Emergency Response Plan
Basic Plan

Hamilton County Public Health

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PREVENT. PROMOTE. PROTECT.

Version 1.1
Date Originally Adopted: June 11, 2018
Date of Last Revision: May 15, 2019
Date of Last Review: May 15, 2019

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IV INTERFACE BETWEEN HCPH AND HAMILTON COUNTY EOC SOP
V INCIDENT ACTION PLAN TEMPLATE
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XI INCIDENT FISCAL RESPONSE AND RECOVERY

XII INCIDENT DOCUMENTATION GUIDE
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1 HAMILTON COUNTY DISASTER HISTORY
2 ROLES OF COUNTY AGENCIES IN EMERGENCY SUPPORT FUNCTIONS
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INTRODUCTION

APPROVAL AND IMPLEMENTATION

The ***Hamilton County Public Health (HCPH) Emergency Response Plan (ERP) – Basic Plan*** replaces and supersedes all previous versions of the HCPH ERP. This plan shall serve as the operational framework for responding to all emergencies, minor disasters, major disasters and catastrophic disasters that impact the public health and medical system in HCPH service jurisdictions, and if called up, within the public health jurisdictions of the cities of Norwood and Springdale. This plan may be implemented as a stand-alone plan or in concert with the ***Hamilton County Emergency Management & Homeland Security Agency's Emergency Operations Plan*** when necessary.

EXECUTIVE SUMMARY

The ***Hamilton County Public Health (HCPH) Emergency Response Plan (ERP) – Basic Plan*** is an all-hazards plan that establishes a single, comprehensive framework for the management of the public health response to incidents within the 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 HCPH ERP incorporates the National Incident Management System (NIMS) as the standard for incident management.

The plan assigns roles and responsibilities to HCPH program areas and specific response teams housed within these programs for responding to emergencies and events. The basic plan of the ERP is not intended as a standalone document but rather establishes the basis for more detailed planning by HCPH staff in partnership with internal and external subject matter experts and community stakeholders. The ERP Basic Plan is intended to be used in conjunction with both the more detailed annexes and attachments included as part of this document or with the standalone plans held by HCPH. Additionally, the ERP is designed to work in conjunction with the ***Hamilton County Emergency Management & Homeland Security Agency's Emergency Operations Plan***.

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.

JURISDICTIONAL AGREEMENT – NORWOOD HEALTH DEPARTMENT

If Norwood Health Department's (NHD) resources are overwhelmed or otherwise insufficient to address the incident, NHD may request assistance from Hamilton County Public Health (HCPH). The provision of assistance will be mobilized through the following steps:

1. NHD's authorized individual or their designee will contact the following, internal points of contact to request assistance:

	Name	Title	Office Phone	Mobile Phone
Primary	John Sherrard	Emergency Response Coordinator		
Secondary	David Carlson	Interim Asst. Health Commissioner		
Tertiary	Greg Kesterman	Asst. Health Commissioner		
Quaternary	Tim Ingram	Health Commissioner		

2. HCPH will confirm that the request was made by an authorized person from NHD. The authorized individuals from NHD include the following:

	Name	Title	Office Phone	Mobile Phone
Primary	Chandra Corbin	Emergency Response Coordinator	513.458.4600	
Secondary	Bryan Williamson	Director of Environmental Health	513.458.4600	
Tertiary	Frank Perrino, M.D.	Interim Health Commissioner	513.458.4600	

3. Once the request is confirmed by HCPH, HCPH's Health Commissioner will be notified that NHD has requested assistance.
4. If the request for assistance is approved, HCPH's Health Commissioner will engage the ERP activation process.

This relationship has been formalized through mutual endorsement of the ERPs of each local health department.

I hereby affirm that NHD will request support from HCPH in accordance with the conditions and process described in this plan.

Frank Perrino, M.D., Interim Health Commissioner, Norwood Health Department

JURISDICTIONAL AGREEMENT – SPRINGDALE HEALTH DEPARTMENT

If Springdale Health Department's (SHD) resources are overwhelmed or otherwise insufficient to address the incident, SHD may request assistance from Hamilton County Public Health (HCPH). The provision of assistance will be mobilized through the following steps:

1. SHD's authorized individual or their designee will contact the following, internal points of contact to request assistance:

	Name	Title	Office Phone	Mobile Phone
Primary	John Sherrard	Emergency Response Coordinator		
Secondary	David Carlson	Interim Asst. Health Commissioner		
Tertiary	Greg Kesterman	Asst. Health Commissioner		
Quaternary	Tim Ingram	Health Commissioner		

2. HCPH will confirm that the request was made by an authorized person from SHD. The authorized individuals from SHD include the following:

	Name	Title	Office Phone	Mobile Phone
Primary	Matt Clayton	Health Commissioner		
Secondary	Ella Jergens	Director of Environmental Health		
Tertiary	Amy Ellis	Director of Nursing		

3. Once the request is confirmed by HCPH, HCPH's Health Commissioner will be notified that SHD has requested assistance.
4. If the request for assistance is approved, HCPH's Health Commissioner will engage the ERP activation process.

This relationship has been formalized through mutual endorsement of the ERPs of each local health department.

I hereby affirm that SHD will request support from HCPH in accordance with the conditions and process described in this plan.

Matt Clayton, Health Commissioner, Springdale Health Department

STATEMENT OF PROMULGATION

The ***Hamilton County Public Health (HCPH) Emergency Response Plan (ERP) – Basic Plan*** is an all-hazards plan that establishes a single, comprehensive framework for the management of the public health response to incidents within the county. The ERP establishes the basis for coordination of HCPH resources and response to provide public health and medical services during an emergency or disaster.

This plan shall serve as the operational framework for responding to all emergencies, minor disasters, major disasters and catastrophic disasters that impact the public health and medical system in HCPH service jurisdictions, and if called up, within the public health jurisdictions of the cities of Norwood and Springdale. This plan may be implemented as a stand-alone plan or in concert with the ***Hamilton County Emergency Management & Homeland Security Agency's Emergency Operations Plan*** when necessary.

All HCPH program areas are directed to implement training efforts and exercise these plans in order to maintain the overall preparedness and response capabilities of the agency. HCPH will maintain this plan, reviewing it and reauthorizing it at least annually; findings from its utilization in exercises or real incidents will inform updates.

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

[signature] 5-15-2019

Timothy Ingram
Health Commissioner
Hamilton County Public Health

Date

RECORD OF CHANGES

The Health Commissioner authorizes changes to the ***Hamilton County Public Health Emergency Response Plan – Basic Plan***. Change notifications are sent to those on the distribution list. To annotate changes:

1. Add new pages and destroy obsolete pages.
2. Make minor pen and ink changes as identified by letter.
3. Record changes on this page.
4. File copies of change notifications behind the last page of this ERP.

Change Number	**Date of Change**	**Print Name**	**Title**
1	8/20/18	John Sherrard	Emergency Response Supervisor
Version Number: 1.1	Added language for how the agency engages the board of health during incident response.		
Change Number	**Date of Change**	**Print Name**	**Title**
2	8/20/18	John Sherrard	Emergency Response Supervisor
Version Number: 1.1	Added **Attachment XI** – Added language describing how HCPH recovers costs of funds and resources expending during emergency response operations.		
Change Number	**Date of Change**	**Print Name**	**Title**
3	8/20/18	John Sherrard	Emergency Response Supervisor
Version Number: 1.1	Added ***Appendix 11 – HCPH Agreements and Contingent Contracts***. Appendix identifies existing MOAs, MOUs and contracts to be used in an emergency.		
Change Number	**Date of Change**	**Print Name**	**Title**
4	8/20/18	John Sherrard	Emergency Response Supervisor
Version	Added ***Appendix 4 – HCPH CMIST Partner List***. Appendix		

Number: 1.1	identifies access and functional needs partners developed in PHEP BP2.		
Change Number	**Date of Change**	**Print Name**	**Title**
5	8/20/18	John Sherrard	Emergency Response Supervisor
Version Number: 1.1	Added language describing/identifying HCPH's policy on using volunteers to support response efforts.		
Change Number	**Date of Change**	**Print Name**	**Title**
6	8/20/18	John Sherrard	Emergency Response Supervisor
Version Number: 1.1	Added **Attachment XIV – IMAC/EMAC Request SOG**. The Appendix describes the process by which the agency provides resources in response to an IMAC/EMAC request from another jurisdiction/state.		
Change Number	**Date of Change**	**Print Name**	**Title**
7	8/20/18	John Sherrard	Emergency Response Supervisor
Version Number: 1.1	Added ***Appendix 7 – HCPH Profile of Access and Functional Needs***. Appendix identifies floodplains in Hamilton County.		
Change Number	**Date of Change**	**Print Name**	**Title**
8	8/20/18	John Sherrard	Emergency Response Supervisor
Version Number: 1.1	Added ***Appendix 7 – HCPH Profile of Access and Functional Needs*** identifies all social vulnerability index scores for each census tract in HCPH's jurisdiction.		
Change Number	**Date of Change**	**Print Name**	**Title**
9	8/20/18	John Sherrard	Emergency Response Supervisor

Version Number: 1.1	Added language to the plan defining psychological first aid; how psychological first aid will be made available to the HCPH personnel; and identifies situations that may require psychological first aid for the agency's response personnel.		
Change Number	**Date of Change**	**Print Name**	**Title**
10	8/20/18	John Sherrard	Emergency Response Supervisor
Version Number: 1.1	Added language to plan describing how emergency legal authorities differ from standard procedures.		
Change Number	**Date of Change**	**Print Name**	**Title**
11	8/20/18	John Sherrard	Emergency Response Supervisor
Version Number: 1.1	Added language to the plan describing the process for coordination with state response agencies for large-scale or complex incidents.		
Change Number	**Date of Change**	**Print Name**	**Title**
12	8/20/18	John Sherrard	Emergency Response Supervisor
Version Number: 1.1	Added language describing the interface between ESF-8 and the Disaster Preparedness partners at the local level.		
Change Number	**Date of Change**	**Print Name**	**Title**
13	8/20/18	John Sherrard	Emergency Response Supervisor
Version Number: 1.1	Added **Attachment I – GCDPC/HCPH Interface Procedure**. Appendix describes HCPH's roles and responsibilities that directly support GCDPC members during response and recovery.		
Change Number	**Date of Change**	**Print Name**	**Title**

14	8/20/18	John Sherrard	Emergency Response Supervisor
Version Number: 1.1	Updated ***Appendix 3 – HCPH CMIST Profile***. Updated appendix with updated census numbers.		
Change Number	**Date of Change**	**Print Name**	**Title**
15	8/20/18	John Sherrard	Emergency Response Supervisor
Version Number: 1.1	Added ***Appendix 13 – National Incident Management System (NIMS) 2017 Refresh***. Added appendix describing the highlights and key changes to NIMS in the 2017 refresh.		
Change Number	**Date of Change**	**Print Name**	**Title**
16			
Version Number:	(Description of Change)		
Change Number	**Date of Change**	**Print Name**	**Title**
17			
Version Number:	(Description of Change)		
Change Number	**Date of Change**	**Print Name**	**Title**
18			
Version Number:	(Description of Change)		

RECORD OF DISTRIBUTION

A single copy of this ***Hamilton County Public Health Emergency Response Plan*** is distributed to each person in the positions listed below.

Date Received	Program Area	Title	Name
5/17/18	Emergency Preparedness Program	Emergency Response Supervisor	John Sherrard
5/15/19	Emergency Preparedness Program	Emergency Response Supervisor	John Sherrard

This plan is available to all agency staff via the shared X:drive (**X:HCPH Plans and SOGs/PLANS and SOGS/Emergency Response Plan – Basic Plan**) in electronic format and one copy can be found on the book shelf by the Emergency Preparedness Supervisor in hard copy format.

SECTION I

1.0 PURPOSE

Hamilton County Public Health (HCPH) has developed this ***Emergency Response Plan (ERP) – Basic Plan*** in order to support HCPH's mission to protect and improve the health of all HCPH jurisdiction residents at all times, even during emergencies. This plan was developed to operationalize the execution of HCPH's mission in emergencies by providing the direction to plan for and respond to natural, technological and man-made incidents with a health impact so that negative health impacts are prevented, reversed or minimized through response.

This ERP is organized into three (3) principle sections designed to guide a response at HCPH. 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 in how response operations are executed at HCPH. 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. Finally, section three (3) provides guidance on development and maintenance of this ERP, associated plans and annexes. This section discusses the necessary stakeholders that should be engaged in the development and review process as well as, provides the guidelines by which all HCPH ERPs, plans and annexes are developed.

The HCPH 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 HCPH 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 ***Hamilton County Emergency Management & Homeland Security Agency's Emergency Operations Plan (Hamilton County EOP)***, other HCPH plans, or annexes.

2.0 SCOPE AND APPLICABILITY

This plan pertains to HCPH and all of its program areas. This plan is always in force and is activated whenever an incident impacts public health and/or medical systems and requires a response by HCPH greater than day-to-day operations.

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 HCPH jurisdiction residents.

The HCPH ERP incorporates NIMS and connects agency response actions to responses at the local, state and federal levels. This plan directs appropriate

HCPH response operations to any incidents that either impact, or could potentially impact, public health or healthcare within Hamilton County or require HCPH to fulfill its roles described in the Hamilton County EOP. The Hamilton County EOP describes the high-level responsibilities of county agencies in response to incidents in Hamilton County. The HCPH ERP supports the Hamilton County EOP through direction of HCPH response activities, and provides needed detail for operations at the agency level. It describes the roles and responsibilities of HCPH program areas during an emergency response.

HCPH has assigned responsibilities in multiple Hamilton County EOP Emergency Support Functions (ESFs) and Annexes as both a primary and support agency. HCPH's roles and responsibilities can be found on the X:drive at ***X:HCPH Plans and SOGs/PLANS and SOGS/ESF 8/ESF Plans for Hamilton County EMA***.

This plan does not address issues related to continuity of operations (COOP) planning at HCPH. All continuity issues are addressed through HCPH's ***COOP Plan – Annex #1***.

Additionally, the coordination of communications is not directed by this plan. Coordinated communications is directed by HCPH's ***Crisis Communications Plan – Annex #3***. However, since coordinated communications is an essential component of all incident responses, this plan identifies how the ERP interfaces with HCPH's ***Tactical Communications Plan*** to ensure that information and messaging are effectively managed and adequately supported across all HCPH response activities.

3.0 SITUATION

While all HCPH employees are expected to contribute to the emergency response and recovery efforts of the community, employees' first responsibility is to their own and their families' safety. Each employee is encouraged to develop family emergency plans to facilitate family safety and self-sufficiency, which in turn will enable employees to assume their responsibility to the county and its citizens as rapidly as possible.

Hamilton County consists of an area of 407.4 square miles and is located in the southwestern corner of Ohio. The county's southern border is defined by the Ohio River. The County encompasses 17 Cities, including the Cities of Cincinnati, Norwood and Springdale, 12 Townships, and 19 Villages. The County contains two metropolitan statistical areas (MSAs) that have received funding through the Cities Readiness Initiative (CRI): City of Cincinnati and Hamilton County.

According to the 2010 population estimate by the United States Census, Hamilton County is the 3rd most populous county in the state of Ohio, with a population of 802,374. The population within HCPH service jurisdictions is 480,068 or 59.8% of the population within Hamilton County. **Figure 1** on the shows a map of HCPH service jurisdictions. HCPH's largest service jurisdiction is Colerain Township, with a population of 58,499.

Hamilton County is bordered by Butler County to the north; Warren County to the northeast; Clermont County to the east; Boone County, Kentucky to the southwest; Kenton County, Kentucky to the south; Campbell County, Kentucky to the southeast; and Dearborn County, Indiana to the west.

Six roadway bridges, two railroad bridges, and one pedestrian bridge connect Hamilton County to Northern Kentucky (the Cincinnati Southern Bridge (Norfolk Southern), the Brent Spence Bridge (I-71/I-75), the Chesapeake and Ohio Bridge (CSX), the Clay Wade Bailey Bridge (U.S. 25/42/127), the John A. Roebling Suspension Bridge (KY 17), the Taylor Southgate Bridge (U.S. 27), the Newport Southbank Bridge (Pedestrian- known as the Purple People Bridge), the Daniel Beard Bridge (I-471) and the Combs-Hehl Bridge (I-275).

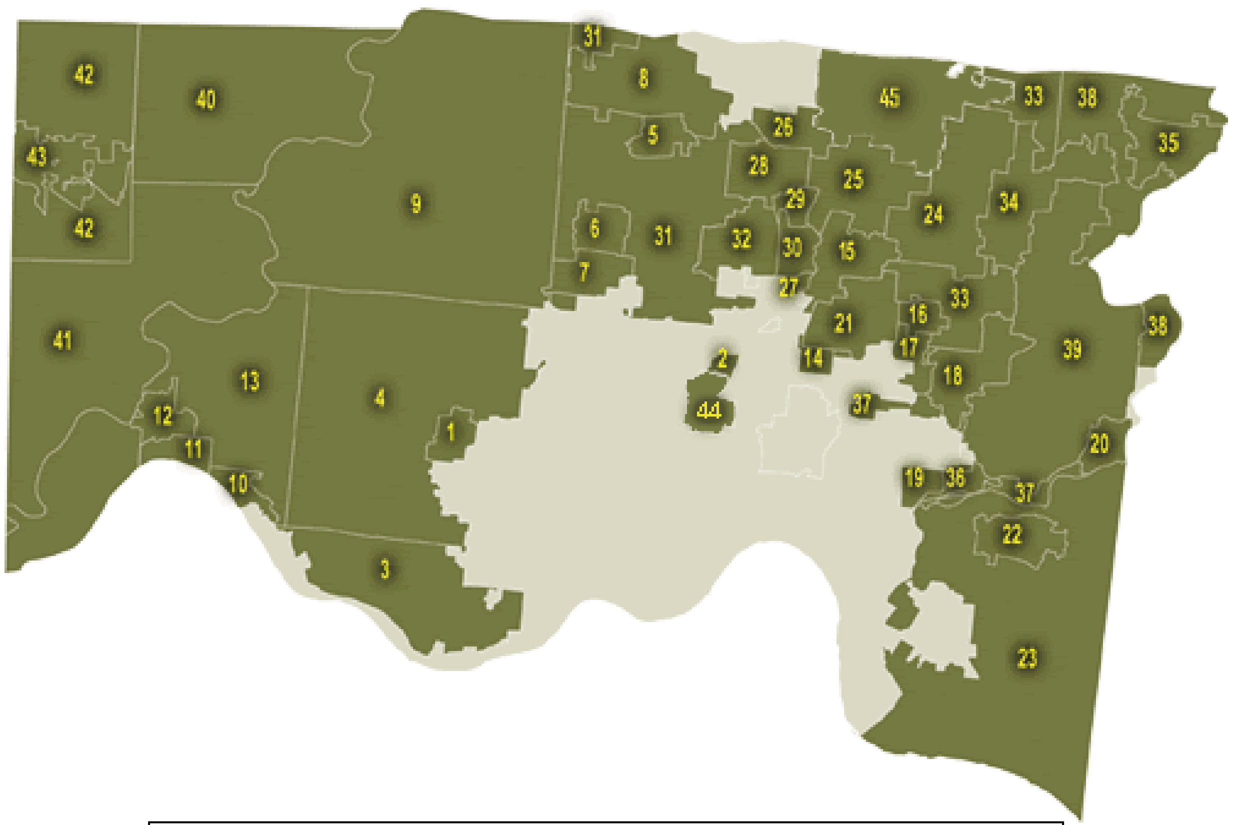
Four major railroad companies (CSX, Norfolk Southern, Indiana and Ohio Railway, and Amtrak) operate in the County supporting both freight and passenger transportation. CSX has an average of 60-70 trains traversing daily on its seven lines, classification yard (Queensgate Yard) and other support yards. Norfolk Southern operates approximately 40 trains daily on its three major routes and classification yards (Gest Street – with an intermodal yard on the grounds of the former Cincinnati Union Terminal; Sharon Yard in Sharonville, and Berry Yard in Bond Hill). The Indiana and Ohio Railway operates one yard (McCullough Yard). Amtrak runs into and out of the Cincinnati Union Terminal.

The County has 15 Hospitals and Medical Centers (Bethesda Evendale; Christ; Children's (2); Drake; University; Mercy West, Anderson; Jewish; Select Specialty Hospital; Shriners; Summit Behavioral Health; Bethesda North (Tri-Health); Good Samaritan; and Veteran's Affairs Medical Center. The County hosts four professional sports teams (Cincinnati Reds, Cincinnati Bengals, FC Cincinnati and Cincinnati Cyclones). The county has multiple large venues and sporting arenas (Great American Ballpark, Paul Brown Stadium, U.S. Bank Area, Nippert Stadium, Fifth Third Bank Arena, Cintas Center, Riverbend Music Center, and Cincinnati Music Hall).

The County also has ten (10) Class I Dams. Class I Dams have a storage volume greater than 5,000 acre-feet or a height greater than 60 feet. In addition, failure of these dams would result in the probable loss of human life and/or present a serious hazard to health, damage to homes, high value industrial or commercial properties or major public utilities.

Figure 1: Hamilton County Public Health Service Jurisdictions

Hamilton County Public Health serves the following communities in Hamilton County.



1. Cheviot
2. Elmwood Place
3. Delhi Twp
4. Green Twp
5. Greenhills
6. Mt. Healthy
7. N. College Hill
8. Forest Park
9. Colerain Twp
10. Addyston
11. North Bend
12. Cleves
13. Miami Twp
14. Golf Manor
15. Reading
16. Deer Park
17. Silverton
18. Madeira
19. Fairfax
20. Terrace Park
21. Amberley Village
22. Newtown
23. Anderson Twp
24. Blue Ash
25. Evendale
26. Glendale
27. Arlington Hts
28. Woodlawn
29. Lincoln Hts
30. Lockland
31. Springfield Twp
32. Wyoming
33. Sycamore Twp
34. Montgomery
35. Loveland
36. Mariemont
37. Columbia Twp
38. Symmes Twp
39. Indian Hill
40. Crosby Twp
41. Whitewater Twp
42. Harrison Twp
43. Harrison
44. St. Bernard
45. Sharonville

Hazard Analysis Summary

Hamilton County is subject to events that could potentially result in a large scale disaster. These events include: floods, urban/structural fires, tornadoes, hazardous materials incidents, earthquakes, transportation incidents, droughts, power failures, severe weather and winter storms, civil disorder, extreme heat and cold weather, terrorism, port security breaches, and public health incidents. Contributing factors such as seasonal weather patterns, special events, and the time of day have an impact on the likelihood and severity of each hazard.

Due the geographic, economic, and social attributes, Hamilton County is vulnerable to a wide array of hazards that threaten its communities, businesses, and environment.

The following hazards were identified to pose a threat to the County. These hazards were then grouped into three priority areas:

Natural Hazards:

- Tornadoes/Severe Thunderstorms
- Floods
- Landslides
- Wind Events
- Winter Storms
- Drought
- Earthquake
- Pandemic
- Foreign Animal Disease
- Wildfire

Technological Hazards:

- Power Failure
- Hazardous Materials Release
- Train Derailment
- Dam/Levee failure
- Urban Conflagration

Human Caused Hazards:

- Terrorist Acts
- Cyber Events
- Civil Disturbance
- Sabotage
- School Violence

There are no public health hazards; rather, all hazards could lead to impacts on public health, which may require HCPH to respond using this plan. Potential impacts include the following:

- Community-wide limitations on maximal health for residents;
- Widespread disease and illness;
- Establishment of new diseases in the County;
- Heat-related illnesses and injuries;
- Hypothermia;
- Dehydration;
- Widespread injuries or trauma;
- Overwhelmed medial facilities;
- Insufficient resources for response, especially medial 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

Incidents in Hamilton County have largely been attributed to the county's geographic location and accessibility. Hamilton County's surrounding counties, states and airports may cause the county to become affected by incidents or events originating from outside its borders. These external events have the ability to directly impact both public health and medical services statewide by causing a demand for preventative and healthcare measures. Most notably, public health threats such as infectious diseases have the ability to arrive to Hamilton County through travel-related mechanisms. The following airports are located within Hamilton County or within close proximity to Hamilton County:

1) Cincinnati Municipal Airport – Lunken Field, Cincinnati, Ohio
2) Butler County Regional Airport – Hogan Field, Hamilton, Butler County, Ohio (17 miles)
3) Cincinnati/Northern Kentucky International Airport, Hebron, Kentucky (21 miles)
4) Middletown Regional Airport, Middletown, Butler County, Ohio (31 miles)
5) Dayton International Airport, Dayton, Ohio (58 miles)

Public Health and Medical Incidents – Recent History

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

- Meningitis Outbreak - In October 2012, patients of Cincinnati Pain Management Clinic physicians were identified as having received injections of a potentially contaminated medication that was linked to an outbreak of fungal meningitis. HCPH staff were assembled to contact approximately 210 individuals that may have received the potentially contaminated medication. This was part of an outbreak that affected people in locations in several states across the United States.
- Oak Glen Oil Release – In March 2014, HCPH responded to a 20,000 gallon oil pipeline release in Colerain Township.
- Ebola Preparedness – In October 2014, a citizen in the United States contracted Ebola, which lead to extensive coordination and planning with local, state and federal partners. A county and regional Ebola Response Plan was developed.
- Harmful Algal Blooms Incident – In September 2015, HCPH responded to Harmful Algal Blooms in the Ohio River.
- Zika Preparedness – In 2016, due to the threat of Zika and confirmed cases in Florida, HCPH developed a Zika Response Plan.
- Hepatitis A – HCPH responded to numerous hepatitis A cases in 2018 and 2019. Ohio Department of Health (ODH) declared a statewide community outbreak of hepatitis A in January 2019.
- Pertussis, Shigella, Legionella, Salmonella, Scabies, Norovirus, Influenza and GI Outbreaks – HCPH disease investigators and epidemiologists frequently respond to these outbreaks on an annual basis.

Hamilton County EMHSA THIRA

In July 2016, Hamilton County Emergency Management & Homeland Security Agency (EMHSA) completed its ***Threat and Hazard Identification and Risk Assessment (THIRA)***. The THIRA detailed and quantified hazards from significant historic events and the hazard's likelihood of occurrence. According to the indexed hazards in **Figure 2**, natural biohazards and drought are unlikely to occur in the county while wind events, such as tornados, hazardous materials releases, landslides, transportation incidents and floods were ranked as the most likely hazards to occur in Hamilton County.

Within Hamilton County, there are diverse events that reoccur yearly (e.g., county fair, shows, concerts, festivals, college and professional sporting events, etc.), with the occasional nationally recognized events (e.g., World Choir Games, Veterans Wheelchair Games, MLB All-Star Game, Civil Rights Baseball Game, etc.). An incident that occurs at any major event may significantly affect public health and medical services both within the hosting county and have cascading

effects potentially across adjacent counties, the region, or statewide depending on the nature of the incident.

HCPH personnel refer daily to the Ohio Homeland Security/Strategic Analysis Information Center (SAIC) Daily Briefing for a list of events occurring within the county and the State.

Figure 2 – Hamilton County EMHSA THIRA Hazard Ranking Assessment

Rank	Threat/Hazard	Probability	Magnitude	Warning Time	Duration	Total Score
1.	Wind Events (including Tornado)	3.67	2.58	3.83	1.00	**3.10**
2.	Hazardous Materials Release	3.67	1.92	4.00	2.42	**3.07**
3.	Landslide/Subsidence	3.92	1.83	3.58	1.92	**3.04**
4.	Transportation Incidents	3.25	2.25	4.00	2.08	**2.95**
5.	Flood (including Dam/Levee failure)	3.92	2.25	3.25	2.75	**2.94**
6.	Power Failure	2.75	2.08	4.00	2.83	**2.75**
7.	School Violence	2.67	2.67	3.75	1.58	**2.72**
8.	Severe Storms (including Lightning & Hail)	3.67	1.33	3.17	1.00	**2.63**
9.	Cyber Attack	2.75	1.83	4.00	2.33	**2.62**
10.	Winter Storms	3.67	1.58	1.42	2.42	**2.58**
11.	Terrorism	1.83	3.00	3.83	1.92	**2.49**
12.	Extreme Temperatures	3.25	1.75	1.17	3.00	**2.46**
13.	Pandemic	2.33	2.67	1.50	3.83	**2.46**
14.	Fire Hazards (including Urban and Wildfires)	2.00	2.58	4.00	1.75	**2.45**
15.	Structural Collapse	2.33	2.08	3.58	2.17	**2.43**
16.	Civil Disturbance	2.50	1.83	3.33	2.50	**2.43**
17.	Sinkhole/Karst	2.50	1.42	4.00	1.50	**2.30**
18.	Earthquake	1.92	2.08	3.92	1.00	**2.18**
19.	Radiological Incidents	1.17	2.50	3.75	2.67	**2.10**
20.	Drought	2.17	1.25	1.08	3.92	**1.90**
21.	Natural Biohazards	2.08	1.25	1.33	3.92	**1.90**

Other Hazards Not Evaluated	
Avalanche	Hurricane
Celestial Event (Meteors)	Nuclear Attack
Electromagnetic Pulse (EMP)	Volcano

For an in-depth review of historical events in Hamilton County, consult ***Appendix 1 – Disaster History from the State of Ohio Enhanced Hazard Mitigation Plan***.

HCPH's Role in the Greater Cincinnati Disaster Preparedness Coalition

HCPH is a **core** member of the Greater Cincinnati Disaster Preparedness Coalition (GCDPC). The GCDPC is a regionally-focused group of multidisciplinary agencies, organizations, and hospitals who collaborate in planning and response in order to prepare for, respond to, and recover from disasters, mass casualty incidents, public health emergencies, or other catastrophic incidents.

