlined in this plan are on file in the Greene County Emergency Services office. These references include:

1. Federal

- a. Robert T. Stafford Disaster Relief and Emergency Assistance Act, Public Law 93-288, as amended by Public Law 100-77.
- b. Emergency Planning and Community Right to Know Act (SARA Title III).
- c. OSHA 1910.120.
- d. Civil Defense Act of 1950, as amended.
- e. Oil Spill Prevention Act of 1990.

2. State

- a. G.S. 166-A Emergency Management Act.
- b. N.C. Oil Spill Act.
- c. Executive Order 73.
- d. State Mutual Aid Agreement

3. Local

- a. Greene County Emergency Management Ordinance
- b. Proclamation for State of Emergency
- c. Termination of State of Emergency
- d. Local Emergency Planning Committee By Laws
- e. Mutual Aid Agreements for Fire and Rescue
- f. Mutual Aid Agreements with Municipalities
- g. Agreements with American Red Cross
- h. Haz-Mat response.

B. General

- 1. Actions taken during emergencies/disasters require that legal guidelines be followed in order to assure protection of the public.
- 2. Verbal mutual aid agreements exist between some agencies and departments within the county.

3. Agencies tasked with responsibilities in the Emergency Operations Plan are responsible for the development of standard operating procedures/guidelines to implement their particular function. Additionally, they are responsible for providing copies of these documents to the Emergency Management office for inclusion in the implementation manual.

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
DATE OF REVIEW: MARCH 1995**

I. BASIC PLAN

The basic plan established the framework for a viable emergency response capability. The role of every organization, agency or activity expected to contribute to an emergency response should be identified and its specific role(s) specified. The basic plan describes the general environment that would establish the probable preconditions and assumptions for execution of the plan; a concept of operations, organization, assignment of responsibilities, coordinating instructions, an explanation of how the plan is to be administered, logistically supported specifies the command, control, communication system, procedures that will be relied upon to alert, notify, recall and employ emergency response forces, warn and protect citizens, protect property and request aid/support from other local communities, the State and/or Federal government.

Provisions have been made in the plan for:

Page/Reference

- | | |
|---|----------------------|
| a. Identifying the functions and responsibilities of responding organizations, agencies and individuals. This listing should include voluntary and private organization/groups where appropriate. | SEC.B.II.A-C,P. 1-16 |
| b. Referencing law/ordinances and other source documents that establish the legal basis for planning and carrying out emergency responsibilities. | BP.VI,A.1-3,P. BP-8 |
| c. Identifying the individual by title who is responsible for implementing the plan and directing the emergency response (e.g., chief executive, mayor, governor and county executive). | SEC.A.III.B.P. B-4 |
| d. Obtaining assistance in an emergency from private sector and voluntary organizations. | BP.III.C.P. B-4 |
| e. Referencing mutual aid and other written agreements with voluntary organizations and other Federal, State, Local and private organizations. | BP.IV.B.3.M.BP-4 |

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| f. Organizations, agencies and individuals to prepare standard operating procedures (SOP's) and checklists, which detail how their assigned tasks, will be performed to support implementing the plan. | BP.VI.P.BP-9 |
| g. Including an overall concept of operations which communicates the essence of planned arrangements (e.g., what will occur, where, when, who will be in charge, etc.), with respect to the operating time periods, (e.g. pre-, trans-, and post-disaster/emergency condition. | BP.III.P.BP3-7 |
| h. Addressing the following emergency planning requirements:
Direction and Control
Alert and Warning
Communications
Emergency Public Information
Contamination Monitoring and Control
Emergency Support Services
Evacuation
Sheltering
Continuity of Government
Resource Management
Other:
Hazard Specific Checklist | SEC. A
SEC. C
SEC. C
SEC. D
NOT ADDRESSED
BP & ALL SECTIONS, SEC.C
SEC. J
SEC. K
BP.II.b-4,P.BP-3 & SEC. A
SEC. M

SEE IMPLEMENTATION
MANUAL |
| i. A purpose or mission statement that describes the reason for the development of the plan and its annexes. | BP.I.P.BP-1 |
| j. A situation statement that describes the geographic characteristics, population at risk to specific hazards and potential hazard considerations (based on CPG 1-35) on which the plan is based. | BP.II.A.,BP1-2 |
| k. Identifying those assumptions that are appropriate for inclusion in the plan. | BP.II.B.,BP 2-3 |
| l. Providing administrative and logistical support to all response organizations and the general public (if required). | BP.III.M.P.BP-5 |

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| m. Definitions of terms and acronyms. | SEE
GLOSSARY/ACRONYMS IN
IMPLEMENTATION MANUAL |
| n. Maps identifying high hazard areas and pre-selected monitoring points for emergencies. | IN IMPPEMENTATION
MANUAL |
| o. Special needs of handicapped and elderly persons. | SEC.B.II.C.5.c. P.B-8 |
| p. Emergency information (materials/instructions) for groups whose primary language is not English (if appropriate). | SEC.D.III.A.8.P.D-3 |
| q. Addressing readiness operations and describing actions to be taken during periods of heightened risk. | BP.III.P.BP.4-6 |
| r. Requesting State assistance in those cases where local resources cannot meet response or recovery requirements. | BP.III.C.P.BP-5 |
| s. Requesting Federal assistance in those cases where State/Local resources cannot meet response or recovery requirements. In addition, provisions must be made for incorporating the Federal response. (State Plan Only). | BP.III.C.P.BP-4 |
| t. Block diagrams illustrating each organization and sub-organization roles. | SEE IMPLEMENTATION
MANUAL IN EM OFFICE |

II. DIRECTION, CONTROL, COMMUNICATIONS AND WARNING

State and local governments should have the capability to direct and control those activities of government that are essential to saving lives, protecting property and restoring government services during and following a major emergency. A description of how emergency response forces will be sued to protect citizens and property when it is necessary to respond, contain (if possible) and recover from the hazards the jurisdiction faces should be included. This description should detail command and control relationships, alerting and warning, communications, response and recovery procedures and use of emergency facilities and field forces to provide the command and control needed for each disaster response operation on a 4-hour basis.

Provisions have been made in the plan for:

- | | |
|--|--------------------------------------|
| a. Describing who is in charge for each emergency or disaster situation and where direction and control will emanate from (EOC or in disaster situations where field forces are used as the on-scene commander). | SEC.A.III.A&B.B.A-2-5 |
| b. Determining the need to evacuate | SEC.A.II.C.B(2).P.B-2 |
| c. Identifying the individual responsible for issuing evacuation orders. | SEC.A.III.C.B(2).P.B-2 |
| d. An alternate EOC (either fixed or mobile) to serve as a backup if the primary EOC is not able to function. | SEC.A.II.A.4,P.A-1 |
| e. Identifying the official responsible for managing the EOC during emergency periods. | SEC.A.II.A-5.P.A-2 |
| f. Identifying by title or position in the plan, personnel assigned to the EOC in the event of a crisis situation. | SEC.A.III.C-1.A-8.P.4-5 |
| g. Identifying program and administrative authority and fiscal procedures needed for emergency operations. | BP.III.C.P.BP3-7 |
| h. Identifying the circumstances under which pre-delegated authorities would become effective and when they would be terminated. | BP.III.CP.BP-4 |
| i. Identifying alternate sites for departments or agencies having emergency functions. | SEC.A.II.A.5,P.A-2 |
| j. Lines of succession to assure continuous leadership, authority and responsibility in key positions. | CONCEPT OF OPERATIONS (EACH SECTION) |
| k. The identification and use of resources for special or critical facilities, including radiological laboratories. | SEC.P.III.D.P.P-3 |
| l. Logistical support for food, water, lighting, fuel, etc., to support EOC staff and personnel deployed to the disaster site. | SEC.B.II.C.3.FF.P.B-6 |

m. Including radiological protection officers and disaster analysis staff, including recorders, analysts and plotters as a part of the EOC staff.	RP NOT ADDRESSED IN PLAN (SEE IMPLEMENTATION MAUAL)
n. Primary and backup radio communications (fixed and mobile).	SEC.C.III.A.5.P.C-4
o. Describing the methods of communications between the EOC, field forces if employed, shelter, lodging, feeding facilities, adjacent jurisdictions and State EOC.	SEC.C.III.B.2.B.P.C-4
p. The timely activation and staffing of emergency support personnel.	SEC.B.II.C.P.B-1
q. Operational and administrative support to department or agency personnel assigned to the EOC, disaster site or at agency's work, control or dispatch center.	SEC.B.II.3.G.T.P.B-6
r. Including a clear and concise summary of emergency functions, command and control, relationships and support communications system.	SEC.A.III.A-C.P.A-1-4
s. Detailing the communication requirements for emergency response organizations and warning systems for notifying the general public.	SEC.C.II.A.P.C.1-2
t. A disaster effects monitoring and reporting capability applicable to all hazards the jurisdiction faces.	SEC.L.III.B.2-3, P.L-3
u. Establishing a means to warn the public in the event of a disaster situation, defining responsibilities of agencies or personnel and describing activation.	SEC.C.III.A.1-6.P.A-3-6
v. Developing an emergency classification and action level scheme consistent with that established by the facility licensee and the State for those jurisdictions located within a 10 -mile radius of a commercial nuclear power plant.	N/A

w. Developing a flood warning system for those jurisdictions subject to frequent flooding.	N/A
x. Warning the hearing impaired and non-English speaking groups where appropriate.	SEC.C.III.A.1-6.P.A 3-6
y. Ensuring EOC staff members can be recalled on short notice.	SEC.B.II.C.3.A.P.B-4
z. Identifying a commander responsible for on-scene direction and control in the event of an emergency.	SEC.A.III.B.B-4
aa. Describing EOC functions, layout, concept operations, duties of staff, use of displays and message forms and bringing the EOC to full readiness on a continuous 24-hour basis, for communications and other emergency functions.	SEC.A.III.C.P.A-4
bb. The collection and display of damage assessment information in the EOC.	SEC.L.III.B.1-3.P.L-3
cc. The use of aerial radiological monitoring to support radiological monitoring and assessment needs.	SEC.P.III.F.P. P-3
dd. Communication links between State and local EOC's and Federal and private organizations, if appropriate.	SEC.D.III.B.1-2.P.C.2-3
ee. Two-way radio communications between the EOC and emergency response forces, such as police, fire/rescue and public works.	SEC.C.III.B.2.A.P.C-4
ff. Two-way radio communications between the EOC and other forces, such as hospitals, ambulance dispatch points and amateur communications network.	SEC.C.III.B.2.b.P.C-4
gg. Ensure communications staff members can be recalled on short notice.	SEC.C.III.A.P.C-4
hh. Obtaining telephone services during emergencies.	SEC.C.III.B.1.P.C-3
ii. Obtaining radiation exposure rates using a network of reporting services.	NOT ADDRESSED

jj. A continuous 24-hour warning point to alert key officials and activate the public warning system.	SEC.C.III.A.P.C-1
kk. The warning point to simultaneously activate all warning devices.	SEC.C.III.A.2.,P.C-1
ll. Warning special locations, such as schools, hospitals, nursing homes, major industries, institutions and places of public assembly.	SEC.C.II.A.6.P.C-2
mm. Notifying key officials in the event of an emergency.	SEC.C.III.A.1.P.C-3
nn. Protecting resources (i.e., essential personnel and equipment) during disaster situations.	SEC.M.III.P.M-2
oo. A central coordination point(s) for obtaining, analyzing, reporting and retaining (e.g., events log) disaster related information (casualty information, property damage, fire status, number of evacuees, radiation dose, etc.) for EOC staff and/or field forces.	BP.III.C.P. BP-4
pp. The radiological monitors to provide data to the EOC.	NOT ADDRESSED
qq. The EOC workers to acknowledge/authenticate reports.	SEC.A.III.C.2.P.A-5
rr. The dissemination of emergency information within the emergency organization and other units of local, State and Federal government.	SEC.A.II.B.2.P.B-2
ss. Implementing resource controls.	SEC.M.III.P.M-2
tt. Safeguarding essential records for continuing government functions, protection the rights or individuals, etc.	PB.IV.B.B-7
uu. Implementing protective measures based on protective action guides and other criteria consistent with the recommendations of EPA, DHEW, FDA, etc.	N/A

III. EMERGENCY SUPPORT SERVICES

Emergency Support Services (ESS) should develop the operational planning and preparedness capabilities to respond in the event of an emergency. These organizations collectively perform the services that allow the jurisdiction to react to and recover from disaster events. Additionally the agencies provide the necessary support that allows evacuation operations to be implemented.

- a. General: (The following may not be applicable to every ESS)

Law Enforcement – LE	Public Works – PW
Fire and Rescue – FR	Emergency Management
Health/Medical – HM	Agency (S/L) – EM

Provisions have been made in the plan for:

- | | |
|---|--|
| a. All emergency support services and vital facilities and essential industries to train radiological protection personnel (radiological response team personnel and radiological monitors). | N/A |
| b. Obtaining and maintaining monitoring equipment for radiation hazard protection and exposure control. | N/A |
| c. Tasking each emergency support service to maintain current internal notification/re-call rosters and communication systems. | SEC.B.II.C.2.b.P.B-2
SEC.B.II.C.4.e.P.B-3 |
| d. Emergency support services to obtain the appropriate protective equipment, instruments, antidotes and clothing (as necessary) to perform assigned tasks in a hazardous chemical or radiological environment. | NOT ADDRESSED |
| e. Tasking each emergency support service to develop SOP's that address how the agency will accomplish its assigned tasks and will deal with the hazards the jurisdiction faces. | SEC.B.II.C.2.b.P.B-2
SEC.B.II.C-2-19.P.B.2-19 |

f. The preparation of mutual aid agreements.	BP.IV.A.P.BP-8 FORWARD OF PLAN
g. Maps/Charts of the local area for all emergency support services.	IN EMERGENCY SERVICES OFFICE.
h. Handling inquires and informing families on the status of individuals injured or missing due to a disaster event.	SEC.K.III.P.D-3
i. Logistical support during emergency operations.	SEC.A.III.A.7.P.A-4
j. Reporting the appropriate information (casualties, damage assessment, radiation levels, etc.) to the EOC during emergency operations.	SEC.B.II.C.3.L.P.B-5
k. The direction and control of emergency support services personnel during emergency operations.	SEC.A.II.A.1.P.A-5
l. Designating a representative for each support service to report to the EOC during an emergency to advise decision makers, to coordinate with other operating forces and to direct and control their own response.	SEC.A.III.C.P.C-4
m. Recovery operations during disaster events.	SEC.N.
n. Estimating total population exposure.	SEC.P.III.D.P.P-3
o. Maintaining dose records for emergency workers and ensuring that dosimeters are read at appropriate frequencies.	N/A
p. A decision chain for authorizing emergency workers to incur exposures in excess of the EPA general protective action guides.	N/A
q. Specifying action levels for determining the need for decontamination.	SEC.P.III.B.1.P.P-2

b. Specific

Provisions have been made in the plan for:

1. Law Enforcement

- a. Traffic control during an emergency. SEC.E.III.A.P.E.2-3
- b. Relocating and housing prisoners in the event of an emergency. SEC.E.III.A.9.P.E-3
- c. The use of law enforcement personnel to assist in movement to shelter or evacuate. SEC.E.III.A.1.P.E-2
- d. Security for critical facilities and resources. SEC.E.III.A.1.P.E-3
- e. Security in the disaster and other affected areas. SEC.E.II.A.1.P.E-2
- f. Law enforcement in reception centers, lodging, feeding facilities and emergency shelters. SEC.E.II.A.1.P.E-2
- g. The protection of property and damaged areas. SEC.E.III.A.1.P.E-1
- h. Evacuating disaster areas during emergency operations. SEC.E.III.A.1.P.E-1
- i. Limiting access to the evacuation areas. SEC.E.III.A.5.P.E-3

2. Fire and Rescue

- a. The deployment of fire/rescue personnel and equipment in the event of an emergency. (F) SEC.B.II.C.15.P-15
(R) SEC.B.II.B.3.D.P.B-4
- b. Fire protection in emergency shelters. (F)SEC.B.II.C.15.P.B-15
- c. Providing decision makers advice on the hazards associated with hazardous materials. SEC.B.II.C.15.O.P.B-15
- d. Rescuing injured people during emergency operations. SECB.II.C.11.b.P.B-12

- | | |
|--|------------------------|
| e. Alerting all emergency support services of the dangers associated with technological hazards and fire during emergency operations. | SEC.B.II.C.3.k.P.B-5 |
| 3. Health/Medical | |
| a. Inoculating individuals if warranted by the threat of disease. | SEC.A.II.C.6.d.P.B-9 |
| b. Determining the radiation levels for contaminated and exposed individuals and for the treatment and care of these individuals, including decontamination. | N/A |
| c. Expanding mortuary services in an emergency. | SEC.B.II.C.6.h.P.B-9 |
| d. Establishing and operating emergency medical care centers for essential workers in the hazardous area following the evacuation of the general population. | N/A |
| e. Provide for health/medical care at shelter or congregate care facilities. | SEC.B.II.C.6.b.P.B-8 |
| f. Health/medical services in reception and care facilities. | SEC.B.II.C.6.b.P.B-9 |
| g. Obtain emergency medical support and hospital care during and after an emergency. | SEC.B.II.C.16.a.P.B-9 |
| h. Reducing the patient population in hospitals, nursing homes and other health care facilities if evacuation is necessary and continuing medical care for those that cannot be evacuated. | SEC.B.II.C.6.v.P.B-10 |
| i. Identifying hospitals, nursing homes and other facilities that could be expanded into emergency treatment centers for disaster victims. | SEC.B.III.C.6.v.P.B-10 |
| j. Crisis augmentation of health/medical personnel, e.g. nurses', aides, paramedics, Red Cross and other trained volunteers. | SEC.B.II.C.6.a.P.B-8 |

- | | |
|--|------------------------|
| k. Transport and care of individuals from the disaster site to medical facilities. | SEC.B.II.C.11.b.P.B-12 |
| 4. Public Works/Public Utilities | |
| a. Clearance of debris in an emergency. | SEC.B.II.C.7.c.P.B-10 |
| b. Backup electrical power to the EOC. | SEC.B.II.C.7.f.P.B-10 |
| c. Preparation and maintenance of a resource list that identifies source, location and availability of earthmoving equipment, dump trucks, road grades, fuel, etc., that could be used to support disaster response/recovery operations. | SEC.B.II.C.7.b.P.B-10 |
| d. The repair and restoration of essential services and vital facilities. | SEC.B.II.C.7.a.P.B-10 |
| e. A portable water supply during an emergency. | SEC.B.II.C.7.a.P.B-10 |
| f. Restoring utilities to critical and essential facilities. | SEC.B.II.C.7.f.P.B-10 |
| g. Sanitation services during an emergency. | SEC.B.II.C.7.f.P.B-10 |
| 5. Emergency Management Agency | |
| a. Assigning shelter/reception center teams. | SEC.B.II.C.3.P.B-5 |
| b. Coordinating EOC operations. | SEC.B.II.C.Q.P.B-5 |
| c. The distribution of bulk-stored radiological monitoring equipment. | N/A |
| d. Staffing a report section in the EOC during disaster operations. | SEC.B.II.C.q.P.B-5 |

IV. EVACUATION

In the development, maintenance and exercise of an EOP, a capability should exist to evacuate people and move resources (i.e., food, medical, radiological) from threatened areas. It should offer the flexibility to satisfy the full spectrum of evacuation considerations that apply to the jurisdiction. The fundamental assumption for evacuation is that sufficient warning time will be available to evacuate the population that is threatened. In addition, an assortment of evacuation options that are tailored to the different types of hazards (natural, technological and nuclear) the jurisdiction faces should be available to the decision maker for implementation.

Provisions have been made in the plan for:

- | | |
|---|--|
| a. Identifying transportation policy and transportation resources (i.e., movement control, use of public and private vehicles, etc.). | SEC.G.III.A&B.P.G-4 |
| b. The relocation (personnel, critical supplies, equipment) of essential resources to the reception area. | SEC.M.III.A.6.P.M-3 |
| c. Identifying the number of people requiring transportation to reception areas along with the means to get them there. | SEC.J.II.A.1.P.J-1 |
| d. Identifying centrally located staging areas and pickup points for persons without private automobiles or other means of transportation. | SEC.J.III.A.1&2.P.J-4 |
| e. Identifying the single individual by title or agency responsible for the coordination of all public transportation resources planned for use in an evacuation. | SEC.J.III.A.6.P.J-4 |
| f. Designating rest areas along movement routes where evacuees can obtain fuel, water, medical aid, vehicle maintenance, information and comfort facilities. | N/A |
| g. Movement control guidance which details the population at risk, evacuation routes, zones, alerting/warning of the public, identifies reception areas and routes for return to residence. | SEC.J
OTHER DOCUMENTS IN
EM OFFICE |
| h. Handling vehicles with mechanical problems. | SECJ.III.B.d.P.J-5 |
| i. Vehicle security and parking in the reception area. | SEC.E.III.A.1.P.E-2 |
| j. Transportation for essential workers to commute to hazardous areas. | N/A |
| k. Evacuees to receive instructional materials showing evacuation zones, routes, reception areas, parking facilities, food services and medical clinics. | SEC.E.III.A.4.P.E-3 |

- I. The evacuation of the handicapped, elderly and persons in institutions (i.e., prisoners, hospital patients, students, etc.). SEC.J.III.B.2.h.i.P.J-5
- m. Re-entry into hazard area. SEC.J.III.A.1.P.J-3
- n. Dealing with potential impediments for evacuation, including contingency measures. SEC.J.III.A.3&5.P.J-3

V. RECEPTION AND CARE/IN-PLACE PROTECTION

Suitable protection and emergency lodging should be provided in shelters with essential life support systems for persons displaced as a result of any type of emergency. Shelter considerations include protective measures, care for evacuees and care for those people who must rely on in-place sheltering because certain circumstances did not allow evacuation.

Provision have been made in the plan for:

- a. Identifying facilities (schools, churches, motels, restaurants) that are appropriate for short term use as lodging and feeding facilities for evacuees that do not require fallout shelter protection. SEC.K.II.A.2.P.K-1
- b. Providing living space (at least 10 sq. ft. per individual) for protection from fallout for each person evacuated from the threatened area. NOT ADDRESSED
- c. Identifying those facilities suitable as public fallout shelters (including shelter capacity, protection factor and the allocation of shelter spaces to the public) as a result of the national facility survey or by any other means. OTHER SURVEY DOCUMENTS LOCATED IN THE GREENE CO. EM OFFICE
- d. The crisis training of radiological monitors for all public fallout shelters planned for use. N/A
- e. Identifying upgradable facilities (including shelter capacity, if protection factor is known and the allocation of shelter spaces to the public) which can be used as a supplementary shelter resource, if required. N/A

f. The use of expedient fallout shelters only after all appropriate upgradable facilities have been used.	N/A
g. A crisis shelter stocking plan.	SEC.K.II.B.1.P.K-1
h. Designating facilities for lodging institutionalized or special needs group.	N/A/ (NONE IDENTIFIED)
i. Designating facilities within commuting distance of the hazardous area for essential workers and their families.	NOT ADDRESSED
j. Identifying campgrounds to accommodate families evacuating in recreational vehicles.	NOT ADDRESSED
k. The assignment of responsibilities to individual(s), organization(s) for emergency mass feeding operations.	SEC.K.III.A.2.P.K-3
l. Identifying facilities for mass feeding.	SEC.K.III.A.1.P.K-1/SEC.B
m. Crisis upgrading of shelters.	N/A
n. Crisis marking of unmarked facilities	N/A
o. The management of reception and care activities (registration, staffing, lodging, feeding, pertinent evacuee information, etc.).	SEC.K.III.A.1&2.P.K-2
p. Assigning evacuees to lodging and fallout shelters (if applicable) and feeding facilities.	NOT ADDRESSED
q. Assigning trained managers and staff to all facilities during any period of lodging or fallout shelter occupancy.	SEC.K.III.A.1&2.P.K-3
r. Maintaining shelter areas free from contamination (monitoring, decontamination, quarantine, etc.).	SEC.P.III.D.P.P-3
s. Controlling the exposure of personnel within the jurisdiction to hazardous substances.	SEC.P.III.C.P.P-2
t. The distribution of exposure-inhibiting or mitigating drugs, vaccines or other preventives.	N/A

VI. EMERGENCY PUBLIC INFORMATION

An emergency public information (EPI) system should provide for the dissemination of official information and instruction in order to facilitate timely and appropriate public response in an emergency. Information should be released through a designated spokesperson to people that have been evacuated and to those people that were not evacuated.

Provision have been made in the plan for:

- | | |
|---|-------------------------|
| a. An information office which is the official point of contact for the media during an emergency. | SEC.D.III.A.1&B.1.P.D-3 |
| b. An authoritative spokesperson designated as the public information officer (PIO). | SEC.D.II.A.2.P.D-2 |
| c. The PIO to coordinate with the departments or agencies the release of information to the public. | SEC.D.III.A.1P.D-2 |
| d. The distribution of emergency public information materials using all sources available such as newspapers, radio, television, etc. | SEC.D.III.A.3.P.D-3 |
| e. The preparation of EPI guidance materials based on all hazards affecting the jurisdiction (pamphlets, magazines, etc.). | SEC.D.III.A.8.P.D-3 |
| f. Disseminating prescribed emergency information materials available for use by the media. | SEC.D.III.A.8.P.D-3 |
| g. Disseminating EPI materials for the visually impaired and non-English speaking groups, if appropriate. | SEC.D.III.A.8.P.D-3 |
| h. Written or oral agreements with the information media for dissemination of emergency public information and emergency warnings. | SEC.D.II.B.5.P.D-2 |
| i. Points of contact for release of public information in an emergency. | SEC.D.II.B.5.P.D-2 |
| j. Including EBS operation area planning requirements. | SEC.D.III.A.5.P.D-1 |
| k. Disseminating essential information to the public, including the appropriate protective actions to be taken. | SEC.D.II.B.5.P.D-2 |

- | | |
|---|-----------------------|
| l. Authenticating all sources of information being received and verified for accuracy. | SEC.D.III.A.6.i.P.D-3 |
| m. Clearing information with the chief executive before release to the media. | SEC.D.III.A.1.P.D-3 |
| n. Addressing rumor control. | SEC.D.III.A.5.P.D-2 |
| o. Informing the public about places of contact for missing relatives, continued emergency services, restricted areas, etc. | SEC.D.III.A.3.P.D-3 |
| p. Announcements urging residents to share their homes with evacuees. | N/A |

VII. ADMINISTRATION AND LOGISTICS

Provisions have been made in the plan for:

- | | |
|---|----------------------|
| a. Review and written concurrence from all departments of government and private sector organizations assigned emergency responsibilities. | BP.P-1 |
| b. Approval and promulgation of the plan. | BP.P-1 |
| c. Identifying the approval date. | BP.P-1 & EACH PAGE |
| d. Identifying the office or individual (by job title) that is responsible for the maintenance (review/update) of the plan and for ensuring necessary changes and revisions to the plan are prepared, coordinated, published and distributed. | BP.V.A&B.P.BP-8 |
| e. Updating, as necessary, based on deficiencies identified through drills and exercises, changes in local government's structure, technological changes, etc. | BP.V.A&B.P.BP-8 |
| f. A resource inventory listing that includes source and quantity. | RESOURCE MANUAL |
| g. Statements which identify additional emergency resource requirements for personnel, equipment and supplies. | SEC.B.II.C.3.h.P.B-5 |
| h. Identifying the availability and accessibility of resources. | SEC.B.II.C.4.g.P.B-5 |

- | | |
|---|-----------------------|
| i. A table of contents listing the sections in the basic plan, annexes and appendices. | INTRODUCTION-5 |
| j. The training of response staff and specialized teams to carry out emergency functions. | SEC.B.II.C.3.dd.P.B-6 |
| k. Accelerated training of shelter managers in a crisis building period. | SEC.B.II.C.3.dd.P.B-6 |
| l. Storage, maintenance and replenishment/ replacement of equipment and materials (medical supplies, food, water, radiological instruments, etc.). | SEC.M.III.A.B.C.P.M-2 |
| m. Reviewing those portions of the plan actually implemented in an emergency event in order to determine if revisions can be made that would improve disaster response and recovery operations. | BP.V.A&B.P.BP-8 |

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
NRT-1A CROSSWALK REVIEW
SECTION 0 (AND OFFICE DOCUMENTS)
MARCH 1995**

1. Identify and describe the facilities in the district that possess extremely hazardous substances and the transportation routes which such substance may travel within the district; SEC.P.II.A.1&2.P.P-1
TIER II REPS. IN EM
OFFICE

Review: References to EHS facility information is provided within the plan. The information, as well as its upkeep, is located in the Greene Co. Emergency Mgt. office. Transportation routes are identified per facility in the information sheets kept on computer and hardy copy in the Greene Co. Emergency Mgt. office.

Large and small facility information provided in the implementation manual.

2. Identify and describe other facilities that may contribute to additional risk virtue of the proximity to the above mentioned facilities; (Found on Haz Mat Risk
Analysis Facility Info. Sheet
at Green Co. EM Office

Review: Reference is made for a request of said facilities within the information sheets. The information sheets kept by the Greene Co. EM office has this information well defined.

3. Identify and describe additional facilities included in the plan that are subject to additional risks due to their proximity to facilities with extremely hazardous substances; (Found on Haz Mat Risk
Analysis Facility

Review: Reference is made for a request of said facilities within the information sheets. The information sheets provided have this information well defined.

Large and small facility information provided.

4. Include methods for determining that a release of extremely hazardous substances has occurred and their area of population likely to be affected by such release.

SEC.P.II.P.P-2
(Found on the Haz Mat Risk Analysis Facility at the Greene Co. EM office

Review: The method for determining that a release has occurred relies on the existence of procedures prepared by the facilities and verified by the Facility Emergency Coordinator. The availability of monitoring systems for determining releases is sought on the information sheets.

Large and small information sheets provided.

5. Designate a community emergency coordinator and facility emergency coordinator, who shall make determinations necessary to implement this plan.

SEC.P.II.A.1.P.P-1
(Haz Mat Risk Analysis Facility Info. Sheet in SEC.P

Review: The community emergency coordinator and facility emergency coordinator positions are designated within the plan. The facility emergency coordinator or his alternate is designated in the facility information sheets.

Large and small sample information sheets are contained in the Implementation Manual.

6. Include procedures for providing reliable, effective and timely notification by the facility emergency coordinator and the community emergency coordinator to persons designated in the emergency plan and to the public that a release has occurred.

SEC.P.II.B.2.P.P-3
SEC.D.III.A.8.P.D-2

Review: Notification capabilities are referenced throughout the plan. Methods for notification by the facility emergency coordinator rely on the existence of facility SOP. The LEPC may wish to encourage and verify such SOP.

7. Include methods and procedures to be followed by facility owners, operators and local emergency and medical personnel to respond to a release of extremely hazardous substances.

SEC.P.III.F.P.P-5

Review: Facility per facility SOP. The LEPC may wish to encourage and verify the existence of this SOP, as well as the SOP's that local agencies are charged with maintaining in the plan.

Large and small information sheets provided.

8. Include a description of emergency equipment and facility in the community subject to the requirements of this subtitle and an identification of the persons responsible for such equipment and facilities.

BP.III.B.6.P.BP-6
SEC.P.III.G.P.P-3
SEC.P.III.H.P.P-3
(Haz Mat Risk Analysis
Facility Info. Sheet)

Review: The LEPC may wish to verify the information that the facility coordinator has been tasked to identify and the status of a county resource manual. Adequate references concerning resources are made in the plan. The facility information sheets include a comprehensive listing section for facility resources.

Large and small information sheets provided.

9. Include methods and procedures to be followed by facility owners, operators and local emergency and medical personnel to respond to a release of extremely hazardous substances.

SAME AS IN ITEM 7

Review: LEPC verification as in item 7.

10. Describe methods in place in the community and in each of the affected facilities for determining the areas likely to be affected by the release.

SEC.P.III.H.P.P-3
(Haz Mat Risk Analysis
Facility Info Sheet in the
Greene Co. EM office.

Review: This information is requested in the facility information sheets from the facilities. The LEPC may want to encourage and verify and facility SOP's regarding this assessment. The LEPC is also tasked with vulnerability analysis and may want to review their own procedures.

11. Describe evacuation plans including those for precautionary evacuations and alternate traffic routes. SEC.G.III.A.3.P.G.1&2
SEC.G.III.B.3.b.P.G-3

Review: Responsibility of evacuation decision are identified in the plan for the community. Request for facility on-site evacuation plans may be added to the facility information sheets if the LEPC so desires. Evacuation routes are referenced in another document located at the Greene Co. Emergency Mgt. office.

12. Include methods and schedules for exercising the emergency plan. SEC.M.III.H.P.M-5

Review: Commitment to exercising is noted. It should be noted that the new guidance from FEMA denotes a full-scale exercise every four years with rotating scenarios in regard to the local emergency management office's involvement,

13. Include the training programs, including schedules, for training of local emergency response and medical personnel. SEC.P.III.H.P.P-5

Review: Training commitments are referenced in the plan. No schedules ate attached or is coordination in relation to the state training identified, but quarterly schedules do go out from the state's training office to the local coordinator's office.

14. The plan must demonstrate coordination with adjacent jurisdictions. SEC.M.III.K.P.M-6
BP.III.A.4.P.BP-6

Review: There is acknowledgement of jurisdictional coordination; however, mutual aid agreements with specific jurisdictions is not referenced although these agreements whether written or oral, probably exist. The LEPC may wish to coordinate information with surrounding bordering facilities.

ADDITIONAL NOTES:

A letter indicating that the LEPC Chairperson has reviewed the plan is not being provided at this time.

Examples of specific facility information were provided.

It should be noted that this plan follows the new "Model Systems" prototype that the N.C. Division of Emergency Management has provided to the counties. The facility information sheets are neatly filled out and all information included is up to date.

The EPI system should provide for the dissemination of official information and instruction in order to facilitate timely and appropriate public response in an emergency. Information should be released through a designated spokesperson to people that have been evacuated and to those people that were not evacuated.

GREENE COUNTY EMERGENCY OPERATIONS PLAN CRITICAL POSITIONS

Critical positions with knowledge, skills and abilities responsible for providing the essential services.

- A. The Executive Group consists of the following; and is Responsible for overall direction and control of operational forces and operational policies.
 - 1. Chairperson, Board of County Commissioners
 - 2. Greene County Manager
 - 3. Greene County Emergency Services Director
 - 4. Mayors of Towns

- B. The Operations Group consists of the following:
 - 1. EOC Operations Management
 - a. ES Director (EOC Operations Manger)
 - b. Clerical support staff

 - 2. Law Enforcement
 - a. Sheriff's Captain
 - b. NC Highway Patrol Liaison
 - c. Clerical support staff

 - 3. Emergency Services
 - a. Assistant Fire Marshal / Fire Inspector
 - b. EMS Coordinator/Supervisor
 - c. Transportation Director
 - d. Clerical support staff

 - 4. Human Services
 - a. Health Director
 - b. Social Services Director
 - c. School Superintendent
 - d. American Red Cross Liaison

 - 5. Analysis and Resources
 - a. Public Works Director
 - b. Finance Office
 - c. Damage Assessment Officer
 - d. Support staff of Damage Assessment Section/Team(s), recorders, analysts and section plotters.

6. HazMat (when needed)
 - a. President, Fire Association
 - b. President, Rescue Squad
 - c. Emergency Services Director

7. Donated/Unmet Needs
 - a. Director, Greene County Cooperative Extension Services
 - b. Others as appropriate

8. Volunteers
 - a. Amateur radio operators

GREENE COUNTY EMERGENCY OPERATIONS PLAN SUCCESSION OF AUTHORITY

Greene County Board of Commissioners

Line of Succession:

Chairperson, County Board of Commissioners
County Manager, Greene County

Communication/Warning

Line of Succession:

Sheriff or Captain
Emergency Services Director or Assistant
Communications Supervisor

Public Information

Line of Succession:

County Manger
Chairperson, County Board of Commissioners

Law Enforcement

Line of Succession:

Sheriff, Greene County
Chief Deputy, Greene County Sheriff's Department
Shift Captain, Greene County Sheriff's Department

Fire Services

Line of Succession:

Emergency Services Director/Fire Marshal
Assistant Emergency Services Director/Fire Marshal
President, Greene County Firemen's Association

Rescue/Mass Casualty

Line of Succession:

Greene County Emergency Medical Services Coordinator
Greene County Rescue Association President
Greene County EMS Unit Captains

Public Works

Line of Succession:

Greene County Public Works Director
Greene County Assistant Public Works Director
Town Public Works Director

Public Health Services

Line of Succession:

Director, Greene County Health Department
Environmental Health Supervisor
Nursing Supervisor

Shelter/Mass Care

Line of Succession:

Executive Director, Wilson-Greene Chapter of American Red Cross
Chapter Chairperson, Wilson-Greene Chapter of American Red Cross
Chapter Disaster Chairperson, Wilson-Greene Chapter of American Red Cross

Resource Management

Line of Succession:

Finance Director, Greene County
Emergency Services Director

Greene County Emergency Services

Line of Succession:

Emergency Services Director
Assistant Emergency Services Director

Volunteer Organization

Line of Succession:

Director, Greene County Interfaith
Emergency Services Director

Greene County Local Emergency Planning Committee

Line of Succession:

Chairperson, LEPC
Fire Chief of Fire District
Assistant Emergency Services Director

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
CONTACT INFORMATION WITHIN THE DEPARTMENT**

Vital Facilities	Contact Person	Number	Other
Electrical Distribution System	Progress Energy Pitt & Greene EMC	800-419-6356 800-622-1362	
Water Distribution System	David Jones	252-747-5720	
Transportation Resources & Facilities	Mike Lovett	252-747-8474	
Communications Networks	Lemmie Smith	25-747-3411	
Public Buildings (Which buildings are vital)	Don Davenport	252-747-3446	
Emergency Services Facilities	Randy Skinner Michelle Shackelford	252-747-2544 252-747-2544	
Landfill and Debris Sites	David Jones	252-747-5720	
Public and Private Supply Centers			

Greene County Fire Departments	Location	Contact Person	Number
Arba	2001 Jesse Hill Rd	Brad Harrison	252-747-5562
Bull head	7553 Hwy 58 N	Chris West	252-238-3078
Castoria	5118 Hwy 91	Steve Marshburn	252-747-1224
Fort Run	2985 Fort Run Rd	Lloyd Carter, Jr.	252-747-8530
Hookerton	404 E. Main St. Hookerton	Marty Morris	252-747-2108
Jason	6846 Hwy 903 S	Curtis Hilbourn	252-566-3993
Maury	3659 Hwy 903 N	Leonard Hardy	252-747-5423
Scuffleton	153 Fire Station Rd	Raymond Smithson	252-746-4363
Shine	84 Shine Rd	Tully Layden	252-747-5765
Snow Hill	410 SE Second St, Snow Hill	Dana Hill	252-747-3445
Walstonburg	409 N. Wilson St, Walstonburg	Don Holloman	252-753-3418

Evacuation Centers	Address	Principal	Phone Number
Greene Central High School	140 School Dr Snow Hill, NC 28580	Steve Bryant	252-747-3814
West Greene Elementary School	303 Kingold Blvd. Snow Hill, NC 28580	Emily Baker	252-747-3955
Greene County Middle School	485 Middle School Rd Snow Hill, NC 28580		252-747-8191

GREENE COUNTY EMERGENCY OPERATIONS PLAN LOGISTICAL INFORMATION

Determine space and logistics needs for alternate operating sites.

The County EOC (located in the Emergency Services Building, Snow Hill) serves as the central direction and control point for countywide emergency response activities. Should this facility become inoperable, the alternate EOC is the Greene County Courthouse, Snow Hill and will be utilized for direction and control functions.

Priority list of governmental service re-establishment

Vital facilities that have priority for power restoration:

- a. Communications Center
- b. Emergency Operations Center
- c. Water Distribution Centers
- d. Greene County Office Complex (Health Department)
- e. Greene County Schools (Emergency Shelters)

Vital county services and prioritization of county services re-establishment:

- a. Emergency Services;
- b. Fire, EMS, Law Enforcement
- c. General Human Services
- d. Public Health, DSS, Environmental
- e. Water and Public Works Departments
- f. General Administration
- g. Inspections

Identify needs for infrastructure, supplies and personnel to ensure continuation of services.

- a. Utilities/energy systems (electricity, fuel, water/sewer).
- b. Vital facilities (communications shelters, essential goods management, and essential personnel management) necessary for performing immediate response/recovery functions.

Identify record preservation policy and practice improvements.

- a. Vital Records: health, birth/death, land, criminal, tax, licensing, legal, utility, system map, fire department, public works and any other records necessary for continuing government functions.

- b. Vital records maintained by respective departments, Register of Deeds for county has vaulted room for record preservation.
- c. The county should investigate developing a system of converting records to a digital format.

Develop Multi-hazard Plan with continuity of operations information including new operating and staging areas, records preservation practices and prioritization of county services re-establishment. (Hazard Mitigation Plan in progress)

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
MEETING WITH CRITICAL DEPARTMENT HEADS
NOVEMBER 19, 2003**

Greene County EOP Interview Schedule

Dickie Hill – 9:30

Dickie Hill Emergency Services Director

Lee/Chris – 9:45

Lee Worsley County Manager

Chris Roberson Assistant County Manager

David Jones – 10:00

Davis Jones Public Works Director

Becky Sutton – 10:15

Becky Sutton Tax Office

Linda Sewall – 10:30

Linda Sewall Health Director

Brenda Jackson – 11:00

Brenda Jackson Social Services Director

Lemmie Smith – 11:30

Lemmie Smith Sheriff

Mike Lovett – 11:15

Mike Lovett Transportation Director

Glen Dail – 11:30

Glen Dail Greene County Schools

Donald Davis – 11:45

Donald Davis Mayor of the Town of Snow Hill

Susan Casper – 12:00

Susan Casper Mayor of the Town of Walstonburg

Ken Garris – 12:15

Ken Garris Mayor of the Town of Hookerton

The citizens of Greene County and the Greene County Emergency Services Department would benefit from the following:

- a. Implementation of a GIS System, with critical facilities located, evacuation route and detour routes.
- b. Establish emergency operations and preparedness training at regular intervals, quarterly, semi-annual or annual.
- c. Evaluate hiring more full time EMS personnel and increasing the number of volunteer EMS personnel. Implement regular training and evaluation.
- d. Look for opportunities to train with bordering counties and municipalities. Develop cooperative relationships with bordering counties and municipalities.
- e. Cross training of departments to share knowledge and to develop understanding within each department of the purpose and function that each department has and the available resources and experience. This will also develop synergy among the departments.
- f. The 911 system needs to be addressed. A back up system currently does not exist.
- g. Backup power sources needs to be added to the vital facilities that currently do not have a backup power supply. Addition mobile power generator should be made available for emergency operations.
- h. Implementation of training in the opening of emergency shelters. Identify additional facilities that could be used as emergency shelters and identify staff to open and operate the additional shelters. There are currently two facilities identified as emergency shelters, identifying at least two additional facilities as backups or overflow facilities.
- i. Provide training and education material to the general public on what to do and where to go during an emergency.
- j. Evaluation of security for the water and wastewater system for the county and local municipalities. Develop a plan and process to implement security measures.

FOREWORD

The Greene County Emergency Operations Plan was developed to address multiple hazards, which threaten a jurisdiction. Through use of a functional format, the document encourages an Integrated Emergency Management System (IEMS) approach to disasters and fosters prompt, efficient and coordinated response operations by elements of the emergency organization. IEMS requires a system-wide integration of skills, people and resources. IEMS recognizes that plans developed for one type of emergency are extremely useful for other emergency situations and a significant amount of emergency operational capability can be established by addressing broadly applicable functions.

This document presents a Basic Plan, which serves, as a summary document to the supporting sections. The sections define who will do what and when in an emergency situation. Defining the roles of each response agency reduces confusion, chaos and conflict during emergencies and significantly decreases vulnerability of the public and their property to hazardous threats.

This plan does not attempt to define for each agency how to perform the tasks. The manner in which the tasks are to be performed is contained in the agency Standard Operation Procedures or Guidelines which are contained in the supporting document that supports this plan.

An additional companion document entitled **SUPPORTING DOCUMENT MUST BE CONSULTED WHEN IMPLEMENTING PORTIONS OF THIS PLAN.** This document contains agency agreements, SOP's, agreements between government and private organization, memorandums of understandings, organizational charts, agency checklists, standard news releases, etc.

This plan meets the requirements of FEMA planning guidance, CPG 1-8, CPG 1-8A, NRT-1 and the legal responsibilities identified in North Carolina General Statutes, Chapter 166-A. It provides all the necessary elements to insure that local government can full fill its legal responsibilities for emergency preparedness.

The Greene County Emergency Operations Plan for Multi-Hazards dated 1995 is hereby rescinded.

GREENE COUNTY EMERGENCY OPERATIONS PLAN GLOSSARY

American Red Cross – The American Red Cross is a humanitarian organization, led by volunteers, that provides relief to victims of disasters and helps people prevent, prepare for and respond to emergencies. It does this through services that are consistent with its Congressional Charter and the Principles of the International Red Cross Movement.

Annex (functional) – Parts of the EOP that begin to provide specific information and direction; should focus on operations, what the function is and who is responsible for carrying it out, emphasize responsibilities, tasks, procedures and operational actions that pertain to the function being covered, including activities to be performed by anyone with a responsibility under the function. Should clearly define and describe the policies, procedures, roles and responsibilities inherent in the various functions before, during and after any emergency period.

Appendix, Hazard-specific (of Annex) – Addresses each hazard that threatens the jurisdiction. Unique characteristics of various hazards will not be adequately covered in the functional annexes; to properly treat such unique factors is the purpose or role of the hazard-specific appendixes to the functional annexes.

Attack – A hostile action taken against the United States by foreign forces or terrorists, resulting in the destruction of or damage to military targets, injury or death to the civilian population or damage or destruction to public and private property.

Basic Plan – The Basic Plan is an overview of the jurisdiction's emergency response organization and policies. It cites the legal authority for emergency operations, summarizes the situations addressed by the EOP, explains the general concept of operations and assigns responsibilities for emergency planning and operations.

CERCLA – The Comprehensive Environmental Response, Compensation and Liability Act of 1980 (Superfund) regarding hazardous substance releases into the environment and the cleanup of inactive hazardous waste disposal sites; establishes authority to tax chemical and petroleum industries to finance a \$1.6 billion response trust fund (the Superfund or Fund) and provides broad Federal authority to respond directly to releases or threatened releases of hazardous substances and pollutants for contaminants that may endanger public health or welfare or the environment. EPA is primarily responsible for implementing Superfund. Under CERCLA, EPA may take legal action to force those responsible for hazardous substance releases to clean them up or to reimburse EPA for costs of cleanup. Reauthorized via SARA. (Codified as: 42 USC 9601 et. seq.)

Checklist – Written (or computerized) enumeration of actions to be taken by an individual or organization, meant to aid memory rather than provide detailed instruction.

Chief Executive Official – The official of the community who is charged with authority to implement and administer laws, ordinances and regulations for the community. He or she may be a mayor, city manager, etc.

