

New York State Comprehensive Emergency Management Plan

Pandemic Annex



**Disaster Preparedness
Commission**

**Prepared by the New York State
Disaster Preparedness Commission**

March 2021

List of Plan Revisions

Date of Revision	Subject Matter	Reviewed by	Page(s)
January 2007	Administrative Change (Gov.)	Planning Section	Title Page
January 2007	GOER HR Guidance Memo	Planning Section	New Attachment (#5)
April 2008	Administrative Change (Gov.)	Planning Section	Title Page
April 2009	Scoping / Risk basis	Planning Section	All
August 2011	Entire Document review	Planning Section	All
October 2011	Entire Document review	Planning Section	All
January 2012	Entire Document review	Planning Section	All
March 2012	Activation Levels	Planning Section	All
January 2013	Annual Review	Planning Section	All
March 2015	Annual Review/Ebola Virus	Planning Section	All
March 2016	Annual Review	Planning Section	All
April 2017	Annual Review	Planning Section	All
March 2018	Changes warranted to address ESF construct, State Operating Levels, SEOC Organizational structure	Planning Section	All pages reviewed and updated as warranted.
January 2019	Annual Review/NYSDOH Update	Planning Section	All
January 2020	Annual Review & EMAP Update	Planning Section	All
June 2020	COVID-19 Response Update	Planning Section	All
March 2021	Annual Review & Update	Planning Section	All

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New York State Comprehensive Emergency Management Plan

Pandemic Annex

Section I: General Considerations and Planning Guidelines

A. Introduction

Although remarkable advances have been made in science and medicine during the past century, we are constantly reminded that we live in a universe of microbes that are forever changing and adapting themselves to the human host and the defenses that humans create. While science has developed highly effective vaccines and treatments for many infectious diseases that threaten public health, the United States faces a burden of influenza that results in approximately 36,000 deaths and more than 200,000 hospitalizations each year. In addition to this human toll, seasonal influenza is annually responsible for a total cost of over \$10 billion in the United States¹. The State is constantly monitoring any new, potential threats, such as the coronavirus, which has the potential to spread across the globe.

A pandemic could have a much more severe impact and has the potential to cause more death and illness than any other public health threat². The last three pandemics, in 1918, 1957, and 1968, killed approximately 40 million, 2 million, and 1 million people worldwide, respectively. If a pandemic virus with similar virulence to the 1918 strain emerged today, in the absence of intervention, it is estimated that 1.9 million Americans could die and almost 10 million could be hospitalized over the course of the pandemic, which may evolve over a year or more. While the current COVID-19 pandemic is still evolving, the national death toll is over 500,000 individuals, with expectations of the death toll to continue to increase through Spring 2021. Over the course of the end of 2020 and beginning of 2021, new variants and strains were discovered and were found to be more infectious than past strains.

It should be noted that while many planning efforts on a local, county, State, or Federal level may reference pandemic planning in terms of an influenza outbreak, the same concepts are applicable on all levels to any type of viral outbreak. Throughout this Annex there will be references to pandemic influenza planning documents and guidance, which would be utilized in response to a variety of pandemic situations, such as the COVID-19 pandemic in 2020.

New York State leadership recognizes the threat of a pandemic on the State's population, critical infrastructure sectors, the private sector, the economy, and our way of life. Multiple State planning endeavors are complete with continuing efforts to maintain/update policies, issues, mechanisms, and responsibilities in preparing for and responding to this type of threat and emergency. Furthermore, both agency-specific and multi-agency planning efforts have been completed and will continue to build upon the foundation of the State's collective response.

This Annex outlines New York State's strategy in preparing for, responding to, and recovering from a pandemic in a collective, multi-agency State approach.

¹ Homeland Security Council, *National Strategy for Pandemic Influenza*; November 2005.

² U.S. Department of Health and Human Services, *HHS Pandemic Influenza Plan*; November 2005.

B. Purpose

The State Comprehensive Emergency Management Plan (CEMP) has been structured into three distinct, but interconnected volumes. These are:

- Volume 1: All-Hazard Mitigation Plan
- Volume 2: Response and Short-Term Recovery
- Volume 3: Long-Term Recovery Plan

The purpose of the State CEMP is to identify the State's overarching policies, authorities and response organizational structure that will be implemented in an emergency or disaster situation that warrants a State response. In addition, the State CEMP identifies the lines of coordination and the centralized coordination of resources that will be utilized in directing the State's resources and capabilities in responding to and recovering from a disaster. Moreover, the State CEMP serves as the foundational framework for the State's response levels and serves as the operational basis on which other functional and hazard-specific annexes will build upon.

The purpose of this Annex is to ensure that the strategic and broad-based nature of the State CEMP is more defined to allow the State to adequately prepare for, respond to, and recover from a pandemic. This will include utilizing individual agency activities as well as the activities of the State's Emergency Support Functions (ESFs), as appropriate. Furthermore, this Annex identifies the key mechanisms in coordinating with the local response and identifies the lines of coordination to interoperate with the Federal response, including the U.S. Department of Health and Human Services (HHS) *Pandemic Influenza Plan*, via the National Response Framework (NRF).

C. Scope

In March 2014, the New York State Department of Health (DOH) released the updated DOH *Pandemic Influenza Response Plan*. This plan was initially released in 2006. The plan takes a comprehensive and in-depth approach for assisting public health officials and healthcare providers in preparing for and responding rapidly and effectively to a pandemic, consistent with national guidance. The scope of this plan focuses on the response activities of State and local public health officials in the public health sector. The primary concepts include, but are not limited to, surveillance and laboratory testing, healthcare planning, infection control, clinical guidelines and vaccine procurement, distribution, and use.

This Annex applies to any pandemic that warrants a response beyond standard agency statutory obligations to a collective State Disaster Preparedness Commission (DPC) response. This Annex applies to all State agencies and authorities that may be directed to respond to such an event and builds upon the process and structure of the State CEMP by addressing unique policies, situations, operating concepts, and responsibilities. Response operations to this type of event will encompass the efforts of the DOH *Pandemic Influenza Response Plan* and utilize existing capabilities of other functional and hazard-specific annexes to the State CEMP. Further, this Annex acknowledges that local and State response capabilities may be exceeded, necessitating the use of Federal agencies and resources.

If a potential novel strain of virus is evident in animals in the State, then State response operations for animal depopulation shall be coordinated as stated in Appendix 1 of the ESF #11 – Agriculture and

D. Situation

Pandemics occur when a novel virus with little or no natural immunity emerges and has the potential to infect a large populous through efficient human to human transmission; resulting in a potential widespread illness. Animals are the most likely reservoir and vector for these emerging viruses. Historically, avian viruses played a role in the last three influenza pandemics. Two of these pandemic-causing viruses remain in circulation and are responsible for the majority of influenza cases each year.³

Advanced planning and preparedness are critical components necessary to mitigate the impact a pandemic might have on the populous. A pandemic is likely to come in waves or phases, each lasting weeks or months. The unique characteristics of a pandemic may strain local, State, and Federal resources. It is unlikely that there will be sufficient personnel, equipment, and supplies to adequately respond to a pandemic that could overwhelm our nation's health and medical capabilities.

In addition, while a pandemic will not cause any "physical" damage, it will ultimately threaten all critical infrastructures by affecting essential personnel in the workplace for a period of time. This warrants planning efforts to consider a strategy that extends well beyond the health and medical sector, to include sustaining critical infrastructure, private-sector activities, the movement of goods and services, and economic and security considerations.

During the 2020-21 Novel Coronavirus (SARS-CoV-2 or COVID-19) response, the tactics used were new and innovative. COVID-19 required a higher level of surveillance, increased testing, social distancing, and mitigation protocols, and approaches to vaccination that had not been performed before. The increase testing had been reached through drive-thru and walk-thru testing sites across the state, a model which the State developed and was the first to deploy. For the first time in recent history, the State of New York employed social distancing and mask-wearing mandates as mitigation efforts, intended to slow the spread of the disease. The vaccination delivery required a collaborative approach through State-run sites, locally run sites, and medical and pharmaceutical delivery.

In 1999, the World Health Organization (WHO) published guidance that defined the phases of a pandemic. Updated guidance was published in 2005, 2013, and again in 2017 to redefine these phases. The most recent publication in 2017 provides a significant amount of data from the 2009 influenza A (H1N1) pandemic. Diagram 1 below identifies the current WHO classification system of a pandemic.

The current WHO guidance from 2017 includes a risk-based management approach to a pandemic; as linked to preparedness, response, and recovery, the conceptual framework encourages members to develop flexible plans based on a national risk assessment. In 2014, the Centers for Disease Control and Prevention (CDC) published their updated response framework.

³ Source: U.S. Centers for Disease Control and Prevention

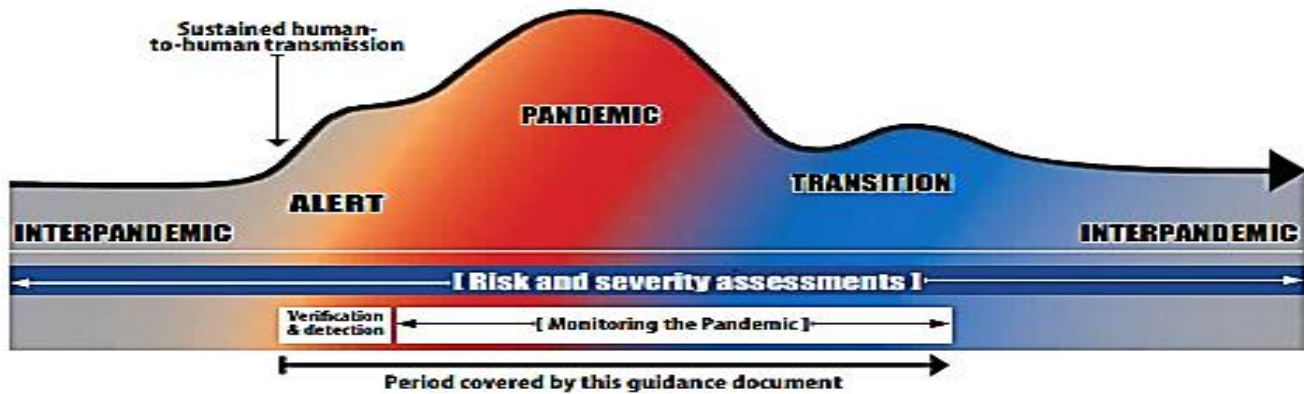


Diagram 1: The continuum of pandemic phases and surveillance components - Source: WHO, WHO Guidance for Surveillance during and Influenza Pandemic; November 2017.

It is important to note that the WHO does not identify a post-pandemic period to the phase schema. Although not part of the WHO phases for tracking the emergence of a pandemic, mitigation and recovery should be a part of every emergency response plan. Mitigation and recovery actions should be focused on continuing public health actions, including communication with the public on issues such as when public gatherings can resume, and continued monitoring of possible outbreaks of infection.

Represented in six pandemic intervals, the CDC intervals provide a general framework for continuity purposes, but also accommodates unique planning considerations and flexibility to execute at all levels: local, State, and Federal. The CDC intervals are outlined in Diagram 2 below.

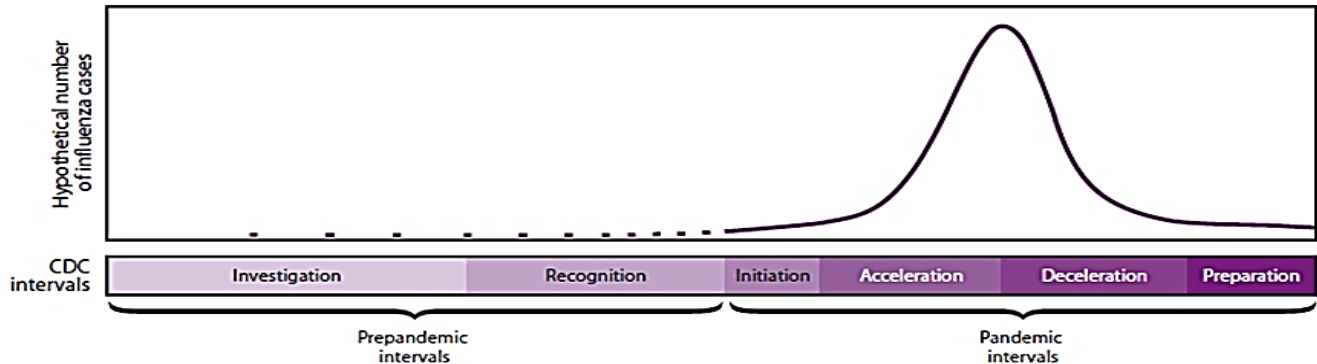


Diagram 2: *Preparedness and response framework for novel influenza A virus pandemics: CDC intervals* - Source: U.S. CDC, *Updated Preparedness and Response Framework for Influenza Pandemics*; September 2014.

This schema has been utilized by the HHS in the development of the Federal plan and by the DOH in developing the DOH *Pandemic Influenza Response Plan*. The goal of the schema is to assist public health officials and healthcare providers with preparedness, response, and recovery should a pandemic occur. Each of these plans identifies response actions relative to a “phase” or “intervals” of the pandemic. (See Table 1 on the following page).

Characteristic	COVID-19 (Current estimates, 2019-current) **	2009 H1N1 Flu (U.S. final estimates, Apr. 2009 – Apr. 2010)	Moderate (1958 / 68 - like)	Severe (1918 – like)
Illnesses	2,132,321	60.8 Million	90 Million (30%)	90 Million (30%)
Outpatient Medical Care	Not Reported	Not Reported	45 Million (50%)	45 Million (50%)
Hospitalizations	226,926	274,304	865,000	9,900,000
ICU Care	14,271	Not Reported	128,750	1,485,000
Mechanical Ventilation	3394	Not Reported	64,875	742,000
Deaths	116,862	12,469	209,000	1,903,000

Table 1: Number of Episodes of Illness, Healthcare Utilization, and Deaths Associated with H1N1 Influenza and Moderate and Severe Pandemic Scenarios. These estimates based on extrapolation from past pandemics in the United States. Note that these estimates do not include the potential impact of interventions not available during the 20th century pandemics - Source: U.S. HHS, CDC.

**Note: Statistics for the COVID-19 pandemic are unsettled as of this publication; the statistics included were compiled as of June 17, 2020 and are evolving on a daily basis.

The severity of a pandemic will be based on the virulence of the virus that presents itself. While the virulence of the virus cannot be predicted, two scenarios may be considered based on historical pandemics. Table 2 below identifies the potential number of indexed cases, deaths, and healthcare utilizations with moderate and severe pandemics.

