RICHLAND PUBLIC HEALTH
AND
SHELBY CITY HEALTH DEPARTMENT

EMERGENCY RESPONSE PLAN
- BASIC PLAN
For Richland County, OH

Jurisdictional Agreement Attachment I

Richland Public Health
Prevent. Promote. Protect.

Shelby City Health Department
Live Healthy. Stay Healthy.

Version 2.0
Date Originally Adopted: December 8, 2007
Date of Last Review: October 19, 2018
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RPH/SCHD ERP RECORD OF REVIEW/CHANGES

Change Number: 1	**Date of Change**	**Print Name & Signature**	**Title**
	12/15/2017	Susan McFarren, RN	Planner
Version Number: 2	ERP Revised for ODH submission		
Change Number: 2	**Date of Change**	**Print Name & Signature**	**Title**
	04/16/2018	Susan McFarren, RN	Planner
Version Number: 2	ERP Corrections for resubmission		
Change Number: 3	**Date of Change**	**Print Name & Signature**	**Title**
	05/15/2018	Susan McFarren, RN	Planner
Version Number: 2	Promulgation Completed		
Change Number: 4	**Date of Change**	**Print Name & Signature**	**Title**
	10/11/2018	Susan McFarren, RN	Planner
Version Number: 3	Added cost recovery content required by rubric		
Change Number: 5	**Date of Change**	**Print Name & Signature**	**Title**
	10/11/2018	Susan McFarren, RN	Planner
Version Number: 3	Added Google Drive procedures for document filing. Added computer systems to time keeping section and person responsible for fiscal operations		
Change Number: 6	**Date of Change**	**Print Name & Signature**	**Title**
	10/11/2018	Susan McFarren, RN	Planner
Version Number: 3	Added place holder for functional Needs Partner List		
Change Number: 7	**Date of Change**	**Print Name & Signature**	**Title**
	10/11/2018	Susan McFarren, RN	Planner

Version Number 3	Updated MOU tables to include cost and POC, and contact information		
Change Number: 9	**Date of Change**	**Print Name & Signature**	**Title**
	10/11/2018	Susan McFarren, RN	Planner
Version Number: 3	Added decision maker for IMAC/EMAC requests and updated request procedures		
Change Number: 10	**Date of Change**	**Print Name & Signature**	**Title**
	10/12/2018	Susan McFarren, RN	Planner
Version Number: 3	Added types of incidents in which PFA may be needed to Disaster Mental Health Annex		
Change Number: 11	**Date of Change**	**Print Name & Signature**	**Title**
	10/12/2018	Susan McFarren, RN	Planner
Version Number: 3	Incorporated EEI information regarding state-and-local coordination call and local HC's role		
Change Number: 12	**Date of Change**	**Print Name & Signature**	**Title**
	10/12/2018	Susan McFarren, RN	Planner
Version Number: 3	Updated roles of HCC partners in emergencies and PH roles in assisting them		
Change Number: 13	**Date of Change**	**Print Name & Signature**	**Title**
	10/15/2018	Susan McFarren, RN	Planner
Version Number: 3	Updated CMIST profile		
Change Number: 14	**Date of Change**	**Print Name & Signature**	**Title**
	10/15/2018	Susan McFarren, RN	Planner
Version Number: 3	Added NIMS Refresh info		
Change Number: 15	**Date of Change**	**Print Name & Signature**	**Title**
	10/16/2018	Susan McFarren, RN	Planner
Version Number: 3	Updated MOU tables to include cost and POC, and contact information		
Change Number:	**Date of Change**	**Print Name &**	**Title**

16		**Signature**	
	10/17/2018	Susan McFarren, RN	Planner
Version Number: 3	Added Flood Plain Map; Added Richland County SVI Scores; Added		
Change Number: 17	**Date of Change**	**Print Name & Signature**	**Title**
	10/17/2018	Susan McFarren, RN	Planner
Version Number: 3	Added how emergency legal authorities used during a response differ from standard procedures		
Change Number: 18	**Date of Change**	**Print Name & Signature**	**Title**
	12/18/2018	Susan McFarren, RN	Planner
Version Number: 3	Updated Attachment XVI-NIMS Trainings with updated version numbers		
Change Number: 19	**Date of Change**	**Print Name & Signature**	**Title**
	03/01/2018	Susan McFarren, RN	Planner
Version Number: 3	Updated IMAC and EMAC Procedures		
Change Number: 20	**Date of Change**	**Print Name & Signature**	**Title**
	03/01/2018	Susan McFarren, RN	Planner
Version Number: 3	Updated RHCC and RPHC Roles		
Change Number: 21	**Date of Change**	**Print Name & Signature**	**Title**
	03/01/2018	Susan McFarren, RN	Planner
Version Number: 3	Corrected CMIST Profile		
Change Number: 22	**Date of Change**	**Print Name & Signature**	**Title**
	03/01/2018	Susan McFarren, RN	Planner
Version Number: 3	Updated limitations of volunteer use		
Change Number: 23	**Date of Change**	**Print Name & Signature**	**Title**
	03/01/2018	Susan McFarren, RN	Planner
Version Number: 3	Added RHCC roles		

Previous Reviews (Plan Version 1)

DATE OF REVIEW/MEETING	CHANGES MADE	BY
2/4/2013	Removed federal emergency threat levels, Updated and revised table of contents	S. McFarren, RN
2/15/2013	Added NIMS integration Guide & PHICS resources (separate notebook)	S. McFarren, RN
9/16/2013	Added listing of community partner agencies	S. McFarren, RN
9/15/2014	Added new Annexes	S. McFarren, RN
10/30/2014	Review and update w/Richland Co. Partners in Preparedness (RCPP)	S. McFarren, RN
2/19/2015	Added new Annexes. Updated w/staffing changes.	S. McFarren, RN
5/13/2015	Added procedures for obtaining public feedback	S. McFarren, RN
5/14/2015	Added Acronyms	S. McFarren, RN
9/29/2015	Reviewed and added NECO Concept Plan	S. McFarren, RN
1/22/2016	Reviewed. Updated staffing	S. McFarren, RN
5/17/2016	Reviewed. Added AAR/IP Protocols	S. McFarren, RN
6/20/2016	Reviewed IAP Template and updated Recovery Plan Template	S. McFarren, RN
8/01/2016	Added R.C. ESF#8	S. McFarren, RN
09/01/2016	Updated Demobilization Template	S. McFarren, RN
11/02/2016	Added NECO Plan	S. McFarren, RN
11/7/2016	Mandatory NIMS/ICS Staff Training Compliance SOP	S. McFarren, RN
12/23/2016	Added Hazards and Mitigation Plan updates	S. McFarren, RN
12/27/2016	Updated roles and responsibilities	S. McFarren, RN
12/28/2016	Updated IP guidance	S. McFarren, RN
05/3/2017	Reviewed/Updated PFL	S. McFarren, RN

Record of Distribution

A hard copy of the ***Richland Public Health/Shelby City Health Department Emergency Response Plan (RPH/SCHD ERP)*** has distributed to the people below:

Date Delivered:	Program/Agency:	Name:	Title:
9/11/2018	RPH	Martin Tremmel	Health Commissioner
9/11/2018	RPH	Amy Schmidt	Director of Nursing
9/11/2018	RPH	Joe Harrod	Director of Environmental Health
9/11/2018	RPH	Richard Grega	Director of HR, Legal & IT
9/11/2018	RPH	Kevin VanMeter	Director of Fiscal Operations
9/11/2018	RPH	Julie Chaya	Director of Health Education
			Epidemiologist
9/11/2018	RPH	Heather Foley	Public Health Nurse Supervisor
9/11/2018	RPH	Susan McFarren	Emergency Preparedness and Response Planner
9/11/2018	SCHD	Ajay Chawla, MD	Health Commissioner
9/11/2018	SCHD	Kim Skiffington	Administrator
9/11/2018	SCHD	Beth Conrad	Director of EH

ACRONYMS

AAR/IP	After Action Report/Improvement Plan
ACF	Administration for Children & Families
ADA	Americans with Disabilities Act
APHT	Applied Public Health Team
ARC	American Red Cross
BEHRP	Bureau OF Environmental Health and Radiation Protection
BID	Bureau of Infectious Diseases
BOH	Board of Health
CBRNE	Chemical, Biological, Radiological, Nuclear, & Explosive
CDC	Centers for Disease Control and Prevention
CERC	Crisis Emergency Risk Communications
CERT	Community Emergency Response Team
CFLOP	Command, Finance/Administration, Logistics, Operations, & Planning
CFR	Code of Federal Regulations
CMIST	Communication, Medical, Independence, Supervision, & Transportation services
CONOPS	Concept of Operations
COOP	Continuity of Operations Plan
DAS	Department of Administrative Service
DC	Department Commander
DCM	Disaster Case Management
DEM	Division of Emergency Management
DHHS	Department of Health and Human Services
DM	DOC Manager

DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Operational Response Team
DOC	Department Operation Center
DODD	Department of Developmental Disabilities
DOE	Department of Energy
DOH	Department of Health
EAS	Emergency Alert System
EEI	Essential Elements of Information
EMA	Emergency Management Agency
EMAC	Emergency Management Assistance Compact
EMS	Emergency Management Service
EMS	Emergency Medical Service
EMT	Executive Management Team
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
EPA	Environmental Protection Agency
ERC	Emergency Response Coordinators
ERP	Emergency Response Plan
ERT	Environmental Response Team
ERU	Emergency Response Unit
ESF	Emergency Support Function
FASSS	Finance & Administration Section Chief/Staff Support Section
FBI	Federal Bureau of Investigation
FEMA	Federal Emergency Management Agency
FEMA PA	Federal Emergency Management Agency Public Assistance Program

FMS	Federal Medical Station
FRMAC	Federal Radiological Monitoring and Assessment Center
GETS	Government Emergency Telecommunication Service
HAN	Health Alert Network
HASP	Health and Safety Plan
HHS	Health and Human Services
HIPAA	Health Insurance Portability & Accountability Act of 1996
HIRA	Hazard Identification Risk Assessment
HPP	Hospital Preparedness Program
HR	Human Resources
HSEEP	Homeland Security Exercise and Evaluation Program
HSPD-5	Homeland Security Presidential Directive-5
HSPD-8	Homeland Security Presidential Directive-8
IAP	Incident Action Plan
IC	Incident Commander
ICS	Incident Command System
IDRT	Internal Disaster Response Team
ILCNCO	Independent Living Center of North Central Ohio
IMAC	Intrastate Mutual Aid Compact
IMAT	Incident Management Assistance Team
IMATS	Inventory Management Tracking System
IMS	Incident Management System
IRCT	Incident Response Coordination Team
IRMS	Inventory Resource Management System
IT	Information Technology

JIC	Joint Information Center
JIS	Joint Information System
LEPC	Local Emergency Planning Committee
LFA	Lead Federal Agency
LHD	Local Health Department/District
LNO	Liaison Officer
MAA	Mutual Aid Agreement
MACC	Multi-Agency Communication Center
MARCS	Multi-Agency Radio Communications System
MCI	Mass Casualty Incident
MCM	Medical Countermeasure
MERRT	Medical Emergency Radiology Response Team
MFI	Mass Fatality Incident
MHT	Mental Health Team
MOU	Memorandum of Understanding
MRC	Medical Reserve Corp
MRDD	Mental Retardation and Developmental Disabilities
NDMS	National Disaster Medical System
NIMS	National Incident Management System
NIOSH	National Institute of Occupational Safety and Health
NMRT	National Medical Response Team NMRT
NRC	National Regulatory Commission
NRF	National Response Framework
NRP	National Response plan
NVRT	National Veterinary Response Team

OAC	Ohio Administrative Code
OAKS AM	Asset Management OAKS
ODH	Ohio Department of Health
ODOT	Ohio Department of Transportation
OFA	Office of Financial Affairs
OGC	Office of General Council
OHP	Ohio Health Preparedness
OHR	Office of Human Resources
OM	Operations Management
OMORT	Ohio Mortuary Operational Response Team
OPHCS	Ohio Public Health Communications System
OPU	Office of Public Utilities
ORBIT	Outbreak Response and Bioterrorism Response Team
ORC	Ohio Revised Code
OSRT	Ohio Special Response Team
PAHPA	Pandemic & All-Hazards Preparedness Act of 2006
PD	Police Department
PFL	People First Language
PHE	Public Health Emergency
PHEP	Pubic Health Emergency Preparedness
PHI	Protected Health Information
PHS	Public Health Service Act of
PIO	Public Information Officer
POC	Points of Contact
POD	Point of Dispensing

PPD-8	Presidential Policy Directive #8
PSC	Planning Section Chief
RCBDD	Richland County Board of Developmental Disabilities
RCPP	Richland County Partners in Preparedness
RDF	Rapid Deployment Force
RERT	Radiological Emergency Response Team
RHC	Regional Healthcare Coordinator
RPH	Richland Public Health
RPH/SCHD	State Health Department
RPHC	Regional Public Health Coordinator
RSOI	Reception, Staging, Onward movement and Integration (of a resource)
RSS	Receiving Staging and Storing
SA	Situational Awareness
SAIC	Strategic Analysis Information Center
SCHD	Shelby City Health Department
SDRP	State Disaster Relief Program
SERC	State Emergency Response Commission
SME	Subject Matter Expert
SNS	Strategic National Stock Pile
SOG	Standard Operating Guide
SOP	Standard Operating Procedure
SPCA	Society for Prevention of Cruelty to Animals
SRC	State Revised Code
STARRC	Simple, Timely, Accurate, Relevant, Credible, and Consistent
THIRA	Threat and Hazard Identification & Risk Assessment

U.S.C.	United States Congress
USDA	United States Department of Agriculture
USPHS	United States Public Health Service
VHA	Veterans Health Administration
VOID	Volunteer Organizations Active in Disaster
VOIP	Voice over Internet Protocol (Phone System)
VS	Vital Statistics
WENS	Wireless Emergency Notification System
WMD	Weapons of Mass Destruction

DEFINITIONS

The Glossary for this plan is found in: ***Appendix 11***

INTRODUCTION

Approval & Implementation

The ***Richland Public Health/Shelby City Health Department Emergency Response Plan-Basic Plan (ERP)*** replaces and supersedes all previous version of the ERP. This plan shall serve as the operational framework for responding to all emergencies, minor disasters, major disasters and catastrophic disasters that impact the health of the residents of Richland County.

The ***Richland Public Health/Shelby City Health Department Emergency Response Plan (ERP)*** is a multijurisdictional plan that covers the jurisdictions of both health departments in Richland County. Staff members of both agencies have participated in the planning process and agree that this plan will be trained and utilized in their respective jurisdictions.

During emergencies Shelby City Health Department will seek support from Richland Public health. Likewise, Richland Public Health confirms support of Shelby City Health Department, as outlined in the signed agreement, Attachment I. This plan may be activated as a stand- alone plan or may be integrated into the North East Central Ohio (NECO) or the State Health Department (RPH/SCHD) Emergency Response Plans. This plan has 18 Annexes, 18 Attachments and 15 Appendices.

Executive Summary

The ***Richland Public Health/Shelby City Health Department Emergency Response Plan (ERP)*** is an all-hazards plan that establishes a single, comprehensive framework for the management of the public health response to incidents within Richland County. The plan is activated when it becomes necessary to assess incidents or to mobilize the resources identified herein in order to protect the public's health. The ***ERP*** incorporates the National Incident Management System (NIMS) as the standard for incident management.

The plan assigns roles and responsibilities to RPH/SCHD staff members during a response to emergencies and events. This basic plan is not intended as a standalone document, but rather, establishes the basis for more detailed planning by the staff of RPH/SCHD in partnership with local, regional, and state partners and stakeholders. The ***ERP Basic Plan*** is intended to be used in conjunction with the more detailed annexes and attachments included as part of this document.

Additionally, the ***ERP*** is designed to work in conjunction with the ***North East Central Ohio (NECO) ERP*** and the ***State Health Department ERP.*** The successful implementation of the plan is contingent upon a collaborative approach with a wide range of partner agencies and organizations that are responsible for crucial resources and tasks during incident operations. The plan recognizes the significant role partner agencies and organizations perform during incidents.

This plan is available to RPH staff via the RPH intranet site in electronic format. A hard copy of this plan can be found in the RPH planner's office, at SCHD administration office, all directors and supervisor's offices, and the Health Commissioners' office (total 10 hard copies. Staff may view the plan via the intranet at any time or request to view one of the available hard copies. Staff is notified by e-mail when changes to the plan are completed, and new hard copies are distributed.