GREENE COUNTY EMERGENCY OPERATIONS PLAN GLOSSARY

Civil Air Patrol – Volunteer pilots who offer their time and aircraft for emergency use in search and rescue, messenger service, light transport flights, airborne communications and reconnaissance support.

Command Post – A centralized base of operations established near the site of a hazardous materials incident.

Community – A political entity which has the authority to adopt and enforce laws and ordinances for the area under its jurisdiction. In most cases, the community is an incorporated town, city, township, village or unincorporated area of a county. However, each State defines its own political subdivisions and forms of government.

Contamination – The undesirable deposition of a chemical, biological or radiological material on the surface of structures, areas, objects or people.

SERC – State Emergency Response Commission for the state in which the facility is located. Oversees local committees' information and operations; approves submitted local response plans; intermediary between Federal and local officials in SARA compliance. See "SERC."

LEPC – The Local Emergency Planning Committee for the Emergency Planning District in which the facility is located; required by federal law and some state laws to develop contingency plans (for planning districts as set forth by the State Commission).

Community Emergency Coordinator – A person appointed for the local emergency planning committee (pursuant to SAR), who makes determinations necessary to implement plans and who receives official emergency notification of releases.

Community Information Coordinator – Official designated to receive public requests for facility information required under Title III.

Comprehensive Cooperative Agreement (CCA) – For each state, a single budgetary vehicle for applying for and receiving financial assistance for several discrete FEMA-administered programs. Negotiated separately for each State via FEMA Regional offices. Mechanism for distribution of Title III training grants.

Comprehensive Emergency Management (CEM) – An integrated approach to the management of emergency programs and activities for all four emergency phases (mitigation, preparedness, response and recovery), for all types of emergencies and disasters (natural, manmade and attack) and for all levels of government (local, State and Federal) and the private sector.

Congregated Care Facilities (CCF aka Shelter) – Public or private buildings in the host areas planned for use to lodge and care for evacuees. Generally, assigned space is approximately 40 square feet per person.

Continuity of Government – Plans and procedures for ensuring the survival and operational capabilities of government processes and lines of succession. This includes the protection and maintenance of agency and departmental vital records.

GREENE COUNTY EMERGENCY OPERATIONS PLAN GLOSSARY

Challenged – The state of being mentally or physically handicapped.

Dam – A barrier built across a watercourse for the purpose of impounding, controlling or diverting the flow of water.

Damage Assessment/Estimation – The conduct of on the scene surveys following any disaster to determine the amount of loss or damage caused by the incident. Extent of damage is assessed in all types of disasters such as flash flood, tornado, winter storm, hurricane, nuclear power incident and chemical explosion.

Decontamination – The reduction or removal of a chemical, biological or radiological material from the surface of a structure, area, object or person.

Disaster – An occurrence or imminent threat of widespread or severe damage, injury or loss of life or property resulting from any natural or man made accidental, military or paramilitary cause.

Disaster Field Office – The office established in or near the designate area of a Presidentially declared major disaster to support Federal and State response and recovery operations. The DFO houses the FCO and ERT and where possible the SCO and support staff.

Disaster Recovery Center – Places established in the area of a Predidentially declared major disaster, as soon as practicable, to provide victims the opportunity to apply in person for assistance and/or obtain information relating to that assistance. DRCs are staffed by local, State and Federal agency representatives, as well as staff from volunteer organizations (e.g. the ARC).

Dose (Radiation) – A general term indication the quantity (total or accumulated) of ionizing radiation or energy absorbed by a person or animal.

Dose Rate – The amount of ionizing radiation which an individual would absorb per unit of time.

Dosimeter – An instrument for measuring and registering total accumulated exposure to ionizing radiation.

Earthquake – The sudden motion or trembling of the ground produced by abrupt displacement of rock masses, usually within the upper 10 to 20 miles of the earth's surface.

Electromagnetic Pulse – A sharp pulse of energy radiated instantaneously by a nuclear detonation which may affect or damage electronic components and equipment.

Emergency – Any occasion or instance—such as a hurricane, tornado, storm, flood, tidal wave, tsunami, earthquake, volcanic eruption. Landslide, mudslide, snowstorm, fire, explosion, nuclear accident or any other natural or man-made catastrophe that warrants action to save lives and to protect property, public health and safety.

GREENE COUNTY EMERGENCY OPERATIONS PLAN GLOSSARY

Emergency Action System (EAS) – A voluntary network of broadcast stations and interconnecting facilities, which have been authorized by the Federal Communications Commission to disseminate information during an emergency, as provided by the Emergency Broadcast System Plan. EBS is made up of AM, FM and TV broadcast stations and non-governmental electronic communications operating in a voluntary organized manner during natural/manmade emergencies or disasters at national, state or local levels. This system keeps the public informed.

Emergency Environmental Health Services – Services required to correct or improve damaging environmental health effects on humans, including inspection for food contamination, inspection for water contamination and vector control; providing for sewage and solid waste inspection and disposal; clean-up and disposal of hazardous materials and sanitation inspection for emergency shelter facilities.

Emergency Health Services – Services required to prevent and treat the damaging health effects of an emergency, including communicable disease control, immunization, laboratory services, dental and nutritional services; providing first aid for treatment of ambulatory patients and those with minor injuries; providing public health information on emergency treatment, prevention and control; and providing administrative support including maintenance of vital records and providing for a conduit of emergency health funds from State and Federal governments.

Emergency Management – Organized analysis, planning, decision-making, assignment and coordination of available resources to the mitigation of, preparedness for, response to or recovery from major community wide emergencies. Refer to local and state emergency legislation.

Emergency Management Assistance (EMA) – FEMA program of financial contributions to assist the States and their political subdivisions to develop a capability for civil defense by assisting them on a 50-50 funds matching reimbursement basis.

Emergency Management Coordinator (EMC) – The Emergency Response person responsible to the Direction and Control Group for coordinating the response activities of the combined government, industry and public forces at work in the disaster.

Emergency Medical Services (EMS) – Local medical response teams, usually rescue squads or local ambulances services which provide medical services during a disaster.

Emergency Medical Technician (EMT) – Person nationally or state certified as trained to provide a specific level of emergency medical care, usually at the actual scene of an emergency which led to the injuries being treated, prior to transport to a hospital.

Emergency Mortuary Services – Services required to assure adequate death investigation, identification and disposition of bodies; removal, temporary storage and transportation of bodies to temporary morgue facilities; notification of next of kin; and coordination of mortuary services and burial of unclaimed bodies.

GREENE COUNTY EMERGENCY OPERATIONS PLAN

GLOSSARY

Emergency Operations Center (EOC) – The protected site from which civil government officials (municipal, county, State and Federal) exercise centralized direction and control in an emergency. Operating from an EOC is a basic emergency management concept. For effective emergency response, all activities must be centrally directed and coordinated. The person in charge of the disaster directs the response from this location and all community officials assigned primary emergency response tasks coordinate their actions from this center. The EOC should have adequate work space, be supplied with maps, status boards, etc. which are visible to all EOC staff and have communications capability so that the EOC staff may communicate with their departments and field forces. The EOC also serves as a Resource Center and coordination point for additional field assistance. It provides executive directives and liaison to state and federal government and considers and mandates protective actions. The EOC may be partially activated with key staff persons meeting periodically or it may be fully activated, thus operating on a continuous 24 hour basis, depending on the situation.

Emergency Operations Plan (EOP) – An all hazards document, which briefly, clearly and concisely specifies actions to be taken or instructions to be given in the event of natural disasters, technological accidents or nuclear attack. The plan identifies predetermined assumptions, objectives and existing capabilities.

Emergency Operations Exercise – Emergency operations training for Emergency Operating Center (EOC) personnel, including civil government officials, under conditions of a simulated emergency.

Emergency Planning Zone – Areas around a facility for which planning is needed to ensure prompt and effective actions are taken to protect the health and safety of the public if an accident occurs. The REP Program and CSEPP use the EPZ concept.

➤ In the REP Program, the two EPZs are:

- Plume Exposure Pathway (10-mile EPZ). A circular geographic zone (with a 10-mile radius centered at the nuclear power plant) for which plans are developed to protect the public against exposure to radiation emanating from a radioactive plume caused as a result of an accident at the nuclear power plant.
- Ingestion Pathway (50-mile EPZ). A circular geographic zone (with a 50-mile radius centered at the nuclear power plant) for which plans are developed to protect the public from the ingestion of water or foods contaminated as the result of a nuclear power plant accident.

➤ In CSEPP, the EPZ is divided into three concentric circular zones:

- Immediate Response Zone (IRZ). A circular zone ranging from 10 to 15 km (6 to 9 miles) from the potential chemical event source, depending on the stockpile location on-post. Emergency response plans developed for the IRZ must provide for the most rapid and effective protective actions possible, since the IRZ will have the highest concentration of agent and the least amount of warning time.

GREENE COUNTY EMERGENCY OPERATIONS PLAN GLOSSARY

- **Protective Action Zone (PAZ).** An area that extends beyond the IRZ to approximately 16 to 50 km (10 to 30 miles) from the stockpile location. The PAZ is that area where public protective actions may still be necessary in case of an accidental release of chemical agent, but where the available warning and response time is such that most people could evacuate. However, other responses (e.g. sheltering) may be appropriate for institutions and special populations that could not evacuate within the available time.
- **Precautionary Zone (PZ).** The outermost portion of the EPZ for CSEPP, extending from the PAZ outer boundary to a distance where the risk of adverse impacts to humans is negligible. Because of the increased warning and response time available for implementation of response actions in the PZ, detailed local emergency planning is not required, although consequence management planning may be appropriate.

Emergency Public Information – Information disseminated primarily in anticipation of an emergency or the actual time of an emergency; in addition to providing information as such, frequently directs actions, instructs and transmits direct orders. Includes rumor control processes. During an emergency it is essential that the community have the capability to disseminate, in a timely manner, official emergency public information. An effective public information program is instrumental in saving lives and limiting the loss of property. A Public Information Official (PIO) must be appointed to provide a single source of information to the media. Information thus will be non-conflicting and key officials will be free to concentrate on the response. The PIO must have the capability to fully utilize the media to provide fast, accurate, official information and instructions to the public. A center should be designated where press conferences will be given and news releases issued. This will be the only source of information for the media, to that key emergency operating facilities and activities will not be disrupted by media attempts to gain access. (See PIAT and JPIC)

Emergency Response – The response to any occurrence which results, or is likely to result, in a release of a hazardous substance due to an unforeseen event.

Emergency Response Guidebook (ERG) – Published and distributed by DOT for response personnel's initial use on scene at HazMat events. Latest issue is dated "1987". Earlier editions should be discarded.

Emergency Response Team – An interagency team, consisting of the lead representative from each Federal department or agency assigned primary responsibility for an ESF and key members of the FCO's staff, formed to assist the FCO in carrying out his/her coordination responsibilities. The ERT may be expanded by the FCO to include designated representatives of other Federal departments and agencies as needed. The ERT usually consists of regional level staff.

Emergency Response Team Advance Element – For Federal disaster response and recovery activities under the Stafford Act, the portion of the ERT that is first deployed to the field to respond to a disaster incident. The ERT-A is the nucleus of the full ERT.

GREENE COUNTY EMERGENCY OPERATIONS PLAN GLOSSARY

Emergency Response Team National – An ERT that has been established and rostered for deployment to catastrophic disasters where the resources of the FEMA Region have been, or are expected to be, overwhelmed. Three ERT-Ns have been established.

Emergency Support Function – In the FRP, a functional area of response activity established to facilitate the delivery of Federal assistance required during the immediate response phase of a disaster to save lives, protect property and public health and to maintain public safety. ESFs represent those types of Federal assistance which the State will most likely need because of the impact of a catastrophic or significant disaster on its own resources and response capabilities, or because of the specialized or unique nature of the assistance required. ESF missions are designed to supplement State and local response efforts.

Emergency Support Team – An interagency group operating from FEMA headquarters. The EST oversees the national level response support effort under the FRP and coordinates activities with the ESF primary and support agencies in supporting Federal requirements in the field.

Emergency Worker – Workers employed during an emergency to work specifically in disaster roles such as debris removal, engineering services, dike construction, water removal, etc. Also any person engaged in operations required to minimize the effects of a fixed nuclear facility emergency. Environment-Water, air and land and the interrelationship which exists among and between them and all living things.

EPA – U.S. Environmental Protection Agency: primary CERCLA agency; chair of NRT. Title III Hotline (800) 535-0202; in Washington, D.C. (202) 479-2449, 8:30 a.m. – 4:30 p.m. Monday – Friday. (Also known as CEPP Hotline.)

Evacuation – A population protection strategy involving orderly movement of people away from an actual or potential hazard and providing reception centers for those without their own resources for temporary relocation.

Evacuee – That individual which is moved to an area of less risk.

Exercise – Maneuver or simulated emergency condition involving planning, preparation and execution; carried out for the purpose of testing, evaluating, planning, developing, training and/or demonstrating emergency management systems and individual components and capabilities, to identify areas of strength and weakness for improvement of emergency plan (EOP).

Exercise Scenario – Background detail (domestic, international, political, military, etc.) against which an exercise is conducted.

Exposure/Exposed – When an employee is subjected to a hazardous chemical in the course of employment through any route of entry (inhalation, ingestion, skin contact or absorption, etc.) and includes potential (e.g. accidental or possible) exposure.

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Exposure Rate (Radiological) – The amount of ionizing radiation to which an individual would be exposed or which he or she would receive per unit of time.

Extremely Hazardous Substance (SARA) – EPA list of 300 plus substances named in Appendix D of 40 CFR Part 300, as described in SARA section 302(a)(2). Section 302, 303 and 304 of CERCLA apply to these substances. Length of list may be altered by EPA review process.

Federal Coordinating Officer – The person appointed by the President to coordinate Federal assistance in a Presidentially declared emergency or major disaster.

Federal Emergency Management Agency (FEMA) – A federal agency tasked with national emergency preparedness and disaster response. Responsibilities include assistance in all aspects of community planning, preparedness and response to the full range of likely disasters and emergencies, including recommendation for a Presidentially declared disaster area and administration of disaster funds. Provides a range of expertise and administrative skills in community preparedness planning via state emergency offices. It also deals in flood insurance, temporary emergency housing, training of state and local emergency response personnel and funding of preparedness projects and functions.

Field Assessment Team – A small team of pre-identified technical experts that conduct an assessment of response needs (not a PDA) immediately following a disaster. The experts are drawn from FEMA, other agencies and organizations—such as the U.S. Public Health Service, U.S. Army Corps of Engineers, U.S. Environmental Protection Agency and the American Red Cross—and the affected State(s). All FAsT operations are joint Federal/State efforts.

Fire Department – A paid or voluntary professional fire department with jurisdiction over Local Emergency Response; receives reports from facilities under Title III.

Flash Flood – Follows a situation in which rainfall is so intense and severe and runoff so rapid that it precludes recording and relating it to stream stages and other information in time to forecast a flood condition.

Flash Flood Warning – Means a flash flood is imminent within an area, take immediate action.

Flash Flood Watch – Indicates that a flash flood is possible or probable within an area, stay alert.

Flood – A general and temporary condition of partial or complete inundation of normally dry land areas from overflow of inland or tidal waters, unusual or rapid accumulation or runoff of surface waters or mudslides/mudflows caused by accumulation of water.

Foreseeable Emergency – Any potential occurrence such as, but not limited to, equipment failure, rupture of containers or failure of control equipment which could result in an uncontrolled release of a hazardous chemical.

GREENE COUNTY EMERGENCY OPERATIONS PLAN GLOSSARY

Full Protective Clothing – Clothing that will prevent gases, vapors, liquids and solids from coming in contact with the skin. Full protective clothing includes the helmet, self-contained breathing apparatus, coat and pants customarily worn by firefighters (turn-out or bunker coat and pants), rubber boots, gloves, bands around legs, arms and waist, and fact mask, aw well as covering for neck, ears and other parts of the head not protected by the helmet, breathing apparatus or face mask.

General Statute (G.S.) – The specific form of state law codified and recorded for reference.

Governor’s Authorized Representative – The person empowered by the Governor to execute, on behalf of the State, all necessary documents for disaster assistance.

Hazard – Any situation that has the potential for causing damage to life, property and the environment.

Hazard Analysis – A process used by emergency managers to identify and analyze crisis potential and consequences.

Hazard Identification – The Hazard Identification is part FEMA’s CPG 1-35, of the “Hazard Identification, Capability Assessment and Multi-Year Development Plan” (HICA/MYDP, op.cit.) information system, which is completed (and updated annually) by State and local emergency management organizations. The Hazard Identification provides a structured approach for identifying those hazards judged by local officials to pose a significant threat to their jurisdiction.

HazMat, Hazardous Materials – Any substance or material in a particular for or quantity which the Secretary of Transportation finds may pose an unreasonable risk to health, safety and property. Substances so designated may include explosive, radioactive materials, etiologic agents, flammable liquids or solids, combustible liquids or solids, poisons, oxidizing or corrosive materials and flammable gases. Defined via rulemaking process, under authority of PL 93-633.

Hazardous Materials Incident (Stationary) – Uncontrolled, unlicensed release of hazardous materials from a fixed site.

Hazardous Materials Response Team – A team of specially trained personnel who respond to a hazardous materials incident. The team performs various response actions including assessment, fire fighting, rescue and containment; not responsible for cleanup operations following incident.

Hazardous Materials Transportation Incident – Uncontrolled, unlicensed release of hazardous materials during transport outside a fixed-site operation.

Hazardous Wastes – Discarded materials that EPA regulated under authority of the Resource Conservation and Recovery Act (RCRA) (42 USC 6901 et. seq.) because of public health and safety concerns. Under RCRA, a hazardous waste is fully regulated from “cradle to grave” that is, from time of creation until properly discarded.

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HICA-MYDP – Hazard Identification, Capability Assessment and Multi-Year Development Plan. (See CPG 1-35)

High-Hazard Areas – Geographic locations that for planning purposes have been determined through historical experience and vulnerability analysis to be likely to experience the effects of a specific hazard (e.g. hurricane, earthquake, hazardous materials accident, etc.) resulting in vast property damage and loss of life.

Hurricane – Pronounced rotary circulation, constant wind speed of 74 miles per hour (64 knots) or more.

ICS – Incident Command System: combination of facilities, equipment, personnel, procedures and communications operating within a common organizational structure with responsibility for management of assigned resources to effectively direct and control the response to an incident. Intended to expand as situation requires larger resource, without requiring new, reorganized command structure.

Immediate Situation Report – If a significant emergency/disaster occurs a report providing information on the severity of the problems to the EOC.

In-Place Sheltering – Directing of personnel to remain in a building or seek shelter in a building or structure, in lieu of evacuation, for protection from a life safety threat, i.e. vapor cloud or explosion. In-place sheltering is defined as “the indoors sheltering of people to prevent external contact or inhalation of harmful chemicals”. All air circulating devices should be shut off and windows and doors closed. It is anticipated in-place sheltering will last a short time, no more than a few hours.

Integrated Emergency Management System (IEMS) – A system which allows improved capability by all levels of government to mitigate, prepare for, respond to and recover from all disasters or emergencies. IEMS utilizes a strategy for implementing emergency management activities which builds upon those functions which are common to preparedness for any type of occurrence; and which provides for special requirement of individual emergency situations. Seeks function based plan annexes which can be adapted to varied hazard events.

Joint Information System – Under the FRP, connection of public affairs personnel, decision-makers and news centers by electronic mail, fax and telephone when a single Federal-State-local JIC is not a viable option.

Joint Public Information Center (JPIC) – A center established near the scene of a disaster or emergency for issuing emergency information. It provides a central location for the joint issuance of accurate information to news media representatives by all levels of government and private industry. This center should be a large room with limited access, close to the scene, where the media can receive information and be provided with work space. A JPIC is established for written and verbal news releases to the media. The Joint Public Information Center provides a central location where news media representatives can receive accurate current information concerning the incident. (See PIAT)

GREENE COUNTY EMERGENCY OPERATIONS PLAN GLOSSARY

Liability – An obligation to do or refrain from doing something; a duty which eventually must be performed; and obligation to pay money; also used to refer to one's responsibility for his conduct.

Liable – To be responsible for; to be obligated in law. (See liability)

Local Government – Political subdivision of the State.

Mass Care – The actions that are taken to protect evacuees and other disaster victims from the effects of the disaster. Activities include providing temporary shelter, food, medical care, clothing and other essential life support needs to those people that have been displaced from their homes because of a disaster or threatened disaster.

Mitigation – Is an activity that actually eliminates or reduces the probability of such disaster occurrence, or reduces the effects of a disaster. Mitigation includes such action as zoning and land used management, safety and building codes, flood proofing of buildings and public education.

Mutual Aid Agreements – Formal or informal understanding between jurisdictions that pledge exchange of emergency or disaster assistance.

NOAA – National Oceanic and Atmospheric Administration: central agency in development of CAMEO computer system for hazmat response and planning use, especially air-plume and surface slick dispersion modeling. Functions under the Department of Commerce. Provides Scientific Support Coordinators (SSCs) in coastal marine areas. SSCs serve as members of the OSC's staff, as scientific and technical advisors. Their capabilities include contingency planning, surface/subsurface trajectory forecasting, resource risk analysis, technical hazard data assessment and general communications. The SSC serves a principal point-of-contact for members of the scientific community.

National Incident Management System (NIMS) – A system mandated by HSPD-5 that provides a consistent nationwide approach for Federal, State, local and tribal governments; the private-sector and nongovernmental organizations to work effectively and efficiently together to prepare for, respond to and recover from domestic incidents, regardless of cause, size or complexity. To provide for interoperability and compatibility among Federal, State, local and tribal capabilities, the NIMS includes a core set of concepts, principles and terminology. HSPD-5 identifies these as the ICS; multi-agency coordination systems, training, identification and management of resources (including systems for classifying types of resources), qualification and certification and the collection, tracking and reporting of incident information and incident resources.

National Warning System (NAWAS) – The Federal Warning System, used to disseminate warnings of imminent natural disaster or enemy attack into Regional Warning System which passes it to the State Warning Points for action.

National Weather Service (NWS) – A Federal Agency tasked with forecasting weather and providing appropriate warning of imminent natural disaster such as hurricane, tornados, tropical storms, etc.

North Carolina Response Commission – The North Carolina Emergency Response Commission is empowered by the Governor to serve as the State Emergency Response Commission in accordance with the Federal “Emergency Planning and Community Right-to-Know Act of 1986”, Section 301 of the Act requires the Commission to designate state emergency planning districts, approve appointment of members to Local Emergency Planning Committees for each emergency planning district and revise emergency planning district designations and Local Emergency Planning Committee appointment, as deemed appropriate.

Nuclear Detonation – An explosion resulting from fission and/or fusion reactions in nuclear material, such as that from a nuclear weapon.

On-Scene Commander – Official who directly commands and allocates local resources and supervises all local operations at the scene.

PL – Public Law, citation referring to the session of Congress enacting the law followed by a number indicating the order of that Congress’ laws in which it took effect.

Preliminary Damage Assessment – A mechanism used to determine the impact and magnitude of damage and the resulting unmet needs of individuals, businesses, the public sector and the community as a whole. Information collected is used by the State as a basis for the Governor’s request for a Presidential declaration, and by FEMA to document the recommendation made to the President in response to the Governor’s request. PDAs are made by at least one State and one Federal representative. A local government representative familiar with the extent and location of damage in the community often participates; other State and Federal agencies and voluntary relief organizations also may be asked to participate, as needed.

Public Information Officer (PIO) – On-scene official responsible for preparing and coordinating the dissemination of public information in cooperation with other responding Federal, State and local government agencies. Also called Public Affairs Officers (PAO).

Radiation Sickness – The symptoms characterizing the sickness known as radiation injury, resulting from excessive exposure of the whole body to ionizing radiation.

Radiological Monitoring – The process of locating and measuring radiation by means of survey instruments that can detect and measure (as exposure rates) ionizing radiation.

Reception Center – A center established to register evacuees and to assess their needs. If an evacuation is ordered, suitable facilities to be used as reception centers must be designated. The centers will be used to register evacuees for emergency shelter or, if temporary shelter is not required because evacuees will stay elsewhere, to ascertain where they can be contacted. Persons requiring temporary shelter will be directed to a shelter location. (NOTE: Reception and shelter facilities may be at the same location.)

GREENE COUNTY EMERGENCY OPERATIONS PLAN GLOSSARY

Recovery – Activity involves assistance to return the community to normal or near normal conditions. Short-term recovery returns vital life support systems to minimum operating standards. Long-term recovery may continue for a number of years after a disaster and seeks to return life to normal or improved levels. Recovery activities include, temporary housing, loans or grants, disaster unemployment insurances, reconstruction and counseling programs.

Regional Operating Center – The temporary operations facility for the coordination of Federal response and recovery activities located at the FEMA Regional Office (or Federal Regional Center) and led by the FEMA Regional Director or Deputy Director until the DFO becomes operational. Once the ERT-A is deployed, the ROC performs a support role for Federal staff at the disaster scene.

Resource Management – Those actions taken by a government to: identify sources and obtain resources needed to support disaster response activities; coordinate the supply allocation, distribution and delivery of resources so that they arrive where and when most needed; and maintain accountability for the resources used.

Risk – The probability that damage to life, property and the environment will occur.

Risk Analysis – Assesses probability of damage (or injury) due to hazardous materials release and actual damage (or injury) that might occur, in light of the hazard analysis and vulnerability analysis. Some planners may choose to analyze worst-case scenarios. Use of Chemical Profiles in the CEPP technical guidance or a similar guide to obtain information.

Risk Area – An area considered likely to be affected by a release of a toxic chemical. Risk areas are based on recommended isolation distances (i.e. one-half mile radius in all directions and one mile downwind), identifiable land features (streets, addressed, rivers, etc.) and predominate wind directions.

Rumor Control Center – A center established to provide a contact point for the public to call for additional information. The center is located adjacent to the JIC.

SARA – Superfund Amendments and Reauthorization Act of 1986 (PL99-499). Extends and revises Superfund authority (in Title I & II). Title III of SARA includes detailed provisions for community planning and Right-to-Know systems.

Secondary Hazard – A threat whose potential would be realized as the result of a triggering event that of itself would constitute an emergency. For example, dam failure might be a secondary hazard associated with earthquakes.

SERC – State Emergency Response Commission, designated by the Governor, responsible for establishing hazmat planning districts and appointing/overseeing Local Emergency Planning Committees.

GREENE COUNTY EMERGENCY OPERATIONS PLAN GLOSSARY

Shelter – A facility to house, feed and care for persons evacuated from a risk area for periods of one or more days. For the risk areas the primary shelter and the reception center are usually located in the same facility.

Shelter Manager – An individual who provides for internal organization, administration and operation of a shelter facility.

Staging Area – A pre-selected location having large parking areas such as a major shopping area, schools, etc. The area is a base for the assembly of persons to be moved by public transportation to host jurisdictions and a debarking area for returning evacuees. Several of these areas should be designated to each evacuating jurisdiction.

Standard Operating Procedures (SOP's) – Set of instructions having the force of a directive, covering features of operations which lend themselves to a definite or standardized procedure without loss of effectiveness and implemented without a specific direct order from higher authority.

State Coordinating Officer – The person appointed by the Governor to coordinate State, Commonwealth or Territorial response and recovery activities with FRP related activities of the Federal Government, in cooperation with the FCO.

State Emergency Operations Plan – Plan designated specifically for State-level response to emergencies or major disasters; which sets forth actions to be taken by the State and local governments, including those for implementing Federal disaster assistance. (See EOP, op. cit.)

State Emergency Response Team (SERT) – A team of emergency response personnel from the Department of Crime Control and Public Safety who are dispatched to the scene of a disaster in order to evaluate condition, offer advice and coordinate all recovery activities.

State Liaison – A FEMA official assigned to a particular State, who handles initial coordination with the State in the early stages of an emergency.

State Warning Point (SWP) – The State facility (State Highway Patrol Communications Center) that receives warnings and other emergency information over NAWAS and relays this information in accordance with current directives.

Storm Surge – A dome of sea water created by the strong winds and low barometric pressure in a hurricane that causes severe coastal flooding as the hurricane strikes land.

Super Fund Amendments and Reauthorization Act of 1986

GREENE COUNTY EMERGENCY OPERATIONS PLAN GLOSSARY

Terrorism – The use of or threatened use of criminal violence against civilians or civilian infrastructure to achieve political ends through fear and intimidation, rather than direct confrontation. Emergency Management is typically concerned with the consequences of terrorist acts directed against large numbers of people (as opposed to political assassination or hijacking, which may also be considered “terrorism”).

Traffic Control Points – Places along evacuation routes that are manned to direct and control movement to and from the area being evacuated.

Tornadoes – Spawned by hurricanes sometimes produce severe damage and casualties. If a tornado is reported in your area, a warning will be issued.

Tsunami – Sea waves produced by an undersea earthquake. Such sea waves can reach a height of 80 feet and can devastate coastal cities and low-lying areas.

Vulnerability – The susceptibility to life, property and the environment to damage if a hazard manifests its potential.

Vulnerability Analysis – Identifies what is susceptible to damage. Should provide information on: extent of the vulnerable zone; population, in terms of size and types that could be expected to be within the vulnerable zone; private and public property that may be damaged, including essential support systems and transportation corridors; and environment that may be affected and impact on sensitive natural areas and endangered species. Refer to the CEPP technical guidance or DOT’s Emergency Response Guidebook to obtain information on the vulnerable zone for hazardous materials release. A standard vulnerability analysis has been developed by EPA to assist communities in addressing sec. 303 of Title III.

Warning Point – A facility that receives warning and other information and disseminates or relays information in accordance with a prearranged plan.

Warning Signal – An audible signal, sounded on public outdoor devices.

Watch – Indication by the NWS that, in a defined area, conditions are favorable for the specified type of severe weather (e.g.; flash flood watch, severe thunderstorm watch, tornado watch, tropical storm watch).

**GREENE COUNTY
EMERGENCY OPERATIONS PLAN
INSTRUCTIONS FOR USE**

It is intended that this plan in conjunction with the supporting document, be used by the response organizations to obtain maximum use of existing resources, organizations and systems in their response to emergencies and disasters that could and/or have occurred in the county.

The format utilized is:

- Basic Plan:** To be used by chief executives and policy officials.
- Sections:** Address the specific functions for use by the operational coordinators and assistant coordinators.
- Support Document:** Contain technical information, details and methods (such as standard operating procedures and checklist) for use by response personnel.

Each section of the plan contains a purpose statement for that section and identifies the agency with primary responsibility for implementing that particular section and also identifies those agencies responsible for providing support. All individuals with assigned responsibilities should be familiar with the entire plan, however added emphasis must be given to those sections for which they are primarily responsible. While all circumstances cannot be addressed, the content of this plan should be used as a guide for those things that do occur but not specifically addressed herein.

All agencies assigned responsibilities in this plan are responsible for the development of standard operating procedures or guidelines to establish policies on how to conduct operations as assigned in this plan. Agency SOP's are to be filed with the Greene County Emergency Management office for consolidation into the support manual.

DISTRIBUTION LIST

County Board of Commissioners/County Manager	1
Emergency Services Office	1
Mayor, Town of Walstonburg	1
Mayor, Town of Hookerton	1
Mayor, Town of Snow Hill	1
Sheriff	1
Social Services Director	1
Health Director	1
Finance Director	1
Superintendent of Schools	1
Fire Marshal's Office/Fire Departments	11
EMS Office/Rescue Squads	8
County Landfill & Solid Waste	1
County Library	1
American Red Cross	1
NC Division of Emergency Management – Eastern Branch Office	1
Area 3 Coordinator	1
Register of Deeds	1
Parks & Recreation	1
Tax Office	1
Clerk of Superior Court	1
Board of Elections	1
Cooperative Extension Service	1
Economic Development	1
Council on Aging	1
Greene Lamp	1
Transportation Department	1
Greene County Healthcare, Inc.	1
Mental Health	1
Inspections Department	1
Greene County Interfaith	1
TOTAL	48

TO: County Government
Municipal Government
Residents of Greene County

By virtue of the powers and authority vested in me as the Chairman, County Board of Commissioners, I hereby promulgate and issue the Greene County Emergency Operations Plan dated for December 2004 as a regulation and guidance to provide for the protection of the residents of Greene County.

This plan outlines the coordinated actions to be taken by the County Officials and volunteer organizations to protect lives and property in natural or man made disasters. It identifies forces and resources available for employment to prevent, minimize and recover from injury, loss of life and destruction of property which tragically characterizes disasters.

This plan is effective for planning on receipt and for execution when directed. The County Manager is responsible for the maintenance and updating of this plan, as required, in coordination with appropriate participating agencies and units of government.

This plan rescinds the Greene County Multi-Hazards plan and all changes, dated March 1995.

Sincerely,

Denny Garner
County Board of Commissioners

STATEMENT OF APPROVAL

The undersigned agree to the responsibilities assigned to their organization in the Greene County Emergency Operations Plan, dated December 2004.

Chairman, County Board of Commissioners

Date

County Manager, Greene County

Date

Director, Emergency Services/Communications

Date

Sheriff, Greene County/Communications

Date

Director, Greene County Social Services

Date

Director, Greene County Health Department

Date

Superintendent, Greene County Schools

Date

Director, Public Works

Date

Disaster Chairman, American Red Cross

Date

Director, Tax Office

Date

Director, Greene County Interfaith

Date

Director, Transportation Department

Date

Mayor, Snow Hill

Date

Mayor, Walstonburg

Date

Mayor, Hookerton

Date

Appendix A...

Greene County Isolation Order

Appendix B...

Greene County Quarantine Order

Appendix C...

Greene County Health Department ICS Organization Chart

**Greene County Point of
Dispensing Incident
Management System:
Command and General Staff**

Public Health Incident
Commander
Local Position Title:
Health Director
Name: Linda Sewall

Back-up: EMS Director
Name: Randy Skinner

Clinic Safety Officer
Local Position Title: Lab
Technician/Safety Officer
Name: Tina Letchworth
Back-up: Environmental
Health Supervisor
Name: Ashley Severson

Clinic Liaison Officer
Local Position Title:
Health Director
Name: Linda Sewall
Back-up: Preparedness
Coordinator
Name: Joy Brock

Clinic Site Commander
Local Position Title:
Nursing Supervisor
Name: Chris Miller
Back-up: Child Health
Nurse
Name: Angela Allen

Public Information Officer
Local Position Title:
County Manager
Name: Don Davenport
Back-up: County Finance
Officer
Name: Shawna Wooten

Finance/Administration
Section Chief

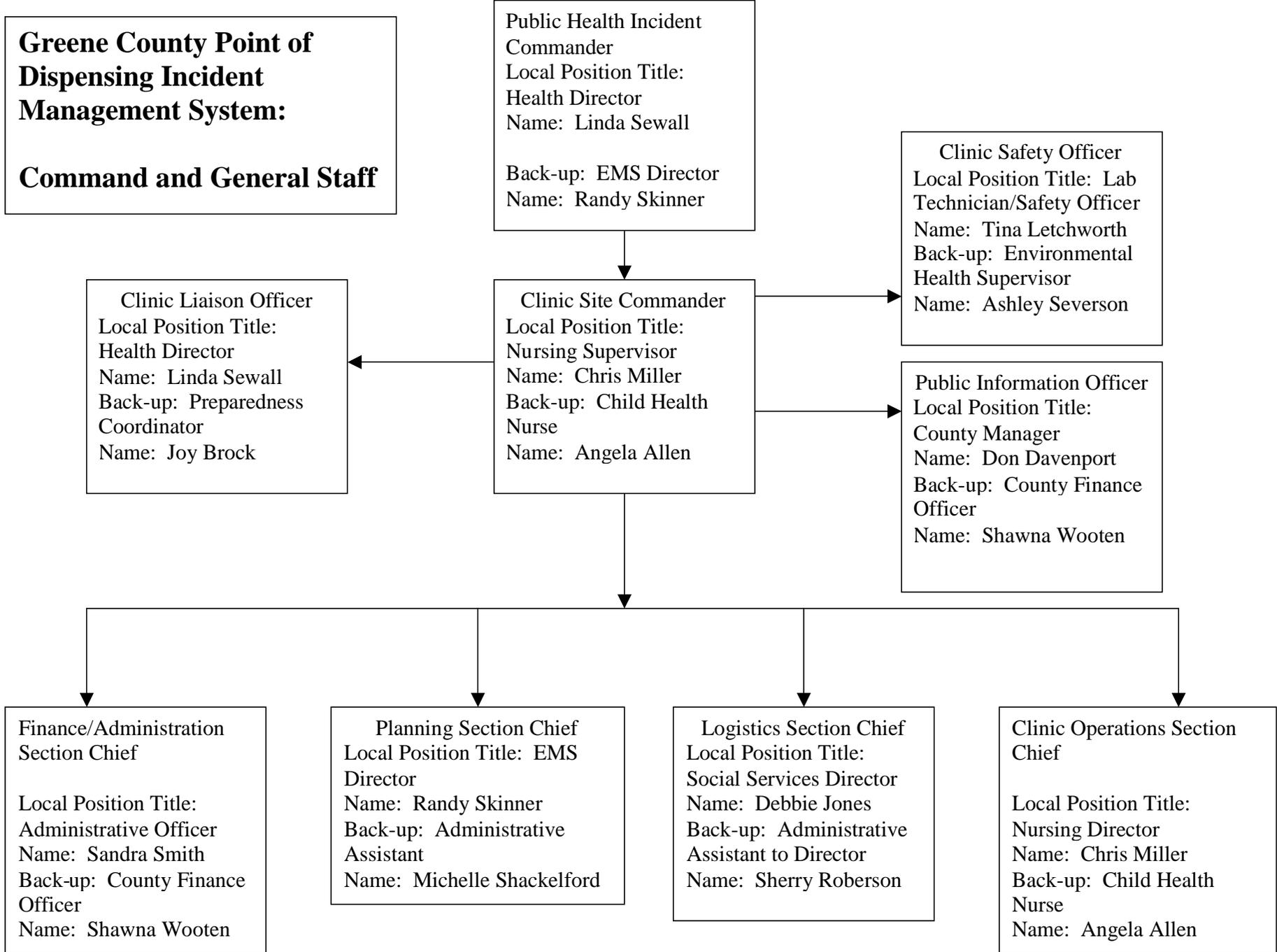
Local Position Title:
Administrative Officer
Name: Sandra Smith
Back-up: County Finance
Officer
Name: Shawna Wooten

Planning Section Chief
Local Position Title: EMS
Director
Name: Randy Skinner
Back-up: Administrative
Assistant
Name: Michelle Shackelford

Logistics Section Chief
Local Position Title:
Social Services Director
Name: Debbie Jones
Back-up: Administrative
Assistant to Director
Name: Sherry Roberson

Clinic Operations Section
Chief

Local Position Title:
Nursing Director
Name: Chris Miller
Back-up: Child Health
Nurse
Name: Angela Allen



Appendix D...

Method of Reporting

10A NCAC 41A .0102 METHOD OF REPORTING

- (a) When a report of a disease or condition is required to be made pursuant to G.S. 130A-135 through 139 and 10A NCAC 41A .0101, with the exception of laboratories, which shall proceed as in Subparagraph (d), the report shall be made to the local health director as follows:
- (1) For diseases and conditions required to be reported within 24 hours, the initial report shall be made by telephone, and the report required by Subparagraph (2) of this Paragraph shall be made within seven days.
 - (2) In addition to the requirements of Subparagraph (1) of this Paragraph, the report shall be made on the communicable disease report card or in an electronic format provided by the Division of Public Health and shall include the name and address of the patient, the name and address of the parent or guardian if the patient is a minor, and epidemiologic information.
 - (3) In addition to the requirements of Subparagraphs (1) and (2) of this Paragraph, forms or electronic formats provided by the Division of Public Health for collection of information necessary for disease control and documentation of clinical and epidemiologic information about the cases shall be completed and submitted for the following reportable diseases and conditions identified in 1 5A NCAC 19A .0101(a) acquired immune deficiency syndrome (AIDS); brucellosis; cholera; cryptosporidiosis; cyclosporiasis; E. coli 01 57:H7 infection; ehrlichiosis; Haemophilus influenzae, invasive disease; Hemolytic-uremic syndrome/thrombotic thrombocytopenic purpura; hepatitis A; hepatitis B; hepatitis B carriage; hepatitis C; human immunodeficiency virus (HIV) confirmed; legionellosis; leptospirosis; Lyme disease; malaria; measles (rubeola); meningitis, pneumococcal; meningococcal disease; mumps; paralytic poliomyelitis; psittacosis; Rocky Mountain spotted fever; rubella; rubella congenital syndrome; tetanus; toxic shock syndrome; trichinosis; tuberculosis; tularemia; typhoid; typhoid carriage (Salmonella typhi); vibrio infection (other than cholera); and whooping cough.
 - (4) Communicable disease report cards, surveillance forms, and electronic formats are available from the Division of Public Health, 1915 Mail Service Center, Raleigh, North Carolina 27699-1915, and from local health departments.
- (b) Notwithstanding the time frames established in 10A NCAC 41A .0101 a restaurant or other food or drink establishment shall report all outbreaks or suspected outbreaks of foodborne illness in its customers or employees and all suspected cases of foodborne disease or foodborne condition in food-handlers at the establishment by telephone to the local health department within 24 hours in accordance with Subparagraph (a)(1) of this Rule. However, the establishment is not required to submit a report card or surveillance form pursuant to Subparagraphs (a)(2) and (a)(4) of this Rule.
- (c) For the purposes of reporting by restaurants and other food or drink establishments pursuant to G.S. 1 30A-1 38, the following diseases and conditions listed in 1 0A NCAC 41A .0101(a) shall be reported: anthrax; botulism; brucellosis; campylobacter infection; cholera; cryptosporidiosis; cyclosporiasis; E. coli 01 57:H7 infection; hepatitis A; salmonellosis; shigellosis; streptococcal infection, Group A, invasive disease; trichinosis; tularemia; typhoid; typhoid carriage (Salmonella typhi); and vibrio infection (other than cholera).
- (d) Laboratories required to report test results pursuant to G.S. 130A-139 and 10A NCAC 41A .0101(c) shall report as follows:
- (1) The results of the specified tests for syphilis, chlamydia and gonorrhea shall be reported to the local health department by the first and fifteenth of each month. Reports of the results of the specified tests for gonorrhea, chlamydia and syphilis shall include the specimen collection date, the patient's age, race, and sex, and the submitting physician's name, address, and telephone numbers.
 - (2) Positive darkfield examinations for syphilis, all reactive prenatal and delivery STS titers, all reactive STS titers on infants less than one year old and STS titers of 1:8 and above shall be reported within 24 hours by telephone to the HIV/STD Prevention and Care Branch at (919) 733-7301, or the HIV/STD Prevention and Care Branch Regional Office where the laboratory is located.
 - (3) With the exception of positive laboratory tests for human immunodeficiency virus, positive laboratory tests as defined in G.S. 130A-139(1) and 10A NCAC 41A .0101(c) shall be reported to the Division of Public Health electronically, by mail, by secure telefax or by telephone within the time periods specified for each reportable disease or condition in 10A NCAC 41A .0101(a). Confirmed positive laboratory tests for human immunodeficiency virus as defined in 10A NCAC 41A .0101(b) shall be reported to the HIV/STD Prevention and Care Branch within seven days of obtaining

reportable test results. Reports shall include as much of the following information as the laboratory possesses: the specific name of the test performed; the source of the specimen; the collection date(s); the patient's name, age, race, sex, address, and county; and the submitting physician's name, address, and telephone number.

History Note: Authority G.S. 130A -134; 130A -135; 130A -138; 130A -139; 130A -141;
Temporary Rule Ef. February 1, 1988, for a period of 180 days to expire on July 29, 1988; Ef. March 1, 1988;
Amended Ef. October 1, 1994; February 3, 1992; December 1, 1991; May 1, 1991; Temporary Amendment Ef. December 16, 1994, for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Temporary Amendment Expired June 16, 1995;
Amended Ef. April 1, 2003; August 1, 1998.

Appendix E...

Duties of Local Health Director: Report Communicable Diseases

10A NCAC 41A .0103 DUTIES OF LOCAL HEALTH DIRECTOR: REPORT COMMUNICABLE DISEASES

(a) Upon receipt of a report of a communicable disease or condition pursuant to 10A NCAC 41A .0101, the local health director shall:

- (1) immediately investigate the circumstances surrounding the occurrence of the disease or condition to determine the authenticity of the report and the identity of all persons for whom control measures are required. This investigation shall include the collection and submission for laboratory examination of specimens necessary to assist in the diagnosis and indicate the duration of control measures;
 - (2) determine what control measures have been given and ensure that proper control measures as provided in 10A NCAC 41A .0201 have been given and are being complied with;
 - (3) forward the report as follows:
 - (A) The local health director shall forward all authenticated reports made pursuant to G.S. 130A-135 to 137 of syphilis, chancroid, granuloma inguinale, and lymphogranuloma venereum within seven days to the regional office of the Division of Public Health. In addition, the local health director shall telephone reports of all cases of primary, secondary, and early latent (under one year's duration) syphilis to the regional office of the HIV/STD Prevention and Care Branch within 24 hours of diagnosis at the health department or report by a physician.
 - (B) The local health director shall telephone all laboratory reports of reactive syphilis serologies to the regional office of the Division of Public Health within 24 hours of receipt if the person tested is pregnant. This shall also be done for all other persons tested unless the dilution is less than 1:8 and the person is known to be over 25 years of age or has been previously treated. In addition, the written reports shall be sent to the regional office of the Division of Public Health within seven days.
 - (C) Except as provided in (a)(3)(A) and (B) of this Rule, a local health director who receives a report pursuant to 10A NCAC 41A .0102 regarding a person residing in that jurisdiction shall forward the authenticated report to the Division of Public Health within seven days.
 - (D) Except as provided in (a)(3)(A) and (B) of this Rule, a local health director who receives a report pursuant to 10A NCAC 41A .0102 regarding a person who resides in another jurisdiction in North Carolina shall forward the report to the local health director of that jurisdiction within 24 hours. A duplicate report card marked "copy" shall be forwarded to the Division of Epidemiology within seven days.
 - (E) A local health director who receives a report pursuant to 10A NCAC 41A .0102 regarding a person who resided outside of North Carolina at the time of onset of the illness shall forward the report to the Division of Public Health within 24 hours.
- (b) If an outbreak exists, the local health director shall submit to the Division of Public Health within 30 days a written report of the investigation, its findings, and the actions taken to control the outbreak and prevent a recurrence.
- (c) Whenever an outbreak of a disease or condition occurs which is not required to be reported by 10A NCAC 41A .0101 but which represents a significant threat to the public health, the local health director shall give appropriate control measures consistent with 10A NCAC 41A .0200, and inform the Division of Public Health of the circumstances of the outbreak within seven days.

*History Note: Authority G.S. 130A -141; 130A -144;
Temporary Rule Ef. February 1, 1988, for a period of 180 days to expire on July 29, 1988; Ef. March 1, 1988;
Amended Ef. April 1, 2003; December 1, 1991; September 1, 1990.*

Appendix F...