TABLE. Preparedness and response framework for novel influenza A virus pandemics: World Health Organization phases and CDC intervals, with federal and state/local indicators

World Health Organization phases	CDC intervals	Federal indicators for CDC intervals	State/Local indicators for CDC intervals
Interpandemic phase: Period between influenza pandemics	Investigation: Investigation of novel influenza A infection in humans or animals	Identification of novel influenza A infection in humans or animals anywhere in the world with potential implications for human health	Identification of novel influenza A infection in humans or animals in the United States with potential implications for human health
Alert phase: Influenza caused by a new subtype has been identified in humans	Recognition: Recognition of increased potential for ongoing transmission of a novel influenza A virus	Increasing number of human cases or clusters of novel influenza A infection anywhere in the world with virus characteristics, indicating increased potential for ongoing human-to-human transmission	Increasing number of human cases or clusters of novel influenza A infection in the United States with virus characteristics indicating increased potential for ongoing human-to-human transmission
Pandemic phase: Global spread of human influenza caused by a new subtype	Initiation: Initiation of a pandemic wave	Confirmation of human cases of a pandemic influenza virus anywhere in the world with demonstrated efficient and sustained human-to-human transmission	Confirmation of human cases of a pandemic influenza virus in the United States with demonstrated efficient and sustained human-to-human transmission
	Acceleration: Acceleration of a pandemic wave	Consistently increasing rate of pandemic influenza cases identified in the United States, indicating established transmission	Consistently increasing rate of pandemic influenza cases identified in the state, indicating established transmission
	Deceleration: Deceleration of a pandemic wave	Consistently decreasing rate of pandemic influenza cases in the United States	Consistently decreasing rate of pandemic influenza cases in the state
Transition phase: Reduction in global risk, reduction in response activities, or progression toward recovery actions	Preparation: Preparation for future pandemic waves	Low pandemic influenza activity but continued outbreaks possible in some jurisdictions	Low pandemic influenza activity but continued outbreaks possible in the state

Table 2: Preparedness and response framework for novel influenza A virus: World Health Organization phases and CDC intervals, with federal and state/local indicators - Source: U.S. CDC, Updated Preparedness and Response Framework for Influenza Pandemics; September 2014.

It is evident that a pandemic may have far-reaching effects on the population as well as a variety of critical infrastructure sectors⁴, especially the public health sector. This is especially true when noting that the modalities that were present in previous pandemics pale in comparison to those of the twenty-first century. The potential severity of such an event, and its impact on the society creates a major concern for governments at all levels.

This Annex will attempt to tie additional response activities to the CDC Intervals for tracking to the State Emergency Operations Center (EOC) activation levels as identified in Volume 2 of the State CEMP, *Response and Short-Term Recovery*. However, the CDC Intervals nationally may not always correspond to State EOC activation levels, since New York State may not be experiencing the same pandemic challenges as other states.

E. Planning Assumptions

1. A pandemic is a public health emergency that rapidly takes on significant political, social, and economic dimensions. A pandemic is likely to affect all sectors of the critical infrastructure, public and private.
2. Susceptibility to the pandemic subtype will be universal. Traditional planning for influenza pandemics predicts that 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. However, as seen with the COVID 19 pandemic, other viruses may have different clinical attack rates.
3. The number of hospitalizations and deaths will depend on the virulence of the pandemic virus.
4. Multiple waves (periods during which community outbreaks occur across the country) of illness may be likely to occur with each wave lasting two to three months. Historically, the largest waves have occurred in the fall and winter, but the seasonality of a pandemic cannot be predicted with certainty.
5. The public healthcare system will be overwhelmed across multiple nodes within the system, from virus testing to treatment centers. The situation may therefore warrant rapid expansion of the State's hospital & Intensive Care Unit (ICU) bed capacity, testing capacities, and require attending regulatory waivers from the State.
6. Workforce levels across multiple sectors may be overwhelmed and require augmentation, through mutual aid, intrastate, and interstate assistance. State healthcare workforce levels will be a particular area that will require augmentation and considerations for alternate levels of care provided will be made.
7. Although the government and health care workforce will be in extremely high demand, social distancing and business closures mean statewide unemployment claims will skyrocket during a Level 1 pandemic. The State Department of Labor (DOL)'s unemployment processing call centers will be strained to handle the sharp increase in call volume.

⁴ Homeland Security Council, *National Strategy for Pandemic Influenza Implementation Plan*; May 2006

8. New York's public health system relies on local health departments (LHDs) with authority and responsibility for public health preparedness and response at the local level. The DOH provides leadership, support, and coordination of this effort, including during a multi-jurisdictional emergency. Although pandemics may affect multiple jurisdictions simultaneously, all jurisdictional responsibilities are maintained.
9. The response to a pandemic may require new approaches to mitigate, surveil, prevent, and respond to the spread of the disease. These include drive-thru testing, mask mandates, and geographic restrictions or micro-clusters.
10. The State may need to implement protective actions (non-medical containment) that will likely be unfavorable to the general public. This may include closing schools, restricting travel, suspending mass gatherings, and imposing isolation or quarantine measures on the general public.
11. The incubation period can vary between 2-21 days. Non-medical containment will likely be covering the span of the incubation period until symptoms are presented.
12. Decisions about non-medical containment measures will be made in an atmosphere of considerable scientific uncertainty. Containment measures must be adapted to the epidemiological context of each phase of the pandemic.
13. Non-medical containment measures will be the principal means of disease control until adequate supplies of vaccine and/or antiviral medications are available.
14. Response actions need to be swift and decisive, necessitating the use of a variety of State and Federal statutes and authorities to effectively respond to and recover from a pandemic.
15. Vaccination and antiviral treatment are anticipated to be the most effective medical strategies for reducing pandemic virus morbidity and mortality. However, effective vaccines or antiviral medications may be non-existent or in limited supply. The State will promote, and coordinate use of vaccines and/or antivirals based on their availability and the best scientific evidence at the time. The DOH maintains a vaccine distribution plan that will be used to govern the distribution of a viral vaccine; that plan may be activated for subsequent pandemic responses coordinated by the State EOC.
16. Activities identified in any given pandemic phase are not necessarily assumed to be completed during that phase; activities started in one phase may continue into subsequent phases or reoccur as additional waves of the pandemic become evident.
17. It is possible that the State, in its response, may be eradicating animals that serve as a vector as well as responding to a pandemic impacting the population.
18. State agencies supporting this Annex may need to implement their lines of succession as identified in their agency-specific continuity of operations plan.
19. Government at all levels will likely be overwhelmed in a pandemic. This may have an adverse effect on the ability of the State to acquire support from Emergency Management Assistance Compact (EMAC) partners or acquire adequate Federal support under the NRF.

20. As evidenced by the COVID-19 outbreak, a Level 1 pandemic in New York State will likely induce a crisis of resource scarcity. Given the symptomatic variance of each viral pandemic, it may be difficult to predict which types of durable medical supplies will be in high demand during a given outbreak; however, the need for personal protective equipment (PPE) is a likely constant. This plan assumes that supplies of PPE will be strained during future pandemics of any kind.
21. During a nationwide pandemic outbreak, federal resources including medical supplies from the Strategic National Stockpile (SNS) may be limited.
22. In a situation of perceived or actual nationwide resource scarcity, there will be a market run on PPE and other virus-specific durable supplies, the State may seek federalization of the procurement process to offset open market competition.
23. The federal Defense Production Act (DPA) may be invoked for a nationwide pandemic accompanied by a scarcity of durable medical supplies, however, the outputs of that process will provide a belated benefit to states whose apex occurs relatively early in the pandemic cycle.
24. The New York Division of Military and Naval Affairs (DMNA) will likely be activated for a pandemic of the same speed and scale as COVID-19, i.e. a pandemic warranting the sustained activation of the State EOC at a Level 1 posture. DMNA will provide augmented staff and expertise to support all relevant ESFs.
25. The Governor may request that hospitals expand their bed capacity by as much as 100% to accommodate projected hospitalization needs at the apex of the pandemic. The DOH will issue regulatory waivers to allow hospital directors and county authorities to meet these requests legally. The Governor may also establish alternate care sites at non-traditional locations such as convention centers and college campuses. Surge capacity should include considerations for infectious disease and non-infectious disease patient care.
26. Without federalization of the procurement process, states will compete with each other on the open market for supplies during a pandemic crisis defined by resource scarcity. This will lead to additional resource scarcity, price gouging, and cascading issues downrange.

F. Concept of Operations

1. Initial notification of novel flu cases (in non-humans) may be realized through Federal or State agricultural agencies. Similarly, initial notification of a potential case of a pandemic in humans may be realized through Federal or State health surveillance networks. In either of the above noted cases, this information will be quickly disseminated throughout the Nation and the State of New York.
2. If a pandemic is discovered in the State (in non-humans), response actions will commence as identified in the *Emerging Infectious Diseases in Non-Human Populations Appendix* to the ESF #11 – Agriculture and Natural Resources Annex. Surveillance in the public health sector will be elevated to identify potential cases of the virus in humans.
3. Initial notification of a potential pandemic in New York State will likely come from practitioners, LHDs or from hospital emergency departments. This information will be realized through a variety of formal

information and reporting mechanisms that exist within the health and hospital networks, overseen by the DOH.

4. Samples for testing and surveillance taken by the provider will be sent to a local laboratory for analysis and/or sent to the Wadsworth Center and the CDC for confirmation. At the direction of the DOH, LHDs may consider establishing diagnostic testing centers at dispersed locations within geographic “hot spots” in the State. These may include walk-thru or drive-thru testing centers and need not be collocated with treatment facilities. Testing locations and testing operations in general will require a constant stream of testing supplies and trained practitioners capable of efficiently conducting mass testing operations. When the State EOC is at Level 1 activation, the State EOC will maintain and provide a running list of testing sites, along with hours of operation and points of contact, in the daily Leaders Intelligence Report (LIR).
5. Upon receipt of a confirmation that a potential pandemic has started or is imminent, notifications will be made to the public health sector via the mechanisms managed by the DOH.
6. Upon receipt, New York State Office of Emergency Management (OEM) will consult with the DOH and other State agencies, as appropriate, to determine if conditions warrant a collective State response. At this point, a Multi-Agency Coordination (MAC) Group conference call would be initiated to consider the demographics and implications of the potential event.
7. Consideration will be given to activate multiple ESFs to explore the anticipated response issues and consequences specific to the disease. The discussion should determine if the event can be mitigated through daily statutory-type responses (at the State and/or local level) or if the response warrants an activation of the State EOC.
8. If conditions warrant the activation of the State EOC, then State OEM will notify the appropriate ESF coordinating and member agencies, including ESF #1, ESF #3, ESF #4, ESF #5, ESF #6, ESF #7, ESF #8, ESF #11, ESF #12, ESF #13 and ESF #15. In addition, State OEM will notify the county emergency manager(s), and others as deemed necessary.
9. State OEM will coordinate response activities in support of ESF #8 and the Coordinating Agency – DOH, along with the other activated ESFs, being cognizant of response operations at the local level, and may utilize local/regional EOCs to facilitate response activities.
10. The Governor could exercise his authority and issue a State Disaster Emergency Declaration to direct any and all State agencies, including non-DPC agencies, to provide assistance under the coordination of the DPC. For a pandemic of the speed and scale of a nationwide novel coronavirus outbreak, i.e. warranting interstate response coordination, the Governor may also request that the Federal government issue a Major Disaster Declaration.
11. State assistance will be supplemental to local efforts. Support may include providing public health and emergency medical support, mortuary support, implementing traditional and/or non-traditional Points of Dispensing (PODs) for vaccine, providing security in quarantine and isolation, providing human-needs support and requesting/supporting operations of the SNS.
12. State OEM will coordinate with the Federal Department of Homeland Security (DHS)/Federal Emergency Management Agency (FEMA) and ensure coordination with State and Federal ESFs.

13. At the discretion of the Governor, the DMNA with New York National Guard (NYNG) may be activated to augment the State's pandemic response capabilities and personnel. The NYNG may support, at minimum, State ESF #1, ESF #3, ESF #5, ESF #6, ESF #7, ESF #8, and ESF #9. The DMNA may provide military installations to stage supplies and personnel to staff those locations. The NYNG may provide vital transportation and logistical support to ESF #1 and ESF #7 with augmented trucking and warehousing capabilities.
14. The DOH will coordinate with the New York State Office of General Services (OGS) to maintain and enhance the Medical Emergency Response Cache (MERC) resources likely to be in high demand during the pandemic apex. ESF #7 will consider forward staging of resources to reduce travel time to areas of impact.
15. State OEM will coordinate with the Department of Corrections and Community Supervision (DOCCS), Division of Industries (Corcraft Products) to produce relevant supplies such as hand sanitizer, to offset resource scarcity where appropriate.
16. As applicable, the OGS and the Executive Chamber will establish a system for processing and tracking frontline medical supplies procured through donations. The Executive Chamber will be responsible for vetting large corporate donations. Donations will be parsed into frontline medical supplies and other supplies; donations will be warehoused and tracked by the OGS.

G. Legal Authorities

This authority to develop this Annex and implement specific response actions to effectively respond to a pandemic can be found in a variety of New York State Laws, regulations, and Federal authorities, including:

1. State Authorities

- Agriculture and Markets Law
 - Article 5 – Diseases of Domestic Animals
- Correction Law
 - Section 141 – Contagious disease in facility
- Executive Law
 - Article 2-B – General provisions related to disasters
 - Article 26 – General authority for Division of Homeland Security and Emergency Services (DHSES)
- Military Law
 - Sections 3 and 6 – Governor's power to order the organized militia into state service in emergencies
- Public Health Law
 - Article 2, Title I – General authority for Department of Health
 - Article 2, Title II – Public Health Council
 - Article 3 – Local Health Organizations
 - Article 13 – Nuisances and Sanitation
 - Article 21 – Control of Acute Communicable Diseases

- NY Code, Rules and Regulations
 - Title 10 – Department of Health Regulations

2. Federal Authorities

- 42 U.S.C. Chapter 68 – Disaster Relief
- 42 U.S.C. § 247d – Public Health Emergencies
- 42 U.S.C. § 264 – Regulations to control communicable diseases
- 42 U.S.C. § 267 – Quarantine stations, grounds, and anchorages
- 42 U.S.C. § 268 – Quarantine duties of consular and other officers
- 42 U.S.C. § 270 – Quarantine regulations governing civil air navigation and civil aircraft
- 42 U.S.C. § 271 – Penalties for violating of quarantine laws
- 50 U.S.C. Chapter 55 – Defense Production Act
- 42 C.F.R. Chapter I, Subchapter F, Part 70 – Interstate Quarantine
- 42 C.F.R. Chapter I, Subchapter F, Part 71 – Foreign Quarantine
- 49 C.F.R. § 390.23 – Federal motor carrier safety regulation; relief from regulations during an emergency

H. Annex Maintenance, Distribution, and Revision Process

The State OEM Planning Section has the responsibility for the development, review, and maintenance of all multi-agency response plans under the State CEMP. As required under New York State Executive Law Article 2-B, each ESF annex shall undergo an annual review and update on or before February 15th of each year and be posted online (if applicable) no later than March 31st of each year.

During the annual review by the Planning Section for its material, this plan is examined for both content and format. For updates that do not impact operational mechanisms or processes, the appropriate edits are initiated within the Planning Section and do not warrant external involvement. Plan updates will also be conducted based upon experiences and lessons learned from exercises or real-world events, or through administrative changes in government. Planning Section updates and/or edits affecting operational capabilities, responsibilities, or otherwise impacting operations will engage stakeholders in a variety of ways, such as verbally, by document review, meetings, webinars, or any combination thereof. Final drafts will be socialized to all appropriate agencies/personnel upon completion.

New York State Comprehensive Emergency Management Plan

Pandemic Annex

Section II: Risk Reduction

A. Preparedness

To some extent, risk reduction measures are taken on an on-going, routine basis. While more risk reduction activities will be implemented during a pandemic alert phase and pandemic period, recent events throughout the world have resulted in additional preparedness measures in a variety of ways.