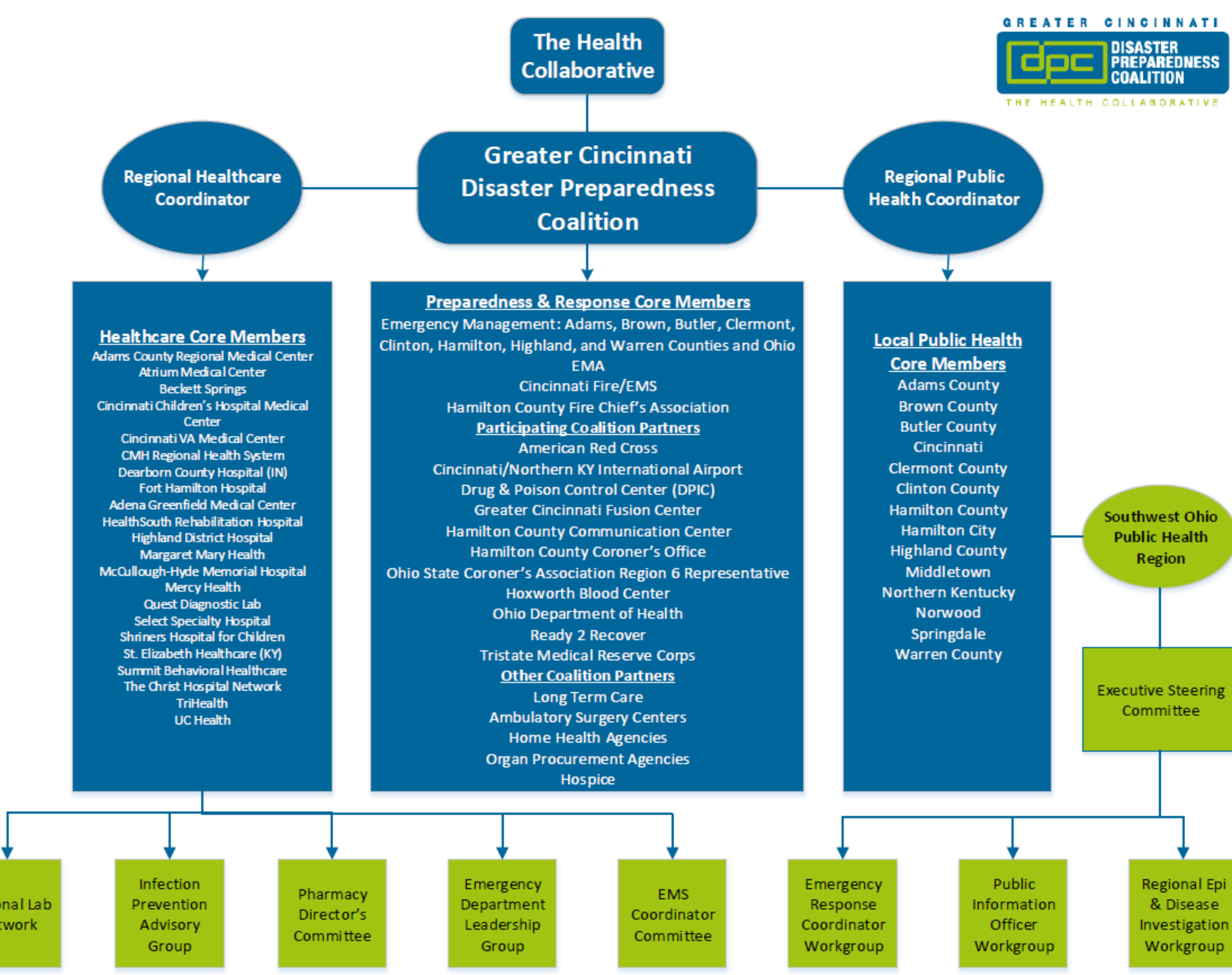
The region served by the GCDPC includes the tristate area which includes Southwest Ohio, Northern Kentucky, and Southeast Indiana. The Coalition's mission is to promote and enhance the emergency preparedness and response capabilities of healthcare entities through:

- Building partnerships to support health preparedness
- Engaging with community organizations to foster public health, medical, and mental/behavioral health networks
- Facilitating communication, information and resource sharing
- Promoting situational awareness among DPC members.
- Coordinating training, drills, exercises
- Strengthening medical surge capacity and capabilities
- Assisting emergency management and ESF #8 partners

As a core member, HCPH contributes to regional healthcare planning, preparedness, and response through the following activities:

- Attendance at regularly scheduled Coalition meetings (bimonthly)
- Participation in Coalition initiatives as needed/requested
- Participate in information sharing, emergency planning and surveillance activities, supported by the Regional Public Health and Healthcare Coordinator, as needed/requested through the following groups (see Coalition Organizational Chart on the following page):
    - Executive Steering Committee
    - Emergency Response Coordinator Workgroup
    - Regional Epidemiology and Disease Investigator Workgroup
    - Public Information Officer Workgroup
- Participate in Coalition-sponsored training, exercises and drills upon request
- Works collaboratively with Coalition core members and partners on Coalition initiatives and Coalition program activities aimed at supporting Hospital Preparedness Program (HPP) capabilities

Figure 3 – Coalition Organizational Chart



Greater Cincinnati Disaster Preparedness Coalition Organizational Chart August 2017

- Share ESF #8 Responsibilities/duties as needed with the Coalition representative (Regional Healthcare Coordinator) and/or local hospital response staff during an incident
- Support Medical Surge operations as able/applicable to incident
- Refer to **Attachment I – GCDPC/HCPH Interface Procedure** for a description of HCPH's roles and responsibilities that directly support GCDPC members during response and recovery.

Emergency Support Function (ESF)- 8

Many health-related impacts are beyond the scope of HCPH alone and require involvement of other county partners with responsibilities for addressing incidents with impacts on health. These agencies and organizations comprise ESF-8 Public Health and Medical Services in the county. Health and Medical Services provides coordinated local assistance to supplement 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.

HCPH and The Health Collaborative each serve as coordinating agencies for ESF-8 at the Hamilton County Emergency Operations Center (EOC).

ESF-8 Public Health and Medical Services will partner with the *ESF-6 Mass Care* team 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 Hamilton County.

ESF-8 involves supplemental assistance to other local health departments and jurisdictional governments within the county in identifying and meeting the health and medical needs of victims of a minor/major disaster, emergency, or terrorist attack. This support is categorized in the following functional areas:

a. Assessment of health/medical needs
b. Organization and intra/inter-jurisdictional relationships
c. Health surveillance and epidemiological investigation
d. Laboratory testing and analysis
e. Prevention and control practices
f. Communications/notification
g. Mass prophylaxis/vaccination
h. Health/medical equipment and supplies
i. Food/drug/medical device safety
j. Health care personnel augmentation
k. Patient evacuation
l. Hospital care
m. Public health information
n. Limitation on movement
o. Vector control
p. Veterinary services

q. Worker health and safety
r. Environmental concerns-drinking water and waste management
s. Radiological/chemical/biological hazard consultation
t. Fatality Management – victim identification/mortuary services
u. Mental health care
v. Emergency Medical Services (EMS)
w. Law enforcement support
x. Recovery activities

Each ESF representative is responsible for the dissemination of information that may be of value to other ESF representatives located in the Hamilton County EOC. This information sharing contributes to the response and recovery during an emergency/disaster of any type.

The HCPH Health Commissioner and *The Health Collaborative* will co-coordinate the provision of local health and medical assistance to fulfill the requirements identified by the affected local authorities having jurisdictional control. Included in the ESF-8 are overall public health and medical response. The ESF-8 will utilize resources primarily from:

- Local Public Health agencies;
- Hospitals and healthcare agencies
- The local American Red Cross Medical Assistance Team which includes medical response, patient evacuation, and definitive medical care

In addition to ESF-8, HCPH may also support other ESFs during a response (such as ESFs 3, 6, 10, 11, 14 and 15). Delineation of responsibilities at the county level can be found in ***Appendix 2 – Roles of County Agencies in Emergency Support Functions***.

Within Annexes A through O of the Hamilton County EOP, all of the ESFs are defined and the basic responsibilities accepted by elected officials, managers, county departments and community agencies in response to a disaster. The annexes also details Primary and Support Agencies by ESF. Hamilton County's EOP can be found at http://www.hamiltoncountyohioema.org/emergency-operations-plan/.

Delineation of the responsibilities at the state level can be accessed on the Ohio EMA website at: https://www.ema.ohio.gov/Documents/Ohio_EOP/tab_c.pdf.

Delineation of responsibilities at the federal level can be accessed at https://www.fema.gov/media-library-data/20130726-1825-25045-0604/emergency_support_function_annexes_introduction_2008_.pdf.

Access and Functional Needs

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. The access and functional needs identified in HCPH service jurisdictions, as well as within the cities of Norwood and Springdale, have been detailed in ***Appendix 3 – HCPH CMIST Profile***. Potential impacts from an incident may require HCPH to respond by initiating or supporting the following activities to address an incident:

- Prophylaxis and Dispensing
- Epidemiological Investigation and Surveillance
- Infection Control
- Prevention
- Morgue Management
- Medical Surge

HCPH 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 5.3.11 for additional details.).

For a list of the agency's access and functional needs partners, refer to ***Appendix 4 - HCPH CMIST Partner List.***

4.0 ASSUMPTIONS

- All HCPH staff with identified emergency response functions are trained and capable of performing their roles within the Incident Command Structure.
- The county is vulnerable to hazards, which may lead to emergencies or disasters anywhere in the county.
- A HCPH response may be necessary to support any local jurisdiction affected by a variety of hazards and incidents.
- An incident may occur with little or no warning.
- To ensure appropriate public health response, HCPH must be prepared to respond to any incident with the ability to impact the 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.
- Every communicable-disease incident globally has the potential to impact the county.
- HCPH may have to make provisions to continue response operations for an extended period of time as dictated by the incident.

- All response agencies will operate under in accordance with NIMS and respond as necessary to the extent of their available resources.
- HCPH will support and work in partnership with local response efforts.
- Incidents are distinct, but they all have common elements that can be effectively managed through plans.
- In addition to HCPH, resources from local, regional, State, and Federal governments and from private or volunteer organizations may also be engaged during an incident.
- Additional assistance may be available in a declared disaster or emergency.
- Most incidents to which HCPH responds will not result in a declaration.
- Incidents can affect HCPH responders, staff, volunteers, vendors, partners, and the families of each group, impacting the Agency's ability to respond.
- HCPH may have incomplete information, as it must rely on federal, state and local partners to provide some critical details during response.
- HCPH may receive competing requests for support beyond its available resources.
- HCPH personnel may be assigned to assist other local health departments (LHD) under the direction of a local incident management system, or may be assigned to various roles or tasks within a regional, state or federal level incident management system
- The resources needed for an effective response (e.g., vaccine or personal protective equipment) may be unavailable or in limited supply.
- Incidents may require more or different resources than what HCPH has readily available.
- Although great care has been taken to provide direction for HCPH response activities, it is impossible to account for all contingencies, and the leadership in the response organization must rely on their best judgment when the plan does not directly address a particular issue. As such, response leadership must have the training and tools to direct effective incident response activities.
- Prioritizing who will receive prophylaxis will be under guidance and direction from ODH and/or US Department of Health and Human Services Centers for Disease Control and Prevention (CDC) through HCPH.
- Every component of the HCPH ***ERP*** will work effectively during response, unless testing or implementation proves otherwise.

SECTION II

5.0 CONCEPT OF OPERATIONS

5.1 ORGANIZATION AND RESPONSIBILITIES

All HCPH staff have a role in supporting and participating in the agency's preparedness and response efforts. The following personnel and groups have critical responsibilities in agency preparedness and response efforts.

5.1.1 HEALTH COMMISSIONER

The Health Commissioner is the lead health official for HCPH. During incident response, the Health Commissioner has the following responsibilities:

- Inform Ohio Department of Health of actual or potential health emergencies.
- Set policy and guidance for HCPH and HCPH jurisdictional service area health response.
- Support and authorize the Incident Commander (IC) to lead agency response.
- Monitor the response progress through briefings and updates on the situation.
- Provide additional guidance and direction to HCPH response staff, as needed.
- Represent HCPH, or assign a HCPH representative, at the Hamilton County EOC, as necessary
- Engage the health commissioners from the cities of Cincinnati, Norwood and Springdale, as necessary.
- Engage and brief the Southwest Ohio Public Health Regional (SWOPHR) leadership group, as necessary.
- Engage Ohio Department of Health to request public health and medical resources support, if necessary.

5.1.2 MEDICAL DIRECTOR

As the lead health expert for HCPH, the HCPH Medical Director could be engaged in any incident response. The Medical Director's responsibilities include the following:

- Provide medical consultation to the Health Commissioner, Assistant Health Commissioners, and response personnel.

- Inform medical policy and guidance for HCPH and statewide health response.
- Engage local and state partners regarding medical decisions and guidance.
- Engage other local health department commissioners and medical directors within Hamilton County, as appropriate.
- Engage Ohio Department of Health on matters that require their consultation or clarification of existing guidance.
- Engage the federal government on matters that require their consultation or clarification of existing guidance.

5.1.3 EMERGENCY PREPAREDNESS PROGRAM

The Emergency Preparedness (EP) Program has the primary responsibility for coordinating emergency preparedness, planning and response for HCPH.

The Health Commissioner has the primary responsibility for facilitating the activation of the ERP and the department operations center (DOC). If the Health Commissioner is unavailable or chooses to delegate responsibility, activation may be successfully facilitated by either Assistant Health Commissioner, the EP Supervisor, or the EP Preparedness Specialist.

To facilitate a consistent application of the ERP in all incidents, EP will utilize **Attachment II – Public Health Operations Guide (PHOG)**. Engaged HCPH staff will begin utilizing the PHOG as soon as they are notified of an incident.

5.1.4 COMMON RESPONSIBILITIES FOR HCPH

All HCPH Departments may be asked to support the response and may provide agency staff to respond to an incident.

HCPH staff is expected to do the following:

- Maintain appropriate timekeeping records/documents.
- If required, use ICS Form 252 as prescribed by the Finance Section.
- Follow any organizational procedures set by the individual leading the response.
- Support execution of the Hamilton County EOP; the HCPH responsibilities are listed in ESF-8 (Annex H) of the Hamilton County EOP. http://www.hamiltoncountyohioema.org/wp-content/uploads/2015/09/ESF-8-Health-Medical.pdf

Staff will learn their job assignment and hours of operation upon arrival and checking in. Personnel assignments are made within the chain-of-command structure based on the required minimum qualifications for the position; the knowledge, training, experience, and subject matter expertise of individual staff; and the resources available at the time.

Staff from the program area that actually performs the function as a part of normal work will be prioritized for assignment to that function.

Staff that is reassigned to work in a capacity that is other than their normal daily job will be given a job action sheet that explains the job responsibilities and to whom they report.

Staff will not be given job assignments they are not able to do or cannot be trained to perform.

To assure a timely response and activation of response plans, HCPH maintains a staffed reporting telephone number whereby, physicians, hospitals and other health care providers and the public can phone to report communicable disease or other public health emergencies 24 hours a day, seven days a week. Outside of regular business hours, an on-call supervisor receives calls. The supervisor can coordinate a public health response and communicate with relevant partners for situational awareness and subject matter expertise.

Direction and control functions of HCPH will vary according to the situation and circumstances. This function may be initiated immediately upon the onset of an event, such as when a tornado occurs, or develop gradually as the situation evolves, such as when a widespread flooding occurs. Additionally, direction and control functions may be long term in nature such as during a pandemic, changing significantly as the situation moves from response to recovery. Composition of staff assigned to the direction and control function may change significantly as the situation progresses through the various stages of an emergency and into the recovery phase.

5.2 INCIDENT DETECTION, ASSESSMENT AND ACTIVATION

This section describes the process for activating the ERP. The ERP may be activated in one of two ways:

- The Health Commissioner personally 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 Health Commissioner is not available, either Assistant Health Commissioner or the EP Supervisor can authorize activation of the ERP. If the ERP is activated in this way, response will begin 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 Health Commissioner. Barring deactivation by the Health Commissioner, response personnel then complete identified response actions.

Activation of the ERP marks the beginning of the response.

5.2.1 INCIDENT DETECTION

Any HCPH staff who 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 divisions beyond the currently involved division(s), with an expectation for significant, interdivision 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 HCPH;
- Need for resources or support from outside HCPH;
- Significant or potentially significant mortality or morbidity;
- The incident has required response from other agencies, and it is likely to or has already required response from the local jurisdiction's health department.

5.2.2 INCIDENT ASSESSMENT

The Incident Assessment is the parallel of the "Incident Size-Up" described in the Incident Command System (ICS). It is a formal process for reviewing and evaluating an emergency incident and informs the level of activation. The assessment can be done either via a telephone or a face-to-face meeting. The purpose of the assessment is to review the situation, determine the activation level, and document the decision.

Supervisors/Directors will immediately inform one or both Assistant Health Commissioners and the Health Commissioner of any incident that they believe is likely to require activation of the ERP. Following notification, one or both of the Assistant Health Commissioners will contact the Emergency Preparedness Supervisor. These notifications will trigger an Initial Incident Assessment Meeting, which must take place via phone or face-to-face within 1 hour of the initial detection of the threat.

5.2.3 INCIDENT ASSESSMENT MEETING

During the Incident Assessment Meeting, those in attendance will go through the following Incident Assessment Meeting agenda items as outlined below:

1. Incident Summary
2. Situation Overview
3. Response Requirements
4. Establish Current Organization

5. Adjourn

The outcome of the Incident Action Meeting will determine the activation level.

5.2.4 ACTIVATION DETERMINATION

The results of the Initial Incident Assessment Meeting will determine if the plan will be activated and the Activation Level. After determining the necessary activation level during the Initial Incident Assessment Meeting, activation of the plan will occur. Activation of the ERP indicates that the incident is of sufficient significance to warrant a response beyond day-to-day operations

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

If it is determined there is a need to activate the ERP, then the decision is posed to those in the Incident Assessment Meeting whether to activate the HCPH DOC in support of the ERP.

Once the determination is made to activate the ERP, the meeting group will identify whether the incident requires Command or Coordination.

- If HCPH is in the command of the incident, then an Incident Commander will be identified by the Incident Assessment Meeting group.

- If HCPH is supporting the ICS with coordination, then an Agency Coordinator will be identified by the Initial Assessment Meeting group.

5.2.5 ACTIVATION NOTIFICATIONS

If the ERP is activated, the Health Commissioner, or other designee, will determine if the following partners will be notified that we have activated our ERP:

- Directors/Supervisors
- Hamilton County EMHSA
- Board of Health
- Elected Officials
- Other Hamilton County LHDs
- SWOPHR leadership group
- Other community partners

Activation notifications include, at a minimum, the following pieces of information:

1. A summary of the incident.
2. A description of the activation level the agency is operating under.
3. Primary points of contact for the incident.

4. Estimated time for distribution of the first Situation Report.
5. DOC activation status.

Notifications can be made via the Operational Public Health Communication System (OPHCS), RAVE Alert emergency communication system and/or email within a least one (1) hour of the conclusion of the Incident Assessment Meeting or the determination that the ERP has been activated.

Activation Level	Description	Minimum Command Function & Staffing Recommendations
Level 1 Routine Operations	Routine incidents to which HCPH responds on a daily basis and for which day-to-day SOPs and programmatic resources are sufficient.	Normal, Day-to-Day Staff DOC not activated
Level 2 Situation Awareness & Monitoring	• An emergency with limited severity, size, or actual/potential impact on health or welfare but that cannot be handled at the programmatic level • Requires a minimal amount of coordination and agency engagement to conduct response; situational awareness and limited coordination are the primary activities • Examples: Power outage in a nursing home; water disruption requiring limited state support	•Response Lead (1) •Public Information (1) •Situation Awareness Section (1) Consider activation of the DOC Hamilton County EOC unlikely to be activated
Level 3 Partial Activation	• An emergency with moderate-to-high severity, size, or actual/potential impact on health or welfare • Requires significant coordination and agency engagement to conduct response, likely with significant engagement from other county partners; Hamilton County EOC may be activated • Examples: Widespread radiation contamination in a facility; multicounty disease outbreak requiring significant local support; water disruption requiring substantial state support and guidance; flooding	•Response Lead (1) •Public Information (1) •Partner engagement (1) •Situational Awareness (2) •Planning Support (1) •Operational Coordination (1) •Resources Support (1) •Staffing Support (1) DOC activation required Hamilton County EOC may be activated
Level 4 Full Activation	• An incident with extensive severity, size, or actual/potential impact on health or welfare; may be of such magnitude that the available assets that were put in place for the response are completely overwhelmed • Requires an extreme amount of coordination and agency engagement to conduct response; almost certain engagement of multiple state partners; Hamilton County EOC most likely activated • Examples: Pandemic influenza; mass casualty incident from chemical plume; bioterrorism attack; tornado	FULL STAFFING: • Response Lead (1) •All Section/Function Leads and key support staff (16+) • All other functions and positions, as identified by activated plans DOC activation required Hamilton County EOC activated

Execution of the ERP may require staff mobilization and activation of the HCPH DOC. The HCPH DOC is a facility/location where the agency's response personnel can be collected to promote coordination of response activities. The HCPH DOC is located in the large conference room. Activation of the DOC is described in **Attachment III – DOC Activation Standard Operating Procedure**.

5.2.6 BOARD OF HEALTH NOTIFICATION

The HCPH Board of Health (BOH) will be engaged and notified, at the discretion of the Health Commissioner, whenever the HCPH ERP is activated. The BOH may also be engaged and notified (for BOH situational awareness) at the Health Commissioner's discretion for any incident which may adversely affect public health but not rise to the level of necessitating ERP activation.

The BOH will be notified by phone, text or email. Unless delegated, this outreach is made by the Health Commissioner. At a minimum, the BOH President will be contacted to inform the BOH of the incident and response operation initiation.

5.3 COMMAND, CONTROL, AND COORDINATION

HCPH 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 with the policies and procedures detailed in this plan.

5.3.1 INCIDENT COMMAND AND MULTIAGENCY COORDINATION

Depending on the incident, HCPH may either lead or support the response. HCPH uses ICS to structure and organize response activities when leading an incident response. Similarly, when supporting an incident response, HCPH utilizes NIMS principles for a multiagency coordination system to coordinate response efforts with those efforts of the existing incident command structure and other supporting agencies/entities.

See **Attachment II – Public Health Operations Guide** for details on implementation.

5.3.2 INCIDENT COMMANDER/AGENCY COORDINATOR

HCPH response activities are managed by a single individual ("Response Lead"), who serves in the command function of the response organization.

The position title is different depending on whether HCPH is leading the incident response or providing incident support. When leading the incident, HCPH uses the ICS title Incident Commander (IC); when supporting the response, HCPH uses the title Agency Coordinator (AC). A Response Lead has the same authorities, regardless of the title.

5.3.3 BASIC AUTHORITIES FOR RESPONSE

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

- The IC/AC may utilize and execute any approved component (i.e., attachment, appendix, or annex) of the ERP;
- IC/AC may direct all resources identified within any component of the ERP in accordance with agency policies;
- IC/AC 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/AC may engage the minimum requirements for staffing as outlined in the activation levels of the plan;
- The IC/AC may authorize incident-related in-state or out of state travel for response personnel;
- IC/AC may authorize exempt staff to work a schedule other than their normal schedule, as needed;
- The IC/AC must obtain approval through the Health Commissioner to approve emergency expenditures using the agency credit card. The Finance Officer manages the financial terms of the agency credit card. The use of the agency credit card needs to be arranged with the Finance Officer.

LIMITATIONS OF AUTHORITIES

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

- The IC/AC must engage human resources management when staffing levels begin to approach any level that is beyond those pre-approved within this plan. Human Resources must authorize engagement of staff beyond those pre-approved levels;
- The IC/AC may not authorize bargaining unit staff to work a schedule other than their normal schedule without authorization from 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/AC must adhere to the policies of HCPH regarding overtime/comp-time and should clarification on these policies or exemption be required, the IC/AC must engage Human Resources management;

- The IC/AC must obtain approval through the Health Commissioner to approve emergency expenditures using the agency credit card. The Finance Officer manages the financial terms of the agency credit card. The use of the agency credit card needs to be arranged with the Finance Officer.

5.3.4 INCIDENTS WITH HCPH AS THE LEAD AGENCY

When leading the response, HCPH may employ ICS and organize the response personnel and activities in accordance with the associated ICS resources and principles.

As the lead agency, HCPH 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/county partners and the Hamilton County EOC as needed. Resources and support provided to HCPH for incident response will ultimately be directed by the IC, in accordance with the priorities and guidance established by the Health Commissioner and the parameters established by the supplying entities.

HCPH 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.

5.3.5 INCIDENTS WHEN HCPH IS INTEGRATED INTO AN ICS STRUCTURE LED BY ANOTHER AGENCY

For incidents in which HCPH is integrated into an existing ICS structure led by another agency, HCPH provides personnel and resources to support that agency's response. HCPH 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 HCPH 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 may, at any time, recall such integrated staff or resources.

If such support is needed, HCPH will determine the appropriate activation level and assign an AC to lead the integration activities. In such responses, the Planning Support Section Chief will track engagement of HCPH 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 AC of any attempt to circumvent the established parameters, as well as of any unapproved use of HCPH resources. The AC will then work with the incident's IC to determine an appropriate resolution.

5.3.6 INCIDENTS WITH HCPH IN A SUPPORTING ROLE

For incidents in which HCPH is a support agency, the IC is supplied by another agency. For these incidents, HCPH assigns an AC 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 Hamilton County EOC is activated, the HCPH AC coordinates all agency actions that support any ESFs in which HCPH has a role. In such incidents, the AC will ensure that all HCPH actions to address incidents for which the Hamilton County EOC is activated are coordinated through the Hamilton County EOC. Interface between the agency and the Hamilton County EOC is further detailed in **Attachment IV - Interface between HCPH and the Hamilton County EOC Standard Operating Procedure**.

5.3.7 PROCESS FOR COORDINATION WITH STATE RESPONSE AGENCIES FOR LARGE-SCALE OR COMPLEX INCIDENTS

> <u>Context</u> - *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 polished participation in the state-and-local coordination call.*
>
> *The steps defined below align with the ODH resource on state and local response coordination.*

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 HCPH and ODH will contribute to the establishment of these essential elements of information (EEI). Once finalized, HCPH will identify the POCs within the agency who will lead the implementation/identification of each EEI.

HCPH 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 HCPH 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.

5.3.8 HCPH INTERFACE BETWEEN ESF-8 AND THE GREATER CINCINNATI DISASTER PREPAREDNESS COALITION PARTNERS

The plans that currently support the ESF-8 and GCDPC interface include:

- HCPH Emergency Response Plan;
- Hamilton County EMHSA Emergency Operations Plan;
- GCDPC Emergency Response Procedures.

The Greater Cincinnati Disaster Preparedness Coalition (GCDPC) is a regionally-focused group of multidisciplinary agencies, organizations, and hospitals who collaborate in planning and response in order to prepare for, respond to, and recover from disasters, mass casualty incidents, public health emergencies, or other catastrophic incidents.

The GCDPC largely comprises ESF-8 partners in the tristate area which includes Southwest Ohio, Northern Kentucky, and Southeast Indiana. 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.
- 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.
- Fire & EMS: provide patient transport to care facilities. Support fit-testing for PPE and training on donning and doffing.
- American Red Cross: Activate their Disaster Health Services and Disaster Mental Health Services volunteers in support of Mass Care operations. Activate their Disaster Medical Assistance Team in response to a Mass Casualty or Mass Fatality Incident. Support the opening of Family Assistance Centers in accordance with the Hamilton

County Mass Fatality Plan. Support critical incident stress management operations for emergency responders.

The role of the Regional Healthcare Coordinator in local and multicounty incidents is to:

1) Facilitate prompt, clear, and precise information sharing among participating coalition members and jurisdictional authorities to promote common situational awareness; through situational reports.

2) Facilitate the interface between the DPC members and appropriate jurisdictional authorities to establish effective support for medical surge events; to include bed availability statistics and patient movement options.

3) Facilitate resource support by expediting the mutual aid process or other resource sharing arrangements among the DPC members and support the request and receipt of assistance from local, state, and federal authorities;

4) If needed, establish a presence either in person or virtually with HCPH as co-coordinating ESF-8 lead agencies at the Hamilton County EOC during a county or multicounty response. The Regional Public Health Coordinator has a seat in the local EOC that can be filled upon request.

5.3.9 LEGAL COUNSEL ENGAGEMENT

During any activation of the emergency response plan, HCPH's 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 Director of Health,
- Anything else for which legal counsel is normally sought.

HCPH legal counsel is integrated at the outset through the activation notification. The Health Commissioner or either Assistant Health Commissioners normally engage legal for assistance. HCPH staff must go through senior management prior to contacting legal counsel.

The contact information for HCPH's legal counsel is the following:

NeeFong Chin
Hamilton County Prosecutor's Office

William Howard Taft Law Center
230 East 9th Street, Suite 4000
Cincinnati, OH 45202

5.3.10 INCIDENT ACTION PLANNING

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

- What do we want to do?
- Who is responsible for doing it?
- How do we communicate with each other?
- What is the procedure if someone is injured?

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

For additional information on the planning process, see ***Appendix 5 - The Planning Process***.

5.3.11 ACCESS AND FUNCTIONAL NEEDS

HCPH coordinates response actions to ensure that access and functional needs are appropriately addressed during response. HCPH will coordinate the following:

- HCPH utilizes jurisdictional risk assessments identified within the Annexes of the Hamilton County Hazard Mitigation Plan to identify and prioritize jurisdictional public health hazards and vulnerabilities;
- Review of incident details 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.

The Emergency Response Supervisor has primary responsibility for the provision of these services.

HCPH engages other internal/external programs that serve individuals with access and functional needs. These include the following:

- Maternal and Child Health (Children and Pregnant women)

- Council on Aging of Southwestern Ohio (Residents of long-term care facilities)
- HIV/STD (Individuals with chronic illness)
- Injury Prevention (Individuals with a drug addiction)
- Hamilton County Developmental Disabilities Services
- Hamilton County Mental Health and Recovery Services

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

Communication

Every emergency will affect populations who may have special information needs related to the incident. This includes any persons unable to receive messages through mainstream media, persons unable to act on crucial messages and potentially life-saving information, or persons who require specialized information relevant to their circumstances, capabilities, and available resources. Examples of affected vulnerable populations include:

a. Persons with limited English proficiency
b. Persons with physical or cognitive impairments or disabilities (ranging from minor impairments where independence and ability to function are maintained to no ability to survive independently).
c. Blind, visually impaired, low vision
d. Deaf, hearing impaired, hard-of-hearing
e. Frail elderly or seniors
f. Children, unattended minors, runaways, latchkey kids
g. Persons with limited or no access to information or limited escape routes (geographically isolated)
h. Undocumented persons, political dissidents, or others who may not avail themselves to government or other services.
i. Ex-convicts, registered offenders and other clients of the criminal justice system
j. Culturally isolated persons with little or no interaction or involvement outside of their immediate community (including religious, ethnic, sexual orientation etc.)
k. Medically dependent or medically fragile
l. Chemically dependent
m. Tourists, homeless or shelter dependent
n. Poor, or extremely low income

o. Single parents with no support systems

p. Owners of pets (including companion animals), and livestock

q. Those for whom the messages or recommended protective actions present a serious challenge to important cultural or religious beliefs.