Novel Influenza Screening Form



Human Influenza A (H5)

Human Influenza A (H5) Domestic Case Screening Form

CDC Case ID: _____

1. Reported By			
Date reported to state or local health department: ____ / ____ / ____ <small>m m d d y y y y</small>		State/ local Assigned Case ID: _____	
Last Name: _____		First Name: _____	
State: _____	Affiliation: _____	Email: _____	
Phone 1: _____	Phone 2: _____	Fax: _____	
2. Patient Information			
City of Residence: _____		County: _____	State: _____
Age at onset: _____ <input type="checkbox"/> Year(s) <input type="checkbox"/> Month(s)	Race: <i>(Choose One)</i> <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian/Other Pacific Islander		
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity: <input type="checkbox"/> Non Hispanic <input type="checkbox"/> Hispanic		
3. Optional Patient Information			
Last Name: _____		First Name: _____	
4. Signs and Symptoms			
A. Date of symptom onset: ____ / ____ / ____ <small>m m d d y y y y</small>			
B. What symptoms and signs did the patient have during the course of illness? (check all that apply)			
<input type="checkbox"/> Fever > 38° C (100.4° F)	<input type="checkbox"/> Feverish (temperature not taken)	<input type="checkbox"/> Conjunctivitis	
<input type="checkbox"/> Cough	<input type="checkbox"/> Headache	<input type="checkbox"/> Shortness of breath	
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Other (specify): _____		
C. Was a chest X-ray or chest CAT scan performed? <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If yes*, did the patient have radiographic evidence of pneumonia or respiratory distress syndrome (RDS)? <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unknown			

Epidemiologic Risk Factors

CDC Case ID:

5. Travel/Exposures					
A. In the 10 days prior to illness onset, did the patient travel to any of the countries listed in the table below? <input type="checkbox"/> Yes* <input type="checkbox"/> No** <input type="checkbox"/> Unknown If yes*, please fill in arrival and departure dates for all countries that apply. **If patient did not travel outside U.S., skip to question 6.					
Country	Arrival Date	Departure Date	Country	Arrival Date	Departure Date
<input type="checkbox"/> Afghanistan			<input type="checkbox"/> Myanmar (Burma)		
<input type="checkbox"/> Bangladesh			<input type="checkbox"/> Nepal		
<input type="checkbox"/> Brunei			<input type="checkbox"/> North Korea		
<input type="checkbox"/> Cambodia			<input type="checkbox"/> Oman		
<input type="checkbox"/> China			<input type="checkbox"/> Pakistan		
<input type="checkbox"/> Hong Kong			<input type="checkbox"/> Papua New Guinea		
<input type="checkbox"/> India			<input type="checkbox"/> Philippines		
<input type="checkbox"/> Indonesia			<input type="checkbox"/> Saudi Arabia		
<input type="checkbox"/> Iran			<input type="checkbox"/> Singapore		
<input type="checkbox"/> Iraq			<input type="checkbox"/> South Korea		
<input type="checkbox"/> Israel			<input type="checkbox"/> Syria		
<input type="checkbox"/> Japan			<input type="checkbox"/> Taiwan		
<input type="checkbox"/> Jordan			<input type="checkbox"/> Thailand		
<input type="checkbox"/> Laos			<input type="checkbox"/> Turkey		
<input type="checkbox"/> Lebanon			<input type="checkbox"/> Viet Nam		
<input type="checkbox"/> Macao			<input type="checkbox"/> Yemen		
<input type="checkbox"/> Malaysia					
For the questions 5B to 5E, In the 10 days prior to illness onset, while in the countries listed above . . .					
B. Did the patient come within 1 meter (3 feet) of any live poultry or domesticated birds (e.g. visited a poultry farm, a household raising poultry, or a bird market)? <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes*					
C. Did patient touch any recently butchered poultry? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
D. Did the patient visit or stay in the same household with anyone with pneumonia or severe flu-like illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
E. Did the patient visit or stay in the same household with a suspected human influenza A(H5) case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
F. Did the patient visit or stay in the same household with a known human influenza A(H5) case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown * SEE Influenza A (H5): Interim U.S. Case Definitions					

CDC ID:

6. Exposure for Non Travelers	
For patients whom did not travel outside the U.S., in the 10 days prior to illness onset, did the patient visit or stay in the same household with a traveler returning from one of the countries listed above who developed pneumonia or severe flu-like illness?	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes*, was the contact a confirmed or suspected H5 case patient?	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes*: CDC ID: _____ STATE ID: _____	

Laboratory Evaluation

7. State and local level influenza test results	
Specimen 1	
<input type="checkbox"/> NP swab <input type="checkbox"/> Bronchoalveolar lavage specimen (BAL) <input type="checkbox"/> NP aspirate <input type="checkbox"/> OP swab <input type="checkbox"/> Other _____	Date Collected: ___ / ___ / ___ m m d d y y y y
Test Type: <input type="checkbox"/> RT-PCR <input type="checkbox"/> Direct fluorescent antibody (DFA) <input type="checkbox"/> Viral Culture <input type="checkbox"/> Rapid Antigen Test*	Result: <input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Influenza (type unk) <input type="checkbox"/> Negative <input type="checkbox"/> Pending
*Name of Rapid Test: _____	
Specimen 2	
<input type="checkbox"/> NP swab <input type="checkbox"/> Bronchoalveolar lavage specimen (BAL) <input type="checkbox"/> NP aspirate <input type="checkbox"/> OP swab <input type="checkbox"/> Other _____	Date Collected: ___ / ___ / ___ m m d d y y y y
Test Type: <input type="checkbox"/> RT-PCR <input type="checkbox"/> Direct fluorescent antibody (DFA) <input type="checkbox"/> Viral Culture <input type="checkbox"/> Rapid Antigen Test*	Result: <input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Influenza (type unk) <input type="checkbox"/> Negative <input type="checkbox"/> Pending
*Name of Rapid Test: _____	
Specimen 3	
<input type="checkbox"/> NP swab <input type="checkbox"/> Bronchoalveolar lavage specimen (BAL) <input type="checkbox"/> NP aspirate <input type="checkbox"/> OP swab <input type="checkbox"/> Other _____	Date Collected: ___ / ___ / ___ m m d d y y y y
Test Type: <input type="checkbox"/> RT-PCR <input type="checkbox"/> Direct fluorescent antibody (DFA) <input type="checkbox"/> Viral Culture <input type="checkbox"/> Rapid Antigen Test*	Result: <input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Influenza (type unk) <input type="checkbox"/> Negative <input type="checkbox"/> Pending
*Name of Rapid Test: _____	

CDC ID:

8. List specimens sent to the CDC		
Select a SOURCE* from the following list for each specimen: Serum (acute), serum (convalescent), NP swab, NP aspirate, bronchoalveolar lavage specimen (BAL), OP swab, tracheal aspirate, or tissue		
Specimen 1: <input type="checkbox"/> Clinical Material <input type="checkbox"/> Extracted RNA <input type="checkbox"/> Virus Isolate	Source*: -----	Collected : ___ / ___ / ___ m m d d y y y y Date Sent: ___ / ___ / ___ m m d d y y y y
Specimen 2: <input type="checkbox"/> Clinical Material <input type="checkbox"/> Extracted RNA <input type="checkbox"/> Virus Isolate	Source*: -----	Collected : ___ / ___ / ___ m m d d y y y y Date Sent: ___ / ___ / ___ m m d d y y y y
Specimen 3: <input type="checkbox"/> Clinical Material <input type="checkbox"/> Extracted RNA <input type="checkbox"/> Virus Isolate	Source*: -----	Collected : ___ / ___ / ___ m m d d y y y y Date Sent: ___ / ___ / ___ m m d d y y y y
Specimen 4: <input type="checkbox"/> Clinical Material <input type="checkbox"/> Extracted RNA <input type="checkbox"/> Virus Isolate	Source*: -----	Collected : ___ / ___ / ___ m m d d y y y y Date Sent: ___ / ___ / ___ m m d d y y y y
Specimen 5: <input type="checkbox"/> Clinical Material <input type="checkbox"/> Extracted RNA <input type="checkbox"/> Virus Isolate	Source*: -----	Collected : ___ / ___ / ___ m m d d y y y y Date Sent: ___ / ___ / ___ m m d d y y y y
Carrier:		Tracking #:
9. Case Notes:		

Appendix G...

Algorithm -- can be used by
healthcare providers to screen for
novel influenza virus

There is a 2-page worksheet that
accompanies the algorithm.

*Algorithm can be found in the hard
copy of the Greene County
Pandemic Influenza Preparedness
& Response Plan*

*Worksheet can be found in the hard
copy of the Greene County
Pandemic Influenza Preparedness
& Response Plan*

*Worksheet can be found in the hard
copy of the Greene County
Pandemic Influenza Preparedness
& Response Plan*

Appendix H...

Enhanced Surveillance for Avian Influenza in Humans

Enhanced Surveillance for Avian Influenza in Humans

Assumptions

- CDC will provide updated information and guidance on avian influenza through the Health Alert Network
- The current threat from a novel influenza virus with the potential to cause significant human illness and possibly a pandemic is the avian influenza A (H5N1) virus which has been widely circulating in poultry since December 2003 throughout Asia, Africa, and Europe.
 - This outbreak of influenza A (H5N1) virus has resulted in over 260 human cases in ten countries; over 160 of these cases have been fatal [data as of January 22, 2007].
 - All of these cases have had exposure to poultry.
 - No evidence of sustained person to person transmission of the virus has been documented, although there have been a few instances of limited person to person transmission.
 - If this novel virus does become efficiently transmitted from person to person, a pandemic would likely ensue.
- While H5N1 is the greatest current threat, other avian influenza subtypes have infected humans, and surveillance should be in place to detect other novel influenza viruses as well.

Surveillance Criteria and Epidemiologic Risk Factors

The current outbreak of influenza A (H5N1) in humans is still zoonotic in nature. The H5N1 virus has been transmitted directly from infected birds to humans in the vast majority of cases; there has been no evidence to suggest efficient person to person transmission of the H5N1 virus.

The primary risk factor associated with these H5N1 infections in humans is intense **direct contact with poultry**. All of the human cases have occurred in countries where a simultaneous outbreak of H5N1 in poultry is occurring.

Updated information on human cases of avian influenza is available on the World Health Organization website. The Animal World Health Organization maintains a list of countries experiencing the outbreak in animals. (Links to these websites are provided under Resources).

During a pandemic alert phase 3 with a novel influenza virus infecting humans but no / minimal evidence of person to person transmission (as in the current outbreak with influenza A [H5N1]), all patients with an influenza-like illness should be asked about:

- recent travel to countries where the novel virus has been identified in animals or humans
- exposure to anyone with suspected or known avian influenza
- intense exposure to poultry or domestic birds
 - Did the patient come within 3 feet of any live poultry or domesticated birds?
 - Did the patient visit a poultry farm, a household raising poultry, or a live bird market?
 - Did the patient touch any recently butchered poultry or surfaces where poultry was recently butchered?

Testing for avian influenza H5N1 infection in humans should be considered in the following situations

- A hospitalized patient with a radiographically confirmed pneumonia or severe respiratory illness for which an alternative diagnosis has not been established who has a **history of travel** within 10 days of symptom onset to a country with documented avian influenza infections in poultry or humans.
- A patient (hospitalized or ambulatory) with less severe influenza-like illness¹ with onset of symptoms within 10 days of contact with poultry, domestic birds, or a known or suspected novel influenza virus case patient within an affected country.
- A refugee from a country with outbreaks of avian influenza in poultry or humans who develops an influenza-like illness within 10 days of arrival to the United States.

Testing for novel virus infections (H5N1 or other) should also be considered in the following situations:

- A poultry or swine worker who develops an influenza-like illness with a history of exposure to infected² poultry or swine within 10 days of symptom onset.
- A laboratory worker who works with novel influenza viruses

¹For the purposes of enhanced surveillance for avian influenza infections in humans, influenza-like illness is defined as documented fever > 100.4°F (38.0°C) AND cough, sore throat, or shortness of breath.

²Poultry and swine would be considered infected if they tested positive for influenza through routine surveillance coordinated by the NC Department of Agriculture or if influenza testing was requested because of illness in the animals.

Testing for some novel influenza viruses (H5 and H7) is available through the State Laboratory of Public Health (SLPH) and the public health regional laboratories in North Carolina. To request testing for novel influenza viruses in humans, healthcare providers should call their local health department or the General Communicable Disease Control branch epidemiologist on-call at (919) 733-3419; an epidemiologist is available 24/7 for consultation regarding testing and management of patients with suspected novel influenza virus infections.

Resources

1. US DHHS Pandemic Influenza Plan has a supplement on surveillance (Supplement 1) which contains interim recommendations for the surveillance and diagnostic evaluation of cases of human infection with avian influenza A (H5N1) as well as a human influenza (H5) case screening and report form. These documents are available at http://www.hhs.gov/pandemicflu/plan/sup_1.html
2. Situation updates on avian influenza infections in humans infections can be found at the World Health Organization website http://www.who.int/csr/disease/avian_influenza/en/
3. Up to date information on the current outbreak of avian influenza H5N1 in poultry can be found at the World Organization for Animal Health [Office International des Epizooties (OIE)] website http://www.oie.int/downld/AVIAN%20INFLUENZA/A_AI-Asia.htm

Appendix I...

NC State Laboratory of Public Health Pandemic Influenza Preparedness and Response Plan

North Carolina State Laboratory of Public Health Pandemic Influenza Preparedness and Response Plan

The goal of this plan is to be prepared and to ensure a coordinated, timely response to requests for influenza laboratory testing.

Test Methods

The North Carolina State Laboratory of Public Health (NCSLPH) routinely performs viral culture for propagation and detection of influenza virus. All initial clinical specimens are inoculated into cell culture. The cell culture is observed via light microscopy for cell death or cytopathic effect (CPE) which indicates viral replication. If CPE is observed or specimen has a positive hemadsorption (HAD) test, slides are prepared for subsequent manipulation and fluorescent viewing upon challenge with influenza A and influenza B group reagents.

Influenza As are sub-typed with fluorescent antibody-hemagglutinin (FA-H) antigen FA-H1 and FA-H3 reagents. However, if only the influenza A group reagent is reactive, (the subsequent testing for FA-H1 and FA-H3 is negative), NCSLPH will assume the possibility of another hemagglutinin antigen being present and remove the specimen to the BSL-3 laboratory for reverse transcriptase polymerase chain reaction (RT-PCR) or real-time RT-PCR analysis. NCSLPH has molecular reagents for influenza types A and B, and subtypes H1, H3, H5 and H7.

In addition, if there is strong reason to suspect a novel influenza infection [an epi link to a known avian influenza (AI) case or exposure to poultry potentially infected with AI] the specimen will be directly taken into the BSL-3 and analyzed by molecular means (RT-PCR or real-time RT-PCR). The latter scenario is dependent on close communication between the General Communicable Disease Control (GCDC) Branch Epidemiology staff, the submitter, and the NCSLPH.

Commercial rapid antigen testing is less sensitive for detecting most influenza viruses and should not be relied upon for diagnosis of novel or avian influenza viral infection.

Specimen Collection for Influenza

Each specimen container should be labeled with either a unique ID # or the patient's first and last name, and the collection date. Ship all specimen types with cold packs to keep specimen at 4°C.

The preferred choices of specimen are throat washing or swab and nasopharyngeal washing or swab. For some novel or avian influenza viral infections (e.g. avian influenza A/ H5N1), there may be a higher frequency of virus detection in throat samples compared to nasal samples; please consult with the GCDC branch (telephone 919-733-3419) to determine which type of specimen should be obtained.

Use only Dacron or rayon swabs with plastic or metal shafts. Do not use calcium alginate tipped OR wooden shafted swabs, as they may contain substances that inactivate some viruses and/or inhibit amplification.

Nasopharyngeal Swab – Carefully swab the posterior nasopharyngeal area via the external nares with a dry sterile tipped swab. Break off the swab tip into a vial containing 2 ml of viral transport medium. Screw the cap on tightly.

Nasal Washing – Approximately 3-7 mLs of sterile PBS is aspirated into a rubber bulb. The patient should be placed on their side in a supine position. Gently press one nostril closed with finger pressure. Use the point of the bulb to completely occlude the other side. The PBS is then squeezed into the nose and quickly aspirated. Secretions are then placed into a sterile vial. Screw the cap on tightly.

Nasal Swab - Insert dry swab into nasal passage and allow it to absorb secretions. Place swabs in viral transport medium and break off at the neck of vial. Screw the cap on tightly.

Throat Swab – Vigorously rub the posterior wall of the pharynx with a dry, sterile, swab. The swab should not touch the tongue or buccal mucosa. Break off the swab tip into a vial of viral transport medium. Screw the cap on tightly.

Throat Washings – Patient should gargle with 3-5 mLs of sterile PBS (0.15 M sodium chloride and 0.01 M sodium phosphate, pH 7.0-7.6). The PBS is collected into a vial containing 2 ml of viral transport medium. Screw the cap on tightly.

Required Submission Forms

All influenza specimens will be logged in using Virology/Serology accession numbers. Links to the forms are shown below. The patient's health care provider **must** complete the submission (requisition) forms.

The submission form can be found at <http://slph.state.nc.us/Forms/DHHS-3431.pdf> and also in Appendix H-2.

Please fill out all forms as completely as possible with the following information or the specimen may be considered UNSATISFACTORY for testing:

- **Symptom onset date**
- **Date of collection**
- **Return address**
- **Epidemiologic risk factors including epi links and travel history**

Finally, be sure to specify on form DHHS-3431 that influenza testing is requested. It may need to be handwritten in "Other" category.

Shipping Instructions

Any suspect influenza specimen should be shipped as a DIAGNOSTIC SPECIMEN. The shipper (hospital or clinic) – not the transport company – is responsible for the shipment until the package reaches the consignee (NCSLPH). Specimens can be shipped via FedEx, United States Postal Service (USPS), or the State Courier system. Ship by the fastest means possible. *Transit time of less than 24 hours will optimize virus detection.*

FedEx Shipping

For more complete instructions for FedEx shipping, please see the following website: <http://www.fedex.com/us/services/packaging/diagnosticbrochure.pdf>

Primary Packaging

The primary receptacle(s) must be water-tight. Multiple primary receptacles must be wrapped individually to prevent breakage. When determining the volume of diagnostic specimens being shipped, include the viral transport media. Primary receptacle(s) must not contain more than 500 mL or 500 g. *The diagnostic specimen consists of the primary receptacle and its contents.*

Secondary Packaging

- Use enough absorbent material to absorb the entire contents of all primary receptacles in case of leakage or damage. Secondary packaging must meet the IATA packaging requirements for diagnostic specimens including 1.2 meter (3.9 feet) drop test procedure. Since infectious substance packaging surpasses the requirements for diagnostic specimen packaging, the IATA Packing Instruction 602 can be used as well. Infectious substance packaging will have the required specification markings on packaging:

("UN" will be in a circle):  **4G/CLASS 6.2/99/GB/2450**
e.g.,

- Secondary packaging must be watertight. Follow the packaging manufacturer or other authorized party's packing instructions included with the secondary packaging. Secondary packaging must be at least 100 mm (4 inches) in the smallest overall external dimension. Must be large enough for shipping documents, e.g. air waybill.

Outer Packaging

The outer packaging must not contain more than 4 L or 4 kg. Cold packs must be placed outside the secondary packaging.

- **Cold Packs:** The cold packs must be leak-proof.
- Each package and the air waybill must be marked with the following exact wording:

**UN 3373 DIAGNOSTIC
SPECIMEN
PACKED IN COMPLIANCE
WITH
IATA PACKING INSTRUCTION
650**

- An itemized list of contents must be enclosed between the secondary packaging and the outer packaging. Place in a sealed plastic bag to protect from moisture. A Shipper's Declaration for Dangerous Goods is **NOT** required for Diagnostic Specimens.

USPS or State Courier Shipping

If using the USPS or State Courier system, the viral culture kits from the NCSLPH may be used.

- Ship specimen(s) to the State Laboratory the same day collected. Although this kit was designed for up to four specimens, the cost of the transport media is negligible and unused media can simply be discarded.
DO NOT DELAY SHIPMENT OF SPECIMENS UNTIL ALL FOUR VIALS OF TRANSPORT MEDIA ARE USED.
- Wrap the properly labeled inoculated transport medium (primary container) in an absorbent material, i.e. paper towel, and place into a leak proof secondary container (50 ml conical tubes).
- The empty plastic shipping tubes used to transport excess media should be used to maintain a tight pack for the specimens being submitted.
- Place two frozen ice packs to the shipping container.

- Place secondary container(s) containing specimen(s) or empty tubes for a total of 4 tubes between the ice packs.
- Place completed forms in plastic bag and slide into space at narrow end of ice pack.
- Replace styrofoam lid on the box, seal cardboard box, and attach return pre-addressed shipping label over existing label.

Shipping Address: NC State Laboratory of Public Health
306 N. Wilmington Street
Raleigh, NC 27601

NCSLPH Standard Operating Procedures

Notification

There is no need to notify NCSLPH personnel when submitting routine influenza specimens. However, when specimens from suspected novel or avian influenza cases arrive at NCSLPH, the following internal staff will be notified by phone, email, or verbally: Laboratory Director, Assistant Laboratory Director, Virology/Serology Supervisor, and Public Health Scientist.

Laboratory Handling

If the specimen is from a suspected case of novel or avian influenza, **the specimen will not be inoculated into cell culture**. The primary specimen will be taken directly to the BSL-3 for nucleic acid isolation and subsequent real time RT-PCR typing and sub-typing.

For routine influenza submissions, specimens will be inoculated into cell culture. Cell culture will be observed by light microscopy for the presence of CPE which indicates viral replication. If CPE is present or the specimen has a positive HAd test, slides will be prepared for subsequent manipulation and fluorescent viewing with influenza A or B group reagents. Influenza As will subsequently be sub-typed with FA-H1 and FA-H3 group reagents. However, if only the influenza A group reagent is reactive, (the subsequent testing for FA-H1 and FA-H3 is negative), NCSLPH will assume the possibility of another hemagglutinin antigen being present and remove the specimen to the BSL-3 laboratory RT-PCR or real-time RT-PCR analysis.

Reporting resultsFor novel and avian influenza specimens

For RT-PCR results, allow 2-3 working days for sample preparation, RT-PCR testing, and reporting results.

- 1). If the RT-PCR is negative for the presence of novel or avian influenza viral RNA (novel or avian influenza viral RNA not detected by RT-PCR), the specimen is assumed negative for novel or avian influenza and testing for other respiratory pathogens may be indicated.

- 2). If the RT-PCR is positive for the presence of novel or avian influenza viral RNA (novel or avian influenza viral RNA detected by RT-PCR), the specimen is assumed positive and the primary specimen will be forwarded to CDC for further analysis.

In either situation, the GCDC Branch Epidemiology staff and the submitter will be notified with a call and a formal report will be sent via the mail.

For routine influenza specimens

For culture and typing results, allow 5-7 working days for inoculation, viral propagation, fluorescent staining, and reporting results.

- 1). If no CPE is observed by day 7, HAd is performed. If HAd is negative, the specimen will be signed out as: "Negative-no virus isolated." A computer-generated report will be issued to the submitter via the mail.

- 2). If CPE is observed or the specimen is HAd positive, slides will be made and the specimen will be signed out as: "Positive- isolate identified as _____." The submitter will be called and a computer-generated report will be sent out via the mail.

Appendix J...

Laboratory Submission Form
NC DHHS 3431

[1] 1. Last Name	First Name	MI
2. Patient Number (Social Security Number)		— H
3. Address	4. Date of Birth	
Zip Code	Month	Day Year
5. Race <input type="checkbox"/> 1. White <input type="checkbox"/> 2. Black <input type="checkbox"/> 3. American Indian <input type="checkbox"/> 4. Asian <input type="checkbox"/> 5. Native Hawaiian/Pacific Islander <input type="checkbox"/> 6. Unknown		
6. Hispanic or Latino Origin? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. Unknown		
7. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	8. Co. of Residence	
9. Medicaid Client? <input type="checkbox"/> Yes If yes, enter # <input type="checkbox"/> No		—

VIROLOGY

North Carolina
 Department of Health and Human Services
State Laboratory of Public Health
 Leslie Wolf, PhD, Director
 Virology/Serology Laboratory
 306 North Wilmington Street • P.O. Box 28047
 Raleigh, NC 27611-8047
 Phone: (919) 733-7544 • Fax: (919) 715-7700

[2] SEND REPORT TO: FEDERAL TAX NO. _____ _____ _____ Zip Code: _____	[3] SPECIMEN SOURCE	[4] DATE COLLECTED	STATE LAB NUMBER
	(a)		
	(b)		
	(c)		

[5] PHYSICIAN AND/OR CLINIC: _____ _____ Prenatal (Due Date: _____) _____ STD _____ OTHER	[6] ONSET DATE
Weekday phone #: _____ After hours phone #: _____ Fax Phone #: _____	

[7] INFECTIOUS AGENT(S) SUSPECTED OR TEST(S) REQUIRED <input type="checkbox"/> Herpes simplex virus <input type="checkbox"/> Other	[8] DATE SPECIMEN(S) SUBMITTED
---	--------------------------------

[9] PATIENT SIGNS AND SYMPTOMS						
GENITAL <input type="checkbox"/> Vesicles <input type="checkbox"/> PID <input type="checkbox"/> Cervicitis <input type="checkbox"/> Urethritis <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Mucopurulent discharge <input type="checkbox"/> Atypical Lesion	RASH <input type="checkbox"/> Macular <input type="checkbox"/> Papular <input type="checkbox"/> Vesicular <input type="checkbox"/> Petechial <input type="checkbox"/> Focal <input type="checkbox"/> Hemorrhagic	RESPIRATORY <input type="checkbox"/> Cough <input type="checkbox"/> Pneumonia <input type="checkbox"/> Bronchitis <input type="checkbox"/> Croup <input type="checkbox"/> Pharyngitis	CNS <input type="checkbox"/> Seizures <input type="checkbox"/> Meningitis <input type="checkbox"/> Encephalitis <input type="checkbox"/> Nuchal rigidity <input type="checkbox"/> Paralysis	CARDIOVASCULAR <input type="checkbox"/> Chest Pain <input type="checkbox"/> Pericarditis <input type="checkbox"/> Myocarditis <input type="checkbox"/> Pleurodynia GASTROINTESTINAL <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Diarrhea	GENERAL <input type="checkbox"/> Fever to _____ ° <input type="checkbox"/> Headache <input type="checkbox"/> Fatigue <input type="checkbox"/> Sore Throat <input type="checkbox"/> Jaundice <input type="checkbox"/> Conjunctivitis	

Recent Vaccination History: _____ Travel History: _____

LABORATORY REPORT

TEMPERATURE ON ARRIVAL: _____	FROZEN	COLD	AMBIENT	DATE RECEIVED						
CONCERNING YOUR SPECIMEN <input type="checkbox"/> No name on specimen <input type="checkbox"/> Name on specimen and form do not match <input type="checkbox"/> 4 or more days between collection and receipt of specimen <input type="checkbox"/> specimen broken or leaked in transit <input type="checkbox"/> Specimen received ambient <input type="checkbox"/> Collected in incorrect transport media <input type="checkbox"/> Patient does not meet testing criteria (see attached) <input type="checkbox"/> Specimen forwarded to CDC for: _____ DATE: _____	SPECIMEN SOURCE	TEST METHOD:							INTERPRETATION: <input type="checkbox"/> Negative: No virus detected. <input type="checkbox"/> Virus detected using molecular assay. <input type="checkbox"/> Virus detected using DFA method. <input type="checkbox"/> Viral-like agent detected. Further testing in process. <input type="checkbox"/> Positive: virus identified as: _____	
		NON-HUMAN HETEROPLDID CELLS	HUMAN HETEROPLDID CELLS	PRIMARY MONKEY KIDNEY CELLS	HUMAN DIPLOID CELLS	HUMAN RD CELLS	VERO CELLS	EGG/AL/AMIN		NUCLEIC ACID AMPLIFICATION
INTERPRETIVE COMMENTS:					Results telephoned to _____ date _____ by _____	Preliminary Report Date: _____ Reporting Technologist: _____ Final Report Date: _____ Reporting Technologist: _____				

DHHS 3431 (Revised 1/07)
 Laboratory (Review 7/09)

INSTRUCTIONS FOR COMPLETION OF THIS FORM AND SPECIMEN SUBMISSION

1. Clearly label each specimen primary container with the patient's first and last name, specimen source and collection date. Specimens without names or incorrectly labeled specimens will not be tested.
2. Please type or print. To avoid delays in testing, fill out all items in Section 1 through 9. ENCLOSE SUBMISSION FORM IN A PLASTIC BAG TO PREVENT CONTAMINATION DUE TO POSSIBLE LEAKAGE.
3. Submit no more than three specimens per patient with each form.
4. Additional forms or specimen collection and transport kits are available from:

Laboratory Mailroom
306 North Wilmington Street
P.O. Box 28047
Raleigh, NC 27611-8047
(919)733-7656
5. For additional information, see "SCOPE, A Guide to Laboratory Services" on our web site at <http://slph.state.nc.us> or contact the Virology/Serology Laboratory at (919) 733-7544.

SUGGESTED SPECIMENS FOR VIROLOGY

DISEASE OR SYNDROME	ETIOLOGIC AGENT	SPECIMEN OPTIONS
Central Nervous System	Echovirus Poliovirus Coxsackievirus Herpes simplex virus Mumps virus Eastern equine encephalitis virus California encephalitis virus West Nile virus	Throat swab, feces, CSF Throat swab, feces, CSF Throat swab, feces, CSF Throat swab, brain tissue, CSF Throat swab, urine, CSF CSF, brain tissue CSF, brain tissue CSF, brain tissue
Respiratory System	Influenza virus Parainfluenza virus Adenovirus Respiratory syncytial virus*	Throat swab, NP wash/swab Throat swab, NP wash/swab Throat swab, NP wash/swab, conjunctival swab Throat swab, NP wash/swab
Rash, Vesicular	Herpes simplex virus Varicella zoster virus* Coxsackievirus	Vesicle fluid, scraping Vesicle fluid, scraping Throat swab, feces
Myopericarditis	Coxsackievirus Echovirus	Throat swab, feces, pericardial fluid Throat swab, feces, pericardial fluid
Other	Cytomegalovirus*	Urine, throat swab

KEEP SPECIMENS COLD BUT NOT FROZEN (COLD PACK AND LEAK-PROOF STYROFOAM CONTAINER) AND DELIVER TO THE LABORATORY WITHIN 48 HOURS OF COLLECTION.

*Specimens for CMV, RSV, or VZV culture should be refrigerated immediately after collection and delivered to the Laboratory within 24 hours. Never freeze specimens for VZV, CMV or RSV culture.

INTERPRETATION OF VIRUS DETECTION RESULTS

Failure to detect virus may be the result of a number of factors including improperly collected specimens, specimens collected at a period in the disease when the patient is not shedding virus, improperly transported specimens, or lack of sensitivity in the system being used.

Since people may asymptotically carry a variety of viruses, viruses may be detected which are unrelated to the current clinical illness. Detection of specific viral agents must be interpreted in relation to the specimen source, clinical information and other laboratory information.

Appendix K...

The Advisory Committee on Immunization Practices (ACIP) and the National Vaccine Advisory Committee (NVAC) provided recommendations to the Department of Health and Human Services on the use of vaccines in an influenza pandemic...

Vaccine Priority Group Recommendations*

Tier	Subtier	Population	Rationale
1	A	<ul style="list-style-type: none"> Vaccine and antiviral manufacturers and others essential to manufacturing and critical support (~40,000) Medical workers and public health workers who are involved in direct patient contact, other support services essential for direct patient care, and vaccinators (8-9 million) 	<ul style="list-style-type: none"> Need to assure maximum production of vaccine and antiviral drugs Healthcare workers are required for quality medical care (studies show outcome is associated with staff-to-patient ratios). There is little surge capacity among healthcare sector personnel to meet increased demand
	B	<ul style="list-style-type: none"> Persons > 65 years with 1 or more influenza high-risk conditions, not including essential hypertension (approximately 18.2 million) Persons 6 months to 64 years with 2 or more influenza high-risk conditions, not including essential hypertension (approximately 6.9 million) Persons 6 months or older with history of hospitalization for pneumonia or influenza or other influenza high-risk condition in the past year (740,000) 	<ul style="list-style-type: none"> These groups are at high risk of hospitalization and death. Excludes elderly in nursing homes and those who are immunocompromised and would not likely be protected by vaccination
	C	<ul style="list-style-type: none"> Pregnant women (approximately 3.0 million) Household contacts of severely immunocompromised persons who would not be vaccinated due to likely poor response to vaccine (1.95 million with transplants, AIDS, and incident cancer x 1.4 household contacts per person = 2.7 million persons) Household contacts of children <6 month olds (5.0 million) 	<ul style="list-style-type: none"> In past pandemics and for annual influenza, pregnant women have been at high risk; vaccination will also protect the infant who cannot receive vaccine. Vaccination of household contacts of immunocompromised and young infants will decrease risk of exposure and infection among those who cannot be directly protected by vaccination

	D	<ul style="list-style-type: none"> Public health emergency response workers critical to pandemic response (assumed one-third of estimated public health workforce=150,000) Key government leaders 	<ul style="list-style-type: none"> Critical to implement pandemic response such as providing vaccinations and managing/monitoring response activities Preserving decision-making capacity also critical for managing and implementing a response
2	A	<ul style="list-style-type: none"> Healthy 65 years and older (17.7 million) 6 months to 64 years with 1 high-risk condition (35.8 million) 6-23 months old, healthy (5.6 million) 	<ul style="list-style-type: none"> Groups that are also at increased risk but not as high risk as population in Tier 1B
	B	<ul style="list-style-type: none"> Other public health emergency responders (300,000 = remaining two-thirds of public health workforce) Public safety workers including police, fire, 911 dispatchers, and correctional facility staff (2.99 million) Utility workers essential for maintenance of power, water, and sewage system functioning (364,000) Transportation workers transporting fuel, water, food, and medical supplies as well as public ground public transportation (3.8 million) <p>Telecommunications/IT for essential network operations and maintenance (1.08 million)</p>	<ul style="list-style-type: none"> Includes critical infrastructure groups that have impact on maintaining health (e.g., public safety or transportation of medical supplies and food); implementing a pandemic response; and on maintaining societal functions
3		<ul style="list-style-type: none"> Other key government health decision-makers (estimated number not yet determined) Funeral directors/embalmers (62,000) 	<ul style="list-style-type: none"> Other important societal groups for a pandemic response but of lower priority
4		<ul style="list-style-type: none"> Healthy persons 2-64 years not included in above categories (179.3 million) 	<ul style="list-style-type: none"> All persons not included in other groups based on objective to vaccinate all those who want protection

*The committee focused its deliberations on the U.S. civilian population. ACIP and NVAC recognize that Department of Defense needs should be highly prioritized. DoD Health Affairs indicates that 1.5 million service members would require immunization to continue current combat operations and preserve critical components of the military medical system. Should the military be called upon to support civil authorities domestically, immunization of a greater proportion of the total force will become necessary. These factors should be considered in the designation of a proportion of the initial vaccine supply for the military.

Other groups also were not explicitly considered in these deliberations on prioritization. These include American citizens living overseas, non-citizens in the U.S., and other groups providing national security services such as the border patrol and customs service.

B. Definitions and rationales for priority groups

1. Healthcare workers and essential healthcare support staff

a) Definition

Healthcare workers (HCW) with direct patient contact (including acute-care hospitals, nursing homes, skilled nursing facilities, urgent care centers, physician's offices, clinics, home care, blood collection centers, and EMS) and a proportion of persons working in essential healthcare support services needed to maintain healthcare services (e.g. dietary, housekeeping, admissions, blood collection center staff, etc.). Also included are healthcare workers in public health with direct patient contact, including those who may administer vaccine or distribute influenza antiviral medications, and essential public health support staff for these workers.

b) Rationale

The pandemic is expected to have substantial impact on the healthcare system with large increases in demand for healthcare services placed on top of existing demand. HCW will be treating influenza-infected patients and will be at risk of repeated exposures. Further, surge capacity in this sector is low. To encourage continued work in a high-exposure setting and to help lessen the risk of healthcare workers transmitting influenza to other patients and HCW family members, this group was highly prioritized. In addition, increases in bed/nurse ratios have been associated with increases in overall patient mortality. Thus, substantial absenteeism may affect overall patient care and outcomes.

2. Groups at high risk of influenza complications

a) Definition

Persons 2-64 years with a medical condition for which influenza vaccine is recommended and all persons 6-23 months and 65 years and older. Excludes nursing home residents and severely immunocompromised persons who would not be expected to respond well to vaccination.

b) Rationale

These groups were prioritized based on their risk of influenza-related hospitalization and death and also their likelihood of vaccine response. Information from prior pandemics was used whenever possible, but information from interpandemic years was also considered. Nursing home residents and severely immunocompromised persons would be prioritized for

antiviral treatment and/or prophylaxis and vaccination of healthcare workers and household contacts who are most likely to transmit influenza to these high risk groups.

3. **Critical infrastructure**

a) Definitions and rationale

Those critical infrastructure sectors that fulfill one or more of the following criteria: have increased demand placed on them during a pandemic, directly support reduction in deaths and hospitalization; function is critical to support the healthcare sector and other emergency services, and/or supply basic necessities and services critical to support of life and healthcare or emergency services. Groups included in critical infrastructure are needed to respond to a pandemic and to minimize morbidity and mortality, and include the following sectors:

- Persons directly involved with influenza vaccine and antiviral medication manufacturing and distribution and essential support services and suppliers (e.g., growers of pathogen-free eggs for growth of vaccine virus) production activities
- Key government leaders and health decision-makers who will be needed to quickly move policy forward on pandemic prevention and control efforts
- Public safety workers (firefighters, police, and correctional facility staff, including dispatchers) are critical to maintaining social functioning and order and will contribute to a pandemic response, for example by ensuring order at vaccination clinics and responding to medical emergencies
- Utility service workers (water, power, and sewage management) are prioritized as the services they provide are also essential to the healthcare system as well as to preventing additional illnesses from lack of these services unrelated to a pandemic.
- Transportation workers who maintain critical supplies of food, water, fuel, and medical equipment and who provide public transportation, which is essential for provision of medical care and transportation of healthcare workers to work and transportation of ill persons for care
- Telecommunication and information technology services critical for maintenance and repairs of these systems are also essential as these systems are now critical for accessing and delivering medical care and in support of all other critical infrastructure
- Mortuary services will be substantially impacted due to the increased numbers of deaths from a pandemic and the fact that impact will be high in the elderly, a growing segment of the population

4. **Public health emergency response workers**

a) Definition

This group includes persons who do not have direct patient care duties, but who are essential for surveillance for influenza, assessment of the pandemic impact, allocation of public health resources for the pandemic response, development and implementation of public health policy as part of the response, and development of guidance as the pandemic progresses.

b) Rationale

Persons in this sector have been critical for past influenza vaccine pandemics and influenza vaccine shortages and little surge capacity may be available during a public health emergency such as a pandemic.

5. Persons in skilled nursing facilities

a) Definition

Patients residing in skilled nursing facilities. Not included in this group are persons in other residential settings (e.g., assisted living) who are more likely to be mobile, in a setting that is less closed, and have decentralized healthcare.

b) Rationale

This group was not prioritized for vaccine because of the medical literature finding poor response to vaccination and occurrence of outbreaks even in the setting of high vaccination rates. Other studies have suggested that vaccination of healthcare workers may be a more effective strategy to prevent influenza in this group. Further, surveillance for influenza can be conducted in this group and antiviral medications used widely for prophylaxis and treatment. Ill visitors and staff should also be restricted from visiting nursing home facilities during outbreaks of pandemic influenza. This strategy for pandemic influenza vaccine differs from the inter-pandemic vaccination strategy of aggressively vaccinating nursing home residents. The rationale considers several factors: 1) these populations are less likely to benefit from vaccine than other groups who are also at high risk; 2) other prevention strategies feasible for this group are not possible among other high-risk groups; 3) the overall morbidity and mortality from pandemic is likely to severely impact other groups of persons who would be expected to have a better response to the vaccine; and 4) a more severe shortage of vaccine is anticipated.

6. Severely immunocompromised persons

a) Definition

Persons who are undergoing or who have recently undergone bone marrow transplantation and others with severe immunodeficiency (e.g., AIDS patients with CD4 counts <50, children with SCID syndrome, recent bone marrow transplant patients). The numbers of persons in these categories is likely much smaller than the anticipated number assumed in tiering above, but sources for more specific estimates have not been identified.

b) Rationale

These groups have a lower likelihood of responding to influenza vaccination. Thus, strategies to prevent severe influenza illness in this group should include vaccination of healthcare workers and household contacts of severely immunocompromised persons and use of antiviral medications. Consideration should be given to prophylaxis of severely immunocompromised persons with influenza antivirals and early antiviral treatment should they become infected.

7. Children <6 months of age

a) Rationale

Influenza vaccine is poorly immunogenic in children <6 months and the vaccine is currently not recommended for this group. In addition, influenza antiviral medications are not FDA-approved for use in children <1 year old. Thus, vaccination of household contacts and out-of-home caregivers of children <6 months is recommended to protect this high-risk group.

Appendix L...

Letter from the North Carolina
Division of Public Health regarding
priority groups



North Carolina Department of Health and Human Services
Division of Public Health • Office of the State Health Director
1915 Mail Service Center • Raleigh, North Carolina 27699-1915

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Leah Devlin, DDS, MPH
State Health Director

October 15, 2004

Dear Colleague,

First, I want to acknowledge the unprecedented situation in which we find ourselves with a critical shortage of influenza vaccine as we enter the 2004-2005 flu season. We appreciate the difficulties this places on you and pledge our support to you in any way we can.

The purpose of this letter is to inform health care providers in North Carolina that the Centers for Disease Control and Prevention's (CDC) recommendation regarding which priority groups should receive influenza vaccination is an enforceable rule referenced in the NC Administrative Code. Priority groups for influenza vaccine include:

- all children ages 6 months to 23 months
- adults aged 65 years of age and older
- persons aged 2-64 years with underlying chronic medical conditions
- all women who will be pregnant during the influenza season
- residents of nursing homes and other chronic-care facilities
- children aged 6 months -18 years on chronic aspirin therapy
- healthcare workers involved in direct patient care
- out-of-home caregivers and household contacts of children <6 months

As described in the communicable disease rules for public health, application of the CDC's current recommendations about priority groups for influenza vaccination is pursuant to **Rule 10ANCAC 41A .0201:**

"...Guidelines and recommended actions published by the Centers for Disease Control and Prevention shall supercede those contained in the Control of Communicable Disease Manual and are likewise incorporated by reference..."

Until further notice, North Carolina public health rules require that influenza vaccine only be used for individuals in these eight priority groups on a first-come, first-serve basis.

Health care providers can inform non-priority group individuals who report for influenza vaccination that the CDC recommendation has force of law in North Carolina. If you have

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vaccine doses remaining after strictly following these guidelines, please contact us at 919-715-0988 or the local health department in your community so that vaccine may be used for other high-risk individuals.

Attached is additional information that may assist you in managing your patients including:

- a poster that can be displayed in your office explaining the priority groups to be vaccinated
- the CDC Questions & Answers: 2004-05 Flu Season, and
- the CDC Influenza Vaccine Update for Immunization Grantees, Version 2: October 13, 2004, 5:00pm EDT

We will continue to provide you with regular updated information as the situation evolves.

Thank you for your continued good efforts as we work together to assure the best use possible of North Carolina's limited supply of influenza vaccine.

A handwritten signature in black ink that reads "Leah Devlin". The signature is written in a cursive, flowing style.

Leah Devlin, DDS, MPH,
State Health Director

Attachments

Appendix M...

The Advisory Committee on Immunization Practices (ACIP) and the National Vaccine Advisory Committee (NVAC) provided recommendations to the Department of Health and Human Services on antiviral drug use in an influenza pandemic...

Antiviral Drug Priority Group Recommendations*

	Group	Estimated population (millions)	Strategy**	# Courses (millions)		Rationale
				For target group	Cumulative	
1	Patients admitted to hospital***	10.0	T	7.5	7.5	Consistent with medical practice and ethics to treat those with serious illness and who are most likely to die.
2	Health care workers (HCW) with direct patient contact and emergency medical service (EMS) providers	9.2	T	2.4	9.9	Healthcare workers are required for quality medical care. There is little surge capacity among healthcare sector personnel to meet increased demand.
3	Highest risk outpatients—immunocompromised persons and pregnant women	2.5	T	0.7	10.6	Groups at greatest risk of hospitalization and death; immunocompromised cannot be protected by vaccination.
4	Pandemic health responders (public health, vaccinators, vaccine and antiviral manufacturers), public safety (police, fire, corrections), and government decision-makers	3.3	T	0.9	11.5	Groups are critical for an effective public health response to a pandemic.
5	Increased risk outpatients—young children 12-23 months old, persons >65 yrs old, and persons with underlying medical conditions	85.5	T	22.4	33.9	Groups are at high risk for hospitalization and death.

6	Outbreak response in nursing homes and other residential settings	NA	PEP	2.0	35.9	Treatment of patients and prophylaxis of contacts is effective in stopping outbreaks; vaccination priorities do not include nursing home residents.
7	HCWs in emergency departments, intensive care units, dialysis centers, and EMS providers	1.2	P	4.8	40.7	These groups are most critical to an effective healthcare response and have limited surge capacity. Prophylaxis will best prevent absenteeism.
8	Pandemic societal responders (e.g., critical infrastructure groups as defined in the vaccine priorities) and HCW without direct patient contact	10.2	T	2.7	43.4	Infrastructure groups that have impact on maintaining health, implementing a pandemic response, and maintaining societal functions.
9	Other outpatients	180	T	47.3	90.7	Includes others who develop influenza and do not fall within the above groups.
10	Highest risk outpatients	2.5	P	10.0	100.7	Prevents illness in the highest risk groups for hospitalization and death.
11	Other HCWs with direct patient contact	8.0	P	32.0	132.7	Prevention would best reduce absenteeism and preserve optimal function.

*The committee focused its deliberations on the domestic U.S. civilian population. NVAC recognizes that Department of Defense (DoD) needs should be highly prioritized. A separate DoD antiviral stockpile has been established to meet those needs. Other groups also were not explicitly considered in deliberations on prioritization. These include American citizens living overseas, non-citizens in the U.S., and other groups providing national security services such as the border patrol and customs service.

**Strategy: Treatment (T) requires a total of 10 capsules and is defined as 1 course. Post-exposure prophylaxis (PEP) also requires a single course. Prophylaxis (P) is assumed to require 40 capsules (4 courses) though more may be needed if community outbreaks last for a longer period.

***There are no data on the effectiveness of treatment at hospitalization. If stockpiled antiviral drug supplies are very limited, the priority of this group could be reconsidered based on the epidemiology of the pandemic and any additional data on effectiveness in this population.