1. Awareness and Surveillance

- a. WHO has identified various strains of flu and a potential pandemic as an international priority. The WHO uses an intelligence and surveillance networking from across the globe.
- b. HHS conducts extensive surveillance and monitoring through the CDC. Extensive outreach has been conducted abroad as well as to state health departments in the United States. Surveillance nodes include state-level information as well as outpatient surveillance, mortality surveillance, hospital surveillance and virologic surveillance.
- c. In the United States, surveillance for animal-borne viruses is conducted by states and the U.S. Department of Agriculture (USDA) Animal and Plant Health Inspection Service (APHIS). Diagnostic testing is performed by state and industry laboratories, with confirmatory testing by USDA/APHIS Veterinary Services at the National Veterinary Services Laboratories in Ames, Iowa.
- d. The DOH utilizes several disease surveillance networks that actively collect and analyze information to determine an outbreak of a disease, including a pandemic.
- e. Per the DOH *Pandemic Influenza Response Plan*, DOH has and will continue to promote pandemic awareness throughout the public health sector.

2. Planning and Training

- a. The WHO has developed a plan for international events and has issued guidance to each country. Similarly, HHS has developed a national plan for coordinating response and recovery activities of Federal agencies identified in the *U.S. Department of Health and Human Services Plan for Pandemic Influenza*. This plan also includes planning guidance for states to follow, which was utilized by the DOH.
- b. The DOH has developed the DOH *Pandemic Influenza Response Plan*. The plan applies public health support to local government and the health sector. The DOH *Pandemic Influenza Response Plan* will be supportive of this Annex to the State CEMP, which coordinates response activities to other sectors in a multi-agency setting.
- c. Per the DOH *Pandemic Influenza Response Plan*, DOH will promote and institute a variety of training throughout the public health sector before, during and after a pandemic.
- d. Several State-level exercises have been conducted and serve as training and planning components in preparing for a pandemic.
- e. DHSES will conduct periodic exercises, including but not limited to table-top and functional exercises, to assess the State EOC's response to a simulated pandemic outbreak similar to COVID-19. Any exercise will test the plans, policies, and procedures intended to guide the response to a pandemic.

3. Continuity of Operations Planning and Workforce Support

- a. State agencies have been actively involved in Continuity of Operations Planning (COOP). DPC agencies were provided two guidance documents and training programs to use to assist in their COOP efforts. The documents, issued by the State OEM, exceeded the minimum benchmarks found in NFPA 1600 (*Standard on Disaster/Emergency Management and Business Continuity Programs*) and guidance from the FEMA. Relative to a pandemic, the document identified a mechanism for identifying mission critical activities, mitigation, prioritization of programs and a line of succession of at least three persons deep. Many of the DPC agencies have used this COOP methodology and have completed their COOP efforts.
- b. The State has a variety of vendors and contractors that could augment State agency personnel during a pandemic. The OGS maintains the State's contract and procurement mechanism, which includes personnel that can be acquired through staffing services.
- c. The DOH *Pandemic Influenza Response Plan* has identified workforce support mechanisms that could be used during a pandemic to ensure disaster mental health services training is made available during a pandemic.
- d. In 2019, the State received its accreditation under Emergency Management Accreditation Program (EMAP); included in the accreditation is a Continuity Plan requirement for the DPC agencies. All DPC agencies have completed their COOPs as of 2019.

New York State Comprehensive Emergency Management Plan

Pandemic Annex

Section III: Response

A. Overview

In identifying the State's response actions, it is important to note that during a pandemic, LHDs will retain their responsibility. The key functional areas of the pandemic virus response are surveillance and epidemiologic investigation, vaccine and antivirals operations, non-medical containment, surge capacity, infection control guidance to healthcare facilities, and risk communications. The role of the State is to provide the oversight to a locally generated response and support the activities noted above. In providing support, the State response must be postured to coordinate with local government to fill response shortfalls and must also be able to fully utilize and coordinate State and Federal assets in the response.

The ESF annexes to the State CEMP Volume 2 identify multi-agency activities in coordinating a collective State response in support of a specific function or activity. Each ESF is comprised of various agencies that are assembled to coordinate the activities of their own agency in support of the ESF's activities. Agency-specific support of the ESF supplies an individual focus of that agency from the agency representative. Typically, the agency representative will not coordinate agency-specific activities outside the parameters or missions of the ESF. Thus, if an agency is needed to support multiple ESFs, and multiple ESFs are activated, then each agency may need to send multiple representatives to support the various ESFs.

B. Alert, Notification, and Activation

There are several pandemic levels that are identified by both the WHO and CDC that follow a similar progression and response. Therefore, it is important to understand the relationship between the CDC Intervals, the DOH activities and State EOC activation levels to have an accurate picture of the correlation between the Federal and State response plans.

It is important to reiterate that multiple waves of a pandemic can be anticipated throughout the life cycle of the event. If the State, in its response, identifies that a pandemic is subsiding or is between waves, then response efforts may be scaled back to assess the response and prepare for the next wave, if any. On the following page is a chart that will outline the actions of the three organizations as the stages of the pandemic progress.

Steady-State of Operations

The State EOC maintains a readiness posture, while conducting normal day-to-day, steady-state operations, including surveillance, and monitoring of any potential emergency, via the State Watch Center (SWC). Likewise, disease surveillance is ongoing at the state and national level by the DOH and the CDC, respectively. The corresponding CDC intervals for this readiness posture would be the *Investigation Interval* and the *Recognition Interval*. Apart from continued surveillance and monitoring of any potential emergency situation, no further action would be taken at this time.

CDC Intervals	EOC Activation Levels	NYS DOH / ESF #8 Actions
		NYS OEM Triggers
PRE-PANDEMIC INTERVALS		
Investigation Interval: The investigation interval is characterized by low pandemic influenza activity, although outbreaks might continue to occur in certain jurisdictions	Steady State of Operations	Initial Notification of Pre-Pandemic, coordinate planning activities with bordering jurisdictions and unique Review exercise and modify the plan on a periodic basis
Recognition Interval: WHO or CDC confirms cluster of novel influenza A with sustained and efficient human-to-human transmission anywhere in the world.		A Steady State of Operations will remain to enhance surveillance of the pandemic virus will be initiated
		Activate the Interagency Task Force on Influenza Preparedness and meet with state agency partners to review and modify plan as necessary
		Review, exercise and modify plan. Make contact with NYS DOH, NYS DAM; send Health Alert Network (HAN) Notification to Task Force Members
PANDEMIC INTERVALS		
Initiation Interval: Confirmation of human cases of a pandemic influenza virus in the United States with demonstrated efficient and sustained human-to-human transmission.	Level 4 or 3	Interface with the appropriate counterparts at the National Level/Monitor Department and Regional Office staffing needs/Participate in HHS/CDC public information briefings/HERDS and program based applications systems are initiated Level 4 or 3: NYS OEM receives notification from NYS DOH that a potential pandemic may be imminent or is occurring in the United States Multi-Agency Coordination (MAC) Group discussion; Continue enhanced surveillance of the pandemic virus; review, exercise and modify plan; identify potential impacts
Acceleration Interval: Consistently increasing rate of pandemic influenza cases identified in the State, indicating established transmission.	Level 2 or 1	-Monitor and implement recommendations from programmatic or issue based sub groups. -Coordinate communication and recommendations with the NYS DPC agencies. ----- -In coordination with State and Federal partners, determine the need for activation of the NYS MCMDD Plan and relevant response actions to support operations. -Maintain communications with the NYS Interagency Taskforce on Influenza Preparedness and initiate the appropriate actions per relevant plans Level 2: If the event is impacting the population in New York State, a Multi-Agency Coordination (MAC) Group discussion will decide Emergency Support Function (ESF) representation. Level 1: When notification is received that a potential pandemic may be imminent in the state: MAC Group remains activated, possible activation of National Response Framework and emergency support function (ESF) #8 – Public Health and Medical Services
Deceleration Interval: Consistently decreasing rate of pandemic influenza cases identified in the State. Preparation Interval: Low pandemic influenza activity, although outbreaks possible in the State.	Level 3 or 4	Initiate after-action activities, continue to promote vaccinations, respiratory etiquette, and hygiene Based upon the guidance of leadership and ESF #8, the EOC could begin to reduce the activation level retrograde activities are begun Begin after action debriefing process/develop After-Action Report Steady state of operations similar to the activity in the Investigation Interval, after-action review and debriefing is being conducted

Activation of the State EOC will be as follows:

- **Level 4:** This level may be initiated when the State OEM receives notification from the DOH that a potential pandemic may be imminent or is occurring in the United States and can be identified as being in the following intervals:

- *Initiation Interval* - Confirmation of human cases of a pandemic virus in the United States with demonstrated efficient and sustained human-to-human transmission (CDC).

At this level, the following actions may be taken:

- Ensure that each agency involved with incident management or incident support activities (if any) is providing appropriate situational awareness and resource status information to State and local governments;
- Ensure that each agency establishes priorities in preparing for the event, including identifying available resources, future resources requirements, sector-specific coordination issues, and the ability to implement an agency-specific continuity of operations plan;
- Coordinate and resolve potential policy issues arising from the event and provide strategic coordination as required.

At this point, State and local agencies may take an increased role in monitoring the event and its potential impacts, if any, in the state. Situational reporting and monitoring may be done by the DOH, as conditions warrant.

- **Level 3:** This level may be initiated when the State OEM in discussions with the MAC Group receives an updated notification from the DOH that a potential pandemic is occurring in the United States with some impact in the state. This level can be identified as being in the following interval:

- *Initiation Interval* - Confirmation of human cases of a pandemic virus in the United States with demonstrated efficient and sustained human-to-human transmission (CDC).

If the event is impacting the population in New York State, a MAC Group conference call would be initiated to consider the implications of the potential event. The MAC Group will be composed of members from agencies with direct incident management responsibilities or significant incident management support or resource responsibilities.

At this level, the following actions may be taken:

- This level may include the activation of Incident Command System (ICS) based sections in the State EOC to provide situational reporting and readiness to increase the State's response posture, as appropriate.
- State OEM and the ESF #8 Coordinating Agency – the DOH will jointly identify which ESFs will be required to support the activation level and the current response.
- The DOH through ESF #8 may request that emergency measures be taken by the State to support local response activities.
- State OEM will activate and coordinate the responsibilities for ESF #5 and ESF #7.

- **Level 2:** This level may be initiated when State OEM in discussions with the MAC Group receives ongoing notification from the DOH that a potential pandemic may be imminent or is occurring in New York State and can be identified as being in the following interval:
- Acceleration Interval - Indicated by a consistently increasing rate of pandemic cases identified in the State, indicating established transmission (CDC).

At this level, the following actions may be taken:

- State OEM and the ESF Coordinating Agencies will jointly identify which agencies of each ESF are required to support the activation level and the current response.
 - The DOH through ESF #8 may request that emergency measures be taken by the State to support local response activities.
 - Risk communications will be disseminated to the general public, to include subject matter as identified in the DOH *Pandemic Influenza Response Plan*.
 - Preparations may be made to support isolation or quarantine measures in support of the local response.
 - Travel restrictions may be imposed for the area of concern.
 - Schools and public gatherings in the area of concern may be cancelled or closed. Other institutions, such as rehabilitation facilities, hospitals, correctional facilities, and universities may impose restrictions on ingress and egress in the area of concern.
 - If available, the State may coordinate the distribution of vaccine(s) and antivirals to the population at risk.
- **Level 1:** This level may be initiated when State OEM receives notification from the DOH that a pandemic is occurring in the State and can be identified as being in the following phase:
- Acceleration Interval - Indicated by a consistently increasing rate of pandemic cases identified in the State, indicating established transmission (CDC).
 - This level will likely trigger the activation of the NRF and ESF #8 – Public Health and Medical Services with Federal response.

For Level 1 and Level 2 activations, State OEM will request the following ESF Coordinating Agencies to send a representative to the State EOC:

ESF #1 Transportation: Department of Transportation (DOT)

ESF #3 Public Works and Engineering: Department of Environmental Conservation (DEC)

ESF #4 Firefighting: DHSES/Office of Fire Prevention and Control (OFPC)

ESF #5 Planning: DHSES

ESF #6 Mass Care, Emergency Assistance, Housing, and Human Services: DHSES

ESF #7 Logistics: DHSES

ESF #8 Public Health and Medical Services: DOH

ESF #11 Agriculture and Natural Resources: Department of Agriculture and Markets (DAM)

ESF #12 Energy: Department of Public Service (DPS)

ESF #13 Public Safety and Security: Division of State Police (DSP)

ESF #15 External Affairs: DHSES/Public Information Office (PIO)

At this level, the following actions may be taken:

- State OEM and the ESF Coordinating Agencies will jointly identify which member agencies of each ESF are required to support the activation level.
- Invoking or supporting isolation, quarantine or social-distancing requirements using State and Federal legal authorities, as appropriate, and coordinating with Federal authorities on measures to prevent the interstate spread of a pandemic virus. Actions may include the closing of schools, cancelling public gatherings and imposing movement restrictions in the general public and institutions, such as rehabilitation facilities, hospitals, correctional facilities, and universities.
- Utilizing local, State, and Federal facilities that can serve as triage and treatment centers and medical facilities. These include non-traditional sites (i.e., school gymnasiums) that may be used to support the response. Non-traditional centers may also be used to support mass testing operations that accompany a State EOC Level 1 pandemic, including but limited to “drive-thru” facilities used during the COVID-19 response.
- Organizing and releasing State and Federal public health and medical response assets to include drugs and medical supplies such as antivirals, vaccine(s) (if available) and assets from the State’s MERC and/or the SNS. This may be accomplished using traditional and/or non-traditional PODs.
- In concert with local government, coordinating the implementation of ESF #8, including capabilities under the U.S. Public Health Services (e.g., National Disaster Medical System, Disaster Medical Assistance Teams and Disaster Mortuary Operational Response Teams (DMORT)).
- A Joint Information Center (JIC) may be established by ESF #15 External Affairs to inform the public on health-related matters, movement controls and restrictions. The JIC will serve as a coordinating point with local, State, and Federal authorities on public messages to ensure that communications are consistent and accurate and ensuring that messages address anxieties, alleviate unwarranted concerns or distress, and enlist cooperation with necessary control measures. Risk communications will be disseminated to the general public and will include, but not limited to, topics as identified in the DOH *Pandemic Influenza Response Plan*.
- State agencies will conduct sector-specific outreach to industry providers and the private sector as to the status of their operation and identify any shortfalls in that entity’s ability to maintain its operation.