The following information response strategies will be used to facilitate communication:

a. Distribute information via trusted community based organizations (including social service agencies, faith based organizations, and other service agencies).

b. Provide written materials in Spanish, or other appropriate languages.

c. Inform Spanish Language Media outlets (radio, television, or print), and assure availability of Spanish Language public information staff. Utilize other translation services when appropriate.

d. Utilize contracted TTY services for public information phone banks and publish the number.

e. Use simple, clear language. Review printed information for readability. Provide visuals, such as maps or sketches when relevant.

f. Incorporate suggestions from vulnerable populations, their advocates, or organizations which serve them when preparing and maintaining media tools.

MAPPED LOCATIONS OF AT-RISK POPULATIONS

1. For planning purposes, HCPH Epidemiologists have mapped the following at-risk populations using 2010 Census data:
    a. Elderly
    b. Limited English
    c. No Vehicle
    d. Overall Social Vulnerability
2. HCPH has a community demographics spreadsheet showing language, race, percent poverty, percent on public assistance, percent unemployed, percent of children in poverty and education summaries within the HCPH service jurisdictions.
3. HCPH has mapped out the Social Vulnerability Index (2014) here.
4. A map of the floodplains in Hamilton County and a list of all social vulnerability index scores can be found in ***Appendix 7 - HCPH Profile of Access and Functional Needs***.

HCPH also has access to translation and interpretation services through the agency's Communication Protocols for People Experiencing Disabilities and those with Limited English Proficiency SOG.

5.3.12 DEMOBILIZATION

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.

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.

The IC/AC will ensure the Demobilization Plan is communicated to all DOC staff, the HCPH representative at the MAC and the HCPH liaison at the EOC. See HCPH's Demobilization SOG.

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

1. Develop the Incident Demobilization Plan.
2. Assure completion of demobilization checkout forms by personnel and inspection of equipment as they are released from the incident.
3. Initiate data collection for the After Action Process.

5.3.13 AFTER ACTION REPORT/IMPROVEMENT PLAN(S)

An After Action Report/Improvement Plan (AAR/IP) must be produced whenever one of the following criteria is met:

1. Any activation of the HCPH ERP
2. HCPH opens its DOC due to an emergency or disaster
3. Based on the discretion of the EP Supervisor, if there is a Natural Disaster or a Nationally Significant Event within a HCPH jurisdiction
4. Based on the discretion of the Director of the Epidemiology Division, an AAR/IP will be written if there is an outbreak of Class A or B Reportable Diseases
5. Following an exercise. The exercise will be conducted in accordance with the Homeland Security Exercise and Evaluation Program (HSEEP) criteria.
6. At the request of the Health Commissioner.

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.

See **Attachment VI - Development of an After Action Report/Improvement Plan (AAR/IP) and Completion of Corrective Actions**.

5.3.14 PLAN INTEGRATION

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

At the county level, the HCPH ERP interfaces with the Hamilton County EOP. HCPH provides specificity for how the agency will complete the actions assigned to HCPH in the Hamilton County EOP.

At the local level, the HCPH ERP interfaces with response plans for public health and medical organizations; these include organizations regulated by ODH, like long-term care facilities. HCPH recognizes that all responses are local and will activate the HCPH ERP to support the actions directed by local response plans.

At the regional level, HCPH interfaces with SWOPHR, which is a collection of local health departments in ODH Region 6. The plans produced by SWOPHR are designed to work in concert with the plans of the SWOPHR organization and define how the agencies collaborate during responses that affect one or more of their jurisdictions.

At the state level, ODH interfaces with CDC and ASPR to support public health and medical response, respectively. Although HCPH does not review response plans from ODH, HCPH plans are designed to identify, access and integrate with state plans for support and resources made available to the county. Examples of such resources include the Strategic National Stockpile (SNS), CDC Emergency Response Teams, and medical consultation through ATSDR. These resources and how to access them are included in each of the annexes they support.

5.3.15 SITUATION REPORTS

A situation report (SITREP) may 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 materials), a short yet concise SITREP may be produced. For a 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 HCPH management and Directors for their situational awareness. In addition, SITREPs will be sent electronically to all operational staff. Hardcopies of SITREPs will also be available in the HCPH DOC, if the DOC is active. At the discretion of the HCPH Health

Commissioner, any SITREP may be forwarded electronically to Hamilton County EMHSA, Regional Public Health Coordinators (RPHC), 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/AC, and operational staff.

SITREPs frequency is detailed in the table below.

Activation Level	SITREP Frequency
Level 2 - Situation Awareness & Monitoring	At least daily, if required
Level 3 - Partial Activation	At least at the beginning and end of each operational period
Level 4 - Full Activation	At least at the beginning, the middle, and the end of each staff shift or operational period, whichever is more frequent

See **Attachment VII - Situation Report Template** for a situation report template.

5.3.16 STAFF SCHEDULE (BATTLE RHYTHM)

HCPH staffing unit will maintain staff scheduling and communicate the schedule to assigned staff utilizing **Attachment VIII – Operational Schedule Form**. The completed staff schedule form will be distributed via email or by hard copy.

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

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

5.4 INFORMATION COLLECTION, ANALYSIS AND DISSEMINATION

5.4.1 INFORMATION TRACKING

WebEOC is the 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 and local levels and documenting response actions. All high-level response actions must be documented in WebEOC for accountability and reimbursement. HCPH will also track all agency objectives to ensure that they remain on track for completion. Any incidents that are off-track will immediately be identified to the IC/AC.

To aide in centralized communication, HCPH maintains a dedicated network directory for all response personnel to store incident-related documentation. Further, information will be compiled and analyzed 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, response staff may maintain an Activity Log, using ICS form 214. If used, these logs will be turned in at the end of the shift and filed.

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.

5.4.2 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 8 - EEI Requirements***.

HCPH 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/AC, Public Information Officer (PIO), Planning lead, and Operations lead will contribute to this refinement.

To identify sources of information for EEIs, consult ***Appendix 9 - External POCs*** **and** ***Appendix 10 - Internal HCPH Division and Program POCs***.

5.4.3 INFORMATION SHARING

To ensure that HCPH maintains a common operating picture across all the locations response personnel are engaged, HCPH will execute **Attachment IV - Interface between HCPH and Hamilton County EOC Standard Operating Guide**. This procedure defines the coordination between HCPH and Hamilton County EMHSA, when activated.

6.0 COMMUNICATIONS

HCPH is responsible for maintaining communication with local, regional, state, federal, private and non-profit partners during an incident requiring activation of this plan.

The agency's ***Crisis Communications Plan*** operates in concert with the ongoing response activities in order to ensure accurate and efficient communication with internal and external partners. When engaged in a response, HCPH will ensure the dissemination of information and maintain communication with the following entities to ensure continuity of response operations:

- Applicable HCPH employees
- Hamilton County EOC, as applicable
- ODH, as applicable
- Local Health Departments
- 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 event, 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 (land lines and cellular)
- texting
- email
- fax machines
- Web-based applications, including OPHCS, RAVE Alert and WebEOC.

There are four (4) alert levels employed by HCPH 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.

Incident staff who receive alerts will be expected to take the prescribed actions within the timeframe prescribed.

When notifications or alerts must be sent, HCPH utilizes OPHCS and/or RAVE Alert. OPHCS and RAVE Alert are reliable and secure web-based messaging and alerting systems used to communicate incident information to relevant groups via email, phone and text to support notifications on a 24/7/365 basis. This system is used by HCPH, other local health departments, ODH, hospitals, and other partners, but is not available to the general public. OPHCS and RAVE Alert operate 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.

In the event that HCPH communication resources become overburdened or destroyed, redundant or back-up communication equipment include:

- Governmental Emergency Telecommunication Service (GETS) cards
- Wireless Priority Service (WPS)
- Multi-Agency Radio Communications (MARCS) radios
- Two-way radios

GETS cards will be made available to all HCPH staff. GETS cards consist of phone numbers that receive priority over regular calls, thereby greatly increasing the probability a wired call is received. In addition to GETS cards, WPS allows for personnel priority access and prioritized processing in all nationwide and several regional cellular networks, greatly increasing the probability of call completion. WPS is free service to first responders and is currently being reviewed by agency staff through AT&T via FirstNET or Verizon First Responder.

HCPH maintains three (3) Multi-Agency Radio Communications (MARCS) base units and thirteen (13) MARCS radios that can be deployed to response staff

should HCPH experience power failure or the inability to reach partners. HCPH conducts monthly MARCS radio checks with ODH to verify distributed MARCS radios are operational for emergency use. Both GETS and MARCS radios are maintained and managed by the Emergency Preparedness Supervisor and should be requested through appropriate resource request mechanisms as outlined in this plan.

HCPH may engage primary and redundant methods of communication both at the programmatic and county state level. When responses require the engagement of the Hamilton County EOC, HCPH assumes its role at the ESF-8 desk. From the desk, HCPH may require additional collaboration with other ESFs, Hamilton County EMHSA staff and other state and federal 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 in **Figure 3**. Additional detail of the communication flow is detailed in **Attachment IV - Interface between HCPH and Hamilton County EOC Standard Operating Procedure**.

For a list of partner point of contacts, please refer to ***Appendix 9 - External POCs*****.**

For a contact list of our Southwest Regional Partners, go to **X:_HAN Update\SWOPHR Contact List**.

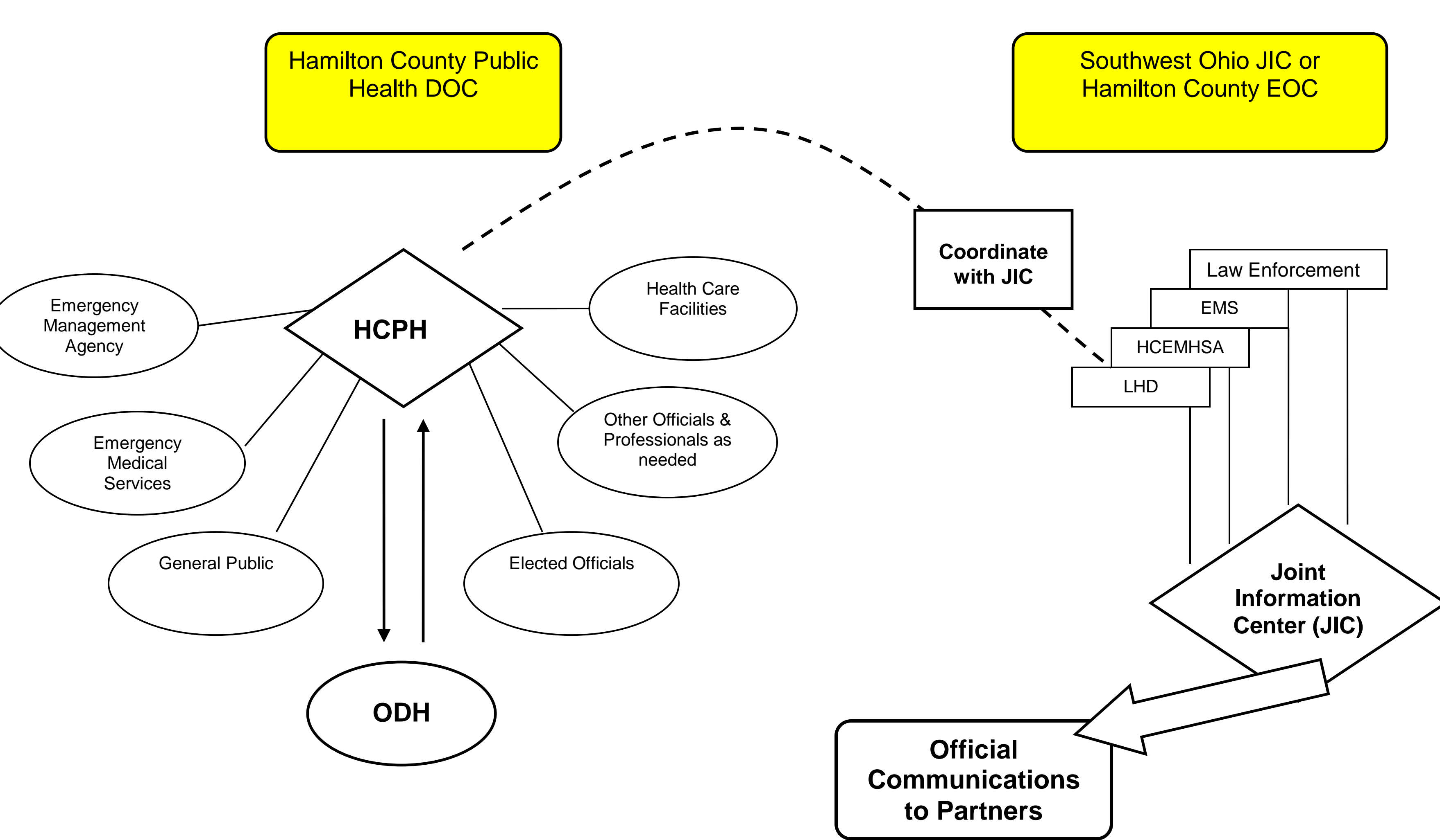
HCPH communicates EEIs and other tactical information through the messaging of information to response staff to ensure responders are well informed on the response operation. Key Messages must include:

- Summary of the incident
- Summary of current operations
- Response Lead
- Objectives to be completed by the agency
- Planned public information activities
- Other engaged agencies

6.1 PUBLIC COMMUNICATIONS

HCPH maintains a PIO to plan and review public communications and messaging activities are outlined in the **Crisis Communications Plan**. This plan will be active during all response activities of HCPH and describes protocols by which Public Information will interface with the HCPH response organization.

Figure 4 - Communication during a Public Health Emergency



7.0 ADMINISTRATION AND FINANCE

7.1 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.

a) In an HCPH-led ICS response, finance and administration duties may be delegated by the IC to the Finance and Administration Section Chief.

b) When HCPH is engaged in coordination, these duties may be delegated by the AC to the Staff Support Section Chief.

7.2 COST RECOVERY

Cost recovery for an incident includes all costs reasonably incurred by HCPH 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.

Examples of cost recovery to be considered for incident are the following:

- Staffing/Labor: Actual wages and benefits and wages for overtime.
- 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.
- Mileage: Mileage may be applicable during the incident for the vehicles directly involved with the incident resolution.
- 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, gloves, pH paper, and chemical classifiers.
- Operational charges: Operational charges are costs to support the response. Some examples would be fuel, water, food.
- Equipment replacement: This includes material used during normal operations that must be replaced due to contamination or breakage during the incident response.

Refer to **Attachment XI – Incident Fiscal Response and Recovery** for details how HCPH will recover the costs of funds and resources expended during emergency response operations.

7.3 LEGAL SUPPORT

HCPH 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.

Legal claims in the aftermath of incidents 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 HCPH Legal Counsel could be required to attend daily operational planning and briefing sessions for their situational awareness and to provide their opinions to ensure the applicable administrative law statutes are recognized and being adhered to.

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

7.4 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 XII - Incident Documentation Guide.**

7.5 EXPEDITED ADMINISTRATIVE AND FINANCIAL ACTIONS

Expedited actions can occur in the forms of approvals for personnel actions and procurement of resources. All expedited actions will be approved by the Health Commissioner, or designee. Any approvals beyond the basic authority of the IC/AC 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 consultation with the HCPH Director of Human Resources.
- Expedited Financial and Procurement Actions: All expedited financial and procurement actions will be coordinated with the Health Commissioner (or designee) and the Finance Officer. No funding will be obligated or committed without the consent of the Finance Officer.

These actions will be tracked in the operational activity log ICS 214 form or chronology of events document and reviewed with the Health Commissioner and Finance Officer as needed. All necessary agency forms will also be completed, in addition to the incident forms.

7.6 EMERGENCY FUNDING LEGAL AUTHORITIES

In response to emergencies, governments at all levels have the ability to make funds available to responding agencies. There are two primary mechanisms by which the funds could be quickly received:

1. Funds are provided as an increase to an existing funding line. In this case, funds would be moved to agencies through an existing grant with responsibilities related to the incident to which they are responding. Moving funds in this manner may only require an abbreviated acceptance process with signature from key personnel.
2. Funds are provided as separate funding provision, through an application process. In this case, agencies will be asked to apply for funds as if they are a new grant. In an emergency, there may be an abbreviated process and elements of a standard application may be suspended. These emergency grants may require short execution periods.

To ensure rapid receipt of these funds, HCPH will expedite the approval process to the extent possible and depending on the funder through Ohio Department of Health's Grant Management Information System (GMIS) or through the Ohio Administrative Knowledge System (OAKS), or by direct receipt of payment and will work directly with key stakeholders to obtain approval of the contract relationship and support availability of additional funds. As a standard operation policy, the Health Commissioner is authorized to receive these funds and to enter into contracts to receive funds on behalf of the agency during non-emergency times as well as during emergency events.

If supplemental funding comes to HCPH as a result of an emergency or "imminent or critical public health incident" via a grant, these funds would be allocated as other grants or what is known as a "special revenue" of the Health District as such that expenses that occur due to the emergency or incident would be allocated to the grant.

If supplemental funding comes to HCPH as a result of an emergency or "imminent or critical public health incident" through a mechanism other than a grant, the funding will be allocated to the division and department(s) that is working toward or completed work on issues related to the emergency or provided services to alleviate the emergency or incident. For example, funding for an infectious disease outbreak would be allocated to the Disease Prevention Division of the Health District if their staff provided services to help with response of the outbreak.

At the BOH's monthly meeting each December, the BOH approves the expenditure limits that affect the next year's operating budget which includes use of the agency credit card for expenditures and that the Health Commissioner must receive BOH approval for expenditures that exceed $25,000 that are not specifically outlined in the budget. As part of the operating budget, an expenditure was approved of up to $50,000 for replacement computers and related hardware in the event an emergency results in damaged systems that prevent staff from providing services. Purchase orders were created in the new budget year to allow purchase of the replacements through approved vendors to allow services to resume as quickly as possible

The Health Commissioner can apply for approval of additional funds as needed to address "an imminent or critical public health incident." Additionally, during an emergency where additional staff are needed, HCPH can obtain additional personnel resources through mutual aid agreements, county resolution, volunteers, or through outside service contracting, such as when HCPH hired nurses to administer vaccines during the H1N1 pandemic.

8.0 LOGISTICS AND RESOURCE MANAGEMENT

8.1 GENERAL

HCPH has a limited amount of materiel and personnel staffing resources available for incident response, and shortfalls are most likely in these commodities. The following seven (7) levels of sourcing have been identified to fill potential resource shortfalls and minimize any time delays in acquiring the asset:

- Source 1: HCPH internal human resource/personnel and inventory management systems. All resources will be queried internally prior to engaging local and county partners or stakeholders. When HCPH requires resources that are not on-hand or have been exhausted, the agency will pursue with regional and State agency partners for resources and potentially the Medical Reserve Corps for personnel resources.

- Source 2: State agency resources. When HCPH resource avenues have been exhausted, the acting logistics section chief will work through the Hamilton County EMHSA to engage State Partners to secure a resource. Ohio EMA may choose to activate the Ohio Emergency Operations Center (Ohio EOC) and ESF Partners to identify and secure a resource (e.g., DAS, ESF-1, ESF-7).
- Source 3: MOUs and MAAs. When a required resource is needed, the Health Commissioner, or designee, will refer to existing MOUs or MAAs to fulfill resource shortfalls. See **Attachment XIII - Southwest Ohio Public Health Region (SWOPHR) Mutual Aid Agreement.** Assistance will be sought from the Finance Department or Legal, as necessary.
- Source 4: Emergency Purchasing. HCPH maintains an agency credit card. Agency staff must get approval from the Finance Director and the Health Commissioner to utilize the agency credit card to purchase items in the event of an emergency.
- Source 5: Interstate Mutual Aid Compact (IMAC). When a resource for HCPH use is not available and cannot be found in the county or the state, the Health Commissioner, or designee, can request IMAC assistance. IMAC is mutual aid agreement through which all political subdivisions can request and receive assistance from any other political subdivisions in the state.
- Source 6: Emergency Management Assistance Compact (EMAC). When a resource for HCPH use is not available and cannot be found in the county or the state, the Health Commissioner, or designee, will work through the Ohio EOC to request interstate resources using the EMAC Process.
- Source 7: Federal Assets. Specialized federal assets to include subject matter experts and material may be required to support state incident response. Federal agencies that support HCPH responsibilities include but are not limited to the CDC, Department of Health and Human Services (HHS), U.S. Environmental Protection Agency (U.S. EPA) and the Department of Energy (DOE). These assets range from requests from the CDC for SNS Medical Countermeasures (MCM) and U.S. EPA and DOE for radiation incidents.

8.2 HCPH RESOURCES

HCPH has identified the three resource priorities for fill during an incident: personnel, material/supplies and transportation.

8.2.1 PERSONNEL RESOURCES

The Planning/Planning Support Section chief will work with Human Resources to fill the shortfalls. If there are insufficient HCPH personnel staffing assets

available internally, HCPH will engage the staffing pools in section 9.3 of this plan.

8.2.2 MATERIEL RESOURCES

In an effort to fulfill materiel resource gaps the Health Commissioner, Assistant Health Commissioner(s), and/or the Logistics/Resources Support Section Chief will research for the asset internally. If the asset is not available, HCPH will do one of the following:

1) Utilize the existing Regional MAA and request the resource from a local health department in the region.
2) Contact Hamilton County EMHSA to make a resource request.
3) Contact ODH to make a resource request.
4) Purchase the resource.

If a resource is borrowed, the resource will be assigned to an equipment custodian for the duration of the incident. Request for medical countermeasures will follow the procedures set forth in the ***Medical Countermeasure Dispensing Plan***.

8.2.3 TRANSPORTATION RESOURCES

HCPH transportation assets are limited for both personnel and material transportation. During an incident response, the Health Commissioner, Assistance Health Commissioner(s), and/or the Logistics/Resources Support Section Chief will determine available HCPH vehicle fleet/ transportation assets for use in the form of vehicles for personnel and materiel transport. If the event involves medical countermeasures, HCPH has an MOU with the Cincinnati Library to provide at least 5 trucks and drivers for materiel transportation. HCPH also has the ability to rent box trucks and larger cargo vans, if needed. Any transportation needs that remain unmet after this engagement will be addressed through engagement with Hamilton County EMHSA.

8.3 MANAGEMENT AND ACCOUNTABILITY OF RESOURCES

8.3.1 MANAGEMENT OF HCPH INTERNAL RESOURCES

The management of HCPH internal resources and assets used in support of an incident will be in compliance with agency protocols. Assets, resources, supplies and material used to assist in the response will be tracked using Excel spreadsheets managed by the Finance Office, and the Inventory Management and Tracking System (IMATS) for MCM, supplies and material managed by the Emergency Preparedness Specialist.

The Logistics/Resources Support Section Chief will manage all internal and external resources and will log the following minimum information for all HCPH material assets involved in response activities:

- Asset tag number
- Serial number and model
- Equipment custodian name
- Description of asset/nomenclature
- Asset storage location
- Asset assigned location

8.3.2 MANAGEMENT OF EXTERNAL RESOURCES

Upon receipt of an external resource, the HCPH IC/AC will accept responsibility of the asset, by entering in relevant information into the tracking system designated. For equipment, supplies or MCMs received by HCPH, 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.

An equipment custodian will be assigned to each external asset received. These assets will be managed in accordance with any instructions or agreements communicated by the owning organization.

8.3.3 RESPONSIBILITIES AND SYSTEMS IN PLACE FOR MANAGING RESOURCES

Each HCPH Director is responsible for managing the internal resources that belong to their Division. When a HCPH 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.

1) When an individual HCPH employee responds or deploys to an incident with a HCPH asset, that employee becomes the equipment custodian and assumes responsibility for the asset throughout the response and demobilization phases.

2) During a response, an update of all resources deployed from HCPH (internal and external) will be compiled at the beginning of and end of each operational period for the HCPH incident lead or authorized designee throughout the response and demobilization phases.

3) 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 For 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.
OCS 213RR Adapted HCPH	Resources 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.

8.4 DEMOBILIZATION OF RESOURCES

Once the response has been scaled down, any remaining assets or equipment used during the incident will be returned to their place of origin. Upon demobilization and recovery of the HCPH asset or resource used in an incident, a full accountability of equipment returning to HCPH will be done. The asset will be inventoried and matched against the asset tag, and serial number, then inspected for damage, serviceability and cleanliness. If all equipment serviceability and cleanliness requirements are met, the assets or resource will be returned to normal service. This can be done using the ICS Form 221 Demobilization Check-Out Form.

- If the equipment deployed is lost, damaged or does not meet serviceability requirements, the HCPH incident lead, or designee and stakeholder, or equipment custodian will collaborate with the Health Commissioner or the Finance Director to determine the next steps in the reconditioning of the asset, salvage or the purchase of a replacement item. The costs for reconditioning and or replacement of the item will be included in the post-incident cost recovery process.

8.5 INTRASTATE MUTUAL AID COMPACT (IMAC)

The Ohio Intrastate Mutual Aid Compact (IMAC), Ohio Revised Code Section 5502.41, was updated on July 3, 2012. IMAC is mutual aid agreement through which all political subdivisions can request and receive assistance from any other political subdivisions in the state; many of the administrative and legal issues are resolved in advance of an incident. All political subdivisions are automatically part of IMAC. The definition of political subdivision is broad and includes not only counties, municipal corporations, villages and townships, but also port

authorities, local health districts, joint fire districts, and state institutions of higher education.

- http://codes.ohio.gov/orc/5502.41 - Intrastate Mutual Aid Compact
- http://codes.ohio.gov/orc/2744.01 - Political Subdivision Definition
- http://codes.ohio.gov/orc/3345.042 - IMAC Participation by State Institutions of Higher Education

Requests for mutual aid can now be made without a formal declaration by the chief executive of a political subdivision and 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. The regional response teams that have been developed, such as bomb, collapse search and rescue, water rescue, and hazardous materials, can also be requested and provided through this mutual aid compact.

Political subdivisions are authorized to enter into mutual aid agreements and new language expressly authorizes political subdivisions to enter into mutual aid agreements with political subdivisions in neighboring states without a governor's declaration of emergency. Many of the same protections set forth in IMAC apply to this form of mutual aid as well. Several neighboring states also have similar provisions which should make working out these mutual aid agreements much easier.

HCPH can make a request to Hamilton County EMHSA to use IMAC to request additional personnel and resources to respond to an emergency where a state of emergency is declared.

Request Process: The Health Commissioner or designee will work with Hamilton County EMHSA to fill out and approve the necessary IMAC Request documents, such as the IMAC Deployment Information Sheet and Resource Request Information Sheet.

- Hamilton County EMHSA will notify the Ohio EMA Watch Office that mutual aid may soon be requested through IMAC.
- Hamilton County EMHSA may directly contact potential assisting entities (i.e., other Ohio county EMAs) to alert them that assistance may be requested.
- See the Ohio IMAC Operations Manual for further information on the IMAC request process.

Refer to **Attachment XIV – IMAC/EMAC Request SOG** for a description of the process by which the agency provides resources in response to an IMAC request from another jurisdiction.

8.6 EMERGENCY MANAGEMENT ASSISTANCE COMPACT (EMAC)

Per State Revised Code 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.

1) 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.
2) The EMAC process may be used to support a Public Health Emergency at either a State, or local jurisdiction level.
3) The request for EMAC resources is an executive level decision. Ohio EMA will support EMAC request. The ODH Director, the Director of State Department of Public Safety, the State EMA Executive Director, and the Governor's Office dictate if EMAC assistance will be sought. To request EMAC resources there must be a Governor's declaration in State.
4) EMAC Process. The HCPH Health Commissioner will request EMAC support through Hamilton County EMHSA, who will then make the request to Ohio EMA. The Health Commissioner (or designee) will fill out and approve any necessary EMAC paperwork which may need to be completed as part of the EMAC request. All EMAC requests will follow Ohio EMA instructions and procedures.

The following website provides additional information on EMAC - https://www.emacweb.org/.

Refer to **Attachment XIV – IMAC/EMAC Request SOG** for a description of the process by which the agency provides resources in response to an EMAC request from another state.

8.7 MEMORANDUMS OF UNDERSTANDING AND MUTUAL AID AGREEMENTS

1) MOUs and MAAs are similar in that they are both designed to improve interagency or interjurisdictional assistance and coordination. MOUs/MAAs are established between emergency response agencies 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 HCPH by allowing the agency access to resources held by the organizations with which agreements have been executed. Both types of agreements must be processed through and approved by the Health Commissioner.

2) Established MOUs and MAAs are retained by each Division and Program that has an existing agreement. The EP Supervisor retains the compilation of original/official agreements. Additionally, the Finance Director 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, Assistance Health Commissioners and the EP Supervisor 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 Health Commissioner, Assistance Health Commissioners and/or the EP Supervisor EP will collaborate on execution of the MOU/MAA.
5) Refer to ***Appendix 11 – HCPH Agreements and Contingent Contracts*** for a list of MOUs and contracts which may be used during an emergency.

9.0 STAFFING

9.1 GENERAL

All HCPH employees are designated as public health responders and can be called upon to fulfill response functions during an incident. The role assigned to any HCPH employee in an incident is dependent upon the nature of the incident and the availability of staff to respond. With approval by HCPH Human Resources, 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 each Division and Human Resources. All staffing considerations will adhere to county personnel policies.

9.2 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.