B. Definitions and rationale for draft priority groups

1. Persons admitted to hospital with influenza infection

a) Definition

Persons admitted to acute care facilities (traditional or non-traditional with a clinical diagnosis of influenza; laboratory confirmation not required). Excludes persons admitted for a condition consistent with a bacterial superinfection (e.g., lobar pneumonia developing late after illness onset) or after viral replication and shedding has ceased (e.g., as documented by a negative sensitive antigen detection test)

b) Strategy

Treatment within 48 hours of symptom onset.

c) Rationale

This group is at greatest risk for severe morbidity and mortality. Although there are no data to document the impacts of antiviral drug treatment among persons who already suffer more severe influenza illness, benefit is biologically plausible in persons with evidence of ongoing virally mediated pathology (e.g., diffuse pneumonia, ARDS). Providing treatment to those who are most ill is also consistent with standard medical practices, would be feasible to implement, and would be acceptable to the public.

d) Population size

The number of persons admitted to hospital in an influenza pandemic would vary substantially depending on the severity of the pandemic and on the ability to expand inpatient capacity, if needed.

e) Unresolved issues

More specific guidance should be provided to healthcare workers on implementing antiviral treatment, including when and when not to treat. In some persons with severe illness, the ability to take oral medication or its absorption may be important issues. For infants <1 year old admitted to hospital, decisions about whether to treat with antiviral drugs may depend on the child's age and potential risk versus benefit as the neuraminidase inhibitors are not licensed for use in infants. If possible, data on time from symptom onset to hospital admission, current use of antiviral drug treatment among inpatients, and its impacts should be collected during inter-pandemic influenza seasons.

2. Healthcare workers and emergency medical service providers who have direct patient contact

a) Definition

Persons providing direct medical services in inpatient and outpatient care settings. Includes doctors, nurses, technicians, therapists, EMS providers, laboratory workers, other care providers who come within 3 feet of patients

with influenza, and persons performing technical support functions essential to quality medical care.

b) Strategy

Treatment within 48 hours of symptom onset.

c) Rationale

Maintaining high quality patient care is critical to reduce health impacts of pandemic disease and to prevent adverse outcomes from other health conditions that will present for care during the pandemic period. Treatment of healthcare providers will decrease absenteeism due to influenza illness and may decrease absenteeism from fear of becoming ill, given the knowledge that treatment can prevent serious complications of influenza. Good data exist documenting the impacts of early treatment on duration of illness and time off work, and on the occurrence of complications such as lower respiratory infections. Treating healthcare providers is feasible to implement, especially for inpatient care providers who can be provided drugs through the occupational health clinic. It also would be acceptable to the public, who would recognize the importance of maintaining quality healthcare and would understand that persons with direct patient contact are putting themselves at increased risk.

d) Population size

There are about 12.6 million persons designated as healthcare workers by the Bureau of Labor Statistics and about 820,000 EMS providers. Among HCWs, two-thirds are estimated to provide direct patient care services.

e) Unresolved issues

Further work is needed to hone definitions and estimate population sizes. Implementation issues include the approach to identifying healthcare providers who would be eligible for treatment and where the treatment would be provided, particularly for outpatient care providers.

3. Outpatients at highest risk for severe morbidity or mortality from influenza infection

a) Definition

The Advisory Committee on Immunization Practices defines groups at high risk (or increased risk) of complications from influenza infection during annual outbreaks based on age (6-23 months and >65 years) and underlying illnesses. Among this population of about 88 million persons, some can be identified who are at highest risk of severe disease and death. These include persons with hematopoietic stem cell transplants (HSCT) and solid organ transplants; those with severe immunosuppression due to cancer therapy or hematological malignancy; persons receiving immunosuppressive therapy for other illnesses (e.g., rheumatoid arthritis); persons with HIV infection and a CD4 count <200; persons on dialysis; and women who are in the second or third trimester of pregnancy.

b) Strategy

Treatment within 48 hours of symptom onset.

c) Rationale

Of the large group of persons who are at increased risk of severe disease or death from influenza, these groups represent the population at highest risk and who are least likely to be protected by vaccination. Studies show that neuraminidase inhibitor therapy decreases complications and hospitalizations from influenza in high-risk persons and one unpublished study shows a significant decrease in mortality among patients who have undergone a hematopoietic stem cell transplant.

d) Population size

About 150,000 persons have had an HSCT or solid organ transplant. Assuming that the period of severe immunosuppression after a cancer diagnosis lasts for 1 year, the population targeted with non-skin, non-prostate cancers would equal the incidence of about 1.35 million persons. Based on a birth cohort of 4.1 million, a 28-week risk period during the second and third trimesters, and an 8-week pandemic outbreak in a community, there would be about 400,000 pregnant women included in this risk group. Further work is needed to estimate the size of other immunosuppressed groups.

e) Unresolved issues

Specific definition of included groups and population sizes.

4. **Pandemic health responders, public safety workers, and key government decision-makers**

a) Definition

Public health responders include those who manufacture vaccine and antiviral drugs; persons working at health departments who are not included as healthcare workers; and those who would be involved in implementing pandemic vaccination or other response components. Public safety workers include police, fire, and corrections personnel. Key government decision-makers include chief executives at federal, state, and local levels.

b) Strategy

Treatment within 48 hours of symptom onset.

c) Rationale

Preventing adverse health outcomes and social and economic impacts in a pandemic depend on the ability to implement an effective pandemic response. Early treatment of pandemic responders will minimize absenteeism and ensure that vaccination and other critical response activities can be maintained. Implementing early treatment for public health workers and vaccine manufacturers is feasible at workplace settings. Public safety workers prevent intentional and unintentional injuries and death, are critical to maintaining social functioning, and will contribute to a pandemic response, for example by ensuring order at vaccination clinics. A small number of decision-makers at federal, state, and local levels are needed to for an effective pandemic response.

d) Population size

An estimated 40,000 workers who produce pandemic vaccine and antiviral drugs in the U.S.; ~300,000 public health workers who would not be included

in the HCW category; 3 million public safety workers; and a small number of government decision-makers.

e) Unresolved issues

Need to define the exact composition and size of this group.

5. Outpatients at increased risk of severe morbidity or mortality from influenza

a) Definition

For planning purposes, this group would include those currently designated as high-risk groups, except for those who have been categorized as being at highest-risk and included in a separate category. This increased-risk group includes persons 6-23 months and >>65 years old, or who have underlying illnesses defined by the ACIP as associated with increased risk. Definition of this group may change based on the epidemiology of the pandemic.

b) Strategy

Treatment within 48 hours of symptom onset.

c) Rationale

Early treatment has been shown to significantly decrease lower respiratory infections and to reduce the rate of hospitalization in elderly and high-risk populations. By extrapolation and based on the results of one small uncontrolled study, significant reductions of mortality can be expected as well. As these risk groups are familiar to the public given recommendations for annual vaccination, communication would be easy and acceptability high.

d) Population size

About 85.5 million persons are included in this group. Although all are at increased risk of annual influenza compared with the healthy under-65 year old population, there are different levels of increased risk for severe complications and death within this category. Further stratification may be possible based on several parameters including number of underlying conditions; recent hospitalization for a high-risk condition, pneumonia, or influenza; and age.

e) Unresolved issues

Stratifying this group into those at greater and lesser risk may be important if antiviral supplies are limited. Implementing treatment will be challenging given that it should be provided at the initial point of care to accrue the greatest benefit from early therapy.

6. Outbreak control

a) Definition

Use of antiviral drugs to support public health interventions in closed settings where an outbreak of pandemic influenza is occurring.

b) Strategy

Treatment of cases and post-exposure prophylaxis of contacts (once daily antiviral medication for 10 days).

c) Rationale

Influenza outbreaks in nursing homes are associated with substantial mortality and morbidity. Nursing home residents also are less likely to respond to vaccination. Post-exposure prophylaxis has been shown to be effective in stopping influenza outbreaks in closed settings.

d) Population size

The number of outbreaks that may occur during a pandemic is unclear. Measures should be implemented to prevent outbreaks including limiting visitors, vaccination of staff, furloughing non-critical staff, and screening and exclusion for illnesses consistent with influenza.

e) Unresolved issues

Should this policy also be implemented in prisons or other settings where explosive spread of illness may occur but the risk for severe complications is not high?

7. Healthcare workers in ER, ICU, EMS, and dialysis settings

a) Definition

Includes all staff in these settings who are required for effective functioning of these health care units.

b) Strategy

Prophylaxis

c) Rationale

Optimally effective functioning of these units is particularly critical to reducing the health impacts of a pandemic. Prophylaxis will minimize absenteeism in these critical settings.

d) Population size

Need to obtain population estimates.

e) Unresolved issues

Population sizes

8. Pandemic societal responders and healthcare workers who have no direct patient contact

a) Definition

This group includes persons who provide services that must be sustained at a sufficient level during a pandemic to maintain public well-being, health, and safety. Included are workers at healthcare facilities who have no direct patient contact but are important for the operation of those facilities; utility (electricity, gas, water), waste management, mortuary, and some transport workers.

b) Strategy

Treatment within 48 hours of symptom onset.

c) Rationale

Maintaining certain key functions is important to preserve life and decrease societal disruption. Heat, clean water, waste disposal, and corpse management all contribute to public health. Ensuring functional transportation systems also protects health by making it possible for people to access medical care and by transporting food and other essential goods to where they are needed.

d) Population size

Within these broad categories, there are about 2 million workers at healthcare facilities who have no direct patient contact; 730,000 utility workers; 320,000 waste management workers; 62,000 in mortuary services; and 2.3 million in transportation. Not all occupations within these categories would be classified as pandemic societal responders. Estimates are that 35% of this population will develop illness and present within 48 hours of onset regardless of pandemic severity.

e) Unresolved issues

Need to stratify within these groups to identify who fills specific pandemic societal response functions and to assess whether those functions could still operate if a substantial proportion of the workforce became ill during a 6-8 week pandemic outbreak within a community. Implementation issues need to be addressed, especially with respect to how persons would be identified as falling within this priority group when presenting for treatment and where that treatment would be provided.

9. Other outpatients

a) Definition

Includes persons not in one of the earlier priority groups.

b) Strategy

Treatment within 48 hours of illness onset.

c) Rationale

Treatment reduces the risk of complications and mortality, reduces duration of illness and shortens time off work, and decreases viral shedding and transmission. If sufficient antiviral supplies are available, providing treatment to all who are ill achieves equity and will be most acceptable to the public.

d) Population size

There are an estimated 180 million persons who are not included in previously targeted groups.

e) Unresolved issues

Consider whether there are any strata that can be defined within this population.

C. Additional NVAC recommendations on antiviral drugs for pandemic influenza

In addition to recommendations for priority groups, NVAC unanimously adopted the following recommendations:

- Sufficient drugs should be stockpiled to address top priorities. NVAC recommends that the minimum stockpile size be about 40 million courses, allowing coverage of the top 7 priority groups.
- Oseltamivir should be the primary drug stockpiled, but some zanamivir also should be obtained as it is effective against some oseltamivir-resistant strains, may be preferred for treatment of pregnant women, and supporting two manufacturers enhances security against supply disruptions. Approximately 10% of the stockpile should be zanamivir if feasible and cost effective. No additional adamantanes should be stockpiled.
- Antiviral drugs can also be used as part of an international effort to contain an initial outbreak and prevent a pandemic. Use to slow disease spread early in a pandemic may be useful but requires large amounts of drug.
- Critical research should be conducted to support development and implementation of recommendations for pandemic influenza antiviral drug use, including:
 - Impact of treatment at hospital admission on outcome
 - Optimal treatment dose for H5N1 and other potential pandemic strains
 - Sensitivity and use of rapid diagnostic tests for H5N1 and other influenza strains with pandemic potential
 - Safety and pharmacokinetics of oseltamivir among infants <1 year old
 - Investigation of the impact of other drugs (new antiviral agents and other classes such as statins) on influenza
- Additional work with public and private sector groups should be done to further hone definitions of target groups and their estimated population sizes, and to provide further guidance on antiviral drug distribution and dispensing.

Appendix N...

Division of Mental Health/
Developmental Disabilities/
Substance Abuse Services
Pandemic Influenza Response

DIVISION OF MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/SUBSTANCE
ABUSE SERVICES
Pandemic Influenza Response

PURPOSE

The behavioral health response appendix to the North Carolina Pandemic Influenza Response Plan describes activities that will be implemented to address how the Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) will respond to the psychological consequences of a pandemic influenza in the state of North Carolina.

DMH/DD/SAS is responsible for periodically reviewing and updating this plan to ensure that information contained within the document is consistent with current knowledge and changing infrastructure. While this appendix serves as a guide specifically for influenza intervention activities during a pandemic, the judgment of public health leadership based on knowledge of the specific virus may alter the strategies that have been outlined.

Priorities of DMH/DD/SAS during pandemic influenza will be to assure the continuation and delivery of essential behavioral health services while providing for the emergency behavioral health needs of the population.

Visit the DMH/DD/SAS web site located at the end of this document for the complete disaster preparedness, response and recovery plan.

SCOPE OF OPERATIONS

This sub function applies to all victims of the pandemic influenza as well as personnel assigned to emergency oriented missions within North Carolina.

DMH/DD/SAS will operate within the established incident command structure.

SITUATION AND ASSUMPTIONS

1. An influenza pandemic in North Carolina will present a massive test of the emergency preparedness system. Advance planning for North Carolina's emergency response could save lives and prevent substantial economic loss.
2. A pandemic will pose significant threats to human infrastructure responsible for critical community services due to widespread absenteeism.
3. Many geographic areas within North Carolina and its neighboring jurisdictions may be affected simultaneously. Localities should be prepared to rely on their own resources to respond. The effect of pandemic influenza on individual communities will be relatively prolonged (weeks to months) in comparison to other types of disasters.

4. North Carolina's healthcare and behavioral healthcare systems will be strained to the breaking point by staff attrition and increased demand for services. Healthcare workers and other first responders may be at higher risk of exposure and illness than the general population further straining the healthcare system.
5. Widespread illness in the community could increase the likelihood of sudden and potentially significant shortages of personnel in other sectors that provide critical public safety services.
6. An effective response to an influenza pandemic will require the coordinated efforts of a wide variety of organizations, both private and public.
7. In an influenza pandemic, preparing for a surge in behavioral health casualties as well as attending to those who believe themselves to be infected is crucial. Disasters, by their inherent conditions, produce the need for behavioral health response. Responding to the psychological and emotional impact of disasters for all people involved is an integral part of a comprehensive and effective disaster response and recovery strategy. Hence, a behavioral health response should be made available to individuals at various venues such as home, school, shelter, hospital, and isolation/quarantine areas.
8. Individuals psychologically impacted often include those involved in treating the physical casualties. In fact, disaster responders, including medical personnel, are a high-risk group for developing trauma-related disorders. Certain members of the workforce (e.g. healthcare workers) may be at increased risk of infection. Those workers at increased risk of infection are an especially vulnerable group due to a real or perceived increased risk of becoming infected themselves, and/or transmitting infection to their friends and families. In addition to assuring access to personal protective equipment, vaccination and prophylactic treatments for first responders and frontline health care workers, health care organizations need to direct attention to mitigating the stress-related psychological effects of disaster response on these individuals. Hence, there is a particular need for sensitivity to personal concerns and obligations when workers, for instance, may be separated from their families and loved ones for long hours and even days.
9. An influenza pandemic may pose substantial short-term and long-term physical, personal, social, and emotional challenges to individuals and/or the community at large.
10. In an influenza pandemic, there may be short and/or long term effects on the behavioral health of individuals due to direct experience with sick and dying loved ones, and on the population as a whole. The particular behavioral health needs of marginalized populations such as homeless people also need to be considered.
11. Critical to planning for pandemic-related behavioral health care within a community includes assisting individuals with pre-existing behavioral health needs. This population may become more vulnerable and may experience increased anxiety, depression, or substance use when their support system is impacted. The need to access medications and psychosocial supports will be a priority as the community support infrastructure deteriorates. Planning for a decline in the emotional status of individuals currently identified as "at-risk" for behavioral health needs includes increased behavioral health counseling, medication management, and support groups.

CONCEPT OF OPERATIONS

DMH/DD/SAS will organize behavioral health response into a comprehensive network to conduct Emergency Support Function #8 - mitigation of the psychosocial impact of any mass casualty incident in coordination with Local Management Entities (LMEs), Red Cross, interfaith agencies, DMH/DD/SAS cadre of volunteers, and private partners. Provision of local behavioral response will be administered as available resources permit.

Because some or all of the state-level resources may quickly be exhausted, DMH/DD/SAS may need to request assistance from Federal Emergency Management Agency (FEMA), the National Disaster Medical System (NDMS) and other states through the Emergency Management Assistance Compact. NDMS consists of the Disaster Medical Assistance Team, the Disaster Mortuary Operation Response Team, Medical Support Unit, Behavioral Health and Stress Management teams, and the Veterinary Medical Assistance Team.

To prepare for a pandemic, DMH/DD/SAS will:

1. Conduct a county-wide space and site resource inventory to determine the availability of staff at shelters, schools, gymnasiums, nursing homes, day care centers, and other potential sites for aggregate care.
2. Assess related behavioral health needs of community, victims, families, behavioral health consumers, emergency workers and their families.
3. Provide oversight and coordination of State response by promoting psychological first aid and resilience for victims and their families as well as coordinating with NC Critical Incident Stress Management to ensure Critical Incident Stress Management is available for first responders and healthcare workers.
4. Provide LME staff and community response partners with literature and educational materials for community-wide distribution, on the human response to disaster, stress reduction and self-help information, and support Public Health community education efforts.
5. Staff will be mindful of the "contagion" factor. Staff is working with public affairs staff to develop messages on this issue. Staff will be prepared and trained to address this issue through the media.
6. Educate healthcare providers, behavioral health responders and the public of the side effects of antivirals. (Side effects may include nervousness, anxiety, difficulty concentrating, lightheadedness and insomnia, dizziness, behavioral changes, delirium, hallucinations, agitation and seizures).
7. Provide assistance to the Office of Citizen Services' CareLine that will:
 - Provide information and education via phone line for the community
 - Assure behavioral health consumers' concerns are addressed
 - Provide information in Spanish

8. Work with Office of Minority Health and Health Disparities, Office of Rural Health and Community Care, and different communities within the state (e.g., ethnic, racial, and religious groups; most vulnerable; special needs; language minorities) to ensure people are identified and can be reached with appropriate behavioral health resources. Identify resources, such as culturally competent and multilingual providers, that could assist in provision of disaster services.
9. In the event of a Presidential Declaration of Disaster, initiate the application process for federal funding. If needed, apply for all FEMA-funded disaster crisis counseling assistance grants. Prepare mandated reports for the federal government.
10. Institutionalize psychosocial support services in order to help workers manage emotional stress during the response to an influenza pandemic and to resolve related personal, professional and family issues.
11. Train behavioral healthcare staff and first responders on how to:
 - Help victims of a disaster emergency deal with the trauma directly associated with an emergency or disaster
 - Provide immediate support
 - Set up rest stations to allow space for psychological first aid to be administered
 - Recognize self limitations
 - Make appropriate referrals for continuing services
12. Train non-behavioral health professionals (e.g., primary-care clinicians, safety and security personnel, community leaders, and staff of cultural and faith based organizations) in basic psychological first aid.
13. With the assistance of DHHS Public Affairs Office, identify and develop pandemic influenza specific education tools and materials regarding the signs of distress, traumatic grief, coping strategies, and building and sustaining personal and community resilience.
14. Create a plan for continuity of operations in case of increased workload or staff losses during a pandemic.
15. Develop and implement table-top exercises focused on behavioral health disaster issues.
16. If there are mass casualties, individuals may have to face, in addition to personal loss, restriction that limit their freedom to mourn for and bury their dead in a timely fashion according to their cultural/religious beliefs. DMH/DD/SAS will assist community response partners to provide appropriate and culturally-sensitive support to individuals and communities.
17. Guidance will also be needed for coping with psychosocial issues such as irrational stigmatization and grief, ethical dilemmas, managing stress when familial roles change, economic hardships, and managing feelings of frustration, anger, and helplessness. Support will be needed for dealing with exhaustion, anger, and fear in patients, peers and self and learning how to take measures to care for self, peers, and family.

(Refer to US DHHS Pandemic Influenza Plan, *Supplement 11: Workforce Support for more information on psychosocial considerations and information needs for healthcare workers*).

RESPONSE PHASES

It is expected that an influenza pandemic will occur in the phases listed below. In actual practice, the distinction between the various phases of pandemic influenza may be blurred or occur in a matter of hours, underscoring the need for flexibility. DMH/DD/SAS' response is detailed in each phase.

World Health Organization Phases

Interpandemic Phases 1 and 2

- Identify private and public sector responding partners in the planning process. Foster coordination and participation among private and public sector partners in the planning process.
- Work within agencies to develop contingency plans for large scale public health disasters like an influenza pandemic.
- Coordinate planning with federal and other neighboring states.
- Provide education and planning guidance to responding partners and community on preparing for and responding to an influenza pandemic.
- Prepare and distribute education materials for workforce and community support to promote resilience.
- Identify major gaps in current ability to effectively respond to an influenza pandemic. Explore possible avenue for addressing and resolving gaps.

Pandemic Alert Phase 3

- Notify LME and community partners of the pandemic alert phase 3 (human infections with a new influenza subtype).
- Designate an official contact person to receive updates.

Pandemic Alert Phase 4

- Update LME and community partners of pandemic alert phase 4 (small clusters of human-to-human transmission of new influenza subtype).
- Monitor bulletins from CDC, WHO, and HAN regarding clinical updates as appropriate.
- Review and update pandemic influenza response and contingency plans.

Pandemic Alert Phase 5

- As appropriate, activate response partners and intensify activities described in phases 1-4.
- Notify LME and community partners of the potential for an influenza pandemic in North Carolina to ensure adequacy of behavioral health response.
- Continue to review pandemic influenza response and contingency plans for large scale public health disasters.

- Monitor bulletins from CDC, WHO, and HAN regarding clinical updates as appropriate.

Pandemic Phase 6

- Implement contingency plans for large-scale public health disasters.
- Ensure designated agency contact available to receive updates from DMH/DD/SAS.
- Provide regular updates to LMEs and community partners of gaps in agency services.
- Coordinate use of available resources during pandemic, including private, public and volunteer resources.
- Coordinate activities with other stated and federal health agencies.
- Assess effectiveness of local response and available local capacity.
- Monitor response of DMH/DD/SAS during pandemic, re-allocate resources as needed
- Apply for FEMA grants as needed.
- Monitor bulletins from CDC, WHO, and HAN regarding clinical updates as appropriate.

Second or Subsequent Waves

- Continue all activities listed under Pandemic phase 6.
- Review, evaluate and modify as needed, the local pandemic response.
- Monitor resources and staffing needs.

Post pandemic Period

- Assess state and local capacity to resume normal behavioral health functions.
- Assess fiscal impact of pandemic response.
- Modify the pandemic influenza response and contingency plans based on lessons learned.

Special Needs Population

Comprehensive pandemic influenza planning must prepare for the behavioral health concerns of populations with special needs. People who depend on frequent appointments for medical care or behavioral health services are vulnerable to the loss of these services due to staff shortages and breakdown in community infrastructure and support system. DMH/DD/SAS will help to ensure that services are provided to the greatest extent possible to these vulnerable populations. Groups with special needs may include:

- Children, adolescents, and the elderly
- Individuals with emotional, cognitive, or physical disabilities
- Individuals with substance use issues
- Individuals living in congregate settings
- Individuals in inpatient health care facilities
- Individuals in state operated facilities
- Individuals who are Deaf or Hard of Hearing
- Individuals who are blind or visually impaired
- The homeless
- The homebound
- Undocumented individuals
- Immigrants
- Groups with special language/cultural needs

Planning and activities to meet the demand for expanded behavioral health services for populations with special needs include:

- Encourage providers to develop a Continuity of Operations Plan for delivery of essential services to special needs populations.
- Educate health and behavioral health care providers and Local Management Entities about vulnerable populations, their special needs during pandemic influenza and the providers' role in addressing those needs.
- Ensure staff and individuals in state operated facilities are considered in planning, preparedness, and response activities.
- Develop need-specific web-based education materials.
- Collaborate with community and faith-based organizations to ensure that behavioral health planning, preparedness, and response activities are culturally appropriate.

Appendix O...

ICCE Net

Intrastate Crisis Communication Enhancement Network

ICCE Net

Intrastate Crisis Communication Enhancement Network

PURPOSE

The objective of this program is to foster regular and structured meetings between and among professionals at the county, regional, and state levels who are responsible for managing public information during a catastrophic health event or an act of bioterrorism. The Office of Public Health Preparedness and Response (PHP&R) considers it essential that a program be established to enhance the ability of those involved to better conduct and coordinate media and public information efforts before, during and after a crisis.

PRIMUS

During a health crisis it is expected that a multitude of public and private agencies will participate in the response. It is imperative that the people from each sector responsible for coordinating public information establish lines of communication within and between the affected counties as well as the affected regions and the state before an event takes place. The more familiar everyone responsible for public health communications is with each other the more likely it is that vital information will be properly exchanged. To that end, it is vital that we develop solid connections with one another and take full advantage of information-sharing opportunities – and to avert information crises – as they arise.

PROGRAM

This program is based upon the concept that in North Carolina there are three distinct spheres of health communication that must be addressed – intracounty, intercounty (regional), and the communication that takes place between counties, regions, and state offices (statewide). When viewed as a whole, they create an intrastate network of health, medical, and emergency organizations that need to communicate with each other before and during a health crisis. Working together in a structured system will enhance the communication abilities of both the individual groups and the network – thus the name Intrastate Crisis Communication Enhancement Network – or ICCE Net.

County

Each county or health district will create a Local Health Information Team (LHIT) comprised of those individuals who are responsible for coordinating media and public information efforts during a health crisis. The county health department's lead public information officer (PIO) will take the lead in creating these groups and scheduling regular meetings. The county's Public Health Regional Surveillance Team (PHRST) will provide oversight and guidance to the county PIOs to help them establish their groups and meeting times. The health department PIO should enlist the aid and partnership of the county's lead PIO or designated media coordinator at the beginning of this effort. (Although not all health departments have

PIOs, most have either a BT coordinator, public health nurse or a health educator who has received media facilitator training and/or has been designated the department's media coordinator. PHP&R will work with the state Local Technical Assistance and Training office to coordinate with nurses, health educators, and others serving as media coordinators.) It is suggested that the meetings be held once a month and that they are held within or as close to the county's Emergency Operations Center as possible to foster interaction with this key office.

The following is a list of core agencies and organizations that should be asked to provide a lead PIO, public affairs officer (PAO), or staff member responsible for media/public information. Others can be added as deemed appropriate by each county or health district.

- County
- Health Department
- Large Municipalities
- Emergency Management (if different from county PIO)
- Hospital(s)
- Emergency Medical Services
- Red Cross
- Home Health
- Hospice
- Fire
- Law Enforcement

Regional

Each PHRST will convene a Regional Crisis Communication Alliance meeting – either in person or via teleconference – on a quarterly basis for training, enhancing familiarity between counties, and to discuss crisis communication needs and tasks. Makeup of the alliance will be determined by the PHRSTs, but should include representatives from the four core groups delineated in Section IV of the "Roles and Missions of North Carolina Public Health Regional Surveillance Teams" document. *Note: See "Regional Level" in the "Guidelines and Objectives" section below.*

The PHR&R Communication Coordinator and the Education and Training Coordinator will assist the PHRSTs with determining agendas and focus.

Statewide

In addition to assisting counties and regions, the PHP&R Communication Coordinator will conduct an annual meeting and provide Emergency Risk Communication training on an ongoing basis. As chairman of the state PHP&R Steering Committee's Public Affairs Subcommittee, the PHP&R Communication Coordinator will seek input and guidance from subcommittee members to help determine scope and need, and to foster better crisis communication interaction between key state departments, the PHRSTs and the LHITs. The PHP&R Communication Coordinator shall also provide regular reports to the PHP&R Steering Committee for oversight and additional guidance.

GUIDELINES AND OBJECTIVES

County Level

Each county or health district is charged with meeting specific requirements outlined in "The Division of Public Health, Office of Public Health Preparedness and Response Agreement Addenda." Conducting meetings according to this plan will fulfill activities one through six under Risk Communication, Activity #4515. Specifically, those activities are:

1. Establish and participate in regional meetings for Public Information Officers (PIOs) from Public Health, Hospital Administration and Law Enforcement.
2. Identify appropriate Risk Communication training opportunities. Identify and maintain contact list of appropriate Public Information Officers and local and regional media facilitators.
3. Coordinate Risk Communication educational activities for PIOs and media facilitators.
4. Develop Risk Communication procedures and protocols.
5. Support and participate in county and regional Risk Communication flow matrix (ICCE Net).
6. Participate in state risk-communication network activities (ICCE Net).

To ensure completion of these activities, PHP&R recommends that each local health department's PIO, media facilitator, or designated media coordinator be the staff person responsible for convening the monthly meeting of PIOs from the groups listed above. These meetings should begin as soon as possible but no later than August 2004.

Note: If the health department does not have a PIO, trained media facilitator or designated media coordinator, it is highly recommended that the health director designate a media facilitator as soon as possible. Past public health crises have demonstrated that, during a crisis it will NOT be possible for the health director to perform his or her duties AND coordinate the media at the same time.

Each county or health district will, with the assistance of the PHRSTs and the PHP&R Communication Coordinator, create an Emergency Risk Communication Plan that establishes policies regarding the communication of health issues within the county and with other counties within the region. Such policies will establish lead spokespeople, approval of messages, message coordination with county and state agencies, message dissemination, media availability schedules, and other key communication elements. Once completed the plans will be submitted to the county's PHRST for review and coordination. If a county has an existing Emergency Risk Communication Plan they will submit their plan to the PHRST for review as soon as possible.

The LHITs also will use their monthly (or regularly scheduled) meetings to determine additional health communication goals and needs specific to their counties. The PHRSTs and PHP&R Communication Coordinator will help facilitate those goals as requested.

Regional Level

According to the "Roles and Missions of North Carolina Public Health Regional Surveillance Teams," each PHRST is charged with meeting specific requirements related to risk communications. Adherence to ICCE Net will help the PHRSTs accomplish many of those requirements as listed in Section IV of the "Roles and Missions" document.

Subsection A of Section IV states: *PHRSTs will ensure that risk communications and release of information to the public and media are only as authorized by competent jurisdictions or authorities. Any announcements or other communications will clearly identify the identity and titles of the source and releaser of information.*

The PHRSTs will accomplish these tenets when facilitating county efforts to establish Emergency Risk Communication Plans and/or when those plans are submitted for final review.

Subsection B states: *PHRSTs will maintain regular communications and consultation with Local Health Departments in their regions and will be prepared to provide:*

1. *Immediate consultation and advice for development of risk communication materials and messages.*
2. *Written, online, and other materials as requested.*
3. *Subject matter expertise, when requested and within the professional qualifications and competence of the PHRST member.*

Providing assistance to the LHITs to help coordinate and conduct their monthly meetings will satisfy the main component of this requirement and facilitate accomplishing the three subsets as listed above.

Subsection C states: *PHRSTs will convene regular conferences with Public Information Officers within their regions. Minimum frequency: Quarterly. Organizations invited will include:*

1. *Local Health Departments*
2. *Hospitals*
3. *Emergency Management agencies*
4. *County and municipal governments*

Convening quarterly meetings in person or via teleconference will satisfy the main component of this requirement. In addition to the four base categories listed above, PHRSTs may want to consider including all members of each LHIT. One strategy would be to limit teleconference participation to members representing the four base categories and inviting all

LHIT members to regular conferences. PHP&R recommends that PHRSTs conduct at least one meeting each year where members meet in person.

Subsection D states: *PHRSTs will maintain contact lists of Public Information Officers in counties in region.*

Facilitating LHIT meetings will naturally lend itself to fulfilling and updating this task.

Subsection E states: *PHRSTs will be prepared to conduct conference calls with one or more counties in region, as circumstances dictate. This capability should be exercised at least quarterly, preferably as a part of an exercise or actual response.*

Following the recommendations under Subsection C above will fulfill most of this requirement.

Subsection G states: *PHRSTs will maintain a regional website with links to NCHAN, CDC, regional and local agencies, etc.*

Quarterly meetings with the LHITs will provide an easy opportunity to assess and determine what types of links and information should be included on the regional website that will address local public information needs.

Subsection I states: *PHRSTs will publish a quarterly newsletter within their region (copies furnished to NC PHP&R) actively marketing their services and support to local health departments and other partners in the region.*

The regular communications with the LHITs via their monthly meetings and the PHRSTs' quarterly meetings should be used to help determine newsletter content, solicit contributions, and establish distribution lists.

State Level

The PHP&R Communication Coordinator will provide guidance and oversight to both the LHITs and the PHRSTs in all aspects of the ICCE Net plan. Additionally, the PHP&R Communication Coordinator will attempt to convene a yearly conference bringing as many of the county, regional, and state ICCE Net members together as possible for education, training, and networking. Funding for the annual conference will be requested in the grant proposal submitted to the CDC for Grant Year 5. If approved, the funding will allow the conference to be offered to participants at no cost other than travel and per diem expenses. (Local health department participants should set aside BT-related Aid to County funds for this purpose.)

Section IV, Subsection J of the PHRST "Roles and Missions" document states: *PHRSTs will obtain training in Crisis Emergency Response Communications for all assigned personnel and will invite regional partners to participate in this training.*

The PHP&R Communication Coordinator, with the help of the Education and Training Coordinator, will establish a schedule to train LHIT and PHRST members how to use the CDC's "Emergency Risk Communication CDCynergy" CD-ROM tool box. Each county and PHRST will be provided a copy of the CD-ROM that includes guidelines and templates for creating a communication plan. The CDCynergy CD-ROM contains many tools and resources and is to be considered the standard for public health emergency-risk communications.

Greene County
Pandemic Influenza
Preparedness & Response Plan

March 2007

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I. Introduction

A. General Overview

According to the World Health Organization, “an influenza pandemic occurs when a new influenza virus appears against which the human population has no immunity, resulting in several, simultaneous epidemics worldwide with enormous numbers of deaths and illness.”

Influenza is a highly contagious respiratory virus that is responsible for annual epidemics in the United States and other countries. Each year, approximately 200,000 people are hospitalized and 36,000 die in the United States from influenza infection or a secondary complication. During an influenza pandemic, the levels of morbidity and mortality from influenza-related complications can increase dramatically worldwide.

Influenza pandemics have the ability to cause significant morbidity, mortality, and to disrupt many aspects of society due to excessive burdens on healthcare, as well as a reduction in the general workforce due to illness and death. During the 20th century, three influenza pandemics caused excess mortality, morbidity and societal burden throughout the world. The “Spanish” influenza pandemic of 1918 killed over 500,000 people in the United States and had a worldwide mortality of 20 to 40 million. The 1918 pandemic was notorious for its predilection for healthy young adults. After 1918, two global outbreaks of influenza A occurred. In 1957, Asian influenza caused approximately 68,000 deaths in the United States. During the Hong Kong pandemic in 1968-69, mortality in the United States was estimated at 34,000 deaths, with 51 million Americans affected by influenza and a total economic burden of \$3.9 billion.

There are two types of influenza viruses, which cause significant disease in humans: type A (Influenza A) and type B (Influenza B). Influenza A viruses are composed of two major antigenic structures essential to the production of influenza vaccines and the induction of immunity: hemagglutinin (H) and neuraminidase (N). These two components define the virus subtype. Influenza A viruses are unique because they can infect both humans and animals and are usually associated with more severe illness than type B influenza viruses. Most influenza A viruses are considered avian in origin.

Influenza viruses mutate frequently resulting in an antigenic drift or a shift. Antigenic drift is a minor change caused by mutation that results in the emergence of a new strain within a subtype. Drifts can occur in both type A and B influenza viruses. Antigenic shift is a major change caused by genetic recombination that results in the emergence of a novel virus strain that has not previously infected humans. Antigenic shifts occur only in influenza type A viruses. An antigenic shift is almost always followed by an influenza pandemic.

Based on observations from previous pandemics, the Centers for Disease Control and Prevention (CDC) has estimated that the economic losses in the United States associated with the next pandemic will range from approximately \$71 billion to \$166 billion. The

level of economic loss will depend on the attack rate of the virus and the resulting morbidity and mortality.

The impact of an influenza pandemic on the healthcare system could be devastating. It has been estimated that in the United States, a moderate pandemic could result in 20 to 47 million people becoming ill; 18 to 42 million outpatient visits; 314,000 to 734,000 hospitalizations; and 89,000 to 207,000 deaths.

B. Purpose of the Plan

This potential for high levels of morbidity and mortality, coupled with the significant disruption to society, make planning for the next influenza pandemic imperative.

The purpose of planning for pandemic influenza is to:

- reduce mortality
- reduce morbidity
- minimize social disruption.

The threat of pandemic influenza is not as much a question of *if*, but rather a question of *when*.

C. Assumptions of an Influenza Pandemic

In order to make plans as realistic as possible when considering the unpredictability of pandemic influenza, a set of assumptions must be made prior to planning. Many of these assumptions are based on experiences and knowledge gained from earlier pandemics. The following list of assumptions regarding an influenza pandemic have been taken from the United States Department of Health and Human Services Pandemic Influenza Plan.

Pandemic planning is based on the following assumptions about pandemic disease:

- Susceptibility to the pandemic influenza subtype will be universal.
- The clinical disease attack rate will be 30% in the overall population. Illness rates will be highest among school-aged children (about 40%) and decline with age. Among working adults, an average of 20% will become ill during a community outbreak.
- Of those who become ill with influenza, 50% will seek outpatient medical care.
- The number of hospitalizations and deaths will depend on the virulence of the pandemic virus.
- Risk groups for severe and fatal infections cannot be predicted with certainty. During annual fall and winter influenza season, infants and the elderly, persons with chronic illnesses, and pregnant women are usually at higher risk of complications from influenza infections. In contrast, in the 1918 pandemic, most deaths occurred among young, previously healthy adults.

- The typical incubation period (the time between acquiring the infection until becoming ill), for influenza averages 2 days. We assume this would be the same for a novel strain that is transmitted between people by respiratory secretions.
- Persons who become ill may shed virus and can transmit infection for one-half to one day before the onset of illness. Viral shedding and the risk for transmission will be greatest during the first 2 days of illness. Children will shed the greatest amount of virus and, therefore are likely to pose the greatest risk for transmission.
- On average about 2 secondary infections will occur as a result of transmission from someone who is ill. Some estimates from past pandemics have been higher, with up to about 3 secondary infections per primary case.
- In an affected community, a pandemic outbreak will last about 6 to 8 weeks. At least two pandemic disease waves are likely. Following the pandemic, the new viral subtype is likely to continue circulating and to contribute to seasonal influenza.
- The seasonality of a pandemic cannot be predicted with certainty. The largest waves in the U.S. during 20th century pandemics occurred in the fall and winter. Experience from the 1957 pandemic may be instructive in that the first U.S. cases occurred in June but no community outbreaks occurred until August and the first wave of illness peaked in October.

Below are several other assumptions that provide a basis for preparedness activities pertaining to pandemic influenza:

- Influenza pandemics are expected, but unpredictable and arrive with very little warning.
- Outbreaks can be expected to occur simultaneously throughout much of the U.S., preventing shifts in human and material resources that usually occur in the response to other disasters.
 - Localities should be prepared to rely on their own resources to respond.
 - As with many public health emergencies, the effect of influenza on individual communities will be relatively prolonged (weeks to months) in comparison with other types of disasters.
 - Health care workers and other first responders may be at higher risk of exposure and illness than the general population, further straining the health care system.
 - Effective prevention and therapeutic measures, including vaccine and antiviral agents, will be delayed and in short supply.
 - Widespread illness in the community could increase the likelihood of sudden and potentially significant shortages of personnel that provide critical public safety services.

D. Phases of an Influenza Pandemic

The new World Health Organization Global Influenza Preparedness Plan, released in April 2005, is an updated version of a 1999 document. WHO decided to update the original plan in response to recent developments surrounding the H5N1 avian influenza virus, including endemic animal infection in several Southeast Asian countries and continuing human cases, better understanding of the evolution of flu viruses, new

techniques for diagnosis and vaccine development, improved antivirals, and the ongoing revisions of the International Health Regulations.

The new plan lays out six pandemic phases and appropriate public health responses for each one. The new WHO plan defines additional phases (beyond those defined in the 1999 document) during which coordinated international public health actions could be taken to gain time for developing vaccines and implementing preparedness measures planned in advance. The plan also emphasizes the importance of intersectoral planning and involving partners outside the health sector, such as agriculture, transport, trade, labor, defense, education, and the judicial branches of government, as well as partners in industry and nongovernmental organizations. The Greene County Pandemic Influenza Plan describes actions to be taken during each of the WHO pandemic phases.

Phases of an Influenza Pandemic - World Health Organization, 2005

Interpandemic Period	
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.
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.
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.
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.
Phase 5	Large cluster(s) but human-to-human spread is still localized, suggesting that the virus is becoming increasingly better adapted to humans but may not yet be fully transmissible (substantial pandemic risk).
Pandemic Period*	
Phase 6	Pandemic phase: increased and sustained transmission in the general population.
Postpandemic Period	
Return to Interpandemic Period (Phase 1)	

* Second or subsequent pandemic waves may follow the initial wave, usually within three to nine months.

Appropriate Public Health Response for Each Pandemic Phase - WHO, 2005

Phase 1 - Interpandemic Period	Strengthen influenza pandemic preparedness at the global, regional, national, and subnational levels.
Phase 2 - Interpandemic Period	Minimize the risk of transmission to humans; detect and report such transmission rapidly if it occurs.
Phase 3 - Pandemic Alert Period	Ensure rapid characterization of the new virus subtype and early detection, notification, and response to additional cases.
Phase 4 - Pandemic Alert Period	Contain the new virus within limited foci or delay spread to gain time to implement preparedness measures, including vaccine development.
Phase 5 - Pandemic Alert Period	Maximize efforts to contain or delay spread, to possibly avert a pandemic and to gain time to implement pandemic response measures.
Phase 6 - Pandemic Period	Minimize the impact of the pandemic.

E. Impact of an Influenza Pandemic

FluAid is a test version of software created by programmers at the CDC. It is designed to assist state and local level planners in preparing for the next influenza pandemic by providing estimates of potential impact specific to their locality. FluAid provides only a range of estimates of impact in terms of deaths, hospitalizations, and outpatient visits due to pandemic influenza. The software cannot describe when or how people will become ill, nor how a pandemic may spread through a society over time.

The potential impact of a moderate pandemic in Greene County was modeled using the FluAid software. Ranges of deaths, hospitalizations, and outpatient visits for clinical attack rates of 15%, 25%, and 35% are shown in the tables below.

Deaths (Number of Cases)			
Age Group	Gross Attack Rates		
	15%	25%	35%
0 - 18 years most likely	0	0	0
19 - 64 years most likely	4	6	9
65+ years most likely	4	7	9
TOTAL: most likely	8	13	18

Hospitalization (Number of Cases)			
Age Group	Gross Attack Rates		
	15%	25%	35%
0 - 18 years most likely	2	3	4
19 - 64 years most likely	23	38	53
65+ years most likely	11	18	25
TOTAL: most likely	36	59	82

Outpatient Visits (Number of Cases)			
Age Group	Gross Attack Rates		
	15%	25%	35%
0 - 18 years most likely	487	811	1,135
19 - 64 years most likely	946	1,577	2,208
65+ years most likely	188	313	438
TOTAL: most likely	1,621	2,701	3,781

Calculated using FluAid software (<http://www2.cdc.gov/od/fluaid/default.htm>) for a Greene County population of 20,167.

F. Planning Committee

The Greene County Pandemic Influenza Planning Committee was assembled in late 2006 and includes the following agencies and its representation:

- Greene County Health Department
 - ❖ Health Director - Linda Sewall
 - ❖ Nursing Director - Chris Miller
 - ❖ Preparedness Coordinator - Joy Brock
 - ❖ Communicable Disease Nurse - Charlotte Sasser

- Greene County Emergency Services
 - ❖ Director - Randy Skinner

- Greene County Social Services
 - ❖ Director - Debbie Jones
- Greene County Schools
 - ❖ School Nurse - Kathy Dail
- County of Greene
 - ❖ County Manager - Don Davenport
- Greene County Sheriff's Department
 - ❖ Sheriff - Lemmie Smith

Planning Committee members will continue meeting in order to further discuss and update, as necessary, the Greene County Pandemic Influenza Preparedness & Response Plan. Members will also continue to prepare and plan for a countywide, multi-agency pandemic influenza response.

II. Command and Control

A. Local Emergency Operations Plan

The Greene County Emergency Operations Plan (EOP) was updated in December 2004. The Greene County EOP predetermines actions to be taken by government agencies and designated private organizations with Greene County (which are in addition to their day to day responsibilities) to reduce the vulnerabilities of people and property to disaster and establish capabilities to respond effectively to the actual occurrence of a disaster or threat of a disaster.

All state and local governments are required to have an emergency operations plan, which addresses all hazards. However, pandemic influenza is likely to pose unique challenges that may not be addressed in current emergency operations plans. Because of these challenges, the Greene County Pandemic Influenza Preparedness and Response Plan will be an appendix of the Greene County Emergency Operations Plan. Some of the relevant issues that must be addressed in these plans include:

- Medical services and healthcare workers may be overwhelmed during the influenza pandemic.
- Healthcare workers may not be able to provide essential care to all patients in need.
- Unlike the typical disaster, because of increased exposure to the virus, essential community services personnel such as healthcare personnel, police, firefighters, emergency medical technicians, and other first responders, may be more likely to be affected by influenza than the general public.
- Unlike typical natural disasters, during which critical components of the physical infrastructure may be threatened or destroyed, an influenza pandemic may also pose significant threats to the human infrastructure responsible for critical community services. This threat will be due in part to widespread absenteeism in the workforce.

Significant decreases in the workforce could impact distribution of food, home meal deliveries, day care, garbage collection and other critical services.

- Work with veterinary and other animal health partners in veterinary components of pandemic planning and response.

B. Role of Public Health

Greene County Health Department will take the lead role for Greene County for pandemic influenza planning and response.

- Greene County Health Director will lead the county response to pandemic influenza or any other contagious disease emergency in Greene County. The Health Director will serve as the Incident Commander for the Public Health Incident Command System (ICS) and will also serve as the lead advisor to the Greene County Emergency Operations Center (if opened) on any health issues regarding pandemic influenza. The Health Director is also responsible for issuing isolation and quarantine orders.
- Preparedness Planner will review the Greene County Pandemic Influenza Preparedness and Response Plan at least semiannually and update the plan as needed. Will be responsible for the review and update of the Pandemic Flu plan and implementation of the plan as deemed necessary by the Greene County Health Director. Preparedness Planner will be responsible for overseeing that this plan and the corresponding Greene County Strategic National Stockpile (SNS) Plan will be reviewed and exercised annually. Evaluations of the exercises will be conducted and the recommended updates will be made to this plan and the corresponding SNS Plan.
- Greene County Health Department Staff are required to maintain and update plans and Standard Operating Guidelines regarding response to public health emergencies. These plans and guidelines contain specific information regarding mass vaccination clinic activities, surveillance, and treatment center coordination. Details related to clinic operations include staffing of the clinics, supplies and equipment needed, clinic layout, waste management, security of vaccines, job action sheets for assigned staff, and contact information for key clinic personnel can be found in the Greene County SNS Plan, which is kept on-file at the Greene County Health Department.
- Additional Roles of Greene County Public Health
 - Identification of public and private sector partners needed for effective planning and response.
 - Coordination with adjoining jurisdictions.
 - Maintain and exercise the Local Response Plan and the SNS Standard Operating Guidelines.
 - Continue to emphasize annual influenza vaccine and the use of pneumococcal vaccine during the preparation phases of the pandemic.
 - Identify priority groups for vaccination.