Statement of Promulgation

This Richland ***Public Health (RPH)/ Shelby City Health Department (SCHD) Emergency Response Plan (ERP)*** was written in order to develop, implement and maintain viable public health emergency response capabilities in Richland County. This ***ERP*** complies with applicable internal agency policy, local and state regulations, and supports recommendations provided by the Federal Emergency Management Agency's Federal Preparedness act. It serves as the operational framework for responding to emergencies and minor, major, and catastrophic disasters in Richland County. The fundamental assumption is that an emergency has the potential to overwhelm the capabilities of local agencies and resources and is needed to save lives and protect the public's health.

This ***ERP*** shall be maintained by RPH and reviewed annually. Components and annexes of the plan will be included in trainings and exercised regularly based on the CDC Public Health Preparedness Capabilities. The annual review and updates shall include an updated risk assessment and results of exercise and real life event improvement plans.

This version of the plan replaces and supersedes all previous versions.

This ***ERP*** is hereby adopted, and all RPH and SCHD program areas are directed to implement it. All previous versions of the ***RPH ERP*** are hereby rescinded.

Signature and Title — Date

~~Martin Tremmel, RS, MPA, JD~~ Commissioner for R-P-H — 4-25-19

~~Health Commissioner, RPH~~

Ajay Chawla — 4/26/19

Ajay Chawla, MD
Medical Director/Health Commissioner, SCHD

ORGANIZATION

This ***ERP*** is organized into three (3) sections designed to guide a response by RPH/SCHD.

Section one (1) describes the details and context necessary for planning. This section provides an overview of the situational context, assumptions, and describes existing hazards with potential to impact public health and medical services.

Section two (2) provides detailed direction on how response operations are executed at RPH/SCHD. This section covers the preliminary steps necessary for incident assessment, response activation, provides guidance on the execution of response operations, and details the processes that take place after a response.

Section three (3) provides guidance on development and maintenance of this ***ERP***, associated plans and annexes. This section discusses the necessary stakeholders that are engaged in the development and review process and provides the guidelines by which all RPH/SCHD ***ERP*** and annexes are developed.

SECTION I

1. PURPOSE/MISSION

RPH planner has developed this ***ERP – Basic Plan*** in order to support RPH's mission: "to assess, maintain, and improve the health and safety of the environment and community through quality public health services" (*Adopted by the Board of Health, November 19, 2012)* and SCHD's mission: "to protect, promote and improve the health of our citizens through integrated State, County, & community efforts".

This plan was developed to operationalize the execution of RPH's and SCHD'S mission in emergencies by providing the direction to plan for and respond to events such as a chemical or radiological incident, communicable disease outbreak, bioterrorism event, natural disaster, technological, man-made or other public health emergency so that negative health impacts are prevented, reversed or minimized through response.

This ***ERP*** is designed to serve as the foundation by which all response operations at the agency are executed. As such, the ***Basic Plan*** is applicable in all incidents for which the ***ERP*** is activated, and all components of this plan must be developed and maintained in accordance with section three. This plan may be used as a stand-alone document, or executed in concert with the **Plan's Annexes**, ***Appendices,*** the ***NECO Concept Plan*** and the ***RPH/SCHD ERP)***.

2. SCOPE and APPLICABILITY

This plan is intended to be a tool that utilizes the RPH and SCHDs' existing program expertise and personnel to provide surveillance, internal and external mitigation, event tracking, rapid public health risk assessment, community education, coordination with community partners, dissemination of information, event command and control through the Incident Command System, and post event recovery recommendations. The rapid health risk assessment of an event will determine the breadth and depth of the Health Departments' response and recommendations. The plan will be activated when RPH and/or SCHD requires a response greater than day-to-day operations.

This plan is always in force and is activated whenever an incident impacts public health and/or medical systems anywhere in Richland County and requires a response greater than day-to-day operations.

Potential impacts from an incident may require RPH/SCHD to respond by initiating or supporting the following functions to address an incident:

- Assessment of health/medical needs
- Organization and intra/inter-jurisdictional relationships
- Health surveillance and epidemiological investigation
- Prevention and control practices
- Infection control
- Communications/notification
- Mass prophylaxis/dispensing/vaccination
- Health/medical equipment and supplies (and requests) including SNS
- Food/drug/medical device safety
- Health care personnel augmentation
- Patient evacuation
- Public information and warning
- Information sharing with partners
- Limitation on movement/ Community Containment/ Isolation and Quarantine orders
- Vector control
- Veterinary services liaison
- Worker health and safety
- Environmental concerns-drinking water, waste management, sanitation
- Radiological/chemical/biological hazard consultation
- Radiologic Community Reception Center coordination and staffing
- Fatality Management – victim identification/mortuary services/ expedited death certification/ Family Assistance Center Operations and Staffing
- Family Assistance Center operations and staffing
- Mental health care liaison
- Emergency Medical Services (EMS) liaison
- Law enforcement support

- Mass Care Shelter augmentation
- Medical surge
- Community Recovery
- Strategic National Stockpile Requests
- Community recovery activities
- Volunteer Management
- Continuity of operations

The RPH and SCHD Health Commissioners may coordinate the provision of local health and medical assistance to fulfill the requirements identified by the affected local authorities during emergencies. RPH/ SCHD may also request crisis augmentation of health personnel from near-by-communities, the North East Central Ohio Public Health Emergency Preparedness (NECO) Region, the Ohio Department of Health (ODH) and the CDC (Centers for Disease Control and Prevention).

The scope of this plan is not limited by the nature of any particular hazard. This plan is written to apply with equal effectiveness to all hazards that impact public health and healthcare, whether they are infectious or noninfectious, intentional or unintentional, or threaten the health of Richland County residents.

This ***ERP*** incorporates NIMS and connects agency response actions to responses at the local, regional, state, and federal levels. This plan directs appropriate RPH response operations to any incidents that either impact, or could potentially impact, public health or healthcare within Richland County or requires RPH/SCHD to fulfill its roles described in the county EOP (ESF # 8).

This plan does not address detailed issues related to the ***Continuity of Operations Plans (COOP)*** of RPH and SCHD. RPH and SCHD both have and maintain COOPs as Annexes to this plan. In the event that essential health functions cannot be provided in the regular physical location, Richland Public Health or Shelby City Health Department will relocate operations to the EMA or the Richland County Fair Grounds. The Executive Management Team (EMT), Internal Disaster Team (IDRT), Board of Health (BOH) and essential personnel representing all aspects of the Health Department(s) (including Nursing, Epidemiology, Environmental Health, and IT) will address the restoration of basic services to the community. The Executive Management Team and IDRT will convene at the relocation site. Refer to the ***RPH and SCHD Continuity of Operations Plans*** *in ANNEX 1of this plan.*

Additionally RPH maintains a ***Crisis and Emergency Risk Communications Annex*** which is an annex to the base plan. Even though coordination of communications is not directed by this plan, however, coordinated communications is an essential component of all incident responses, this plan identifies how the ***ERP*** interfaces with the ***Crisis and Emergency Risk Communications Annex*** to ensure that information and messaging are effectively managed and adequately supported across all county response activities.

3. SITUATION

RPH located at 555 Lexington Avenue in Mansfield, OH is a countywide Public Health Agency serving all communities in Richland County with the exception of Shelby City, in which Shelby City Health Department (SCHD, 43 West Main Street, Shelby, OH 44875) maintains its own Environmental Health Department, Vital Statistics and contracts some nursing services through Galion City Health Department in Crawford County. This ERP encompasses Shelby City Health department and the city of Shelby per their health commissioner and department of health request.

A three person Board of Commissioners governs the county. Ohio Congressional Districts 7 and 12 Ohio House. District 2, and Ohio Senate District 22, represents the county at the federal and state levels.

RPH/SCHDs recognize a public health emergency as "**Any incident, event, or situation** demanding immediate action on the part of the public health system in order to prevent disease and injury or maintain public health within the community of service. Emergencies can be natural or man-made (deliberate or accidental)".

All hazards have the potential for causing a public health emergency, but could include an occurrence or imminent threat of a communicable disease, contamination caused or believed to be caused by Bioterrorism, an epidemic or pandemic disease, a natural disaster, a chemical attack or accidental release, or a nuclear attack or accident that poses a substantial risk of a significant number of human fatalities or incidents of permanent or long-term disability. Therefore, the entire population of Richland County could be affected by a public health emergency. Potential Impacts may include:

- Community-wide limitations on maximal health for residents;
- Widespread disease and illness;
- Establishment of new diseases in the State;
- Heat-related illnesses and injuries;
- Hypothermia;
- Dehydration;
- Widespread injuries or trauma;
- Overwhelmed medical facilities;
- Insufficient resources for response, especially medical countermeasures;
- Insufficient personnel to provide adequate public health response;
- Development of chronic health conditions within a population;
- Lasting impairments of function or cognition;
- Development of birth defects;

- Premature death.

A. Emergency Support Function #8

Public Health Emergency Support Function #8 (ESF-8) – Health and Medical Services provides coordination of local and regional jurisdictional resources in response to public health and medical care needs following a minor/major disaster or emergency, or during a developing potential medical situation.

The plans that currently support the ESF-8 and Health Care Coalition (HCC) interface include:

- ***RPH/SCHD Emergency Response Plan***;
- ***Richland County Emergency Management Agency Emergency Operations Plan***;
- ***NECO Regional Public Health and Medical Coordination Plan***;

Richland Public Health (RPH) will coordinate the management of ESF-8 Functions at the Richland County Emergency Operations Center (EOC). ESF-8 Public Health and Medical Services will partner with the ESF-6 Mass Care partners to support all individuals and organizations in regards to mass care services (including sheltering) that may be required to support disaster response and recovery operations in Richland County.

This ***ERP*** highlights the pivotal role of the public health system in Richland County in emergency preparedness and response. Any major emergency that may cause numerous fatalities, severe illness and/or injuries, disruption of normal life systems and, possibly property loss will have a powerful impact on Richland County's economic, physical, and social infrastructures. Disasters occurring in Richland County could impact community health standards and require a medical response. Wastewater, solid waste, potable water, and health services could be affected. This would necessitate health advisories and interventions including disease control management.

To prepare for and respond to an emergency of great severity and magnitude will require rapid response and surveillance, robust communications systems, and trained and available public and private medical workforces including volunteers to perform essential tasks. All of these efforts must be planned for and coordinated.

This plan provides guidance for a well-coordinated and effective response on behalf of the citizens of Richland County. It outlines coordination of emergency response activities of RPH/SCHD with those of other agencies. RPH/SCHD have initiated and maintained close working relationships with community partners and stakeholders. RPH was a founding agency and maintains membership (as does SCHD) in the local Health

Care Coalition, Richland County Partners in Preparedness (RCPP) and may utilize or have mutual aid agreements (when applicable) with the following (but not limited to) agencies:

- Emergency Management Agency (EMA)
- Richland County Partners in Preparedness (Local Health Care Coalition)
    - Work group: Greater Mansfield Health Coalition
- Emergency Medical Services (EMS)
- Medical/Health/Behavioral care providers
- Fire, Law enforcement and other local, state, and federal responders
- Local Emergency Planning Committee (LEPC)
- First Call 211
-
    - Community Emergency Response Team (CERT)
    - Medical Reserve Core (MRC)
    - OSRT
    - American Red Cross (ARC)
    - Academic institutions (Schools of nursing, public schools)
    - Mental Health Agencies
    - RSVP
    - United Way
    - Ham Radio techs
    - CODA
    - Religious Groups
    - Amish Community
- Richland County Coroner's Office
- Area Agency on Aging
- Richland County Mental Health Board
- Local Hospitals
- Third Street Family Health Services
- Nursing Homes and Long Term Care Facilities
- Local MRDD Board
- Other organizations and agencies as determined by the emergency

The possible roles of RPH/SCHD and local partners during an emergency can be found in Attachment XVII, pages 4,10-13 and 15, and Attachment XIX,

The potential roles of State partner agencies can be found in Attachment XVII, pages 8, 14-15 and Attachment XIX.

The potential roles of Federal partner agencies can be found in Attachment XVII, pages 7-15, Attachment XIX and Appendix 14.

B. Neighboring Jurisdictions

Richland County is located in north central Ohio. The county is bordered by Huron County (north), Ashland County (east), Knox County (south), Morrow County (southwest), and Crawford County (west).

Incidents in the County have largely been attributed to the county's geographic location and accessibility. Richland County contains approximately 572 lane miles of Interstate, U.S., and State Routes. The major east west roadways in the county include U.S. Route 30 and State Routes 39. The major north south roadway in the county is I 71. Richland County is situated at approximately midpoint between Cleveland and Columbus.

Richland County may be affected by incidents or events originating outside its borders (Figure 2). These external events have the ability to directly impact both public health and medical services countywide by causing a demand for preventative and healthcare measures:

HAZARD SOURCE	THREAT	COUNTY
Cleveland Hopkins International Airport	MCI, MFI, Introduction of new contagious diseases.	Cuyahoga
Port Columbus International Airport	MCI, MFI, Introduction of new contagious diseases.	Franklin
Faith based missionary work and travel	MCI, MFI, Introduction of new contagious diseases.	Ashland, Crawford, Morrow, Knox, Holmes, Huron
National resource industry (fracking)	Water contamination, MCI, MFI, Hazardous materials incidents.	Ashland, Crawford, Morrow, Knox, Holmes, Huron
Pipeline Production	Water contamination, MCI, MFI, Hazardous materials incidents.	Ashland, Crawford, Morrow, Knox, Holmes, Huron
Tourism	Introduction of new contagious diseases.	Ashland, Crawford, Morrow, Knox, Holmes, Huron
Cultural impacts: Under immunized Amish Under immunized Migrant Workers	Infectious disease outbreaks Introduction of new contagions.	Ashland, Crawford, Morrow, Knox, Holmes, Huron
Ashland County Railway	Hazardous materials incidents. Railway accidents	Ashland
Davis-Besse Nuclear Station	Radiation Accident	In 50 mi. radius/ Ottawa County
179th Airlift Wing National Guard Base	MCI, MFI, Terrorism Target	Richland
Mansfield Lahm Regional Airport	MCI, MFI	Richland

Figure 2

Most notably, public health threats such as infectious diseases have the ability to arrive to the county through a travel-related mechanism.

Ohio is home to the highest number of Amish congregations. Today, Amish number nearly 60,000 in Ohio spread across 52 individual settlements and over 400 church districts (Young Center, 2010). The Amish and Mennonite communities do not

consistently immunize. They are known to travel internationally to provide mission work and may be exposed to and import communicable diseases.

According to the ***Latino Cultural Connections*** migrant seasonal farm workers are integral to Ohio agriculture. Ohio farmers grow more than 30 commercial crops, and rely on migrant labor in the planting, cultivating, harvesting, processing, and packaging of more than 70% of those crops. Further, an estimated 6,000 migrant seasonal farm workers are employed statewide in Ohio's nursery and landscaping industries. These laborers are overwhelmingly Hispanic. In 2010, Ohio had 13,737 migrant workers and family members. Around 70% of these workers are undocumented. The immunization rates of these workers are inconsistent.

C. Geography

The current population in Richland County is estimated at 121,942 per the 2014 US Census. Richland County is comprised of three cities, six incorporated villages, eighteen townships and twenty-one unincorporated neighborhoods. The county seat is Mansfield.

There are rural farms and large Mennonite and Amish populations. Cropland and pastures account for 46.83% of all land use. The county also features significant amounts of forested land, including 1,154 acres of state parks, forest, nature preserves, and wildlife areas. Richland County has a total area of 500 square miles (1300 sq. km2) of which 495 square miles is land and 4.0 square miles (1.0%) is water. Richland County's landscape features gently rolling hills. Much of the county is located in the western foothills of the Allegheny Plateau. The highest elevation in Richland County is 1,510 feet; this point is located in Springfield Township near Lexington-Springmill Road at Apple Hill Orchards. In addition to being the highest point in Richland County, this location is the second highest elevation in Ohio.

Richland County is part of eight watershed areas. Three of these (the Huron, Sandusky, and Upper Vermilion) flow north to Lake Erie. The remaining five (Rocky Fork, Black Fork, Clear Fork, Upper Kokosing and Upper Olentangy) flow south to the Ohio River: (see also Richland County Flood Plain Map, Appendix 21).