HCPH will utilize the HCPH COOP Plan to inform how staff 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 HCPH COOP Plan.

9.3 STAFFING POOLS

HCPH Divisions will be tapped to provide staffing for incidents that can be effectively supported by their staff. The following HCPH staffing pools could be considered for fulfilling staffing requirements:

1) Qualified program staff from involved Divisions;
2) Specific roles for program personnel that are defined in functional or incident-specific annexes included in this plan;
3) The EP Program comprises the primary Subject Matter Experts (SME) for each of HCPH response areas; members of this group may be selected to serve key leadership roles during incident response;
4) IC/AC role may be filled by the Health Commissioner or either Assistant Health Commissioner or their designee.

Other Partner Staffing pools include the following:

1) Staffing agreements in Mutual Aid Agreements or Memorandums of Understanding -- LHDs within Hamilton County and Regional LHDs
2) County Employees – County Resolution dated 6/13/16
3) State (ODH) and Federal Agencies
4) Tristate Medical Reserve Corps
5) Contract staff, especially for positions requiring specific skills or licensure (such as nurses);
6) Staffing request through IMAC;
7) Staffing request through EMAC.

The Health Commissioner, Assistant Health Commissioner(s), EP Supervisor and Human Resources will be engaged, as appropriate, prior to outreach efforts to these alternate staffing pools.

9.4 HCPH POLICY ON USING VOLUNTEERS

HCPH actively utilizes volunteers from the Tristate Medical Reserve Corps (MRC). In the event this volunteer pool does not meet the requirements of the response, volunteers from other local volunteer programs can be utilized including the Community Emergency Response Team (CERT), Community Organizations Active in Disasters (COAD) and the American Red Cross (ARC).

Volunteers can be used in any non-supervisory capacity for volunteer activities approved by the Health Commissioner, but they must be supervised by a HCPH employee.

Volunteers may not, at any time, operate government vehicles without prior authorization and appropriate licensing. Volunteers may not work in any positions where they have access to patient data or any information protected by HIPPA.

9.5 MOBILIZATION ALERT AND NOTIFICATION

The Planning (Support) Section Chief or designee will prepare a mobilization message for dissemination to response personnel. This message will be shared with the appropriate Division Directors to be passed to their engaged staff. Staff notified for mobilization/deployment will follow these instructions:

1) **Where to report:** All personnel alerted for mobilization/deployment for an incident will report to the HCPH DOC, unless otherwise specified.

2) **When to report:** Staff alerted will report within the required time established by the IC/AC. The goal for initiating deployment is within 30 minutes of notification; arrival times may vary depending on the distance the staff must travel.

3) **Whom to report to:** The staff alerted will report to the DOC Manager or other individual, if designated. The Assistance Health Commissioner of Community Health Services or EP Supervisor will review the responsibilities of assigned staff and consult with them to ensure they are able to receive and process responding personnel.

Upon reporting to the DOC, the staff will be received, checked in, provided an incident summary, assigned and integrated into their role. 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 HCPH 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 HCPH staff member will self-deploy to an incident response**.

9.6 PSYCHOLOGICAL FIRST AID

Psychological first aid (PFA) is “a supportive and compassionate presence designed to reduce acute psychological distress and/or facilitate continued support, if necessary.” PFA includes the following components:

- Providing comfort
- Addressing immediate physical needs
- Supporting practical tasks
- Providing anticipatory information
- Listening and validating feeling
- Linking survivors to social support

- Normalizing stress reactions
- Reinforcing positive coping mechanisms

HCPH Human Resources will work through Hamilton County's Employee Assistance Program to provide grief counseling and PFA support. HCPH will reach out to the Hamilton County Mental Health and Recovery Services Board and Southwest Ohio Critical Incident Stress Management if additional PFA assistance is needed.

HCPH anticipates that PFA may be needed in any incident. Incidents for which higher demand for PFA is anticipated include the following:

- Mass fatality incidents;
- Incidents with significant impact on children;
- Incidents that require extended use of PPE;
- Incidents with significant public demonstration, e.g. vaccination campaigns with limited supply.

10.0 DISASTER DECLARATIONS

10.1 NON-DECLARED DISASTERS

HCPH 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 HCPH resources and assets as necessary to prepare for, respond to, and recover from an event.

10.2 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.

10.2.1 PROCESS FOR STATE DECLARATION OF DISASTER EMERGENCY

HCPH's role in the emergency declaration process is to provide subject matter expertise and situational information. HCPH cannot declare an emergency or disaster; only the Governor may do so. HCPH, as a county level agency, may be asked by the Hamilton County EMHSA to weigh in on the effects of a disaster and its public health implications. The Health Commissioner and any HCPH staff member that the Health Commissioner deems necessary to include will act as consultants to the Hamilton County EMHSA-led disaster declaration process. As a participant in the declaration process, HCPH 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 the Governor declares a disaster, then HCPH will coordinate with other federal, state and local agencies through the Hamilton County EOC. HCPH functions as both a primary and support agency for multiple ESFs coordinated by the Hamilton County EOC Operation Room.

10.2.2 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.

10.2.3 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

11.0 PLAN DEVELOPMENT AND MAINTENANCE

11.1 USING PEOPLE-FIRST LANGUAGE IN PLANS

People-first language is a type of linguistic prescription in English. It aims to avoid perceived and subconscious dehumanization when discussing people with disabilities and is sometimes referred to as a type of disability etiquette. People-first language can also be applied to any group that is defined by a condition rather than as a people: for example, "those that are homeless" rather than "the homeless."

The basic idea is to use a sentence structure that names the person first and the condition second, for example "people with disabilities" rather than "disabled people" or "disabled", in order to emphasize that "they are people first". Because English syntax normally places adjectives before nouns, it becomes necessary to insert relative clauses, replacing, e.g., "asthmatic person" with "a person who has asthma."

HCPH will use people-first language in all of its plans, including the Basic Plan, Attachments, Appendices and Annexes according to the ODH-provided people-first language resource described in ***Appendix 6 – Communicating with and about Individuals with Access and Functional Needs***.

11.2 PLAN FORMATTING

All plan components will align with the definitions, organization and formatting described below. Additionally, use both appropriate terminology for access and functional needs and person-first language throughout the ERP, consistent with the standards described in ***Appendix 6 - 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 referenced, annexes are designated with <u>**bold, underlined font**</u>.
- 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.

11.3 REVIEW AND DEVELOPMENT PROCESS

- The planning shall be initiated and coordinated by the EP Program. Planning shall address revisions to the ERP Basic Plan, as well as

revision or development of any other ERP components. The EP Program will form a collaborative planning team to include one or more of the following staff:

  - Assistant Health Commissioner of Community Health Services (CHS)
  - Health Commissioner
  - Emergency Preparedness Specialist
  - Representative for access and functional needs
  - SMEs from both within HCPH and without

- Revisions will be will determined on an annual revision schedule and by identifying gaps and lessons learned through exercise and real-word events, or by the direction of the Health Commissioner or the Assistance Health Commissioner of CHS. 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.
- The EP Program will develop an achievable work plan by which content will be developed, vetted and reviewed prior to final submission. The collaborative team will identify the needs for improvement and update the plan component(s). Once EP Program has prepared the plan revisions, the components will be submitted to reviewers prior to being submitted for approval. Any feedback will be incorporated and then the updated document will be presented for approval.
- Once these elements are identified, revised processes are developed for improvement or replacement. In order to maintain transparency and record of collaboration, the EP Program will record planning and collaborating meetings by designating a scribe to record meeting minutes to sustain a record of recommendations from collaborative ERP meetings. These meeting minutes may be accessed by following the below file path:
- **X:HCPH Plans and SOGs\PLANS and SOGS\BASE PLAN\HCPH Review\Plan Development**
- On the next page are the established plan, annex, attachment and appendix review schedules. The EP Program will establish a key activities schedule for the plan they are managing to meet the thresholds identified below. Planning team members will work to ensure that plan components are staggered so that reviews do not become overwhelming.

Items	Cycle
Plan	Annual
Annex	Annual
Attachment	Annual
Appendix	Annual, or as needed

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 EP Supervisor or designee.

11.4 REVIEW AND ADOPTION OF THE ERP – BASIC PLAN AND ITS ATTACHMENTS

- The basic plan and its attachments shall be reviewed by the EP Program and endorsed by the Health Commissioner. Once adopted, the basic plan and its attachments shall be reviewed annually, from the last date the plan was authorized. The purpose of this review will be to consider adoption of proposed changes, i.e., revisions, additions or deletions that were identified during the year. If adopted, the changes will be incorporated, and the basic plan and its attachments will be reauthorized.
- Any HCPH Division may initiate changes to the basic plan and its attachments by submitting the proposed changes to the EP Program for presentation to the Health Commissioner during the annual review.
- Proposed changes may be approved for use in response activities by the EP Supervisor before adoption by the Health Commissioner; such approval is only valid until the annual review, after which the Health Commissioner must have adopted the proposed changes for their continued use in response activities to be allowable.

11.5 REVIEW AND ADOPTION OF APPENDICES TO THE BASIC PLAN

- Because appendices are complementary to the basic plan, they may be approved for inclusion, revision or expansion by the EP Supervisor. Any HCPH Division may initiate changes to appendices by submitting the proposed changes to the ERP. All appendices should be reviewed by the EP Program and, if necessary, the appropriate Division Director(s) upon inclusion, revision or expansion, but it is not necessary, at any time, for the Health Commissioner to approve appendices.

11.6 DEVELOPMENT AND ADOPTION OF ANNEXES AND ITS ATTACHMENTS

- Once adopted, annexes and their attachments shall be reviewed annually. Development and adoption will be facilitated by the EP Program and conducted by a review team, which will comprise the following: (a) all HCPH Division Directors with responsibilities in the annex or attachments, (b) any other subject matter experts designated by the EP Supervisor in group a, and (c) appropriate representatives from outside the agency, including county partners and representatives of individuals with access and functional needs. The review committee will be led by a chair, who will be the EP Supervisor; this chair will be ultimate approver of both new and existing annexes and their attachments. The purpose of this review will be to consider adoption of proposed changes that were identified during the year. If adopted, the changes will be incorporated, and the revised annexes will be reauthorized by the identified approvers.
- Any HCPH Division may initiate changes to annexes and its attachments by submitting the proposed changes to the ERP for presentation to the identified reviewers. Please note that if an attachment is a directive, then that attachment must be updated through the existing directive policy.
- Proposed changes may be approved for interim use in response activities by the EP Supervisor outside the review cycle; such approval is only valid until the annual review, after which the review committee must have adopted the proposed changes for their continued use in response activities to be allowable.

11.7 DEVELOPMENT AND ADOPTION OF APPENDICES TO AN ANNEX

- Because appendices to annexes are complementary, they may be approved for inclusion, revision or expansion by the EP Supervisor at any time. Any HCPH Division may initiate changes to an appendix to an annex by submitting the proposed changes to the ERP. All appendices should be reviewed by the review committee upon inclusion, revision or expansion, but it is not necessary, at any time, for those reviewers to approve appendices before they are added to an annex.

11.8 VERSION NUMBERING AND DATING

Version history for the ERP and all of its annexes are tracked under one numbering system as follows: #.##. The first digit represents the overarching version, which accounts for the organization, structure and concepts of the ERP. The second-two digits represent revisions of or expansions of other components of the plan. 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 has to be updated. 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.

11.9 PLAN FORMATTING

For plan formatting, see ***Appendix 12 – HCPH Plan Style Guide***.

11.10 PLAN PUBLISHING

Emergency response plans will be made available for review by the public on-line on the HCPH emergency preparedness website. The EP Supervisor will be responsible for communicating to HCPH's Public Information Officer (PIO) and HCPH's Assistant Health Commissioner for CHS when the emergency response plan has been revised and new version is available for public publishing. Prior to the web publishing of the revised plan, the EP Supervisor and the Assistant Health Commissioner for CHS 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, PIO will coordinate with HCPH's Communications Specialist to publish the ERP online. Public comment to the ERP will be accepted via email and tabled in addition to the proposed changes between revision cycles for consideration.

12.0 TRAINING AND EXERCISES

<u>Training</u>

1. HCPH staff will be trained according to the standards established in the Multiyear Training and Exercise Plan (TEP) and the HCPH Workforce Development Plan.

2. At the minimum, all employees will receive introductory NIMS training and ICS (IS-100 and IS-700) within the first 6 months of hiring.

3. Employees with identified command and general staff roles will require advanced training (IS-200, IS-300, IS-400 and IS-800). Further training may be required as new procedures are developed.

4. All upper level management, Division Directors/Supervisors and employees who will serve a role in ICS will be provided DOC Training by the Emergency Preparedness Program.

5. HCPH's training and exercise programs are administered by the EP Program in coordination with the local emergency response agencies. The TEP helps prepare HCPH to optimally address both the natural and technical hazards that it faces.

6. The Multiyear TEP is a living document that will be updated and refined annually. The Multiyear TEP provides a roadmap for HCPH to follow in accomplishing the priorities described by ODH. Each priority is linked to a corresponding National Priority, and, if applicable, an Improvement Plan (IP) action.

7. Included in the Multiyear TEP is the training and exercise schedule, which provides graphic illustration of the proposed activities, scheduled over a 5-year period. It is representative of the natural progression of training and exercises that should take place in accordance with the building-block approach.

8. HCPH will work with ODH, Ohio Emergency Management Agency, Hamilton County EMHSA, local police and fire as well other partners to assure that as trainings become available through these and other partners and stakeholders; that HCPH will facilitate those applicable trainings to staff, volunteers and others.

Exercises

Training will additionally be conducted in conjunction with exercise of the Plan. The Plan shall be activated at least once a year in the form of a simulated emergency to provide practical controlled operational experience to those individuals who have emergency response roles.

13.0 DOCUMENT DEFINITIONS AND ACRONYMS

Definitions and acronyms related to the HCPH ERP Base Plan are in ***Appendix 14 – Definitions & Acronyms***.

14.0 LEGAL AUTHORITIES

The following are a list of legal authorities for local and state public health agencies.

14.1 COUNTY HEALTH DEPARTMENT AND BOARDS OF HEALTH

- *RC §301.24 County health department or agency.*
  - Provides authority to the electors to create a county health department by charter. In accordance with the county charter, the county health department shall exercise all powers and perform

all duties vested in or imposed upon authorities of city or general health districts. http://codes.ohio.gov/orc/301.24

- *RC §3709.01*
    - The state shall be divided into health districts. The townships and villages in each county shall be combined into a health district and shall be known as a "general health district." http://codes.ohio.gov/orc/3709.01
- *RC §3709.03 (A)*
    - A general health district advisory council is comprised of the president of the board of county commissioners, the chief executive of each non-city municipal corporation, and the president of the board of the township trustees of each township. http://codes.ohio.gov/orc/3709.03
- *RC §3709.02 (A)*
    - Boards of health are comprised of five members, each serving a five-year term. http://codes.ohio.gov/orc/3709.02
- *RC §3709.03 (B)*
    - This advisory council appoints four persons to serve on the board of heath, with the remaining member to be appointed by the health district licensing council. At least one member of the board of health shall be a physician. http://codes.ohio.gov/orc/3709.03

14.2 AUTHORITIES OF OHIO DEPARTMENT OF HEALTH

- *General Powers*
    - The Department of Health receives its general authority by statute.
- *RC §3701.13 Supervisory Powers*
    - The department of health shall have supervision of all matters relating to the preservation of the life and health of the people. http://codes.ohio.gov/orc/3701.13
- *RC §3701.13 "Ultimate Authority" Regarding Quarantine and Isolation.*
    - The Department of Health has "ultimate authority" in matters of quarantine and isolation, which it may declare and enforce, when neither exists, and modify, relax, or abolish, when either has been established. http://codes.ohio.gov/orc/3701.13
- *RC §3701.13 Immunization.*
    - The department may approve methods of immunization against the diseases specified in section 3313.671 of the Revised Code for the purpose of carrying out the provisions of that section and take such

actions as are necessary to encourage vaccination against those diseases. http://codes.ohio.gov/orc/3701.13

- *RC §3313.671 Immunization*
  - Requirements related to schools.http://codes.ohio.gov/orc/3313.671
- *RC §3701.352 Violation of rule or order prohibited.*
  - No person shall violate any rule the director of health or department of health adopts or any order the director or department of health issues under this chapter to prevent a threat to the public caused by a pandemic, epidemic, or bioterrorism event. http://codes.ohio.gov/orc/3701.352
- *Special Duties and Powers of Director of Health*
  - The director of health is charged with several special powers and responsibilities under Ohio law.
- *RC §3701.14 (A) Epidemic and Pandemic Investigation*
  - The director of health shall investigate or make inquiry as to the cause of disease or illness, including contagious, infectious, epidemic, pandemic, or endemic conditions, and take prompt action to control and suppress it. The reports of births and deaths, the sanitary conditions and effects of localities and employments, the personal and business habits of the people that affect their health, and the relation of the diseases of man and beast, shall be subjects of study by the director. The director may make and execute orders necessary to protect the people against diseases of lower animals, and shall collect and preserve information in respect to such matters and kindred subjects as may be useful in the discharge of the director's duties, and for dissemination among the people. When called upon by the state or local governments, or the board of health of a general or city health district, the director shall promptly investigate and report upon the water supply, sewerage, disposal of excreta of any locality, and the heating, plumbing, and ventilation of a public building. http://codes.ohio.gov/orc/3701.14
- *RC §3701.146 Powers and duties regarding tuberculosis; public health council standards.*
  - In taking actions regarding tuberculosis, the director of health has all of the following duties and powers: (1) The director shall maintain registries of hospitals, clinics, physicians, or other care providers to whom the director shall refer persons who make inquiries to the department of health regarding possible exposure to tuberculosis. (2) The director shall engage in tuberculosis surveillance activities, including the collection and analysis of epidemiological information relative to the frequency of tuberculosis infection, demographic and geographic distribution of tuberculosis

cases, and trends pertaining to tuberculosis. (3) The director shall maintain a tuberculosis registry to record the incidence of tuberculosis in this state. (4) The director may appoint physicians to serve as tuberculosis consultants for geographic regions of the state specified by the director. Each tuberculosis consultant shall act in accordance with rules the director establishes and shall be responsible for advising and assisting physicians and other health care practitioners who participate in tuberculosis control activities and for reviewing medical records pertaining to the treatment provided to individuals with tuberculosis. http://codes.ohio.gov/orc/3701.146

- *O.A.C. 3701-73-01 (A)(1) Epidemic and Pandemic Investigation*
  - Such an investigation may be initiated when a local health district has reported documented cases of illness indicative of epidemic or pandemic conditions.
- *O.A.C. 3701-73-01 (A)(1) Animal Based Diseases*
  - The director may make and execute orders necessary to protect persons from animal-based diseases.
- *RC §3701.04 (B) (2) Volunteer Responders*
  - The director may establish fees, procedures, standards, and requirements necessary for recruiting, registering, training, and deploying the volunteers. http://codes.ohio.gov/orc/3701.04
- *RC §3701.03 General duties of director of health.*
  - The director of health shall perform duties that are incident to the director's position as chief executive officer of the department of health. The director shall administer the laws relating to health and sanitation and the rules of the department of health. The director may designate employees of the department and, during public health emergency, other persons to administer the laws and rules on the director's behalf. Nothing in this section authorizes any action that prevents the fulfillment of duties or impairs the exercise of authority established by law for any other person or entity. http://codes.ohio.gov/orc/3701.03

14.3 DELEGATION OF POWERS TO LOCAL HEALTH DEPARTMENTS

- *Ex parte Company (1922), 106 Ohio St. 50, 139 N.E. 204*
  - The state may assign or delegate its power to preserve the public health and the duties incident to that power to either state or local authorities. It has done so through the General Assembly.
- *RC §3701.342*

  - The director of health shall adopt rules establishing minimum standards and optimum achievable standards for boards of health and local health departments. The minimum standards shall assure that boards of health and local health department provide for: (A) Analysis and prevention of communicable disease; (B) Analysis of the causes of, and appropriate treatment for, the leading causes of morbidity and mortality; (C) The administration and management of the local health department; (D) Access to primary health care by medically underserved individuals; (E) Environmental health management programs; (F) Health promotion services designed to encourage individual and community wellness. The director shall adopt rules establishing a formula for distribution of state health district subsidy funds to boards of health and local health departments. The formula shall provide no subsidy funds to a board or department unless it meets minimum standards and shall provide higher funding levels for boards and districts that meet optimum achievable standards. http://codes.ohio.gov/orc/3701.342
- *See D.A.B.E., Inc. v. Toledo-Lucas Cty. Bd. Of Health, 96 Ohio St. 3d 250, 773 N.E. 2d 536, 2002-Ohio-4172*
  - Local boards of health are granted broad authority for promulgating orders and regulation, so long as they possess proper rule-making authority and subject matter jurisdiction.
- *RC §3709.21*
  - The board of health of a general health district may make such orders and regulations as are necessary for its own government, for the public health, the prevention or restriction of disease, and the prevention, abatement, or suppression of nuisances. Such board may require that no human, animal, or household wastes from sanitary installations within the district be discharged into a storm sewer, open ditch, or watercourse without a permit therefor having been secured from the board under such terms as the board requires. All orders and regulations not for the government of the board, but intended for the general public, shall be adopted, recorded, and certified as are ordinances of municipal corporations and the record thereof shall be given in all courts the same effect as is given such ordinances, but the advertisements of such orders and regulations shall be by publication in a newspaper of general circulation within the district. Publication shall be made once a week for two consecutive weeks or as provided in section 7.16 of the Revised Code, and such orders and regulations shall take effect and be in force ten days from the date of the first publication. http://codes.ohio.gov/orc/3709.21

- *RC §3709.21*
    - In cases of emergency caused by epidemics of contagious or infectious diseases, or conditions or events endangering the public health, the board may declare such orders and regulations to be emergency measures, and such orders and regulations shall become effective immediately without such advertising, recording, and certifying. http://codes.ohio.gov/orc/3709.21
- *RC §307.61 Institutions subject to inspection of commissioners or board of health.*
    - Each public or private hospital, reformatory home, house of detention, private asylum, and correctional institution shall be open at all times to inspection by board of county commissioners or the board of health of the general health district or the city health district in which the institution is located. http://codes.ohio.gov/orc/307.61
- *RC §3313.67 Immunization of pupils to prevent spread of diseases….*
    - Except as provided in division (A)(2) of this section, the board of education of each city, exempted village, or local school district may make and enforce such rules to secure the immunization of, and to prevent the spread of communicable diseases among the pupils attending or eligible to attend the schools of the district, as in its opinion the safety and interest of the public require. A board of education shall not adopt rules under division (A)(1) of this section that are inconsistent with divisions (B) and (C) of section 3313.671 of the Revised Code. Boards of health, legislative authorities of municipal corporations, and boards of township trustees, on application of the board of education of the district, at the public expense, without delay, shall provide the means of immunization to pupils who are not so provided by their parents or guardians. The board of education shall keep an immunization record for each pupil, available in writing to the pupil's parent or guardian upon request, which shall include: Immunizations against the diseases mentioned in division (A) of section 3313.671 of the Revised Code; Any tuberculin tests given pursuant to section 3313.71 of the Revised Code; Any other immunizations required by the board pursuant to division (A) of this section. Annually by the fifteenth day of October, the board shall report a summary, by school, of the immunization records of all initial entry pupils in the district to the director of health, on forms prescribed by the director. http://codes.ohio.gov/orc/3313.67
- *RC §3313.68 Employment of medical personnel….*
    - The board of education of each city, exempted village, or local school district may appoint one or more school physicians and one

or more school dentists. Two or more school districts may unite and employ one such physician and at least one such dentist whose duties shall be such as are prescribed by law. Said school physician shall hold a license to practice medicine in Ohio, and each school dentist shall be licensed to practice in this state. School physicians and dentists may be discharged at any time by the board of education. School physicians and dentists shall serve one year and until their successors are appointed and shall receive such compensation as the board of education determines. The board of education may also employ registered nurses, as defined by section 4723.01 and licensed as school nurses under section 3319.22 of the Revised Code, to aid in such inspection in such ways as are prescribed by it, and to aid in the conduct and coordination of the school health service program. The school dentists shall make such examinations and diagnoses and render such remedial or corrective treatment for the school children as is prescribed by the board of education; provided that all such remedial or corrective treatment shall be limited to the children whose parents cannot otherwise provide for same, and then only with the written consent of the parents or guardians of such children. School dentists may also conduct such oral hygiene educational work as is authorized by the board of education. The board of education may delegate the duties and powers provided for in this section to the board of health or officer performing the functions of a board of health within the school district, if such board or officer is willing to assume the same. Boards of education shall co-operate with boards of health in the prevention and control of epidemics. http://codes.ohio.gov/orc/3313.68

- *RC §3707.01 Powers of board; abatement of nuisances.*
  - The board of health of a city or general health district shall abate and remove all nuisances within its jurisdiction. It may, by order, compel the owners, agents, assignees, occupants, or tenants of any lot, property, building, or structure to abate and remove any nuisance therein, and prosecute such persons for neglect or refusal to obey such orders. Except in cities having a building department, or otherwise exercising the power to regulate the erection of buildings, the board may regulate the location, construction, and repair of water closets, privies, cesspools, sinks, plumbing, and drains. In cities having such departments or exercising such power, the legislative authority, by ordinance, shall prescribe such rules and regulations as are approved by the board and shall provide for their enforcement. The board may regulate the location, construction, and repair of yards, pens, and stables, and the use, emptying, and cleaning of such yards, pens, and stables and of water closets, privies, cesspools, sinks, plumbing, drains, or other places where offensive or dangerous substances or liquids are or

may accumulate. When a building, erection, excavation, premises, business, pursuit, matter, or thing, or the sewerage, drainage, plumbing, or ventilation thereof is, in the opinion of the board, in a condition dangerous to life or health, and when a building or structure is occupied or rented for living or business purposes and sanitary plumbing and sewerage are feasible and necessary, but neglected or refused, the board may declare it a public nuisance and order it to be removed, abated, suspended, altered, or otherwise improved or purified by the owner, agent, or other person having control thereof or responsible for such condition, and may prosecute him for the refusal or neglect to obey such order. The board may, by its officers and employees, remove, abate, suspend, alter, or otherwise improve or purify such nuisance and certify the costs and expense thereof to the county auditor, to be assessed against the property and thereby made a lien upon it and collected as other taxes. http://codes.ohio.gov/orc/3707.01

- *RC §3707.02 Proceedings when order of board is neglected or disregarded.*
    - When an order of the board of health of a city or general health district, made pursuant to section 3707.01 of the Revised Code, is neglected or disregarded, in whole or in part, the board may elect to cause the arrest and prosecution of all persons offending, or to perform, by its officers and employees, what the offending parties should have done. If the latter course is chosen, before the execution of the order is begun, the board shall cause a citation to issue and be served upon the persons responsible, if residing within the jurisdiction of the board, but if not, such citation shall be mailed to such persons by registered letter, if the address is known or can be found by ordinary diligence. If the address cannot be found, the board shall cause the citation to be left upon the premises, in charge of any person residing thereon, otherwise it shall be posted conspicuously thereon. The citation shall briefly recite the cause of complaint, and require the owner or other persons responsible to appear before the board at a time and place stated, or as soon thereafter as a hearing can be had, and show cause why the board should not proceed and furnish the material and labor necessary and remove the cause of complaint. If the persons cited appear, they shall be fully apprised of the cause of complaint and given a fair hearing. The board shall then make such order as it deems proper, and if material or labor is necessary to satisfy the order, and the persons cited promise, within a definite and reasonable time, to furnish them, the board shall grant such time. If no promise is made, or kept, the board shall furnish the material and labor, cause the work to be done, and certify the cost and expense to the county auditor. If the material and labor are itemized and the statement is accompanied by the certificate of the

president of the board, attested by the clerk, reciting the order of the board and that the amount is correct, the auditor has no discretion, but shall place such sum against the property upon which the material and labor were expended, which shall, from the date of entry, be a lien upon the property and be paid as other taxes are paid. http://codes.ohio.gov/orc/3707.02

- *RC §3707.021 Injunction.*
  - When an order of the board of health of a city or general health district, made pursuant to section 3707.01 of the Revised Code, is not complied with in whole or in part, the board may petition the court of common pleas for an injunction requiring all persons to whom such order of the board is directed to comply with such order. The court of the county in which the offense is alleged to be occurring may grant such injunctive relief as the equities of the case require. http://codes.ohio.gov/orc/3707.021
- *RC §3707.03 Correction of nuisance or unsanitary conditions on school property.*
  - The board of health of a city or general health district shall abate all nuisances and may remove or correct all conditions detrimental to health or well-being found upon school property by serving an order upon the board of education, school board, or other person responsible for such property, for the abatement of such nuisance or condition within a reasonable but fixed time. The board of health may appoint such number of inspectors of schools and school buildings as is necessary to properly carry out this section. http://codes.ohio.gov/orc/3707.03+
- *RC §3707.07 Complaint concerning prevalence of disease; inspection by Health Commissioner.*
  - Upon a complaint or a reasonable belief that an infectious or contagious disease exists in a house or other locality, the city board of health/general health district shall have the site inspected by its Health Commissioner. If the disease exists, the board may send the person(s) diseased to a hospital or other place provided for such person(s), may restrain the person(s) exposed from interaction with others, and prohibit ingress/egress to/from the premises. http://codes.ohio.gov/orc/3707.07+
- *RC §3707.08 Isolation of persons exposed to communicable disease; placarding of premises.*
  - When a person known to be exposed to a communicable disease declared quarantinable by the board of health of a city or general health district or department of health is reported, the board shall restrict the person to his place of residence or other suitable place, prohibit entrance to or exit from the place without the board's

permission, and enforce any restrictive measures prescribed by the department. When the person is required by the board or department of health to be isolated, the board shall at once separate the person from others in the premises. The board shall place a placard in a prominent place at the premises identifying the name of the disease. No person isolated or quarantined by a board shall leave the premises without the written permission of the board. http://codes.ohio.gov/orc/3707.08