- Develop a system to estimate the number of persons in priority groups for vaccination.
 - Assure the security of influenza vaccine during storage and delivery when it becomes available. Planning for civil unrest due to pandemic should also be considered.
 - Maintain the Information Management Guidelines and ensure coordination with local emergency management coordinators, hospitals, and special populations in their area.
 - Maintain media relations at the local Joint Information Center (JIC).
 - Maintain a 24/7 contact list of key health department staff, local partners, and the media.
- North Carolina has a strong public health system involving both state agencies and local health departments that provide the foundation for responding to a pandemic. North Carolina has a core set of statutes dealing with communicable disease control that would therefore be essential tools in identifying and responding to pandemic influenza.
 - G.S. 130A-134 -130A-142 - Establish requirements for physicians, laboratories and other designated entities to report listed communicable diseases and conditions to local health departments and for local health departments to report this information to the NC Division of Public Health. Also provides immunity for making such reports. Gives rulemaking authority for listing communicable diseases and conditions and form, content and timing of reports to the Commission for Health Services (CHS). The rules are found at 10A NCAC 41A .0100. G.S. 130A-141.1 allows the State Health Director to require temporary reporting of symptoms, trends or diseases that may indicate a danger to the public health without going through the rulemaking process first.
 - G.S. 130A-143 - Provides for strict confidentiality of communicable disease information unless one of eleven listed exceptions is met. The exceptions allow such information to be shared with other public health agencies and, under limited circumstances, with law enforcement, to prevent or control the spread of communicable diseases or conditions.
 - G.S. 130A-144 - Sets out provisions requiring the investigation and control of communicable diseases and conditions. The CHS adopts specific control measures for communicable diseases that must be followed to prevent the spread of disease. Local Health Directors are charged with enforcing control measures, and the statutes require persons to comply with control measures, including Paragraph (f) that states all persons shall comply with control measures, including submission to examinations and tests. The control measure rules are found at 10A NCAC 41A .0200. This statute also requires physicians, medical facilities and laboratories to provide public health officials access to medical or other records as part of the investigation of a known or suspected communicable disease outbreak or investigation of a known or suspected case.

- G.S. 130A-145 - Establishes the authority of the State Health Director and of a local health director to issue isolation or quarantine orders. The isolation or quarantine order initially lasts up to 30 days but can be extended by court order. (Isolation authority is defined in G.S. 130A-2(3a) and Quarantine authority is defined in G.S. 130A-2(7a)).
- G.S. 130A-146 - Sets out special requirements for transportation of dead bodies for persons who have died from highly communicable diseases.
- G.S. 130A-147 - Gives the CHS authority to adopt rules for the detection, control and prevention of communicable diseases.
- G.S. 130A-480 – Establishes mandatory syndromic surveillance program to review electronic hospital emergency department data to detect and investigate public health threats that may be related to a terrorist incident using NBC agents or an epidemic or infectious, communicable or other disease.

C. Roles and Responsibility of State vs. County

The State of North Carolina has in place legal authority necessary for preparedness, and operational authority is also in place for public health and other health-related emergency response entities at the state and local levels of government. The federal government has been granted authority to support affected states or jurisdictions as necessary.

The US DHHS is the Federal government's lead agency for the preparation, planning, and response to an influenza pandemic. As such, the DHHS will:

- Coordinate the Federal government's response to the public health and medical requirements of an influenza pandemic
- Provide the US HHS Secretary's Command Center (SCC) as the national incident command center for all health and medical preparedness, response, and recovery activities
- Authorize the Centers for Disease Control and Prevention (CDC) primary responsibility for tracking an influenza pandemic and managing the operational aspects of the public health response

To this end, the CDC will augment local and state resources for a pandemic response, as available, in the following areas:

- Disease surveillance
- Epidemiological response
- Diagnostic laboratory services and reagents
- Education and communication
- Disease containment and control

State and local officials provide the first line of response with respect to preparing and planning for a pandemic at their own jurisdictional level to:

- Identify and manage local resources to deal with a pandemic.
- Appropriately isolate ill persons and recommend appropriate resources within mass quarantine measures.
- Impose other community containment measures as required.

D. Legal Authority for Isolation/Quarantine and Declaring a State of Emergency

The Federal government has primary responsibility for preventing the introduction of communicable disease from foreign countries into the United States. States and local jurisdictions have primary responsibility for isolation and quarantine within their borders. By statute, the U.S. Department of Health and Human Services (US DHHS) Secretary may accept state and local assistance in the enforcement of federal quarantine and other health regulations and may assist state and local officials in the control of communicable disease. Public health officials at the federal, state, and local levels may seek the assistance of their respective law enforcement counterparts to enforce a public health order related to isolation and quarantine.

On April 1, 2005, by Executive Order, the President of the United States added "Influenza caused by novel or reemergent influenza viruses that are causing, or have the potential to cause, a pandemic" to the list of federally quarantinable communicable diseases under the Public Health Service Act. [42 USC 264(b)]

Local health directors will have jurisdiction for ordering isolation and quarantine. The following statutes detail this authority:

- G.S. 130A-144 - Sets out provisions requiring the investigation and control of communicable diseases and conditions. The NC Division of Public Health adopts specific control measures for communicable diseases that must be followed to prevent the spread of disease. Local Health Directors are charged with enforcing control measures and the statutes require persons to comply with control measures, including Paragraph (f) that state all persons shall comply with control measures, including submission to examination and tests. This statute also requires physicians, medical facilities, and laboratories to provide public health officials access to medical or other records as part of the investigation of a known or suspected communicable disease outbreak or investigation of a known or suspected case.
- S. 130A-145 - Establishes the authority of the State Health Director and Local Health Director to issue isolation and quarantine orders. The isolation and quarantine order is initially binding for 30 days, but can be extended by court order.
- S. 130A-17 - Provides the Secretary of Health and Human Services or the Local Health Director with the authority to enter premises when necessary to enforce

provisions of Chapter 130A or rules adopted by the NC Division of Public Health or Local Board of Health.

- G. S. 130A-18 - Allows the Secretary of Health and Human Services or Local Health Director to pursue injunctive relief in superior court for violation of Chapter 130A or rules adopted by the NC Division of Public Health or Local Board of Health.
- G. S. 130A-19 - Allows Secretary of Health and Human Services or Local Health Director to issue an order to abate a public health nuisance. If the person does not comply, court action to order the abatement can be pursued.
- G. S. 130A-20 - Allows the Secretary of Health and Human Services or Local Health Director to order abatement of an imminent hazard or to enter property and abate the imminent hazard.
- G. S. 130A-25 - Makes a violation of any of the laws in Chapter 130A or rules adopted pursuant to Chapter 130A a misdemeanor. Paragraph (b) details provision for specific sentencing outside of the Structured Sentencing Act for persons violating control measures or isolation or quarantine measures. Persons convicted under this section can be sentenced for up to two years in designated prisons with the ability to properly manage prisoners with communicable diseases.
- G. S. 15A-401(b)(4) - Allows a law enforcement officer to detain a person violating an order restricting the freedom of movement of a person or access to a person issued by the State or Local Health Director at a place designated by the Health Director until the person's initial appearance before a magistrate or judge. This provision is intended to prevent the spread of the disease to others in the courts or jails as part of the normal processing of someone on criminal charges.
- G. S. 15A-534.5 - Allows the judge or magistrate at an initial appearance to deny bail if the judge or magistrate determines that a person arrested for violation of the State of Local Health Director's order restricting their freedom of movement or access to them poses a threat to others. It also allows the judge or magistrate to confine the person to a designated area that will prevent the threat to others.

Isolation and quarantine orders to be used in Greene County will be standardized and are included as *Appendix A (Isolation Order)* and *Appendix B (Quarantine Order)*.

The Chairperson of the Greene County Board of Commissioners will declare a State of Emergency for Greene County and assume direction and control of emergency operations. Greene County Manager will implement the County Emergency Plan by authority of the Chairperson, Greene County Board of Commissioners.

E. Incident Command Structure

All pandemic influenza response activities will be conducted within an incident command structure and consistent with the National Incident Management System (NIMS).

The Greene County Health Department will take the lead role for Greene County for pandemic influenza planning and response. The Health Director will serve as the Incident Commander for the Public Health Incident Command System (ICS) and will also serve as the lead advisor to the Greene County Emergency Operations Center (if opened) on any health issues regarding pandemic influenza. The Greene County Public Health Command Center would likely be activated during Phase 4 of an influenza pandemic, upon authorization from the Greene County Health Director. Activation of the Greene County Public Health Command Center would occur before or in conjunction with the opening of the Greene County Emergency Operations Center, and would also depend on whether disease activity is present in Greene County.

The ICS organization chart for Greene County Health Department is included as *Appendix C*. Currently, the Health Director, Preparedness Coordinator, and Nursing Director are establishing an ICS organization chart specific to pandemic influenza response.

Greene County Government agencies will be integrated and organized in accordance with NIMS. During an influenza pandemic, the Greene County Director of Emergency Services may serve as the Incident Commander. However, the Greene County Health Director will always serve as the lead advisor on any communicable disease health issue within the county. The following statutes apply to response to pandemic influenza through coordination with Emergency Management and Public Health:

- G.S. 166A-5(3)b1 - Requires a special component of the Emergency Operations Plan to be prepared in coordination with the State Health Director that includes specific provisions regarding public health matters, including guidelines for prophylaxis and treatment of exposed and affected persons, allocation of the National Pharmaceutical Stockpile and appropriate conditions for quarantine and isolation to prevent further transmission of disease.
- G.S. 166A-6 - Provides for the Governor's authority to make a Disaster Proclamation and sets out the Governor's powers once a disaster has been declared.
- G.S. 166A-40 - 53 - Establishes the Emergency Management Assistance Compact (EMAC) in conjunction with other states to provide mutual aid and support in managing declared emergencies or disasters.

III. Surveillance

A. Sentinel Surveillance Program

By watching for outbreaks of flu and testing for different strains of flu, public health agencies can help control outbreaks, determine appropriate treatments, and determine the effectiveness of vaccines. North Carolina's General Communicable Disease Control Branch and the State Laboratory of Public Health have continuously participated in the U.S. Influenza Sentinel Physicians Surveillance Network since the 2000-2001 flu season.

Each week, sentinel physicians, university health centers, hospitals/medical centers and public health agencies across the state report influenza-like illness (ILI) to the national Centers for Disease Control and Prevention (CDC) and collect representative samples for virus strain identification. The reports include the total number of patient visits to each practice or agency for that week and the number of those patients with symptoms of influenza-like illness (ILI), broken down into four age groups. For purposes of this surveillance program, the ILI case definition is a fever of 100°F or higher along with a cough or sore throat.

For the 2006-2007 flu season, 74 health providers in 45 counties throughout the state have agreed to participate in the sentinel program and to regularly report influenza-like illness to CDC. This group of sentinels includes a wide variety of physician practice types (pediatrics, family practice and internal medicine) in 19 local health departments, 15 college and university student health centers, 34 private practices, and 6 hospital clinics. In addition to tracking flu cases among North Carolina residents, this system enables North Carolina and CDC to monitor influenza in a very diverse student population that includes students from other states and countries.

Greene County Health Department serves as a sentinel influenza surveillance site for Greene County. The Nursing Director, as well as the Health Director, monitors the sentinel data. Timely identification of circulating influenza virus strains can help detect new strains with pandemic potential and can also help determine whether antiviral drugs might be useful in preventing or treating ILI. The current influenza sentinel surveillance program started on October 1, 2006 and will end on May 19, 2007.

Greene County does not have a hospital. Residents of Greene County typically utilize one of the following hospitals: Lenoir Memorial Hospital in Kinston, Pitt County Memorial Hospital in Greenville, Wayne Memorial Hospital in Goldsboro, and Wilson Memorial Hospital in Wilson. It is known, that cases identified through Pitt County Memorial Hospital will be investigated in conjunction with the Public Health Epidemiologist.

Bill Cleve, Public Health Epidemiologist at Pitt County Memorial Hospital, is part of the statewide effort to strengthen public health preparedness in North Carolina. The Public Health Epidemiologist program is a network of epidemiologists based within 11 of the state's largest medical facilities. The Public Health Epidemiologists:

- serve as an in-hospital liaison to local health departments;
- perform surveillance for community-acquired infections of public health significance (including outbreaks);
- perform surveillance for defined syndromes which may be indicative of a terrorist attack;
- assist with epidemiological investigations; and
- provide education to clinicians within the health system.

On a daily basis, the Public Health Epidemiologist at Pitt County Memorial Hospital conducts active surveillance within the hospital for clusters of syndromes (influenza-like, gastrointestinal, neurological, and fever and rash illness) that may represent a community outbreak. All significant increases in cases are investigated and are reported to local health departments when determined to represent a related cluster. Weekly reports of surveillance findings are sent out to local health directors.

The Pitt County Memorial Hospital-based Public Health Epidemiologist Program serves the following counties - Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Nash, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington, and Wilson.

Greene County Health Department has a multi-disciplinary Epidemiology (Epi) Team that is responsible for surveillance, identification, and response to health threatening events in the community. The Epi Team is responsible for...

- good decision-making, which determines actions involved in providing good control measures;
- meeting on a regular basis to share information;
- analyzing what was done in past investigations; and
- preparing for future activities.

A key component of North Carolina's Public Health Preparedness and Response Plan is the establishment of seven regional public health teams called Public Health Regional Surveillance Teams (PHRSTs). There are seven Regional Surveillance Teams located across North Carolina that serve as resources and consultants to county health departments in their respective regions, enhancing the capacity to protect against and respond to acts of terrorism, disease outbreaks, and natural disasters at the local level. PHRSTs are available to health departments and hospitals 24 hours a day, 7 days a week. Each PHRST is comprised of four core positions: 1) physician epidemiologist, 2) nurse epidemiologist, 3) industrial hygienist, and 4) administrative assistant. In addition to these core positions, there are NC State Laboratory of Public Health personnel based in three regions, Pharmacist positions in three regions, and affiliated Field Veterinarian positions from the NC Department of Agriculture in all seven regions. Greene County Health Department is part of PHRST Region 1 - based out of Greenville, Pitt County.

The North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT) is the early event detection system of the North Carolina Public Health Information Network. The NC Division of Public Health created NC DETECT in 2004

to address the need for early event detection in North Carolina using a variety of secondary data sources. NC DETECT is used to detect disease outbreaks quickly so that public health officials are provided the ability to respond to potential events in a timely fashion. In addition to emergency department data, NC DETECT receives data on a daily basis from the Carolinas Poison Center, Piedmont Wildlife Center, Pre-hospital Medical Information System, and NC State College of Veterinary Medicine Laboratories. These data sources, both human and animal, allow public health officials to have a multi-dimensional view of North Carolina. Currently, no one at Greene County Health Department monitors NC DETECT on a daily basis. The Nurse Epidemiologist with PHRST - Region 1 monitors NC DETECT on a daily basis for our region.

As of March 16, 2007, there are 98 hospitals submitting data on a daily basis to NC DETECT. Each of the counties that surround Greene County has a hospital: Lenoir Memorial Hospital in Kinston, Pitt County Memorial Hospital in Greenville, Wayne Memorial Hospital in Goldsboro, and Wilson Memorial Hospital in Wilson. All four of these hospitals are submitting data to NC DETECT.

NC DETECT was formerly known as the North Carolina Bioterrorism and Emerging Infection Prevention System. The name was changed to reflect that the system could be used for a myriad of public health surveillance needs, such as influenza, varicella and post-natural disaster surveillance, in addition to emerging infection detection.

B. Reporting Cases of Novel Influenza Viruses to Local Health Department

Reporting of novel influenza viruses by healthcare providers and laboratories to the local health department will follow procedures set by North Carolina State Law 10A NCAC 41A.0101 Reportable Diseases and Conditions, which can be found at www.epi.state.nc.us/epi/gcdc/pdf/10ANCAC41A.pdf and 10A NCAC 41A.0102 Method of Reporting (*Appendix D*). All cases of suspected novel influenza will be reported to the Greene County Health Department immediately by phone. Novel influenza was added to the list of reportable diseases in North Carolina in June 2006.

If a local healthcare provider suspects novel influenza, during any pandemic phase, they are to report it immediately to the Greene County Health Department.

- Linda Sewall, Health Director
 - 252.747.8183 (work)
 - 252.526.8271 (cell)

- Chris Miller, Nursing Director
 - 252.747.8183 (work)

- Charlotte Sasser, Communicable Disease Nurse
 - 252.747.8183 (work)

For cases that need to be reported outside of normal business hours (Monday - Friday, 8:00 a.m. - 5:00 p.m.), local healthcare providers should contact Linda Sewall, Health Director at (252) 526-8271.

C. Reporting Cases of Novel Influenza Viruses to State

Reporting of novel influenza viruses by the local health department to the state will follow procedures set by North Carolina State Law 10A NCAC 41A.0103 Duties of Local Health Director: Report Communicable Diseases (*Appendix E*). Upon notification of a suspected novel influenza case in Greene County, the Greene County Health Director will gather necessary information and immediately contact the General Communicable Disease Control Branch - Epidemiology Section - of the North Carolina Division of Public Health via the 24/7 phone number (919) 733-3419. An epidemiologist is available 24/7 for consultation regarding testing and management of patients with suspected novel influenza virus infections. Upon guidance from the General Communicable Disease Control Branch, the Greene County Health Director will post the case on the NC Health Alert Network (HAN) for notification to health departments and hospitals throughout the state.

D. Investigating Cases of Novel Influenza Viruses

Investigation of a novel influenza case will follow procedures set by North Carolina State Law 10A NCAC 41A.0103 Duties of Local Health Director: Report Communicable Diseases (*Appendix E*). Early in the pandemic, Greene County Health Department will investigate all suspect cases of novel influenza, but once the pandemic is widespread, NC Division of Public Health will probably advise local health departments to stop doing case investigations. The Greene County Health Director and Nursing Director will work with the reporting entity to verify the diagnosis, collect specimens for testing at the State Lab (and/or Regional Lab in Greenville), determine any necessary control measures, and contact persons potentially exposed to the novel influenza case. Current case report forms (*Appendix F - Novel Influenza Screening Form*) will be completed as quickly as possible and sent to the General Communicable Disease Control Branch - Epidemiology Section - of the North Carolina Division of Public Health.

E. Case Definition

Testing for avian influenza A (H5N1) should be considered on a case-by-case basis in consultation with state and local health departments for hospitalized or ambulatory patients with: documented temperature of $>100.4^{\circ}\text{F}$ ($>38^{\circ}\text{C}$); one or more of the following: cough, sore throat, or shortness of breath; history of contact with poultry (i.e. visited a poultry farm, a household raising poultry, or a bird market); or a known or suspected human case of influenza A (H5N1) in a H5N1 affected country within 10 days prior to onset of symptoms. The case definition will differ as we learn more about the epidemiology of H5N1 or if a different subtype causes the pandemic. The revised version of the NC Pandemic Influenza Plan includes an algorithm that can be used by healthcare providers to screen for novel influenza virus (*Appendix G*).

F. Plans for Counting Cases and Deaths

During the Pandemic Alert Period (phases 3, 4, and 5), all cases and deaths from a novel influenza virus will be reported immediately to the Greene County Health Department via the methods described in the earlier section - Reporting Cases of Novel Influenza Viruses to Local Health Department. During the Pandemic Period (phase 6), a daily log of cases (classified as suspect, probable, or confirmed - depending on current case definitions), a daily count of hospitalized pandemic influenza cases, and deaths due to pandemic influenza will be sent to the Health Department via fax or email. Information will be received from healthcare providers, hospitals, and funeral homes. The Health Department will be responsible for gathering countywide numbers of cases and deaths to report to the State Health Department.

G. Pandemic Phase Activities

1. Interpandemic Period - Phases 1 and 2
 - Health Department will maintain participation in the Sentinel Surveillance Program
 - Reportable communicable diseases and conditions are reported to the Health Department either by phone or disease report cards
 - Health Director receives weekly reports from the Pitt County Memorial Hospital-based Public Health Epidemiologist
 - Monitor the NC Health Alert Network (HAN)
 - Investigate suspected influenza outbreaks (i.e. schools, daycares, nursing homes)
 - Health Department will disseminate clinical information regarding novel viruses based upon information from WHO, CDC, and NC Division of Public Health
 - Greene County Schools will contact the Health Department about absenteeism related to influenza
2. Pandemic Alert Period - Phase 3
 - Nursing Director and/or Health Director will meet with local healthcare providers to emphasize how and why to report novel influenza cases to the Health Department
 - Provide local healthcare providers with a copy of the algorithm that can be used to screen for novel influenza virus
 - Communicate with NC Cooperative Extension - Greene County and Department of Agriculture regarding the sharing of information related to avian influenza monitoring in animal populations
 - Epi Team will receive training that is pertinent to pandemic influenza
 - Enhance surveillance among travelers/refugees from geographic areas in which novel influenza viruses have been isolated (*Appendix H*)
 - If a novel influenza case is reported, the Health Department will work with the reporting entity to verify the diagnosis, collect specimens for testing at the State Lab, determine any necessary control measures, and contact persons potentially exposed to the novel influenza case

3. Pandemic Alert Period - Phases 4 and 5
 - Educate Health Department Staff and other healthcare providers on changes in pandemic phase and reporting procedures
 - Monitor absenteeism in schools and daycares related to influenza
 - Active surveillance for ILI (influenza-like illness) in travelers returning to Greene County from areas where novel influenza virus infections have been confirmed in humans
 - All cases and deaths from a novel influenza virus will be reported immediately to the Greene County Health Department
4. Pandemic Period - Phase 6
 - The number of pandemic influenza cases and deaths for Greene County will be compiled by the Health Department
 - Health Department will utilize NC DETECT to monitor ILI in hospital emergency departments
 - NC Division of Public Health will likely recommend that local health departments stop conducting investigations of influenza cases once the pandemic is considered widespread

IV. Lab Diagnostics

A. NC State Laboratory of Public Health Pandemic Influenza Preparedness and Response Plan

The Greene County Health Department and other local healthcare providers will follow the North Carolina State Laboratory of Public Health Pandemic Influenza Preparedness and Response Plan (*Appendix I*). The goal of this plan is to be prepared and to ensure a coordinated, timely response to requests for influenza laboratory testing. Upon contacting the Greene County Health Department in regards to a suspected case of novel influenza, the local healthcare provider will be provided with a copy of the State Laboratory Plan.

Key Points to mention:

- PCR testing for novel influenza virus will only be done at the State Lab and one of the three Regional Labs (there is a Regional Lab located in Greenville - PHRST Region 1). Therefore, it is possible that local healthcare providers in our region will first send specimens to the Regional Lab before, or in addition to, sending them to the State Lab.
- Laboratories should not try to perform viral culture on specimens of suspected novel influenza cases.
- Commercial rapid antigen testing is less sensitive for detecting most influenza viruses and should not be relied upon for diagnosis of novel or avian influenza viral infection.

B. Laboratory Submission Form NC DHHS 3431

The Laboratory Submission Form NC DHHS 3431 (*Appendix J*) will be used for all novel influenza specimens collected. The use of this standard and already in-use form will ensure a coordinated, timely response to requests for influenza laboratory testing. Upon contacting the Greene County Health Department in regards to a suspected case of novel influenza, the local healthcare provider will be provided with a copy of the Laboratory Submission Form.

C. Pandemic Phase Activities

1. Interpandemic Period - Phases 1 and 2
 - Health Department Staff involved in communicable disease surveillance and investigation will become familiar with the North Carolina State Laboratory of Public Health Pandemic Influenza Preparedness and Response Plan
2. Pandemic Alert Period - Phase 3
 - Provide local healthcare providers with guidance and copies of the North Carolina State Laboratory of Public Health Pandemic Influenza Preparedness and Response Plan
 - Inform local healthcare providers of the testing procedures for novel influenza cases and provide them with guidance and copies of the Laboratory Submission Form NC DHHS 3431
3. Pandemic Alert Period - Phases 4 and 5
 - Suspected cases of novel influenza will have specimens collected, shipped and tested according to the North Carolina State Laboratory of Public Health Pandemic Influenza Preparedness and Response Plan
4. Pandemic Period - Phase 6
 - Testing for the pandemic influenza strain will not continue for all suspected cases. Periodic testing will be conducted and communicated to healthcare providers for the purpose of drug resistance testing.

V. Vaccine

A. Priority Groups

Vaccination is the primary control measure to prevent influenza. It is assumed that vaccine against a pandemic strain of influenza will not be available for four to six months after the start of a pandemic. When vaccine does become available, the demand will exceed the supply for some time. Because of this, the limited supply needs to be prioritized for distribution and administration.

Two federal advisory committees, the Advisory Committee on Immunization Practices (ACIP) and the National Vaccine Advisory Committee (NVAC), provided recommendations to the Department of Health and Human Services on the use of vaccines in an influenza pandemic. These guidelines may be adopted by the federal

government and are included as (*Appendix K*). Local health departments will have some flexibility in defining priority groups and sub-prioritizing within them.

Greene County will follow the vaccine priority group guidelines when officially distributed by the federal health agencies. CDC recommendation has force law in North Carolina. As described in the communicable disease rules for public health, application of the CDC's current recommendations about priority groups for influenza vaccination is pursuant to Rule 10A NCAC 41A.0201: "...guidelines and recommended actions published by the Centers for Disease Control and Prevention shall supercede those contained in the Control of Communicable Disease Manual and are likewise incorporated by reference..." (*Appendix L*).

B. Estimation of Doses Needed

Influenza Vaccine Estimations Worksheet

Essential Personnel for Pandemic Response	Tier	Population in Greene County	Vaccine Estimations	
			Single-dose	Multi-dose
Public Health & Healthcare Personnel				
Vaccine/antiviral manufacturers & essential support	1A	0		
Healthcare workers with direct patient contact <u>and</u> essential support workers to maintain healthcare services	1A	200		20
Public health workers with direct patient contact (including vaccinators)	1A	10		1
Public health emergency response workers <u>critical</u> to pandemic response	1D	5		0.5
Other public health emergency responders	2B	15		1.5
Public Safety Personnel				
Sheriff Deputies	2B	25		2.5
Firefighters	2B	250		25
911 dispatchers	2B	10		1
Correctional facility staff	2B	<i>working on this number</i>		
Essential Community Service Personnel				
Key government leaders	1D	10		1
Essential utility workers (power, water, sewage)	2B	15		1.5
Transportation workers	2B	10		1
Essential telecommunications/IT	2B	5		0.5
Other key government health decision-makers	3	10		1
Funeral directors/embalmers	3	10		1
Totals		575		57.5 → 58

Groups at High Risk of Influenza Complications	Tier	Population in Greene County	Vaccine Estimations	
			Single-dose	Multi-dose
Persons 65 years and older				
1 or more high-risk medical conditions	1B	970	970	
Healthy (no high-risk medical conditions)	2A	1450		145
Persons 6 months to 64 years				
2 or more high-risk medical conditions	1B	300	300	
History of hospitalization for influenza, pneumonia or other influenza high-risk condition in the past year	1B	10	10	
Pregnant women	1C	316	316	
Household contacts of severely immunocompromised persons	1C	200		20
Household contacts of children <6 months old	1C	300		30
Healthy children 6-23 months	2A	700		70
1 high-risk medical condition	2A	500		50
Totals		4,746	1,596	315

C. Storage and Distribution

Storage and distribution of pandemic influenza vaccine will be in accordance with the Greene County Strategic National Stockpile (SNS) Plan. All vaccine will be administered as 10 dose multi-packs (if available) except for the following groups, which will be administered single-dose vaccine due to their mobility and risk status: persons 65 years and older with one or more high-risk medical conditions; persons 6 months to 64 years with 2 or more high-risk medical conditions; persons 6 months to 64 years with a history of hospitalization for influenza, pneumonia or other influenza high-risk condition in the past year; and pregnant women. Mass vaccination clinics run by the health department will follow the SNS Plan as well as be based on seasonal influenza mass vaccine clinics.

D. Pandemic Phase Activities

1. Interpandemic Period - Phases 1 and 2
 - Review and exercise county SNS plan
 - Determine what type of POD will be used (i.e. Traditional, Super, or Drive-thru)

- Monitor pandemic influenza vaccine information provided by CDC
 - Encourage pneumococcal vaccination of high-risk populations
2. Pandemic Alert Period - Phase 3
 - Estimate number of people in priority groups for pandemic influenza vaccine administration
 - Utilize immunization registry to monitor adverse events related to the pandemic influenza vaccine
 - Identify sources of additional vaccinators, if needed for surge
 3. Pandemic Alert Period - Phases 4 and 5
 - Submit forms to the NC Division of Public Health Immunization Branch with estimates for priority groups to receive pandemic influenza vaccine
 - Establish communication with Immunization Branch regarding vaccine acquisition
 - Review plans for mass vaccination clinic
 - Confirm location to be used for mass vaccination clinic
 4. Pandemic Period - Phase 6
 - Determine expected timeline for vaccine availability
 - Prepare for mass vaccination clinic - set dates, times, and location; and determine which individuals will be vaccinated and how to contact them
 - Administer pandemic influenza vaccine as it becomes available
 - Track doses of pandemic influenza vaccine administered

VI. Antivirals

A. Priority Groups

The antiviral armamentarium for chemoprophylaxis and treatment of influenza includes two main classes of antiviral agents, the adamantanes (amantadine and rimantadine) and the neuraminidase inhibitors (zanamivir and oseltamivir). However, the Centers for Disease Control and Prevention (CDC) recommended against the use of the adamantanes for treatment or prophylaxis during the 2005-06 influenza season because of resistance. This interim recommendation remains in effect until susceptibility can be re-established. The adamantanes have activity against only influenza A, while the neuraminidase inhibitors have activity against both influenza A and B. Recent evidence indicates that amantadine has no, or only limited, activity against the H5N1 avian influenza A strains circulating in Asia. While the adamantanes are much less expensive and in greater supply compared to the neuraminidase inhibitors, current evidence suggests that the neuraminidase inhibitor oseltamivir is the best antiviral to stockpile for chemoprophylaxis and treatment during the next influenza pandemic. However, both adamantanes and neuraminidase inhibitors may play a role in chemoprophylaxis and treatment depending on the following factors:

- Susceptibility of the pandemic influenza strain to currently available antiviral medications
- Prophylactic and therapeutic efficacy of the respective antiviral agents against the strain

- Number of doses of the respective antiviral agents available via the public and private sectors
- Size of the target populations recommended to receive chemoprophylaxis or treatment
- Cost and reimbursement

The main goals of chemoprophylaxis and treatment are to reduce the human influenza infection rate and to reduce human morbidity and mortality associated with the pandemic strain. Reduction of the infection rate via chemoprophylaxis should be the last preventive option and should follow implementation of other recommended or indicated preventive efforts (e.g., restrictions on travel and communal events, isolation of ill persons, quarantine of exposed persons, implementation of infection control measures such as the use of masks and diligent hand washing, and vaccination).

If sufficient stockpiles of antivirals exist at the time the pandemic reaches the United States, chemoprophylaxis efforts in North Carolina should prioritize those persons deemed at high risk of exposure and indispensable to carrying out public health, clinical and public safety-related functions during the early stages of the pandemic while vaccine is being produced and vaccination clinics are being established and placed in operation.

If there are insufficient stockpiles of antiviral agents for chemoprophylaxis, treatment should be directed toward those same groups and also target groups at increased risk of morbidity and mortality, as prioritized by the CDC. Antiviral drug priority group recommendations have been drafted by the National Vaccine Advisory Committee (NVAC) and are outlined in the US DHHS Pandemic Influenza Plan, released in November 2005 (*Appendix M*).

The early epidemiology of disease associated with the next pandemic strain may identify high risk groups that are somewhat different from those identified during the prior pandemics and outbreaks due to novel influenza viruses. However, our knowledge of seasonal influenza indicates that infants and children 6 to 23 months, adults over age 65, and adults and children with malignancy, cardiopulmonary disease (such as asthma and other chronic lung diseases, congenital heart disease, congestive heart failure) and chronic renal disease (including those with renal failure on dialysis) are those primarily at risk for increased morbidity and mortality.

Greene County will follow the antiviral priority group guidelines when officially distributed by the federal health agencies and, as antivirals are available for use.

Key Point to mention:

- At this time, the first 5 priority groups are for treatment, rather than prophylaxis. In a situation where the supplies of antivirals are limited and therefore are directed only at treatment, the health department will probably not have much, if any, of a role in dispensing antivirals since this will happen through hospitals and private providers. However, in the event of sufficient antiviral supplies, the health department will likely play a role in dispensing antivirals.

B. Estimation of Doses Needed

Antiviral Medication Estimations Worksheet

Antiviral Priority Group	Population in Greene County	# of courses needed
Group 1 (Treatment)		
Patients admitted to the hospital	82	82
Group 2 (Treatment)		
Healthcare workers with direct patient contact	180	180
EMS workers	175	175
Group 3 (Treatment)		
Immunocompromised persons	150	150
Pregnant women	316	316
Group 4 (Treatment)		
Pandemic health responders	25	25
Public safety workers	300	300
Key government decision makers	10	10
Group 5 (Treatment)		
Young children 12-23 months	472	472
Persons 65 and older	2,420	2,420
Persons with underlying medical conditions	1,300	1,300
Group 6 (Post exposure prophylaxis)		
Outbreak response in nursing homes	N/A	N/A
Group 7 (Prophylaxis)		
Healthcare workers in EDs	0	0
Healthcare workers in ICUs	0	0
Healthcare workers in dialysis centers	9	36
EMS providers	175	700
Group 8 (Treatment)		
Pandemic societal responders	60	60
Healthcare workers without direct patient contact	150	150
Totals	5,824	6,376

C. Storage and Distribution

Storage and distribution of antivirals, if available and effective, will be in accordance with the Greene County Strategic National Stockpile (SNS) Plan. At this time, the first 5 priority groups are for treatment, rather than prophylaxis. In a situation where the supplies of antivirals are limited and therefore are directed only at treatment, the health department will probably not have much, if any, of a role in dispensing antivirals since this will happen through hospitals and private providers. However, in the event of sufficient antiviral supplies, the health department will likely play a role in dispensing antivirals. Treatment is defined as one course (10 capsules); post-exposure prophylaxis also equals one course (10 capsules); and prophylaxis is assumed to require four courses (40 capsules), though more may be required if pandemic activity lasts for a longer period of time in the community. Antivirals may be distributed at mass distribution clinics, but may also be distributed on a more individualized basis to certain high-risk groups. Mass distribution clinics run by the health department will follow the SNS Plan.

D. Private Sector Supplies

There are no private stockpiles of antivirals in Greene County at this time. Local proprietors do not wish to stockpile antivirals for fear of not being reimbursed for their investment.

E. Pandemic Phase Activities

1. Interpandemic Period - Phases 1 and 2
 - Review and exercise county SNS plan
 - Determine possible mass antiviral distribution site
2. Pandemic Alert Period - Phase 3
 - Estimate number of people in priority groups for pandemic influenza antiviral treatment and prophylaxis administration
 - Receive guidance from NC Division of Public Health regarding the CDC's most current recommendations on daily dosage and duration of therapy of antivirals for treatment and chemoprophylaxis
 - Continue to maintain immunization registry to track antiviral supplies, distribution, use, and adverse event tracking
3. Pandemic Alert Period - Phases 4 and 5
 - Establish communication with NC Division of Public Health regarding antiviral acquisition
 - Review priority groups
 - Review SNS plan for mass distribution clinic
 - Confirm location to be used for mass distribution clinic
4. Pandemic Period - Phase 6
 - Determine expected timeline for antiviral availability
 - Prepare for mass distribution clinic - set dates, times, and location
 - Ensure readiness for receipt, transport, storage, security, tracking and delivery/distribution of antivirals

VII. Disease Containment

A. Use of Isolation and Quarantine

Determinations for the use of isolation and quarantine will follow the Department of Health and Human Services and Centers for Disease Control and Prevention's *Interim Pre-pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States*.

Decisions on whether to utilize isolation and quarantine will depend on the observed severity of the pandemic event, its impact on specific subpopulations, the expected benefit of the interventions, the feasibility of success in modern society, the direct and indirect costs, and the consequences on critical infrastructure, healthcare delivery, and society. Implementation of quarantine and isolation needs to be early enough to preclude the initial steep upslope in case numbers and long enough to cover the peak of the anticipated epidemic curve while avoiding intervention fatigue.

Isolation of ill individuals will reduce the onward transmission of disease after such individuals are identified. Isolation of all persons with confirmed or probable pandemic influenza may occur in the home or healthcare setting, depending on the severity of an individual's illness and/or the current capacity of the healthcare infrastructure. Isolation will be suggested for all stages of a pandemic influenza event regardless of the severity of the event. Isolation may be mandatory during WHO Pandemic Phases 1-5, however would probably become voluntary during WHO Pandemic Phase 6 due to the widespread infection and the assumed inability of the public health system to track all pandemic influenza cases.

The goal of isolation is to reduce transmission by reducing contact between persons who are ill and those who are not. Ill individuals not requiring hospitalization would be requested to remain at home voluntarily for the infectious period, approximately 7-10 days after symptom onset. This would usually be in their homes, but could be in a home of a friend or relative. Voluntary isolation of ill children and adults at home is predicated on the assumption that many ill individuals who are not critically ill can, and will need to be cared for in the home.

Quarantine of members of households with ill persons will facilitate the termination of transmission chains. Voluntary home quarantine of members of households with confirmed or probable influenza case(s) may also occur. Quarantine will be suggested for all stages of a pandemic influenza event, but may not be recommended if the pandemic event is unusually mild. Quarantine may be mandatory during WHO Pandemic Phases 1-5, however would probably become voluntary during WHO Pandemic Phase 6 due to the widespread infection and the assumed inability of the public health system to track all pandemic influenza cases.

The goal of quarantine is to reduce community transmission from members of households in which there is a person ill with pandemic influenza. Members of households in which

there is an ill person may be at increased risk of becoming infected with a pandemic influenza virus. As determined on the basis of known characteristics of influenza, a significant proportion of these persons may shed virus and present a risk of infecting others in the community despite having asymptomatic or only minimally symptomatic illness that is not recognized as pandemic influenza disease. Thus, members of households with ill individuals may be recommended to stay home for an incubation period, 7 days (voluntary quarantine) following the time of symptom onset in the household member. If other family members become ill during this period, the recommendation is to extend the time of voluntary home quarantine for another incubation period, 7 days from the time that the last family member becomes ill.

Upon suspicion or confirmation of an individual with novel influenza virus infection, mandatory isolation and quarantine may be facilitated through the order of the Greene County Health Director. Draft orders will be used and the person(s) affected will be notified and presented with the order. The Sheriff's Department may also be notified in order to enforce the mandatory isolation and quarantine order.

If isolation and quarantine becomes a voluntary action, the community will be advised as to how many days to remain at home, when to seek care, and where to call for information.

B. Monitoring and Caring for Isolation and Quarantine

Requirements for success of isolation include prompt recognition of illness; appropriate use of hygiene and infection control practices in the home setting; measures to promote voluntary compliance; commitment of employers to support the recommendation that ill employees stay home; and support for the financial, social, physical, and mental health needs of patients and caregivers.

Requirements for success of quarantine include the prompt and accurate identification of an ill person in the household; voluntary compliance with quarantine by household members; commitment of employers to support the recommendation that employees living in a household with an ill individual stay home; the ability to provide needed support to households that are under voluntary quarantine; and guidance for infection control in the home. Additionally, adherence to ethical principals in use of quarantine during pandemics, along with proactive anti-stigma measures should be assured.

In addition, ill individuals and their household members need clear, concise information about how to safely care for an ill individual in the home, and when and where to seek medical care. Informational messages about how to safely care for persons at home, how to minimize disease transmission in the household, and how and when to seek medical care will be broadcast on television and radio, as well as through newsprint.

During the World Health Organization's Pandemic Phases 1-5, persons under mandatory isolation and quarantine will be contacted by the Greene County Health Department on a daily basis to check on illness and possible needs. During Phase 6 of a pandemic

influenza and/or during voluntary isolation and quarantine, quite the opposite will be in effect -- persons will not be contacted on a daily basis to check on illness and possible needs.

C. Needs of Vulnerable Populations

Vulnerable populations for a pandemic influenza event may extend beyond the special medical needs and “sheltered in” persons identified during many disasters. The effects of a pandemic influenza event that extend beyond providing healthcare, such as the effects of social distancing measures, can make certain segments of the community vulnerable and will need to be taken into consideration for certain populations.

Special needs and vulnerable populations can be identified as, but not limited to:

- Senior citizens and frail elderly
- Children
- Persons who live alone
- Physically disabled
- Blind and visually impaired
- Deaf and hard of hearing
- Spanish-speaking (Hispanic)
- Homebound
- Impoverished
- Mentally disabled
- Incarcerated
- Residents of nursing homes/assisted living facilities
- Immuno-compromised persons

Addressing the needs for all special needs and vulnerable populations in Greene County will require additional time and planning on the parts of many agencies and organizations in the county. Greene County has already begun educating its county employees and the general population about preparing for a pandemic influenza. Additionally, Greene County Department of Social Services maintains a registry for persons with special needs and the Health Department has obtained numerous pandemic influenza preparedness educational materials in Spanish for distribution to the Hispanic community.

Special Needs Registry - Greene County Department of Social Services maintains a registry for persons with special needs. The special needs registry is a database containing information about individuals in Greene County with special needs who may require assistance in the event of a disaster. If there is a disaster, those on the registry will be contacted and given information about how to prepare for or respond to the disaster, given information regarding facilities or shelters, and to check on their well being. The information may also be used to assist emergency personnel and volunteers in providing assistance. Participation in the Special Needs registry is voluntary. As of March 20, 2007, there were 31 persons listed on the special needs registry.

Spanish-speaking (Hispanic) population - It is estimated that 8.0% of Greene County's population is Hispanic. Due to language and cultural barriers, this population has been identified as a vulnerable population for a pandemic influenza event in Greene County. Greene County Health Department has obtained numerous pandemic influenza preparedness educational materials in Spanish for distribution to the Hispanic community.

Greene County Health Department has recently learned of a new opportunity in which we can reach out to the Hispanic population. *Viva Greenville* is a Hispanic newspaper in Eastern North Carolina, developed by Hispanics and delivered monthly to over 100 locations in Eastern North Carolina. This newspaper can provide pandemic influenza news and information to the Hispanic population.

Senior Citizens - It is estimated that 12.0% of Greene County's population is 65 and over. Pre-pandemic planning by Greene County will include working with the Greene County Council on Aging (Senior Center) and faith-based organizations to prepare for assisting with this vulnerable population during a pandemic event. It is assumed that many seniors live alone and it is realized that educating them in regards to planning for their possible medical needs during a pandemic event needs to happen.

Children - It is estimated that 27.0% of Greene County's population is 19 and under. Pre-pandemic planning by Greene County will include working with Greene County Schools and Lenoir/Greene Partnership for Children (also known as Smart Start) to facilitate communication and planning to address childcare for this population during times of disease containment such as isolation, quarantine, and social distancing.

D. Personal Protective Equipment

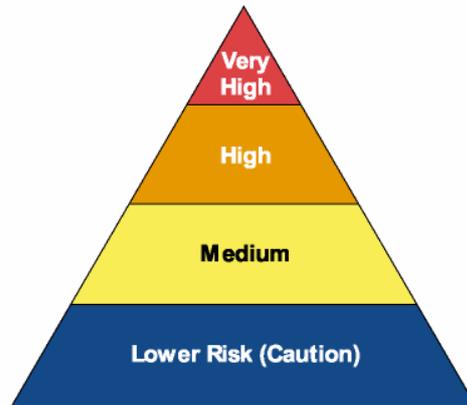
Employee risks of occupational exposure to influenza during a pandemic may vary from very high, high, medium, or lower (caution) risk. The level of risk depends in part on whether or not jobs require close proximity to people potentially infected with the pandemic influenza virus, or whether they are required to have either repeated or extended contact with known or suspected sources of pandemic influenza virus.

Employers of critical infrastructure and key resource employees (such as law enforcement, emergency response, or public utility employees) may consider upgrading protective measures for these employees beyond what would be suggested by their exposure risk due to the necessity of such services for the functioning of society as well as the potential difficulties in replacing them during a pandemic (for example, due to extensive training or licensing requirements).

To help employers determine appropriate work practices and precautions, the Occupational Safety and Health Administration (OSHA) has divided workplaces and work operations into four risk zones, according to the likelihood of employees' occupational exposure to pandemic influenza. The vast majority of American

workplaces are likely to be in the medium exposure risk or lower exposure risk (caution) groups.

Occupational Risk Pyramid for Pandemic Influenza



Very High Exposure Risk:

- Healthcare employees (for example, doctors, nurses, dentists) performing aerosol-generating procedures on known or suspected pandemic patients (for example, cough induction procedures, bronchoscopies, some dental procedures, or invasive specimen collection).
- Healthcare or laboratory personnel collecting or handling specimens from known or suspected pandemic patients (for example, manipulating cultures from known or suspected pandemic influenza patients).

High Exposure Risk:

- Healthcare delivery and support staff exposed to known or suspected pandemic patients (for example, doctors, nurses, and other hospital staff that must enter patients' rooms).
- Medical transport of known or suspected pandemic patients in enclosed vehicles (for example, emergency medical technicians).
- Performing autopsies on known or suspected pandemic patients (for example, morgue and mortuary employees).

Medium Exposure Risk:

- Employees with high-frequency contact with the general population (such as schools, high population density work environments, and some high volume retail).

Lower Exposure Risk (Caution):

- Employees who have minimal occupational contact with the general public and other coworkers (for example, office employees).

Personal Protective Equipment (PPE)

While administrative and engineering controls and proper work practices are considered to be more effective in minimizing exposure to the influenza virus, the use of PPE may also be indicated during certain exposures. If used correctly, PPE can help prevent some exposures; however, they should not take the place of other prevention interventions, such as engineering controls, cough etiquette, and hand hygiene. Examples of personal protective equipment are gloves, goggles, face shields, surgical masks, and respirators (for example, N95). It is important that personal protective equipment be:

- Selected based upon the hazard to the employee;
- Properly fitted and some must be periodically refitted (e.g., respirators);
- Conscientiously and properly worn;
- Regularly maintained and replaced, as necessary;
- Properly removed and disposed of to avoid contamination of self, others or the environment.

Employers are obligated to provide their employees with protective gear needed to keep them safe while performing their jobs. The types of PPE recommended for pandemic influenza will be based on the risk of contracting influenza while working and the availability of PPE.