Level 1 Protocols:

Level 1 Protocols are special project-style lines of effort initiated by DHSES leadership when a pandemic of the scale and speed of COVID-19 appear to be an imminent threat to the people of New York State. As early as practical – and ideally prior to the Acceleration Interval – DHSES will consult with the DOH to determine if a pandemic shows a trajectory warranting activation of Level 1 Protocol. DHSES will also consider the likelihood of resource scarcity, as well as the State’s ability to mitigate that scarcity,

when deciding on activation of the Level 1 Protocol. Following Level 1 activation, the projects itemized below will be delegated at the discretion of the DHSES Commissioner:

1. Assemble the MAC Group and establish the process for daily priority setting:
 - Identify specific roles and responsibilities for the MAC Group and establish appropriate briefing schedules for leaders to identify priorities and understand the evolution of the response.
 - Develop processes for capturing task completion and assistance with communicating the MAC Group intent each level of the response.
2. Deploy information systems (e.g. dashboards) to keep the MAC Group informed of actionable information:
 - Evaluate capability for delivering a Common Operating Picture to MAC Group leaders to facilitate access to the similar, required information.
 - Provide a mechanism for the delivery of actionable information and data to county and local leaders, health officials, and emergency managers.
 - Analyze specific information and assess critical requirements to fill knowledge gaps essential for decision making.
3. Utilize the tools in New York Responds (NYR) to prepare and provide a geospatial decision-support dashboard, data collection, and web-based reporting system to provide situational awareness:
 - Web-based mapping dashboard to assist by providing maps, visualizations, and analysis tools to help understand population health risk (population characteristics and vulnerability, cases/ deaths, and projected needs), health care facility/ provider information (location, capacity, capabilities), suppliers, response team locations, and related conditions (quarantined areas, impacted institutions, transportation status, etc.).
 - Mobile data collection tools for field personnel to collect and share information (including status of response activities, updates on testing/ cases, or provider capabilities) via geospatial dashboards.
 - Data-driven narratives, story maps, and visualizations that communicate risks and issues to the operational centers, field personnel, county and local leadership and the public.
4. Develop appropriate and actionable event-specific plans to mitigate and recover from the pandemic:
 - Survey the landscape of applicable response plans, identify gaps, and prioritize event-specific plans and updates based on the epidemiology of the pandemic and Statewide circumstances.
 - Develop plans appropriate for the risk and executable at the appropriate level of response.
 - Assist with the development of processes and procedures to capture “sustains” and “improves” throughout the immediate response to inform the development of plans.

Standing down from Level 1:

At a point identified by The Executive Chamber, the State EOC activation level may be downgraded to a Level 2, Level 3, or Level 4 with the ability to quickly return to a higher level, if needed. A State EOC activation level where response efforts have been scaled back would likely correspond to the CDC *Deceleration Interval*, which indicates a consistently decreasing rate of pandemic virus cases in the State.

Stabilization of scarce resource economics is another criterion that may need to be met in order to downgrade from State EOC Level 1. Independent of the deceleration of the pandemic's spread in the State, the leveling out of supply and demand for key healthcare system supplies and equipment to treat the pandemic disease is an important factor when considering reductions to the State EOC's posture. Satisfying this criterion depends on the State's ability to model and continuously monitor the projected intersection of supply and demand for key resources throughout the pandemic.

During a Level 1 pandemic, it can be expected that the State will have received durable and other high-demand medical supplies through a combination of stockpiled inventory, procurement, production, donation, or Federal production/distribution. Additionally, as a pandemic decelerates in New York State, the State may collect and redistribute those high demand resources to other states or areas experiencing an upward trajectory in cases. Any plan for standing down the State EOC, therefore, must be accompanied by a plan to recollect and redistribute medical supplies and equipment. ESFs #1, #7, and #8 will be instrumental in developing and executing the return and redistribution plan.

C. Response Organization/Direction and Control

The State of New York endorses the use of one response organizational structure that will include all responding agencies: local, State, and Federal. State agencies will be organized under the framework of the National Interagency Incident Management System (NIIMS) ICS, as required by Executive Order 26 of 1996, and the National Incident Management System (NIMS), as required by Homeland Security Presidential Directive (HSPD) #5. ICS will be incorporated at the local and Federal levels as well. The over-arching structure of State command and control will be organized as stated in the Volume 2 of the State CEMP, *Response and Short-Term Recovery*. Specific to pandemic, the State will utilize a Unified Command structure to coordinate the overall State response and will utilize all of the NIMS components deemed necessary, including the MAC Group, Area Commands, and other coordinative elements at forward locations.

1. Joint Information Center (JIC)/Public Information

The JIC should serve as the sole source of official information regarding all incident activities (local, State, Federal). The JIC should provide a forum for the coordinated release of all information. JIC operations should be coordinated as stated in the Emergency Public Information Annex to the State CEMP. This may include the activation of a hotline or call center to support disseminating public information and adequately respond to public inquiries. Further, absent the Governor, the DOH will serve as the lead in addressing pandemics issues specific that impact humans. The DAM will serve as the lead in addressing pandemics in non-humans, especially if the State is depopulating infected animals.

Whether organized through an ESF #15 JIC or some other line of effort, the Governor may choose to hold press conferences during a Level 1 pandemic in New York State.

Information gathered and compiled by the joint information system will be shared with key agencies (Unified Command Group) and the Executive Chamber to support synchronized messaging across the key leadership.

D. Roles and Responsibilities

This section reviews existing roles, responsibilities, and capabilities of State agencies and ESFs, and provides an overview of the Federal response.

1. Local Government

Local government will be actively involved in the response and should be utilized to the fullest extent possible. Each county, and many local governments, has a CEMP which provides the framework for the jurisdiction's response to emergencies and disasters. As previously identified, the collective efforts of State OEM led to the development of sample plans for local government to use in planning for pandemic viruses; it is anticipated that many counties have some sort of annex in process or completed. Further, it is recognized that some counties do not possess a full public health component and rely upon the State to provide the public health function. As such, those counties, while limited in number, may require more State support than those that have a viable local public health component.

Each locally developed plan will differ in its implementation, including in response capabilities, surge capacities and in the ability to exercise authorities. Therefore, it is prudent upon the State to conduct timely situational reporting to identify any gaps in the protective measures that are promulgated either at the local, State, or Federal levels of the response.

Local government and LHDs play a critical role in a Level 1 pandemic, especially with regard to reporting key resource inventories and making timely resource requests through the NYR system. Local governments and LHDs are the voice of their frontlines to State authorities. Timely and accurate projections of what frontline healthcare locations are likely to need allow the State EOC to effectively coordinate with upstream suppliers and logisticians. During a Level 1 pandemic, LHDs will establish a reporting point of contact (POC), cadence, and basic data sets to inform the State EOC of *projected* resource needs, in addition to routing official current requests through NYR.

2. Emergency Support Functions (ESFs) and Agency-Specific Roles

ESFs that are activated in support of this type of event will collectively utilize the resources available to them pertinent to the operation. ESF Coordinating Agencies will manage all activities within the ESF to effectively respond to the demands of the incident; the ESF Support Agencies will assist and support all activities tasked to the ESF. ESFs will coordinate their actions cognizant of over-arching policies and authorities, statutory or otherwise, as outlined in each ESF Annex and the State CEMP.

Response activities and approaches that were employed during the response to COVID-19 could be used in future pandemics. Agencies and ESFs may be tasked to take on additional roles, and these may or may not be inclusive of the actions below. The actions below are not inclusive of all actions that could be taken, and the agencies identified to support them could be expanded or reduced, as warranted.

a. Mass Testing Sites

Mass testing sites were established during the COVID-19 response to better track the disease and provide for coordinated response by geographic region and need. The expansion of testing across the state allowed for more effective tracking of the virus and through tracing efforts allowed for more efficient preventative methods. Mass testing sites were designed to be either drive-thru or walk-up, allowing for flexibility of the site to accommodate more people, more efficiently. The agencies below provided support to mass testing sites, but are not inclusive of all support provided by State agencies:

- DOH
- Office for People with Developmental Disabilities (OPWDD)
- DMNA
- DHSES
- State University of New York (SUNY)

b. Airport Screening

Airport screening was established during the COVID-19 response to identify travelers coming into the state who may be infected with the virus. This allowed for more effective prevention of spread through early identification and quarantining. The agencies below provided support to airport screening, but are not inclusive of all support provided by State agencies:

- DMNA
- DOH
- Federal Partners

c. Test and Sample Kit Assembly & Transportation

In order to support the volume of testing required during the COVID-19 response, the rapid assembly and distribution of testing kits was crucial. There was also a need, early in the pandemic, to provide rapid transportation from testing sites to labs capable of testing the samples. The agencies below provided support for test kit assembly and distribution and sample transportation, but are not inclusive of all support provided by State agencies:

- DHSES
- DOT
- DSP
- DMNA

d. Labor and Unemployment Support Services

Over the course of the COVID-19 response, stay-at-home orders and restrictions put in place in the State resulted in a rapid increase in unemployment applications. The increase in applications and necessary support was beyond the capability of a single agency alone. As such, the State provided additional support to the DOL through supplemental workforce from various State agencies.

- DOL
- Various volunteers from other agencies

e. Mortuary Affairs Task Force

The high level of morbidity and decedents experienced during the COVID-19 response was beyond the capacity of most morgues and medical examiners/coroners. Even the largest medical examiner's office in the state was quickly overwhelmed. To support the local response to the influx of decedents, the State initiated a task force to provide resources, staff, and other mortuary assistance. The agencies below provided support to the task force, but are not inclusive of all support provided by State agencies:

- DHSES
- DOH
- DOT
- NYS Funeral Directors Association

f. Alternative Care Sites and Healthcare Surge Support

During the response, hospital systems across the State became overwhelmed quickly and reached surge capacity levels early. To supplement the healthcare system, alternative care sites were established or requests for federal resources, such as the USNS Comfort, were made. These sites were established to provide medical care to either non-COVID or COVID patients. The agencies below provided staff and support to the alternative care sites, but are not inclusive of all support provided by State agencies:

- DOH
- DMNA
- DHSES
- OPWDD
- SUNY
- Federal Partners

g. Mass Vaccination Sites

Upon the approval of the COVID-19 vaccine(s), a means to rapidly vaccinate large populations was needed. The more efficient and effective that the State and local partners were able to vaccinate people, the sooner the response could transition to long-term recovery. As such, the State established multiple sites across the state at State-owned properties, where individuals could schedule an appointment, receive the vaccine, be monitored for a set timeframe, and have follow-up appointments scheduled as needed. These sites were modeled similar to the mass testing sites and could be drive-thru or walk-up facilities. The agencies below provided staff and support to the mass vaccination sites, but are not inclusive of all support provided by State agencies:

- DOH
- OPWDD
- DHSES
- DEC
- DMNA
- SUNY

h. Warehouse Expansion and Logistical Support

Over the course of the response, it was recognized that current stockpiles and medical emergency caches were not large enough to hold the supplies required to support the mission. Multiple additional warehouse locations were turned on and required logistical support from

various agencies. The agencies below provided both staff and support, but are not inclusive of all support provided by State agencies:

- DMNA
- DHSES
- DOH
- DOT
- OGS

The following lists the ESF activities specific to this incident. The text identifies only those actions that are unique to this type of event and are not already identified in each of the above listed documents.

a. ESF #1 – Transportation

The capabilities of ESF #1 may vary during the winter season or in times of disaster that require debris clearance or emergency repairs to transportation infrastructure. ESF #1 can assist in:

- Providing guidance for rerouting of traffic in and around affected areas.
- Supporting local response activities, such as snow clearing and removal, if the pandemic occurs over the winter season.
- Supporting traffic and access control points.
- Providing coordination for the passage of Federal assets over the State and local roadways.
- During a Level 1 pandemic, ESF #1 may collocate a representative at supply staging locations to support coordination with transportation resources.

b. ESF #3 – Public Works and Engineering

- In coordination with ESF #8, evaluate the potential health effects related to water and wastewater systems.
- In coordination with ESF #8, evaluate and support the development of Alternate Care Sites to meet projected hospital surge requirements. U.S. Army Corp of Engineers (USACE) was the key federal partner to build the sites and referenced as ESF #3. The NYS Hospital Surge team was looking at SUNY facilities, closed healthcare facilities, and alternative sites (e.g. convention centers).

c. ESF #4 – Firefighting

- Provide coordination for fire resources support through the State Fire Mobilization and Mutual Aid Plan in the event that local responders are affected by the pandemic.

d. ESF #5 – Planning

- Prepare to supplement staffing in ESFs #5 and #7 with additional personnel.
- Coordinate with DOH epidemiological staff to perform routine reporting.
- Activate an Advanced Planning Unit to monitor and model various scenarios.

e. ESF #6 – Mass Care, Emergency Assistance, Housing, and Human Services

- Coordinate the identification and access to facilities that may be used as mass care centers.
- Expand programs for medical reserves and healthcare professionals.

- Build and maintain partnerships with local counties, communities, and agencies (Voluntary Organizations Active in Disasters (VOADS)/Community Organizations Active in Disasters (COADS) to determine potential antibody testing sites.
- Determine possible housing surge needs and determine factors that may contribute to outbreaks in shelter facilities along with measures to reduce those factors.
- Prepare guidance for emergency shelters in the event an incident occurs during the pandemic that will require emergency sheltering.
- In coordination with ESF #8, determine need for Family Assistance Centers.
- Coordinate the use of disaster mental health services for victims and their families, including response agency representatives at the local and State level.
- Coordinate the request, acquisition and distribution of food and water to support the general population in areas that have had movement restrictions imposed. This will be done in close coordination with ESF #13.
- Coordinate with ESF #8 and the State Education Department (SED) to disseminate safe practices, risk information, and sanitary information to the school communities that are at-risk.
- Coordinate with SED on the closure of schools with the appropriate districts and superintendents, including study abroad student repatriation.

f. ESF #7 – Logistics

- Provide support for the procurement of commodities, contracting services, and labor.
- Determine stockpile capacity and anticipate additional warehousing needs, to include centralized and available locations.
- Provide resources, including office space, office furniture, and equipment to support response efforts.
- Identify and secure locations that can be utilized by State and Federal response personnel as staging areas, base camps, or rest and rehabilitation centers.
- Provide logistical support for the transport of equipment and supplies for response efforts.
- Define task forces and responsibilities to avoid duplication of efforts.
- Activate Specimen Transport Task Force (comprised of DOT, Thruway, Office of Parks, Recreation, and Historical Preservation (OPRHP), DMNA, DOCCS, DSP, and DEC).
- Identify, procure, and mobilize needed supplies early. Utilize a surge model to identify regions where both staff and resources may need to be pre-positioned.
- During a pandemic requiring a surge of hospital supplies into the State, ESF #7 is expected to see an increased role. ESF #7 may be supported in such cases by the NYNG (if activated), which will provide logistical expertise, personnel, and assets to support movement and staging of equipment and supplies from their points of origin to staging areas and operating sites.
- For expertise and staffing, key agencies for expanding the logistics function to meet the requirements of a pandemic including OGS and the NYNG.
- Inventory systems may need to evolve beyond a single agency to achieve a consolidated, real-time tracking and reporting visibility. ESF #7 will coordinate through the transition out of a Level 1 pandemic to recollect and redistribute high demand supplies to others in need as determined.