The northwest tip of Richland County is within the ingestion pathway zone (50 mile or 80km radius) of the Davis-Besse Nuclear Power Station. An ingestion pathway zone is concerned primarily with ingestion of food and liquid contaminated by radioactivity.

Richland County has one military installation: 179th Airlift Wing whose mission is to "develop highly qualified operations, logistics, support, and medical professionals who provide theater airlift and mission support to serve the community, state, and nation". The 179th is housed at the Mansfield Lahm regional airport. The airport has the capability to handle large aircraft including the USAF C-5 and the Antonov 124-100 (two of the world's biggest military transport aircraft).

There are two hospital systems in Richland County: Ohio Health (Mansfield and Shelby Hospitals and Ontario stand alone ER) and Avita Health System (Ontario Hospital).

D. Health Care Coalitions

RPH/SCHD are part of the North East Central Ohio (NECO) Planning Region and are member of the NECO Health Care Coalition which meets and plans quarterly.

RPH was a founding agency for the local health coalition Richland County Partners in Preparedness (RCPP) which meets every other month. This coalition maintains bylaws and membership by Memorandum of Understanding. The goal of this coalition is to plan for emergencies and to exercise together. The RPH planner is the secretary of this coalition.

The Richland County and NECO Regional HCCs largely comprises ESF-8 partners in each of the counties in the region. For responses that trigger engagement of ESF-8 partners, the following actions are anticipated by each partner type:

- Hospitals: provide patient care and updates related to medical surge and availability of critical medical supplies. During incidents that impact

infrastructure, hospitals will support evacuation and relocation of identified CMS facility types, e.g. nursing homes. May act as closed PODs.

- Long-term care facilities: provide critical information and resources to their residents. During incidents that impact infrastructure, these facilities will support evacuation and relocation populations from other facilities in the county or the region. May act as closed PODs.
- County Mental Health Boards: provide psychological first aid to responding personnel. Serve as a connection point for care to the broader community. Provide psychological first aid training.
- Fire & EMS: provide patient transport to care facilities. Support fit-testing for PPE and training on donning and doffing. May provide Hazmat response and decontamination.
- American Red Cross: Facilitate setup and operations emergency shelters and of Family Assistance Center (during mass fatality incidents).
- Home Health Agencies: Develop Emergency Plans for home bound patients. May deliver medical countermeasures to their patients.
- Family Health Centers: Encourage the development of Emergency Plans with their patients. May be a closed POD.
- Dialysis Units: Develop Emergency Plans for their facilities for evacuation and shelter-in-place.
- Area Agency on Agency: Provide nurses for Medical Countermeasure distribution, shelters, and alternate care facilities.
- Local and Regional Healthcare Coalition collaboration/coordination is intended to support information sharing, situational awareness / common operating picture, resource support (as applicable), public information coordination, volunteer coordination, complex incident support and technical assistance, and liaison services during an incident which impacts or necessitates health/healthcare involvement.
    - The NECO Regional Healthcare Coalition is facilitated by an elected chair and coordinated by the Regional Healthcare Coordinator (RHCC) and the Regional Public Health Coordinator (RPHC). The NECO Regional Healthcare Coalition directly supports all local Healthcare Coalitions within the NECO Region.
    - The joint role of the RHCC and RPHC during an emergency, incident or planned event is to provide the following support to local and regional coalition stakeholders:
    - Support information sharing amongst coalition partners.
    - Support the development of situational awareness and the creation of a common operating picture through situational reports periodically developed and distributed based on incident generated demands.
    - Serve as a liaison to support the coordination and integration of mutual aid and multi-county/agency resource allocation. Liaison duties may be conducted within a local EOC or virtually through their respective home offices.

- Fulfill response requirements as applicable based on the size, scope, and complexity of the incident. Roles for both the RPHC and RHCC vary based on hazards. See also: ***Appendix 15, NECO Basic Plan***.

E. Richland County Incidents

Richland Public Health has responded to numerous public health and medical incidents in recent years. Among them are the following:

Richland County Outbreaks:

Date	Location	Agent
01/03/2011	Comfort Inn/Splash Harbor	Cryptosporidium
02/14/2011	Clearfork Kindergarten	Streptococcus
04/09/2011	Country Meadows Nursing Home	Norovirus
02/28/2011	Triumph Hospital	Acinetobacter baumannii
01/05/2012	Conrad House	Norovirus
03/08/2012	Wedgewood Estates	Norovirus
08/01/0212	Kindred	Acinetobacter baumannii
11/29/2012/2013	Richland Co. Schools Wrestlers	Staphylococcus aureus
02/02/2013	Step By Step Daycare	Norovirus
11/09/2013	Mohican Sailing Club Dinner	Undetermined
02/22/2014	Newhope Preschool Daycare Pot luck	Norovirus
2014	Ohio Measles Outbreak	Rubeola
07/18/2014	Weekend Clubhouse	Shigella
11/20/2014	Madison Early Childhood	Shigella
12/14/2014	Influenza	Influenza
01/27/2015	McDonalds	Norovirus
01/09/2016	Brookdale LT Care	Norovirus
01/06/2016	Pioneer Career & Tech Center	Norovirus
02/11/2016	First English	Influenza

	Lutheran Daycare	
07/29/2016	Multiple Daycares	Hand Foot and Mouth
12/28/2016	Mansfield Place	Norovirus
01/08/2017	Waterford	Influenza
01/17/2017	Early Childhood Center	Influenza
01/21/2017	Lexington Court	Influenza
01/27/2017	Mifflin Care Center	Influenza
12/19/2016-06/05/2017	Crestview Schools	Streptococcus
03/13/2017	Primrose	Bordatella Pertussis

Richland Public Health Environmental Incidents:

Date	Incident	Outcome
2011-10/2014	Cedar Street Dump Hazardous Waste	Clean-up by City of Mansfield, EPA, & RPH
2015-present	Mansfield VOC Plume Removal Site	Ongoing
07/05/2015	Oil spill, overturned tanker, drainage into creek bed	Hazmat, EPA, Health Department on scene. K&D completed cleanup which was paid for by owner.
8/31/2016	West Nile Virus Positive Pool	Public Information & Warning. Additional spraying.
11/1-11/16/2016	Mercury Spill, Roland Rd.	Hazmat, EPA Health Department deployed. Cleanup
1/22/2016	Mercury Spill Rt. 39	Hazmat, EPA, Health Department deployed. Cleanup
8/23/2017	Diesel Spill	Hazmat, EPA, Health Department deployed. Cleanup

County Incidents

Date	Incident	Outcome
04/10/2012	Straight line winds	Lines down, Clear Fork School Closed due to road flooding, Barn damaged
04/10/2013	Wind Damage straight line winds	Lines down, school closure, structure damage, and flooding
06/12/2013	Thunderstorm, high winds	Minor flash flooding, power outages, golf ball sized hail, tornado sighting & sirens activated (no touchdown).
07/09-11/2013	Flooding Bellville, Butler, Lexington, Ontario, Shelby & wind event	Many homes, businesses damaged. Road damage, bridge damage, evacuations, downed trees, power loss, and two Red Cross shelters opened, multiple road closures
01/18/2014	Governor's emergency declaration for Midwest propane shortage	Mitigation: shipping regulations lifted, effective
04/30/2014	Severe thunderstorm, straight line winds, flooding	House trailer flipped, road closures tree damage, buildings damaged, one person injured and hospitalized
04/08/20015	Tanker truck involved in accident was broached on right real corner of tank. 225 gallons of Gas leaked.	Hole plugged and product pumped to another tanker. Multi fire departments, PDs, EPA, POCO, EMA, ODOT, Air Guard (179th) & Red Cross responded. Three homes evacuated. Road kept closed throughout incident. Scene cleaned up by K&D Cleanup.
07/05/2015	Oil spill, overturned tanker, drainage into creek bed	Hazmat, EPA, Health Department on scene. K&D completed clean up which was paid for by owner.
10/08-10/23/2015	Series of bomb and shooting threats at multiple Richland County Schools	School evacuations, 5 juveniles arrested
10/26/2015	Suspicious briefcase at Speedway parking lot	No bomb found
7/19/2016	Richland Public Health/suspicious package	Law Enforcement/Bomb squad Deployed. No bomb found
8/10/2016	Severe thunderstorm, straight line wind damage	Property damage, lines down, road closures
9/20/2016	Semi-tractor trailer accident	Motor oil, antifreeze spill
10/13/2016	Truck accident	Transformer damage with fluid leak

10/27/2016	Container leak at RED EX	Organic Peroxide spill
11/01/2016	Private residence	Mercury in drain
1/10/2017	Semi-tractor trailer accident	Diesel fuel spill
1/23/2017	Release of unknown product	
1/23/2017	Foundations for Living	Mercury spill
2/8/2017	Semi-tractor Trailer rolled over	Diesel fuel spill
2/8/2017	Ruptured hydraulic line on boom/bucket truck	Oil spill
2/11/2017	Damaged transformer	Oil leak
2/20/2017	Gas line breach	Gas leak
3/28/2017	Semi-tractor trailer accident	Diesel fuel leak
5/17/2017	Omin Source Corp	Dust Bond spill
6/23/2017	Semi-tractor ran over road debris	Diesel fuel leak
7/7/2017	Transformer damage	Oil leak
7/7/2017	Semi over turned	Diesel fuel and Motor oil leak
7/19/2017	Semi-tractor trailer accident	Diesel fuel leak
8/13/2017	Semi-tractor trailer roll over	Spillage of liquid butter
8/22/2017	Semi-tractor trailer tank rupture	Diesel fuel leak
10/15/2017	Semi-tractor trailer roll over	Diesel fuel spill

F. Hazard and Vulnerability Analysis

Participation in hazard vulnerability and risk assessment and hazard mitigation planning is a critical element in emergency preparedness. RPH and SCHD staff members participated in the 2016 whole community process in developing an all-hazards mitigation plan. This plan summarizes the results of the assessment of Richland County's actual hazards, risks and vulnerabilities. This project was spearheaded by the Richland County Emergency Management Agency (EMA). A broad range of stake

holders, jurisdictions, and community partners were involved. This plan was approved by the Ohio EMA mitigation branch and FEMA. The complete report can be found at: www.richlandcountyoh.us/EMA/EMA.html.

Hazards identified in this assessment are as follows:

- Algal Bloom/Water quality
- Climate change
- Dam Failure
- Drought/extreme heat
- Earthquake
- Erosion
- Hazardous materials spill/leak
- Flood
- Severe thunderstorm
- Tornado
- Utility or Infrastructure system failure
- Windstorm
- Severe Winter Storm or Blizzard

Richland Public Health also conducted a hazard vulnerability analysis and identified the following Hazards:

General Health	**Environmental Health**
• Pandemic Influenza	• Air Contamination
• Foodborne Illness Outbreak	• Mega Farm Water/Soil
• Plague	• Toxic Fumes
• Anthrax release	• Gas Explosion
• Other Epidemic/Pandemic	• West Nile
• Pandemic Influenza	• Swimming Pools/drowning
• Measles	• Contaminated Food Product
	• Waterborne Illness
	• Contaminated Water Supply
	• Waterborne Illness
	• Lead
	• Mercury Spill
	• Sewer System Malfunction

	• Burns
	• Radiological Release

There are diverse events that reoccur yearly (e.g., county fair, shows, concerts, festivals, college and high school sport events, etc.). An incident that occurs at any major event may significantly affect public health and medical services both within Richland County and have cascading effects potentially across adjacent counties, the region, or statewide depending on the nature of the incident.

RPH personnel refer daily to the State Homeland Security (SHS)/Strategic Analysis Information Center (SAIC) State Daily Briefing for a list of events and hazards occurring within the State. Events and festivals occurring in Mansfield, OH and Richland County can also be found at http://www.destinationmansfield.com.

G. Access and Functional Needs Statement

Access and functional needs include anything that may make it more difficult—or even impossible—to access, without accommodations, the resources, support and interventions available during an emergency. Access and functional needs statistics identified in the county have been detailed in ***Appendix 3 – Richland County CMIST Profile***.

As the Richland County's leading health agency, RPH works with partners to ensure that all such efforts, as well as any others to mitigate, plan for, respond to and assist in the recovery from hazards, adequately serve individuals with access and functional needs. (See Section 5, page 42 for additional details).

4. ASSUMPTIONS

- Richland County is vulnerable to hazards, which may lead to emergencies or disasters.
- A major local, regional, or statewide emergency causing numerous fatalities, debilitating illnesses or injuries, property loss, and disruption of normal life support systems and possible health care property loss will have an impact on the economic, physical, and social infrastructures of Richland County.
- Emergencies may occur with little or no warning and may be overwhelming.
- To ensure appropriate public health response, RPH/SCHD must be prepared to respond to any incident with the ability to impact health of county residents.
- Incidents may occur across county, State, and jurisdictional lines and may require collaboration or coordination between all levels of government and non-

governmental agencies.

- An all-hazards approach to planning for and implementing response efforts has the greatest chance of providing a successful outcome.
- Physical control of the incident scene requires planning and advanced coordination by all first responders. The IMS using Incident Command is integral to the overall success of the operation.
- The release of a biological, chemical, nuclear, radiological or incendiary agent will result in a public health hazard.
- Resources in a local or regional affected area may be inadequate to respond to the emergency.
- Additional assistance may be available in a declared disaster or emergency.
- Disruption of sanitation services, loss of power, and massing of people in shelters will increase the risk of disease and injury.
- Primary medical treatment facilities may be damaged, overwhelmed, or inoperable.
- An intentional release/attack using infectious or chemical agents may not immediately be recognized as a Weapon of Mass Destruction (WMD) or terrorist event. The first indications of an attack may be the manifestation and recognition of symptoms occurring hours to days later.
- The natural emergence and spread of a virulent infectious disease agent could create a public health emergency similar in impact to that caused by a WMD.
- Terrorist incidents may involve damage or disruption to computer networks, telecommunication systems, or internet systems. In addition, disruption of vital community networks for utilities, transportation, and/or communications could endanger the health and safety of the population. Further, interruptions of emergency response operations could result in substantial economic losses.
- Extensive media interest in a public health emergency will necessitate media management operations and resources beyond those needed for other types of emergency management operations.
- Maintaining preparedness requires public awareness and education.

- Evacuation and shelter strategies rely upon public cooperation.
- The county Emergency Operations Center (EOC) will be the focal point for response and recovery activities.
- Mutual Aid may be requested from the North East Central Ohio (NECO) region (see also Appendix H).
- The state EOC may be activated to monitor and assist when necessary.
- Actions will be initiated to protect Health Department personnel and facilities.
- Incidents can affect Richland County's responders, staff, volunteers, vendors, partners, and the families of each group, impacting the ability to respond.
- Priority is given to resumption of Public Health services.
- The resources needed for an effective response (e.g., vaccine or personal protective equipment) may be unavailable or in limited supply.
- Expenditures will need to be documented per FEMA Public Assistance Grant Guidance.

SECTION II

1. CONCEPT OF OPERATIONS

RPH is regulated by local, State and Federal laws. The RPH BOH appoints the Health Commissioner, and advises and assigns additional responsibilities.

The RPH Health Commissioner serves as the Public Health Coordinator and is responsible for assessing the hazards relating to any existing or anticipated public health threat including the environmental impact of incidents.

SCHD is also regulated by local, State and Federal laws. The SCHD BOH (Mayor) appoints the Health Commissioner, and advises and assigns additional responsibilities.

A. Organization and Responsibilities

All Health Department staff members in Richland County have a potential role in supporting and participating in their agency's preparedness and response efforts.

Therefore, Health Department Employees are required to receive all mandated ICS/NIMS trainings (appropriate to Personnel Tier Level and role) within 60 days of hire per the RPH **Mandatory NIMS/ICS Training Compliance SOP Attachment XVI.** This document summarizes potential roles staff may have in an emergency based on their normal day to day duties. Following a bioterrorism, chemical, radiological incident, communicable disease outbreak, or other public health emergency, RPH staff shall have the responsibility to provide guidance to the residents of Richland County, and partner agencies about basic public health issues dealing with communicable diseases, environmental health, and other health concerns.