- *RC §3707.09 Board may employ quarantine guards.*
    - The board of health of a city/general health district may employ persons to execute its orders and properly guard any house or place containing a quarantined person. http://codes.ohio.gov/orc/3707.09+
- *RC §3707.14 Maintenance of persons confined in quarantined house.*
    - The board of health of a city/general health district shall provide necessities of life for persons confined in a house due to quarantine for contagious diseases. Person quarantined is responsible for cost, unless unable to pay, and, when not, the municipal corporation is responsible for the cost. http://codes.ohio.gov/orc/3707.14+
- *RC §3707.16 Attendance at gatherings by quarantined person prohibited.*
    - No person isolated or quarantined for a communicable disease shall attend any public, private, or parochial school or college, Sunday school, church, or any other public gathering until released from isolation or quarantine by the board. http://codes.ohio.gov/orc/3707.16+
- *RC §3707.17 Quarantine in place other than that of legal settlement.*
    - When a person is quarantined in a county by a city or general health district but has a legal settlement in a municipal corporation or township within the same county other than that in which quarantined or in another county and the individual is unable to pay expenses associated with the service, the place of legal settlement shall be notified and is responsible for such expenses. http://codes.ohio.gov/orc/3707.17+
- *RC §3707.18 Expense of quarantining county public institution.*
    - The expenses for quarantining a county home or other public institution shall be paid by the county when properly certified by the president and clerk of the board of health, or Health Commissioner where there is no board, of the city or general health district in which such institution is located. http://codes.ohio.gov/orc/3707.18+

- *RC §3707.23 Examination of common carriers by board during quarantine.*
    - When a quarantine is declared, all railroads, steamboats, or other common carriers, and the owners, consignees, or assignees of any railroad, steamboat, or other vehicle used for the transportation of passengers, baggage, or freight, shall submit to any rules or regulations imposed and any examination required by a board of health of a city or general health district or Health Commissioner. http://codes.ohio.gov/orc/3707.23+
- *RC §3707.25 Application of quarantine rules to persons and goods on vehicles of transportation.*
    - Rules and regulations passed by a board of health or Health Commissioner shall apply to all persons, goods, or effects arriving by railroad, steamboat, or other vehicle of transportation, after quarantine is declared. http://codes.ohio.gov/orc/3707.25+
- *RC §3707.26 Board shall inspect schools and may close them.*
    - During an epidemic or threatened epidemic, or when a dangerous communicable disease is unusually prevalent, the board may close any school and prohibit public gatherings for as long as necessary. http://codes.ohio.gov/orc/3707.26+
- *RC §3707.30 Care and control of hospital; removal of persons to hospital.*
    - When a person suffering from a dangerous contagious disease is found in a hotel, lodging-house, boardinghouse, tenement house, or other public place in the municipal corporation, the board, if it deems it necessary for the protection of the public health, may remove the person to a hospital. http://codes.ohio.gov/orc/3707.30+
- *RC §3707.31 Establishment of quarantine hospital.*
    - A municipal corporation may establish a quarantine hospital within or without its limits. When great emergency exists, the board of health of a city/general health district may seize, occupy, and temporarily use for a quarantine hospital a suitable vacant house or building within its jurisdiction. http://codes.ohio.gov/orc/3707.31+
- *RC §3707.32 Erection of temporary buildings by board; destruction of property.*
    - The board of health of a city/general health district may erect temporary wooden buildings or field hospital necessary for the isolation or protection of persons or freight thought to be infected, and may employ nurses, physicians, and laborers to operate them, and sufficient police to guard them. The board may disinfect, renovate, or destroy bedding, clothing, or other property when deemed necessary or a reasonable precaution against the spread

of contagious or infectious diseases. http://codes.ohio.gov/orc/3707.32+

- *RC §3707.34 Authority of Health Commissioner regarding quarantine and isolation provisions.*
  - The Health Commissioner of a general or city health district may act on behalf of the board in administering RC sections 3707.04 to 3707.32 regarding quarantine and isolation if the commissioner acts pursuant to a policy the board adopts as described in this section. Each board of health shall adopt a policy specifying the actions a Health Commissioner may take pursuant to this section. http://codes.ohio.gov/orc/3707.34+
- *RC §3701.56 Enforcement of rules and regulations.*
  - The boards of health of a general or city health district, police officers, sheriffs, and others shall enforce the quarantine and isolation orders, and the rules adopted by the Ohio Department of Health (ODH). http://codes.ohio.gov/orc/3701.56+
- *RC §3701.57 Prosecutions and proceedings; injunctive or other relief.*
  - Authorizes the director of health, the board of health of a general or city health district, or any person charged with enforcing the rules of the ODH (under Chapter 3701), to petition the court of common pleas in which the offense is alleged to be occurring. The court may grant injunctive or other appropriate relief as the equities of the case require. http://codes.ohio.gov/orc/3701.57+
- *RC §3707.05 Limitations on Authority*
  - Local boards of health may not take certain actions without permission from the Department of Health. Local boards may not close or prohibit travel on public highways. Local boards may not establish a quarantine of one municipal corporation or township against another. http://codes.ohio.gov/orc/3707.05+
- *RC §3701.13 and RC §3701.28 Statutory Instruction*
  - Statutory language indicates that orders and regulations of the Department of Health trump those of the local health boards. *State Retains Ultimate Control over Public Health Matters*
- *State Bd. Of Health v. city of Greenville (1912), 86 Ohio St. 1, 98 N.E. 1019*
  - The Ohio Supreme Court has determined the grant to a municipality of certain public health powers is not a relinquishment of the state's health control and authority within the municipality's territorial limits. *Public Health Matter of Statewide Concern*

- *Kraus v. City of Cleveland (C.P. 1953), 55 Ohio Op.6, 116 N.E. 2d 779, judgment aff'd (1955) 163 Ohio St. 559, 127 N.E.2d 609.*
  - Since the subject of public health is a matter of statewide concern, courts find the enactments of the General Assembly prevail over local enactments that are in conflict.

15.0 REFERENCES

15.1 FEDERAL

1) National Response Framework (NRF), 2016

2) The National Incident Management System (NIMS), 2008

15.2 STATE

1) Ohio Department of Health Emergency Operations Plan – Basic Plan

2) Ohio Emergency Management Agency Enhanced Hazard Mitigation Plan, 2011.

3) Ohio Emergency Operations Plan, 2016

15.3 COUNTY

1) Hamilton County Emergency Management & Homeland Security Agency Emergency Operations Plan, 2016

2) Hamilton County Emergency Management & Homeland Security Agency Threat and Hazard Identification and Risk Assessment (THIRA), July 2016

ATTACHMENT I – GCDPC/HCPH INTERFACE PROCEDURE

DOCUMENT DESCRIPTION

The purpose of this attachment describes HCPH's roles and responsibilities that directly support Greater Cincinnati Disaster Preparedness Coalition (GCDPC) members during response and recovery.

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HCPH ROLES AND RESPONSIBILITIES

HCPH is a member of the Greater Cincinnati Disaster Preparedness Coalition (GCDPC). DPC's overarching role is to support the health of the community as whole and responsible for control of scare supplies. HCPH may also:

- Support epidemiologic training and investigation;
- Support prevention strategies;
- Assist public communication and outreach tools;
- Provide guidance on legal authorities of surveillance, investigation, enforcement, declaration of emergency;
- Support scare resource access (stockpiles, etc.).

During and after a response, HCPH may support GCDPC by the following:

- Information sharing with GCDPC;
- Conduct assessments of public health/medical needs;
  - Health surveillance
  - Medical surge
- Provide health/medical/veterinary equipment and supplies;
- Assist with patient movement;
- Provide public health and medical information;
- Assist with mass fatality management;
- Support facility operations through provision of expedited inspections;
- Actively participate in a coordinated response between the healthcare and public health sectors for successful management.

ATTACHMENT II - PUBLIC HEALTH OPERATIONS GUIDE

DOCUMENT DESCRIPTION

The content of the Operations Guide (OG) is intended to provide guidance for emergency operations in regards to any planned or unplanned public health event. Position descriptions, checklists, and diagrams are provided to facilitate that guidance. The information contained in this document is intended to enhance the user's experience, training, and knowledge in the application of the emergency response and management principles. This document complies with the intent and tenets of the National Incident Management System (NIMS).

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SECTION I

INTRODUCTION

This guide is intended to be used by HCPH employees who are responsible for initiating emergency response activities. It should be maintained by, and kept with, its primary user at all times. A small blank notebook or writing pad should be kept with this guide at all times to record thoughts and ideas generated through the use of the guide during the response to an incident. This guide is not intended to replace existing emergency operations plans, procedures, or guidelines. It is consistent with the doctrine, concepts, principles, terminology, organizational processes, and guidance in the National Response Framework (NRF) and the National Incident Management System (NIMS).

The guide begins with a brief section on incident action steps common to most emergencies that should be conducted by HCPH response staff. The next section provides guidance and information on emergency response actions that should be initiated during the first 24 hours of an incident. This section is divided into three response timeframes: Immediate (hours 0-2), Intermediate (hours 2-6 and 6-12), and Extended (hours 12-24). After these action steps there is a section on the HCPH emergency response structure. The final section of the guide lists ongoing public health functions and tasks that should be considered beyond the first 24 hours of the response to an incident.

INCIDENT ACTION STEPS

- ☐ Incident detection
- ☐ Incident size-up and assessment
- ☐ Determine activation level
    - Determine DOC activation (see **Attachment III - DOC Activation Standard Operating Procedure**)
- ☐ Establish response organization
- ☐ Issue activation notifications
- ☐ Activate DOC if needed
    - Utilize **Attachment III - DOC Activation Standard Operating Procedure**
- ☐ Prepare ICS 201 form
    - Establish incident objectives
    - Establish operational period and initial staff schedules
    - Establish EEIs
        - See ***Appendix 8 - EEI Requirements***
    - Establish communications plan and provide needed equipment

- ☐ Begin chronology
- ☐ Establish end-state goal
- ☐ Mobilize response staff
- ☐ Establish battle rhythm
    - o Establish SitRep schedule and recipients
        - See **Attachment VII - Situation Report Template**
    - o Establish meeting schedule and participants
        - See **Attachment IX - Battle Rhythm Template**
    - o Establish briefing schedule
        - See **Attachment IX - Battle Rhythm Template**
- ☐ Hold initial incident briefing
- ☐ Determine notification needed for external stakeholders and engage
    - o ODH
    - o Hamilton County EMHSA
    - o Elected Officials
    - o Local partners
    - o Media
    - o Regional Coordinator
    - o Access and Functional Needs Partners
    - o Federal partners
- ☐ Prepare and distribute initial SitRep to identified recipients
- ☐ Begin drafting IAP
    - o See **Attachment V - Incident Action Plan Template**
    - o See planning P – See ***Appendix 5 – The Planning Process***.
        - Initial Incident Actions
        - Maintenance Actions:
- ☐ Review and Revise end-state goal as needed.
- ☐ Issue regular SitReps
- ☐ Maintain Chronology documentation
- ☐ Prepare incident briefings
- ☐ Repeat the Planning Process through each operational period.
    - o End of Incident Actions:
- ☐ Begin Demobilization

- ☐ Complete Demobilization
- ☐ Enter Recovery Phase

INCIDENT DETECTION, ASSESSMENT & ACTIVATION

This section describes the process for activating the ERP. The ERP may be activated in one of two ways:

- The Health Commissioner personally 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 Health Commissioner is not available, either Assistant Health Commissioner or the EP Supervisor can authorize activation of the ERP. If the ERP is activated in this way, response will begin 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 Health Commissioner. Barring deactivation by the Health Commissioner, response personnel then complete identified response actions.

Activation of the ERP marks the beginning of the response.

INCIDENT DETECTION

Any HCPH staff who 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 divisions beyond the currently involved division(s), with an expectation for significant, interdivision 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 HCPH;
- Need for resources or support from outside HCPH;
- Significant or potentially significant mortality or morbidity;
- The incident has required response from other agencies, and it is likely to or has already required response from the local jurisdiction's health department.

INCIDENT ASSESSMENT

The Incident Assessment is the parallel of the “Incident Size-Up” described in the Incident Command System (ICS). It is a formal process for reviewing and evaluating an emergency incident and informs the level of activation. The assessment can be done either via a telephone or a face-to-face meeting. The purpose of the assessment is to review the situation, determine the activation level, and document the decision.

Supervisors/Directors will immediately inform one or both Assistant Health Commissioners and the Health Commissioner of any incident that they believe is likely to require activation of the ERP. Following notification, one or both of the Assistant Health Commissioners will contact the Emergency Preparedness Supervisor. These notifications will trigger an Initial Incident Assessment Meeting, which must take place via phone or face-to-face within 1 hour of the initial detection of the threat.

During the Incident Assessment Meeting, those in attendance will go through the following Incident Assessment Meeting agenda items as outlined below:

1. Incident Summary
2. Situation Overview
3. Response Requirements
4. Establish Current Organization
5. Adjourn

The outcome of the Incident Action Meeting will determine the activation level.

ERP ACTIVATION

The results of the Initial Incident Assessment Meeting will determine if the plan will be activated and the Activation Level. After determining the necessary activation level during the Initial Incident Assessment Meeting, activation of the plan will occur. Activation of the ERP indicates that the incident is of sufficient significance to warrant a response beyond day-to-day operations

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

If it is determined there is a need to activate the ERP, then the decision is posed to those in the Incident Assessment Meeting whether to activate the HCPH DOC in support of the ERP.

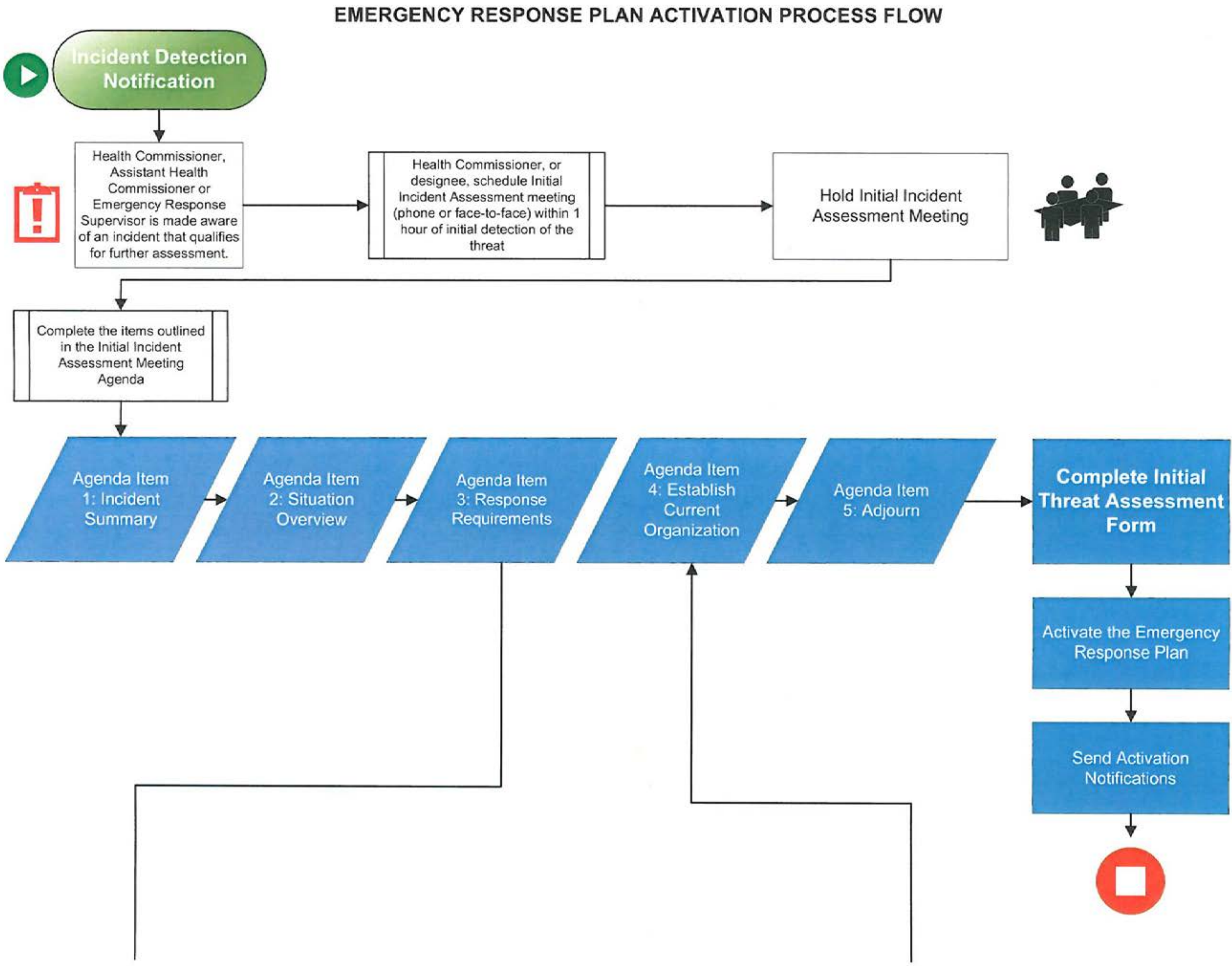
Once the determination is made to activate the ERP, the meeting group will identify whether the incident requires Command or Coordination.

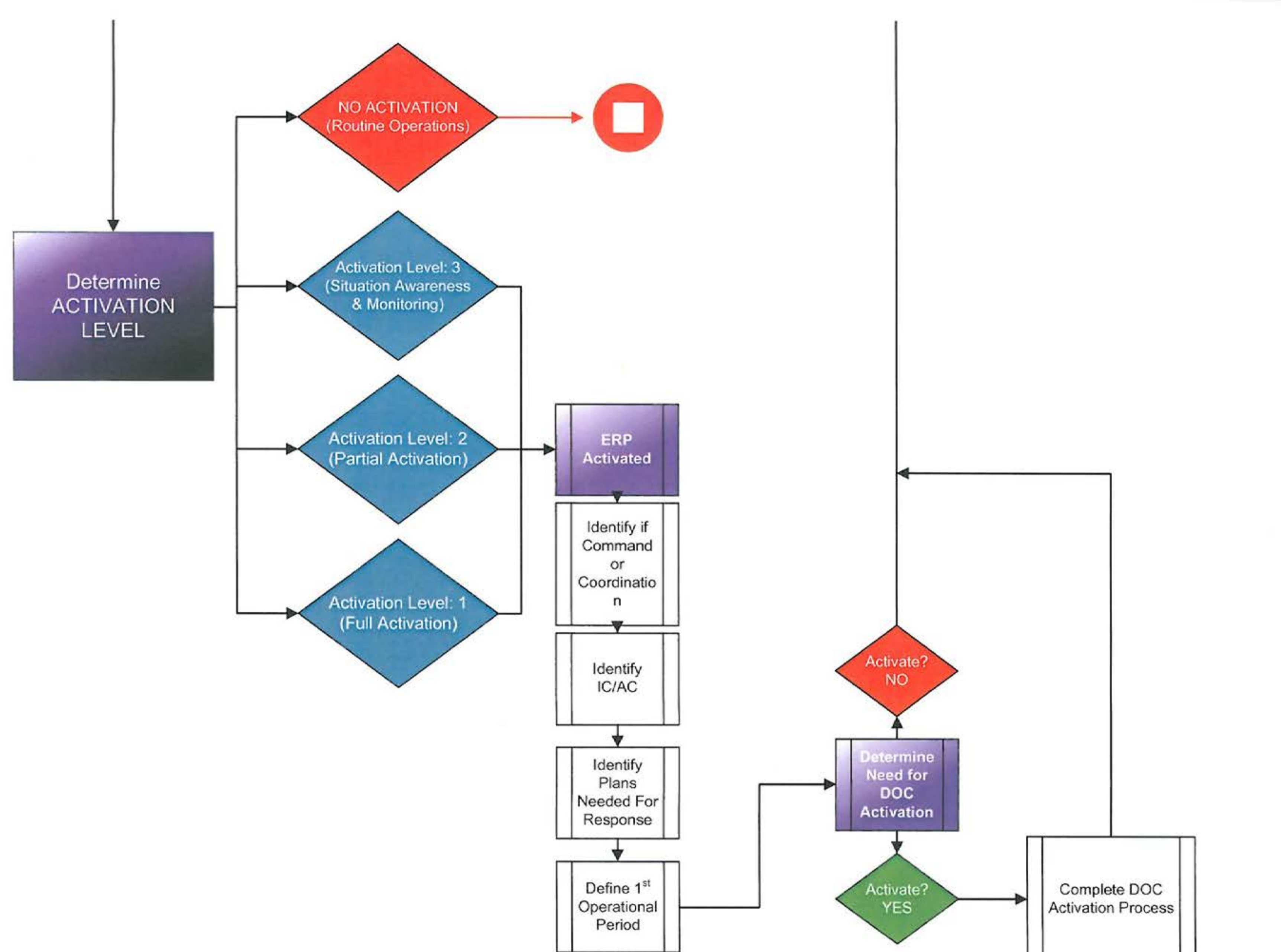
- If HCPH is in the command of the incident, then an Incident Commander will be identified by the Incident Assessment Meeting group.

- If HCPH is supporting the ICS with coordination, then an Agency Coordinator will be identified by the Initial Assessment Meeting group.

Activation Level	Description	Minimum Command Function & Staffing Recommendations
Level 1 Routine Operations	Routine incidents to which HCPH responds on a daily basis and for which day-to-day SOPs and programmatic resources are sufficient.	Normal, Day-to-Day Staff DOC not activated
Level 2 Situation Awareness & Monitoring	• An emergency with limited severity, size, or actual/potential impact on health or welfare but that cannot be handled at the programmatic level • Requires a minimal amount of coordination and agency engagement to conduct response; situational awareness and limited coordination are the primary activities • Examples: Power outage in a nursing home; water disruption requiring limited state support	•Response Lead (1) •Public Information (1) •Situation Awareness Section (1) Consider activation of the DOC Hamilton County EOC unlikely to be activated
Level 3 Partial Activation	• An emergency with moderate-to-high severity, size, or actual/potential impact on health or welfare • Requires significant coordination and agency engagement to conduct response, likely with significant engagement from other county partners; Hamilton County EOC may be activated • Examples: Widespread radiation contamination in a facility; multicounty disease outbreak requiring significant local support; water disruption requiring substantial state support and guidance; flooding	•Response Lead (1) •Public Information (1) •Partner engagement (1) •Situational Awareness (2) •Planning Support (1) •Operational Coordination (1) •Resources Support (1) •Staffing Support (1) DOC activation required Hamilton County EOC may be activated
Level 4 Full Activation	• An incident with extensive severity, size, or actual/potential impact on health or welfare; may be of such magnitude that the available assets that were put in place for the response are completely overwhelmed • Requires an extreme amount of coordination and agency engagement to conduct response; almost certain engagement of multiple state partners; Hamilton County EOC most likely activated • Examples: Pandemic influenza; mass casualty incident from chemical plume; bioterrorism attack; tornado	FULL STAFFING: • Response Lead (1) •All Section/Function Leads and key support staff (16+) • All other functions and positions, as identified by activated plans DOC activation required Hamilton County EOC activated

Execution of the ERP may require staff mobilization and activation of the HCPH DOC. The HCPH DOC is a facility/location where the agency's response personnel can be collected to promote coordination of response activities. The HCPH DOC is located at 250 William Howard Taft Road, Cincinnati, Ohio 45219. The flow chart on the next page outlines the ERP Activation Process Flow.


EMERGENCY RESPONSE PLAN ACTIVATION PROCESS FLOW
Incident Detection Notification
Health Commissioner, Assistant Health Commissioner or Emergency Response Supervisor is made aware of an incident that qualifies for further assessment.
Health Commissioner, or designee, schedule Initial Incident Assessment meeting (phone or face-to-face) within 1 hour of initial detection of the threat
Hold Initial Incident Assessment Meeting
Complete the items outlined in the Initial Incident Assessment Meeting Agenda
Agenda Item 1: Incident Summary
Agenda Item 2: Situation Overview
Agenda Item 3: Response Requirements
Agenda Item 4: Establish Current Organization
Agenda Item 5: Adjourn
Complete Initial Threat Assessment Form
Activate the Emergency Response Plan
Send Activation Notifications


NO ACTIVATION
(Routine Operations)
Determine
ACTIVATION
LEVEL
Activation Level: 3
(Situation Awareness
& Monitoring)
Activation Level: 2
(Partial Activation)
Activation Level: 1
(Full Activation)
ERP
Activated
Identify if
Command
or
Coordinatio
n
Identify
IC/AC
Identify
Plans
Needed For
Response
Define 1st
Operational
Period
Activate?
NO
Determine
Need for
DOC
Activation
Activate?
YES
Complete DOC
Activation Process

ACTIVATION NOTIFICATIONS

If the ERP is activated, the Health Commissioner, or other designee, will determine if the following partners will be notified that we have activated our ERP:

- Directors/Supervisors
- Hamilton County EMHSA
- Board of Health
- Elected Officials
- Other Hamilton County Local Health Departments
- SWOPHR leadership group
- Other community partners

Activation notifications include, at a minimum, the following pieces of information:

1. A summary of the incident.
2. A description of the activation level the agency is operating under.
3. Primary points of contact for the incident.
4. Estimated time for distribution of the first Situation Report.
5. DOC activation status.

Notifications can be made via the Operational Public Health Communication System (OPHCS) and/or email within a least one (1) hour of the conclusion of the Incident Assessment Meeting or the determination that the ERP has been activated.

DOC ACTIVATION

Execution of the ERP may require staff mobilization and activation of the HCPH Department Operations Center (DOC). The HCPH DOC is facility where the agency's response personnel can be collocated to promote coordination of response activities. Activation of the DOC is described in **Attachment III: DOC Activation Standard Operating Procedure**.

COMMON RESPONSIBILITIES CHECKLIST

In addition to position specific responsibilities, the following checklist indicates minimum common responsibilities and requirements. Some tasks are one-time, while others are ongoing for the duration of the incident. Tasks may be delegated to appropriate staff as necessary. This does not relieve the primary agency or representative from performing the roles and responsibilities identified in HCPH plans.

INITIAL/BEGINNING OF OPERATIONAL PERIOD ACTIONS

- ☐ Receive assignment from HCPH and activation instructions.
- ☐ Obtain information on reporting location, time, and travel instructions.
- ☐ Assess personal preparedness and equipment readiness (e.g. personal medications, computer, etc.).
- ☐ Start ICS 214 – Unit/Activity Log.
- ☐ Upon arrival, check in at the designated reporting location. If reporting to your normal work location, make contact with your supervisor and Section Supervisor.
- ☐ Obtain any special communication equipment needed to perform assigned tasks.
- ☐ If applicable, log onto computers and/or programs necessary for the performance of your duties.
- ☐ Acquire work materials necessary to perform your duties.
- ☐ Receive updated briefing from immediate section chief and obtain relevant information related to your position.
- ☐ Establish functionality of assigned position and confirm readiness with your section chief.
- ☐ Participate in meetings and briefings as required or assigned.
- ☐ Conduct all tasks in accordance with HCPH safety policies and directions provided by the Safety Officer and/or your supervisor. Report any unsafe acts or conditions.
- ☐ Complete forms and reports required of your assigned position and ensure proper disposition of assigned incident documentation.
- ☐ Verify that assigned equipment is operational prior to each shift or operational period.
- ☐ Observe all required rest periods.
- ☐ Report any injuries, illnesses, or signs of fatigue in yourself or coworkers to your supervisor.
- ☐ Observe all coworkers for signs of stress or inappropriate behavior. Report concerns to the Safety Officer.

CORE OPERATIONAL PERIOD ACTIONS

- ☐ Maintain ICS 214 – Unit/Activity Log and ICS 252 – Timekeeping Log.
- ☐ Cooperate and work with any assigned supporting agencies and partners.
- ☐ Evaluate progress and unmet needs to determine necessary actions.
- ☐ As applicable to your responsibilities, review and act upon incoming requests and messages using appropriate forms, and/or other applicable software programs.
- ☐ Provide requested information to your section chief.
- ☐ Attend general, staff, and unit planning meetings and briefings as required.
- ☐ Identify and provide outstanding resource requests to your section chief and document using appropriate forms, and/or other applicable software programs.
- ☐ Maintain and account for any assigned personnel and equipment.
- ☐ Cooperate with supporting agencies to determine status of ongoing requests and support activities.
- ☐ Identify and support the reporting times for information supplied by your position, especially information utilized to build situation reports (SITREPs) and the Incident Action Plan (IAP) or Support Plan (SP).
- ☐ Alert your section chief of unusual situations or problems. Pass on information received that would trigger a heightened response.
- ☐ Ensure all activities are documented in the appropriate logs and/or forms.

END OF OPERATIONAL PERIOD CLOSEOUT ACTIONS

- ☐ As applicable for your position, prepare end of shift status report(s).
- ☐ Review outstanding action requests to determine outstanding needs.
- ☐ Brief shift replacement of on-going operations and review previous assigned tasks and unmet needs.
- ☐ Complete any necessary time reporting including ICS 252 – Timekeeping Log.

DEMOBILIZATION

- ☐ Submit all documentation and completed forms to your section chief or the Planning Section/ Documentation Unit, if it is activated.
- ☐ Support development and implementation of the Demobilization Plan.
- ☐ Respond to and support demobilization orders and procedures.
- ☐ Prepare personal belongings for demobilization.
- ☐ Return all assigned equipment to appropriate location.
- ☐ Complete demobilization process checklist.

- ☐ Follow proper checkout/closeout procedures.
- ☐ Facilitate the return of assigned personnel and equipment to their normal status.
- ☐ As directed, participate in after action debriefings and activities.
- ☐ If requested, participate with any special after incident studies or after action reviews (AAR).

COMMON LEADERSHIP RESPONSIBILITIES

- ☐ Determine resource needs and organizational structure; activate additional resources and personnel as dictated by the incident.
- ☐ Request additional staff as appropriate.
- ☐ Request supplies via section chiefs and Logistics.
- ☐ Participate in or conduct incident meetings and briefings, as required.
- ☐ Determine current status of section/unit activities.
- ☐ Confirm requests and estimated time of arrival for staff and supplies.
- ☐ Maintain situational awareness of activated resources.
- ☐ Brief incoming staff.
- ☐ Conduct or arrange for just-in-time training needed for direct reports.
- ☐ Assign staff to specific duties.
- ☐ Identify potential sources of outside assistance, such as contractors and equipment vendors.
- ☐ Develop and implement accountability, safety, and security for personnel and resources.
- ☐ Provide Staff Support Section Chief with a list of supplies to be replenished.
- ☐ Supervise demobilization of unit.