- Additional logistical considerations for ESF #7 during a Level 1 pandemic include methods for managing the flow of following supply sources:
 - State stockpiled equipment/supplies.
 - State procured equipment/supplies (Including the DOH orders).
 - State produced supplies (Including Corcraft Products).
 - Corporate and private citizen donations.
 - Federal supplies (Including from FEMA).

g. ESF #8 – Public Health and Medical Services

ESF #8 will likely have the largest set of tasks and responsibilities during a pandemic. Response and recovery operations will encompass the activities from an agency-specific (statutory) standpoint and from a multi-agency disaster response standpoint. ESF #8 will:

- Assess and implement enhanced surveillance in both affected and unaffected localities and activate revised surveillance protocols, as needed.
- Identify social distancing and isolation protocols.
- Assess bed space/capacity and identify alternate facilities.
- Perform surveillance of schools and colleges.
- Assess and ready the MERC, inventory, and prepare for 24/7 staffing.
- Coordinate the distribution of MERC and obtaining of medical equipment and supplies, pharmaceuticals, and restocking healthcare facilities.
- Evaluate surge capacity for medical staffing.
- Identify screening options and/or travel restrictions necessary to limit exposure.
- Determine highest risk groups (elderly, pediatric, pregnant, immunocompromised, etc.) as appropriate.
- Define groups that will receive priority access to supplies.
- Expand programs for medical reserves and healthcare professionals.
- Activate the DOH Health Operations Center (HOC).
- Identify, procure, and mobilize needed supplies early. Utilize a surge model to identify regions where both staff and resources may need to be pre-positioned.
- Coordinate laboratory testing, providing guidance to local laboratories, and coordinating the use of State and Federal labs to respond to the surge of multiple tests. ESF #8 may consider the use of drive-thru testing facilities during a Level 1 pandemic, similar to those established for the COVID-19 response. DHSES may also need to provide additional logistical support to the DOH for pop-up virus testing centers to provide the DOH an accurate and current number of people infected to refine their projections and facilitate quarantining.
- Develop and disseminate (including to the public, as appropriate) a dynamic, prioritized list of treatment and prophylaxis recommendations, clinical guidelines, and priority recipients. Disseminate case and contact management protocols to ensure suspect cases are promptly identified and isolated, and contacts are located, quarantined, and monitored for symptoms, as appropriate. Dissemination will be done through the ESF #15/JIC in coordination with the MAC Group and State EOC Command.
- Coordinate the identification and access to facilities that may be used for triage, treatment centers, and PODs.
- Request surveillance and modeling data from CDC.

- Obtain surveillance/visibility in country of origin and assess their potential impacts on travel.
- Meet with other ESFs to determine quarantine and isolation wraparound/essential services that may be provided and determine action steps.
- Advise DHSES/State OEM to establish and maintain stockpiles of needed resources such as vaccines, PPE, hand sanitizer, cleaning/disinfectant supplies, body bags, and/or any additional items that would specifically be needed for the particular virus.
- Coordinate State and Federal medical personnel to support inpatient hospital care and outpatient services, including alternate care facilities.
- Activate the *NYS Emergency Medical Services Mobilization Plan* to support local response agencies. Coordinate Emergency Medical Services (EMS) assets in support of jurisdictions that are overwhelmed.
- Coordinate the use of fire services assets to provide Basic Life Support (BLS) services as well as coverage for fire protection, hazardous materials response, and Urban Search and Rescue (USAR).
- Coordinate the use and distribution of antivirals and Federally supplied vaccine (if available) to ensure an adequate supply to priority geographic areas and recipients. The State OEM Planning Section maintains a Vaccine Distribution Plan produced originally for the COVID-19 response. For ESF #8, that plan will have future application during pandemics of similar speed and scale as COVID-19, and it may be customized to plan distribution of vaccines for future pandemic diseases in New York State.
- Identify and utilize facilities that may be used to stage medical supplies, Managed Inventory (MI), MERC, antivirals, or vaccine. Coordinate with planners in ESF #5 and logisticians in ESF #7 to customize implementation of the Hospital Supplies Staging Plan as required.
- Coordinate the use of volunteers that can be used at traditional and/or non-traditional PODs and the SNS mobilization center and distribution sites. ESF #8 will work with the DOH to set up a system to screen and register out-of-state volunteers, relying as necessary on DOH waivers for out-of-state and/or retired, licensed practitioners to immediately practice in New York State.
- Activate infection control procedures and disseminating guidance to minimize transmission of the virus in homes, the community, healthcare facilities and mass care centers. This guidance will include recommendations on PPE that should be worn by State and local responders and other public and private entities. The release of this information will be done through the ESF #15/JIC and in coordination with the MAC Group and local government.
- During the response, ESF #8 will examine the potential of a novel virus to infect other animals and humans through drinking water and wastewater systems.
- Utilize applicable State legal authorities to ensure availability of additional beds and alternate facilities, including State facilities.
- Coordinate with EMAC assets (if supplied) and ESF #8.
- Assessing the public health and medical needs in unison with the Federal Incident Response Coordination Team. This includes an assessment of the healthcare system/facility infrastructure.
- Responding to medical surge capacities; identifying Federal facilities (e.g., Veterans Affairs, Federal military installations) that may be able to support triage and treatment.

- Coordinating the receipt and distribution of the SNS (Managed Inventory), MERC, and obtaining medical equipment and supplies, pharmaceuticals, and restocking healthcare facilities.
- Coordinating State and Federal medical personnel, such as the U.S. Public Health Service (USPHS), National Disaster Medical System (NDMS), and Disaster Medical Assistance Teams (DMAT) to support inpatient hospital care and outpatient services, including in mass care centers.
- As needed, coordinating with DMORT in establishing temporary morgue facilities, victim identification, and processing, preparing, and disposition of the remains. This will be done in strict coordination with the local ME.
- Invoke State legal authorities, such as the suspension of licensing requirements, to support the availability of surge clinical and hospital staffing, holding and control drugs and medical supplies intended for wholesale distribution, obtaining necessary inventories, and coordinating the distribution of assets to the designated locations.
- Recommend to LHDs the most feasible, effective, and enforceable methods of isolation and quarantine to prevent the spread of the virus.
- Provide training, including just-in-time training, to build public health and healthcare.
- Coordinate EMS assets in support of jurisdictions that are overwhelmed.
- Coordinate EMS assets that will serve mass care centers, adjunct medical facilities, and shelter operations. Operations may include assisting in triage, treatment, and transport of affected individuals to primary, secondary, and tertiary facilities.
- Support the procurement and distribution of antivirals and vaccine (if available).

h. ESF #11 – Agriculture and Natural Resources

- If the novel virus is still active in the animal population, ESF #11 will serve as the lead in eradication of that vector. ESF #11 will provide situational status reports on response operations to inform the MAC Group and State EOC Command Staff of the effectiveness of eradication efforts.
- ESF #11 may assist in the trace-forward or trace-back for an event of this type. This will likely be the case if the novel virus first appears in animals and is zoonotic.

i. ESF #12 – Energy

- Identify and support public and private utility providers that may have difficulty continuing to operate due to employee absenteeism.
- If the electric or fuel supply or delivery systems are impacted, ESF #12 will coordinate the implementation of the Energy Emergency Annex to the State CEMP, as required, to support the response. The NYS Energy Research and Development Authority (NYSERDA) is the lead for petroleum and coal emergencies and the DPS is the lead for electrical systems and natural gas emergencies.

j. ESF #13 – Public Safety and Security

- Provide support in implementing security measures at the SNS Mobilization center, traditional and/or non-traditional PODs, and distribution points where medical assets are being distributed to medical personnel.

- Provide support to local law enforcement that have been overwhelmed or affected by the pandemic.
- Coordinate traffic and access control points for areas where travel restrictions were identified, including interstate thoroughfares.
- Support security at mass care centers, adjunct medical facilities, and morgue sites.
- Provide security for the transportation of commodities, supplies, and relief material that may be scarce during a sustained pandemic.
- Develop and determine the need for looting, rioting, protests, and or/curfew plans.
- Develop procedures for quarantine enforcement.

k. ESF #15 – External Affairs

- Activate a JIC.
- Perform rumor control through identification of false information and appropriate dissemination of accurate information, resources, and sources of information for the general public.
- Utilize a single point of information access, through website/social media, as well as donation opportunities and/or key messages.

3. Department of Financial Services, Department of Taxation and Finance, Empire State Development Corporation

- The above noted agencies will disseminate risk communication information throughout the business and financial sectors respective to each agency's purview.
- Based on statutory authorities, each agency will conduct an assessment of the financial sector to ascertain viability, status, and support mitigative measures to lessen the impact of a pandemic on that sector. This may include broad discretionary powers that may be utilized to lessen the impact on banking and interrupt or disturb public confidence in the financial sector.
- Agencies will work collectively to ensure that the business and financial sectors in the state continue to support the general population.
- Agencies will explore opportunities to expedite the receipt and transfer of funds, tax credits, and the receipt of life insurance or disability policies for victims of a pandemic.

4. Governor's Office of Employee Relations, State Civil Service, Department of Labor

- Identify and disseminate guidance to State agencies in human resources issues, concerns, and union-related activities. The guidance should consider leave accruals and any adjustments the State can make to allow employees to attend to themselves or their families if they become ill.
- Jointly identify staffing capabilities on State contract that could support State agency staffing.
- Explore opportunities to expedite the canvass and hiring process, including temporary workers, to fill vacancies in State government.
- Work with the DOL to coordinate recruitment, classification, and assignment of workers to meet essential needs.
- For Level 1 pandemics, DOL will establish a surge workforce and operations optimization capability to handle the exponential spike in State unemployment claims that can be expected to occur.

5. State/Federal Coordination under the NRF and the HHS Pandemic Influenza Response Plan

a) Department of Homeland Security (DHS)/Federal Emergency Management Agency (FEMA)

The DHS/FEMA may implement the NRF, which provides a mechanism for organizing, coordinating, and mobilizing Federal resources to augment State and local resources.

Under the NRF, DHS/FEMA may employ a variety of ESFs for coordinating response and recovery activities. As identified in the HHS *Pandemic Influenza Response Plan*, Federal response planning efforts have definitively pre-identified only one ESF to be activated for a pandemic, that being ESF #8 - Health and Medical Services. However, the plan does identify that other ESFs will be utilized as appropriate during a pandemic.

In New York State, the State ESF #8 will be the lead in coordinating with the Federal ESF #8. The lines of coordination of all the State ESFs can be found in Attachment 2: *State/Federal Coordination for Resources and Resource Support*.

If a Federal Disaster Declaration is issued and FEMA is activated to coordinate the national response, FEMA must take the lead on managing the distribution of high-demand medical supplies. FEMA will deconflict supply management efforts the HHS, which manages the SNS through its Office of the Assistant Secretary for Preparedness and Response (ASPR). See the section on HHS below (Item 5) for specific procedural recommendations that State ESF #8 will issue to HHS.

b) United States Department of Health and Human Services

The HHS has a major role in implementing the HHS *Pandemic Influenza Response Plan* and in being the coordinating agency in ESF #8. An all-inclusive list of activities of HHS during a pandemic is beyond the scope of this document. Therefore, in summary, the HHS will:

1. Under the auspices of the NRF, provide the direction, coordination, and integration of overall Federal efforts to provide public health and medical assistance to the State.
2. Task appropriate Federal agencies in deploying health and medical personnel, equipment, and supplies, including the direct deployment of USPHS in support of health and medical operations.
3. Promulgate and enforce regulations to prevent the spread of communicable diseases.
4. Conduct and support investigative measures into the cause, treatment and prevention of a disease or disorder.
5. In cases of real or perceived resource scarcity, HHS must play an active lead role to alleviate the burden placed on state governments. State ESF #8 will coordinate with HHS, through ASPR, to recommend the following measures:
 - **Transparent management of the National Stockpile** – HHS will proactively report inventory of scarce/high-demand medical resources to State ESF #8, informing the State what amount of support from the National Stockpile it can expect, when, and how that support will be delivered.
 - **Federalization of the procurement process** – HHS will take the lead on procuring scarce/high-demand medical resources and distribute them to states, as necessary through the National Stockpile, or otherwise to states directly by way of the State ESF #8. HHS and FEMA will avoid becoming additional competitors for high-demand resources and “bidding-up” states on the open market.

- **Modular allocation of resources across the country** – HHS and FEMA will take a national view on current and projected pandemic hot-spots, directing the transfer of high-demand resources on loan from the National Stockpile in a modular fashion from one state to another based on current/projected needs.

6. Sector and Agency-Specific Lines of Coordination with the Federal Response for Continuity of Operations

Unlike a traditional disaster, a pandemic is not likely to cause direct, physical damage to the infrastructure. However, a true pandemic will adversely affect the health and welfare of the general population over a large geographic area. The affected population makes up the backbone of our society as we know it. A pandemic that impacts the population on such a large scale may be accompanied by a variety of cascading effects and indirect impacts that have a profound impact on government's ability to provide essential services and maintain our critical infrastructure.

As identified in HSPD-7, critical infrastructure and key resources provide the essential services that underpin American society. The Nation possesses numerous key resources, whose exploitation or destruction could cause catastrophic health effects or mass casualties. Critical infrastructure is so vital that its incapacitation, exploitation, or destruction could have a debilitating effect on security and economic well-being. Consistent with the National Strategy for Homeland Security, the Secretary of Homeland Security has produced the National Infrastructure Protection Plan (NIPP), which outlines national goals, objectives, milestones, and key initiatives to protect the nation's critical infrastructure and key resources (CI/KR).

The NIPP is based upon a risk management framework that takes into account threats, vulnerabilities, and consequences when prioritizing CI/KR protection activities. It provides an integrated, comprehensive approach to addressing physical, cyber, and human threats and vulnerabilities to address the full range of risks to the Nation. The NIPP identifies Federal sector-specific agencies (SSAs) that will support preparedness, response, and recovery across a number of critical infrastructure sectors. It provides a roadmap for identifying CI/KR assets, assessing vulnerabilities, prioritizing assets, and implementing protection measures in each infrastructure sector. For each sector, the NIPP delineates roles and responsibilities for Federal SSAs in carrying out these activities, with DHS as the lead agency and single point of accountability and coordination.

While the NIPP is geared primarily towards protecting the infrastructure, the information and coordination that can be gleaned from the NIPP will be invaluable to the State in response to a pandemic. The vulnerabilities and capabilities for each sector have been identified, the results of which can be extrapolated into the State's pandemic response. This was done at the Federal level when looking at the NRF in relation to the NIPP. NRF response planning is informed by the most current and accurate assessments of CI/KR vulnerabilities. The primary agencies for the ESFs identified in the NRF are to access the information capabilities of the NIPP as they pertain to the response capabilities of the ESF. During the response phase of an incident, the information derived from NIPP implementation can be used to support initial response capabilities under the NRF. During an Incident of National Significance, DHS may designate an Infrastructure Liaison to serve as the principal advisor to the NRF response structure regarding all national and regional CI/KR related issues. In the absence of real-time incident information, the NIPP data can be modeled to provide anticipated consequences, and initial resources can be activated and deployed based on those predictions. Those models can support the State's decision in operational planning cycles during a pandemic. NRF recovery activities benefit from a centralized listing of CI/KR assets by geographic

area, and a mechanism for coordinated damage assessment, available through the NIPP. The NRF emergency response planning mechanism can use this information to prioritize recovery actions and resources.

To meet this challenge, the State has identified key lines of coordination to link existing State resources and capabilities to Federal resource support. State activities include ESF-specific multi-agency coordination with Federal ESFs as identified in the NRF. The technical basis for each agency activity is linked to a specific sector of the critical infrastructure. These concepts can be found in Attachment 2: *State/Federal Coordination for Resources and Resource Support*.

7. Intrastate, Interstate, and International Issues

As with other types of disasters, a pandemic will not stop at borders. In fact, imposing travel restrictions will likely be one of many primary means of non-medical containment. As such, three types of travel-related coordinative concerns need to be addressed: Intrastate, Interstate, and International travel. Key points in coordinating these efforts are as follows:

a) Intrastate Coordination

The recommendation or mandate to impose travel restrictions will be identified by LHDs and ESF #8. State support may be needed to maintain the traffic and access control points, utilizing the capabilities of the State ESFs. Resource support and movement restrictions will be coordinated through local government as appropriate.

b) Interstate Coordination

The recommendation or mandate to impose interstate travel restrictions will be identified by Governor's Office working with neighboring states and the Federal government. As with intrastate coordination, interstate coordination may require support to maintain traffic and access control points, utilizing the capabilities of the State ESFs. The resource support and movement restrictions will be coordinated through local government as well as with the neighboring state(s). The coordination with the local level in New York State will be managed through local government in the State via the command structure in place in New York. Interstate coordination will be managed through the State EOC to the State EOC of the state(s) in question.