1. Role of Health Department -Department Operation Center (DOC):

   The role of the RPH's Department Operations DOC is to provide a central point of coordination for any event that has impact on the health of the general public and to provide coordination between the County EOC, RPC, and SCHD. The Health Department DOC will be the central point of communications, command and control (per the Incident Command System), and dissemination of information to the County Emergency Operations Center. Its role is to act as a liaison and to provide guidance and information to the County EOC on any matters concerning public health.

2. Role of the Richland County Emergency Management Agency/Emergency Operations Center (EOC):

The Emergency Management Agency, functioning under the Emergency Management Agency Director, is responsible to ensure the community knows its vulnerabilities, hazards and threats; plans for emergencies, responds timely and effectively in an emergency or disaster; and conducts recovery operations. The fundamental goal of emergency management is to create and maintain an effective organization to mitigate, prepare for, respond to, and recover from major threats to lives and property. The director is also responsible for coordinating the various components of The emergency management system-fire, law enforcement, emergency medical services, public works, volunteers, and other groups by Incorporating the four phases of emergency management: mitigation, Preparedness, response and recovery, the local director can effectively respond to all hazards (natural, technological, and national security).The director is a designated member of the 9-1-1 Planning Committee, established in Ohio Revised Code (ORC) 4931.42c. The planning committee advises the coordination of all 9-1-1 emergency communications within

the jurisdiction. 9-1-1 is a three-digit telephone number that you can call 24 hours a day for police, fire, or medical emergencies. It saves valuable time in an EMERGENCY. When you call 9-1-1, your call is received by a trained communications dispatcher who takes your information. Then the appropriate police, fire, and/or medical services team located in your area is notified and service is dispatched.

The agency also works directly with the State Emergency Response Commission (SERC), an arm of the Environmental Protection Agency (EPA), and is the recipient of countywide hazardous substances in inventory from all businesses in Richland County.

The emergency operations center (EOC) is the central command and control facility responsible for carrying out the principles of emergency management or disaster management functions at a strategic level during an emergency.

The operational staff members in the EOC are from governmental, non-governmental and private organizations that do not have a primary operational responsibility but do have the knowledge and professional expertise to assess a situation and provide advice.

- Obtain local resources
- Obtain state and federal assistance
- Keep local elected officials informed
- Keep state and federal government informed
- Act as liaison between IC and other agencies
- Facilitate mutual aid
- And more (arrange for sheltering of evacuees, work on recovery issues, etc.)

3. Richland County Health Commissioners:

   The RPH and SCHD Health Commissioners are responsible for the planning and coordination of all public health services on a daily basis. The local Health Commioners are also responsible for controlling and preventing the spread of dangerous contagious or infectious disease that may occur in his jurisdiction. The Richland Public Health Commissioner or Designee is responsible for directing operational response of departmental personnel for both RPH and SCHD during an emergency. These duties may include, but may not be limited to:

   - Activation of the Department Operation Center (DOC).
   - Provision of direction and control over health activities during emergencies.
   - Maintenance of liaison with emergency response groups and volunteer organizations during an emergency.
   - Activation of this plan.
   - Development of resource plans for health services.
   - Provision of appropriate information on protective measures to be taken by the public and responders.
   - Provision of support for other response agencies as necessary.

- Coordination with the Richland County EOC upon notification of its activation.
- Coordination of response efforts with community, local, state and federal partners and authorities.

4. The Richland County Boards of Health:

   Provide governance and policy review of the local health departments and may be called upon to advise/approve such measures as enforced quarantine and isolation, procurement of private property, and other measures. The Health Department's ability to respond to a bioterrorism, chemical, radiological incident, communicable disease outbreak, or public health emergency will be limited by defined laws and policies, jurisdictional boundaries, and available resources.

5. Emergency Preparedness and Response Staff:

   The Public Health Emergency Preparedness (PHEP) planner has the primary responsibility for overseeing and coordinating emergency preparedness and response for the health departments in Richland County. She also facilitates the activation of the ERP and the department operations center (DOC) in support of the Health Commissioner. If the PHEP planner is unavailable, activation may be successively facilitated by a Director or Supervisor as appointed by the Health Commissioner.

6. RPH Directors and Supervisors/ SCPH directors and Administrator:

   Directors and supervisors will hold key positions in the DOC and within the incident command system.

7. RPH and SCHD staff members:

   Complications affecting the health of the community as a result of a disaster or emergency may include disease outbreaks, sanitation problems, and food and water contamination, to name a few, requiring the full support of health department staff. On scene management from RPH/SCHD staff for response operations:

   a. Environmental Health Staff members:

      May have some but will not be limited to the following roles by conducting and coordinating public health assessments of conditions in the communities affected by the emergency and, where possible, determining the potential for health risks:

- Inspect potable and bulk water hauling contractors and temporary water systems. Well and water evaluation
- Mold education
- Vector control
- Hazardous material evaluation/education
- Animal removal recommendation
- Conduct and coordinate food service sanitation programs
- Assist with disease surveillance and investigations
- Wastewater sanitation
- Shelter inspections
- Solid waste management
- Provide and coordinate consultation for household sewage and waste management
- Medical/infectious waste management
- Environmental Protection Agency Liaison
- Chemical incident management
- Radiological incident management
- Field strike team member
- Disaster debris disposal
- IC Safety Officer
- IC Chief or General Staff
- SNS staging and warehouse management
- POD set up and support
- Coordinate county response to public health problems at the Richland County EOC throughout assessment and response

b. Public Health Nursing staff members:

May have but are not limited to the following roles:

- Vaccinations
- Post exposure prophylaxis
- Disease surveillance and investigation: maintain ongoing public health surveillance of affected communities in order to rapidly identify and address public health problems.
- Statistical analysis
- Health education
- Triage
- Other POD support roles
- SNS request and management
- Surge support
- Alternate care site support
- Shelter support
- Radiological Community reception center staffing
- Phone bank staffing

- Isolation and quarantine duties
- Assess and coordinate public health concerns regarding mass fatality efforts in affected communities.
- Fatality management support
- Morgue services
- Family assistance center staffing
  Personal protective equipment use/ education
- Inventory management
- IC Site manager
- IC Operations Chief
- Communications (OPHCS/WENS/HAN) alerts
- Radiation exposure registration and long term follow-up
- Specimen collection and submission

c. Health Education Staff members:

May have some or all of the following roles:

- Public information officer
- Public health emergency alerts
- Information sharing
- Educational support at PODs, Community reception centers, Family Assistance centers

d. Other Support Staff members:

May have some but are not limited to the following roles:

- Facility relocation support
- Management of increased call volume
- Recovery operations
- Warehouse and POD support
- Family Assistance Center support
- Community Reception Center support

e. Miscellaneous Duties:

- Maintain appropriate timekeeping records/documents, to include an ICS Form 252 as prescribed by the Finance Section.
- Follow any organizational procedures set by the individual leading the response.
- Support execution of activated ***ERP*** components.

B. Incident Detection, Assessment, Activation

The Health Commissioner or designee authorizes activation of the ***ERP*** upon determination that an incident requires implementation of one or more of the strategies or plans included herein. If the ***ERP*** is activated in this way, response will begin immediately with incident assessment, which is required to establish the activation level and define the incident response needs, but the need for activation will not be reevaluated.

Response personnel employ the entire process described in this section of this plan and present their recommendation for activation to the Director. Activation of all or part of the ERP marks the beginning of the response.

1. Incident Detection

   Based on information from a variety of possible sources including but not limited to citizen reports, a reported outbreak, or a warning from law enforcement, the Health Commissioner (in collaboration with the management team, medical director, epidemiologist, or community partners) will determine whether it is necessary for RPH to initiate a public health alert.

   Notification of a threatened or actual emergency can also come from warnings by the perpetrators or unexplained disruption or failure of a computer network, telecommunications system, or internet services.

   When RPH becomes aware of a potential or actual public health emergency that is suspected to be the result of a terrorist act or involves a weapon of mass destruction, the police, sheriff's office, FBI and EMA must be notified.

   Any RPH/SCHD staff that become aware of an incident requiring or potentially requiring activation of the ***ERP*** are to immediately notify their supervisor.

   Incidents that meet one or more of the following criteria may potentially lead to activation of the ***ERP***:

   - Anticipated impact on or involvement of the health departments' beyond those currently involved, with an expectation for significant, intra-agency coordination;
   - Potential for escalation of either the scope or impact of the incident;
   - Novel, epidemic or otherwise unique situation that likely requires a greater-than-normal response from ODH;
   - Need for resources or support from regional or state agencies;

- Significant or potentially significant mortality or morbidity;
- The Richland County EMA has activated the EOC;

2. Incident Assessment

Upon notification, the Health Commissioner or designee will immediately assess the situation:

The Health Commissioner will call a meeting of the Richland Public Health Internal Disaster Response Team (IDRT) within one hour of notification.

Verification will occur by ascertaining the origin of the information. The source must be determined to be credible. Information must be consistent with other sources. Characterization of the event must be plausible.

- Should public health become involved in the response? If so, in what way(s)?
- What public health function(s) have been or may be adversely impacted?
- What geographical area(s) have been or may be adversely impacted? Does it fall within the health department's jurisdiction?
- How many people are threatened, affected, exposed, injured, or dead?
- What are the exposure pathways?
- Have critical infrastructures been affected (e.g., electrical power, water supplies, sanitation, telecommunications, transportation, etc.)? If so, in what way(s)?
- Have medical and healthcare facilities been affected? If so, in what way(s)?
- Have public health operations been affected? If so, in what way(s)?
- Are escape routes open and accessible?
- How will current and forecasted weather conditions affect the situation?
- What other agencies and organizations are currently responding to the incident?
- What response actions have already been taken?
- Has information been communicated to responders and the public to protect public health? If so, in what way(s) and by whom?
- Has an Incident Command Post (ICP) been established? If so, where is it?

- Who is the Incident Commander (IC)? How can the IC be contacted?
- Has the local or state Emergency Operations Center (EOC) been activated?

3. Activation

With input from the IDRT, at the Initial Incident Assessment Meeting, the need for activation and the crisis level of the incident will be determined by the Health Commissioner or designee. **Attachment III** initial **Incident Assessment Standard Operating Procedure, Attachment III**.

Individuals/positions) notified, including partner agencies; the person/position that conducts the notification; the communication methods used; the information provided in the notification; and the timeframe in which the notification occurs can be found in **Attachment III** and **Attachment V, Activation Standard Operating Procedure**.

Activation levels and their associated recommended minimum staffing levels supplied from trained agency staff members within the agency are detailed on the next page.

Table 1 – Incident/Activation Levels

Activation Level	Description	Minimum Command Function & Staffing Recommendations
Type 5: Routine Operations	Routine incidents or outbreaks to which RPH/SCHD responds on a daily basis and for which day-to-day SOPs and programmatic resources are sufficient	Normal, Day-to-Day Staff Public information: local, regional possible DOC not activated
Type 4: Small to Moderate Scale Incident Situation Awareness with Partners & Monitoring necessary	One county is affected Response may be handled without regional/out of county assistance or resources An emergency with limited severity, size, or actual/potential impact on health or welfare but could escalate and require assistance if not addressed early in the incident cycle Requires some coordination and agency engagement with community partners to conduct response; situational awareness necessary	The DOC may be activated Incident Command is initiated Public information and warning may be needed EMA Director may be notified Possible EOC activation
Type 3: Moderate to Large Scale Incident	An emergency with moderate-to-high severity, size, or actual/potential impact on health or welfare of Richland County citizens and beyond Requires significant coordination and agency engagement to conduct response Likely significant engagement with other county partners and across jurisdictions The incident may escalate and require regional/state assistance if not addressed early in the incident cycle.	Possible Unified Command Local JIC established All Sections/Function Leads and key support staff May require Regional, State, Federal Resource requests Outside Operations (SNS positioning, PODs) Staffing Support Volunteers State EOC may be activated
Type 2: Large Scale/Complex Incident	One or more regions and/or state are affected Requires coordination regionally, cross regionally, and with the state The incident is expected to escalate	FULL STAFFING: Will require Regional, State, and Federal Resource augmentation Regional, State, or Virtual JIC Sate EOC
Type 1: National Incident	The region, state, and nation are affected Response requires coordination up to the federal level	All of the above Federal assistance required due to incident complexity

C. Command, Control, and Coordination

RPH/SCHD actions may be needed before the ***ERP*** is activated. Engaged personnel will manage the incident according to day-to-day procedures until relieved by response personnel or integrated into the response structure. Once the response begins, actions will be directed in accordance to the policies and procedures detailed in this plan.

1. Response phases

a. Pre-Event Phase

Mitigation and Recovery Activities

As stated before, a bioterrorism, chemical, radiological incident, communicable disease outbreak, or public health emergency may quickly overwhelm the existing local Health Department staff. For the most effective and efficient response to any event, attention to the following tasks is important:

- Effective preparedness and training by local Health Department staff, knowledge of resources that are available within the county and by way of Mutual Aid Agreements with community partners and outside jurisdictions within NECO Region
- Having the ability to provide critical public health information during an emergency by establishing various and redundant communications. systems such as, but not limited to
- Developing protocols for releasing public information regarding an incident. This includes education of the population prior to an incident. Including pre-developed information resources. Prepared fact sheets that pertain to emergencies can also be found on www.richlandhealth.org: Emergency Preparedness. Information is obtained from Regional, State or Federal health authorities including the CDC.
- Disease Surveillance and Reporting: Effective response depends on situational awareness. Disease containment or treatment depends on the early detection of the disease. A robust epidemiological response plan is maintained by RPH. Preplanning ensures that protocols are in place that can be used during Incident Command.

b. Active Phase

- Alerts and Notifications
  It is crucial that responding agencies share information quickly and securely during a bioterrorism, chemical, radiological incident, communicable disease outbreak, or any public health emergency.

RPH and SCPH have communications systems in place that will rapidly and securely transmit and receive health alerts and other information.

- Epidemiology

  The communicable Disease personnel and Environmental Health staff will be responsible for performing and supporting epidemiological investigations. During an event, the Incident Command system-Operations Section chief will supervise the investigation and response efforts of the Health Department's epidemiology tasks. The Richland County Public Health Surveillance and Epidemiological Investigation and Response Plan (Annex 3) and the Richland County Community Containment Plan (Annex 4) provide detailed policies and procedures and standard operating procedures.

- Controlling an Outbreak

  During a disease outbreak, or public health emergency the Health Department may require staff augmentation by other agencies. Plans are in place to horizontally and vertically expand CD staff.

- Laboratory Services

  In a communicable disease outbreak, or public health emergency, laboratory services provide a critical capacity for identifying a potentially infectious agent. RPH has protocols in place for:

  a) Collecting and handling specimens
  b) Identifying and establishing type of testing
  c) Established chain of custody for transporting specimens
  d) Communications between labs and health departments

- Patient Care and Movement

  Patient care and movement includes medical surge, evacuation, alternate care, and is determined at the time of the incident. Preplanning with partners and ongoing collaboration enables more successful operations.

- Mass Vaccination or Chemoprophylaxis

  Mass vaccination or prophylaxis will need to occur rapidly during an infectious disease emergency. Plans and SOPs are in place for

SNS request, staging and storing in Annex 6, and for mass dispensing in Annex 7.

3. Demobilization and Recovery Phase:
Tab F outlines demobilization SOP and Template. Recovery operations are outlined in detail in Annex 18: Richland County Emergency Recovery Plan.

D. Incident Command and Multiagency Coordination

Depending on the incident, RPH/SCHD may either lead or support the response. RPH and SCHD utilize the Incident Command System (ICS) to structure and organize response activities when leading an incident response. Similarly, when supporting an incident response, they are integrated into the ICS structure of the entity that they are supporting utilizing the NIMS principles for a multiagency coordination.

See **Attachment II – Public Health Operations Guide** for details on implementation. See **Attachment XIII – Incident Command System SOP.**

E. Incident Commander/Department Coordinator

RPH/SCHD response activities are managed by a single individual ("Response Lead"), who serves in the command function of the response organization. This is the RPH Health Commissioner or designee.
The position title is different depending on whether RPH is leading the incident response, or providing incident support. When leading the incident, RPH/SCHD uses the ICS title Incident Commander (IC); when supporting the response, RPH/SCHD uses the title Department Coordinator (DC). A Response Lead has the same authorities, regardless of the title.