Workplaces Classified at Very High or High Exposure Risk for Pandemic Influenza - PPE

Those who work closely with (either in contact with or within 6 feet) people known or suspected to be infected with pandemic influenza should wear:

- Respiratory protection for protection against small droplets from talking, coughing or sneezing and also from small airborne particles of infectious material.
 - N95 or higher rated filter for most situations.
 - Supplied air respirator (SAR) or powered air purifying respirator (PAPR) for certain high-risk medical or dental procedures likely to generate bioaerosols.
 - Use a surgical respirator when both respiratory protection and resistance to blood and body fluids is necessary.
- Face shields may also be worn on top of a respirator to prevent bulk contamination of the respirator. Certain respirator designs with forward protrusions (duckbill style) may be difficult to properly wear under a face shield. Ensure that the face shield does not prevent airflow through the respirator.
- Medical/surgical gowns or other disposable/de-contaminable protective clothing.
- Gloves to reduce transfer of infectious material from one patient to another.
- Eye protection if splashes are anticipated.

The appropriate form of respirator will depend on the type of exposure and on the transmission pattern of the particular strain of influenza.

Educate and train employees about the protective clothing and equipment appropriate to their current duties and the duties which they may be asked to assume when others are absent. Education and training material should be easy to understand and available in the appropriate language and literacy level for all employees. Employees need to be fit tested and trained in the proper use and care of a respirator. It is also important to train employees to put on (don) and take off (doff) PPE in the proper order to avoid inadvertent self-contamination. Employees who dispose of PPE and other infectious waste must also be trained and provided with appropriate PPE.

During a pandemic, recommendations for PPE use in particular occupations may change depending on geographic location, updated risk assessments for particular employees, and information on PPE effectiveness in preventing the spread of influenza.

Workplaces Classified at Medium Exposure Risk for Pandemic Influenza - PPE

Employees who have high-frequency, close contact with the general population that cannot be eliminated using administrative or engineering controls, and where contact with symptomatic ill persons is not expected should use personal protective equipment to prevent sprays of potentially infected liquid droplets (from talking, coughing, or sneezing) from contacting their nose or mouth. A surgical mask will provide such barrier protection. Use of a respirator may be considered if there is an expectation of close contact with persons who have symptomatic influenza infection or if employers choose to provide protection against a risk of airborne transmission. It should be noted that wearing a respirator might be physically burdensome to employees, particularly when the use of PPE is not common practice for the work task. In the event of a shortage of surgical masks, a reusable face shield that can be decontaminated may be an acceptable method of protecting against droplet transmission of an infectious disease but will not protect against airborne transmission, to the extent that disease may spread in that manner.

Eye protection generally is not recommended to prevent influenza infection although there are limited examples where strains of influenza have caused eye infection (conjunctivitis). At the time of a pandemic, health officials will assess whether risk of conjunctival infection or transmission exists for the specific pandemic viral strain.

Employees should wash hands frequently with soap or sanitizing solutions to prevent hands from transferring potentially infectious material from surfaces to their mouths or noses. While employers and employees may choose to wear gloves, the exposure of concern is touching the mouth and nose with a contaminated hand and not exposure to the virus through non-intact skin (for example, cuts or scrapes). While the use of gloves may make employees more aware of potential hand contamination, there is no difference between intentional or unintentional touching of the mouth, nose or eyes with either a contaminated glove or a contaminated hand. If an employee does wear gloves, they should always wash their hands with soap or sanitizing solution immediately after removal to ensure that they did not contaminate their hand(s) while removing them.

When selecting PPE, employers should consider factors such as function, fit, ability to be decontaminated, disposal, and cost. Sometimes, when a piece of PPE will have to be used repeatedly for a long period of time, a more expensive and durable piece of PPE may be less expensive in the long run than a disposable piece of PPE. For example, in the event of a pandemic, there may be shortages of surgical masks. A reusable face shield that can be decontaminated may become the preferred method of protecting against droplet transmission in some workplaces. It should be noted that barrier protection, such as a surgical mask or face shield, will protect against droplet transmission of an infectious disease but will not protect against airborne transmission, to the extent that the disease may be spread in that manner. Each employer should select the combination of PPE that protects employees in their particular workplace.

Educate and train employees about the protective clothing and equipment appropriate to their current duties and the duties which they may be asked to assume when others are absent. Employees may need to be fit tested and trained in the proper use and care of a respirator. Also, it is important to train employees to put on (don) and take off (doff) PPE in the proper order to avoid inadvertent self-contamination. During a pandemic, recommendations for PPE use in particular occupations may change, depending on geographic proximity to active cases, updated risk assessments for particular employees, and information on PPE effectiveness in preventing the spread of influenza.

N95

An N95 respirator is a type of particulate respirator. Particulate respirators protect by filtering particles out of the air as you breathe. So, what does N95 stand for?

N = Not resistant to oil

95 = Respirator filters that remove at least 95 percent of airborne particles during “worst case” testing using the “most-penetrating” size of particle are given a 95 rating.

Each Greene County Health Department employee has been properly fit tested for a N95 respirator. Health department employees keep their N95 respirator in their office.

Surgical Mask

Surgical masks are used as a physical barrier to protect employees from hazards such as splashes of large droplets of blood or body fluids. Surgical masks also prevent contamination by trapping large particles of body fluids that may contain bacteria or viruses when they are expelled by the wearer, thus protecting other people against infection from the person wearing the surgical mask.

Greene County Health Department currently has a case (quantity = 1,000) of surgical masks on-hand that will be placed on sick people to limit the spread of infectious respiratory secretions to others.

E. Social Distancing Measures

It is highly unlikely that the most effective tool for mitigating a pandemic (i.e. a well-matched pandemic strain vaccine) will be available when a pandemic begins. This means that we must be prepared to face the first wave of the next pandemic without vaccine and potentially without sufficient quantities of influenza antiviral medications. In addition, it is not known if influenza antiviral medications will be effective against a future pandemic strain. During a pandemic, decisions about how to protect the public before an effective vaccine is available need to be based on scientific data, ethical considerations, consideration of the public's perspective of the protective measures and their impact on society, and common sense.

Two major forms of non-pharmaceutical interventions that could prove extremely important to mitigating the effects of a pandemic influenza event are:

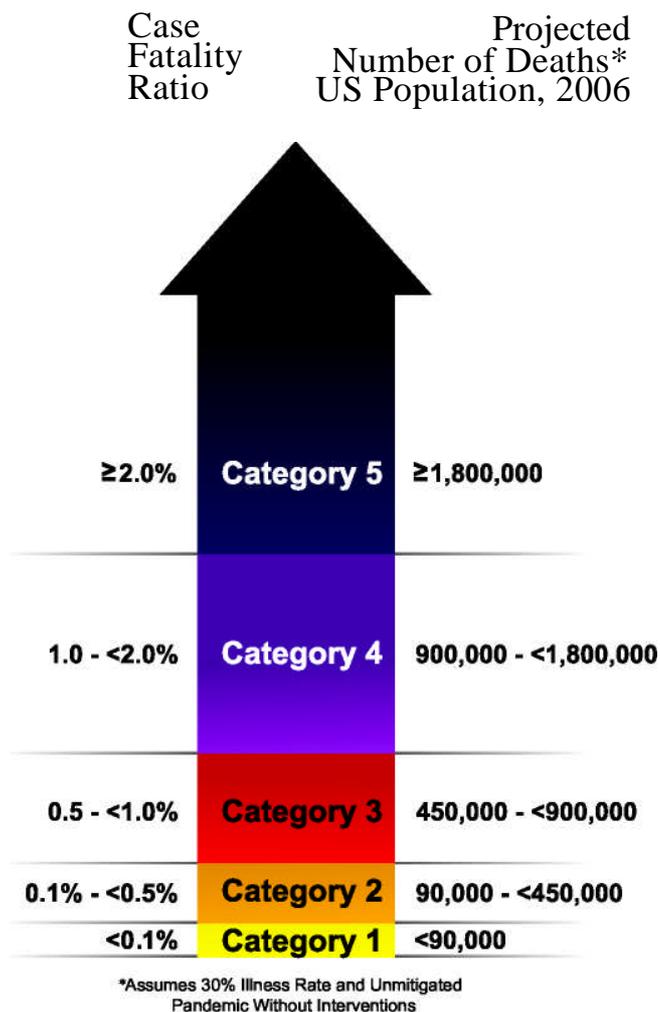
- Dismissal of students from school (including public and private schools as well as colleges and universities) and school-based activities and closure of childcare programs, coupled with protecting children and teenagers through social distancing in the community to achieve reductions of out-of-school social contacts and community mixing.
- Use of social distancing measures to reduce contact between adults in the community and workplace, including cancellation of large public gatherings and alteration of workplace environments and schedules to decrease social density and preserve a healthy workplace to the greatest extent possible without disrupting essential services. Enable institution of workplace leave policies that align incentives and facilitate adherence with the non-pharmaceutical inventions outlined above.

Implementing these interventions in a timely and coordinated fashion will require advance planning.

Decisions about what tools should be used during a pandemic should be based on the observed severity of the event, its impact on specific subpopulations, the expected benefit of the interventions, the feasibility of success in modern society, the direct and indirect costs, and the consequences on critical infrastructure, healthcare delivery, and society. The most controversial elements (i.e. prolonged dismissal of students from schools and closure of childcare programs) are not likely to be needed in less severe pandemics, but these steps may save lives during severe pandemics. Just as Greene County plans and prepares for mitigating the effect of severe natural disasters (i.e. hurricanes), we should plan and prepare for mitigating the effect of a severe pandemic.

Pandemic Severity Index

The *Interim Pre-pandemic Planning Guidance* document introduces a Pandemic Severity Index to characterize the severity of a pandemic. It uses case fatality ratio as the critical driver for categorizing the severity of a pandemic.



The index is designed to enable estimation of the severity of a pandemic on a population level to allow better forecasting of the impact of a pandemic and to enable recommendations to be made on the use of mitigation interventions that are matched to the severity of future influenza pandemics. Future pandemics will be assigned to one of five discrete categories of increasing severity (Category 1 to Category 5). The Pandemic Severity Index provides communities a tool for scenario-based contingency planning to guide local pre-pandemic preparedness efforts. Accordingly, communities facing the imminent arrival of pandemic disease will be able to use the pandemic severity assessment to define which pandemic mitigation interventions are indicated for implementation.

Recommendations for closing childcare facilities will depend upon the severity of the pandemic. The current three-tiered planning approach includes 1) no closure in a Category 1 pandemic, 2) short-term (up to 4 weeks) closure of childcare facilities in a Category 2 or Category 3 pandemic, and 3) prolonged (up to 12 weeks) closure of childcare facilities in a severe influenza pandemic (Category 4 or Category 5). These

actions may only apply to traditional forms of center-based care and large family childcare programs (more than six children). Small family childcare programs may be able to continue operations.

Recommendations for dismissing students from schools will depend upon the severity of the pandemic. The current three-tiered planning approach includes 1) no dismissals in a Category 1 pandemic, 2) short-term (up to 4 weeks) dismissal of students from schools during a Category 2 or Category 3 pandemic, and 3) prolonged (up to 12 weeks) dismissal of students from schools during a severe influenza pandemic (Category 4 or Category 5).

Recommending social distancing of adults in the community, which may include cancellation of large public gatherings; changing workplace environments and schedules to decrease social density and preserve a healthy workplace to the greatest extent possible without disrupting essential services; and ensuring work-leave policies that adhere to social distancing interventions.

The Greene County Health Director will coordinate in advance the timing and implementation of social distancing decisions in Greene County with other surrounding counties, as well as the NC Department of Health and Human Services and the US Department of Health and Human Services.

F. Pandemic Phase Activities

1. Interpandemic Period - Phases 1 and 2
 - Prepared draft isolation and quarantine orders for novel influenza
 - Work with Greene County Schools to identify children on the school lunch program who may be at risk nutritionally if there is a long-term school closure
 - Maintain the Special Needs Registry (Greene County DSS)
 - Identify potential pandemic influenza response personnel and classify them as to their exposure risk
 - Fit test and educate very high and high exposure risk personnel about proper donning and doffing of PPE
 - Identify leaders in the Hispanic community
2. Pandemic Alert Period - Phase 3
 - Educate the community about appropriate group sizes for childcare during closure of schools and childcare programs
 - Meet with Greene County Schools to discuss when and how schools would be closed
 - Conduct community meetings to educate the public and get input on the use of social distancing measures
 - Conduct presentations at school PTO meetings about pandemic influenza, protecting children, and school closure

- Meet with business leaders to discuss the possible implementation of alternate work schedules/locations and the necessity for persons to stay home when ill or exposed
 - Meet with Greene County Sheriff's Department to discuss how mandatory isolation and quarantine would be enforced
 - Draft messages about how to safely care for an ill individual in the home, and when and where to seek medical care for those in isolation/quarantine
 - Meet with Greene County Senior Center and faith-based organizations about providing assistance to the senior population
 - Distribute pandemic influenza information in Spanish to the local Hispanic community
3. Pandemic Alert Period - Phases 4 and 5
- Greene County Health Department will contact persons under mandatory isolation and quarantine on a daily basis to check on illness and possible needs
 - Work with the American Red Cross to provide financial, social, physical and mental health services to those in mandatory or voluntary isolation/quarantine
 - Distribute information about how to safely care for an ill individual in the home, and when and where to seek medical care for those in isolation/quarantine
4. Pandemic Period - Phase 6
- Move towards voluntary isolation and quarantine
 - Consider (and enact if pandemic is severe) the cancellation of mass gatherings and recommended alternations of work schedules for businesses
 - Consider (and enact if pandemic is severe) the closing of schools and childcare programs
 - If schools are closed, work with American Red Cross to provide food to children normally served through the free school lunch program

VIII. Emergency Response

A. Medical Surge

Greene County does not have a hospital. Residents of Greene County are transported to one of the following hospitals in the surrounding counties for emergency care: Lenoir Memorial Hospital in Kinston, Pitt County Memorial Hospital in Greenville, Wayne Memorial Hospital in Goldsboro, and Wilson Memorial Hospital in Wilson. Conversations with hospital representatives reveal that each hospital has in place or is in the process of establishing a pandemic influenza plan. These plans relate mostly to surge capacity and their ability to transfer patients to alternate locations and provide isolation facilities for those who require hospitalization due to a pandemic influenza.

During a pandemic influenza event, it is estimated that approximately 500 - 1,000 beds would be needed to provide care for influenza victims. Hospitals in the Greene County service area are currently utilizing a regional planning process to prepare for an increase in acutely ill patients, which may occur during a public health emergency.

North Carolina is divided into seven regions and each region has designated a regional planning hospital. In our region, Pitt County Memorial Hospital has been designated as the regional planning hospital. Regional hospital planners are identifying overflow locations, which may be used for in-patient or outpatient care. Establishing healthcare facilities in non-traditional sites is a significant task that requires the following issues to be addressed: staffing, equipment, infection control, and legality. Given the potentially high number of ill persons, home health agencies will play an important role during a pandemic influenza. In the event of a pandemic influenza, the quality of material care (i.e. nursing, ventilators, nutrition, and hydration) will deteriorate. Family members or close friends will be expected and needed to provide care to ill individuals that are unable to be hospitalized.

B. Support for Vulnerable Populations

Support for vulnerable populations during a pandemic influenza will be coordinated through various agencies that will provide outreach and assistance to those populations. Extra work is needed in identifying additional local agencies that can provide support to vulnerable populations - we will start by working through our Greene County Local Emergency Planning Committee (LEPC).

Special Needs Registry - Greene County Department of Social Services maintains a registry for persons with special needs. The special needs registry is a database containing information about individuals in Greene County with special needs who may require assistance in the event of a disaster. If there is a disaster, those on the registry will be contacted and given information about how to prepare for or respond to the disaster, given information regarding facilities or shelters, and to check on their well being. The information may also be used to assist emergency personnel and volunteers in providing assistance. Participation in the Special Needs registry is voluntary. As of March 20, 2007, there were 31 persons listed on the special needs registry.

Spanish-speaking (Hispanic) population - Due to language and cultural barriers, this population has been identified as a vulnerable population for a pandemic influenza event in Greene County. Greene County Health Department has obtained numerous pandemic influenza preparedness educational materials in Spanish for distribution to the Hispanic community.

Greene County Health Department has recently learned of a new opportunity in which we can reach out to the Hispanic population. *Viva Greenville* is a Hispanic newspaper in Eastern North Carolina, developed by Hispanics and delivered monthly to over 100 locations in Eastern North Carolina. This newspaper can provide pandemic influenza news and information to the Hispanic population.

Senior Citizens - Pre-pandemic planning by Greene County will include working with the Greene County Council on Aging (Senior Center) and faith-based organizations to prepare for assisting with this vulnerable population during a pandemic event. It is

assumed that many seniors live alone and it is realized that educating them in regards to planning for their possible medical needs during a pandemic event needs to happen.

Children - Pre-pandemic planning by Greene County will include working with Greene County Schools and Lenoir/Greene Partnership for Children (also known as Smart Start) to facilitate communication and planning to address childcare for this population during times of disease containment such as isolation, quarantine, and social distancing. Greene County Health Department will work with Greene County Schools to identify children on the school lunch program who may be at risk nutritionally in the event of long-term closing of schools and childcare programs.

C. Mass Fatality Planning

The vast majority of resources devoted to pandemic management will, and should be, devoted to care for the living. Nonetheless, appropriate and respectful treatment of pandemic flu fatalities is a moral necessity, and can be of significant psychological assurance and comfort to both the intimates of the deceased and the larger community.

Numerous assumptions can be made about mass fatality planning in Greene County:

- Risk groups for severe and fatal infections from pandemic flu cannot be predicted with certainty. During annual fall and winter influenza season, infants, elderly persons, persons with chronic illnesses, and pregnant women are usually at higher risk of complications from influenza infections. In contrast, in the 1918 pandemic, most deaths occurred among young, previously healthy adults. The fatality rate for pregnant women during the 1918 pandemic was over 50%.
- Deaths due to pandemic influenza will exceed deaths due to seasonal influenza.
- The majority of the deceased will not be owners of cemetery property, and available grave property, including in church cemeteries, is in very limited supply in Greene County. New cemetery property or areas for temporary internment may need to be identified. Typically, these properties become memorial spaces after the incident has passed, so this property would likely not again be used for commercial purposes.
- Supplies for caring for the remains of the deceased (such as embalming fluid, coffins, body bags and areas for storage) will be in very short supply during the pandemic period as multiple waves hit the country simultaneously. Area funeral homes may keep approximately one to two weeks worth of additional supplies on hand. Most will try to increase their on-hand supplies in anticipation of a pandemic.
- Funeral directors will likely need guidance on risks of handling bodies of pandemic flu fatalities, but typically have a level of comfort in handling bodies of people with infectious diseases. They practice universal precautions with all bodies.
- One to two trained funeral directors are required to perform the preparation process (recovery, storage, preparation, and casketing) and this process takes about four hours. Funeral directors without crematorium certification could be rapidly trained in performing cremations. From start to finish, an average cremation lasts approximately 4 hours. Neither cremation nor mass cremation has ever been mandated in the United States in any past event. Should mass cremations become necessary, alternative creation sites and technologies, such as large kilns in

brickyards, may be considered. There is a 24-hour waiting period for performing cremations in North Carolina, a rule that is likely to be temporarily lifted during a pandemic.

- Greene County has approximately 10 funeral directors/embalmers. It is not known at this time the number of bodies that could be prepared per day.
- Many families may not be able to have traditional burials and funeral services within several days of the death of the deceased, as it may become necessary to store bodies for longer periods, and personnel to assist with preparation and burial are also affected by the pandemic. If a public gatherings ban were in effect, funerals would need to be postponed until the ban was lifted.
- “Green burials”, involving uncasketed burial without embalming, can be performed with minimal assistance from funeral professionals. This may be a more attractive option to families, particularly rural residents with land, than body storage or funeral postponement. There is also opportunity for fraud or abuse and the public would need to be educated on necessary procedures for green burial, and site selection of graves in families’ cemeteries.
- An autopsy is not required to confirm influenza as the cause of death; however, autopsies may be performed early in the pandemic to confirm the presence of pandemic influenza in North Carolina. The Office of the Chief Medical Examiner and the General Communicable Disease Control Branch of the NC Division of Public Health will determine this.

Extra work is needed in regards to mass fatality planning in Greene County. We will continue to work with the two funeral homes in the county to determine the number of bodies that could be prepared on a daily basis.

D. Psychosocial Support

Disasters, by their inherent conditions, produce the need for behavioral health response. Responding to the psychological and emotional impact of disasters for all people involved is an integral part of a comprehensive and effective disaster response and recovery strategy. A pandemic influenza may pose substantial short-term and long-term physical, personal, social, and emotional challenges to individuals and/or the community at large. Hence, a behavioral health response should be made available to individuals at various venues such as home, school, shelter, hospital, and isolation/quarantine.

Individuals psychologically impacted often include those involved in treating the physical casualties. In fact, disaster responders, including medical personnel, are a high-risk group for developing trauma-related disorders. Certain members of the workforce may also be at increased risk of infection. Those workers at increased risk of infection are an especially vulnerable group due to a real or perceived increased risk of becoming infected themselves, and/or transmitting infection to their family and friends. Hence, there is a particular need for sensitivity to personal concerns and obligations when workers, for instance, may be separated from their families and loved ones for long hours or even days.

Much of the support in Greene County for psychosocial support of the pandemic influenza response workforce and community at-large will be through the Division of Mental Health/Developmental Disabilities/Substance Abuse Services (*Appendix N*). Extra work is needed in regards to psychosocial support in Greene County. Faith-based and other community organizations may be able to provide psychosocial support services and those partners will be contacted for further discussion.

E. Security and Public Safety

During a pandemic influenza event, the Greene County Sheriff's Department will coordinate security and assurance of public safety. Law enforcement resources may include providing security at the vaccine/antiviral storage site, and providing security at mass vaccination clinics or antiviral distribution clinics. Law enforcement officers providing security and assuring the public's safety during a pandemic influenza event will be considered at medium exposure risk and therefore, will be provided with proper PPE for their own safety.

F. Pandemic Phase Activities

1. Interpandemic Period - Phases 1 and 2
 - Communicate with hospitals in surrounding counties regarding medical surge planning
 - Maintain the Special Needs Registry (Greene County DSS)
 - Maintain a list of funeral directors/embalmers in Greene County
2. Pandemic Alert Period - Phase 3
 - Communicate with funeral directors/embalmers regarding mass fatality planning
 - Educate our local PIO on communications during a mass fatality situation and the importance of explaining all steps involved in preparing the deceased and the reasons for these steps
 - Identify individuals responsible for the tracking/record keeping process of mass fatality management and train them in a tracking system (which will include record or recovery of remains, record of any personal effects, a death certificate, record of burial preparation, record of internment and custody chain)
 - Provide education to potential pandemic influenza responders regarding the signs and symptoms of psychosocial problems and advise responders of how and when to seek support
 - Identify local agencies that can provide support to vulnerable populations - contact the Greene County Local Emergency Planning Committee
 - Contact faith-based and other community organizations that may be able to provide support to vulnerable populations as well as psychosocial support services
 - Sheriff's Department will coordinate security and assurance of public safety
 - Train Sheriff's Department on appropriate use of PPE for medium exposure risk

- Create a resource list of suppliers of necessary supplies and begin to stockpile disaster body bags
3. Pandemic Alert Period - Phases 4 and 5
 - Begin in earnest to stockpile disaster body bags and other necessary supplies (i.e. embalming fluid, caskets)
 - Prepare a list of suppliers for items such as refrigerated trucks, refrigerated warehouses, and portable storage units that could be refrigerated (bodies must be stored at 37° - 42° to retard decomposition, and can be stored as long as 6 months at these temperatures before they begin to decay) - approximately 40 bodies can be stored in a regular tractor trailer
 - Identify vehicles and personnel that could be trained in the recovery of remains
 - Determine the NC Medical Examiner plan for investigating unattended deaths during these pandemic phases and phase 6
 - Educate the public, through the media, about the steps involved in traditional burials and what deviations would be expected during a pandemic
 - Authorities will review state laws for burial requirements in order to inform the public of legal burial solutions
 4. Pandemic Period - Phase 6
 - The Health Department's Vital Records office will establish a voluntary "acute death reporting system" with sentinel county registrars in order to report the number of influenza and pneumonia deaths as a proportion of the total number of deaths by week. Vital records will also coordinate mandatory pediatric influenza death reporting, as occurs during non-pandemic phases.
 - Continue to utilize other containment efforts (isolation, quarantine, social distancing, vaccine, antivirals) to mitigate stresses on medical surge
 - Create a Mass Fatalities Unit in the ICS and assign leadership to a local funeral director
 - Designate a spokesperson for the funeral director community to speak to the media about the processes involved in preparing bodies for burial and any deviations from normal procedures necessary because of mass fatalities
 - Identify and train family assistance teams (likely made up of nurses, social workers, or clergy) who can explain the process of preparation for burial
 - Funeral directors without cremation certification will be rapidly trained in performing cremations

IX. Communications

A. Dissemination of Public Information

Greene County Health Department has purchased numerous pandemic influenza educational materials as well as received materials from the NC Division of Public Health. These materials are given out at health fairs, meetings, and presentations as part of our pre-pandemic planning activities. Two of the largest venues for distributing information to the Greene County community are through employers and schools. Greene County Health Department would like to partner with the Greene County

Chamber of Commerce to distribute pandemic influenza information to business leaders in the county. The ultimate goal is for printed information to be available for all employees (i.e. local government, school, business, industry) through the distribution of pandemic influenza preparedness materials to employers.

Greene County Health Department has also purchased Family Preparedness Kits for every household in Greene County. The family preparedness kit is a durable zippered-portfolio full of valuable educational materials. The family preparedness kit has several purposes:

- It serves as a place where all of your important papers can be kept
- If we had to have a mass distribution clinic in the county, it would serve as a place where all of your families' medications could be kept

The Health Department has attended and will continue to attend health fairs in order to help individuals and families prepare for pandemic influenza. In addition, Greene County Health Department is available to give pandemic influenza presentations and materials to any entity in Greene County that requests assistance. Efforts will continue to identify other venues to distribute pandemic influenza preparedness information.

The Health Department has plans to work with Greene County Schools to provide a cold/flu hygiene program for students at Snow Hill Primary School and West Greene Elementary School. Information related to pandemic and seasonal influenza preparedness will be shared with the parents.

The Health Department has plans to work with the Greene County Council on Aging (Senior Center) and faith-based organizations to provide seniors with information related to planning for their medical needs during a pandemic influenza event.

The Hispanic community in Greene County is a vulnerable population concerning communication during a pandemic influenza event due to language and cultural barriers. Greene County Health Department has obtained numerous pandemic influenza preparedness educational materials in Spanish for distribution to the Hispanic community. The Health Department has three interpreters on staff that will play a vital role in communicating/providing information to the Spanish-speaking population in Greene County.

During a pandemic influenza event, accurate, consistent, and timely messages are key in notifying and educating the public. The Health Director and PIO will be responsible for getting those crucial messages out to the public. Information will be given to the public through the use of newsprint, radio, television, flyers, and website, as appropriate. During times when the latest information on pandemic influenza must be communicated with the public as soon as possible, the Greene County Health Director will act as the sole approver of the message to be disseminated. During times when release of information is not extremely time-dependent, content of messages will be shared with other county agencies and entities, though final approval of the message will still reside with the Greene County Health Director.

B. Informing Healthcare Providers

During a pandemic influenza event, state and local health departments will serve as an information resource for the public as well as for healthcare providers. Healthcare providers in Greene County will be kept informed during each phase of the pandemic influenza response. Information will be disseminated to healthcare providers through the use of phone, email, fax, website, and educational materials, as appropriate.

C. Local Health Departments

The Office of Public Health Preparedness and Response created ICCE Net (Intrastate Crisis Communication Enhancement Network) to ensure that public health communicators at all levels of state and local government are interacting on a regular basis. During a pandemic influenza, ICCE Net will prove invaluable to ensuring that communications are uniform across the state at all levels. (*Appendix O*)

Greene County Health Department participates in the North Carolina Health Alert Network (NC HAN). Users at the health department include:

- Angela Allen - Public Health Nurse II
- Joy Brock - Preparedness Coordinator/Health Educator II
- Chris Miller - Nursing Director
- Ashley Severson - Environmental Health Coordinator
- Linda Sewall - Health Director
- Sandra Smith - Administrative Officer

All health department NC HAN users will monitor for messages from the NC HAN and respond as necessary.

Greene County Health Department will also monitor for pandemic influenza information on the Epidemic Information Exchange, Epi-X. Users at the health department will include the Health Director, Nursing Director, and Preparedness Coordinator. These persons will monitor daily Epi-X emails for pertinent information related to pandemic influenza.

D. Pandemic Phase Activities

1. Interpandemic Period - Phases 1 and 2
 - Educate the community about the potential for a pandemic influenza, with a focus on the role that individuals must play in taking care of themselves and their families
 - Communicate with healthcare providers about their role in a pandemic influenza and what they might need to do to protect themselves and their families
 - Train designated health department employees on the NC HAN
 - Distribute family preparedness kits

2. Pandemic Alert Period - Phase 3
 - Educate local businesses regarding pandemic influenza, including how to prepare themselves and their families
 - Obtain materials to disseminate to the public and healthcare providers when an outbreak takes place, with details on how to prevent getting sick, when to stay home, when to seek medical care, how to get the most accurate information, and how to care for your family
 - Monitor NC HAN and Epi-X
3. Pandemic Alert Period - Phases 4 and 5
 - Disseminate pandemic influenza information to the public and healthcare providers
 - Post pandemic influenza information on the county website
 - Conduct public/media briefings, as needed, on the status of the outbreak
 - Monitor NC HAN and Epi-X
4. Pandemic Period - Phase 6
 - Continue regular updates of the public regarding the status of the outbreak, and how and where to receive services

X. Continuity of Operations

A. Local Health Department Plan

Greene County Health Department will develop continuity of operations plans that address, at a minimum:

- Line of succession for the health department
- Approval of continuity of operations plans by the Greene County Board of Health
- Identification of mission essential services and priorities
- Procedures for the reassignment of employees to support public health functions essential during a public health emergency
- Redundancy of mission critical communication and information systems
- Physical relocation of critical Greene County Health Department functions

Greene County Health Department will utilize the continuity of operations planning template prepared by UNC-Chapel Hill. The Health Department will also utilize resources available for continuity of operations planning from the United States Department of Health and Human Services www.pandemicflu.gov website and the North Carolina Department of Health and Human Services www.ncdhhs.gov/panflu/ website.

Greene County Health Department employees play the first responder role during public health emergencies and because of this, their availability during and after normal business hours is required. The Greene County Health Department Family Care Plan is one tool that has been created as a method of family preparedness. The Family Care Plan allows employees to document any special circumstances or situations that could possibly hinder their ability to report to work during a public health emergency (i.e. pandemic influenza).

B. County Plan

Continuity of Government - taken from the Greene County Emergency Operations Plan...

IV. Continuity of Government

- A. Emergency and disaster occurrence could result in disruption of government functions necessitates that all levels of local government and their departments develop and maintain procedures to ensure continuity of government.
- B. The line of succession of the County Board of Commissioners proceeds from the Chairman to the members of the board in accordance with county policy.
- C. Each department is responsible for preservation of essential records and documents to ensure continued operational readiness and to comply with existing laws and ordinances.
- D. Vital Facilities
 1. Several categories of facilities have been identified as essential for an immediate response following a disaster or emergency and others have been identified as critical for long term recovery operations. These categories include:
 - Electrical distribution systems
 - Water distribution systems
 - Health and medical facilities
 - Transportation resources and facilities
 - Communication networks
 - Public buildings
 - Emergency services facilities
 - Landfill and debris sites
 - Public/private supply centers
 2. Information on specific vital facilities and resources will be maintained in the Greene County Office of Emergency Services and accessible from the County EOC.

C. Outreach to Local Businesses

In order to mitigate mass social disruption and the interruption of goods and services, businesses must be prepared to respond to a pandemic influenza event. Their responsibilities include:

- Working to educate their employees about how to protect themselves and their families

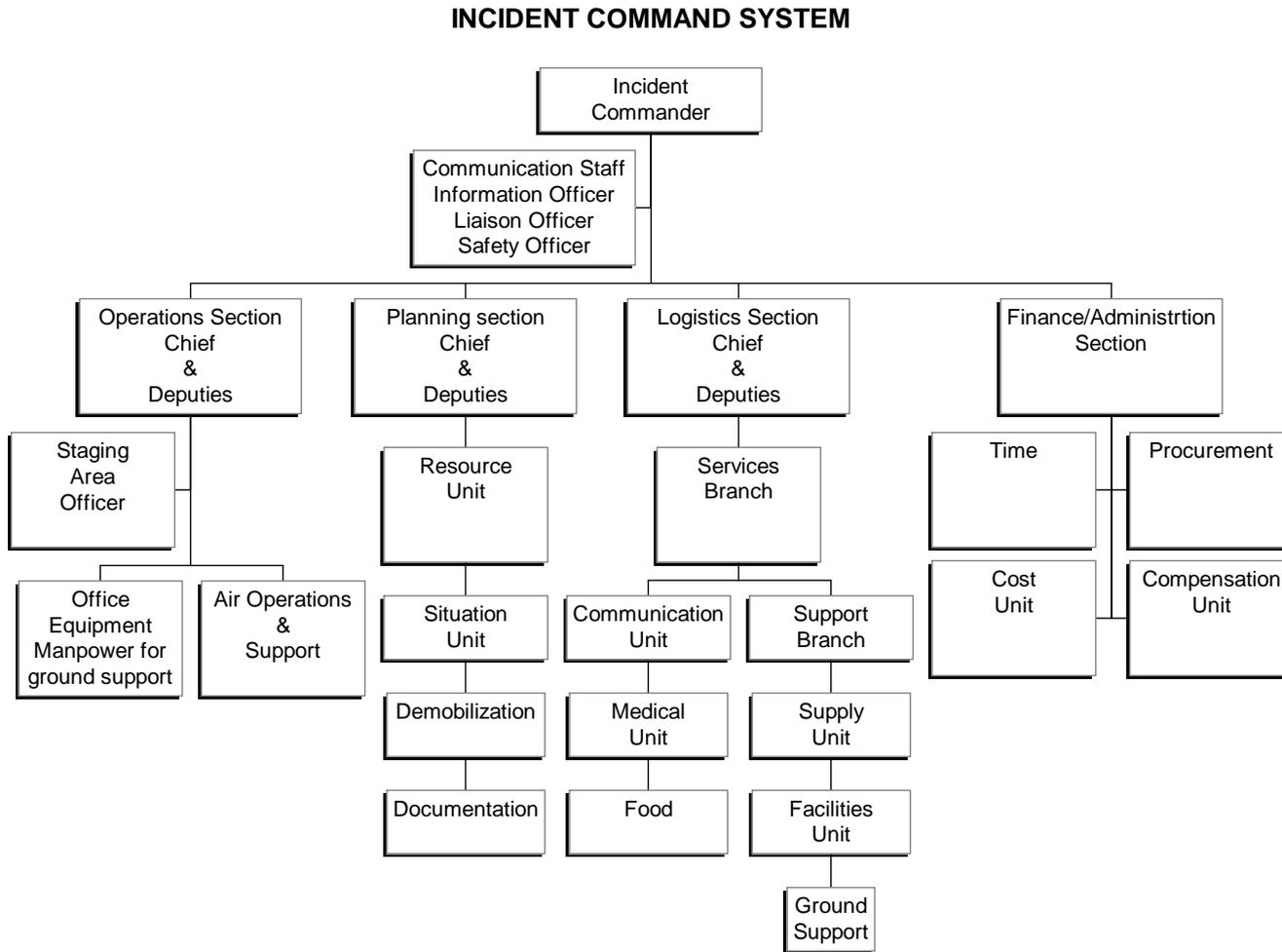
- Planning to continue operations with up to 40% of their workforce absent
- Informing employees about when not to come to work
- Providing for telecommuting or alternate work schedules for key personnel
- Prioritizing essential and non-essential services

Greene County Health Department plans to work with local businesses in the county to inform them of the need for Continuity of Operations Plans, and to assist them in the creation of their plans.

D. Pandemic Phase Activities

1. Interpandemic Period - Phases 1 and 2
 - Educate local business leaders on pandemic influenza
 - Encourage and work with local businesses, including the Health Department, regarding the development of Continuity of Operations Plans specific to pandemic influenza concerns and implications
 - Work with local businesses regarding a business planning checklist (an example can be found at www.ncdhhs.gov/panflu/)
 - Encourage local businesses to promote seasonal influenza and pneumococcal vaccinations among employees
2. Pandemic Alert Period - Phase 3
 - County government department heads will begin to assess and prioritize essential and non-essential services as well as key personnel who may be asked to work from home
 - Remind local business leaders of the importance of allowing sick and exposed persons, as well as parents providing needed childcare services during times of school and/or childcare closure, to remain at home
 - Disseminate information to employees about family preparedness for pandemic influenza to interested businesses
 - Cross train health department staff to perform other job responsibilities in the event of a pandemic influenza event
 - Work with NC Cooperative Extension Service and Department of Agriculture regarding mitigation plans for large animal outbreaks and the possible effects on the agriculture industry
3. Pandemic Alert Period - Phases 4 and 5
 - Educate employees about the Continuity of Operations Plan and how it will be used for pandemic influenza
 - Provide information to local businesses regarding current pandemic influenza events
4. Pandemic Period - Phase 6
 - Greene County government and municipalities will work to assure that essential services are maintained

Greene County will use the Incident Command System Organization



**GREENE COUNTY EMERGENCY OPERATIONS PLAN
DIRECTION AND CONTROL
SECTION A**

Primary Agency: Greene County Board of Commissioners

Supporting Agencies: Greene County Manager
Greene County Emergency Services
Mayors of Municipalities
All County Agency Heads

I. PURPOSE

This section outlines the direction and control procedures for emergency operation and identifies the personnel, facilities and resources which will be utilized in the coordinated response activities.

II. SITUATION AND ASSUMPTIONS

A. Situation

1. Many hazards exist within or near the county which have the potential to cause disasters of such magnitude as to warrant centralization of the direction and control function in order to conduct effective and efficient emergency operations. In these instances the Greene County Emergency Operations Center (EOC) will be opened.
2. Municipalities within the county may exercise independent direction and control of their own emergency resources. Additional resources may be sent to the municipality. Requests for state/federal government assistance will be directed to the county EOC (Emergency Services Director prior to activation).
3. The county EOC may be activated (including representatives from agencies/departments assigned primary responsibility in this plan) if one or more of the following situations occur:
 - a. imminent threat to public safety/health;

- b. extensive multi-agency/jurisdiction response and coordination are necessary to resolve or recover from the emergency situation;
 - c. local resources are inadequate/depleted and significant mutual aid, state and/or federal resources must be utilized to resolve the emergency situation;
 - d. the disaster effects multiple political jurisdictions within the county, which are relying on the same emergency resources to resolve the emergency situation;
 - e. local emergency ordinances are implemented to control the emergency situation.
4. The county EOC (located in the Emergency Services Building, Snow Hill) serves as the central direction and control point for countywide emergency response activities. Should this facility become inoperable, the alternate EOC is the Greene County Courthouse, Snow Hill and will be utilized for direction and control functions.

B. Assumptions

- 1. Most municipalities within the county would not dispatch representatives to the county EOC; but would maintain communications with the county EOC via phone, fax or radio.
- 2. Towns would act in unity with the county on such issues as proclamations, security, evacuation, re-entry, recovery, public information and instructions on protection of life and property.

III. CONCEPT OF OPERATIONS

A. General

- 1. Most of the routine emergency situations within the county are directed by a single agency with direction and control being exercised by the senior on-scene officer. When two or more agencies respond, the response is done in accordance with local ordinances, policies, procedures and agreements.
- 2. Response forces within the county will utilize the NIMS Incident Command System (ICS).

3. Municipalities within Greene County will normally exercise independent direction and control of their resources, outside resources committed to the jurisdictions by the emergency operations center and resources secured through existing mutual aid agreements with other municipalities.
4. Prior to activation of the Greene County Operations Center, requests for state or federal assistance will be directed to the county Emergency Services Director for coordination with the State EOC.
5. The type of the event and the magnitude of the emergency will have a bearing as to when the county EOC will be activated. Officials may elect to activate the EOC under one or all of the following conditions:
 - a. Local resources are inadequate or depleted and significant resources from outside the county must be utilized in the response.
 - b. The disaster affects large areas of the county and the various areas are relying on the same resources therefore mandating prior authorization of resources.
 - c. The health and safety of the county are threatened to such and extent that it will be necessary for multiple departments and agencies to respond to the event in a coordinated manner.
6. Whenever the EOC is activated or activation becomes imminent the Emergency Services Director will notify the EOC personnel and the State EOC. Additionally, he is charged with carrying out all administrative decisions in regards to proper operational procedures of the EOC.
7. Existing standard operating procedures will be utilized within the EOC to manage operations and dispatching of resources.

B. Specific

The overall direction and control of emergency activities is vested with the Chairman of the County Commissioners. The Emergency Management Director (Emergency Services Director) carries out the function of disaster coordination at the commissioners direction. On site management will be established by the incident commander.

C. Staffing

1. Personnel assigned or responding to the EOC will normally be assigned duties in one of the two following groups:
 - a. The Executive Group consists of the following; and is responsible for overall direction and control operational forces and operational policies.
 - Chairperson, Board of County Commissioners
 - Greene County Manager
 - Greene County Emergency Services Director
 - Greene County Sheriff
 - Mayors of Towns
 - b. The Operations Group consists of the following; however, staffing may be adjusted by deletion or addition of private, volunteer or governmental agencies in response to the specific emergency:
 1. EOC Operations Management
 - ES Director (EOC Operations Manger)
 - Clerical support staff
 2. Law Enforcement
 - Sheriff's Captain
 - NC Highway Patrol Liaison
 - Clerical support staff
 3. Emergency Services
 - Assistant Fire Marshal
 - EMS Coordinator/Supervisor
 - Transportation Director
 - Clerical support staff
 4. Human Services
 - Health Director
 - Social Services Director
 - School Superintendent
 - American Red Cross Liaison
 5. Analysis and Resources
 - Public Works Director
 - Finance Office

- Damage Assessment Officer (Tax Office)
 - Support staff of Damage Assessment Section/Team(s), recorders, analysts and section plotters
6. HazMat (when needed)
 - President, Greene County Firemen's Association
 - President, Greene County EMS Association
 - Emergency Services Director
 7. Donated/Unmet Needs
 - Director, Greene County Cooperative Extension Services
 - Wayne, Wilson and Greene County Chapter of American Red Cross
 - Greene County Interfaith Volunteers, Inc.
 8. Volunteers
 - Amateur radio operators
2. EOC personnel will authenticate reports and requests for resources prior to dispatch.
 3. Greene County will operate under the NIMS Incident Command System. (See Organizational Chart on Page 6)

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
ASSIGNMENT OF RESPONSIBILITIES
SECTION B**

I. PURPOSE

This section tasks departments of Greene County, municipalities and quasi-government agencies and some volunteer agencies with specific emergency functions which are in addition to their day-to-day responsibilities. Each agency listed here in is responsible for the development and maintenance of internal standard operating procedures, guidelines, checklists and/or memorandums of understanding in order to accomplish these responsibilities.

II. ORGANIZATION

A. Executive Group (Control)

1. The Greene County Emergency Control Groups consists of:
 - Chairperson of the Board of Commissioners
 - County Manager
 - County Emergency Services Director or Assistant Emergency Services Director
 - Greene County Sheriff
2. The Municipal Emergency Control Group (if established) may consist of the following:
 - Mayor or designee
 - Selected Board Members
 - Clerk of Municipal Council
 - County Emergency Services Director or designee (advisor)

B. Support Groups

When established, this group consists of representatives of pre-determined governmental and volunteer groups. These groups are tasked with the responsibility of implementing control groups decisions.

C. Assignment of Responsibilities

1. **Chairperson, Greene County Commissioners**

- a. Carry out provisions of N.C. General Statutes and local ordinances relating to emergencies.
- b. Declare a State of Emergency for Greene County and assume direction and control of emergency operations in cooperation with other members of the control group to include:
 - Execution of the Greene County Emergency Operations Plan.
 - Order an evacuation to include all or parts of the county.
 - Restrict the sale of alcohol and/or firearms.
 - Order a curfew.
 - Restrict entry into Greene County.
 - Enforce ordinances in effect.
 - Ensure adequate planning for Hazardous Materials events.
 - Ensure that the line of succession for county departments and agencies is adhered to.
 - Relocate the seat of government if administrative offices become damaged beyond usage.
 - Declare a State of Emergency in existence for the unincorporated areas of the county, if necessary.
 - Execute the Greene County Emergency Operations Plan.
 - Implement other measures to protect life and property.
 - Nominate members for the Local Emergency Planning Committee to the Chairman of the State Emergency Response Commission.
 - Coordinate emergency response actions with Chairpersons of adjoining jurisdictions and mayor in Greene County.
 - Direct county personnel to return to work following a disaster or emergency.

2. **County Manger/Public Information Officer**

- a. Implement the County Emergency Plan by authority of the Chairperson, County Board of Commissioners.
- b. Direct county agencies to develop and update emergency plans and SOP's to respond to emergencies.

- c. Support the Emergency Services Department in annual exercises and test of the emergency plan/drills.
- d. Function as the Public Information Officer or assure that a qualified PIO is in place.
- e. Authorize the release of emergency public information, in conjunction with the Chairperson of the Commissioners.
- f. Coordinate emergency response actions with manager of adjoining jurisdictions.
- g. Implement direction, control, coordination and policy making functions as necessary to provide for optimum protection of public health and safety.
- h. Ensure that all responding agencies document expenditures related to coping with the emergency/disaster.
- i. Determine sheltering/evacuation needs, in coordination with Emergency Services.
- j. Issue orders to terminate non-essential functions of local governments and re-direct forces to cope with disaster.
- k. Plan for the activation of damage assessment/recovery functions of local government.
- l. Ensure that persons with special needs have been provided assistance, if needed.
- m. At the beginning of Hurricane Season, review Hurricane procedures.
- n. Provide rumor control in the EOC. Assist with inquiring as to missing relatives, damaged areas, etc.
- o. Provide for clearance of debris on public right of ways.
- p. Inform citizens about evacuation routes, flooded areas and other impediments to evacuations.
- q. Assist in development financial accounting procedures to assist local agencies in recording and reporting emergency expenses.

- r. Assist in the establishment and management of post-disaster donated funds.
- s. Provide county budget information in support of the Governor's request for Presidential Declaration of a disaster.
- t. Ensure that visually impaired and non-English speaking groups have been provided adequate warning materials/instructions.

3. Emergency Services Director

- a. Develop, maintain and update Emergency Operations Plan, standard operating procedures, guidelines, memorandums of understanding, implementing documents and resource manuals used during emergency operations by all county agencies.
- b. Perform assigned duties according to state general statutes and local ordinances.
- c. Develop plans in accordance with Federal and State guidelines.
- d. Coordinate emergency operations within the jurisdiction. Provide support services to municipalities when disaster does not affect area outside of municipalities.
- e. Maintain current notification and recall lists of operational personnel.
- f. Provide for the training, crisis training of emergency forces within the emergency management organization.
- g. Maintain and update a current list of resources in the county.
- h. Receive and coordinate request for resources from municipalities; direct resources to areas of greatest need.
- i. Coordinate with private industry for use of privately owned resources.
- j. Forward request for additional resources to the State EOC for situations in which county resources are unable to meet recovery requirements.