PUBLIC HEALTH EMERGENCY RESPONSE FUNCTIONS AND TASKS DURING THE ACUTE PHASE

This section provides guidance and information on response activities that should be initiated during the first 24 hours (i.e., the acute phase) of most emergencies and disasters. Specific functions and tasks are divided into three response timeframes:

1. **Immediate;**
2. **Intermediate;**
3. **Extended.**

The order in which these activities are undertaken may vary according to the specific incident, particularly during a biological incident or infectious disease outbreak. Because emergency response is a dynamic process, these activities may be repeated

at various stages of the response. Your health department should function as part of a larger overall emergency response effort. In most instances, your health department will not take the lead in responding to an incident. Your health department should always function within the emergency operations plans, procedures, guidelines, and incident management system used by your community.

The following guidance and information should be used as a reference until existing emergency operations plans, procedures, and guidelines are accessed. Each function and task outlined in the following sections of the guide should be accomplished in accordance with existing emergency operations plans, procedures, and guidelines.

IMMEDIATE RESPONSE: HOURS 0 – 2

1. ASSESS THE SITUATION

Initiate the response by assessing the situation. Ask yourself the following questions and use a small blank notebook, writing pad, or other appropriate form(s) to record thoughts and ideas:

- ✓ Should public health become involved in the response? If so, in what way(s)?
- ✓ What public health function(s) has been or may be adversely impacted?
- ✓ What geographical area(s) has been or may be adversely impacted? Does it fall within your 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?
- ✓ Does HCPH have existing mutual-aid agreements with other agencies, organizations, or jurisdictions?
- ✓ 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, state, or tribal Emergency Operations Center (EOC) been activated? If so, where is it operating?

2. CONTACT KEY HEALTH PERSONNEL

Contact personnel within your health department that have emergency response roles and responsibilities. Examples include:

- Administration/Leadership
- Emergency Response Coordinators
- Environmental Health Specialists
- Epidemiologists
- Safety and Health Specialists
- Laboratory Personnel
- Mental and Behavioral Health Personnel
- Medical Officers/Nurses
- Public Information Officer (PIO)
- Medical Examiners/Coroners
- Animal Control Personnel
- Liaisons
- Technical, logistical, and other support personnel

Coordinate with other healthcare providers as necessary. Record all contacts, including unsuccessful attempts, and follow-up actions.

3. DEVELOP INITIAL HEALTH RESPONSE OBJECTIVES AND ESTABLISH AN ACTION PLAN

Develop initial health response objectives that are specific, measurable, achievable, and time-framed. Establish an action plan based on your assessment of the situation. Assign responsibilities and record all actions.

MANAGEMENT BY OBJECTIVES

Within ICS, management by objectives covers six essential steps. These steps take place on every incident regardless of size or complexity.

1. Understand agency authorities, policies and directives
2. Establish incident objectives and priorities
3. Select appropriate strategy
4. Apply tactics appropriate to the strategy
5. Monitor the performance of tactical operations
6. Adjust strategy and tactics as needed to achieve objectives

Objectives answer the question, "What" with regards to desired outcomes and are statements of intent related to the overall incident. Priorities are situational and influenced by many factors, with Safety of Life always being the highest priority. In the planning cycle, incident objectives are established at the initial command meeting. Proper leadership involves developing incident objectives that can effectively guide a large response organization from the initial emergency and crises phase through the cleanup and recovery phase. Objectives all too often cause weak direction and improper tasking. To ensure that the established objectives are appropriate, incident needs must inform the established objectives and their completion timeframes, rather than internal, agency resources.

When objectives are poorly written the responders are not sure what the Command has in mind and are open to a wide range of interpretation that may or may not be on course. Poorly written objectives are:

1. Too general to be meaningful;
2. Incompatible with the resource status;
3. Incapable of accomplishment;
4. Inappropriately assigned;
5. Too limiting to allow the use of alternative approaches or innovation;
6. Incomplete or unclear;
7. Simply unintelligible.

Enter clear, concise statements of the objectives for managing the response. Ideally, these objectives will be listed in priority order. These objectives are for the incident response for this operational period as well as for the duration of the incident. Include alternative and/or specific tactical objectives as applicable.

Objectives should follow the SMART model:

Specific - Provide a precise, unambiguous description of what must be done.

Measurable - Ensure that progress toward and achievement of the objective are determinable.

Action oriented - Use action verbs to describe the expected accomplishment.

Realistic - Ensure it is achievable with the resources that the agency (and assisting agencies) can allocate to the incident, even though it may take several operational periods to accomplish

Time sensitive - Specify the time within which it must be accomplished.

DEVELOPMENT OF INCIDENT OBJECTIVES

Development of objectives is part of the planning cycle. The initial objective-setting process is dynamic and deliberate. As the process goes through a few cycles, it becomes a more open style that addresses all stakeholders concerns. The planning cycle has a four-step pattern that is repeated during each operational period and includes developing the following:

1. Constraints: Understanding the boundaries and setting limits on the response;
2. Objectives: Identifying what to accomplish;
3. Strategy: Deciding on a methodology for accomplishing critical tasks;
4. Tactics: Providing tasking and making assignments for the next operational period.

The four-step pattern emerges quickly as command self-imposes boundaries and limits on response actions (step 1) and directs people to take certain actions (step 2) in a specific way (step 3) in a specific time period (step 4). The first sequence of efforts by responders results in some impact. Based on the feedback, additional objectives are set to continue to mitigate the incident. This cycle happens naturally and repetitively from the initial response actions to the end of the response. However, it works more efficiently if it is part of a pre-incident preparedness planning and exercise program. Initially, the cycle is short and rapid and lengthens as the response grows allowing more time for incident action planning. Command communicates the objectives to a large response organization through Incident Action Plans (IAP), Support Plans (SP) and briefings. Command may divide incident objectives into general objectives and operational (or tactical) objectives in the IAP. General objectives are those broad objectives and policy statements that are usually replicated on each IAP or SP. Operational objectives are those objectives in the IAP/SP that are applicable to the next operational period. These objectives may be continued from the previous IAP/SP if they were not accomplished and/or may be newly stated objectives for the next operational period.

The objective development process works well when facilitated, and when all participants are motivated to work together and desire the best outcome for the incident response. As a rule, there should be no more than seven operational objectives for a given operational period. As objectives are realized, additional ones will naturally follow in subsequent operational periods.

METHODS USED TO DEVELOP INCIDENT OBJECTIVES

The following are four methods used to develop objectives. Each method may be used alone or in combination with one or more of the other methods:

1. Checklist: Used in the early phase of the response to ensure key items are completed. It has pre-assigned responsibilities which helps speed up the response. It gives the UC an opportunity to focus on the unique rather than the common place aspects of the response. It ensures key issues are not overlooked. It can be tailored to the agency's mission. It can list the key tasks of command and general staff positions. It is good for the first four to six hours of a large response effort.

2. Pro-forma Objectives: Used in the early part of the response. They are a short list of generalized objectives that can help provide focus for a growing and expanding organization. They can be customized by adding specifics to general objectives when tasking commercial contractors. They highlight the major concerns of the organization and details are added by command as the response unfolds.

3. Matrix: This method divides the incident into manageable geographic zones and lists objectives for each zone. The UC considers the concerns in each zone and turns each problem into an objective. The y-axis of the matrix lists problem categories (i.e., people, property, environmental issues, economic or funding issues, information and communication needs). The x-axis lists geographic zones (i.e., on-scene, primary response zone, surrounding zone). Most of the problems, concerns and impacts related to the incident should not be overlooked if each box on the matrix is completed with accurate information.

4. Critical Success Factors: Objectives are linked to performance or results. Objectives are set to ensure the CSFs are met.

OBJECTIVE TRACKING

Any time HCPH is actively engaged in an emergency response, whether leading response or supporting response, objectives will be documented and tracked, initially through the ICS 201 form, then through subsequent operational periods by utilizing IAPs/SPs. As needed, objectives will be revised to reflect current incident needs and the response situation.

Mission requests may be received through WebEOC. These mission requests should also be documented and tracked independently of WebEOC in a spreadsheet maintained by response staff in the Planning Section or Planning Support Section.

4. ENSURE THAT THE SITE HEALTH AND SAFETY PLAN (HASP) IS ESTABLISHED, REVIEWED, AND FOLLOWED

Coordinate with the safety officer to identify hazards or unsafe conditions associated with the incident and immediately alert and inform appropriate supervisors and leadership personnel. This can be achieved through site safety briefings and at shift changes. Responder safety and health reports, updates, and briefings should be initiated at this stage of the response. Ensure that medical personnel are available to evaluate and treat response personnel.

5. ESTABLISH COMMUNICATIONS WITH KEY HEALTH AND MEDICAL ORGANIZATIONS

Establish communications with other health and medical agencies, facilities, and organizations that have emergency response roles and responsibilities, and verify their treatment and support capacities (e.g., patient isolation and/or decontamination, etc.) Examples include:

- Emergency Medical Services (EMS)

- Hospitals and clinics
- Laboratories
- Nursing homes/assisted living facilities
- Home health care agencies
- Psychiatric/mental/behavioral health and social services providers
- State and county medical societies
- Liaisons (to special populations, etc.)
- Other health and medical entities, as appropriate

Record all contacts, including unsuccessful attempts, and any follow-up actions.

6. ASSIGN AND DEPLOY RESOURCES AND ASSETS TO ACHIEVE ESTABLISHED INITIAL HEALTH RESPONSE OBJECTIVES

Many objectives may not be achieved immediately during the response. Effective allocation and monitoring of health resources and assets will be required to sustain 24-hour response operations.

7. ADDRESS REQUESTS FOR ASSISTANCE AND INFORMATION

As part of the community response effort, ensure that health-related requests for assistance and information from other agencies, organizations, and the public are either directed to appropriate personnel within your health department or forwarded to appropriate agencies and organizations.

8. INITIATE RISK COMMUNICATIONS ACTIVITIES

Determine whether a Joint Information Center (JIC) and the local or state Emergency Operations Center (EOC) are operational. If so, ensure that a health representative(s) from your department has been assigned as part of a Joint Information System (JIS) to establish communications and maintain close coordination with the JIC. Local public health representative(s) may or may not be physically located in the JIC based on the specific incident and established emergency operations plans, procedures, and guidelines.

Ensure that contact has been established with appropriate personnel within your health department and initiate risk communication activities. Remember to communicate public health messages in the appropriate language(s) to persons with limited English proficiency. A public health information “hotline” can be established to address requests for information from the public.

REMINDER!
PREPARING MESSAGES
EMPLOY THE STARCC PRINCIPLE

YOUR PUBLIC MESSAGE IN A CRISIS MUST BE:

SIMPLE . . . FRIGHTENED PEOPLE DON'T WANT TO HEAR BIG WORDS
TIMELY . . . FRIGHTENED PEOPLE WANT INFORMATION NOW
ACCURATE . . . FRIGHTENED PEOPLE WON'T GET NUANCES SO GIVE IT STRAIGHT
RELEVANT . . . ANSWER THEIR QUESTIONS AND GIVE ACTION STEPS
CREDIBLE . . . EMPATHY AND OPENNESS ARE KEY TO CREDIBILITY
CONSISTENT . . . THE SLIGHTEST CHANGE IN THE MESSAGE IS UPSETTING AND DISSECTED BY ALL

Source: Reynolds, B., Crisis and Emergency Risk Communication by Leaders for Leaders. Atlanta, GA: Centers for Disease Control and Prevention, 2004

9. ENGAGE LEGAL COUNSEL AS PART OF THE EMERGENCY RESPONSE EFFORT

Stay apprised of legal issues as they emerge and consult with appropriate personnel within your health department and jurisdiction.

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 Director of Health,
- Anything else for which legal counsel is normally sought.

HCPH legal counsel is integrated at the outset through the activation notification. There are no internal approvals required to engage the HCPH legal counsel; the IC/AC, their designee or any program staff who normally engage legal may reach out. Contact information for HCPH's legal counsel can be found in **Section 5.3.7** of the HCPH ERP.

10. DOCUMENT ALL RESPONSE ACTIVITIES

Document all response activities using the form(s) within your health department. **Templates 1 through 7** at the back of the guide can also assist with the documentation of response activities.

IMMEDIATE RESPONSE: HOURS 2 – 6

INITIATE THE FOLLOWING ACTIVITIES:

1. VERIFY THAT HEALTH SURVEILLANCE SYSTEMS ARE OPERATIONAL

Health surveillance systems should be fully operational to begin the process of data collection and analysis. Consider human subjects and privacy issues related to data collection, analysis, and storage.

2. ENSURE THAT LABORATORIES LIKELY TO BE USED DURING THE RESPONSE ARE OPERATIONAL AND VERIFY THEIR ANALYTICAL CAPACITY

Laboratories likely to be used during the response should be fully operational to begin the process of specimen collection and analysis. Notify laboratories of any changes in activity during the response. Provide laboratories with lead time to prepare for sample testing and analysis.

3. ENSURE THAT THE NEEDS OF SPECIAL POPULATIONS ARE BEING ADDRESSED

Ensure that the needs of special populations are being addressed through the provision of appropriate information and assistance.

Examples of special populations include:

- Children
- Dialysis patients
- Disabled persons
- Homebound patients
- Patients dependent on home health care services
- Institutionalized persons
- Persons with limited English proficiency
- The elderly
- Transient populations (tourists, migrant workers, the homeless, carnival/fair workers, etc.)

4. HEALTH-RELATED VOLUNTEERS AND DONATIONS

Communicate frequently with the public regarding whether or not health-related volunteers and donations are needed. Volunteer agencies (e.g., the Red Cross) have their own needs that may differ from those of your health department. Volunteer medical personnel must be properly credentialed and insured.

5. UPDATED RISK COMMUNICATIONS MESSAGES

Ensure that risk communication messages are updated and coordinated with other responding agencies and organizations as necessary. If a Joint Information Center (JIC) is operational, update and release messages through the JIC. Ensure that messages on public health information "hotlines" are updated as necessary.

IMMEDIATE RESPONSE: HOURS 6 – 12

INITIATE THE FOLLOWING ACTIVITIES:

1. COLLECT AND ANALYZE DATA THAT ARE BECO MING AVAILABLE THROUGH HEALTH SURVEILLANCE AND LABORATORY SYSTEMS

Begin collecting and analyzing data that are becoming available through established health surveillance systems and laboratories, and evaluate any real-time sampling data. Communicate results to appropriate personnel in a timely manner through established operations plans, procedures, or guidelines.

2. PREPARE AND UPDATE INFORMATION FOR SHIFT CHANGE AND EXECUTIVE BRIEFINGS

Initiate staffing plan and update contact information and rosters to be used by incoming personnel. Apprise incoming personnel of response actions being taken, pending decisions and issues, deployment of resources and assets, updated health response objectives, and current media activities.

3. PREPARE FOR FEDERAL ON-SITE ASSISTANCE

Prepare for the arrival of federal onsite assistance and for the integration of these personnel, resources, and assets into the locally established response structure. Examples include:

- Technical experts and Emergency Response Coordinators (ERCs)
- U.S. Department of Health and Human Services (HHS) Incident Response Coordination Team (IRCT)
- Centers for Disease Control and Prevention (CDC) personnel
- Strategic National Stockpile (SNS)
- Federal Medical Station (FMS)
- Environmental Response Team (ERT)
- U.S. Environmental Protection Agency (EPA) Radiological Emergency Response Team (RERT)

- Veterans Health Administration (VHA) Medical Emergency Radiology Response Team (MERRT)
- Federal Radiological Monitoring and Assessment Center (FRMAC) personnel
- National Disaster Medical System (NDMS) Teams:
    - Disaster Medical Assistance Team (DMAT)
    - National Medical Response Team (NMRT)
    - Disaster Mortuary Operational Response Team (DMORT)
    - National Veterinary Response Team (NVRT)
- U.S. Public Health Service (USPHS) Commissioned Corps Teams
    - Rapid Deployment Force (RDF)
    - Applied Public Health Team (APHT)
    - Mental Health Team (MHT)
- Administration for Children and Families (ACF) Disaster Case Management (DCM) Teams
- Personnel, equipment, resources, and assets via the Emergency Management Assistance Compact (EMAC)
- Other specialized response teams

4. ASSESS HEALTH RESOURCE NEEDS AND ACQUIRE AS NECESSARY

Resources and capacity to meet health response objectives must be reviewed periodically and appropriate action taken to ensure their availability. Effective allocation and monitoring of health resources and assets will be required to sustain 24-hour and extended response operations.

EXTENDED RESPONSE: HOURS 12 – 24

INITIATE THE FOLLOWING ACTIONS

1. ADDRESS MENTAL HEALTH AND BEHAVIORAL HEALTH SUPPORT NEEDS

Initiate preparations for providing mental and behavioral health services, and social services, to health department staff, response personnel, and other persons affected by the event. Address required comfort needs of health department staff.

2. PREPARE FOR TRANSITION TO EXTENDED OPERATIONS OR RESPONSE DISENGAGEMENT

Consider and assess public health functions and tasks that will need to be addressed beyond the first 24 hours (i.e., the acute phase) of the incident based on incoming data and developments. Begin developing a strategy for disengaging and demobilizing public health from the response effort based on the analysis and results of incoming data and existing response objectives.

The state has a critical role in supporting local recovery efforts. Post-disaster recovery is a locally driven process, and the state supports communities by coordinating and/or providing any needed technical or financial support to help communities address recovery needs.

RECOVERY CONTINUUM

The recovery process is best described as a sequence of interdependent and often concurrent activities that progressively advance a community toward its planned recovery outcomes. Decisions made and priorities set by a community pre-disaster and early in the recovery process have a cascading effect on the nature, speed, and inclusiveness of recovery. **Figure 1** depicts the interconnectedness of recovery activities from pre-incident through the long term.

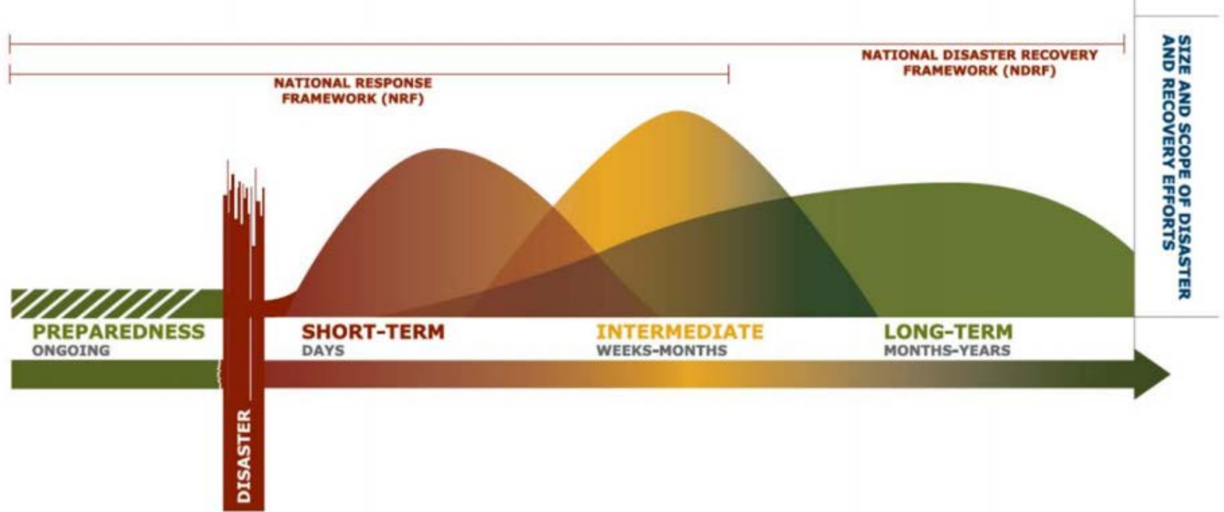


Figure 1: Recovery Continuum

Some of the activities that may occur in the transition to recovery include:

- ☐ Coordination of documentation (gathering and archiving all documents regarding the incident, including costs and decision making).
- ☐ Archiving of data and contact information (ensuring that data and information such as “time snapshots” of GIS maps or contact names and numbers of those participating in EOC activities is captured and available for review and use through the recovery process).
- ☐ Conducting after-action reviews.
- ☐ Advocating for State and Federal Assistance (creating a narrative of the event for the purposes of obtaining Federal assistance).
- ☐ Establishing Disaster Recovery Centers (in most cases, the establishment of a DRC is the responsibility of the impacted community in the early stages of recovery).
- ☐ Working with CDC, the State and other Federal entities.

- ☐ Helping the community to manage expectations (continuing a public information plan or strategy through the transition and into recovery).

The Recovery mission area defines capabilities necessary for communities affected or threatened by any incident to rebuild infrastructure systems, provide adequate, accessible interim and long-term housing that meets the needs of all survivors, revitalize health systems (including behavioral health) and social and community services, promote economic development, and restore natural and cultural resources. The ability to manage recovery effectively begins with pre-disaster preparedness and requires support and resources focused on recovery at the immediate onset of an incident.

Planning
Conduct a systematic process engaging the whole community as appropriate in the development of executable strategic, operational, and/or tactical- level approaches to meet defined objectives.
Public Information and Warning
Deliver coordinated, prompt, reliable, and actionable information to the whole community through the use of clear, consistent, accessible, and culturally and linguistically appropriate methods to effectively relay information regarding any threat or hazard and, as appropriate, the actions being taken and the assistance being made available.
Operational Coordination
Establish and maintain a unified and coordinated operational structure and process that appropriately integrates all critical stakeholders and supports the execution of core capabilities.
Economic Recovery
Return economic and business activities (including food and agriculture) to a healthy state and develop new business and employment opportunities that result in an economically viable community.
Health and Social Services
Restore and improve health and social services capabilities and networks to promote the resilience, independence, health (including behavioral health), and well-being of the whole community.
Housing
Implement housing solutions that effectively support the needs of the whole community and contribute to its sustainability and resilience.
Infrastructure Systems
Stabilize critical infrastructure functions, minimize health and safety threats, and efficiently restore and revitalize systems and services to support a viable, resilient community.
Natural and Cultural Resources
Protect natural and cultural resources and historic properties through appropriate planning, mitigation, response, and recovery actions to preserve, conserve, rehabilitate, and restore them consistent with post disaster community priorities and best practices and in compliance with applicable environmental and historic preservation laws and executive orders.

ON-GOING PUBLIC HEALTH EMERGENCY RESPONSE FUNCTIONS AND TASKS

This section provides a list of public health emergency response functions, tasks, and prevention services that may need to be implemented during an emergency or disaster beyond the first 24 hours (i.e., the acute phase) of the response. These activities should be considered regardless of the type of incident (i.e., natural or technological/man-made). The order in which these activities are undertaken may vary according to the specific incident, particularly during a biological incident or infectious disease outbreak, and geographic location. This information should be used as a reference until existing emergency operations plans, procedures, and guidelines are accessed.

- Environmental hazard identification
- Hazards consultation
- Epidemiological services
- Health and medical needs assessment
- Identification of affected individuals
- Contamination control
- Health surveillance
- Laboratory specimen collection and analysis
- Infectious disease identification, treatment, and control
- Quarantine/isolation
- Public health information
- Risk communication
- Responder safety and health
- Health and medical personnel resources
- Health and medical equipment safety and availability
- Health-related volunteer and donation coordination
- In-hospital care
- Evacuation
- Sheltering
- Special populations’ needs and assistance
- Mass trauma
- Mass fatalities
- Mortuary services

- Mental/behavioral health care and social services
- Potable water
- Food safety
- Vector control and pest management
- Wastewater and solid-waste management/disposal
- Building/facility assessment
- Sanitation/hygiene services
- Continuity of public health programs, services, and infrastructure
- Veterinary services
- Animal rescue/control/shelters
- Long-term community recovery

SECTION II

COUNTY-LEVEL INCIDENT SUPPORT

The National Response Framework (NRF) defines "emergency management" as the coordination and integration of all activities necessary to build, sustain, and improve the capability to prepare for, protect against, respond to, recover from, or mitigate threatened or actual natural disasters, acts of terrorism, or other man-made disasters. HCPH is a county agency responsible for the health and well-being of people residing in HCPH service jurisdictions, doing all it can to prevent infections, injuries, and illnesses from ever occurring by supporting our capability to prepare for, protect against, respond to, recover from, and mitigate all hazards in relation to public health and medical services. Understanding where HCPH fits in the county emergency management effort and its relationships with all levels of emergency management is essential in defining the HCPH response structure.

The HCPH response structure is aligned by the functions it performs to meet HCPH's mission. This has the following advantages:

- HCPH response structure is aligned to its primary missions.
- Planning support, situational awareness, resources support, and Staff support are addressed as separate functions.
- No redundancy of function exists between incident, the county-level, and the state-level.
- The alignment makes resource support efficient.
- The alignment promotes unity of effort.

HCPH RESPONSE STRUCTURE

The HCPH response structure is based upon a dual approach. The first relies on the incident command system for those time when HCPH is the incident lead when responding, such as during a radiation incident within the state. The second approach is a multiagency coordination center (MAC) structure that coordinates HCPH's support for disasters and emergencies, including catastrophic incidents and emergency management program implementation.

There are several ways in which these response structures may be activated. During the initial stages of a response HCPH will, as part of the whole community, focus on projected, potential, or escalating critical incident activities, such as the following:

- Situational Assessment
- Public Messaging
- Command, Control and Coordination
- Critical Communications

- Environmental Health and Safety
- Health and Medical Treatment

The HCPH response structure is activated to either command or coordinate with the affected jurisdiction(s) and provides needed resources and policy guidance in support of incident-level operations. HCPH response staff provide coordination, conduct planning, deploy resources, and collect and disseminate incident information as it builds and maintains situational awareness. HCPH response staff do the following:

- Maintains situational awareness of specific potential threats, events, or incidents.
- Collects, validates, analyzes and distributes incident information.
- Coordinates the use of HCPH resources through mission assignments and interagency agreements.
- Develops the HCPH Support Plan and Functional Plans to source and address identified resource shortfalls.
- Coordinates with the affected jurisdiction(s) to determine initial requirements for HCPH assistance.
- Coordinates support and situational reporting with the Hamilton County EMHSA EOC.
- Deploys initial response resources and other disaster commodities when required.

ORGANIZATION AND STRUCTURE

When not in ICS, HCPH utilizes a multi-agency coordination system for engagement. This response structure is organized into five functional sections coordinated by the Agency Coordinator (AC). These sections are Situational Awareness, Operations Support, Planning Support, Resources Support, and Staff Support. Through these areas HCPH is able to coordinate with the local, state and federal partners to provide support to the incident, and also to receive information on the status of the incident.

Organizing by functional sections provides the opportunity to better align HCPH with the National Incident Management System and ICS principles. Functions are determined by grouping related responsibilities within a section. This functional-organization approach enhances coordination, communications, and facilitation by focusing HCPH efforts to achieve essential tasks for emergency response.

INCIDENT COMMAND SYSTEM OVERVIEW

For the purpose of incident command, HPCH adheres to the structures and principles outlined in ICS and NIMS when leading response. Majority of incidents will not require HCPH to be at the incident level leading response, but rather will require HCPH to support incident response from the county level. As such, majority of this guide will focus on the HCPH response structure for multi-agency coordination.

ICS is a standardized, all hazards incident management approach that:

- Allows for the integrations of facilities, equipment, personnel, procedures and communication operating within a common organizational structure;
- Enables coordinated response among various Departments, Agencies and Jurisdictions; and
- Establishes common processes for planning and managing resources.

ICS is flexible and can be used for incidents of any type, scope and complexity. It allows for its users to adopt an integrated organizational structure to match the complexities and demand of single or multiple incidents.

ICS provides a common management system for people with varying backgrounds, skills and expertise to function within one organization. ICS is a changeable, scalable response organization which allows users to build a management system to fit the needs of the emergency event. To staff the ICS Organization, people may be drawn from multiple agencies that do not routinely work together, and ICS is designed to give standard response and operation procedures to reduce the problems and potential for miscommunication on such incidents.

ESSENTIAL FEATURES

There are 14 essential features of ICS:

1. ***Common Terminology:*** When different organizations are required to work together, the use of common terminology is an essential element in team cohesion and communications. An ICS promotes the use of common terminology and has an associated glossary of terms that help bring consistency to things such as position titles, description of resources and how they can be organized, and the type and names of incident facilities.
2. ***Modular Organization:*** The ICS is organized in such a way as to expand and contract as needed by the incident scope, resources, and hazards. Command is established in a top- down fashion, with the most important and authoritative positions established first.
3. ***Management by Objectives:*** Incidents are managed by aiming toward specific objectives. Objectives are ranked by priority, should be as specific as possible, and must be attainable. Objectives are accomplished by first outlining strategies (general plans of action), then determining appropriate tactics (how the strategy will be executed) for the chosen strategy.
4. ***Incident Action Planning:*** Incident Action Plans (IAPs) ensure that everyone is working in concert toward the same goals by providing all incident supervisory personnel with direction for actions to be taken during the operational period identified in the plan. IAPs provide a coherent means of communicating the overall incident objectives for both operational and support activities. At the core of a functional IAP are well-written objectives. The standard acronym is “SMART” objectives: objectives that are (1) Specific, (2) Measurable, (3) Achievable, (4) Realistic, and (5) Time-sensitive.