F. Basic Authorities for Response

Basic authorities define essential authorities vested in the IC/DC. These authorities are listed below:

- The IC/DC may utilize and execute any approved component (i.e., attachment, appendix or annex) of the ***ERP***;
- IC/DC may direct all resources identified within any component of the ERP in accordance with agency policies;
- IC/DC may set response objectives and develop/approve an incident action plan (IAP), as applicable, in accordance with overall priorities established by the agency administrator or policy group;

- IC/DC may engage the minimum requirements for staffing as outlined in the activation levels of the plan;
- The IC/DC may authorize incident-related in-state travel for response personnel;
- IC/DC may authorize exempt staff to work a schedule other than their normal schedule, as needed;
- IC/DC, if the Health Commissioner, may approve incident expenditures totaling up to $10,000.

G. Limitations of Authorities

Any authorities not included in the Basic Authorities require additional authorization to execute. Key limitations on authority are detailed below:

- If IC/DC is someone other than the Health Commissioner, they are required to get approval from the Health Commissioner for incident expenditures.
- The IC/DC must engage the Health Commissioner when staffing levels begin to approach any level that is beyond those pre-approved within this plan. The Health Commissioner must authorize engagement of staff beyond those pre-approved levels;
- The IC/DC may not authorize bargaining unit staff to work a schedule other than their normal schedule without prior authorization by Human Resources. This includes approval of overtime, changing the number of days staff work in a week, changing the specific days staff work in a week, or changing the number of hours staff work in a day;
- The IC/DC must adhere to the policies of RPH/SCHD regarding overtime/comp-time and should clarification on these policies or exemption be required, the IC/DC must engage the Health Commissioner;
- The IC/DC must seek approval from the Board of Health for incident expenditures totaling more than $10,000. Single expenditures less than $10,000 may be approved by the Health Commissioner. This is to be understood as total incident expenditures, not just the total cost for a single transaction.

H. Incidents with RPH/SCHD as the Lead Agency

When leading the response, RPH employs ICS and organizes the response personnel and activities in accordance with the associated ICS resources and principles.

As the lead agency, RPH supplies the IC who is responsible for (a) protection of life and health, (b) incident stabilization, (c) property protection, and (d)

environmental conservation. The IC will engage local/state partners and the State EOC as needed. Resources and support provided to RPH/SCHD for incident response will ultimately be directed by the RPH/SCHD IC, in accordance with the priorities and guidance established by the Director and the parameters established by the supplying entities.

RPH will remain the incident lead until (a) the incident has resolved and all response resources have been demobilized or (b) command is transferred to another entity.

I. Incidents When RPH/SCHD is Integrated Into an ICS Structure Led By Another Agency

For incidents in which RPH is integrated into an existing ICS structure led by another agency, RPH/SCHD provides personnel and resources to support that agency's response. RPH/SCHD staff may be assigned to assist a local government under the direction of a local incident management system or may be assigned to various roles or tasks within a regional, state or federal incident command system. Assigned RPH/SCHD staff may serve in any ICS role, except for Incident Commander.

With regard to the incident, these staff and resources ultimately report to the Incident Commander. The Health Commissioner(s) may, at any time, recall such integrated staff or resources.

If such support is needed, RPH/SCHD Health Commissioner(s) will determine the appropriate activation level and assign a DC to lead the integration activities. In such responses, the Planning Support Section Chief will track engagement of RPH/SCHD staff and resources and ensure that parameters for their utilization are communicated to both the integrated staff and the receiving Incident Commander.

Integrated staff must refuse any directive from the IC that contradicts the parameters established for their utilization and notify the DC of any attempt to circumvent the established parameters, as well as of any unapproved use of RPH/SCHD resources. The DC will then work with the incident's IC to determine an appropriate resolution.

J. Incidents with RPH/SCHD in A Supporting Role as a Member of a Multi-Agency Coordination Center (MACC)

For incidents in which RPH/SCHD are support agencies, the Incident Commander is supplied by another agency. For these incidents, RPH/SCHD

Health Commissioner(s) assign a Department Coordinator who coordinates the agency's support of the incident. Support activities include the following:

- Support incident management policies and priorities through the provision of guidance or resources.
- Facilitate logistical support and resource tracking.
- Inform resource allocation decisions using incident management priorities.
- Coordinate incident-related information.
- Coordinate and resolve interagency and intergovernmental issues regarding incident management policies, priorities, and strategies.

If the Richland County EOC is activated, the RPH/SCHD DC coordinates all agency actions that support any Emergency Support Functions (ESFs) in which RPH/SCHD have a role. In such incidents, the DC will ensure that all RPH/SCHD actions to address incidents for which the Richland County EOC is activated are coordinated through the Richland County EOC. Interface between the agency and the Richland County EOC is further detailed in, **Attachment VII - Interface between RPH/SCHD and the County EOC Standard Operating Procedure**.

K. Legal Counsel Engagement

During any activation of the emergency response plan, legal counsel is always engaged, regardless of the incident type. The specific topics that require targeted engagement of legal counsel include the following:

- Isolation and quarantine,
- Drafting of public health orders,
- Execution of emergency contracts,
- Immediate jeopardy,
- Any topic that requires engagement of local legal counsel,
- Protected health information,
- Interpretation of rules, statutes, codes and agreements,
- Other applications of the authority of the Health Commissioners or Boards of Health,
- Anything else for which legal counsel is normally sought.

There are no internal approvals required to engage the RPH/SCHD legal counsel; the IC/DC, their designee or any program staff who normally engage legal may reach out. Contact information for RPH/SCHD legal counsel can be found in ***Appendix 5- Contact List***.

L. Incident Action Planning

Every Incident Action Plan (IAP) addresses four basic questions:

1. What do we want to do?
2. Who is responsible for doing it?
3. How do we communicate with each other?
4. What is the procedure if someone is injured?

For the documents included in an IAP, see **Attachment VIII- Incident Action Plan Template**.

M. Access and Functional Needs

RPH Public Health Emergency Preparedness Planner coordinates response actions with the Richland County Partners in Preparedness work group: the greater Mansfield Health Care Coalition to ensure that access and functional needs are appropriately addressed during an incident. The support available through this workgroup includes:

- Agencies that serve residents with Access and Functional Needs developing and exercising their own ***ERPs***
- Review of RPH/SCHD plans to ensure all access and functional needs have been accounted for;
- Outreach to partner organizations that serve access and functional needs;
- Assistance with development of the IAP, to include points of contact for individuals and organizations who serve individuals with access and functional needs;
- Provision of just-in-time training to response personnel regarding serving individuals with access and functional needs.

In addition to the RCPP Workgroup, RPH engages other internal and external programs that serve individuals with access and functional needs. These include the following but not limited to:

- Third Street Family Health Services
- Language Interpretive Services
- American Sign Language Interpretive Services
- Maternal and Child Health (Prenatal and Newborn home visiting)
- Environmental Health (approval of evacuation shelters)
- WIC (Women, Infants and Children with limited financial resources)
- Catalyst Life Services

  The Rehab Center

  Community Center for the Deaf and Hard-of–Hearing

Child and Adolescent Mental Health & Crisis Services
New Beginning Alcohol & Drug Treatment Center
Oasis Peer Center
Forensic Diagnostic Center

- The Center for Individual and Family Services
  Adult Mental Health and Crisis Services
- Richland Newhope (Richland County Board of Developmental Disabilities)
- Area Agency on Aging
- Independent Living Center of North East Ohio
- Ohio Health System
- Avita Health System

There has been a steady increase in agencies (that serve functional needs populations in Richland County) becoming members of RCPP due to the Centers of Medicare and Medicaid Services law mandating that these agencies have emergency plans. Membership in RCPP enables agencies to sign up for WENS for emergency alerts and communications. The RPH Planner processes membership applications, is an administrator of WENS, and is able to send alerts during emergencies. Mass e-mails to partner agencies generated by the planner can also be sent. 211 is another method of sharing information with functional needs populations. The RPH Planner is in the process of recruiting several agencies in RCPP to become Private PODs. The Planner has developed an MOU, Template Plans, and trainings. The training has been completed with Richland County Partners in Preparedness members. Further trainings will be done with the GMAHC agencies.

There is also work being done with the Area Agency on Aging for their nurses to establish a home delivery Medical Countermeasure model.
During infectious disease outbreaks the RPH CD nurses and Epidemiologist support individuals with functional needs by prioritizing services and access. RPH staff members work closely with other Health Care Partners via surveillance, investigation, communication and education.

The NECO Regional HCC is supported by RPH via mutual aid response.

In all communications during incident response and planning, RPH/SCHD will utilize person-first language as described in ***Appendix 6 - Communicating with and about Individuals with Access and Functional Needs***.

RPH has access to translation and interpretation services through a contract with

N. Demobilization and Recovery

Demobilization planning establishes the process by which resources and functions are released from the incident.

Planning for demobilization begins as soon as the incident begins and is informed by the targeted end state, which is the response goal that defines when the incident response may conclude.

Demobilization refers to activities that focus on disengaging response resources as the incident objectives are met, transitioning remaining incident responsibilities to ongoing assets, and promoting rapid return of demobilized response resources to their normal function. There are several important considerations:

1. Demobilization across assets:
The timing of resource demobilization is a complex and difficult decision, with potentially competing priorities between incident managers and managers of individual assets. The managers of individual assets and agencies should always coordinate any decision with the overall incident command. Demobilization of individual assets may occur at widely varying times, with some taking place early in a response if objectives have been met.

2. Representing demobilization to the media and public:
Management of the public's perception of asset demobilization may be very important, depending on the incident and the asset (e.g., the public believing the event is not over, thus being dismayed that an asset is disengaging). This should be considered carefully and addressed through incident management processes, including public information actions that demonstrate that the asset's uses are no longer needed.

3. Continued use of ICS during demobilization:
For medical resources, demobilization (and initial recovery) must occur efficiently because medical backlogs created during response can present a significant risk to the asset's regular patient population (e.g., delays in performing cardiac catheterizations), as well as a financial risk (e.g., loss of revenue from elective surgery). The continued use of ICS processes may be beneficial in addressing backlogs and should be considered during planning for both individual assets and overall incident demobilization (See TAB F for the Demobilization Plan Template). An AAR/IP will be a part of all demobilization plans.

In every incident, a Demobilization Plan will be developed. This plan will include incident-specific demobilization procedures, priority resources for release, and section responsibly related to down-sizing the incident.

Demobilization is led by the Planning Unit, which has three primary functions:

- Develop the Incident Demobilization Plan.

- Assure completion of demobilization checkout forms by personnel and inspection of equipment as they are released from the incident.
- Initiate data collection for the After-Action Process.
  For additional information on the demobilization process see **Attachment II, Public Health Operations Guide and Attachment XVIII, RPH/SCHD Demobilization Plan SOP and Template.**

Recovery from an incident is the process of returning a community to a state of normality. The **Richland County Recovery Framework** is found in **Annex 18** of this plan.

O. After Action Reports/Improvement Plans

An After-Action Report/Improvement Plan (AAR/IP) must be produced whenever the ERP is activated. Completion of an AAR/IP will allow the agency to review actions taken, identify equipment shortcomings, improve operational readiness, highlight strengths/initiatives, and support stronger response to future incidents. The RPH Planner or designee will act as the AAR/IP coordinator, including for incidents that the agency did not lead.
See **Attachment IX, Development of an After-Action Report/Improvement Plan (AAR/IP) and Completion of Corrective Actions**.

P. Plan Integration

Plan execution will be coordinated vertically among all levels of government to ensure singular operational focus.

At the local level, the ***RPH/SCHD ERP*** interfaces with response plans for public health and medical organizations, such as Ohio Health Mansfield Hospital and Avita Health Hospital. The ***RPH/SCHD ERP*** also interfaces with the Richland County Emergency Management Agency's EOC plan as well as being a part of the Richland County Emergency Operations Plan. ***RPH/SCHD ERP*** will activate the RPH/SCHD ERP to support the actions directed by local response plans.

At the regional level, RPH and SCHD interface with the Northeast Central Ohio, Public Health Region 5 (NECO). The plans produced by NECO are designed to work in concert with the plans of the member organizations and define how the agencies collaborate during responses that affect one or more of their jurisdictions.

At the state level, RPH and SCHD will interface with the Ohio Department of Health for guidance and support for public health response. The ***RPH/SCHD ERP*** was designed using the ***State Health Department (RPH/SCHD) ERP*** as a template.

Q. Situation Reports

In general, situation reports (SITREP) will be produced regardless of activation level; however the extent of content will vary depending on the operational complexity, scale, and length of the response. For response operations that require lower numbers of resources (both staff and materiel) a short yet concise SITREP will be produced. For larger scale responses, the SITREP may include more defined response information as it relates to goals and objectives, communications, staffing, schedules, and background information. In addition to these core SITREP informational elements, incident specific information will be added based on the informational needs of the incident response.

SITREPs will be sent electronically to RPH/SCHD Leadership staff, directors and operational staff for their situational awareness. Hardcopies of SITREPs will also be available in the RPH/SCHD DOC, if the DOC is active. At the discretion of the RPH/SCHD Department Commander, any SITREP may be forwarded electronically to the Richland County EMA, NECO, or neighboring LHDs, or other federal, state or local partners for their situational awareness and to foster a common operating picture. Additional SITREP recipients will be based on a per-incident basis, based upon their informational needs and to maintain effective and efficient response coordination among partner responding agencies. These additional recipients will be identified by the staff responsible for disseminating the SITREPs, through discussion with Public Information, the IC/DC, and operational staff.

Activation Level	SITREP Frequency
Type 5, Type 4	At least daily
Type 3	At least at the beginning and end of each operational period
Type 2, Type 1	At least at the beginning, the middle, and the end of each staff shift or operational period, whichever is more frequent

Table 7

See **Attachment X, Situation Report Template.**

R. Operational Schedule (Battle Rhythm)

RPH/SCHD Health Commissioners, or their designees, will maintain staff scheduling and communicate the schedule to assigned staff utilizing **Attachment**

XI, Operational Schedule Template. The completed staff schedule form will be distributed via email or by hard copy.

The operational schedule will also detail essential command staff meetings, established reporting timelines and other necessary coordination requirements. The operational schedule for each operational period will be created by the Planning (Support) Section Chief using the **Operational Schedule Template** and **Attachment XII, Battle Rhythm Template** which is distributed to all response staff at the beginning of their shift.

Upon shift change, staff will be provided a shift change form utilizing Attachment **XIII, Shift Change Briefing Template.**

S. Information Collection, Analysis and Dissemination

1. Information Tracking:

   To aide in centralized communication, RPH maintains a dedicated network directory (Dropbox) with the NECO Regional Partners for all response personnel to store incident- related documentation and to share plans. Further, the documentation team will compile information in a spreadsheet format, including a timeline of events, a directory of involved personnel, and any other data that might be pertinent to response within the network directory folder. Information will be reported via situation reports to the recipients of those reports at the times and disbursement schedules established. At the individual level, all response staff will maintain an Activity Log, using ICS form 214.These logs will be turned in at the end of the shift and filed.

   RPH staff members also have access to Google-drive, which allows for real time sharing of documents.

   Internally in the DOC, information tracking can also be done; however, certain situations may dictate the use of independent or co-dependent information tracking processes. In these situations, information may be tracked via a spreadsheet or through appropriate ICS forms or other means of documentation.

   WebEOC is a mission tasking and tracking system, as well as a portal for information sharing. It is the primary source for distributing documentation to response partners across county, regional, and state levels and includes documentation of response actions.

2. Essential Elements of Information

Essential Elements of Information (EEIs) address situational awareness information that is critical to the command and control decisions. EEIs will be defined and addressed as soon at the response begins, using ***Appendix 9, EEI Requirements***.

RPH/SCHD will include a list of the current EEIs with the completed ICS 201 form and with each IAP. This list will be reviewed during IAP development and refined for each operational period. At a minimum, the IC/DC, PIO, Planning lead and Operations lead will contribute to this refinement. To identify sources of information for EEIs, see also ***RPH Emergency Risk Communication Plan, Annex 2*** TAB-1

In large-scale responses, Ohio EMA will initiate a state-and-local coordination call with state and local response agencies. Local agencies will be identified by local EMA and invited to this call.

Coordination between LHDs and ODH will be critical to ensuring an effective response from public health and consistent participation in the state-and-local coordination call.