The COVID-19 pandemic demonstrated this case in point, as New York State was openly competing with other states, as well as FEMA, for basic PPE and durable supplies such as ventilators. The result of the competition was "pandemic price gouging" by suppliers, which could be mitigated by regulation but only with delayed effects. Absent federalization of the procurement process, interstate coordination will be a vital weapon against price gouging, hoarding, and realized scarcity of resources. In the event of a pandemic affecting the United States, New York State will draft and execute memoranda of understanding with fellow state governments, as necessary escalating through the National Governors Association, to reduce the negative effects of market competition on New York State.

c) International Coordination

Similar to interstate coordination, the recommendation or mandate to impose international travel restrictions will be identified by ESF #8 through health networks with the Federal government and the WHO. As with interstate coordination, international coordination may require support to maintain the traffic and access control points, utilizing the capabilities of the State ESFs and Federal resources. The resource support and movement restrictions will be

coordinated through local government as well as the neighboring country. The coordination with the local level in New York State will be managed through local government in the State via the command structure in place in New York. International coordination will be managed through the State EOC with Federal ESF #15 External Affairs.

New York State Comprehensive Emergency Management Plan

Pandemic Annex

Section IV: Recovery

A. Overview

The nature of a pandemic is such that the event will not likely conclude within a set period of time. Unlike other natural disasters, a pandemic will likely come in waves, causing resurgence in the response until immunity is developed or vaccine has been widely distributed. While the period between waves may be difficult to identify, or predict, recovery from a pandemic begins while the pandemic is still in progress and continues during the periods between waves and following the pandemic. This phase of the response may be recognized following the *Deceleration Interval* (CDC), with an eventual transition to the *Preparation Interval* (CDC).

B. Demobilization of the State Response

The *Preparation Interval* (CDC) of the phase schema is initiated when State OEM receives notification from the DOH that low pandemic virus activity exists while continued outbreaks are possible in the State. This will be based on disease surveillance from the DOH surveillance networks, including Federal counterparts, and the level of requests for State assistance necessary to support the response. As the pandemic subsides and the State EOC demobilizes, several actions or activities may be realized, including:

- Giving consideration to relaxing quarantine and isolation measures, traffic and access control points and demobilizing ICS field components that may have been deployed to coordinate the response.
- Assessing the effectiveness of the sector coordination, communications, and response capabilities during the prior pandemic phases. Adjust as needed in anticipation of the next wave.
- Assessing resources and authorities that may be needed for subsequent pandemic waves.
- Estimating the overall pandemic impact on the State, including mortality, severe morbidity, financial impacts, and the disaster recovery mechanisms that can support the general public.
- Continuing enhanced state surveillance and, via the Federal government, domestic, and international surveillance to detect further pandemic waves.
- Assessing vaccine coverage, identify gaps and effectiveness of targeting to priority groups, and efficiency of distribution and administration; determine the number of persons who remain unprotected.
- Assessing vaccine and antiviral efficacy, safety, and the impact the distribution and administration the medicines had during the pandemic.
- Monitoring continued administration of vaccine to persons not previously protected.
- Continue incorporating mental health messages to facilitate continued self-care and recovery.
- Communicating with local government, healthcare providers, the media, and the public about any subsequent pandemic waves.
- Conducting an assessment of coordination during the period of pandemic disease and revise response plans, as needed. This may include a formal after-action review of pandemic response activities.

C. The Recovery Process

1. Funding and Compensation

Whenever the Governor finds that a disaster has occurred or may be imminent and local capabilities may be exceeded, the Governor may declare a State Disaster Emergency. Whenever the Governor finds that the event is of such severity and magnitude that the State may be overwhelmed, the Governor can request Federal assistance.

The State CEMP outlines the disaster relief funding and programs that would be applicable for an incident of this type. Included are provisions for Public Assistance (PA) and Individual Assistance (IA), which would aid in supporting government response operations and provide some recovery assistance for individuals and their families, businesses and sectors identified in the preceding pages. The implementation of the recovery process is identified in Volume 2 of the State CEMP – *Response and Short-Term Recovery*.

In the event that the animal population is impacted by the pandemic, current Federal statutes provide for some support to the agricultural industry in response to an outbreak of animal disease. While limited, the compensation allows for fair market value of the products that were destroyed to limit the spread of a disease. New York State statutes also contain provisions for indemnity but are limited to the amount of financial support to portions of the agricultural industry. Provisions for indemnity applicable to the agricultural industry can be found in the ESF #11 – Agriculture and Natural Resources Annex, *Appendix for Emerging Infectious Diseases in Non-Human Populations*.

During the Recovery Phase of a major pandemic, DHSES will need to devote special effort to assisting authorities with recouping costs incurred during the Response Phase. DHSES will work with the New York State Department of Budget (DOB) to sort out the various funding streams activated during the pandemic, commonly derived from disaster declarations at the State and Federal levels and establish a plan for seeking reimbursement for all eligible costs incurred.

2. Social and Economic Effects

The economic effects of a pandemic on the State, even on a small scale, may be enormous to the victims and their families, public and private entities, and to subsidiary and support industries of our economy. Employment may be affected over a wide range of sectors, from the farming and subsidiary industries, to distributors, the retail industry, to education, and to government. The impact on the sectors that serve as the foundational elements of our way of life may have a cascading effect. The potential exists for many businesses that rely upon or support those sectors to be severely impacted, including local businesses, distributors, healthcare, and any reliable business, market, or industry. Movement restrictions invoked under State or Federal authorities during the response may promote erratic prices of common products, services, or commodities. This is especially the case in the food service industry where most food providers maintain minimal or “just in time” inventories.

The State will need to take proactive measures in reenergizing the state’s economy. A variety of mechanisms to support the economy and the consumer (general public) in times of disaster are already identified in the State CEMP Volume 3 through the Recovery Support Functions (RSFs). In addition, these efforts may include:

- Monitoring excessive pricing practices to prevent “price-gouging”.
- Providing Unemployment Insurance Benefits and personnel services, including job counseling.
- Providing additional assistance to small businesses with grants and loan programs and assist an even larger group of businesses, through a broad range of services, to help the entire business community.
- Utilizing discretionary powers for abating penalties and extending tax due dates as warranted by the emergency.
- Providing advice on tax law provisions for losses related to the disaster.
- Working with lending institutions in requesting compassion and restraint for victims of a pandemic.

The bullets above note just a few of the potential State mechanisms that could be utilized to reenergize the economy and support the general population. The State’s ability to implement such actions, and others, rests with the agency that has the statutory obligation and authority to do so. Additional recovery programs can be found in Volume-3 of the State CEMP, *Long-Term Recovery*.

3. Continual Mental Health and Workforce Support Services

While unfortunate, it is recognized that a pandemic will likely result in a number of fatalities. In doing so, a pandemic will not discriminate when impacting the population. As a result, many entities, public, private, large, and small, may have workforce support issues that will need to be resolved. The general public may also need support from experiencing the loss of loved ones, but also from experiencing movement and restriction controls that are uncommon to our way of life.

During the response phase, disaster mental health services will be provided through ESF #6 via the State Office of Mental Health (OMH). The OMH is the lead in ensuring that mental health services are available and is responsible for coordinating State and Federal mental health resources that are requested through the State OEM. As the response organization demobilizes, State agencies will be afforded an additional opportunity to acquire mental health support from OMH via the existing response structure. This will allow for a more broad-based coordination of mental health support to State agencies utilizing the reporting and information sharing networks that will be active during the response.

Mental health activities may be ongoing for an extended period of time. Following demobilization, the OMH will serve as the POC in providing mental health services. The support will be recognized through pre-existing channels to provide mental health counseling and workforce resiliency.

The DOH *Pandemic Influenza Response Plan* identifies workforce support concepts and training materials to support the education of the State and local public healthcare partners. The goal in doing so is to assist in turning over the mental health services capability back to the local level for local government and the general public to utilize following the response. Support for local mental health support should be made available to all of the necessary sectors as well as the general public. Through the recovery process, the availability of mental health support should be maintained and consistently disseminated throughout ongoing public information campaigns. This capability should be coordinated through LHDs to reach the needed audiences.

4. Risk Reduction in Recovery

a. Surveillance

Surveillance in the post-pandemic phase will be conducted by State, Federal, and international public healthcare settings. In the State, ongoing virologic surveillance will be carefully coordinated by DOH to optimize the available resources and surveillance methodologies. The surveillance will be essential in quickly identifying any potential imminent waves of the pandemic to allow the State to resume the response posture.

b. Public Awareness

Public awareness and risk communications will be vital in successfully implementing a cohesive and coordinated response. The JIC will be the primary source of releases to the public to provide factual information on the status of activities, clinical signs, and symptoms of the pandemic virus, and what the general public can do to protect themselves. This type of capability needs to continue through the recovery process. Following the demobilization of the JIC, DOH will be the single POC for all pandemic inquiries. The information that can be provided includes fact sheets on the pandemic virus, travel advisories, risk factors, and recommended steps the public can take to reduce their risk of illness. Further, information and education materials may be disseminated through various means, including media outlets, public health networks, web-based applications, and on agency web sites.

Attachments:

Attachment 1: State/Federal Coordination for Resources and Resource Support

Attachment 2: List of References used in Plan Development

Attachment 3: Glossary and List of Acronyms

Attachment 4: NYS Pilot Statewide Telecommuting Program Memo & Bulletin

Attachment 1

State/Federal Coordination for Resources and Resource Support

<i>Critical Infrastructure Sector</i>	<i>State Agency or ESF</i>	<i>Federal Coordination with ESF- resources to support the response.</i>	<i>ESF Coordinating Agency</i>	<i>Federal Sector-Specific Agency (SSA)</i>	<i>State/Federal ESF Coordinative Notes Specific to a Pandemic</i>
Food and Agriculture	ESF #6: Mass Care, Emergency Assistance, Housing, and Human Services	ESF #6: Mass Care, Emergency Assistance, Temporary Housing, and Human Services	DHS/FEMA	USDA, HHS	ESF 6: Non-medical mass care services to include sheltering of victims, organizing feeding operations, emergency first aid, coordinating bulk distribution of emergency relief items.
	ESF #11: Agriculture and Natural Resources	ESF #11: Agriculture and Natural Resources	USDA	USDA, HHS	ESF 11: Can provide nutrition assistance, control and eradication of an animal /zoonotic disease outbreak, assurance of food safety and food security, protection of natural and cultural resources.
Water and Wastewater Systems	ESF #3: Public Works and Engineering	ESF #3: Public Works and Engineering	DOD	DOD	ESF 3: Assessments of public works and infrastructure, executing emergency contract support and real estate services.
	ESF #6: Mass Care, Emergency Assistance, Housing, and Human Services	ESF #6: Mass Care, Emergency Assistance, Temporary Housing, and Human Services	DHS/FEMA	EPA	ESF 6: Coordinating bulk distribution of emergency relief items.

Critical Infrastructure Sector	State Agency or ESF	Federal Coordination with ESF- resources to support the response.	ESF Coordinating Agency	Federal Sector-Specific Agency (SSA)	State/Federal ESF Coordinative Notes Specific to a Pandemic
Dams	ESF #3: Public Works and Engineering	ESF #3: Public Works and Engineering	DOD	DOD	ESF 3: Assessments of public works and infrastructure; executing emergency contract support and real estate services.
	ESF #12: Energy	ESF #12: Energy	DOE	DHS	ESF 12: Provide support and assistance to power producers; actions to assess energy supply demands; technical support to hydroelectric facilities.
	ESF #13: Public Safety and Security	ESF #13: Public Safety and Security	DOJ		ESF 13: Law enforcement support, credentialing, access control, site security, traffic and crowd control, security for the SNS.
Healthcare and Public Health	ESF #6: Mass Care, Emergency Assistance, Housing, and Human Services	ESF #6: Mass Care, Emergency Assistance, Temporary Housing, and Human Services	DHS/FEMA	HHS	ESF 6: Human Services include providing victim-related recovery efforts such as counseling, identifying support for persons with special needs, expediting processing of new Federal benefits claims.
	ESF #8: Public Health and Medical Services	ESF #8: Public Health and Medical Services	HHS		ESF 8: Assessment of public health/medical needs (including behavioral health), public health surveillance, medical care (NDMS) personnel, medical equipment, and supplies.
	ESF #11: Agriculture and Natural Resources	ESF #11: Agriculture and Natural Resources	USDA		ESF 11: Nutrition assistance, control and eradication of an animal/zoonotic disease outbreak, assurance of food safety and food security.
	ESF #15: External Affairs	ESF #15: External Affairs	DHS		

<i>Critical Infrastructure Sector</i>	<i>State Agency or ESF</i>	<i>Federal Coordination with ESF- resources to support the response.</i>	<i>ESF Coordinating Agency</i>	<i>Federal Sector-Specific Agency (SSA)</i>	<i>State/Federal ESF Coordinative Notes Specific to a Pandemic</i>
					ESF 15: Public Affairs, community relations, congressional and international affairs, State and local coordination, and Tribal affairs.
Emergency Services	ESF #4: Firefighting	ESF #4: Firefighting	USDA/FS	DHS	ESF 4: Provides personnel, equipment, and supplies in support of State, local, and tribal agencies involved in rural and urban firefighting operations.
	ESF #5: Information and Planning	ESF #5: Information and Planning	DHS/FEMA		ESF 5: Deploy staff to support emergency response teams, logistics and material, direction and control, information management, resource acquisition and management, including allocation and tracking.
	ESF #7: Logistics	ESF #7: Logistics	GSA/DHS/ FEMA		ESF 7: Support contracting services and security services, and personnel required to support immediate response activities.
	ESF #8: Public Health and Medical Services	ESF #8: Public Health and Medical Services	HHS		ESF 8: Can support emergency first aid.

<i>Critical Infrastructure Sector</i>	<i>State Agency or ESF</i>	<i>Federal Coordination with ESF- resources to support the response.</i>	<i>ESF Coordinating Agency</i>	<i>Federal Sector-Specific Agency (SSA)</i>	<i>State/Federal ESF Coordinative Notes Specific to a Pandemic</i>
	<p>ESF #9: Search and Rescue</p> <p>ESF #13: Public Safety and Security</p>	<p>ESF #9: Search and Rescue</p> <p>ESF #13: Public Safety and Security</p>	<p>DHS/FEMA</p> <p>DHS/DOJ</p>		<p>ESF 9: USAR support as needed.</p> <p>ESF 13: Law enforcement support, credentialing, access control, site security, traffic and crowd control, security for the SNS.</p>

Critical Infrastructure Sector	State Agency or ESF	Federal Coordination with ESF- resources to support the response.	ESF Coordinating Agency	Federal Sector-Specific Agency (SSA)	State/Federal ESF Coordinative Notes Specific to a Pandemic
Commercial Facilities	ESF #4: Firefighting	ESF #4: Firefighting	USDA/FS	DHS	ESF 4: Provides personnel, equipment, and supplies in support of State, local, and tribal agencies involved in rural and urban firefighting operations.
	ESF #5: Information and Planning	ESF #5: Information and Planning	DHS		ESF 5: Deploy staff to support emergency response teams, logistics and material, direction and control, information management, resource acquisition and management, including allocation and tracking.
	ESF #7: Logistics	ESF #7: Logistics	GSA/DHS/ FEMA	DHS/ GSA	ESF 7: Support contracting services and personnel required to support immediate response activities.
	ESF #13: Public Safety and Security	ESF #13: Public Safety and Security	DOJ		ESF 13: Law enforcement support, credentialing, access control, site security, traffic and crowd control, security for the SNS.
	ESF #15: External Affairs	ESF #15: External Affairs	DHS		ESF 15: Public affairs, community relations, congressional and international affairs, State and local coordination, and Tribal affairs.
Defense Industrial Base	ESF #3: Public Works and Engineering	ESF #3: Public Works and Engineering	DOD	DOD	ESF 3: Assessments of public works and infrastructure; executing emergency contract support and real estate services.
	ESF #12: Energy	ESF #12: Energy	DOE		ESF 12: Assist with requests for locating fuel for transportation, communications, emergency operations, and national defense.