- k. Alert and activate county emergency service forces when informed of an impending emergency in the county and associated hazards.
- l. Ensure that emergency information and reports are delivered to responding agencies in a timely manner.
- m. Serve as the Advisor of the Local Emergency Planning Committee as defined by SARA Title III planning requirements.
- n. Coordinate emergency response actions with adjoining Emergency Management Coordinators in adjoining jurisdictions.
- o. Serve as the principal advisor to the executive control group during emergency operations.
- p. Identify and arrange for suitable shelters for identified hazards. Provide shelter supplies. Assure shelter staffs are assigned.
- q. Maintain operational readiness of the EOC, when activated and county communications center daily.
- r. Maintain liaison with utility company representatives for back-up water, power and telephone communications, if required.
- s. Maintain administrative records as needed.
- t. Ensure that operational and narrative journals are maintained during an emergency period.
- u. Ensure adequate warning is disseminated throughout the emergency organization and the county.
- v. Develop procedures to activate the Emergency Broadcast System (EBS).
- w. Provide damage assessment training on an annual basis.
- x. Disseminate, as appropriate, public information and education programs relating to disaster recovery procedures.

- y. Assist with securing DAC facilities and equipment.
- z. Identify and notify applicants that may be eligible for Public Assistance programs.
- aa. Assist the Local Emergency Planning Committee (LEPC) in planning for hazardous material events.
- bb. Ensure that the public is educated through public awareness programs concerning the various hazards in the area and the need to be self-sufficient for a period of three days.
- cc. Ensure the crisis training for county staff to fulfill operational roles.
- dd. Support the LEPC in maintaining liaison with facility emergency coordinators to ensure availability of current information concerning hazardous materials and the correct response to any incident.

4. **Sheriff**

A. Law Enforcement

- 1. Develop and maintain SOP's to direct and control law enforcement operations during emergencies/disasters.
- 2. Provide direction and control for law enforcement, traffic control, evacuations and return home movement.
- 3. Identify law enforcement assistance needs and develop necessary mutual aid agreements to support those needs.
- 4. Provide security for the EOC, staging areas, shelters, vital facilities and essential equipment locations.
- 5. Assist in dissemination of emergency public information and warning to the public and hearing impaired persons.
- 6. Provide security and backup communication forces for the EOC and other facilities deemed to be vital.
- 7. Control ingress and egress into damaged, evacuated and secured areas and facilities.
- 8. Relocate and house prisoners when necessary.
- 9. Coordinate the need for additional law enforcement support with State Highway Patrol and adjacent jurisdictions.

10. Develop procedure to ensure that law enforcement personnel can respond at the awareness level for Hazardous Material incidents.
11. During non-emergency periods serves as the official spokesperson for law enforcement related events. Otherwise coordinate the release of all public information/instructions with the county public information officer.
12. Provide support staff to shelters upon request.

B. Communications

1. Establish and maintain the communications network for two-way communications between the EOC and the field responding forces.
2. Disseminates warning information to emergency response personnel or public.
3. Develop, maintain and update SOP's for communications center operations during emergencies.
4. Provide back-up communications for the EOC and critical points through the use of mobile units.
5. Ensure that communication procedures are established for the use of logs, messages, forms and message control.

5. Director, Social Services Department

- a. Develop, maintain and revise SOP's for Social Services operations during emergency/disaster periods.
- b. Coordinate emergency shelter openings with American Red Cross (ARC) and school systems.
- c. Coordinate with the health department and with other local health care agencies, concerning needs for special medical needs populations and maintain an active up to date list of those populations.
- d. Provide shelter managers, supplies and other support personnel during sheltering periods.
- e. Coordinate transition of emergency shelter operations with American Red Cross (ARC).

- f. Provide liaison to American Red Cross and Salvation Army for the receipt, management and distribution of solicited and unsolicited donated goods following a disaster.
- g. Ensure that nursing homes, rest homes and retirement centers develop evacuation or in-place care plans and coordinate with social services and emergency services department.

6. Director, Health Department

- a. Develop, maintain and revise SOP/guidelines for emergency public health operations during emergencies.
- b. Coordinate health care for emergency shelters and mass care facilities with DSS, Red Cross or Salvation Army (when shelters are opened).
- c. Coordinate with water supply authorities to expedite emergency public water supplies.
- d. Provide health inspection and immunizations to evaluate, detect, prevent or control communicable disease.
- e. Coordinate environmental public health activities for waste disposal, refuse, food, water, sanitation and vector/vermin control in county.
- f. Coordinate with the Social Services Department in the identification and medical care of special needs populations.
- g. Provide inspection of mass care facilities to assure proper sanitation practices are being practiced.
- h. Coordinate with the proper authorities to establish a temporary morgue, or if necessary expand morgue services.
- i. Coordinate public health services in shelter and mass care facilities.
- j. Coordinate the distribution of exposure limiting drugs, medicines, vaccines or other preventative drugs when requested.

- k. Assist American Red Cross with inquires and inform families on status of individuals injured or missing.
- l. Provide support staff to emergency shelters and assist in the operation of the Greene County Pet Shelter.
- m. Consult with other health care providers to identify facilities that could be expanded into emergency treatment centers.
- n. Coordinate efforts of organizations in providing services for animal welfare issues including temporary sheltering for pets.
- o. Continue to provide animal control services.
- p. Provide EOC representative.

7. Director, Public Works Department

- a. Plan for temporary repair and restoration of vital facilities, water distribution, waster water systems and solid waste.
- b. Develop and maintain resource lists with source, location and availability of equipment, fuel and operational personnel to support response/recovery operations.
- c. Assist with debris removal.
- d. Identify manpower and equipment limitations and provide for resources to cover these shortfalls.
- e. Provide storage and access to fuel for emergency service vehicles during emergencies.
- f. Maintain emergency power, water and sanitation resource at vital facilities during periods of emergency.
- g. Develop, maintain and update SOP/guidelines for public works functions during emergency periods.
- h. Terminate non-essential services and re-deploy personnel and equipment resources to areas of greatest need.

- i. Develop procedures/guidelines or memorandums of understandings with municipalities to utilize excess resources to support recovery operations in the county. Coordinate activities with Emergency Services office.
- j. Provide support staff to EOC upon request.

8. Tax Assessor (Damage Assessment)

- a. Develop, maintain and revise SOP/guidelines for county tax operation and record protection during disaster/emergency situations.
- b. Coordinate damage assessment teams conducting field survey and assure teams are properly trained and equipped. Forward assessments to Emergency Services office for transmittal to State EOC.
- c. Provide property tax information assistance for county residents at Disaster Application Centers.
- d. Assist the executive group during the recovery period.
- e. Revise property tax records to reflect damages to privately owned property.
- f. Provide support staff to shelters/EOC upon request.

9. Superintendent, Greene County Schools

- a. Develop, maintain and revise SOP/guidelines for the safety and protection of students, faculty and other personnel during emergency situations.
- b. Coordinate evacuation and transportation operations for students during emergencies.
- c. Provide support personnel, equipment and facilities as necessary (schools, bus drivers, cafeteria personnel and other equipment, etc).
- d. Provide support personnel to the EOC during activation of the facility.
- e. Provide school facilities for temporary shelters and medical treatment facilities, as needed. Develop memorandum of understanding for use of facilities.

- f. Maintain school transportation resources.
- g. During recovery period, effect damage assessment on school properties and report to EM office for computation.
- h. Provide interpreters for other than English speaking persons in shelters (when available).

10. Director, Greene County Transportation Department

- a. Develop, maintain and revise SOP for the transportation of county residents during emergencies.
- b. Plan for the transportation of county residents in a disaster or emergency situation, including those without transportation, elderly, handicapped and other special needs citizens.
- c. Coordinate transportation operations with county schools through the EOC.
- d. Provide current resource list to Emergency Services office.
- e. Make buses, vans and drivers available as needed to effect a coordinated evacuation/transportation operation.
- f. Provide for refueling of vehicles.
- g. Develop memorandum of understanding for use of vehicles and personnel.
- h. Develop procedures to support un-met needs operations, when required.

11. Greene County Cooperative Extension Services

- a. Education citizens of the need to clean food supply, disposal of soil/contaminated foods and contaminated water supplies.
- b. Coordinate activities for the receipt, distribution and management of un-solicited goods following disasters/emergencies.

- c. Provide support to the un-meet needs committee following a disaster/emergency.
- d. Develop informational releases in conjunction with the county public information officer to educate public on donated goods.
- e. Coordinate activities with state level donated goods operation (if established).
- f. Coordinate the efforts of volunteers recruited to assist in the management and distribution of donated goods.
- g. Encourage the donation of money in lieu of donated goods.
- h. Serves as clearing house for information for individuals desiring to donate goods, services or money to victims in other areas of the state/nation.
- i. Provide County Animal Response Team services. (CART)
- j. Provide staff to help in the operation of the Greene County Pet Shelter.

12. **Greene County Council On Aging**

- a. Maintains an aging registry.
- b. Advise officials on the special needs of elderly/home bound citizens.
- c. Assist DSS & Public Health with special needs committee work.
- d. Assist officials with planning outreach efforts for elderly following a disaster.

13. **Greene County Recreation Department**

- a. Assist in deployment and activation of standby generators.
- b. Provide tractor and other available equipment for emergency road clearing.
- c. Assist with logistical support of other agencies.

- d. Coordinate clean up of debris from County facilities.
- e. Be prepared to assist with designated management functions.

14. **Greene County Inspections Department**

- a. Assist in preparation of initial damage assessment report.
- b. Coordinate damage assessment teams countywide and compile detailed reports.
- c. Inspect damaged property and approve for occupancy or post condemnation notices.
- d. Provide rapid inspections of structures following disasters.
- e. Conduct necessary inspections of facilities to approve for occupancy.
- f. Review engineering plans prior to construction as a means of mitigating future disaster situations.

15. **Greene County EMS Coordinator**

- a. Develop, maintain and revise SOP for rescue/mass casualty activities during emergency/disaster situations.
- b. Plan for the coordination of ambulance/rescue activities throughout the county during emergencies/disasters.
- c. Identify equipment, manpower limitations and develop mutual aid agreements for the procurement of needed resources during emergency/disaster events.
- d. Coordinate with area hospitals (outside the county) concerning the receipt of mass casualties during emergency/disaster situations.
- e. Coordinate with County Health Director and Social Services Director to determine emergency transportation needs for special needs population.
- f. Coordinate with appropriate Health Care Agency to determine their needs for transporting patients.

- g. For disasters/emergencies in which the incident command structure is employed, coordinate with the rescue incident commanders to provide Triage services (treatment at scene, categorize injured; priority transportation).
- h. Review procedures for recovery, identification, registration and disposition of deceased. Notify next of kin.
- i. Coordinate, when appropriate, with funeral homes, pathologists, American Red Cross liaison, dentists and other health care professionals.
- j. Provide for the extrication and rescue of victims during emergency operations.
- k. Provide an EMS representative at shelters during operation.
- l. Establish liaison with medical facilities, coordinate with receiving facilities and maintain communications with other response groups.
- m. Supplement medical resources in shelters in coordination with American Red Cross and other volunteer groups.
- n. Maintain a casualty tracking system.

16. Finance Officer/County Administration

- a. Develop and maintain standard operating procedures for county emergency financial record keeping during emergency disasters.
- b. Assist the Tax Officer with documentation of disaster damage to county owned facilities.
- c. Provide county budget information in support of the Governor's request for a Presidential Declaration of Disaster.
- d. Develop financial accounting procedures to assist local agencies in recording and reporting their emergency expenses.

- e. Assist in the establishment and management of post-disaster donated funds.
- f. Coordinate emergency related expenditure procedures with city Finance Directory to ensure that State and Federal forms are submitted.
- g. Provide support staff to shelters/EOC upon request.

17. Mayors, Greene County Municipalities

- a. Mayors
 - 1. Utilize municipal personnel, facilities and equipment resources to support the Greene County Operations Plan (EOP), not to conflict with municipal requirements.
 - 2. Assess the needs of the affected municipality and request resources through the Emergency Services Director.
 - 3. Enforce provisions of local ordinances relating to disasters/emergencies as well as N.C. General Statues.
 - 4. Declare a State of Emergency for the municipality and ensure enforcement.
 - 5. Ensure protection of life and property within the municipality.
 - 6. Assist county officials with damage assessment/recovery activities.
 - 7. Conduct damage assessment surveys utilizing municipal officials within municipal limits. Provide for training of damage assessment teams on a regular basis.
 - 8. Provide copies of municipal agreements, checklists and SOP's to the county Emergency Services office.
 - 9. Coordinate/update amendments to the Emergency Operations Plan (EOP) and coordinate development of internal, interdepartmental and interagency Standard Operating Procedures and memorandums of understanding.
 - 10. Ensure that periodic drills and emergency exercises are conducted in order to assure that current procedures within the EOP for functionally effective for operations.
 - 11. Coordinate policymaking functions necessary to ensure public health and safety within the municipal borders.

12. Make available municipal resources, as appropriate, in response to resource request from other agencies.
 13. Implement emergency policies, procedures and ordinances as appropriate for the governing body.
18. **Greene County Local Emergency Planning Committee (LEPC)**
- a. Carry out the responsibilities for local emergency planning pursuant to Title III and adherence to the policies of the NC Emergency Response Commission.
 - b. Assess and make recommendations as to the current level of and identify existing programs and capabilities.
 - c. Ensure the development of plans to protect the public during a hazardous materials accident by developing the jurisdiction hazardous material Emergency Operating Plan consistent with guidance contained in the N.C. Plan for Multi-Hazards prototype.
 - d. Develop and ensure that procedures for notification are in place and effective in the event of a hazardous materials accident.
 - e. Ensure adequate training of responders to hazardous materials events.
 - f. Identify individuals and/or groups in areas of hazardous materials risk areas with special transportation needs.
 - g. Identify resources needed for response to hazardous materials emergencies and make recommendations to the Board of Commissioners.
 - h. Ensure that the provisions of the Super Fund Amendments and Reauthorization Act of 1986 are complied with.
 - i. Ensure that facility emergency coordinators provide information to the LEPC in a timely manner.

- j. On a yearly basis, publish a legal notice for the emergency planning committee in the local newspaper.
- k. Provide staff support to County EOC upon request.

19. **Amateur Radio Operators**

- a. Provide a liaison to the Greene County EOC during emergency activations.
- b. Transmit/receive emergency traffic as necessary during emergency conditions.
- c. Disassemble and relocate radio equipment to alternate locations, if necessary.
- d. Maintain message log for all traffic.
- e. Support post disaster emergency communication requirements, if needed.
- f. Provide back-up communications at all Greene County Shelters.

20. **Chiefs, Greene County Volunteer Fire Departments**

- a. Assist law enforcement with dissemination of warning of impending disaster/emergency situation.
- b. Provide support personnel to assist in traffic control and rescue operations.
- c. Provide direction and control during hazardous material incidents.
- d. Provide fire protection for shelters, mass care facilities, vital facilities and evacuated areas.
- e. Conduct fire inspections during recovery operations.
- f. Assist in Search and Rescue operations during emergency/disaster situations.

- g. Identify equipment and manpower limitation shortages and develop mutual aid agreements for the procurement of needed resources during emergency and disaster events.
- h. Coordinate fire-fighting activities with the county Fire Marshal during time of emergencies.
- i. Designate staging areas for mutual aid forces responding from outside the county.
- j. Alert all emergency support services to the dangers associated with hazardous materials emergencies.
- k. Support the evacuation of special institutions and handicapped/disabled special needs individuals.

21. **Director, Wayne-Wilson-Greene Chapter of American Red Cross**

- a. Coordinate activities with the Director, Greene County Social Services Department and Greene County Health Department in providing shelter/mass care services.
- b. Provide support personnel as requested for shelter/mass care operations.
- c. Provide shelter managers and staff to operate American Red Cross designated shelters.
- d. Provide training for shelter staff in support of shelter operations.
- e. Arranged for staffing of American Red Cross shelters and feeding of evacuees.
- f. Cooperate/coordinate with Salvation Army and other volunteer agencies in the delivery of mass feeding services.
- g. Designate a coordinator and personnel to assist the Director, DSS in the management of post disaster donated goods.

22. **National Guard**

- a. Coordinate with the county office of Emergency Management regarding the availability of personnel and equipment resources from local military installation.

23. **State and Federal Representatives**

- a. The State EOC, N.C. Division of Emergency Management will coordinate State Government resource requests for Greene County.
- b. N.C. Highway Patrol may provide a liaison to the Greene County EOC, if needed.

24. **Mental Health Director**

- a. Expand crisis operations as needed.
- b. Provide crisis counseling resources during periods of the emergency.
- c. Provide counseling of shelters required.
- d. Provide outreach staff persons to assist with identification of populations needing psychological services.
- e. Provide crisis counseling for emergency responders.
- f. Provide staff to special needs shelters when required.

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
COMMUNICATIONS/NOTIFICATION/WARNING
SECTION C**

Primary Agency: Greene County Sheriff's Department

Supporting Agencies: Greene County Emergency Services Department
Greene County Volunteer Fire Departments
Greene County Rescue Squads

I. PURPOSE

This section describes the county's communication/notification/warning systems, policies and procedures to be used by county government agencies to disseminate warning information to response agencies and the public.

II. SITUATION AND ASSUMPTIONS

A. Situation

1. The county communications center (911) is located at 301 N. Greene Street, Snow Hill and is operated by the Greene County Sheriff's Department. This facility (county warning point) is operational 24 hours per day and receives initial warning. Public inquires are received at this facility and warnings are disseminated to the county forces. The main communications tower is located 173 Carolina Drive, Snow Hill. The main tower is equipped with generator power. The backup tower is located at the intersection of Kingold Blvd. and W. Greene Street.
2. This facility is equipped with TDD machines for communicating with hearing impaired persons, as required by the American with Disabilities Act. This center dispatches all volunteer fire department and EMS units within the county. Additionally, this facility can tone out all agencies on the local government frequency (Animal Control, Emergency Services staff and Public Works).
3. One dispatcher is usually required to receive and dispatch traffic. There is a SOP in place for dispatchers, copy on file in EMO.

4. The remote base station towers are located at Kingold Blvd. and W. Greene Street in Snow Hill and at 173 Carolina Dr, Snow Hill. Carolina Telephone provides dedicated phone lines to the communications center and Emergency Management office to serve the radio nets. Auxiliary power is provided at the base station tower site at 173 Carolina Drive, Snow Hill. The back up tower is located at Snow Hill water tower # 2 (110 Kingold Blvd. Snow Hill). Greene County also has a back-up dispatching console located at the Greene County Emergency Services office (201 Martin L. King, Jr. Parkway). This console can be utilized in the event that we lose our primary dispatching center. This console can dispatch Fire, EMS and the Sheriff's Department and has tone out capabilities. This console is not equipped with a CAD system. It is only an emergency back-up dispatching console.
5. During emergency operations, the sheriff may have to station a deputy with a hand held radio in the EOC for communications with the field units.
6. Emergency Services has the capability to use the Emergency Broadcast System to deliver warnings/instructions to the public. Special needs groups, schools, persons in group quarter, camps and boaters in waterways may require special warning. Greene County has a reverse emergency notification system in place at our communication center from My State USA. This system can send emergency notification to anyone's home, business or cell phone, if they are in the system. Greene County 911 dispatchers have been trained to use this equipment and to send emergency notification messages if applicable.
7. Scanners owned by private citizens, national weather radio (NOAA Weather Radio System) receivers and fire/rescue pagers provide additional means of providing warnings.
8. Emergency Services, Fire & EMS personnel have pagers operated by Greene County Communications.
9. All Fire Departments have audible sirens at their stations.

B. Assumptions

1. Use of all available forms of warning and notification will not provide sufficient warning to the general public and special needs groups.
2. During emergency and disaster situations the commercial telephone system would probably become overloaded thus delaying calls or making call impossible due to increased usage.

3. Some remote communities and isolated groups of individuals may not receive warnings in a timely manner and may be without communications for an extended period of time.
4. Loss of the single communication tower on the law enforcement/fire/rescue repeater system could seriously hamper the ability to page and dispatch emergency personnel.
5. Commercial repair technicians from outside the county would have to be contacted to effect repairs on the communications system. Due to long travel times, they could be delayed in arriving in a timely manner. Technicians come from Gately Communications of Kinston, NC and Radio One of Greenville, NC.
6. State assistance may be needed to procure supplemental communications equipment or to locate available repair technicians following a major disaster.

III. CONCEPT OF OPERATIONS

A. General

1. The Greene County Warning Point (operational 24 hours per day) will initiate notification and warning of appropriate personnel by telephone, radio or pager (fire/rescue) as required, utilizing established notification procedures. This facility may receive warnings directly from the State Warning Point – N.C. Highway Patrol Raleigh Communications Center.
2. Law enforcement, fire and rescue vehicles equipped with public address systems may be used to supplement warnings issued to the general public.
3. The National Weather Service may issue weather watches or warnings directly to the public and the affected communication centers. Also the county warning points may receive notice of watches and warnings via the DCI system.
4. Local government will utilize all communication means possible to disseminate warnings to the public in a timely manner. These means include one or more of the following systems: local radio stations, NOAA Weather Radio; sirens, horns, mobile PA systems, telephones, reverse telephone notification system (My State USA), print media and broadcast over all radio frequencies.

5. The fire/rescue network will be the primary means by which the executive group will communicate with field forces in the county.
6. The N.C. State Emergency Management EOC and the Eastern Branch office will relay watches and warnings received from the National Weather Service utilizing fax and radio capabilities.

B. Specific Systems

1. Telephone/Cellular Service

- a. Commercial telephone service is provided by Embarq.
- b. Cellular phone service is provided in the county by Embarq, U.S. Cellular, Alltel and other cellular telephone companies.
- c. Embarq will be furnished a restoration priority list for telephone service prior and/or following a disaster.

2. Two Way Radio Systems

- a. The county's communication system is designated as the principal system to be used for direction and control activities.
- b. The following county departments, agencies and organizations operate two way radio systems:
 1. Emergency Services Department
 2. Sheriff's Department
 3. Greene County Landfill & Tax Office
 4. County Volunteer Fire Departments
 5. Greene County Animal Control
 6. Greene County Rescue Squads
 7. Greene County Transportation Department
- c. The following county volunteer organizations operate two way radio systems:
 1. Amateur Radio Emergency Services (ARES)
- d. Other two way communication systems which may be used to communicate with the State EOC during emergencies include:
 1. Web EOC
 2. Landline Telephone
 3. Cellular Telephone
 4. Satellite Network & Telephone
 5. NC Viper Radio System

- e. The following communication systems can be accessed from the communications center:
 - 1. Sheriff's Department radio system
 - 2. County fire/rescue network
 - 3. Rescue squad radio system
 - 4. The Local Area Police Network
 - 5. NC Viper Radio System

C. Line of Succession is as shown below:

- 1. Sheriff or Captain
- 2. Emergency Services Director or Assistant
- 3. Communications Supervisor

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
PUBLIC INFORMATION
SECTION D**

Primary Agency: Greene County Manager

Supporting Agencies: Greene County Emergency Services
Greene County Departments and Agencies

I. PURPOSE

This section describes the process for staffing, operating and maintaining a public information system to disseminate understandable emergency information to the public during emergency/disaster situations and respond to answers from media for official information.

II. SITUATION AND ASSUMPTIONS

A. Situation

1. Broadcast and print media will be relied upon to assist in the dissemination of public information to the general public. Most of the media outlets are located outside of the county.
2. The Public Information Officer (County Manager) and the Emergency Management Director have the capability & authority to activate the Emergency Broadcast System to warn the public or provide instructions.
3. The county is served by the following media outlets:
Print: In County: Greene County Standard Laconic
Out of County: Kinston Free Press, Wilson Daily Times, Daily Reflector and News Argus.
Radio: WDLX, Washington, NC; WRNS, Kinston, NC; WKTC, Goldsboro, NC
TV: WNCT-Greenville, NC, WITN-Washington, NC, WRAL-Raleigh, WCTI-New Bern, NC.
4. The county would receive extensive regional and national media coverage during and after an emergency or disaster situation.
5. Greene County will utilize the EBS operational plan for activation of EBS to broadcast warnings to the public by calling the State EOC or the National Weather Service in Newport.

6. Scanners, fire and rescue pagers are used extensively by residents and volunteers in the county. This system may be used to supplement public notification/instructions provided by media outlets.

B. Assumptions

1. In a large scale or protracted emergency period, the County Manager (Public Information Officer) would designate additional staff persons to act as the official spokesperson for the county.
2. In county printed media outlets may not be able to deliver timely emergency public information or instructions.
3. Depending on the severity of the emergency, telephone, radio and television communications may be disrupted. If this occurs, public address systems and door-to-door sweeps may be initiated.
4. Demand for information may be very heavy; therefore, sufficient staff will be provided and trained.
5. Rumor control will probably be necessary, as portions of the public will accept rumors and half-truths as official information.

III. CONCEPT OF OPERATIONS

A. General

1. The content of all news media releases will be cleared through the Public Information Officer and the control group prior to release.
2. For law enforcement related events, the Sheriff or the Chief Deputy will handle all inquiries from the media. When requested, the County Manager or his designee may provide assistance.
3. Public education programs designed to increase public awareness as to the potential hazards in the county, family preparedness matters, shelters, floor prone areas, evacuation routes and hurricane preparedness actions to be taken will be conducted.
4. The Emergency Broadcast System (EBS) must have authorization of the County Manager or the Emergency Management Director to be utilized.
5. The National Weather Service office in Newport will issue weather watches and warnings directly to the public and the media.

6. The control group will take actions to correct false, misleading or erroneous information released by the media.
7. News release disseminated by the county will be provided to the media and faxed to the NC Division of Emergency Management, State EOC.
8. Instructions, guidance and warnings will be provided to isolated and non-English speaking groups during and following emergency/disaster events.

B. Specific

The line of succession for public information is as shown below:

1. County Manager
2. Chairperson, County Board of Commissioners

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
LAW ENFORCEMENT
SECTION E**

Primary Agency: Greene County Sheriff's Department

Supporting Agencies: State Law Enforcement Agencies
[No municipal police departments are located in Greene County]

I. PURPOSE

This section provides for the maintenance of law, order, traffic control and security of vital facilities during emergency/disaster situations.

II. SITUATION AND ASSUMPTIONS

A. Situation

1. The Greene County Sheriff's Department provides law enforcement services 24 hours per day.
2. There are no municipal police departments located in Greene County.
3. State law enforcement agencies that routinely operate within Greene County are the N.C. Highway Patrol, the Division of motor vehicles (DMV-Enforcement), Alcohol Law Enforcement Division and the North Carolina SBI.
4. Federal law enforcement agencies operating within Greene County are the Federal Bureau of Investigation, Federal Marshals, Drug Enforcement Agency and the ATF.
5. Federal and state law enforcement agencies generally cooperate with local law enforcement agencies during emergency events.
6. Areas that would pose increased traffic hazards have been identified in other plans and have been coordinated with local law enforcement agencies.
7. Pre-determined traffic control points have been identified and are well know among local law enforcement agencies.

B. Assumptions

1. Activities of local law enforcement agencies will increase dramatically during the period of disaster/emergency operations.
2. When local law enforcement resources are overwhelmed, state law enforcement resources may be assigned to provide support to local forces.
3. During a period of hurricane evacuation, whether voluntary or recommended, traffic control problems will intensify throughout Greene County and especially along U.S. Highway 58 and U.S. Highway 258 in and through Snow Hill. Traffic flow could be hampered by mechanical failures, accidents and un-timed traffic control light along these routes.
4. Local law enforcement resources would quickly become overtaxed by having to provide traffic control services, security operations and continuing routing patrols/responses.

III. CONCEPT OF OPERATIONS

A. General

1. Law enforcement operations during times of emergencies/disasters will be an expansion of normal functions and responsibilities. These responsibilities will include maintenance of law and order, traffic control, crowd control, security of vital facilities, shelter locations, warning of isolated populations and enforcement of Emergency Proclamation issued by the Board of Commissioners.
2. The Greene County Sheriff's Department will be the overall coordinating law enforcement agency for all law enforcement operations in the county during emergency/disaster events and will operate under the NIMS/ICS principal.
3. All law enforcement operations will remain under the jurisdiction of the senior law enforcement officer of the jurisdiction in which the emergency operations is taking place.
4. Responses to violations of laws and the need to re-deploy law enforcement resources will be coordinated by the senior law enforcement representative in the county EOC.

5. While all law enforcement personnel may be called upon to assist in the warning and movement of isolated persons and persons with special needs, the primary mission will remain traffic control, security in and near evacuated areas and performance of other duties as directed by the senior law enforcement officer in the county EOC.
6. Searches for missing persons will remain under the control of the Greene County Sheriff's Department and Greene County Emergency Services Department with the Greene County Sheriff's Department being the lead agency.
7. When any outside law enforcement agency is requested to provide support to the Greene County Sheriff's Department a ranking officer from that organization will be present in the City or County EOC to coordinate operations of their personnel.
8. Traffic control will be a joint effort of the Greene County Sheriff's Department and State Highway Patrol.
9. Relocation of prisoners from the Greene County jail, if required, is the responsibility of the Greene County Sheriff's Department.
10. The Sheriff's Department has SOP's in place to utilize during emergencies.

B. Specific

The Line of succession for law enforcement operations is as shown below:

1. Sheriff, Greene County
2. Chief Deputy, Greene County Sheriff's Department
3. Shift Captain, Greene County Sheriff's Department

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
FIRE SERVICES
SECTION F**

Primary Agency: Greene County Emergency Services

Supporting Agencies: All Volunteer Fire Departments

I. PURPOSE

This section provides for the coordination of fire activities to ensure the safety of life and property within the county during emergency situations.

II. SITUATION AND ASSUMPTIONS

A. Situation

1. Greene County is served by 11 volunteer fire departments. Many of the departments are located within unincorporated areas of the county. The towns of Walstonburg, Hookerton and Snow Hill have a municipal/rural department.
2. The Greene County Firemen's Association composed of all volunteer fire departments serves as an advocacy group for firefighters. The Greene County Emergency Services Director acts as the county's liaison to Greene County Firemen's Association and is also designated as the county Fire Marshal.
3. The N.C. Division of Forest Resources is the lead agency for forest fire control in Greene County. Forestry maintains equipment for the county at the headquarters in Rocky Mount. Greene is located in district 5-Rocky Mount. District headquarters in located in Rocky Mount.
4. Urban interface has increased the hazard posed by forest fires.
5. All volunteer fire departments rely on the Greene County communications system for primary dispatching and communications.
6. Most of the fire departments are trained at either the awareness or operations level for responding to hazardous materials spills.

7. Mutual aid agreements exist among fire departments within the county.
8. Greene County Emergency Services conducts fire inspections utilizing their fire inspection personnel.
9. N.C. Fire Code provisions are enforced through the Greene County Emergency services office.
10. Castoria Fire Department, Fort Run Fire Department, Hookerton Fire Department, Shine Fire Department, Snow Hill Fire Department and Walstonburg Fire Department have equipment trucks that are equipped with hydraulic extrication equipment.

B. Assumptions

1. Planning and training prior to an incident will significantly reduce the risk to personnel.
2. Existing fire personnel and equipment will be able to cope with most emergency situations through the use of existing mutual aid agreements.
3. When additional or specialized support is required, assistance can be obtained from state and federal agencies.
4. Incidents may require response by multiple local, state and even federal agencies.
5. Fire departments may be requested to perform tasks not associated with routine duties, such as search, traffic control, emergency debris removal, alert, notification, evacuation, shelter staffing, etc.
6. Fire stations will become a community focal point where people seeking basic necessities and information may congregate following an emergency/disaster. It is expected that fire stations in affected areas will be manned during critical periods of emergency/disaster.

III. CONCEPT OF OPERATIONS

A. General

1. The National (NIMS) Incident Management System will be implemented on an appropriate scale at the scene of every fire event in Greene County, if applicable.

If fire or threat of fire is involved, the fire chief of that district or his designated representative will be the incident commander.

2. When one or more state agencies respond to an event, the N.C. Division of Emergency Management's Area 3 coordinator or his designee will serve as the state lead for coordination of all state resources at the scene of the emergency.
3. Volunteer fire stations will not be utilized as shelters for the public. In instances of extreme need volunteer department family members may be housed at the stations.
4. When four or more Greene County volunteer fire departments are dispatched a representative from the county Emergency Services office will be notified and will respond to the scene, when requested by the district fire department or chief officer at the scene.
5. The N.C. Division of Forest Resources is the lead agency for wild land and forest fire control. During forest fire events, the local fire department role will be the protection of structures threatened by the forest fire.
6. Resources required by fire departments beyond those available through mutual aid will be requested through the county Emergency Services office and routed to the State EOC.

B. Specific

The line of succession for fire services is:

1. Emergency Services Director/Fire Marshal
2. Assistant Emergency Services Director/Fire Marshal
3. President, Greene County Firemen's Association
4. Chief Officers, Local Fire Departments

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
RESCUE/MASS CASUALTY/FATALITY
SECTION G**

Primary Agency: County EMS Service
County Fire Service
Greene County Emergency Services

Supporting Agencies: Volunteer EMS Services
Volunteer Fire Departments
Red Cross
NC Emergency Management
Greene County Public Health
County & State Law Enforcement
Local Funeral Homes
NC Regional Medical Examiner's Office/Staff

I. PURPOSE

This section provides for the coordination of rescue/mass casualty activities to ensure the safety of life, property, care, identification, disposal of mass fatalities.

II. SITUATION AND ASSUMPTIONS

A. Situation

1. Greene County has three medical care facilities; Greene County Health Care, Inc., Katie B. Reynolds Pediatric Center and Parkwood Medical Center. These facilities offer general family practice and pediatric care.
2. Residents needing emergency medical attention are transported to Pitt Memorial, Wayne Memorial, Lenoir Memorial and Wilson Memorial hospitals.
3. a. The EMS/rescue squads operating in the county and their level of service are:
 - Arba EMS BLS
 - Castoria EMS BLS
 - Fort Run EMS BLS
 - Greene County EMS ALS

- Hookerton EMS BLS
- Maury EMS BLS
- Shine EMS BLS
- Snow Hill EMS BLS
- Walstonburg EMS BLS

b. There are 2 convalescent transport companies operating in Greene County.

- Elite Medical Transport BLS
- Johnston Ambulance Service BLS

4. The nearest trauma center is Pitt Memorial Hospital in Greenville, which can be reached by East Care helicopter service in about 30 minutes from any point in Greene County.
5. The Regional Medical Examiner is responsible for the care of the deceased. Their office is located at Pitt Memorial Hospital in Greenville, NC
6. A mass casualty SOP is also on file in the Greene County Emergency Services office.

B. Assumptions

1. A large scale or prolonged disaster/emergency period will result in increased demands on the limited EMS/rescue capabilities within the county.
2. Disruption of the county communication systems will severely impede the delivery of EMS/rescue services thus making it more likely that many injured persons will be transported to medical facilities by family or friends who are not trained in EMS procedures.
3. Debris and increased traffic on the limited road network may delay response.
4. Catastrophic disaster may affect large areas of the surrounding counties making nearby medical resources unavailable. Medical resources may have to be secured from other areas of the state.
5. Following a disaster in which rescue facilities are damaged, new bases of operations may have to be established, thus increasing the response time of the EMS/rescue squads.

6. In the event of a mass fatality occurrence, county funeral home directors will be available to assist the county medical examiner in the identification, care and disposition of remains.

III. CONCEPT OF OPERATIONS

A. General

1. During emergency or disaster periods EMS/rescue and fire services must be prepared to support each other utilizing available expertise, equipment and manpower.
2. In an emergency which requires a number of emergency services (e.g. fire, EMS, law enforcement, etc.) to respond, all units regardless of services will be coordinated by NIMIS Unified Command.
3. When needed patient Triage, holding, treatment and transportation areas will be established by the operation officer/EMS Coordinator.
4. When necessary an EMS official will be located at the EOC or command post to coordinate the incoming EMS units and establish communication links with hospitals and the county communications center.
5. East Care and Life Flight air ambulances could be utilized for patient evacuations in times of life threatening situations.
6. Additional EMS/rescue resources will be secured through the State Emergency Operations Center in Raleigh through the county Emergency Operations Center through Web EOC.
7. Operations for mass casualty events will be coordinated by the medical examiner in conjunction with the Emergency Medical Services Coordinator.
8. County funeral directors will serve as support to the medical examiner for the care, identification and disposition of remains.
9. When disaster conditions permit and an estimate can be made of the number of deceased, temporary morgue sites will be selected and activated. Remains will be recovered and evacuated to the temporary morgues for identification purposes and safeguarding of personal effects. Necessary information about each victim will be compiled and processed for the medical examiner. When authorized by medical examiner or designee remains will be released to family members for final disposition.

10. Temporary morgue(s) will be organized and administered by the medical examiner and supported by staffs of the county and local funeral homes. Functions carried out in each morgue will be dictated by the circumstances.
11. Mass burial will only be considered when the number of remains cannot be adequately managed, refrigerated, identified or processed in a timely manner in which to avoid human health concern. Any decision to begin mass burial must be made at the highest levels of local and state government.
12. If there is not a religious or Law Enforcement reason for the disposal of remains by cremation, it would only be considered if it is the wishes of the deceased family members or under orders from the NC Medical Examiner's office.
13. Every effort will be made to recover all remains. However, in the event that is not possible to recover each victim, efforts will be made to notify family for inclusion in an appropriate service.
14. A number of commercial food distributors operate refrigerated trucks. Landscaping firms and farmers operate specialized equipment that could be used to perform heavy rescue and recovery.
15. A number of contractor rental firms operate near Greene County and heavy equipment (cranes, front-end loaders, etc.) may be available from them.

B. Specific

The line of succession for rescue/mass casualty is shown below:

EMS Operations

1. Greene County Medical Director
2. Greene County Emergency Medical Services Coordinator
3. Greene County EMS Association Captain
4. Greene County EMS Units Captains

Mass Fatality Operations

1. NC Medical Examiner
2. Greene County Health Department
3. Greene County Emergency Services
4. Greene County Fire & EMS Departments

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
PUBLIC WORKS
SECTION H**

Primary Agency: Greene County Public Works Department

Supporting Agencies: Hookerton Public Works Department
Snow Hill Public Works Department
Walstonburg Public Works Department
Maury Sanitary Land District
Greene County Emergency Services Department

I. PURPOSE

The purpose of this section is to provide for public works services during an emergency/disaster, including solid waste disposal, water distribution, sewer system and debris removal.

II. SITUATION AND ASSUMPTIONS

A. Situation

1. Greene County

- a. Greene County operates a public works department that is consolidated with the landfill.
- b. The County Public Works department is located at 105 Landfill Rd, Walstonburg. This department is owned and operated by Greene County. This department is comprised of fourteen personnel who operate the county water system and additional personnel who manage the solid waste section. The Public Works department provides water services to the residents and maintains the county system, including billing and collecting for its services. Solid waste is transported to this location by Waste Industries, various municipalities and other private haulers operating within Greene County.
- c. The Greene County Public Works Department has limited public works capability that could be utilized during an emergency. This department has manpower and limited materials that could be used for maintenance of water services during an emergency.

- d. The cities of Snow Hill, Hookerton, Walstonburg and Maury Sanitary Land District provides water and sewer service for their residents. Homes and businesses not served by these systems utilize private wells and septic tanks. Businesses not serviced by these systems utilize private septic tanks and private waste treatment systems.
- e. A number of sewage treatment plants are located in the county, also a number of systems that pump wastewater to other locations are in operation.
- f. Electrical service is provided throughout the county by Progress Energy and Pitt-Greene Electric Cooperative, which purchase power from Progress Energy.
- g. The area's electric utilities have mutual aid agreements with other companies, which allow augmentation of emergency repair crews during emergencies/disasters.
- h. Land based commercial and residential telephone service for the county is provided by Embarq.
- i. National Network, Page South, Answerphone, Southern Communications, Page East, Dial Page and others provide paging service to the area.
- j. Cellular phone service in the area is provided by Sprint, U.S. Cellular and Alltel.
- k. Greene County is served by the Divisions of Highways maintenance yard located in Maury.
- l. Emergency fuel for county vehicles will be available at either the local service stations or school bus garage located in Snow Hill.
- m. All roads in Greene County (excluding towns) are owned by the State government and maintained by the N.C. Department of Transportation, Division of Highways.

2. Municipal

- a. The Town of Snow Hill Public Works department consists of water, sewer, storm sewer, utility maintenance and cemetery sections. Through contract with Waste Industries, the town provides garbage pickup service. The Town of Snow Hill provides maintenance, billing, and collecting services for the private water systems of South Greene and Jason/Shine. The town maintains the Arba water system on a cost plus basis. Arba Water Corporation does its own billing and collecting services. The town of Snow Hill has two elevated water tanks and operates several wells. The town also operates a sewage treatment plant. The work force is comprised of ten operational & 4 administrative people for this department.

- b. The Town of Hookerton Public Works department consists of water, sewage, storm sewer and utility maintenance including the distribution of electricity. Through contract with Onslow Container, the town provides garbage pickup for its residents. The town has a waste treatment plant operated by the public works department. Hookerton has one elevated water tank and operated two wells. The work force consists of 2 operational & 2 administrative people.
- c. The Town of Walstonburg Public Works department consists of water, sewer service and the distribution of electricity. The Town of Walstonburg purchases water from Greene County and bills and collects from its customers. Greene County provides maintenance of the service lines on a cost plus basis. The town has one elevated water storage tank and also operates a sewer treatment plant. The work force consists of 1 operational & 1 administrative people.
- d. Debris is a consequence of certain disasters; the emergency removal of debris by public works forces is critical to restoration of vital/essential services.
- e. A number of logging companies and loggers are located near Greene County which have equipment ideally suited for debris removal and chipping.
- f. Numerous pieces of heavy equipment suitable for debris removal can be found throughout the county at various farms, businesses and industry sites.

3. Sanitary Districts

- a. Maury Sanitary Land District, governed by the Maury Sanitary Board, provides water and sewer services its residents. This sanitary district provides ground storage water tanks and serves two state correctional facilities in addition to its residents and business customers. The Maury Sanitary Land District is comprised of a Board of Directors and two maintenance persons.

B. Assumptions

- 1. All systems would need to come together to provide maximum capabilities under County, Town PWC.
- 2. Following a catastrophic event most roads and streets will be impassable due to debris.

3. Volunteers will be available and willing to assist with emergency debris removal.
4. Interruption of some or all essential services is an expected consequence of an emergency/disaster, resulting in large numbers of people without essential services.
5. A catastrophic event affecting multiple counties and/or states may result in the following consequences:
 - loss of some or all essential services for extended periods of time
 - a shortage of available outside assistance
 - a shortage of materials for repair of utilities overall delay in restoration of essential services
 - rapid exhaustion of local resources
 - attempted price gouging for repair of essential services
6. The N.C. Division of Highways will remove debris from the highway and road system. The division will not remove debris from private property except in extraordinary cases cleared through the State EOC.
7. The N.C. Division of Forest Resources can perform emergency debris removal beyond State property when requested and approved through the State EOC.
8. Privately owned farm and industrial equipment will be heavily utilized by volunteers assisting with debris removal.
9. Controlled burning of debris will be allowed as a means of disposal, authorized by the county Fire Marshal's office.
10. Vital facilities will receive priority in the restoration of essential services. See supporting documents section.
11. The N.C. Division of Forest Resources maintains an operation within the county. Equipment suitable for debris removal activities may be available through Greene County headquarters, from the district office.
12. State owned or supported vehicles can be refueled at the Division of Highways yard equipped with auxiliary power or field fueled from DOT tanker trucks.

III. CONCEPT OF OPERATIONS

A. General

1. The various agencies in Greene County with public works capabilities will assist each other during emergency/disaster periods as their capabilities allow.
2. The coordinator, Public Works in the EOC will receive requests for emergency debris removal, prioritized tasks and deploy available public and private resources. The Greene County fire radio system will be utilized to coordinate debris removal operations.
3. Priority for emergency debris removal will be given to the following:
 - a. potential rescue sites
 - b. known helipads
 - c. EOC
 - d. emergency services locations
 - e. medical facilities
 - f. primary streets and roads
 - g. vital utilities (power lines, substations, waste water plants, and communication sites)
 - h. Disaster application center sites
 - i. shelters
 - j. staging areas and refueling areas
4. N.C. Forest Service unit will be the lead agency for debris removal off of state property, when directed.
5. Temporary debris storage, sorting and chipping sites will be established throughout the affected area to facilitate management of debris. Sites will be located in areas where burning of debris can be done within applicable regulations.
6. The county landfill will assist in the storage, disposal and sorting of large quantities of debris.
7. Sites will be established throughout the affected area for distribution of emergency water supplies to the public and to work sites.
8. Emergency generators, when available, will be deployed to vital public facilities which do not have power.

9. If available, portable toilets will be provided to the general public and to work sites.
10. Fire departments would clear roads in and near their stations to provide access and egress.

B. Specific

The line of succession for Public Works is as shown below:

1. Greene County Public Works Director
2. Greene County Assistant Public Works Director
3. Town Public Works Director

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
PUBLIC HEALTH SERVICES
SECTION I**

Primary Agency: Greene County Health Department

Supporting Agencies: American Red Cross
Greene County Healthcare, Inc.

I. PURPOSE

This section provides for protection of the public's health and provisions for medical services during natural, technological and man caused emergencies.

II. SITUATIONS AND ASSUMPTIONS

A. Situation

1. The County Health Department, located in Snow Hill, is the principal provider of public health services in the county. The department employs five RN Nurses & one nurse practitioner. Maternity care is the highest level of care provided. Acute care, beyond first aid response, will be handled by the Greene County units and patients will be transported to the appropriate medical center.
2. Home Health care is provided by Greene County Health Care and Home Health Hospice to those individuals requiring home health services.
3. The municipalities of Snow Hill, Hookerton and Walstonburg operate sewer systems in Greene County.
4. No mobile home parks operate private water systems or sewer systems. A listing of all mobile home parks is contained in the support manual.

5. Greene County Regional Water System provides water to county residents who reside outside municipalities. Jason and Arba Water Corporations primarily provide service to their communities, but Greene County has the capability of providing water to these systems in emergencies. Arba system is located at RPR 1104 and Jason system is located on RPR 1132. These water systems are susceptible to flooding and contamination problems.
6. Special needs population lists are maintained by those agencies providing services to their clientele. These lists would be available to response personnel through representatives of those agencies.
7. No privately owned sewage system plants operate within the county.

B. Assumptions

1. Most emergency situations can lead to public health and medical problems.
2. A large-scale emergency will result in increased demands on the personnel and equipment resources of the health department and other health care providers in the county.
3. During the recover period following a major disaster/emergency, the health department will focus on controlling the spread of communicable diseases resulting from contaminated water supplies, failed septic tank systems, spoiled or contaminated food supplies and unsanitary living conditions.
4. EMS is most critical within the first 30 minutes of the emergency. Mutual aid assistance usually arrives after this critical period.
5. A catastrophic disaster could result in multiple fatalities resulting in the establishment of temporary morgues and family inquires.
6. When local resources can no longer meet the demand of the situation, additional resource requirements will be requested through the Emergency Services office, who will request assistance through the N.C. Emergency Management EOC.