Upon notification of a State-and-Local Coordination call:

Agency leads will prepare a list of completed and planned actions to share with key POCs at ODH. ODH POCs will contact their local counterparts to discuss key information and incident needs that must be reported throughout the incident. Both RPH/SCHD and ODH will contribute to the establishment of these EEIs. Once finalized, RPH/SCHD will identify the POCs within the agency who will lead the implementation/identification of each EEI.

RPH/SCHD will review the agency's internal capacity to provide the needed response or information in accordance with the established EEI list. Any gaps in capacity will be reported to ODH and assistance requested through established channels. ODH will identify available support and prepare to report during the state-and-local coordination call. The RPH/SCHD Health Commissioner, or otherwise designated spokesperson, will speak on behalf of the agency on all state-and-local coordination calls.

The Health Commissioner/designated spokesperson will address all the EEIs and clearly communicate both completed/planned actions and the response capacity of the agency. For any previously identified gaps in capacity, the Health Commissioner/designated spokesperson will identify the state agency that can provide assistance and defer to that state partner for an update.

3. Information Sharing

To ensure that RPH/SCHD maintain a common operating picture across all locations that response personnel are engaged in, RPH will execute **Attachment VI I- Interface Between RPH/SCHD and the County EOC Standard Operating Guide**. This procedure defines the coordination between RPH, the State EOC, and the RPH Warehouse, when activated.

2. COMMUNICATIONS

As the county's lead health agency, RPH is responsible for maintaining communication with local, regional, state, federal, private and non-profit partners during an incident requiring activation of this plan.

The ***RPH Crisis and Emergency Risk Communications Plan*** outlines operations to be taken in concert with the ongoing response activities in order to ensure accurate and efficient communication with internal and external partners.

During an emergency RPH communications staff will prepare communication mechanisms to routinely translate scientific and health information for communities and policy makers, provide timely and accurate public information and advice to policy makers during an event, and coordinate logistical communications within the internal and external response system.

They will also prepare communicable disease and environmental health fact sheets that would be available for rapid access and distribution to the community. Fact sheets will include: risks to expect, precautions to take and requirements for quarantine, evacuation or shelter-in-place.

When engaged in a response, RPH will ensure the dissemination of information and maintain communication with the following entities to ensure continuity of response operations:

- Applicable RPH employees
- Richland County EOC
- RPH DOC
- Hospitals
- Regional Public Health Coordinators
- Regional Healthcare Coordinators
- City, county, state and federal officials
- Non-governmental partners

- Other support systems, agencies, and/or organizations involved in the incident response

In an incident, communication between the above personnel and groups will be accomplished through a combination of communications systems and devices currently used on a day-to-day basis. These include:

- phone lines
- voice over internet protocol (VOIP)
- mobile phones
- email
- fax machines
- Web-based applications, including the Ohio Public Health Communication System (OPHCS) and Wireless Notification System (WENS)
- Multi-Agency Radio Communications System (MARCS)
- Amateur (HAM) Radio.
- Social Media including Face book and Twitter
- RPH Website

The RPH communications staff will also:

- Link equipment or organizations that can provide two-way radio communications (MARCS radios or walkie talkies), during an event.
- Stay linked to the WENS system in order to reach internal staff and external partners.
- Provide cell phones or other effective mediums of communications to personnel and/or teams assigned to fieldwork.
- Maintain personnel trained in “emergency communications”.
- Establish and maintain, secure and accessible information systems for rapid communication, analysis and interpretation of health data and public access to health information.
- Maintain connections with the Health Alert Network (HAN)
- Secure connections and communications with providers, state and local health agencies.
- Ensure the protection of data and information systems.
- Provide critical public health information to the general public and special populations.
- Maintain a provider contact database that will include:
  Contact Name
  Title
  Agency Affiliation
  Phone number and alternate
  Cell number
  E-mail

Fax number
Address
Services Provided by the Partner Agencies (See ***Appendix) 5 Contact List***

Notifications and alerts will be drafted with input from applicable SMEs in coordination with public information staff engaged in the incident. In addition to the content itself, the developing group will assign the appropriate alert level to the message. Incident staff members who receive alerts will be expected to take the outlined actions within the timeframe prescribed.

When notifications or alerts must be sent, RPH/SCHD utilizes OPHCS. This system provides a secure web portal for ongoing coordination and collaboration on training materials, resources and protocols, and a rapid and redundant call-down communication notification network and alerting system for public health emergency responders. The system is used to communicate incident information to relevant groups via email, fax, phone, pagers and other messaging modalities to support notifications on a 24/7/365 basis. This system is used by RPH, SCHD, other local health departments, hospitals, and other partners, but is not available to the general public. OPHCS operates under two messaging levels, these levels include:

- Messages
- Alerts

OPHCS communications sent as messages do not receive priority, whereas, communications sent categorized as alerts are prioritized over messages that may be in queue for dissemination. These communication levels may be designated when drafting a communication within OPHCS.
OPHCS notifications and alerts will be developed at the direction of the Health Commissioner or designee.

There are four (4) alert levels employed by ODH during emergencies; these designations will be included in the message subject line:

- **Immediate**, which requires a response within one (1) hour of receipt of the message;
- **Urgent**, which requires a response within two (2) hours of receipt of receipt of the message;
- **Important**, which requires a response within four (4) hours of receipt of the message; or
- **Standard**, which requires a response within eight (8) hours of receipt of the message.

In the event that RPH/SCHD communication resources become overburdened or destroyed, redundant or back-up communication equipment includes:

- Multi-Agency Radio Communications (MARCS) radios
- Two-way radios
- HAM Radios

RPH/SCHD maintains Multi-Agency Radio Communications (MARCS).RPH currently houses 10 MARCS radios and SCPH houses 1 MARCS radio that can be deployed to response staff should RPH/SCHD experience a power failure or the inability to reach partners. RPH/SCHD staff members conduct monthly MARCS radio checks with the Ohio Department of Health to verify the MARCS radios are operational for emergency use.

RPH/SCHD may engage primary and redundant methods of communication both at the programmatic, DOC and county level. When responses require the engagement of the Richland County EOC, RPH and/or SCHD assumes its role at the ESF-8 desk. From the desk, RPH/SCHD may require additional collaboration with other ESFs, County EMA staff and other local and state partners. The ESF-8 desk facilitates an environment for situational awareness, information flow and coordination with partners. For a graphical illustration of the information flow, please see the flow chart above (Table 7). Additional detail of the communication flow is detailed in **Attachment VII - Interface between RPH and the Richland County EOC Standard Operating Procedure**.

RPH/SCHDs communicate EEIs and other tactical information through the messaging of information to response staff to ensure responders are well informed on the response operation. Key Messages must include:

Summary of the incident

Summary of current operations

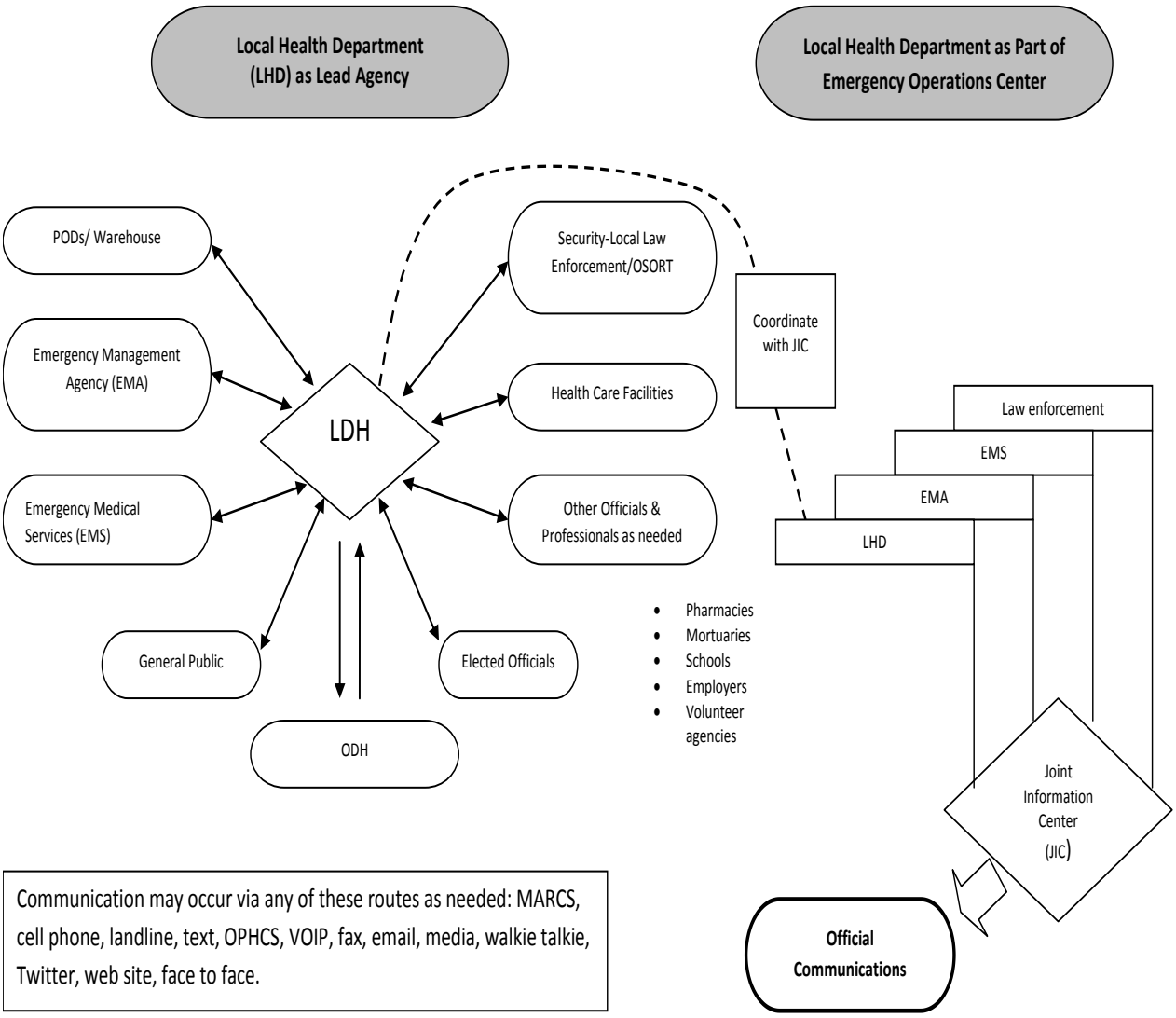
Response Lead

Objectives to be completed by the agency

Planned public information activities

Other engaged agencies

OFFICAL COMMUNICATION PATHWAYS DURING A PUBLIC HEALTH EMERGENCY



A. Public Information and Warning

RPH maintains a Public Information Officer (PIO) to plan and review public communications and messaging activities are outlined in the ***RPH Emergency Risk Communications Plan.*** This plan will be active during all response activities of RPH/SCHD and describes protocols by which Public Information will interface with the ODH response organization.

3. ADMINISTRATION AND FINANCE

A. General

Focused, deliberate and conscientious administrate efforts, recordkeeping and accounting are vital to ensuring a successful response, demobilization and recovery activities. During an incident, it becomes everyone's responsibility for proper documentation and recordkeeping. Collaboration vertically and horizontally between sections is key.

- In a RPH/SCHD-led ICS response, finance and administration duties will be delegated by the IC to the Finance and Administration Section Chief.
- When RPH/SCHD is engaged in coordination, these duties may be delegated by the DC to the Staff Support Section Chief.

B. Cost Recovery

Cost recovery for an incident includes all costs reasonably incurred by RPH/SCHD staff/personnel, including overtime costs for appropriately deployed emergency response personnel, supplies, expendable items and equipment. The cost recovery process begins in the initial incident operational period and continues through the end of demobilization activities.

The Director of Fiscal Operations leads cost recovery for RPH. The Shelby City Finance Director and SCHD Administrator lead cost recovery operations for SCHD.

Depending on whether an emergency response is declared a State Disaster or a Federal Disaster *some* emergency response costs may be reimbursed through State funding or federal funding. Regardless of whether the emergency response is declared a State or Federal Disaster, all requests for reimbursement will initiate from RPH/SCHDs through the Richland County Emergency Management Agency

Established funding streams through which reimbursement may be available include the following:

- State Disaster Relief Program (SDRP) – Administered by the Ohio Emergency Management Agency (Ohio EMA), Disaster Recovery Branch. The SDRP is designed to provide financial assistance to local governments and eligible non-profit organizations impacted by disasters. These funds are intended to SUPPLEMENT NOT SUPPLANT an applicant's resources and therefore, applicants must demonstrate the disaster has overwhelmed local resources and that other avenues of financial assistance have been exhausted prior to requesting assistance through the SDRP.

The SDRP is implemented at the governor's discretion, when federal assistance is not available. Local governments and eligible non-profit organizations must apply, through a written letter of intent, to the program within 14 days of the Program being made available. The supplemental assistance is cost shared between Ohio EMA and the applicant.

- FEMA Public Assistance (PA) Program – administered through a coordinated effort between the FEMA, Ohio EMA, and the applicants. While all entities must work together to meet the overall objective of quick, efficient, effective program delivery, each has a different role. FEMA's primary responsibilities are to determine the amount of funding, participate in educating the applicant on specific program issues and procedures, assist the applicant with the development of projects, and review the projects for compliance.

  The FEMA PA Program provides supplemental Federal disaster grant assistance for debris removal, emergency protective measures, and the repair, replacement, or restoration of disaster-damaged, publicly owned facilities. The PA Program also encourages protection of these damaged facilities from future events by providing assistance for hazard mitigation measures during the recovery process. The Federal share of assistance is not less than 75% of the eligible cost for emergency measures and permanent restoration from major disasters or emergencies declared by the President.

- Public Health response funds for federally designated public health emergencies following a public health emergency declaration by the Secretary of Health and Human Services. The funds would likely be administered through the Ohio Department of Health.

Examples of cost recovery to be considered for incidents may include the following:

- **Staffing/Labor**: Actual wages and benefits and wages for overtime. All labor hours (use of your own employees) should be documented. Depending on the funding source, only overtime/comp time may be reimbursed.
- **Vehicles/Equipment**: for ownership and operation of equipment, including depreciation, overhead, all maintenance, field repairs, fuel, lubricants, tires, and other costs incidental to operation. Standby vehicle/equipment

costs may not be eligible. The equipment normally should be in actual operation performing eligible work in order for reimbursement to be eligible. For FEMA dollars, reimbursement will be based on most current FEMA schedule of equipment rates. Requirements for other funding sources will be provided at the time the dollars are made available.

- **Mileage:** Mileage may be applicable during the incident for the vehicles directly involved in the incident resolution.

- **Materials and Supplies:** These may include items that are used exclusively for incidents that cannot or should not be reused. Some examples would be syringes, personal protective equipment, sharps containers and signs. These may also include costs of materials and supplies used for response/repair (from stock or purchased for purposes of completed project).

- **Operational charges**: Operational charges are costs to support the response. Some examples would be fuel, water, food.

- **Equipment replacement**: This includes materiel used during normal operations that must be replaced due to contamination or breakage during the incident response. For FEMA dollars, reimbursement will be based on most current FEMA schedule of equipment rates. Requirements for other funding sources will be provided at the time the dollars are made available.

- **Rented equipment**: Include invoices and proof of payment for any rented equipment.

- **Mutual aid**: If there is a written mutual aid agreement in effect between jurisdictions (political subdivisions) at the time of the disaster, then associated costs may be eligible. The receiving entity can claim these costs once they are billed by the providing entity and the receiving entity provides payment to them.

C. Legal Support

RPH legal counsel is provided by the Director of Human Resources and Legal. Legal issues that exceed in-house capabilities are provided by the Richland County Prosecutor's Office. Legal support for personnel and work-related issues

will be directed to the Director of Human Resources and Legal and if necessary referred to the Union Representative of the American Federation of State, County & Municipal Employees (AFSCME) Ohio Council 8, and AFL-CIO. Legal counsel will work in collaboration with the incident command team to identify the legal boundaries and/or the ramifications of potential response actions in an effort to avert unintended liability. **Chapter 3701-36 Local Health Departments of Ohio Revised Code will be referenced.**

Legal claims in the aftermath of incidents may include but are not limited to:

- Negligent planning or actions during an incident,
- Workers compensation claims,
- Union or bargaining unit grievances
- Improper use or authority,
- Improper uses of funds or resources.

Depending on the severity and scope of the incident, the RPH/SCHD's legal counsel could be asked to attend operational planning and briefing sessions for their situational awareness and to provide their opinions to ensure that the applicable administrative law statutes are being adhered to.