Critical Infrastructure Sector	State Agency or ESF	Federal Coordination with ESF- resources to support the response.	ESF Coordinating Agency	Federal Sector-Specific Agency (SSA)	State/Federal ESF Coordinative Notes Specific to a Pandemic
			FEMA		ESF 7: Contracting services, including transportation services, in coordination with ESF #1.
Financial Services	ESF #2: Communications ESF #7: Logistics	ESF #2: Communications ESF #7: Logistics	DHS GSA/DHS/ FEMA	Dept. of Treasury	ESF 2: Coordinates to assess the need for telecommunications support for financial sector ISAC. ESF 7: Personnel support for requirements not specifically identified in other ESFs. <i>Note: Federal coordination should be maintained through the Treasury to the Financial and Banking Information Infrastructure Committee (FBIIIC) to a host of State, Federal and private banking, and financial institutions.</i>
Chemical	ESF #1: Transportation ESF #7: Logistics ESF #12: Energy	ESF #1: Transportation ESF #7: Logistics ESF #12: Energy	DOT GSA/DHS/ FEMA DOE	DHS	ESF 1: Processing and coordinating requests for Federal and civil transportation support, coordinating alternate transportation services; coordinating activities conducted under the direct authority of DOT elements such as air, maritime, surface, rail, and pipelines. ESF 7: Contracting services, including transportation services, in coordination with ESF #1. ESF 12: Assist with requests for emergency response actions as they pertain to the Nation's

<i>Critical Infrastructure Sector</i>	<i>State Agency or ESF</i>	<i>Federal Coordination with ESF- resources to support the response.</i>	<i>ESF Coordinating Agency</i>	<i>Federal Sector-Specific Agency (SSA)</i>	<i>State/Federal ESF Coordinative Notes Specific to a Pandemic</i>
					energy supply, locating fuel for transportation, Federal actions to conserve fuel and electric power; provide energy supply information and guidance on the conservation and efficient use of energy to the State, assesses fuel and electric power damage and energy supply and demand.
Government Facilities	ESF #4: Firefighting	ESF #4: Firefighting	USDA/FS	DOI	ESF 4: Provides personnel, equipment, and supplies in support of State, local, and tribal agencies involved in rural and urban firefighting operations.
	ESF #5: Information and Planning	ESF #5: Information and Planning	DHS		ESF 5: Deploy staff to support emergency response teams, logistics and material, direction and control, information management, resource acquisition and management, including allocation and tracking.
	ESF #7: Logistics	ESF #7: Logistics	GSA/DHS/FEMA	DHS/GSA	ESF 7: Support contracting services and personnel required to support immediate response activities.
	ESF #13: Public Safety and Security	ESF #13: Public Safety and Security	DOJ		ESF 13: Law enforcement support, credentialing, access control, site security, traffic and crowd control, security for the SNS.

<i>Critical Infrastructure Sector</i>	<i>State Agency or ESF</i>	<i>Federal Coordination with ESF- resources to support the response.</i>	<i>ESF Coordinating Agency</i>	<i>Federal Sector-Specific Agency (SSA)</i>	<i>State/Federal ESF Coordinative Notes Specific to a Pandemic</i>
	ESF #15: External Affairs	ESF #15: External Affairs	DHS		ESF 15: Public affairs, community relations, congressional and international affairs, State and local coordination, and Tribal affairs.
Critical Manufacturing	ESF #1: Transportation	ESF #1: Transportation	DOT	DHS	ESF 1: Processing and coordinating requests for Federal and civil transportation support, coordinating alternate transportation services.
	ESF #7: Logistics	ESF #7: Logistics	GSA/DHS/FEMA		ESF 7: Contracting services, including transportation services, in coordination with ESF #1.
Communications	ESF #2: Communications	ESF #2: Communications	DHS	DHS	ESF 2: Coordinates to assess the need for telecommunications industry support, ensures such support is available as needed, including personnel.

Attachment 2

List of References Used in Plan Development

The following is a list of documents that were used in the preparation of this Annex:

1. The New York State Comprehensive Emergency Management Plan (CEMP):

 Volume 2: Response and Short-Term Recovery, and all Emergency Support Functions (ESFs), as appropriate.

 Volume 3: Long-Term Recovery Plan
2. The New York State Department of Health, *Pandemic Influenza Response Plan*; March 2014.
3. U.S. Centers for Disease Control and Prevention, *Updated Preparedness and Response Framework for Influenza Pandemics*; September 2014.
4. World Health Organization, *Pandemic Influenza Risk Management: WHO Interim Guidance*; June 2013.
5. World Health Organization, *WHO Guidance for Surveillance during an Influenza Pandemic*; November 2017.
6. U.S. Department of Health and Human Services, *HHS Pandemic Influenza Plan*; November 2005.
7. U.S. Department of Health and Human Services, *Pandemic Influenza Plan Update*; 2017.
8. Homeland Security Council, *National Strategy for Pandemic Influenza*; November 2005.
9. Homeland Security Council, *National Strategy for Pandemic Influenza Implementation Plan*; May 2006.
10. U.S. Department of Homeland Security, *National Infrastructure Protection Plan*; 2013.
11. U.S. Department of Homeland Security, *National Response Framework, Third Edition*; June 2016.
12. Homeland Security Presidential Directive (HSPD) #5 – Management of Domestic Incidents; February 2003.
13. Homeland Security Presidential Directive (HSPD) #7 – Critical Infrastructure Identification, Prioritization and Protection; December 2003.
14. U.S. Centers for Disease Control, *State and Local Planning Checklist*; December 2005.
15. World Health Organization, *Global Influenza Preparedness Plan*; May 2005.
16. World Health Organization, *Review of Latest Evidence on Risks to Human Health Through Potential Transmission of Avian Influenza through Water and Sewage*; March 2006.

Attachment 3

Glossary and List of Acronyms

I. Glossary

Adjuvant: Substances that can be added to a vaccine to increase the effectiveness of the vaccine.

Affected community: An at-risk community experiencing endemic (widespread and recurring) or epidemic (isolated) cases in humans or domestic animals of a virus with human pandemic potential.

Antiviral medications: Medications presumed to be effective against potential pandemic virus strains.

Arrival screening: Medical screening upon arrival to detect individuals who have signs of illness or who are at high risk of developing illness.

Asymptomatic: Without symptoms.

At-risk community: An unaffected community with insufficient medical, public health, or veterinary capacity to prevent, detect, or contain a virus with pandemic potential.

Containment: Contain an outbreak to the affected region(s) and limit of spread of the pandemic through aggressive attempts to contain via isolation, quarantine, or social distancing.

Continuity of operations: Refers to the capability to ensure the performance of essential functions during any emergency or situation that may disrupt normal operations.

Countermeasures: Refers to pre-pandemic and pandemic virus vaccine and antiviral medications.

Critical infrastructure: Systems and assets, whether physical or virtual, so vital to the United States that the incapacity or destruction of such systems and assets would have a debilitating impact on security, national economic security, national public health or safety, or any combination of those matters. Specifically, it refers to the critical infrastructure sectors and key resources identified in Homeland Security Presidential Directive 7 (HSPD-7).

Delegation of authority: Identification, by position, the authorities for making policy determinations and decisions at headquarters, field levels, and other organizational locations, as appropriate.

Domestic animals: Livestock, including poultry, and other farmed birds or mammals; does not include companion animals such as dogs, cats, or pet birds.

Dose sparing strategies: Strategies to increase virus vaccine immunogenicity and minimize the dose of vaccine necessary to confer immunity.

Epidemic: A pronounced clustering of cases of disease within a short period of time; more generally, a disease whose frequency of occurrence is in excess of the expected frequency in a population during a given time interval.

Essential functions: Functions that are absolutely necessary to keep a business operating during a pandemic, and critical to survival and recovery.

Geographic quarantine: The isolation of localities with documented disease transmission from localities still free of infection.

High-risk community: An at-risk community that is located in proximity to an affected area, or in which a wildlife case of the virus with pandemic potential has been detected.

Highly Pathogenic Avian Influenza (HPAI): An infection of poultry caused by any influenza A virus that meets the World Organization for Animal Health (OIE) definition for high pathogenicity based on the mortality rate of chickens exposed to the virus.

Isolation: Separation of infected individuals from those who are not infected.

Key assets: Subset of key resources that are “individual targets whose destruction could cause large scale injury, death, or destruction of property, and/or profoundly damage our national prestige or confidence.”

Key resources: Publicly or privately controlled resources essential to the minimal operations of the economy and government. This refers to the four key resources identified in HSPD-7 and the National Infrastructure Protection Plan. These four key resources include: dams; government facilities; commercial facilities; and nuclear reactors, material, and waste.

Live bird marketing system (LBMS): Live poultry markets in the United States and the poultry distributors and poultry production premises that supply those markets.

Lines of succession: Refers to the sequential order or ranking of individuals who would assume authority and responsibility if the leadership is incapacitated or unavailable.

Pandemic: A worldwide epidemic when a new or novel strain of a virus emerges in which humans have little or no immunity and develops the ability to infect and be passed between humans.

Pandemic vaccine: Vaccine for specific influenza virus strain that has evolved the capacity for sustained and efficient human-to-human transmission. This vaccine can only be developed once the pandemic strain emerges.

Points of Dispensing (PODs): Locations or facilities where state and/or local authorities will be distributing vaccine or anti-viral medications, if available. These types of facilities are considered “traditional PODs”. Non-traditional PODs would be a means to distribute vaccine or antivirals while maintaining social distancing, such as “drive through” centers where occupants of a vehicle do not exit the vehicle but receive the required medication.

Post-exposure prophylaxis: The use of antiviral medications in individuals exposed to others with a virus to prevent disease transmission.

Prophylaxis: The prevention of a disease or of a process that can lead to disease. With respect to pandemic viruses this specifically refers to the administration of antiviral medications to healthy individuals for prevention of the virus.

Quarantine: Separation of individuals who have been exposed to an infection but are not yet ill from others who have not been exposed to the transmissible infection.

Sector: Part or division of the national economy.

Sector-Specific Agency: Federal departments and agencies identified under HSPD-7 as responsible for infrastructure protection activities in a designated critical infrastructure sector or key resources category.

Social distancing: Infection control strategies that reduce the duration and/or intimacy of social contacts and thereby limit the transmission of a virus. There are two basic categories of intervention: transmission interventions, such as the use of facemasks, may reduce the likelihood of casual social contacts resulting in disease transmission; contact interventions, such as closing schools or canceling large gatherings, eliminate or reduce the likelihood of contact with infected individuals.

Surge capacity: Refers to the ability to expand provision of services beyond normal capacity to meet transient increases in demand. Surge capacity within a medical context denotes the ability of health care or laboratory facilities to provide care or services above their usual capacity, or to expand manufacturing capacity of essential medical materiel (e.g., vaccine) to meet increased demand.

Telecommuting: Working from home or an alternate site and avoiding coming to the workplace through telecommunication (computer access).

Treatment course (antiviral medications): The course of antiviral medication prescribed as treatment (not prophylaxis) for a person infected with an agent susceptible to the antiviral medication.

Treatment course (vaccine): The course of vaccine required to induce protective immunity against the target of the vaccine.

Virulence: Virulence refers to the disease-evoking severity of the virus.

Wave: The period during which an outbreak or epidemic occurs either within a community or aggregated across a larger geographical area. The disease wave includes the time during which disease occurrence increases rapidly, peaks, and declines back toward baseline.

II. List of Acronyms

APHIS	Animal and Plant Health Inspection Service
BLS	Basic Life Support
CDC	U.S. Centers for Disease Control and Prevention
CEMP	NYS Comprehensive Emergency Management Plan
CI/KR	Critical Infrastructure and Key Resources
COOP	Continuity of Operations Planning
DHS	Department of Homeland Security
DMAT	Disaster Medical Assistance Teams
DMNA	Division of Military and Naval Affairs
DMORT	Disaster Mortuary Services
DOD	Department of Defense
DOT	Department of Transportation

DPC	NYS Disaster Preparedness Commission
DPS	Department of Public Service
EMS	Emergency Medical Services
EOC	Emergency Operations Center
EMAC	Emergency Management Assistance Compact
EPA	U.S. Environmental Protection Agency
ERT-A	Federal Emergency Response Team-A
ESF #1	Emergency Support Function (Transportation)
ESF #2	Emergency Support Function (Communications)
ESF #3	Emergency Support Function (Public Works and Engineering)
ESF #4	Emergency Support Function (Firefighting)
ESF #5	Emergency Support Function (Information and Planning)
ESF #6	Emergency Support Function (Mass Care, Emergency Assistance, Housing, and Human Services)
ESF #7	Emergency Support Function (Logistics)
ESF #8	Emergency Support Function (Public Health and Medical Services)
ESF #9	Emergency Support Function (Search and Rescue)
ESF #10	Emergency Support Function (Oil and Hazardous Materials Response)
ESF #11	Emergency Support Function (Agriculture and Natural Resources)
ESF #12	Emergency Support Function (Energy)
ESF #13	Emergency Support Function (Public Safety and Security)
ESF #15	Emergency Support Function (External Affairs)
FEMA	Federal Emergency Management Agency
HAN	NYS DOH Health Alert Network
HHS	U.S. Department of Health and Human Services
HPAI	Highly Pathogenic Avian Influenza Virus
HSPD #5	Homeland Security Presidential Directive-5; NIMS
IA	Individual Assistance
ICS	Incident Command System
IMT	State Incident Management Team
ITS	NYS Office of Information Technology Services
JIC	Joint Information Center
LHD	Local Health Department
MERC	Medical Emergency Response Cache
MI	Managed Inventory
NDMS	National Disaster Medical System
NFPA 1600	Standard on Disaster/Emergency Management and Business Continuity
NIMS	National Incident Management System
NIIMS	National Interagency Incident Management System
NIPP	National Infrastructure Protection Plan
NRF	National Response Framework
NYSERDA	NYS Energy, Research and Development Authority
OMH	NYS Office of Mental Health
OSTP	Office of Science and Technology Programs
OTDA	Office of Temporary and Disability Assistance
PA	Public Assistance
PFO	Principal Federal Official
POD	Point of Dispensing

PPE	Personal Protective Equipment
State OEM	New York State Office of Emergency Management
State EOC	State Emergency Operations Center
SNS	Strategic National Stockpile
SSA	Sector Specific Agencies
USDA	U.S. Department of Agriculture
USPHS	U.S. Public Health Service
WHO	World Health Organization
WPU	NYS DEC Wildlife Pathology Unit

Attachment 4

***NYS Pilot Statewide Telecommuting Program
Memo & Bulletin***

During the State response to the Novel Coronavirus Pandemic in 2020-21, a number of approaches were employed to ensure adequate social distancing and safety protocols could be applied correctly. One such approach included the implementation and use of a Statewide Telecommuting Program. This program was initiated on March 16, 2020 and was extended a number of times. The memo and bulletin on the following page provided the policy, guidance, and included an application for those who wished to telecommute. This approach was employed well and appeared to ensure more appropriate application of preventative measures during the pandemic.