III. CONCEPT OF OPERATIONS

A. General

1. The health department will implement effective environmental health, nursing and health education practices to minimize the incident of disease.
2. The health department will coordinate health care in Red Cross approved shelters and mass care facilities (if established). Services will be rendered in agreement with the ARC-Health Department protocols.
3. Inspections of damaged areas and shelters will be carried out in order to monitor food preparation, rest room facilities, pest control, sanitation, inoculations and water purification needs.
4. Testing of water supplies will be overseen by the health department.
5. The movement of home bound patients normally cared for by home health care service and those special needs populations (when required) will be the responsibility of the agency rendering services to them at the time of the disaster.
6. The health director will coordinate with the county PIO concerning the distribution of information relating to disaster related health procedures and advisories.
7. Animal Control, animal care and the Pet Shelter will function under the control of the Health Department's Animal Control Division.
8. Both the towns and county utilize the animal control facility on 903 North of Snow Hill.
9. If large animal control facilities are needed the hunting club preserves could be utilized.
10. The animal control division will coordinate with the County Animal Response Team within the agriculture extension office.

B. Specific

The line of succession for Public Health Services is as shown below:

1. Director, Greene County Health Department
2. Environmental Health Supervisor
3. Nursing Supervisor

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
EVACUATION/RE-ENTRY
SECTION J**

Primary Agency: Greene County Transportation Department

Supporting Agencies: Greene County Schools

I. PURPOSE

This section provides for coordinated evacuation and re-entry of the county population when necessary during emergencies.

II. SITUATION AND ASSUMPTIONS

A. Situation

1. A hazard analysis and vulnerability assessment has been completed which identifies the types of threats the county is most vulnerable to.
2. Segments of the population that pose special considerations in any evacuation; non-English speaking groups and persons living in remote areas of the county are being identified with assistance from several sources.
3. An attempt has been made by the Greene County Department of Social Services and the Health Department to identify special needs populations, which may have special evacuation requirements.
4. A comprehensive hurricane evacuation study was completed in 1987 for Eastern North Carolina. This study included a traffic analysis defining evacuation routes and clearance times, potential areas that could flood and a behavioral analysis.
5. Greene County emergency personnel have experienced a general evacuation in recent years, thus obtaining considerable experience in evacuation and re-entry procedures.
6. Greene County Transportation Department and Greene County Schools operate buses and human services vans owned by the county.

7. The county contains numerous mobile homes located on individual sites or in mobile home parks.
8. Greene County or its municipalities do not issue or utilize formal re-entry permits.
9. Decisions on re-entry into damaged or isolated areas will be made by the Control Group(s) of the affected jurisdictions.
10. U.S. Highway 264, 13 and 258, N.C. Highway 58, 903 and 91 are the major traffic routes in and out of the county. Evacuations that require the use of these routes could become impossible or greatly delayed.
11. The key bridges within the county for evacuation of county residents to move outside the county or for evacuees traveling through the county are listed in the Basic Plan (P-2).

B. Assumptions

1. Emergency situations may require evacuation of all or part of the county. Small-scale localized evacuations may be needed as a result of a hazardous materials incident, major fire or other incident. Large-scale evacuation may be needed in the event of an impending hurricane.
2. Sufficient warning time will normally be available to evacuate the threatened population.
3. Traffic control resources must be in place prior to the public release on an evacuation order.
4. Evacuation and re-entry information will be made available to the public by all available means.
5. If there is significant potential threat, some residents will evacuate prior to being advised to do so by public officials.
6. Most evacuees will seek shelter with relatives or friends rather than accept public shelter.
7. Some residents may refuse to evacuate regardless of warnings.
8. Some people will lack transportation. Others who are ill or disabled may require vehicles with special transportation capabilities. Still, others who are non-English speaking may have to be provided interpreters.

9. Debris or damage to the roadway could hamper re-entry.
10. Effective evacuation should be completed during daylight hours.
11. Large-scale evacuations from ocean front counties or contiguous counties will impact Greene County.
12. Effective traffic control points will facilitate orderly re-entry into isolated or evacuated areas.
13. Evacuations, when ordered by the Chairperson of the Commissioners, will be **voluntary** rather than mandatory.
14. Re-entry into evacuation areas will be ordered by the Chairperson of the Board of Commissioners after the emergency or disaster situation has ceased to be a threat to life and property.

III. CONCEPT OF OPERATIONS

A. General

1. The responsibility of ordering a countywide evacuation or re-entry rests with the Chairperson, Board of Commissioners. If a single municipality is to be evacuated, the mayor will issue the order. If the evacuation or re-entry involves multiple jurisdictions or an area outside of a municipality, the order will be issued at county level by the Chairperson, Board of Commissioners.
2. Public information concerning the Chairperson's evacuation or re-entry orders will be released through all available media.
3. The incident commander at the scene of an isolated emergency in Greene County has the authority to order an evacuation of the area specific to the incident. The Emergency Services Director or staff should be made aware of isolated evacuation.
4. Regional coordination of traffic control, shelter/mass care and public information will enhance the total evacuation and re-entry process. The N.C. Emergency Management EOC will coordinate regional evacuation activities.
5. Law enforcement will implement traffic control for evacuation and re-entry.

6. All transportation services within the county will be coordinated by the Greene County Transportation Department. All contract providers of transportation services to the county will be coordinated by the transportation official from the EOC.

B. Specific

1. Evacuation

- a. Traffic control points to support evacuation have been predetermined.
- b. The size of the threatened area to be evacuated will be determined by conditions at the time of the emergency.
- c. Access to defined evacuation areas will be denied to non-essential personnel once an evacuation order has been issued.
- d. Vehicles experiencing mechanical problems during the evacuation will be moved off the roads by necessary means as authorized by law enforcement officials.
- e. Stranded motorists will be assisted by law enforcement officers in reaching a location of best available shelter.
- f. Institutions (nursing homes, rest homes, retirement centers, etc.) within the county must develop procedures for evacuation of patients or residents. When the capabilities of an institution to meet resource requirements are exceeded, the institution will be assisted by the EOC with resource procurement.
- g. Schools will develop evacuation procedures. Pre-designated buses will be utilized for students without their own vehicles. Schools within the danger zone for hazardous material spills will develop procedures for in-place sheltering and "walk away" evacuations. Parents will be advised of the location of reception centers.
- h. That segment of the county's population lacking transportation to a shelter facility will be assisted by the most appropriate means of transportation available.
- i. Designated special needs shelter will be opened to accommodate that population; specialized means of transportation will be needed to accomplish movement of these people to the shelter. Due to the limited numbers of specialized vehicles available for transport, evacuation of the special needs populations will be initiated in advance of a general evacuation.

2. Re-entry

- a. The decision to allow re-entry to any evacuated/restricted areas of Greene County will be made to the Chairperson, Board of Commissioners, based on considerations of public safety.
- b. Evacuated emergency service equipment and personnel will re-enter prior to the re-entry of the public.
- c. The Chairperson, Board of Commissioners will establish the order for the re-entry of the public.
- d. Staging area for incoming resources will be established. All incoming relief resources and personnel reporting to Greene County will be routed to one of the following staging areas:
 1. Greene County Office Complex
 2. West Greene School
 3. Snow Hill Primary
 4. Greene Central
 5. Greene County Recreation Complex
- e. Privately owned sites for forward staging throughout the county will be negotiated and utilized, as needs dictate.
- f. Certain regional staging areas will be utilized as mobilization points to receive and organize emergency relief personnel and equipment.
- g. Sections of the county may remain isolated or closed to the public even after re-entry begins.

C. Line of succession is as shown below:

1. Director, Greene County Transportation Department
2. Director, School Transportation Operations

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
SHELTER/MASS CARE
SECTION K**

Primary Agency: Wilson-Greene County Chapter of American Red Cross

Supporting Agencies: Greene County Schools
All Greene County Departments

I. PURPOSE

This section provides for the care of the population through the identification of shelters and provision of mass care and social services in the shelters.

II. SITUATION AND ASSUMPTIONS

A. Situation

1. Based upon the county's hazard analysis there are several emergencies for which shelters may be required including severe storms, tornadoes, floods, hazardous material accidents, fires and hurricanes. (See Basic Plan for complete listing).
2. There are no identified HURRICANE shelters for pre-landfall used in Greene County; however, the Wilson-Greene County Chapter of the American Red Cross has been designated as a host agency for hurricanes approaching North Carolina coast and in this connection the Wilson-Greene American Red Cross chapter is required to activate two (2) shelters to accommodate evacuees from the coastal area.
3. Greene County does not have the capability for auxiliary power at any designated shelters. All shelters would have to rely upon auxiliary power.
4. The Wayne-Wilson-Greene Chapter of the American Red Cross has surveyed four schools in the county for sheltering. **Greene Central, West Greene, Greene County Middle and Snow Hill Primary.**

5. Out of county sheltering for Greene County residents (excluding special needs) will be coordinated through the State EOC and Greene County EOC.
6. A written agreement exists between the American Red Cross, Greene County Department of Social Services and the Greene County Board of Education for the coordination of and use of school facilities for shelter/mass care activities.
7. Farmville Health Care Center (4351 S. Main St Farmville-Hwy 258 South of Farmville) can assist Greene County in the housing of the special medical needs population. This institution can accommodate up to 8 residents.

B. Assumptions

1. Local grocery stores, restaurants and other businesses will support initial shelter/mass care operations with donations of emergency supplies.
2. For out-of-county evacuation, sufficient shelter capacity exists in adjacent counties. Shelter location can be arranged and made available.
3. A high percentage of evacuees will seek shelter with friends or relatives rather than go to public shelter.
4. Churches and other groups may open shelters independently. These shelters can not be supported by the county or American Red Cross.
5. Evacuees will be provided with public information in the shelter concerning the emergency event.
6. Following a disaster there will be an abundance of goods delivered to the disaster area by well-intended citizens outside the impacted area.

III. CONCEPT OF OPERATIONS

A. General

1. Chairperson of the County Commissioners or his designee in coordination with the Emergency Services Director or designee will make decisions on when and where to open shelters in a countywide emergency. However, in a small isolated emergency the incident commander may request the opening through the Emergency Services Director or designee.

2. Upon notification of a requirement for sheltering by the Greene County Emergency Services Director, the American Red Cross Chapter, serving as the lead agency for shelter/mass care, will coordinate opening and operation with the Greene County DSS and will mutually support shelter operations with shared personnel and support services whenever possible.
3. If additional shelter support is needed following a disaster event, request for assistance should be made through the State EOC by the county EOC.
4. Public and private providers of institutional care (medical and residential) remain responsible for shelter plans for their residents.
5. Greene County will not assume any RESPONSIBILITY-LIABILITY for unauthorized shelter openings during emergency events.
6. The Greene County Department of Social Services, the Greene County Board of Education, the American Red Cross and the Emergency Services Director will decide when shelters are to be closed.
7. At each Greene County supported shelter location the county will provide health/medical support (Public Health), communications (Ham Radio), fire protection (local fire department) and security (Sheriff's Department).
8. Churches, fire station and community center can be used as pick up points for persons or groups requiring transportation to shelters.
9. Crisis intervention and mental health counseling should be provided at shelters.
10. Residents utilizing public shelter spaced will be instructed to bring medications, blankets, special foods, formulas for children and a supply of food for personal consumption. No weapons or pets are allowed in shelters. Pets are only allowed at Greene Central High School Pet Shelter. Dogs & Cats only, no exotic animals.
11. The Greene County Sheriff's Department will enforce security within the shelter and the area(s) immediately adjacent to the shelter (including parking locations).
12. Residents will be instructed not to bring pets, alcohol, drugs (other than prescription which will be turned in to the nursing staff), guns, boom boxes, radios, TVs, perishable goods or other weapons. Law enforcement will have the authority to search bags and confiscate any items brought into the shelter. Confiscated items will be returned upon leaving the shelter.

13. Children under 18 years of age must be accompanied by an adult when entering the shelter.
14. Security for shelters opened within municipalities will be provided by the Sheriff's Department.
15. No Convicted Sex Offenders will be allowed to stay at any Greene County Shelters with the general population. All convicted sex offenders will shelter at the Greene County Sheriff's Department at 301 N. Greene St, Snow Hill.
16. The nearest EMS unit will provide emergency medical transportation from shelters to area hospitals. Greene County Transportation Department, private ambulance companies or private vehicles will provide non-emergency transportation from shelters to area hospitals, doctor offices or medical clinics if the need arises.
17. Shelters will be closed as soon as conditions allow for safe return of evacuees to their homes.
18. Request for additional shelter openings will be coordinated with the Wayne-Wilson-Greene County Chapter of the American Red Cross.
19. Greene County has one Pet Shelter, which is located at Greene Central High School Agriculture building. Greene County Animal Control and Greene County Agriculture Extension service will operate this shelter.

B. Specific

The line of succession for shelter/mass care is as shown below:

1. Executive Director, Wayne-Wilson-Greene Chapter of American Red Cross
2. Chapter Chairperson, Wayne-Wilson-Greene Chapter of American Red Cross
3. Chapter Disaster Chairperson, Wayne-Wilson-Greene Chapter of American Red Cross

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
DAMAGE ASSESSMENT
SECTION L**

Primary Agency: Greene County Tax Supervisor

Supporting Agencies: Greene County Emergency Services
Greene County Building Inspections
Greene County Planning Department
Greene County Recreation Department

I. PURPOSE

This section describes the process of damage assessment reporting procedures and outlines the criteria for individual assistance and public assistance programs, qualifications.

II. SITUATION AND ASSUMPTIONS

A. Situation

1. Most hazardous events which may affect Greene County or its municipalities have the potential for causing damage. A planned damage assessment program is essential for effective response and recovery operations.
2. If a significant emergency/disaster occurs, the following series of damage assessment activities will be conducted by local governments:
 - a. Initial impact assessment by field services
 - b. Preparation of an Immediate Situation Report for control group
 - c. Determination of the need for outside assistance and resources
 - d. Notification/transmittal of Immediate Situation Report to the County Emergency Operations Center
 - e. Initiation of detailed damage assessment activities including dispatch of teams to the field.
 - f. Summarization of field information gathered by damage assessment teams for the control group
 - g. Submission of detailed damage assessment information by the control group to the County Emergency Operations Center.

3. Electric power is essential in order to duplicate county tax maps needed for detailed damage assessment. Individual maps are filed in the tax office by parcel name and number.
4. The magnitude of the emergency/disaster may necessitate a need for additional personnel trained in damage assessment.
5. Persons trained and experienced in damage assessment can be found throughout the state, in local and state government and in the business community.
6. Following a disaster, independent damage assessment activities will be conducted by a variety of organizations including but not limited to:
 - a. State and Federal Damage Assessment Team
 - b. American Red Cross
 - c. Insurance Companies
 - d. Utility Companies

B. Assumptions

1. A catastrophic disaster will exceed the damage assessment resources of the county and will require additional damage assessment personnel.
2. State, County and Municipal personnel not impacted by the emergency/disaster may be available to assist with impact assessment.
3. A catastrophic disaster will impede the ability of emergency services to provide immediate situation reports.
4. The demand for information by the media may interfere with the county's ability to conduct impact assessment.
5. Damage to the utility systems and the communications systems may hamper the impact assessment process.
6. The thoroughness and accuracy of damage assessment can affect the receipt of recovery assistance.

III. CONCEPT OF OPERATIONS

A. General

Responsibility for preliminary and detailed damage assessment lies with county and municipal governments and other not-for-profit entities (if their facilities are affected).

B. Specific

1. Damage assessment activity will coordinate from the county EOC by:
 - a. Greene County Tax Assessor
 - b. County Appraiser – Tax Office
 - c. GIS Mapping
2. The damage assessment officer will coordinate the compilation of damage assessment information; the plotting of damaged areas on local maps and the preparation of damage assessment report for the control group.
3. Damage assessment reports will include, but not be limited to information on persons affected, victim mass care, infrastructure survival, damage to vital facilities and economic impact.
4. Damage assessment reports will be forwarded to the County EOC.
5. Damage assessment reports will be reviewed to determine if any outside assistance will be necessary to recover from the event.
6. The Governor may request a Presidential Declaration of a “major disaster”, “major emergency” or a specific federal agency disaster declaration (SBA, Dept. of Agriculture, Corps of Engineers) to augment state, local and private relief efforts.
7. When the President issues a “Major Disaster Declaration” two basic types of disaster relief assistance is authorized:
 - a. Individual Assistance (IA) includes:
 - Temporary housing (100% federal dollars)
 - Individual/Family Grants (IFG) 25% state and 75% federal dollars
 - Disaster unemployment assistance
 - Disaster loans

- Legal services to low income families
 - Consumer counseling; assistance in obtaining insurance benefits
 - Social Security benefits assistance
 - Veterans Assistance
 - Casualty loss tax assistance
- b. Public Assistance (PA) 75% federal and 25% state funds
- debris removal
 - emergency protective measures
 - funds to permanently repair, repair road systems, water control/disposal/treatment facilities, public buildings, public equipment, public recreational facilities, etc.
8. When a major federal declaration is received, the President appoints a Federal Coordinating (FCO) and the Governor appoints a Governor's authorized representative (GAR) to coordinate relief efforts and delivery of disaster assistance.
9. A disaster field office (DFO) will be established near the disaster area. If the disaster affects a large region a satellite DFO may be opened to handle disaster claims.
10. Disaster Application Centers (DAC) will be established in the disaster area for individuals to make application for assistance. When needed, DAC can be opened in the following locations:
1. Greene County Office Complex
 2. Senior Citizens Center - Alternate
11. If the declaration includes Public Assistance, an applicants briefing will be conducted for those officials in county, state and private non-for-profit entities wishing to apply for reimbursements of disaster related expenses. During this briefing each eligible entity will submit a Notice of Interest (NOI) and appoint an Applicants Agent to coordinate the submission of disaster documentation to the DFO.

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
RESOURCE MANAGEMENT
SECTION M**

Primary Agency: Greene County Finance Office

Supporting Agencies: Greene County Emergency Services

I. PURPOSE

This section provides a system of identifying and locating resources within the county and a method of activating those resources during an emergency. The preservation, conservation and replenishment of these resources are also included.

II. SITUATION AND ASSUMPTIONS

A. Situation

1. Many of the resources listed below would be critical in both an immediate response and long term recovery period within the county. These critical resources may include:
 - Personnel
 - Equipment
 - Facilities
 - Information
 - Commodities
2. The Greene County Emergency Services office maintains a list of the resources available within the county from both public and private sources. It is generally recognized that these resources, somewhat limited in scope, would be inadequate to fulfill all the needs of the various agencies in a protracted emergency/disaster.

B. Assumptions

1. Locally owned or controlled resources will be first employed to respond to a disaster or emergency situation in the county.
2. Adequate local resources to respond to a long- term emergency would not be available in the county.

3. Necessary personnel, equipment and supplies will be available initially to support the emergency response.

III. CONCEPT OF OPERATIONS

A. General

1. County and municipal departments and agencies will use their own resources and equipment during emergencies and will have control over the management of these resources when the resources are needed to respond to the emergency situations.
2. Staging area(s) for incoming resources will be identified as needed for location in accessible areas as a mobilization point for incoming resources Central Receiving & Distribution Point (CRDP).
3. The Finance officer will prepare routing procurement procedures for the acquisition or replacement of resources during day-to-day operation and also develop a procurement system to acquire expendable supplies during emergencies.
4. The Emergency Services office will also identify those resources and capabilities that are available in local businesses and industry and other contributing organizations and develop the mutual aid agreements required to acquire those resources to support the county under emergency conditions.
5. Resource management will be coordinated from the county emergency operations center during countywide emergency/disaster situations under the leadership of the Emergency Management Director. The agency that has day-to-day control of a resource needed to respond to a disaster will continue to have operational control of the resource during an emergency period.
6. Coordinators of the various functions within county government will coordinate the need for additional personnel, equipment and/or relocation of supplies with the Finance officer or her designee.

B. Specific

The line of succession for resource management is as shown below:

1. Finance Director, Greene County
2. Emergency Services Director

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
RECOVERY OPERATIONS
SECTION N**

Primary Agency: Greene County Emergency Services

Supporting Agencies: All Greene County Departments
All Greene County Municipalities

I. PURPOSE

This section presents a system for the provision of disaster recovery assistance following a disaster or emergency event.

II. SITUATION AND ASSUMPTIONS

A. Situation

1. Recovery refers to those measures undertaken by a community following a disaster to return all systems to normal or improved levels. Recovery does not just happen, despite the fact that citizens generally take the initiative in “picking up the pieces” and trying to resume the activities that make up community life. Effective recovery consist of a complex array of interdependent and coordinated actions. These actions are under taken at several levels (individual, organizational, community and national) over a long period of time.
2. A properly managed recovery program will allow the prompt restoration of essential services, the reconstruction of damaged property and the resumption of traditional lifestyles.
3. Recovery from a significant disaster will be managed in two identifiable phases:
 - a. Short Term Recovery

This is the emergency reaction phase which begins with the implementation of emergency plans. Actions during this period include:

 - initial emergency response (i.e., fire/rescue, law enforcement, EMS operations, mass care)

- initial impact assessment
- emergency debris removal from transportation routes
- restoration of vital services
- security of damaged and evacuated areas
- management and distribution of donated goods
- preliminary damage assessment
- temporary repairs to roads and bridges to make passable

b. Long Term Actions

Actions taken during this phase include:

- completion of damage assessment
 - completion of debris removal
 - request for disaster
 - Declaration/assistance – restoration of essential facilities
 - repair/rebuilding of damaged public and private facilities and buildings
 - repair/rebuilding of private roadways and bridges
 - repair/rebuilding of private homes and businesses
 - hazard mitigation project
4. A request from the Governor to the President of the United States for a Presidential Declaration will be based on the magnitude and severity of the situation and the inability of the county to recover without assistance.
 5. The President's Disaster Relief Program is designated to supplement the efforts and available resources of state and local government, voluntary relief organizations and other forms of assistance such as insurance. The President's declaration of a major disaster or an emergency authorized federal assistance under the Stafford Act and triggers other federal disaster relief programs as well.
 6. A full Presidential Declaration of Disaster includes all of the following emergency assistance programs.
 - Public Assistance (PA)
 - Individual Assistance (IA)
 - Small Business Administration Assistance
 - Hazard Mitigation Programs

7. In lieu of a full Presidential Declaration, federal assistance can also be delivered through a partial declaration, emergency declaration or any combination of the following:
 - Search and Rescue Assistance
 - Fire Suppression Assistance
 - Health and Welfare measures
 - Emergency Conservation Program
 - Emergency Loans for Agriculture
 - Disaster Loans for Homeowners and Businesses
 - Repairs to Federal Aid System Roads
 - Tax Refunds/IRS Assistance to victims
 - Voluntary Agency Assistance via Red Cross
 - Department of Defense Pre-declaration Emergency Assistance (via Stafford Act)
8. There exists in the county a United States Department of Agriculture County Emergency Board responsible for providing leadership and coordination for all USDA emergency programs at the county level. Guidance, direction and assistance on emergency programs are provided by the USDA State Emergency Board.
9. The President may declare an emergency in the absence of a Governor's request when the emergency involves a subject area for which the Federal Government exercises exclusive or preeminent responsibility and authority.
10. Close cooperation among the agents of local, state and federal government will be essential in expediting assistance to the county after any Presidential Declaration.
11. Hazard Mitigation Grants will be available through FEMA after a Presidential Declaration; the grant total will be based on the amount of Public Assistance funds provided to county applicants.
12. As potential applicants for Public Assistance, local governments and private non-for-profit agencies must thoroughly document disaster-related expenses from the onset of an emergency/disaster.
13. Businesses which intend to apply for Small Business Administration Disaster Loans, etc. will need thorough documentation of the history of the business and the effect of the disaster on the business.

14. Greene County will automatically become eligible for federal assistance in a county contiguous to its borders receives a declaration for emergency federal assistance.

B. Assumptions

1. A major disaster will have a significant long-term economic impact on the county.
2. Unsolicited resources and donated goods can be expected from outside the impacted area. The county must be prepared to manage this influx of resources and goods as part of the recovery effort
3. Space will be available for the operation of one or more Disaster Applications Centers in the county following a Presidential Declaration of Disaster.
4. A Disaster Field office and depending on the area of the disaster, satellite field offices will be set up in the state by the Federal Emergency Management Agency. The DFO (and any satellite offices) will be near the disaster site. It is highly unlikely that a DFO or satellite DFO will be established in Greene County due to the lack of suitable facilities for such an office.
5. Individuals with unmet needs (generally those lacking means or adequate insurance) to recover from the long-term effects of the disaster will be identified in the initial damage assessment.
6. A minimum loss of 30% on one of the county's major crops will qualify the county agribusiness community for USDA Disaster Assistance; however, the loss must be incurred as a result of natural disaster.
7. The state's share of PA funds provided for Public Assistance will be 25%, supplementing the mandated federal share of 75%. However, the President may wave the mandatory 25% contribution by the state in large-scale disasters, which have a high impact on the state budget.
8. Mitigation actions taken prior to a disaster have become increasingly important to local officials who must bear the agony of loss of life and property when disaster strikes.

III. CONCEPT OF OPERATIONS

A. General

1. County government is responsible for the coordination and support of recovery activities.
2. Recovery operations will initially be coordinated from the Emergency Operations Center.
3. Accurate emergency logs and expenditure records will be kept from the onset of the disaster by each local government agency/organization on standardized forms that have been developed for local government. These forms will be available through the county Finance office.
4. The President may authorize the utilization of any federal equipment, personnel and other resources.
5. The Governor may request a Presidential Declaration or specific federal agency declarations, i.e. Small Business Administration, Department of Agriculture, Corps of Engineers, etc., to augment state, local, private disaster relief efforts.
6. The FSAVASC will be the lead agency for agricultural disasters under an agency declaration where loss is confined to agriculture, the following actions will occur:
 - Damage Assessment
 - USDA County Emergency Board meeting
 - Exchange of information on available programs/actions plus other counties affected, state review of damage assessment reports – Decision made by State Board on “concurring and not concurring” with information in the damage assessment reports.
 - Forwarding of reports to Farmers Home national headquarters to support a request for designation of the county for FHA Emergency Loans.
7. A Presidential Declaration of Disaster will initiate the following series of events:
 - a. A Federal Coordinating Officer (FCO) will be appointed by the President to coordinate the federal efforts.

- b. A State Coordinating Office (SCO) and Governor's Authorized Representative (GAR) will be appointed by the Governor to coordinate state efforts.
 - c. A Disaster Field Office (DFO) will be established within the state (central to the damaged areas) from which the disaster assistance programs will be administered.
 - d. Disaster Application Centers (DAC) will be established in the affected areas to accommodate persons needing Individual Assistance. DAC will be established at the following locations:
 - 1. Greene County Office Complex
 - 2. Senior Citizens Center - Alternate
 - e. An applicant's briefing will be held to explain Public Assistance eligibility criteria for officials of the county, cities and private non-profit organizations. The Emergency Services office will assist with identification and notification of potential applicants.
 - f. Each eligible entity will submit a Notice of Interest (NOI) within thirty days of the declaration.
8. A Presidential Declaration of Disaster may authorize two basic types of disaster relief assistance:
- a. Individual Assistance (IA) – supplementary federal assistance provided under the Stafford Act to individuals and families adversely affected by a major disaster or an emergency. Such assistance may be provided directly by the Federal Government or through State or Local Governments or disaster relief organizations.

Individual Assistance can consist of any or all of the following:

- temporary housing (100% federal dollars)
- individual and family grants (IFG) 75% federal, 25% state/local funds
- disaster unemployment assistance
- disaster loans to individuals, business and farmers
- agricultural assistance
- legal services to low-income families and individuals

- consumer counseling and assistance in obtaining insurance benefits
 - the Cora Brown Fund
 - Veteran's assistance
 - casualty loss tax assistance
- b. Public Assistance (PA) – supplementary federal assistance provided under the Stafford Act to state and local governments or certain private non-profit organizations; organizations other than assistance for the direct benefit of individuals and families. Categories of Public Assistance available include:
- debris removal
 - emergency protective measures
 - permanent work repair, restore or replace road systems, water control facilities, public buildings and equipment, public utilities, public recreational facilities, etc.
9. Following the Public Assistance applicant's briefings, Damage Survey teams will be dispatched from the DFO to inspect every damaged site and prepare Damage Survey Reports (DSR) for each applicant. The DSR will provide a recommended scope of work and give estimated costs in accordance with FEMA eligibility criteria. The criteria allows repairs or restoration of facilities to their predigested condition in accordance with applicable codes, specifications and standards.
10. A Public Assistance Damage Survey team will be comprised of the following:
- a. A federal representative who will serve as the team leader.
 - b. A state representative
 - c. Local applicant's representative
11. The Emergency Services Director or designee will take the lead in determining mitigation projects needed following a disaster and make applications for available mitigation grants.
12. Following any major emergency or disaster event a critique will be held to evaluate the jurisdictions response to the event. A critique will include the following issues related specifically to recovery:
- a. Mitigation of potential problems through us of Hazard Mitigation Grants.
 - b. Plan revision based on lessons learned

- c. Unmet needs status
- d. Management of donated goods
- e. Interagency cooperation
- f. Damage Survey Report process
- g. Recovery training needed
- h. Development of agency SOP's to address specific needs

B. Specific

The line of succession for the recovery is as shown below:

1. Emergency Services Director
2. Assistant Emergency Services Director

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
UNMET NEEDS/DONATED GOODS/VOLUNTEER ORGANIZATION
SECTION O**

Primary Agency: Greene County Interfaith Volunteers, Inc

Supporting Agencies: Greene County Department of Social Services
Greene County Council on Aging
Wayne-Wilson-Greene Chapter of American Red Cross
Greene County Cooperative Extension Services

I. PURPOSE

To facilitate the management, collection, distribution and delivery of goods and volunteer services donated to support disaster relief efforts and to assist in providing unmet needs to disaster victims inside the county.

II. SCOPE

This section assures the expeditious collection and delivery of solicited and unsolicited goods, provides for the coordination and response of recovery efforts of volunteers (those that have been pre-assigned and those that are spontaneous arrivals) and does not interfere with the control/usage of pre-designated goods/services donated to private charitable groups and helps fulfill unmet needs of victims.

III. SITUATION AND ASSUMPTIONS

A. Situation

1. Usually individuals and businesses not directly affected by a disaster are eager to assist disaster victims through donations of goods, services and money.
2. Lack of an organized system for the management, identification and organization of donations will result in chaos for victims of disasters.
3. The timely release of information and guidance to the public on the types of relief supplies needed and the collection/delivery points is essential to the management of donated goods and volunteer services.

4. Donations of goods and services must be managed at the county level to minimize the impact on the local economy.
5. Local resources may be available or will be overwhelmed by the magnitude of the disaster.
6. Greene County Interfaith Volunteers, Inc. has some food on hand that is used for commodity foods. They also have access to the state food bank.
7. In the past churches, fire stations, radio stations and other community facilities have been collection points for donations of disaster supplies.

B. Assumptions

1. Suitable space, personnel and equipment will either be available or made available from the individuals or firms within the business community to coordinate the receipt, storage, distribution and/or shipment of donated goods and/or supplies.
2. Unsolicited donations of goods and services can be expected in large-scale disasters.
3. In large-scale disasters (affecting multiple areas of the state) the Governors office of Citizens Affairs will establish an 800 number to receive donations.
4. Regional distribution centers to receive and dispatch arriving donations will be established by the state.
5. County governments affected by a disaster will establish distribution centers within or close to the disaster area(s).
6. Non-useful and unwanted goods can be expected and will have to be disposed of in a manner agreeable to all parties providing disaster relief.
7. Charitable, religious and community service groups will offer assistance in a number of areas.
8. Telephone numbers will be established and well publicized for individuals wishing to donate goods, services and money.
9. Local governments may establish local disaster donation funds separate from the charitable organization offering assistance to victims.

10. All efforts will be made to utilize the donations given as disaster relief for the purpose they were intended.
11. Volunteers not affiliated with any organization relief groups will be discouraged from going directly to the site of the disaster.
12. Persons and organizations wishing to donate goods and services will be encouraged to register with the county EOC or the State EOC (when outside the county).
13. Immediately following the disaster the county EOC will provide an assessment of supplies needed and communicate these needs to SERT through the area office.

IV. CONCEPT OF OPERATIONS

A. General

1. The magnitude of the disaster will dictate the number of persons required for the management of donated goods and services.
2. Staging areas suitable to receive goods and coordinate volunteers have been identified in the county by Interfaith volunteers when needed will be:
 - a. Greene County Education Center/LCC Clothes Bank
 - b. GCI Lodge/Warehouse
3. Donations of goods and services will be utilized to the fullest extent possible to lessen the efforts of the disaster on the victims and will be used for the purpose they were donated (to the fullest extent possible).
4. Volunteers arriving in the county will be advised of the need to be fully self-contained and of the housing and feeding arrangements (if any).
5. Donations of cash will be encouraged in lieu of goods. Cash donations may be made to Greene County Interfaith Volunteers, Inc (Non-profit Tax deduction).
6. Volunteers not already affiliated with an established relief organization will be encouraged to affiliate with one operating in the county.
7. Donations will be used to alleviate the areas of greatest need priority first.

8. Inquiries from persons seeking information on injured, missing or deceased relatives will be referred to the EOC or other agencies handling this function.
9. All groups and agencies providing disaster relief will coordinate their activities through the county EOC.
10. Goods that have been deemed to be surplus to the needs of disaster victims will be disposed of in a manner consistent with policies established by the county Emergency Management Agency.
11. After disaster assistance centers close, a committee comprised of all agencies providing disaster relief will meet to determine the needs of the victims not met by donations.

B. Specific

1. The county donated goods/volunteer coordinator will establish contact with the state volunteer coordinator.
2. Volunteers will be accepted from churches, civic groups, fire departments, EMS/rescue units and other established community service groups.
3. Every effort will be made to match the goods and services donated to the needs of the victims.
4. The Public Information Officer for the county will be the official spokesperson for this function.
5. Donations of used bedding will not be accepted under any circumstances.
6. Goods deemed unsuitable for distribution will be disposed of in a suitable manner.
7. Transportation of goods donated to victims outside of the county will be the responsibility of the donor.
8. Shipments leaving the county will be labeled, catalogued and coordinated with the State and County EOC. These shipments will be packaged to accomplish the following:
 - Timely and undamaged arrival at destination
 - Identification of contents

- Minimal need of re-packing
- Ease of loading and unloading
- Elimination of hazardous or inappropriate goods.

9. The line of succession for donated goods is as shown below:

1. Director, Greene County Interfaith
2. Salvation Army
3. Wayne-Wilson-Greene American Red Cross

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
HAZARDOUS MATERIALS
SECTION P**

Primary Agency: Greene County Local Emergency Planning Committee

Supporting Agencies: Greene County Emergency Services
Volunteer Fire Departments
Identified SARA Facilities

I. PURPOSE

This section provides additional information for a response to a hazardous material emergency and assists the Local Emergency Planning Committee (LEPC) in meeting its requirements under the Emergency Planning and Community Right to Know Act – SARA Title III (SARA) of 1986.

II. SITUATION AND ASSUMPTIONS

A. Situation

1. The specific facilities and the facility emergency coordinators involved with hazardous materials subject to the emergency planning requirements of Section 302 of the Superfund Amendments and Reauthorization Act of 1986 (SARA Title III) have been identified and are listed in the support manual. Presently approximately 40 facilities file reports with the LEPC.
2. Hazardous materials emergencies could occur from any one of several sources including shipping, roadway transportation, aircraft accident or fixed facilities in the county. The routes most often used to transport hazardous materials in and through the county are U.S. Highways 13, 258, 264 and N.C. Highways 58, 903 and 91.
3. A hazardous material accident could result in the spread on contaminants in varying degree throughout the county or in the destruction of dwellings and property from fire or explosion necessitating evacuation or sheltering of large segments of the population of the county.

4. Volunteer firefighters are usually the first responders to incidents involving hazardous materials and are limited in their response capabilities to defensive measures. Most of the fire departments are trained to the awareness level of certification.
5. Victims of hazardous materials accidents may require unique or special medical care not typically available in the county or area.
6. The Local Emergency Planning Committee (LEPC) has been established in the county by the State Emergency Response Commission to assist in identifying the magnitude of the chemical hazard present in the community, assess the vulnerability of the community to the hazard and provide planning guidance for emergency response to hazardous materials events.
7. Hazardous materials emergencies may occur without warning requiring immediate response actions and may result in short or long term health, environmental and economic effect.
8. The local jurisdiction must be prepared to respond to the Haz-Mat incident without assistance from outside the jurisdiction including notification and warning of the public, evacuation or in-place sheltering, immediate first aid and isolation of the scene.
9. No state agencies are trained beyond the awareness level to respond to a hazardous materials incident except RRT-1.
10. The county does not have any trained radiological monitoring teams. Response to a radiological emergency would be limited to monitoring area.
11. Greene County mandates the display of NFPA placards for identification of hazardous substances within a facility.
12. The LEPC does not charge a fee to receive the Tier II reports, but retains the authority to do so at a later time.
13. The LEPC does receive the N.C. Community Right to Know reports required to be filed by industry with fire departments under NCGS 95-173.
14. Facility emergency response plans filed with the LEPC are filed in the Emergency Services office and with the local fire departments.
15. State facilities in the county report their chemical to the LEPC.

16. At this time, the LEPC has not mandated the filing of N.C. Community Right to Know reports and Tier II reports in tandem, but retains that authority.
17. No industry or military Haz-mat teams exist in Greene County at the present time.
18. No Greene County fire departments operate Haz-Mat teams.

B. Assumptions

1. Planning and training prior to an accident will significantly reduce the risk of loss of life to response personnel.
2. If a fixed facility is involved in a hazardous material incident, it will have provided the information on all chemicals are required by SARA Title III Section 304 and NCGS 95-173 (N.C. Community Right to Know).
3. Emergency response personnel are knowledgeable in the use and availability of local resources.
4. The hazardous material involved in an accident can be identified within a reasonable period of time from the owner of the facility, the vehicle from the shipping documents, from the properties of the material itself or from information provided pursuant to Title III or the N.C. Right to Know Act. For facilities, it is assumed that the facility involved in a hazardous material accident will attempt to provide all information required by SARA Title III Section 304.
5. The U.S. DOT (DOT p. 5800.6) Emergency Response Guidebook or an equivalent document, either alone or in combination with other information sources will be used as a guide for initial action to be taken to protect the responders and the general public when responding to incident involving hazardous materials.
6. Parties responsible for the hazardous material incident are charged with clean up costs. If no responsible party can be identified, then the expense of clean up is borne by county government.

III. CONCEPT OF OPERATIONS

A. General

1. There are several types of incidents involving a response to hazardous materials that responders could be faced with in Greene County. Hazardous material incidents could include:
 - incidents at fixed facilities
 - shipping incidents
 - highway accidents involving hazardous materials
 - unknown material in the rivers and intercoastal waterways
2. The level of response will be determined by:
 - the amount of toxicity of the material involved in the accident or release
 - the population or property threatened, the level or protective equipment required for the involved substances
 - the type and availability of protective equipment required for the released material
 - the probable consequences should no immediate actions be taken
3. When responding to a fire at a location where hazardous materials are known to be present the responders will assume the involvement of the most toxic substance at that location unless otherwise informed.
4. Incident command will be implemented on an appropriate scale at the scene of every hazardous material event in the county. The fire chief of the district in which the event occurs will be the incident commander.
5. Greene County recognizes the role and authority of the U.S. Coast Guard Marine Safety office and the district office located in Wilmington, N.C.
6. Warning and notification of the public, including warning and notification to special populations such as the handicapped, will be accomplished in accordance with the Communication and Warning section (Section C) of this plan. Where procedures for public warning have been developed for the population and institutions in the hazard zones surrounding identified fixed facilities, those procedures will be followed.

As necessary, emergency vehicles with effective sound devices (sirens and/or public address systems) may be used as a public alerting system. If a fixed notification system is in place around the facility for emergency area the vehicles may be used as a backup system. The vehicles will be dispatched within the evacuation area, will stop at each quarter ($\frac{1}{4}$) mile in populated areas and at each house or group of houses that are more than $\frac{1}{4}$ mile apart. The emergency vehicle will notify the public of the situation and/or recommended protective action.

7. To ensure receipt of the initial warning by all members of the community, each route should be run twice if possible. The second run or back run will be to confirm alert and notification. Back runs need only stop at houses that are dark at night or where is apparent that people are not complying with instructions. If necessary, door-to-door alerting will be accomplished during the second run.
8. Training programs for emergency responders in the county will be through individual agency in-service training programs, community college courses and other offering of related training. Exercise schedules for this plan are developed and maintained by the Emergency Management office.
9. The Greene County Emergency Operations Plan will serve as the official LEPC plan for response to hazardous material events/emergencies.
10. Current SARA information is on file in the Greene County Emergency Management office and is accessible after hours through the emergency services (county) communication center.
11. The Greene County Emergency Operations Plan will be coordinated with surrounding jurisdictions regarding these facilities that pose problems for a multi-jurisdictional response.

B. Specific

The line of succession for Haz-Mat events is as shown below:

1. Chairperson, LEPC
2. Fire Chief of Fire District
3. Assistant Emergency Services Director

**GREENE COUNTY EMERGENCY OPERATIONS PLAN
TERRORISM – WEAPONS OF MASS DESTRUCTION
SECTION Q**

Primary Agencies: Greene County Office of Emergency Services
Greene County Sheriff's Department
Greene County Health Department
Greene County Mental Health
Wilson-Greene Chapter, American Red Cross
Greene County Health Care

I. PURPOSE

This section provides guidance and defines responsibilities of emergency personnel in response to domestic terrorist incidents that may require coordination with other agencies.

II. SITUATION AND ASSUMPTIONS

A. Situation

1. The threat of a major incident-involving terrorist has increased.
2. Terrorist incidents could include the use of explosives, weapons of mass destruction (WMD) and releases of hazardous materials. WMD's can include explosives, chemicals, biological, nuclear and incendiary devices. Such situations can pose significant health and safety concerns to the population, property and environment.
3. Initial emergency response efforts will focus on protecting human health, environment and property. Such measures could involve parallel efforts to include: command and control, evacuation, fire suppression, rescue, mass casualty/triage operations, contaminant control and clean up.
4. During emergencies law enforcement agencies will expand their operations to provide increased protection required to lessen disaster conditions.

B. Assumptions

1. Two major complications that emergency personnel will encounter during a terrorist incident are:

- The limited number of trained Fire/EMS/Law Enforcement personnel available.
 - Individuals or groups working without authority and/or independently from organized efforts.
2. Major terrorist incidents could threaten a significant number of people within this county.
 3. Emergency response personnel (Fire, EMS, Law Enforcement, Emergency Management) and qualified technical experts will be available with equipment and resources to detect, analyze, evaluate and cope with most incidents.
 4. Planning, training and coordination of emergency response personnel will serve to reduce hazards and associated risk. Proper development and execution of terrorist intelligence through the law enforcement community and providing information and training to the emergency responders will significantly reduce the number of casualties from a terrorist attack or WMD incident. Warning, detention, prevention and remedial measures will reduce the effect of these attacks.
 5. Jurisdictions may be able to cope with minor situations. However, should an incident become a major emergency, additional emergency resources could be rapidly deployed through existing mutual aid agreements and could be further augmented, if necessary, by county, state, federal and private industry.
 6. A combination of trained personnel and operation equipment can be positioned to detect, measure, report, analyze, evaluate and conduct counter measure operations. Trained local emergency response organizations can effectively manage an accident scene with technical assistance from the state and federal agencies.
 7. First responders will be first on the scene and may not be prepared to manage it and are likely to be on their own for several hours or more until specialized resources become available.
 8. Substances involved in an incident can be identified within a reasonable time from many sources. These include, but not limited to:
 - USDOT Emergency Response Guidebook
 - NIOSH Guidebook
 - First Responder Chem-Bio Handbook

- Material Safety Data Sheets (MSDS)
 - SARA Tier II Emergency and Hazardous Chemical Inventories
 - Shipping Papers
 - Placards and product labels and containers
 - CHEMTREC, etc.
9. Emergency planning efforts will assume that most of the population will cooperate with local officials and follow recommended protective activities. Such measures could include evacuation instructions for relocation to designated areas.
- Private automobiles, agency vehicles, buses and Transportation Department vans will be the primary means of transportation for evacuation movement. Available alternate transportation resources would be coordinated to support evacuation of public without transportation, special needs individuals (e.g. handicapped, mobility impaired, developmentally disabled) and the elderly.
 - The initial movement of population(s) at risk may occur immediately following the on scene assessment of the situation by emergency response authorities or by the issuance of an evacuation order by county officials.
 - Evacuees could be isolated from their homes for extended periods of time.
10. The first unit to arrive on the scene must not blindly rush to individual victims, but must first perform a rapid assessment of the situation and ensure that proper personnel, equipment and supplies are dispatched to provide essential lifesaving efforts. These actions and initial decision (in the first few minutes) will influence the entire response and management of the incident. Proper actions and decisions will avoid confusion, chaos and inefficiency. The responders must take in account the possibility of secondary devices for intentionally injuring emergency responders.

III. CONCEPT OF OPERATIONS

As part of the awareness program associated with the acts of terrorism, the first responders must ensure their own protection and the protection of all responding departments. Below are the primary components of the concept of operations. Primary first responders can address some components; the Incident Command System (ICS) will address the others.

- A. Threat Assessment - Will be addressed by local law enforcement agencies, SBI, FBI, ATF and other law enforcement agencies. These groups would provide information to determine the threat level of the incident.
- B. Notification Level, Internal/External, Primary/Secondary - Listed below are the primary response and support agencies which are part of the notification process:
 - 1. Law Enforcement
 - 2. EMS
 - 3. Emergency Services
 - 4. Fire Service
 - 5. Surrounding Hospitals
 - 6. Medical Facilities
 - 7. Health Department
 - 8. State Emergency Management
 - 9. Public Information Officer(s)
 - 10. Hazardous Waste Office (State of North Carolina)

This list can be expanded as the need arises or as the scope of operations expands. The IC can dismiss departments if the situation changes. Each agency should develop its own internal notification procedures.

- C. Command and Control-Response – In any response to a terrorist incident, the Incident Command System will provide all responders with a full accountability system for the entire incident. In addition, under the ICS concept, numerous agency representatives can be the Incident Commander over the time frame and the incident.
- D. Crisis Management – Includes measures to identify, acquire and plan the use of resources needed to anticipate, prevent and resolve a threat or act of terrorism.
- E. Consequence Management – Includes measure to protect public health and safety, restore essential government services, provide emergency relief of governments, businesses and individuals affected by the consequence of terrorism.
- F. It is essential that emergency response personnel familiarize themselves with their organizations Standard Operating Guidelines and the Greene County Incident Command organizational structure.

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