Legal counsel may also support the execution of Memorandums of Understanding (MOUs), Mutual Aid Agreements (MAAs) and requests for resources through the Emergency Management Assistance Compact.

D. Incident Documentation

Documentation is critical to response, review and recovery activities. Documentation supports (a) cost recovery, (b) resolution of legal matters, (c) evaluation of incident strategies, both during the incident and afterwards, (d) development of the IAPs, and (e) development of the AAR/IP. All forms completed or prepared for response will be collected at the end of each operational period. Staff will be required to turn in all required documentation before the end of their shifts.

Cost-recovery Documentation is vital to all cost recovery, administration actions regarding personnel, payroll, benefits, financial and procurement recordkeeping. The Finance/Administration section will use activity/incident logs/forms or chronology as the tracking mechanisms for determining resources expended and initiating any follow on/additional documentation (e.g., receipts, injury reports, accidents investigations).

Documentation procedures are further detailed in **Attachment XIV - Incident Documentation Guide and Appendix 16, Sensitive Documentation Policy**.

E. Expedited Administrative and Financial Actions

Expedited actions can occur in the forms of approvals for personnel and procurement of resources. All expedited actions must be approved by the Health Commissioner or their designee. Any approvals beyond the basic authority of the IC/DC must engage the process detailed below.

- **Expedited Personnel and Staffing Actions**: All requests for expedited personnel actions, e.g. personnel staffing increases or overtime approval, require approval of the Health Commissioner or their designee.
- **Expedited Financial Actions:** All expedited financial actions must be approved by the Health Commissioner or their designee. No funding will be obligated or committed without the consent of the Health Commissioner or their designee.
- **Expedited Procurement**: All expedited procurement must be approved by the Health Commissioner or their designee.

All expedited actions will be briefed during the incident operational briefings and shift change briefs. These actions will be tracked in the operational activity log ICS 214 form or chronology of events document and reviewed with the RPH/SCHD Health Commissioner as needed.

- When RPH is engaged in coordination, these duties may be delegated by the DC to the Staff Support Section Chief.

In response to emergencies, governments at all levels have the ability to make funds available to responding agencies. RPH would accept these funds through an increase to an existing funding line. In this case, funds would be moved to RPH through the existing PHEP grant with responsibilities related to the incident that is occurring. Moving funds in this manner may only require an abbreviated acceptance process with signature from key personnel. The Board of Health has authorized the Health Commissioner to receive these funds, which allows the Health Commissioner to enter into contracts or receive funds on behalf of the agency during emergencies, without prior BOH approval.

During emergencies, the RPH Health Commissioner can petition the BOH for a waiver of the standard budgeting process, which normally requires BOH approval. With the consent of the BOH President, the Health Commissioner may allocate funds to critical programs. Those allocations will remain in force until the next, regularly scheduled BOH meeting, at which time they will be reviewed. Unless the BOH rejects the allocations made at that time, the funds may continue to be used as previously assigned. This power will persist with the identified funds until the end of the emergency.

During normal operations, purchases over $10,000 and the entering into contracts require BOH approval. In a public health emergency these

restrictions may be waived, allowing the Health Commissioner to apply funds as needed to address an imminent or critical public health incident.

4. LOGISTICS AND MANAGEMENT

A. General

RPH and SCHD have a limited amount of materiel and personnel staff resources available for incident response, and shortfalls are likely in these commodities during an emergency. The following six (6) levels of sourcing have been identified to fill potential resource shortfalls and minimize time delays in acquiring assets:

- Source 1: RPH/SCHD internal human resources/personnel and inventory. All resources will be assessed internally prior to engaging local partners or stakeholders for support.

- Source 2: Volunteers. RPH maintains close ties with local and regional volunteer agencies, who attend the RCPP meetings. RPH has utilized volunteers in past emergencies.

- Source 3: MOUs and MAAs. When a required resource is needed, the Health Commissioners (or their designee) will refer to existing MOUs or MAAs to fulfill resource shortfalls including MAAs within the NECO region. Assistance will be sought from legal counsel as necessary.

- Source 4: Interstate Mutual Aid Compact (IMAC). When RPH/SCHD resource avenues have been exhausted, the acting logistics section chief will request the needed resources via the Richland County EMA.

- Source 5: Emergency Purchasing and Contracts. Special provisions have been described in Section 7.5 (above) that detail how emergency procurement and contracts can be executed.

- Source 6: Emergency Management Assistance Compact (EMAC). When RPH/SCHD requires a resource that cannot be found in the state, the Richland County EMA will work through the State EOC to request intrastate resources using the EMAC Process.

- Source 7: Federal Assets. Specialized federal assets to include subject matter experts and materiel may be required to support the state (and thus

the local) incident response. Federal agencies that support state Public Health emergencies include but are not limited to the Centers for Disease Control (CDC), Department of Health and Human Services (HHS), the Department of Energy (DOE), Disaster Mortuary Operational Response Teams (DMORT), and National Mobile Disaster Hospitals. Example: requests for Strategic National Stockpile (SNS) assets: medical countermeasures (MCM) are forwarded to the state health department, who then requests the assets from the CDC.

B. RPH/SCHD Resources

RPH/SCHD has identified the three resource priorities for fill during an incident: personnel, materiel/supplies and transportation.

1. Personnel Resources

The Planning/Planning Support Section chief will work with RPH/SCHD Administration to fill staffing shortfalls. If there are insufficient RPH/SCHD personnel staffing assets available internally, RPH will request the use of the Richland County Medical Reserve Corps, NECO, and/or request assistance through the Richland County EMA.

2. Materiel resources

In an effort to fulfill materiel resource gaps the acting Logistics/Resources Chief will assess the RPH/SCHD current inventory of supplies for the required asset or resource. If the resource is found, a request will be made to that Program Director for the asset. If available, the resource will then be released for the incident. Request for medical countermeasures will follow the procedures set forth in the ***RPH Point of Dispensing Plan*** and the ***RPH Strategic National Stockpile (SNS) Plan.***

3. Transportation resources

RPH/SCHD transportation assets are limited for both personnel and materiel transportation. During an incident response, the Logistics/Resources Support Section Chief will collaborate with RPH/SCHD Facilities Director to determine available RPH/SCHD vehicle fleet/ transportation assets for use in the form of sedans and vans for personnel and materiel transportation requirements. Any transportation needs that remain unmet after this engagement will be addressed through engagement of the Richland County EMA.

C. Management and Accountability of Resources

1. Management of RPH/SCHD Internal Resources

a. The management of RPH/SCHD internal resources and assets used in support of an incident will be in compliance with ***RPH/SCHD EOP*** **ERF#5: Resource Management.** Assets and resources used to assist in the response will be tracked using existing spreadsheets and worksheets. The CDC's SNS management system, IMATS, will be used for MCM inventory control.

During an incident. The Logistics/Resources Support Section Chief will manage all internal and external resources and will log the following minimum information for all RPH/SCHD materiel assets involved in response activities:

- Serial number and model (if applicable)

Equipment custodian name

- Description of asset/nomenclature
- Asset storage location
- Asset assigned location

2. Management of External Resources

Upon receipt of external resources, the RPH/SCHD IC/DC in collaboration with the Logistics/Resources Support Section Chief will accept responsibility of the asset, by entering in relevant information into the designated tracking system. For equipment, supplies or MCMs received by the RSS warehouse, IMATS will be used in providing receipt documentation and asset visibility.

The system(s) used will track the asset through its demobilization and transfer back to its owning organization.

These assets will be managed in accordance with instructions or agreements communicated by the owning organization.

3. Responsibilities and Systems in Place for Managing Resources

Each RPH/SCHD Director is responsible for managing the internal resources that belong to their program. When a RPH/SCHD asset or resource is requested for internal or external use during a response, the responsibility for that resource will be transferred to the incident response lead, using the determined inventory system and asset/resource transfer and receipt documentation. It is then the responsibility of the response lead to account for/track the resource, its use, sustainment and demobilization.

When an individual RPH/SCHD employee responds or deploys to an incident with a RPH/SCHD asset, that employee becomes the equipment

custodian and assumes responsibility for the asset throughout the response and demobilization phases.

Resources received by RPH/SCHD will be inventoried at the beginning and end of each operational period and the inventory reported to the logistics chief or designee throughout the response and demobilization phases.

The following Incident Command System (ICS) forms will be used to assist in resource accountability tracking and post incident cost recovery:

ICS Form Number	ICS Form Title	ICS Form Purpose
ICS 204	Assignment List	Block #5. Identifies resources assigned during operational period assignment.
ICS 211	Check-In List (Personnel)	Records arrival times or personnel and equipment at incident site and other subsequent locations.
ICS 213 RR	Resource Request	Is used to order resources and track resources status.
ICS 215	Operational Planning Worksheet	Communicates resource assignments and needs for the next operational period.
ICS 219	Resource Status Card (T-Card)	Visual Display of the status and location of resources assigned to the incident
ICS 221	Demobilization Check Out	Provides information on resources released from an incident.

Table 8

D. Demobilization of Resources

As the incident deescalates, assets and equipment will be returned to the original owners.

When RPH/SCHD shares an asset or resource used in an incident, a full accounting of it will be completed by the logistics chief or designee. The asset will be inventoried using its serial number, then inspected for damage, serviceability and cleanliness. If all equipment serviceability and cleanliness requirements are met, the asset or resource will be transferred to its appropriate storage place and/or returned to normal service.

If the equipment deployed is lost, damaged or does not meet serviceability requirements, the RPH/SCHD incident lead, or designee and stakeholder will collaborate with the RPH/SCHD Health Commissioner to determine the next steps in reconditioning, salvaging or the purchase of a replacement. The costs for reconditioning and/or replacing items will be included in the post-incident cost recovery process.

E. Ohio Intrastate Mutual Aid Compact (IMAC)

Ohio Revised Code (ORC) 5502.41 created the Ohio Intrastate Mutual Aid Compact (IMAC). It is a mutual aid agreement through which all political subdivisions can request and receive assistance from any other political subdivision in the state. Per ORC 2744.01, local health departments fall under this category for a political subdivision.

The Health Commissioner or their designee makes the decision about the need to request IMAC assets. Following approval, the Logistics Chief will first query for available resources within the RPH/SCHDs and will collaborate with Human Resources (HR) to query internal databases and the various RPH inventory systems for the required resource. The Logistics Chief will engage the other Section Chiefs of the need for the request. When all of the local resource options have been exhausted, the IMAC request process will proceed.

Requests for mutual aid can now be made by the IC/DC or their designee, without a formal declaration by the chief executive of a political subdivision. This will be accomplished in the following way:

- The Health Commissioner or IC/DC (usually the same) makes the decision to request mutual aid. If the IC/DC is not the Health Commissioner, the Health Commissioner will be notified of the need for IMAC for approval.
- The IC/DC assigns the logistics chief to make a request to Richland County EMA for the needed resources.
- The following information will be provided the to the Richland County EMA Director by the Logistics Chief:
    - ❖ A description of the incident, disaster, exercise, or training activity, planned event, or emergency
    - ❖ A description of the assistance aid needed
    - ❖ An estimate of the length of time for staging of the assistance or aid will be needed
    - ❖ The specific place and time for staging of the assistance and point of contact information at that location

- The Logistic Chief will notify the Regional Public Health Coordinator of the IMAC request. The Regional Public Health Coordinator will provide assistance and support for any request submitted by a public health agency. This includes but is not limited to:
    - ❖ In coordination with Richland County EMA, support the identification of public health resource and/or capabilities within the NECO Region
    - ❖ Support and/or facilitate emergency notification and information sharing regarding a request
    - ❖ Provide technical assistance and coordination services regarding a request within the NECO Region

The first eight hours of assistance is expressly identified as not requiring reimbursement.

Requests can also be made for assistance with training, exercises and planned events.

Regional response teams, such as bomb, search and rescue, water rescue and hazardous materials teams can also be requested through IMAC.

RPH and/or SCHD can use IMAC resources to fill response gaps in the following (but not limited to) ways:

- Personnel for: inspections; vaccination clinics; other countermeasure distribution centers; epidemiological surveillance and investigation; administrative assistance; specimen collection, conveyance, and testing; SNS receiving, staging storing, and transport; consulting; environmental testing; continuity of operations; communications; community containment; community reception center operations; and fatality management operations;
- Equipment (including personal protective equipment)
- Facilities
- Services
- Supplies
- Other resources as deemed necessary

RPH and/or SCHD can also fill **IMAC r**equests from other jurisdictions in Ohio. When this occurs the above process would be the same for seeking the asset within RPH and/or SCHD. The Health Commissioner or their designee makes the decision about sending assets to the requesting health jurisdiction. Following approval, the Directors will query for the resources within their departments and also collaborate with Human Resources (HR) for staffing requests. If such resources are identified, provision of those resources is at the discretion of the

applicable section Chief, in consultation with HR and the Director of Fiscal Operations.

F. Emergency Management Assistance Compact (EMAC)

Per Ohio Revised Code (ORC) 5502.4, the purpose of this compact is to provide for mutual assistance between the states entering into this compact in managing any emergency or disaster that is duly declared by the governor of the affected state(s), whether arising from natural disaster, technological hazard, man-made disaster, civil emergency aspects of resources shortages, community disorders, insurgency, or enemy attack.

This compact shall also provide for mutual cooperation in emergency-related exercises, testing, or other training activities using equipment and personnel simulating performance of any aspect of the giving and receiving of aid by party states or subdivisions of party states during emergencies, such actions occurring outside actual declared emergency periods.

The EMAC process may be used to support a Public Health Emergency at either a State, or local jurisdiction level.

When local resources are exhausted, resource requests may be sent to the Ohio EMA. The process for these requests will be made in the same way as above (Authorized by the Health Commissioner and sent by the Logistics Chief to the local EMA). The local EMA Director will then forward the request to the State EMA. When the request reaches the State EMA, the state sources the resource need to IMAC, federal, private sector, volunteer, or EMAC.

All EMAC requests must follow Ohio EMA instructions and procedures.
The request for EMAC resources is an executive level decision. The Ohio Department of Health Director, the Director of State Department of Public Safety, the State EMA Executive Director, and the Governor's Office decide if EMAC assistance will be sought. To request EMAC resources the Governor will declare an emergency or disaster, authorizing funds to be expended for response and recovery, and activating EMAC.

The affected state's EMAC Authorized Representative or EMAC Designated Contact opens an event in the online EMAC Operations System, alerting both the National Coordinating State and National EMA that a request for resources is likely.

See also **Attachment XV: EMAC Request and Fulfillment Process**.

RPH or SCHD may also receive a request for EMAC. *Receiving states will only accept resources from the **State of Ohio**. For local resources to qualify as State resources, the providing agency must enter into an intergovernmental agreement with Ohio EMA.*

Once the provision of the resource has been approved by the RPH/SCHD Health Commissioner, the asset is found and released by the applicable Director. Ohio EMA will begin a dialog with the requesing state, in collaboration with RPH/SCHD.

Receiving states will only accept resources from the State of Ohio. An intergovernmental agreement with Ohio EMA will allow RPH/SCHD's resources to be designated as State of Ohio resources.

RPH/SCHD staff deployed through this mechanism will be paid, e.g. compensation, travel reimbursement, etc., by RPH/SCHD and will receive the same benefits as if working at his/her home station. The employee will carry with him/her all the liability protections of a RPH/SCHD employee afforded to him/her by his/her home station and applicable law.

Ohio EMA assumes no responsibility for this/these employee(s) other than the submission of completed reimbursement request through the EMAC reimbursement process, and the transmittal of reimbursement from the requesting State to RPH/SCHD.

Upon completion of the intergovernmental agreement, Ohio EMA, the receiving organization and RPH/SCHD will develop and execute the plan for the checkout of the resource, the transportation of the resource, and the onward movement of the resource into the requesting state's incident response operations.

G. Memorandums of Understanding, Mutual Aid Agreements and Other Agreements

Memoranda of Understanding (MOUs) and Mutual Aid Agreements (MAAs) are both designed to improve interagency or inter-jurisdictional assistance and coordination. MOUs/MAAs are established between emergency response agencies and other private and public entities, to identify their agreements to collaborate, communicate, respond and support one another during a disaster or other public health emergency. Understandings regarding the incident command structure, patient and resource management, processes and policies in place for requesting and sharing of staff, equipment and consumable resources, as well as payment, are generally addressed in an MOU/MAA. These agreements expand the capacity of RPH/SCHD by allowing

the agency access to resources held by the organizations with which agreements have been executed.