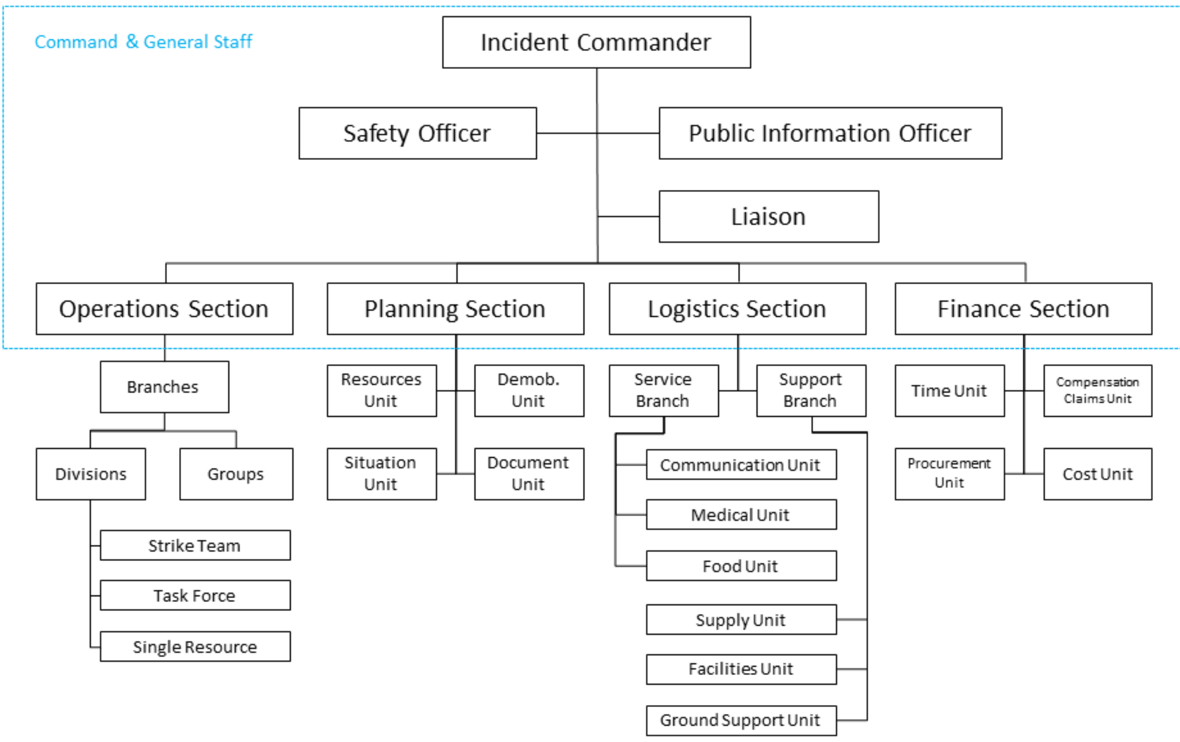
5. ***Manageable Span of Control:*** To limit the number of responsibilities and resources being managed by any individual, the ICS requires that any single person's span of control should be between three and seven individuals, with five being ideal. In other words, one manager should have no more than seven people working under them at any given time. If more than seven resources are being managed by an individual, then they are most likely being overloaded and the command structure needs to be expanded by delegating responsibilities (e.g. by defining new sections, divisions, or task forces). If fewer than three, then the position's authority can probably be absorbed by the next highest rung in the chain of command.
6. ***Incident Locations and Facilities:*** Various types of operational support facilities are established in the vicinity of an incident to accomplish a variety of purposes. Typical designated facilities include Incident Command Posts, Staging Areas, Mass Casualty Triage Areas, and others as required.
7. ***Comprehensive Resource Management:*** A key emergency management principle is that all assets and personnel during an event need to be tracked and accounted for. Comprehensive resource management ensures that visibility is maintained over all resources so they can be moved quickly to support the preparation and response to an incident, and it helps ensure a coordinated demobilization.
8. ***Integrated Communications:*** The use of a common communications plan is essential for ensuring that responders can communicate with one another during an incident. Communication equipment, procedures, and systems must operate across jurisdictions (interoperable).
9. ***Establishment and Transfer of Command:*** A role of responsibility can be transferred during an incident for several reasons: As the incident grows, a more qualified person is required to take over as Incident Commander to handle the ever-growing needs of the incident, or in reverse when an incident reduces in size to the point that command can be passed down to a less qualified person. Other reasons to transfer command include jurisdictional change, if the incident moves locations or area of responsibility, or normal turnover of personnel due to extended incidents.
10. ***Chain of Command:*** Each individual participating in the operation reports to only one supervisor. This eliminates the potential for individuals to receive conflicting orders from a variety of supervisors, thus increasing accountability, preventing freelancing, improving the flow of information, helping with the coordination of operational efforts, and enhancing operational safety.
11. ***Unified Command:*** A Unified Command involves two or more individuals sharing the authority normally held by a single Incident Commander (IC). Unified Command is used on larger incidents usually when multiple agencies or multiple jurisdictions are involved.
12. ***Accountability:*** Effective accountability at all levels and within individual functional areas during an incident is essential. For this reason, ICS requires

individuals to adhere to specific procedures regarding such things as checking in and out at their assigned work area, tracking equipment/resources assigned to them, and reporting to their IC Supervisor at established intervals.

13. ***Dispatch/Deployment:*** This concept refers to the idea that personnel and equipment should only respond/be dispatched when requested by an appropriate authority. Despite good intentions, self-deployed personnel and resources can make it more difficult for resource managers to effectively manage an emergency.
14. ***Information and Intelligence Management:*** This refers to the processes that an organization will use to gather, analyze, share, and manage incident-related information and intelligence to maintain a common operation picture and situational awareness.

ORGANIZATIONAL ELEMENTS

At each level within an ICS organization, individuals with primary responsibilities have distinct titles, and follow this typical organizational structure (Note, HCPH has additional specific positions that build out from these standard positions):



The standard organizational elements are described below:

Command Staff: These individuals report directly to the Incident Commander (IC) and consist of the Public Information Officer (PIO), Safety Officer, and Liaison Officer.

Section: The organization level having functional responsibility for primary segments of incident management (Operations, Planning, Logistics, Finance/Administration). The Section level is organizationally between Branch and IC.

Branch: The organizational level having functional responsibility for major parts of the incident operations. The Branch level is organizationally between Section and Division/Group in the Operations Section, and between Section and Units in the Logistics Section.

Division: The organizational level having responsibility for operations. The Division level is organizationally between the Strike Team and the Branch.

Group: Groups are established to divide the incident into functional areas of operation. Groups are organizationally located between Branches (when activated) and Resources in the Operations Section.

Unit: The organization element having functional responsibility for a specific incident planning, logistics, or finance/administration activity.

Task Force: A dissimilar group of resources with common communications and a leader that may be pre-established and sent to an incident, or formed at an incident.

Strike Team: Specified combinations of the same kind and type of resources (similar), with common communications and a leader.

Single Resource: An individual piece of equipment and its personnel complement, or an established crew or team of individuals with an identified work supervisor that can be used on an incident.

The following table shows the standard ICS titles associated with the various organizational levels, and the titles of support personnel:

Organizational Level	Title	Support Position
Incident Command	Incident Commander	Deputy
Command Staff	Officer	Assistant
General Staff (Section)	Chief	Deputy
Branch	Director	Deputy
Division / Group	Supervisor	None Applicable
Unit	Leader	Manager
Strike Team / Task Force	Leader	Single Resource Boss

The following provides brief descriptions of the responsibilities normally assigned to Command and General Staff positions within the ICS structure:

Command Staff	Responsibilities
Public Information Officer	Determine, according to direction from the IC, any limits on information release and develop accurate, accessible, and timely information for use in press/media briefings. Conduct periodic media briefings and arrange for tours and other interviews or briefings that may be required. Monitor and forward media information that may be useful to incident planning and maintain current information for incident responders.
Safety Officer	Identify and mitigate hazardous situations and ensure safety messages and briefings are made. Exercise emergency authority to stop and prevent unsafe acts. Review the Incident Action Plan for safety implications and assign assistants qualified to evaluate special hazards. Initiate preliminary investigation of accidents within the incident area and review and approve the Medical Plan.
Liaison Officer	Act as a point of contact for other agency representatives. Maintain a list of assisting and cooperating agencies and agency representatives, and assist in setting up and coordinating interagency contacts. Monitor incident operations to identify current or potential inter-organizational problems. Participate in planning meetings providing current resource status, including limitations and capabilities of agency resources. Provide agency-specific demobilization information and requirements.

General Staff	Responsibilities
Finance Section Chief	Manage all financial, administrative, cost tracking, claims, and procurement aspects of an incident.
Logistics Section Chief	Provide facilities, services, and material in support of the incident response and the IC.
Operations Section Chief	Manages all tactical operations at an incident in accordance with the IAP.
Planning Section Chief	Provides planning services for the incident. Collects situation and resources status information, evaluates it, and processes the information for use in developing action plans.

HCPH ICS POSITIONS

When activated at HCPH, ICS provides a framework within which personnel and resources can be applied to an incident in a structured, cost-effective manner to drive quickly and efficiently toward successful incident resolution. The HCPH ICS structure includes elements of coordination, command and control, planning, finance and administration, logistics and operations.

The primary coordination center for HCPH is the Department Operations Center (DOC) but could also include the Hamilton County EMHSA EOC.

The HCPH Health Commissioner serves as the Agency Administrator, defined as the Chief Executive Officer (or designee) of the agency or jurisdiction that has responsibility for the incident. The Health Commissioner has the ultimate agency decision making authority; provides the delegation of authority to the Incident Commander or Agency Coordinator; and sets the agency priorities, critical information requirements, and essential elements of information during the initial stages of response activation.

The Health Commissioner receives guidance and direction from HCPH senior management, which is comprised of Assistant Health Commissioners, Division Directors and Division Supervisors. Additionally, when requested, HCPH will support a second Executive Group established by the Hamilton County EMHSA EOC with senior HCPH leadership group members as designated by the Health Commissioner.

PLANNING

The Planning function is responsible for the collection, evaluation, dissemination, and use of information about the incident situation. Under ICS activation, the Planning Section can include a Planning Section Chief (PSC), Resource Unit Leader (RESL), Situation Unit Leader (SITL), Documentation Unit Leader (DOCL), Demobilization Unit Leader (DMOB), and Technical Specialists, among others. Planning prepares status reports, accumulates and posts situation information, maintains status of resources assigned to the incident, and prepares and documents the IAP.

Incident action planning is more than just preparation and distribution of the IAP. It includes routine activities performed during each operational period of an incident response that provide a steady tempo and routine structure to incident management. The ICS Planning “P” is a guide to the steps, relative chronology, and basic elements for managing an incident (see ***Appendix 5 – The Planning Process***). By incorporating the Planning “P” into planning efforts, a framework for incident management can be established that provides a rough playbook for managing public health operations under catastrophic incident conditions.

FINANCE & ADMINISTRATION

A central focus of any finance and administration effort during incident operations is tracking costs for potential reimbursement. State government offices conducting incident command operations under a declared disaster may seek Federal Emergency Management Agency (FEMA) reimbursement or other federal funding for eligible costs.

Additional finance and administration duties include management of all financial aspects of incident operations, coordination on any claims or compensation issues (i.e., workers compensation), provision of finance updates for inclusion in situation reports, and maintenance of clear documentation of all expenditures for provision of health department services.

LOGISTICS

The Logistics Section is responsible for identifying and arranging for the following during incident operations:

- Facilities
- Transportation
- Communications
- Supplies
- Equipment maintenance and fueling
- Food services (for responders)
- Medical services (for responders)

OPERATIONS

The Operations function is responsible for all operational activities in the DOC and in the other General Staff Sections supporting incident response and recovery efforts. Specifically, the Operations Section is responsible for:

- Providing direction and control for DOC operations;
- Maintaining DOC functionality;
- Implementing the IAP and the incident strategies contained within;
- Supporting management of incident tactical activities, including establishing operational boundaries;
- Assisting with formulation of IAP;
- Supporting field components of the on-scene incident response, as requested;
- Accomplishing DOC mission objectives tasked to the Operations Section, and supporting other Sections in completion of their task objectives;
- Managing several specific Groups (described in the following section); and
- Forwarding all pertinent requests to the DOC Manager and HCPH Executive Group.

ICS POSITIONS

Incident Commander: The individual responsible for overall management of the incident.

Command Staff: The Command Staff consists of the Public Information Officer, Safety Officer, and Liaison Officer. They report directly to the Incident Commander. They may have an Assistant or Assistants, as needed.

Officer: Officer is the ICS title for the personnel responsible for the Command Staff positions of Safety, Liaison, and Public Information.

General Staff: The group of incident management personnel reporting to the Incident Commander. They may have one or more Deputies, as needed. The General Staff consists of the Operations Section Chief, Planning Section Chief, Logistics Section Chief, and Finance/Administration Section Chief.

Section: The organizational level with responsibility for a major functional area of the incident, e.g., Operations, Planning, Logistics, Finance/Administration.

Chief: The ICS title for individuals responsible for functional

Sections: Operations, Planning, Logistics, and Finance/Administration.

Branch: The organizational level having functional or geographic responsibility for major parts of the Operations or Logistics functions.

Director: The ICS title for individuals responsible for supervision of a Branch.

Division/Group: Divisions are used to divide an incident geographically. Groups are used to divide an incident functionally.

Supervisor: The ICS title for individuals responsible for a Division or Group.

Strike Team: A specified combination of the same kind and type of resources with common communications and a Leader.

Task Force: A combination of single resources assembled for a particular tactical need with common communications and a Leader.

Unit: The organizational element having functional responsibility for a specific incident Planning, Logistics, or Finance/Administration activity.

Leader: The ICS title for an individual responsible for a Task Force, Strike Team, or functional Unit.

Resources: Personnel and equipment available, or potentially available, for assignment to incidents. Resources are described by kind and type (e.g., Type III Helicopter) and may be used in tactical, support, or overhead capacities at an incident.

Position	Responsibilities
Incident Commander	1. Ensure welfare and safety of incident personnel. 2. Supervise Command and General Staff. 3. Obtain initial briefing from current Incident Commander and agency administrator. 4. Assess incident situation: • Review the current situation status and initial incident objectives. Ensure that all local, State and Federal agencies impacted by the incident have been notified. 5. Determine need for, establish, and participate in Unified Command. 6. Authorize protective action statements, as necessary. 7. Activate appropriate Command and General Staff positions. Safety Officer must be appointed on hazardous materials incidents: • Confirm dispatch and arrival times of activated resources. • Confirm work assignments. 8. Brief staff: • Identify incident objectives and any policy directives for the management of the incident. • Provide a summary of current organization. • Provide a review of current incident activities. • Determine the time and location of first Planning Meeting. 9. Determine information needs and inform staff of requirements. 10. Determine status of disaster declaration and delegation of authority.
Public Information Officer	1. Obtain briefing from Incident Commander: • Determine current status of Incident (ICS Form 209 or equivalent). • Identify current organization (ICS Forms 201 and 203, resource lists, etc.). • Determine point of contact for media (scene or Command Post). • Determine current media presence. 2. Participate in Administrative Officer's briefing: • Determine constraints on information process. • Determine pre-existing agreements for information centers, Joint Information Centers (JICs), etc.

	3. Assess need for special alert and warning efforts, including the hearing impaired, non-English speaking populations, and industries especially at risk for a specific hazard, or which may need advance notice in order to shut down processes. 4. Coordinate the development of door-to-door protective action statements with Operations. 5. Prepare initial information summary as soon as possible after activation.
Safety Officer	1. Obtain briefing from Incident Commander and/or from initial on-scene Safety Officer. 2. Identify hazardous situations associated with the incident. Ensure adequate levels of protective equipment are available, and being used. 3. Staff and organize function, as appropriate: • In multi-discipline incidents, consider the use of an Assistant Safety Officer from each discipline. • Multiple high-risk operations may require an Assistant Safety Officer at each site. • Request additional staff through incident chain of command. 4. Identify potentially unsafe acts. 5. Identify corrective actions and ensure implementation. Coordinate corrective action with Command and Operations. 6. Ensure adequate sanitation and safety in food preparation. 7. Debrief Assistant Safety Officers prior to Planning Meetings. 8. Prepare Incident Action Plan Safety and Risk Analysis (USDA ICS Form 215A). 9. Participate in Planning and Tactics Meetings: • Listen to tactical options being considered. If potentially unsafe, assist in identifying options, protective actions, or alternate tactics. • Discuss accidents/injuries to date. Make recommendations on preventative or corrective actions. 10. Attend Planning meetings. 11. Participate in the development of Incident Action Plan (IAP): • Review and approve Medical Plan (ICS Form 206). • Provide Safety Message (ICS Form 202) and/or approved document.

	• Assist in the development of the "Special Instructions" block of ICS Form 204, as requested by the Planning Section. 12. Investigate accidents that have occurred within incident areas: • Ensure accident scene is preserved for investigation. • Ensure accident is properly documented. • Coordinate with incident Compensation and Claims Unit Leader, agency Risk Manager, and Occupational Safety and Health Administration (OSHA). • Prepare accident report as per agency policy, procedures, and direction. • Recommend corrective actions to Incident Commander and agency. 13. Coordinate critical incident stress, hazardous materials, and other debriefings, as necessary. 14. Document all activity on Unit Log (ICS Form 214).
Liaison Officer	1. Obtain briefing from Incident Commander: • Obtain summary of incident organization (ICS Forms 201 and 203). • Determine companies/agencies/non-governmental organizations already involved in the incident, and whether they are assisting (have tactical equipment and/or personnel assigned to the organization), or cooperating (operating in a support mode "outside" the organization). 2. Obtain cooperating and assisting agency information, including: • Contact person(s). • Radio frequencies. • Phone numbers. • Cooperative agreements. • Resource type. • Number of personnel. • Condition of personnel and equipment. • Agency constraints/limitations. 3. Establish workspace for Liaison function and notify agency representatives of location. 4. Contact and brief assisting/cooperating agency representatives and mutual aid cooperators. 5. Interview agency representatives concerning resources and capabilities, and restrictions on use-provide this information at planning meetings. 6. Work with Public Information Officer and Incident Commander to coordinate media releases associated with

	inter-governmental cooperation issues. 7. Monitor incident operations to identify potential inter-organizational problems. Keep Command apprised of such issues: • Bring complaints pertaining to logistical problems, inadequate communications, and strategic and tactical direction to the attention of Incident Management Team (IMT). 8. Participate in Planning Meetings. 9. Document all activity on Unit Log (ICS Form 214).
Operations Section Chief	1. Obtain briefing from Incident Commander: • Determine incident objectives and recommended strategies. • Determine status of current tactical assignments. • Identify current organization, location of resources, and assignments. • Confirm resource ordering process. • Determine location of current Staging Areas and resources assigned there. 2. Organize Operations Section to ensure operational efficiency, personnel safety and adequate span of control. 3. Establish operational period. 4. Establish and demobilize Staging Areas. 5. Attend Operations Briefing and assign Operations personnel in accordance with Incident Action Plan (IAP): • Brief Staging Area Manager on types and numbers of resources to be maintained in Staging. • Brief tactical elements (Branches, Divisions/Groups, Task Force/Strike-Team Leaders) on assignments, ordering process, protective equipment, and tactical assignments. 6. Develop and manage tactical operations to meet incident objectives. 7. Assess life safety: • Adjust perimeters, as necessary, to ensure scene security. • Evaluate and enforce use of appropriate protective clothing and equipment. • Implement and enforce appropriate safety precautions. 8. Evaluate situation and provide update to Planning Section: • Location, status, and assignment of resources.

	• Effectiveness of tactics. • Desired contingency plans. 9. Determine need and request additional resources. 10. Notify Resources Unit of Section Branches, Divisions/Groups, Strike Teams/Task Forces, and single resources which are staffed, including location of resources and names of leaders. 11. Keep Resources Unit up to date on changes in resource status. 12.Write formal Operations portion of IAP with the Planning Section Chief, if so directed by the Incident Commander: • Identify assignments by Division or Group. • Identify specific tactical assignments. • Identify resources needed to accomplish assignments.
Planning Section Chief	1. Obtain briefing from Incident Commander: • Determine current resource status (ICS Form 201). • Determine current situation status/intelligence (ICS Form 201). • Determine current incident objectives and strategy. • Determine whether Incident Commander requires a written Incident Action Plan (IAP). • Determine time and location of first Planning Meeting. • Determine desired contingency plans. 2. Activate Planning Section positions, as necessary, and notify Resources Unit of positions activated. 3. Establish and maintain resource tracking system. 4. Complete ICS Form 201, if not previously completed, and provide copies to Command, Command Staff, and General Staff. 5. Advise Incident Command Post (ICP) staff of any significant changes in incident status. 6. Compile and display incident status summary information. Document on ICS Form 209, Incident Status Summary (or other approved agency forms): • Forward incident status summaries to Agency Administrator and/or other designated staff once per operational period, or as required. • Provide copy to Public Information Officer. 7. Obtain/develop incident maps. 8. Establish information requirements and reporting

	schedules for ICP and field staff. 9. Prepare contingency plans: • Review current and projected incident and resource status. • Develop alternative strategies. • Identify resources required to implement contingency plan. • Document alternatives for presentation to Incident Commander and Operations, and for inclusion in the written IAP. 10. Meet with Operations Section Chief and/or Command, prior to Planning Meetings, to discuss proposed strategy and tactics and diagram incident organization and resource location. 11. Conduct Planning Meetings according to following agenda. 12. Supervise preparation and distribution of the written IAP, if indicated. Minimum distribution is to all Command, Command Staff, General Staff, and Operations personnel to the Division/Group Supervisor level: • Establish information requirements and reporting schedules for use in preparing the IAP. • Ensure that detailed contingency plan information is available for consideration by Operations and Command. • Verify that all support and resource needs are coordinated with Logistics Section prior to release of the IAP. • Include fiscal documentation forms in written IAP as requested by the Finance/Administration Section. • Coordinate IAP changes with General Staff personnel and distribute written changes, as appropriate. 13. Coordinate development of Incident Traffic Plan with Operations and the Ground Support Unit Leader. 14. Coordinate preparation of the Safety Message with Safety Officer. 15. Coordinate preparation of the Incident Communications Plan and Medical Plan with Logistics. 16. Instruct Planning Section Units in distribution of incident information. 17. Provide periodic predictions on incident potential. 18. Establish a weather data collection system, when necessary. 19. Identify need for specialized resources; discuss need with Operations and Command; facilitate resource requests

	with Logistics. 20. Ensure Section has adequate coverage and relief. 21. Hold Section meetings as necessary to ensure communication and coordination among Planning Section Units. 22. Ensure preparation of demobilization plan, if appropriate. 23. Ensure preparation of final incident package and route to Agency Administrator for archiving or follow-up after Incident Management Team (IMT) demobilization. 24. Provide briefing to relief on current and unusual situations. 25. Ensure that all staff observe established level of operational security. 26. Ensure all Planning functions are documenting actions on Unit Log (ICS Form 214). 27. Submit all Section documentation to Documentation Unit.
Logistics Section Chief	1. Obtain briefing from Incident Commander: • Review situation and resource status for number of personnel assigned to incident. • Review current organization. • Determine which incident facilities have been/should be activated. 2. Ensure Incident Command Post and other incident facilities are physically activated, as appropriate. 3. Confirm resource ordering process. 4. Assess adequacy of current Incident Communications Plan (ICS Form 205). 5. Organize and staff Logistics Section, as appropriate, and consider the need for facility security, and Communication and Supply Units. 6. Assemble, brief, and assign work locations and preliminary work tasks to Section personnel: • Provide summary of emergency situation. • Provide summary of the kind and extent of Logistics support the Section may be asked to provide. 7. Notify Resources Unit of other Units activated, including names and location of assigned personnel. 8. Attend Planning Meetings. 9. Participate in preparation of Incident Action Plan (IAP): • Provide input on resource availability, support needs, identified shortages, and response time-lines for key resources.

	• Identify future operational needs (both current and contingency), in order to anticipate logistical requirements. • Ensure Incident Communications Plan (ICS Form 205) is prepared. • Ensure Medical Plan (ICS Form 206) is prepared. • Assist in the preparation of Transportation Plan. 10. Review IAP and estimate section needs for next operational period; order relief personnel if necessary. 11. Research availability of additional resources. 12. Hold Section meetings, as necessary, to ensure communication and coordination among Logistics Branches and Units. 13. Ensure coordination between Logistics and other Command and General Staff. 14. Ensure general welfare and safety of Section personnel. 15. Provide briefing to relief on current activities and unusual situations. 16. Ensure that all personnel observe established level of operational security. 17. Ensure all Logistics functions are documenting actions on Unit Log (ICS Form 214). 18. Submit all Section documentation to Documentation Unit.
Finance/Administration Section Chief	1. Obtain briefing from Incident Commander: • Incident objectives. • Participating/coordinating agencies. • Anticipated duration/complexity of incident. • Determine any political considerations. • Obtain the names of any agency contacts the Incident Commander knows about. • Possibility of cost sharing. • Work with Incident Commander and Operations Section Chief to ensure work/rest guidelines are being met, as applicable. 2. Obtain briefing from agency administrator: • Determine level of fiscal process required. • Delegation of authority to Incident Commander, as well as for financial processes, particularly procurement. • Assess potential for legal claims arising out of incident activities. • Identify applicable financial guidelines and policies, constraints and limitations. 3. Obtain briefing from agency Finance/Administration

	representative: • Identify financial requirements for planned and expected operations. • Determine agreements are in place for land use, facilities, equipment, and utilities. • Confirm/establish procurement guidelines. • Determine procedure for establishing charge codes. • Important local contacts. • Agency/local guidelines, processes. • Copies of all incident-related agreements, activated or not. • Determine potential for rental or contract services. • Is an Incident Business Advisor (IBA) available, or the contact information for an agency Financial/Administration representative? • Coordinate with Command and General Staff and agency Human Resources staff to determine the need for temporary employees. • Ensure that proper tax documentation is completed. • Determine whether hosting agency will maintain time records, or whether the incident will document all time for the incident, and what forms will be used. 4. Ensure all Sections and the Supply Unit are aware of charge code. 5. Attend Planning Meeting: • Provide financial and cost-analysis input. • Provide financial summary on labor, materials, and services. • Prepare forecasts on costs to complete operations. • Provide cost benefit analysis, as requested. • Obtain information on status of incident; planned operations; changes in objectives, use of personnel, equipment, aircraft; and local agency/political concerns. 6. Gather continuing information: • Equipment time – Ground Support Unit Leader and Operations Section. • Personnel time – Crew Leaders, Unit Leaders, and individual personnel. • Accident reports – Safety Officer, Ground Support Unit Leader, and Operations Section. • Potential and existing claims – Operations Section, Safety Officer, equipment

	contractors, agency representative, and Compensation/Claims Unit Leader. • Arrival and demobilization of personnel and equipment – Planning Section. • Daily incident status – Planning Section. • Injury reports – Safety Officer, Medical Unit Leader, and Compensation/Claims Unit Leader. • Status of supplies – Supply Unit Leader and Procurement Unit Leader. • Guidelines of responsible agency – Incident Business Advisor, local administrative personnel. • Use agreements – Procurement Unit Leader and local administrative personnel. • What has been ordered? – Supply Unit Leader. • Unassigned resources – Resource Unit Leader and Cost Unit Leader 7. Meet with assisting and cooperating agencies, as required, to determine any cost-share agreements or financial obligation. 8. Coordinate with all cooperating agencies and specifically administrative personnel in hosting agency. 9. Initiate, maintain, and ensure completeness of documentation needed to support claims for emergency funds, including auditing and documenting labor, equipment, materials, and services: • Labor - with breakdown of work locations, hours and rates for response personnel, contract personnel, volunteers, and consultants. • Equipment - with breakdown of work locations, hours and rates for owned and rented aircraft, heavy equipment, fleet vehicles, and other equipment. • Materials and supplies purchased and/or rented, including equipment, communications, office and warehouse space, and expendable supplies. 10. Initiate, maintain, and ensure completeness of documentation needed to support claims for injury and property damage. (Injury information should be kept on contracted personnel formally assigned to the incident, as well as paid employees and mutual aid personnel). 11.Ensure that all personnel time records reflect incident activity and that records for non-agency personnel are transmitted to home agency or department according to policy: • Notify incident management personnel when emergency timekeeping process is in effect

	and where timekeeping is taking place. • Distribute time-keeping forms to all Sections-ensure forms are being completed correctly. 12. Ensure that all obligation documents initiated by the incident are properly prepared and completed. 13. Assist Logistics in resource procurement: • Identify vendors for which open purchase orders or contracts must be established. • Negotiate ad hoc contracts. 14. Ensure coordination between Finance/Administration and other Command and General Staff. 15. Coordinate Finance/Administration demobilization. 16. Provide briefing to relief on current activities and unusual events. 17. Ensure all Logistics Units are documenting actions on Unit Log (ICS Form 214). 18. Submit all Section documentation to Documentation Unit.

SECTION III

TEMPLATE 1: ICS 214 FORM – ACTIVITY LOG

This template allows for the creation of a running log through the documentation of contacts made and response actions initiated during the initial hours of an incident until existing forms or logs are accessed. All contacts, including unsuccessful attempts, and follow-up actions should be recorded below. The initial resulting record can be used to identify particular areas in your emergency operations plan, procedures, or guidelines that may need revision.

A fillable ICS 214 Form can be found here:
https://training.fema.gov/EMIWeb/IS/ICSResource/assets/ICS%20Forms//ICS%20Form%20214,%20Activity%20Log.pdf

ICS 214 ACTIVITY LOG

PURPOSE

The Activity Log (ICS 214) records details of notable activities at any ICS level, including single resources, equipment, Task Forces, etc. These logs provide basic incident activity documentation, and a reference for any after-action report.

PREPARATION

An ICS 214 can be initiated and maintained by personnel in various ICS positions as it is needed or appropriate. Personnel should document how relevant incident activities are occurring and progressing, or any notable events or communications.

DISTRIBUTION

Completed ICS 214s are submitted to supervisors, who forward them to the Documentation Unit. All completed original forms must be given to the Documentation Unit, which maintains a file of all ICS 214s. It is recommended that individuals retain a copy for their own records.

NOTES

- The ICS 214 can be printed as a two-sided form.
- Use additional copies as continuation sheets as needed, and indicate pagination as used.

Block #	Block Title	Instructions
1	**Incident Name**	Enter the name assigned to the incident.
2	**Operational Period** • Date and Time From • Date and Time To	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	**Name**	Enter the title of the organizational unit or resource designator (e.g., Facilities Unit, Safety Officer, and Strike Team).
4	**ICS Position**	Enter the name and ICS position of the individual in charge of the Unit.
5	**Home Agency** (and Unit)	Enter the home agency of the individual completing the ICS 214. Enter a unit designator if utilized by the jurisdiction or discipline.
6	**Resources Assigned**	Enter the following information for resources assigned:
	• Name	Use this section to enter the resource's name. For all individuals, use at least the first initial and last name. Cell phone number for the individual can be added as an option.
	• ICS Position	Use this section to enter the resource's ICS position (e.g., Finance Section Chief).