MEMORANDUM

March 16, 2020

TO: Directors of Human

Resources FROM: Michael N. Volforte

SUBJECT: Pilot Statewide Telecommuting Programs for M/C, CSEA, PEF and UUP-represented Employees

We have received frequent requests for guidance on deploying employees to telecommute as we move to implement social distancing precautions recommended by the Department of Health in response to the novel Coronavirus COVID-19.

We have entered into agreements with CSEA, PEF and UUP that create a Pilot Statewide Telecommuting Program (Telecommuting Pilot Program) covering employees represented by those unions. The Pilot Program also covers M/C employees. The Telecommuting Pilot Program is effective immediately and remain in effect through May 14, 2020. An Implementation Bulletin and a Telecommuting Application Form are attached to this memorandum.

Wherever existing agency telecommuting programs conflict with Telecommuting Pilot Program guidelines, the Pilot Program guidelines control for the duration of the Pilot Program. **There is no need to re-enroll current telecommuters with the new form.** Similarly, if you already have a telecommuting application and enrollment process you can continue to use it. If you do not have an established telecommuting program, please use the attached application form. Any pre-existing telecommuting programs will revert to their regular guidelines upon expiration of the Telecommuting Pilot Program.

While you should refer to the attached Implementation Bulletin for full details, key points to be aware of in administering the Telecommuting Pilot Program include the following:

- Your agency Executive Team, subject to any approval required by your Deputy Secretary to the Governor, should review and approve expansion/implementation of telecommuting in advance. Considerations might include, but not be limited to, determination of which program areas and types of employees would be suitable for telecommuting and the availability of any necessary IT infrastructure to support telecommuting. As events unfold you may find that you need to expand or contract the scale of telecommuting you approve to meet operating needs. Bear

in mind, our goal is to implement these programs as widely as possible in light of operational needs.

- Employees may request to telecommute, or they can be assigned to telecommute by management where such assignments meet operating needs as determined by agency management.
- There is no limit on the number of days per week/pay period that employees may be allowed/assigned to telecommute under these pilot programs. In determining how often telecommuting can take place, managers should balance challenges inherent in managing remote work with our need to increase social distancing to reduce transmission of COVID-19. Where the nature of the work allows for effective remote supervision, frequency of telecommuting should be maximized for the duration of these Telecommuting Pilot Programs.
- Telecommuters must submit a work plan describing the work they will complete at their alternate work location for approval prior to telecommuting. Managers have discretion to determine the form such work plans can take. However, to ensure that work is managed properly, it is strongly recommended that work plans not cover more than a week at a time. In some cases, daily work plans may be preferable. Managers are expected to ensure that work described in the work plans is accomplished in a timely fashion and may base decisions on approval of subsequent work plans submitted by any employee on their performance in a telecommuting situation.
- Telecommuters must have a set work schedule and abide by all operative state and agency rules and policies.

Additional details are provided in the attached agreements. We have received many questions regarding whether telecommuting arrangements can be used to assist employees with sudden child-care gaps due to extended school closures resulting from COVID-19. This is a determination that each Director of Human Resources must make based on the circumstances of any given case. Where such employees are assigned work that can be managed effectively in a telecommuting situation and the supervisor and employee have established a routine that will allow the supervisor to ensure that the telecommuter is working an approved schedule, this can be permitted under the Telecommuting Pilot Program to ease the burden on employees affected by emergency school closures.

Please work with your Deputy Secretaries on your operational plans to utilize this Pilot.

Please direct any questions regarding implementation of the Pilot Telecommuting Program to GOER at 518-474-6988.

Implementation Bulletin
Pilot Statewide Telecommuting Programs
for M/C, CSEA, PEF and UUP-Represented Employees

Overview

The State of New York is responding to an outbreak of respiratory illness caused by COVID-19 that was first detected in Wuhan City, Hubei Province, China and which continues to expand. New York confirmed its first cases of person-to-person spread with this virus March 3, 2020 and is taking active measures to contain the spread of this virus.

Telecommuting arrangements are an important component of a multi-layered strategy to prevent sustained spread of COVID-19 among the state workforce. This program strikes a balance between ensuring government can continue to function, while providing appropriate precautions for state employees to prevent the spread of illness.

The State has entered into agreements with CSEA, PEF and UUP that create a Pilot Statewide Telecommuting Program (Telecommuting Pilot Program) due to public health concerns presented by the Coronavirus. This Pilot Program also applies to M/C employees. Where management determines it to be operationally feasible or necessary, telecommuting shall be assigned or approved for employees represented by these unions to the greatest extent possible.

Wherever existing agency/facility/campus telecommuting programs conflict with Telecommuting Pilot Program guidelines, the Pilot Program guidelines control for the duration of the Pilot Program.

There is no need to re-enroll current telecommuters with the new form. Similarly, if you already have a telecommuting application and enrollment process that is working, you can continue to use it. If you do not have an established telecommuting program, please use the attached application form. Any pre-existing telecommuting programs will revert to their regular guidelines upon expiration of the Pilot Programs.

Definitions

Telecommuting -- an alternate work arrangement that allows employees to conduct all or some of their work away from the official work site. Under the Telecommuting Pilot Program, Employees may telecommute any number of days per week, up to and including full-time, based on operating needs.

Official Work Site -- the employee's State-provided workstation. This is the employee's usual and customary work address.

Alternate Work Site -- A location away from the State-provided work site where the employee is authorized to conduct business. This location must meet all criteria set forth in this document and be approved by the telecommuter's supervisor or another manager with appropriate authority.

Telecommuting Application -- An application form, furnished by management, and completed by the employee requesting to become an approved telecommuter.

Telecommuting Work Plan -- A document completed by the telecommuter, in a format specified by the telecommuter's supervisor, for each telecommuting day. The work plan provides important information about each telecommuting day including hours worked, and work performed. Multiple

telecommuting days may be included on a single work plan. The work plan must be signed by the telecommuter and the supervisor/manager.

Participation

Employees may be assigned to telecommute where such assignment meets operating needs and reduces opportunities for transmission of COVID-19. Where management mandates participation, an employee shall have 24 hours from notice of such ordered participation to appeal to the agency/facility/campus head or their designee (see appeal process below).

Employees may also request to participate on a voluntary basis. During the term of this Telecommuting Pilot Program, such requests should be granted to the greatest extent possible. In order to request to participate, the employee must submit a Telecommuting Application to their supervisor/manager. The supervisor/manager will review the employee Telecommuting Application to make an *initial* determination whether an employee meets the criteria within 48 hours. Application will be sent to the Director of Human Resources or their designee(s) for final approval which will be provided within 48 hours of receipt. All responses will be in writing.

Once a Telecommuting Application has been approved, participation and start dates may be subject to equipment availability.

Telecommuting is not an employee entitlement and is not operationally feasible for all job functions. Management determinations as to which job functions are eligible for telecommuting are final and cannot be appealed. Full discretion to either approve or disapprove an application for telecommuting rests solely with management, but applications should be widely granted so long as they are consistent with operating need. An individual's participation in the Pilot Program can be suspended or cancelled at management's sole discretion with 48 hours' advance written notice to the employee.

Employee Appeal Process -- If an employee in a job function deemed eligible for telecommuting by management has their telecommuting application disapproved or if an employee wishes to contest mandated telecommuting, they may appeal to the agency/facility/campus head or their designee in writing within 24 hours of the denial.

The appeal shall state the reasons for disagreement with management's determination. A decision on the appeal shall be rendered by the Director of Human Resources or their designee(s) within seven (7) calendar days stating the reasons for the decision if denied.

Denials of applications for telecommuting under the Telecommuting Pilot Program are not grievable under any collective bargaining agreements.

General Guidelines

Employees must comply with all NYS and agency/facility/campus laws, rules, and guidance required at the official work site when telecommuting. Failure to abide by all rules, laws, and guidance may result in exclusion from Telecommuting Pilot Program and/or administrative action, including disciplinary action.

Employees must complete a telecommuting training if one is provided before any telecommuting is permitted. This includes, but is not limited to, training in the use of any software required for remote access, data security procedures, and any necessary orientation to the process of submitting work plans.

Telecommuters are responsible for submitting work plans regardless of whether they are participating on a voluntary basis or assigned to participate by their supervisor/manager. The work plan provides important information about each proposed telecommuting day including hours worked, and work performed. Multiple telecommuting days may be included on a single work plan. The work plan must be signed by the telecommuter and the supervisor/manager. Employee performance in a telecommuting setting should be one factor considered in approval of telecommuting work plans. In some cases, employees approved for Telecommuting Pilot Program participation may not have a particular work plan approved, in which case the manager can allow the employee to revise and resubmit the work plan or direct the employee to report to their Official Work Station for the period covered by the at-issue work plan.

Telecommuters will treat telecommuting days like regular workdays and will be expected to maintain a regular work routine while telecommuting. Managers may require telecommuters to have a set telecommuting schedule that is specified on the work plan. Telecommuters will work their entire approved workday (including overtime when appropriate and authorized). Telecommuters must request time off in advance and submit all leave requests as currently required. All current laws, regulations, contract provisions and standard rules governing employee work schedules apply.

A telecommuter is required to report to the official work site upon management's request at any time. A telecommuter may request to charge leave accruals in lieu of returning to the official work site. Such requests will be reviewed in accordance with all normal standards governing use of leave accruals. When telecommuters are required by management to report to the official work site on a scheduled telecommuting day, there is no expectation that the telecommuter will be granted a substitute telecommuting day in return. However, with flexibility as a key component of the program, at the discretion of management, a scheduled telecommuting day may be changed within the same pay period. If a telecommuter is required to report to their official work site, they will not be reimbursed for travel, nor may they be paid for travel.

Telecommuters must be available via all required methods of communication throughout the workday. Should a telecommuter not be available through official channels, the management will contact the telecommuter via their personal contact information provided in the Work Plan.

Telecommuters may be required to forward their official work site phone to the phone that will be used while telecommuting.

In-Person meetings at the telecommuter's alternative work site are *prohibited*. This restriction does not preclude a telecommuter from participating in phone or web-based meetings from their alternate work site.

Unless otherwise directed, telecommuters will not be excused from work when a directed departure is issued for the official work site. Conversely, if an emergency occurs at the alternate work site and the telecommuter is unable to work at the telecommuting site that day or if the telecommuter is unable to, for any reason, continue working during their scheduled hours, the Supervisor/Manager may direct the telecommuter to come to the official work site or grant authority to charge accruals.

Employees must safeguard all passwords used in connection with agency/facility/campus service files or programs and ensure sensitive information is protected.

Temporary, seasonal, part-time, and probationary employees may be allowed to telecommute with HR approval.

Equipment and Supplies

The employer will not provide telecommuters durable equipment such as desks, chairs, file cabinets, or other office related furniture. Similarly, the employer will not be able to provide a laptop or other similar device to all telecommuters. The use of an employee's personal computer may be dependent on the use of **Virtual Desktop Infrastructure (VDI) or Virtual Private Network (VPN) or Access to Email, OneDrive and/or SharePoint via Outlook Web Access, all of which may require an RSA token. Management will determine which connection mechanism is appropriate based on operational need.**

Telecommuters using personal devices will receive instruction on how to obtain any necessary software and/or an RSA token. These must be tested before telecommuting can begin.

Minimal office supplies may be provided by the employer and should be requested during the telecommuter's in-office work period. Supplies will not be shipped to the alternate work site. Any out-of-pocket expenses incurred for supplies, equipment, food, commuting, etc. will not be reimbursed.

Generally, the telecommuter must have an internet connection with bandwidth that is appropriate for conducting official business without disruption. The telecommuter is responsible to secure and pay for an internet connection. The agency will not reimburse internet costs. In limited instances, telecommuting assignments that do not require an internet connection may be available. Where such assignments meet operating needs, they can be made/approved.

The telecommuter is responsible for having a phone for all work-related calls.

If an assigned RSA hard token or other work item is lost or stolen, the telecommuter must immediately notify their Supervisor/Manager and refer to the agency's usage agreement for portable Media and End User Devices and complete all steps outlined within the policy/procedure.

When the Telecommuting Pilot Program ends, the employee must return the RSA hard token, if applicable, and any supplies issued on their next workday unless otherwise specified by management.

Agency Policies/Security of Information

Any agency/facility/campus information possessed by the telecommuter cannot be shared with or made available to any other individuals.

Telecommuters must ensure that official records and information are secure and not maintained in a way that would make them available to any other individuals.

Telecommuters are responsible for adhering to all State, agency, facility, university or campus policies, procedures and standards concerning use of computer equipment and the security of data/information while telecommuting. These policies, procedures and standards can be found in the Policies and Procedures section of the Agency, facility, university, or campus Intranet or on the ITS website.

Unauthorized access to or disclosure of official information or systems must be immediately reported to the telecommuter's supervisor/manager. Such unauthorized access or disclosure,

including the release of confidential information or the personally identifiable information of Agency, facility, university or campus staff or customers, which happened due to the telecommuter's neglect, will be addressed through administrative actions.

Telecommuters must protect and safeguard files, documents, equipment, and other materials transported back and forth between the official work site and the alternate work site. Telecommuters shall protect official records and documents from unauthorized disclosure or damage and shall comply with all established policies and procedures regarding such matters.

Telecommuters must also take the following specific precautions:

- a. Only take confidential information offsite when authorized by their supervisor.
- b. Do not transmit confidential information from work e-mail to personal e-mail addresses or text messaging services (e.g. icloud.com, aol.com, yahoo.com or g-mail.com).
- c. Securely store all hard copy documents or office media so that others cannot access it.
- d. Do not communicate confidential information where others can listen.
- e. Place documents requiring destruction in Confidential/Sensitive destruction bins located at the official worksite.

Telecommuters will be required to take appropriate action to protect the items from damage or theft. Loss or theft of equipment must immediately be reported to the telecommuter's supervisor/manager. Any suspected data breach containing sensitive data must immediately be reported to the telecommuter's supervisor and the telecommuter must complete any required documentation of the suspected breach.

Under no circumstance may official data or information be transferred to or stored on any personal devices. Under no circumstance may the telecommuter allow agency issued equipment to be used by any other person however agencies will not necessarily provide agency issued equipment to telecommute unless they determine that they can do so. Telecommuters must log off and secure any computer being utilized to conduct official business when not in use.

Management will not access or otherwise use any personal information on an employee's personal device.

Program Dates

The Telecommuting Pilot Program is effective as of March 17, 2020 and shall run through May 14, 2020. It can be extended upon agreement between the State and participating unions. This Pilot Program can be cancelled by the State in its sole discretion with one-week advance written notice to participating unions.