1. MOU/MAA must be processed through and approved by the Health Commissioner, utilizing legal counsel as needed.
2. Established RPH/SCHD MOUs and MAAs are retained by each program that has an existing agreement. The RPH/SCHD Health Commissioner's office retains the compilation of original/official agreements. Additionally, the RPH/SCHD HC also retains copies that have financial commitments.
3. Upon an incident response, it is incumbent upon the Logistics/Resources Support Section Chief to inquire with the Health Commissioner to determine whether any MOUs and MAAs are applicable to the response activities.
4. If an MOU or MAA is determined to be needed during an incident, the IC/DC, RPH/SCHD Health Commissioner and the RPH/SCHD office or program area will collaborate on execution of the MOU/MAA.

5. STAFFING

A. General

All RPH/SCHD employees are designated as public health responders and can be called upon to fulfill response functions during an incident. The role assigned to any RPH/SCHD employee in an incident is dependent upon the nature of the incident and the availability of staff to respond. With approval by RPH/SCHD Health Commissioners, staff may be asked to work outside of business hours or for periods of time longer than a standard work day. Staff rosters are maintained by the Human Resources Director.

B. Staffing Activation Levels

Staffing levels will be determined in accordance with the activation level. Just as the activation level could change, staffing levels will remain flexible throughout the incident and adjusted as needed. Staffing levels will be evaluated in development of the IAP and updated for each operational period.

See Section 5: Activation Levels Table 1 for staffing requirements.

RPH/SCHD will utilize the ***RPH/SCHD's COOPs*** to inform how staff members are reallocated from their day-to-day activities to incident response. This will be done as needed, as ***ERP*** activation does not automatically activate the ***COOPs***.

C. Staffing Pools

RPH/SCHD Health Commissioners and/or the Directors will conduct an ongoing assessment of the incident and determine if extra staffing is required.

The following RPH/SCHD staffing pools could be considered for fulfilling staffing requirements:

- Qualified staff from other programs or sections;
- Providing just in time (JIT) training for other staff to fill appropriate positions.
- Specific roles for personnel that are defined in functional or incident-specific annexes included in this plan;
- The RPH/SCHD directors comprises the primary SMEs for each of RPH/SCHD's response areas and may be selected to serve key leadership roles during incident response;
- IC/DC role may be filled by the Health Commissioner or any director or their designee.

Staff can be notified by the Web Emergency Notification System (WENS) by the PHEP Coordinator of Planner, or Directors and Managers will be responsible for contacting staff in staffing pools via phone call downs.

Other Partner Staffing pools include the following:

- County agencies (e.g., EMA, Sheriff's Office, etc.)
- Contract staff, especially for positions requiring specific skills or licensure;
- Staffing agreements in Mutual Aid Agreements or Memorandums of Understanding;
- Staffing request through Intrastate Mutual Aid Compact and Emergency Management Assistance Compact (EMAC);
- Federal Entities.

D. Mobilization Alert and Notification

The Health Commissioner or designee will prepare a mobilization message for dissemination to RPH/SCHD staff. Staff will be notified using WENS or RCHD/SCHD 24/7 Phone Chain. Staff notified for mobilization/deployment will follow these instructions:

1**. Where to report**: Staff will report to the RPH DOC, unless otherwise specified.

2. **When to report**; Staff alerted will report within the time established by the IC/DC.

3**. Whom to report to**: Staff alerted will report to the DOC Manager or other individual, as designated.

Upon reporting to the DOC, the staff will sign in, be provided with an incident summary, and assigned and integrated into their role in the ICS. At this time, the staff could be deployed to another location in support of the incident response. All reasonable efforts will be made to inform RPH/SCHD employees who will be deployed to another location, on what to prepare for in relation to time expected for deployment and providing the appropriate packing list information. **No RPH/SCHD staff member will self-deploy to an incident response.**

6. DISASTER DECLARATIONS

A. Non-Declared Disasters

RPH/SCHD may respond to an incident as set forth in law and outlined in this plan without a formal declaration of a disaster or a state of emergency with the expectation that local resources will be used and that no reimbursement of costs will be requested. The Health Commissioner or designee may redirect and deploy agency resources and assets as necessary to prepare for, respond to, and recover from an incident.

B. Declared Disasters

The difference between a disaster declaration and declaration of a state of emergency is that a state of emergency can be declared as the result of an event that is not perceived as a disaster. Also, an emergency declaration is generally of lesser scope and impact than a major disaster declaration. However, in both cases, additional resources can be requested.

A state of emergency may be declared by the board of county commissioners of any county, the board of township trustees of any township, or the mayor or city manager of any municipal corporation.

Either a disaster declaration or a state of emergency issued by the Governor of the State provides the affected jurisdictions access to resources and assistance of state agencies and departments, including the National Guard. A declaration also releases emergency funds.

The Governor may declare a disaster without an official local declaration. When the Governor declares a disaster, it allows state agencies some additional abilities. These abilities may include but are not limited to request waivers of purchasing requirements, such as competitive bidding, for emergency needs or

the allotment of monies to be used or the purpose of providing disaster and emergency aid to state agencies and political subdivisions or for other purposes approved by the controlling board, as stated by ORC 127.19.

The Governor may also declare a disaster if the threat of a disaster or emergency is imminent. A state of emergency may also be declared whenever the Governor believes that an emergency exists.

1. Process for State Declaration of Disaster Emergency

RPH/SCHD cannot declare an emergency or disaster; only county commissioners, township trustees, mayors or city managers, or the State Governor may do so. The Health Commissioner's (or designee's) role in the emergency declaration process is to provide subject matter expertise and situational information to the governing body tasked with making the declaration. As a participant in the declaration process, RPH/SCHD may consider (a) potential impacts to county residents, (b) lack of necessary resources to address the emergency, or (c) the need to expedite procurement of goods and services.

If a disaster is declared, then RPH/SCHD will coordinate with other federal, state and local agencies through the County EOC. RPH/SCHD functions as both a primary and support agency for multiple ESFs coordinated by the County EOC.

2. Presidential Declaration of Disaster or Emergency

A presidential disaster declaration or emergency can be requested by the governor to the U.S. President through FEMA, based on damage assessment, and an agreement to commit State funds and resources through the long-term recovery process.

FEMA will evaluate the request and recommend action to the White House based on the disaster damage assessment, the local community, and the state's ability to recover. The decision process could take a few hours or several weeks, depending on the nature of the disaster.

3. Secretary of HHS Public Health Emergency Declaration

For a federal Public Health Emergency (PHE) to be declared, the Secretary of the Department of Health and Human Services (HHS) must, under section 319 of the Public Health Service (PHS) Act, determine that either (a) a disease or disorder represents a PHE; or (b) that a PHE, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. The

declaration lasts for the duration of the emergency or 90-days but may be extended by the Secretary.

Response support available through the declaration may include (a) issuing grants, (b) entering into contracts, (c) conducting and supporting investigations into the cause, treatment, or prevention of the disease or disorder, and (d) temporary reassignment of state and local personnel. Declaration of a PHE does not require a formal request from state or local authorities.

Section III

1. PLAN DEVELOPMENT AND MAINTENANCE

A. Plan Formatting

All plan components align with the definitions, organization and formatting described below. Appropriate terminology for access and functional needs and person-first language is used throughout the ERP, consistent with the standards described in ***Appendix 9 - Communicating with and about Individuals with Access and Functional Needs.***

Plan: A collection of related documents used to direct response or activities.

- Plans may include up to four types of documents, which are the following: Basic Plan, Attachment, Appendix and Annex.
- When referenced, plans are designated with ***bold, italicized, underlined font***.

Basic Plan: The main body of a plan; a basic plan is a primary document and may include attachments, appendices and annexes.

Attachment: A supplementary document that is necessarily attached to a primary document in order to address deficiencies; inclusion of an attachment is necessary for a primary document to be complete.

- Attachments are included immediately after the primary document that they supplement and are designated by Roman numerals.
- When referenced, attachments are designated with **bold font**.

Appendix: Any complementary document, usually of an explanatory, statistical or bibliographic nature, added to a primary document but not necessarily essential to its completeness, and thus, distinguished from an attachment; inclusion of an appendix is not necessary for a primary document to be complete.

- Appendices are included immediately after the attachments of the primary document to which they are added and are designated by numbers.
- When referenced, appendices are designated with ***bold, italicized font***.

Annex: Something added to a primary document, e.g., an additional plan, procedure or protocol, to expand the functionality of the primary document to which it is attached; it is distinguished from both an attachment and an appendix in that it can be developed independently of the primary document and, thus, is considered an expansion of the primary document and not merely a supplement or a complement.

- In a plan, annexes guide a specific function or type of response.
- Annexes are included immediately after the appendices of the primary document to which they are added and are designated by capital letters.
- When considered independently from the basic plan, annexes are themselves, primary documents and may include attachments and appendices, but never their own annexes.
- Attachments to annexes are designated by Roman numerals preceded by the letter of the annex and a dash, e.g., "A-I."
- Appendices to annexes are designated by numbers preceded by the letter of the annex and a dash, e.g., "A-1."
- Though developed independently from the primary document, an annex must be activated as part of the plan and cannot be activated apart from it
- Font, Font size, Footers, Headers etc. can be found in ***Appendix 10***.

B. Development and Review Process

The development and review process is initiated and coordinated by the PHEP Coordinator/Planner, who also sets the plan development schedule.

The plan development schedule is also based on real world events, PHEP deliverable deadlines, and the Multiyear Training and Exercise Plan.

The plan development and reviews will follow the Internal Disaster Response Team (IDRT) meeting schedule (every other month), but additional reviews can be added. The collaborative development and review team consists of the IDRT members and will address revisions to the ERP Basic Plan, attachments, appendices and annexes. In addition to the PHEP Coordinator/Planner, the development and review team includes the following members:

- RPH/SCHD Health Commissioners
- Director of Environment Health
- Finance Director

- Director of HR, Legal and IT
- Director of Nursing, PHEP Coordinator
- PHEP Planner
- Director of Community Health Prevention Sciences
- Director of WIC
- PIOs
- Supervisors
- Representative from the access and functional needs workgroup;
- Subject Matter Experts (SME's) from both within RPH/SCHD and without (as needed)

The Basic Plan, its attachments, appendices and annexes to the Basic Plan are approved for inclusion, revision or expansion by the Health Commissioners in Richland County. Once adopted, all components will be reviewed annually by the review team. The purpose of this review will be to consider adoption of proposed changes that were identified during the year. Proposed changes will then be reviewed by the development and review team and submitted to the Health Commissioner(s) and the respective Boards of Health for approval.

Revisions will also be determined by identifying gaps and lessons learned through exercise and real-world events.

Production of an after-action report following the exercise of a plan or annex, will determine the need for the level of revision needed to existing plans, annexes, attachments, and appendices. Applicable findings from AAR/IPs must be reviewed and addressed during review of each plan component.

Revisions can also be made at the request of RPH/SCHD PHEP Coordinator/Planner or other RPH/SCHD staff.

Members of the development and review team will identify the needs for improvement and the PHEP Coordinator/Planner will update the plan components. Once the PHEP Coordinator/Planner has prepared the plan revisions, the components will be submitted back to the development and review team prior to being submitted for approval to the respective Health Commissioners and Board of Health. Any feedback will be incorporated and then the updated document will be re-submitted for approval.

In order to maintain transparency and record of collaboration, RPH/SCHD will record development and review meetings by designating a scribe to record meeting minutes to sustain a record of recommendations from collaborative ERP meetings. These meeting minutes will be forwarded to all parties involved in the process.

The ERP Basic, Attachments, Appendices and Annexes are reviewed at bimonthly IDRT team meetings. Below are the established plan, annex, attachment and appendix review schedules. The PHEP Coordinator/Planner will work to ensure that plan components are staggered so that reviews do not become overwhelming.

Item	Cycle
Basic Plan	Annual in May
Attachments	Annual in July
Appendices	Annual, in September, or as needed
Annexes	Annual (1-2/ per) meeting)

Proposed changes to plans in-between the review cycle shall be tabled for further discussion at the review cycle meeting to be presented and approved or rejected by the collaborative team. In the interim, the changes may be used for response if approved by the Health Commissioner(s) or designee(s).

Revision meetings will be documented with sign-in sheets and minutes.

C. Plan Publishing

Emergency response plans will be made available for review by the public on-line on the emergency preparedness page of the RPH website. The PHEP Coordinator will be responsible for communicating to the Health Commissioner and Public Information Officer (PIO) when the emergency response plan has been revised and a new version are available for public review. Prior to the web publishing of the revised plan, the Health Commissioner will determine the attachments, annexes and appendices that will be redacted from the public version of the plan. Once the plan is prepared for public viewing, the Health Commissioner will publish the ERP online. Public comment to the ERP will be accepted via email (http://www.richlandhealth.org) and tabled in addition to the proposed changes between revision cycles for consideration.

D. Version Numbering and Dating

Version history for the ERP and all of its attachments, appendices and annexes are tracked under one numbering system as follows: 20##. ##. The

first four digits represents the year of the version, followed by the month the version was created. Example: a plan that was revised in September of 2017 would be signified as 2017.09. Substantial changes to the plan, e.g. the organization, structure or concepts, require the adoption of a new version of the ERP. Changes to other components are tracked within the currently adopted version of the ERP.

The ERP is also tracked by the last date reviewed and the last date revised. If a review does not necessitate any revisions, only the date of review will be documented. Likewise, each attachment, appendix, and annex is tracked by the last date revised. Primary documents and their attachments will always share the same review date, since they must be reviewed together. By contrast, the revision dates for appendices may differ from those of the primary documents they complement, as they can be approved at any time (see also, ***Appendix 10***.

2. DOCUMENT DEFINITIONS

See ***Appendix 11***.

The following list of Authorities and References includes Executive Orders, Agency Directives, statutes, rules, plans and procedures that provide authorization and operational guidelines as relevant to a public health response.

3. AUTHORITIES

A. Federal

- "The Robert T. Stafford Disaster Relief and Emergency Assistance Act", as amended, 42 U.S.C. Sections 5121, et seq.
- National Plan for Telecommunications Support in Non-Wartime Emergencies
- Executive Order 12148, Formation of the Federal Emergency Management Agency
- Executive Order 12656, Assignment of Federal Emergency Responsibilities
- Homeland Security Presidential Directive #5 (HSPD-5), Management of Domestic Incidents, 2003
- Homeland Security Presidential Directive #8 (HSPD-8), National Preparedness, 2003
- Presidential Policy Directive 8 (PPD-8), National Preparedness, 2011
- Uniform Administrative Requirements for Grants and Cooperative Agreements to state and Local Governments, 44 CRF Parts 13 and 206.

B. State: See Appendix 12 Authorities

C. Local: Appendix 12 Authorities

4. REFERENCES

A. Federal

- National Response Framework (NRF), 2016
- The National Incident Management System (NIMS), Third Edition October 2017
- Public Health Accreditation Board Standards and Measures
- PHEP Grant Core Deliverables 2017-18
- Health Insurance Portability and Accountability Act (HIPPA)
- Department of Homeland Security Management Directive System MD Number 11042.1; Safeguarding Sensitive but Unclassified (For Official use only) Information, 1.6.2005
- FOIA.gov
- RPH Records Retention Policy
- Centers for Disease Control and Prevention Website: www.cdc.gov
- Department of Homeland Security Management Directive System MD Number 11042.1; Safeguarding Sensitive but Unclassified (For Official use only) Information, 1.6.2005

B. State

- ODH Infectious Disease Control Manual
- ODH ERP, Sample Plan Template
- Ohio Department of Health website: www.odh.ohio.gov

C. Regional

- Northeast Central Ohio (NECO) Region 5 Regional Concept of Operations Plan
- 2017 Regional Mutual Aid Agreement among Public Health Agencies in Northeast Central Ohio - Region 5 June 22nd, 2017
- NECO Public Health Planning Coalition Bylaws

D. Local

- Richland County Hazard Mitigation Plan, 2017
- Richland County Emergency Operations Plan - Annex H, 2018

- Richland Public Health COOP
- SCHD COOP
- RCPP Membership MOU and Bylaws
- Richland County Census Date