Block #	Block Title	Instructions
	• Home Agency (and Unit)	Use this section to enter the resource's home agency and/or unit (e.g., Des Moines Public Works Department, Water Management Unit).
7	**Activity Log** • Date/Time • Notable Activities	• Enter the time (24-hour clock) and briefly describe individual notable activities. Note the date as well if the operational period covers more than one day. • Activities described may include notable occurrences or events such as task assignments, task completions, injuries, difficulties encountered, etc. • This block can also be used to track personal work habits by adding columns such as "Action Required," "Delegated To," "Status," etc.
8	**Prepared by** • Name • Position/Title • Signature • Date/Time	Enter the name, ICS position/title, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).

TEMPLATE 2: LEADERSHIP ASSIGNMENTS

This template allows for the documentation of health department leadership assignments made during the public health response to an incident. Not all assignments will necessarily be staffed due to variations in health department resources and response requirements for a particular incident. Blank space is provided at the end of the template to allow users to list additional locations and assignments as necessary.

Response Assignment	Assigned Leadership	Date & Time In/Out
Incident Command Post (ICP)		
Site Control		
Site Health/Safety		
Health Dept. Operations		
Operations/ Command Center		
Field Operations		
Epidemiology Services		
Laboratory Support		
Information Systems		
Community Services		
Administrative Services		
Environmental Services		
Communications		
Liaison Officer (LNO)		
Emergency Operations Center (EOC)		
Command		
Safety		
Planning		
Operations		
Response Assignment	**Assigned Leadership**	**Date & Time In/Out**
Logistics		
Finance/Administration		
Intelligence/Investigations		
Joint Information Systems (JIS)		
Joint Information Center (JIC)		

Joint Operations Center (JOC)		
Joint Field Office (JFO)		
Decontamination Site(s)		
Hospitals, Clinics, and other medical facilities		
Strategic National Stockpile (SNS) receipt site(s)		
Vaccine/Medicine distribution site(s)		
Shelter(s)		
RSS Warehouse		

TEMPLATE 3: ICS 201 FORM

PURPOSE

The Incident Briefing (ICS 201) provides the Incident Commander (and the Command and General Staffs) with basic information regarding the incident situation and the resources allocated to the incident. In addition to a briefing document, the ICS 201 also serves as an initial action worksheet. It serves as a permanent record of the initial response to the incident.

PREPARATION

The briefing form is prepared by the Incident Commander for presentation to the incoming Incident Commander along with a more detailed oral briefing.

DISTRIBUTION

Ideally, the ICS 201 is duplicated and distributed before the initial briefing of the Command and General Staffs or other responders as appropriate. The "Map/Sketch" and "Current and Planned Actions, Strategies, and Tactics" sections (pages 1–2) of the briefing form are given to the Situation Unit, while the "Current Organization" and "Resource Summary" sections (pages 3–4) are given to the Resources Unit.

NOTES:

- The ICS 201 can serve as part of the initial Incident Action Plan (IAP).
- If additional pages are needed for any form page, use a blank ICS 201 and repaginate as needed.

A fillable ICS 201 Form can be found here:
https://training.fema.gov/EMIWeb/IS/ICSResource/assets/ICS%20Forms//ICS%20Form%20201,%20Incident%20Briefing.pdf

TEMPLATE 4: SITUATION TEMPLATE

DOCUMENT DESCRIPTION

This document serves as the template for creation of situation reports (SitReps) during an emergency response.

See **Attachment VII – Situation Report Template**.

TEMPLATE 5: SHIFT CHANGE BRIEFING

DOCUMENT DESCRIPTION

The Shift Change Briefing Template will be created by the Planning Section and distributed to all responders at the beginning of their shift to foster situational awareness of the current state of the operational response activities.

See **Attachment X – Shift Change Briefing Template**.

TEMPLATE 6: ICS FORM 213RR – RESOURCE REQUEST FORM

DOCUMENT DESCRIPTION

The Resource Request (ICS 213 RR) is utilized to order resources and track resource status.

A fillable ICS 201 Form can be found here:
https://training.fema.gov/EMIWeb/IS/ICSResource/assets/ICS%20Forms//ICS%20Form%20213%20RR,%20Resource%20Request%20Message.pdf

Resource Request (ICS 213 RR), **ADAPTED FOR HCPH**

1. Incident Name:	**2. Date/Time**	**3. Resource Request Number:**

Requestor

4. Order (Use additional forms when requesting different resource sources of supply.)**:**

Qty.	Kind	Type	Detailed Item Description: (Vital characteristics, brand, specs, experience, size, etc.)	Cost	**5. Resource Status** Received by	Date/ Time	Assigned to	Released to	Date/ Time

6. Requested Delivery/Reporting Location:

7. Suitable Substitutes and/or Suggested Sources:

8. Requested by Name/Position:	**9. Priority:** ☐ Urgent ☐ Routine ☐ Low	**10. Section Chief Approval:**

Logistics

11. Logistics Order Number:	**12. Supplier Phone/Fax/Email:**
13. Name of Supplier/POC:	

14. Notes:

1. Incident Name:		2. Date/Time	3. Resource Request Number:
	15. Approval Signature of Logistics Rep:	16. Date/Time:	
	17. Order placed by:		
Finance	18. Reply/Comments from Finance:		
Finance	19. Finance Section Signature:	20. Date/Time:	
ICS 213 RR, Page 1			

Updated by HCPH July 31, 2017

ICS 213 RR

Resource Request

Purpose. The Resource Request (ICS 213 RR) is utilized to order resources and track resource status.

Preparation. The ICS 213 RR is initiated by the resource requestor and initially approved by the appropriate Section Chief or Command Staff. The Logistics and Finance/Administration Sections also complete applicable sections of the form.

Distribution. This form is maintained in order to track resource status and assist with determining incident costs.

Block Number	Block Title	Instructions
1	Incident Name	Enter the name assigned to the incident.
2	Date/Time	Self-explanatory
3	Resource Request #	Self-explanatory
4	Order	Specify quantity, item description, and cost. Complete resource status section after resource is received
5	Resource Status	Enter applicable resource status fields
6	Requested Delivery/Reporting Location	Enter location requested resource delivery/reporting location
7	Suitable Substitutes and/or Suggested Sources	Enter possible substitute items if exact requested resource is not available. Provide supplier information if known.
8	Requested by Name/Position:	Requestor's name and position
9	Priority	Select Urgent, Routine or Low priority
10	Section Chief Approval	Obtain appropriate Section Chief signature for request
11	Logistics Order Number	Enter Logistics Order Number if applicable
12	Supplier Phone/Fax/Email	Enter resource Supplier's phone/Fax/Email
13	Name of Supplier/POC	Enter name of resource supplier/POC
14	Notes	Any relevant notes regarding the request
15	Approval Signature of Authorized Logistics Rep	Enter approval signature of an authorized Logistics Section representative
16	Date/Time	Self-explanatory
17	Order placed by	Enter name of individual who places order for requested resource(s)
18	Reply/Comments from Finance	Any relevant notes regarding the request
19	Finance Section Signature	Enter approval signature of an authorized Finance/Admin Section representative
20	Date/Time	Self-explanatory

TEMPLATE 7: ICS FORM 221 DEMOBILIZATION CHECK OUT FORM

DOCUMENT DESCRIPTION

The Demobilization Check-Out (ICS 221) ensures that resources checking out of the incident have completed all appropriate incident business, and provides the Planning Section information on resources released from the incident. Demobilization is a planned process and this form assists with that planning.

A fillable ICS 201 Form can be found here: https://training.fema.gov/emiweb/is/icsresource/assets/ics%20forms/ics%20form%20221,%20demobilization%20check-out.pdf

ATTACHMENT III - DOC ACTIVATION STANDARD OPERATING PROCEDURE

DOCUMENT DESCRIPTION

The purpose of this Standard Operating Procedure (SOP) is to establish guidelines to ensure the Hamilton County Public Health (HCPH) Department Operations Center (DOC) is functional and operational at all times, including equipment, staffing, activation, de-activation and maintenance procedures.

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APPLICABILITY

This SOP applies to all HCPH staff assigned roles and responsibilities in the DOC during emergency preparedness, response and recovery phases, plus non-routine events.

DEFINITIONS

HAMILTON COUNTY EMERGENCY MANAGEMENT & HOMELAND SECURITY AGENCY (EMHSA) EMERGENCY OPERATIONS CENTER (EOC)

CONCEPT OF OPERATIONS

GENERAL

It is the responsibility of local and county governments to reasonably protect life, property, and the environment from the effects of disasters. While most emergencies are handled by the local jurisdiction, Hamilton County is called upon to provide supplemental assistance and coordination whenever the consequences of a disaster exceed local capabilities. Additionally, local and county entities may proactively take certain measures to prepare for pre-planned events. If needed, the Ohio Emergency Management Agency (Ohio EMA) may be requested to provide assistance in a disaster or pre-planned event. Assistance may take the form of mobilizing state resources, activating specialized response teams, or providing equipment to support emergency operations.

While extensive effort and years of experience of responders have been brought into this plan in order to make it applicable and appropriate to emergency management activities, it should be recognized that this plan functions to provide guidance and should not be rigidly applied to every disaster or pre-planned event. Every situation will present different and unique challenges, complexities, and requirements. The specific tasks, assignments, and provisions contained within this plan may have to be modified to deal effectively with the actual situation at hand.

EMERGENCY OPERATIONS CENTER

The Hamilton County Emergency Operations Center (EOC) is located at the City of Cincinnati-Hamilton County Regional Operations Center (ROC), a permanent facility located in Cincinnati, Ohio.

The ROC is the physical location at which the EMHSA coordinates with all appropriate entities involved in the response in order to provide interagency coordination, develop a common operating picture, and share information with executives who have the authority to make decisions in support of incident response. Coordinating and support entities may supplement personnel at the ROC by utilizing WebEOC, a web-based information management system that provides a single access point for the collection and dissemination of disaster or event-related information.

The Hamilton County EOC is activated at multiple levels to facilitate the process that allows all levels of government to work together more effectively. Coordination should occur across different disciplines between the Incident Command or the local jurisdictions and Hamilton County, as well as between the county and the State of Ohio.

EMERGENCY ACTIVATION LEVELS

Large-scale emergencies, such as a tornado or terrorist incident, may require the immediate activation of the Hamilton County EOC. Other emergencies are slower in onset and may not require that all response capabilities be activated. The EMHSA utilizes a graduated system that ensures the level of response scales to the scope of the disaster. The following levels describe the response activities the county may undertake. Response operations may transition from one level to the next without formal pronouncement.

LEVEL 1 – STEADY STATE

The EMHSA operates out of the ROC during regular business hours. At all times the EMHSA has a Primary and Alternate Duty Officer assigned to monitor for potential emergencies in and around Hamilton County. This includes, but is not limited to, monitoring the weather daily, being aware of upcoming pre-planned events, and monitoring local emergencies that have the potential to exceed local response capabilities.

LEVEL 2 – SITUATIONAL AWARENESS AND MONITORING

The EMHSA has been alerted to a specific hazard or event that has the potential to require a response. The EMHSA coordinates with entities that may have knowledge of the hazard or event to determine if any assistance may be required. Coordinating and support entities may be put on standby in the event they are requested to respond to the Hamilton County EOC. The Primary or Alternate Duty Officer has the responsibility for sharing event-specific information with the EMHSA Director or his/her designee and appropriate response partners.

LEVEL 3 – PARTIAL ACTIVATION

The EMHSA Director or his/her designee activates the EOC. Activation of the EOC may occur at the request of the Incident Commander, fire chief, law enforcement chief, or a local executive administrator. Appropriate coordinating and support entities are requested to respond to the ROC to fulfill their responsibilities as outlined in this EOP based on the needs of the disaster.

A proclamation of a local State of Emergency may be made at this time by the chief elected official of the affected local jurisdiction or by other legally designated personnel. The EMHSA Director or his/her designee will notify the Ohio EMA of the incident and the activation of the Hamilton County EOC. Ongoing communications and documentation of damage and needs assessment information will be maintained

between the Hamilton County EOC and the Ohio EMA. Ohio EMA staff may be sent to the ROC to coordinate with the Hamilton County EOC.

The EMHSA Director, his/her designee, or the EOC Coordinator will evaluate the status of the EOC including whether or not to maintaining current operations, progress to Level 4 or deactivate to Level 2 or below.

LEVEL 4 – FULL ACTIVATION

The EMHSA Director, his/her designee, or the EOC Coordinator will request all coordinating and support entities respond to the ROC. A proclamation of a local State of Emergency may be made by multiple jurisdictions within the county and Hamilton County may declare a State of Emergency as well. The EMHSA Director or his/her designee will request assistance from the Ohio EMA. Ongoing communications and documentation of damage and needs assessment information will be maintained between the affected jurisdiction, the Hamilton County EOC, and the Ohio EMA.

Hamilton County will prepare to receive state and federal assistance once confirmation and approval of the request has been received. Activities may include:

- Identification of staging areas for state and federal resources
- Identification of the state and/or federal missions that need to be addressed
- Identification of local liaisons to state and federal ESF representatives
- Coordinating state and federal assessment briefings
- Processing appropriate local documentation required for declaration/assistance

The EMHSA Director, his/her designee, or the EOC Coordinator will evaluate the status of the EOC including whether or not to maintain current operations or deactivate to Level 3 or below.

AUTHORITY

The Hamilton County EOP shall be activated when the EMHSA stands up to Emergency Activation Level 2, or upon a Declaration of State of Emergency by the Hamilton County Board of County Commissioners.

DECLARATION OF A STATE OF EMERGENCY

Declarations of a State of Emergency may be made when a disaster has reached a level where additional resources will be needed, or it is anticipated that the scale of the disaster shall exceed the capabilities of Hamilton County. While outside resources may be obtained through mutual aid agreements that do not necessitate a declaration, declaring a State of Emergency will facilitate the process of obtaining State, and possibly Federal, assets.

A State of Emergency may be verbally declared by the President of the Board of County Commissioners (BoCC) upon finding that a disaster has occurred or the threat of a disaster is imminent within Hamilton County. If the President of the BoCC is absent from the county or incapacitated in any way, the Vice President may declare in the President’s absence. If the President and Vice President of the Board of County Commissioners is absent, the remaining County Commissioner may declare in their

absence. A formally-executed resolution shall then be prepared for the Board's signatures. A sample resolution can be found in Attachment #2 to this EOP.

Upon declaration of a State of Emergency the Hamilton County BoCC shall have certain powers as outlined in the Ohio Revised Code (ORC) Sections 307 – Board of County Commissioners – Powers, and 5502 – Department of Public Safety. The State of Emergency shall not exceed a period of seven (7) days unless renewed by a majority vote of the Hamilton County BoCC.

RECOVERY OPERATIONS

Hamilton County EOC and field-based staff WILL continue to monitor incident situation and coordinate State-level response and recovery resources and missions. If Federal Declarations were issued, Recovery Operations are coordinated through the Hamilton County EOC. For incidents for which a Joint Field Office was established, Recovery Operations are conducted from the Hamilton County EOC and/or the Joint Field Office. If Recovery Operations continue following the closure of the Joint Field Office, operations may switch to the Hamilton County EOC or agency-based programmatic office(s). Hamilton County EMHSA administers disaster assistance programs for the private and public sectors, and provides technical assistance to public officials on emergency management programs and disaster assistance. Response operations are coordinated with FEMA and other federal agencies from the Hamilton County EOC and the Joint Field Office.

DEPARTMENT OPERATIONS CENTER (DOC)

The facility that supports a centralized HCPH incident response activities and coordinates the agency's emergency disaster response and recovery activities, with local/state agencies including, local health departments (LHDs), Public Health Regions, the Hamilton County EOC, the ESF-8 Desk, and federal agencies such as Centers for Disease Control and Prevention (CDC) or U.S. Department of Health and Human Services (HHS).

INCIDENT COMMAND SYSTEM (ICS)

A standardized emergency management concept specifically designed to allow its user(s) to adopt an integrated organizational structure equal to the complexity and demands of a single or multiple incidents.

INCIDENT COMMANDER/AGENCY COMMANDER (IC/AC)

The on-site HCPH individual who is in command and has ultimate authority for all critical incident decisions related to the event.

NATIONAL INCIDENT MANAGEMENT SYSTEM (NIMS)

A systematic, proactive approach to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work together seamlessly and manage incidents involving all threats and hazards - regardless of cause, size, location, or complexity - in order to reduce loss of life, property and harm to the environment. The NIMS is the essential foundation to the National Preparedness

System and provides the template for the management of incidents and operations in support of all five National Planning Frameworks.

DOC GUIDING PRINCIPLES

The HCPH DOC is the facility used to support the centralized HCPH incident response activities, and coordinate the agency's emergency response and recovery functions, plus non-routine events. DOC performance must be effective, efficient and timely to facilitate response and recovery activities, and coordination with Hamilton County EOC, ESF-8 Desk, and HCPH Warehouse operations as well as any other the HCPH incident response operations. Communications, logistics and administrative procedures are identified to support such efforts; while ensuring proper documentation for lessons learned, improvement planning and litigation.

DOC PROCEDURES

ACTIVATION

1. HCPH will activate the DOC as a facility for planning, coordinating and managing information and resources during an emergency, incident, or a non-routine event. The DOC facilitates coordination between the Hamilton County EOC, the ESF-8 Desk, Local Health Departments (LHDs), the Southwest Ohio Public Health Region (SWOPHR), Centers for Disease Control and Prevention (CDC) and other state and federal agencies [e.g., U.S. Department of Health and Human Services (HHS), U.S. Department of Homeland Security (DHS), U.S. Environmental Protection Agency (EPA), Federal Bureau of Investigation (FBI), U.S. Army Corps of Engineers (USACE)], during emergencies, or non-routine events. The HCPH DOC will adopt the county levels of hazard analysis and risk assessment.
2. Hamilton County EMHSA has four (4) activation levels which may prompt HCPH DOC activation and operation. DOC activation may also be at the discretion of the Health Commissioner, either Assistant Health Commissioner or the Emergency Preparedness (EP) Program, and may open if the Hamilton County EOC ESF-8 Desk is activated.
3. The DOC may be activated at different functional levels based on a needs assessment or request. The Health Commissioner, either Assistant Health Commissioner, the EP Supervisor or the IC/AC will determine what DOC level of activation is necessary. The activation levels will be scalable and may change to meet the incident requirements over time.
4. When the HCPH DOC is activated, the Health Commissioner, either Assistant Health Commissioner, the EP Supervisor or the IC/AC shall make the decision on the best use of the DOC and support services, in relation to the incident objectives, Incident Action Plan (IAP) and designated DOC functions. A pre-designated Staff Support Section Manager (SSSM) or DOC Manager, identified by the Health Commissioner, either Assistant Health Commissioner or the EP Supervisor, shall facilitate the operations of the DOC functions and support staff.

5. PARTIAL ACTIVATION: A partial DOC activation occurs when a response is required, but is mostly related to assessing, monitoring, and coordinating public health or disease issues. The Health Commissioner, either Assistant Health Commissioner, the EP Supervisor or IC/AC shall partially activate the DOC with the necessary staff upon receiving notification, in order to meet the level of required response and the needs of the agency. A partial DOC activation may include low threat emergency situations and is characterized by a serious but manageable incident and a response that is coordinated from within HCPH's Divisions.
6. FULL ACTIVIATION: Full activation of the DOC is required when a major incident occurs and/or a complex, multi-jurisdictional/agency, disaster response is essential. The Health Commissioner and/or either Assistant Health Commissioner will determine the staff required to meet the needs of the situation and accomplish the incident objectives during full activation.
7. Upon receiving the emergency notification, the Health Commissioner or either Assistant Health Commissioner (or designee) shall contact the EP Program to order the activation of the DOC. When the emergency notification is made directly to the EP Supervisor, he/she may activate the DOC, providing notice to the Health Commissioner/designee as quickly as possible. At that time, the Health Commissioner/designee and/or the Assistant Health Commissioner/designee may also activate incident response and appoint an IC/AC, where appropriate. When HCPH incident response is initiated and DOC activation is ordered, the IC/AC will direct the EP Supervisor, or designee, to activate the DOC and the SSSM position. The SSSM and staff will activate the DOC to the required operational level, per the IC/AC, to support the operation(s).
8. The IC/AC may direct the SSSM to perform activation/notifications as needed:
    a. HCPH Internal Divisions
    b. HCPH External
        - Hamilton County EMHSA
        - ODH
        - Community Partners, if necessary

DOC FACILITY

1. The primary HCPH DOC location is at: 250 William Howard Taft Road, Cincinnati, Ohio 45219.
2. The alternate HCPH DOC location is to be determined at the time of the incident by the County Facilities Department.
3. The space in the DOC accommodates operational equipment and adequate staff working space for 80+ staff in permanent work stations; temporary stations can be created to accommodate additional staff. There are 3 meeting rooms which may be configured to fit operational needs (e.g., work groups, briefings, meetings) as required.

4. HCPH will also have access to the TB Clinic located at 184 East McMillan Street, Cincinnati, Ohio 45219 for an additional meeting space.
5. All the equipment, including computers/ HCPH network, televisions, projectors, power supply, other functional needs and supplies will remain in working order at all times. DOC phone landlines (both digital and analog) and computers will be updated regularly and be mission ready at all times.
6. The entrance for visitors to the DOC will be through the 250 William Howard Taft building lobby.

OPERATIONAL READINESS

1. The EP Program will work with the Health Commissioner to ensure the DOC is operationally ready at all times, including equipment, trained staffing, activation and deactivation procedures, and maintenance.
2. The DOC facility can be operational within 30-minutes of notification during normal business hours (Monday-Friday from 8:00 a.m. to 4:00 p.m.).
3. During non-business hours, the DOC facility can be operational within 30-minutes of a person arriving at HCPH following notification (Monday-Friday from 4:00 p.m. to 8:00 a.m., weekends and holidays).
4. Specific Job Action folders will be prepared, supplied and available in the DOC containing explanation of duties, responsibilities, implementing instructions, associated documentation, activity log, and note pad for designated DOC positions.

STAFFING AND RESPONSIBILITIES

1. The EP Program will be responsible to pre-designate a DOC Management Team and a SSSM. The EP Program will also maintain a list for DOC staffing, including alternate staff for back-up.
2. Staffing levels will be expanded, or reduced, as needed to support HCPH operational needs. Two (2) positions required to maintain the DOC during an event are:
    a. Staff Support Section Manager (SSSM) or DOC Manager
    b. Communication Unit Leader
3. The EP Supervisor shall ensure that all staff that is designated as having an assigned role within the DOC during an incident is trained in DOC and Hamilton County EOC operations.
4. EP Program Responsibilities
    a. Provides SSSM to coordinate a list of primary and alternate staff for DOC assignments.
5. Staff Support Section Manager or DOC Manager

a. Ensures the HCPH Response remains in an operational state for immediate activation
b. Determines and recommends staffing levels in accordance with the incident-level to ensure that activities are supported by reviewing activation and demobilization requests
c. Publishes and updates the HCPH Response operational tempo
d. Provides an HCPH Response staff plan for support from the HCPH Response units to the Future Planning Section
e. Responsible for supporting the activation, operation and deactivation of the DOC.
f. Provides service and support of the DOC facility, while the SSSM will refer all requests to the Logistic Section (i.e., equipment procurement, repairs, food, water, utilities, and personal accommodations for the DOC staff).
g. Coordinates DOC needs (e.g., computers, copiers, fax) with the Information Technology Unit Leader (if activated) or the Logistics and Technology Unit.
h. Coordinates clerical support for the DOC.
i. Transfers DOC records (e.g., DOC Sign-In/Sign-Out Log) to the Planning Section/Documentation Unit upon DOC deactivation.
j. Provide orientation on DOC equipment (e.g., computers, copiers, fax, projectors)
k. Supports the operations of display equipment and software.
l. Operates video switching and video monitor equipment in support of DOC operations.
m. Ensures that there are adequate and functional computers, software, and associated equipment.
n. Supports WebEOC training and orientation in conjunction with the Hamilton County EMHSA.

6. Information Technology Unit Leader
    a. Oversees the IT Specialists
    b. Provides input to the Planning Support Section
    c. Coordinates with the SSSM for DOC staff software training and maintains communication with all DOC staff.
    d. Provides orientation on DOC equipment/programs [e.g., Multi-Agency Radio Communication System (MARCS) units, and Message Center database].
    e. Supports WebEOC training and orientation in conjunction with the Hamilton County EMHSA.

f. Supports video, telephone, radio and other communication systems in the DOC; in conjunction with the SSSM.

g. Coordinates technology support as needed.

h. Ensures the computer links with the Hamilton County EOC are operational.

i. Identifies and recommends additional IT needs to the SSSM.

OPERATIONAL PERIODS

1. Operational periods should be flexible and scalable to meet the incident's need(s). The DOC may operate in two 12-hour or three 8-hour operational periods during a disaster for 24-hour operational coverage; if needed. Additionally, DOC operations may require staffing only during normal business hours; with coverage designated by the Health Commissioner/designee. Staffing of the DOC is incident need specific and flexible by nature.
2. Staff will be briefed at the start of each shift concerning the situation status and debriefed prior to being released from duty in the DOC. Staff is responsible for briefing their replacement of current situation, duties and procedures related to the DOC position.

FORMS AND DOCUMENTATION

1. Documentation within the DOC must be timely, accurate and complete. The DOC will maintain and store all Job Action Sheet hard copies. All documentation, information, completed forms, logs, updated status boards and appropriate briefing reports will be given to the Planning Section/Documentation Unit to be catalogued and preserved.
2. If needed, hardcopies of all the HCPH ICS forms will be printed. All ICS forms are located here **X:\HCPH Plans and SOGs\PLANS and SOGs\ICS Forms**.
3. HCPH DOC ICS Sign-In/Sign-Out Logs
   a. Every staff member upon arrival at the DOC will sign-in and will sign-out of the DOC upon departure using the ICS-211 form.
   b. Every staff member will report to the SSSM or to the designated person and receive a status briefing.
4. Both the HCPH DOC Maintenance Log and ICS-211 Sign-In/Sign-Out Logs will be maintained in the DOC.

ATTACHMENT IV - INTERFACE BETWEEN HCPH AND HAMILTON COUNTY EOC STANDARD OPERATING GUIDE

DOCUMENT DESCRIPTION

This SOG establishes guidelines for the interface of HCPH response personnel, the HCPH DOC and the Hamilton County EOC, especially the ESF#8 Desk. This SOG is intended to support coordination and prevent both delays and duplication of effort at HCPH. Application of this SOG that in any way leads to either a delay or duplication of effort is, therefore, inconsistent with this SOG.

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BACKGROUND

Hamilton County Public Health (HCPH) serves as both the primary and coordinating agency for Emergency Support Function (ESF) #8 (Public Health and Medical Services). Additionally, HCPH has supporting roles in numerous other ESFs, including numbers 3, 6, 10, 11, 14 and 15. In significant incidents, the Hamilton County Emergency Management & Homeland Security Agency (EMHSA) Emergency Operations Center (EOC) may be activated to coordinate execution of ESF plans and procedures.

As needed, HCPH may choose to active the HCPH Department Operations Center (DOC) to support HCPH response personnel.

ROLES AND RESPONSIBILITIES

The roles and responsibilities of each of the major HCPH entities are described below. For the purposes of this SOG, the ESF#8 Desk has been included as a HCPH entity, since HCPH serves at the primary and coordinating agency for ESF#8.

1) HCPH Response Personnel
    a. HCPH response personnel are the collective group of HCPH staff assigned to address an incident. HCPH response personnel include any individuals involved at any step in the response process, from activation through demobilization.
    b. Their responsibility is to execute the pre-defined actions in the relevant response plans and to conduct other response actions that protect the public's health AND align with HCPH's responsibilities and mission.
    c. Depending on the needs of the incident, HCPH response personnel may work directly with the Hamilton County EOC, or their engagement may be facilitated by the HCPH DOC.

2) HCPH DOC
    a. When activated, the HCPH DOC is the facility through which HCPH response actions are coordinated and directed.
    b. The purpose of the DOC is to coordinate the execution of all HCPH response actions, regardless of the ESF those actions support—or even if the actions support an ESF. When activated, the DOC is the primary point for coordination and control of the HCPH response. As such, the DOC is the "one-stop-shop" for situational awareness on incident response for HCPH leadership and personnel.
    c. The DOC is only activated when response personnel determine that additional coordination or control is needed to successfully execute emergency response actions. When engaged, the DOC works directly with HCPH response personnel and the Hamilton County EOC.

3) ESF#8 Desk

   a. The ESF#8 Desk coordinates the execution of missions assigned to any of the ESF#8 agencies. HCPH shares primary ESF#8 coordination responsibilities with The Health Collaborative. HCPH has many ESF#8 responsibilities. HCPH staff assigned to the ESF#8 Desk may engage other ESF#8 partners.

   b. The purpose of the ESF#8 Desk is to ensure execution of all ESF#8 missions and to ensure that all ESF#8 partners maintain a common operating picture with the Hamilton County EOC. Although HCPH supports numerous ESFs, the ESF#8 Desk is uniquely focused on only the ESF#8 missions; missions assigned to other ESFs are not the responsibility of the ESF#8 Desk, even if they are the responsibility of HCPH. The ESF#8 Desk is equally concerned with all ESF#8 missions, whether assigned to HCPH or to another ESF#8 partner.

   c. The ESF#8 Desk can only be activated if the Hamilton County EOC is activated. Absent such an activation, the roles and responsibilities assigned to ESF#8 partners are the responsibility of each tasked agency, and these agencies would work with EMHSA to ensure they maintain a common operating picture and a coordinated response.

4) HCPH Representative(s) to Other ESFs

   a. HCPH ESF representatives represent HCPH in its role as a support agency in other ESFs. In this capacity, the representative(s) can commit HCPH resources, engage additional HCPH personnel, and complete the HCPH-assigned work described in the Hamilton County EOP.

   b. The purpose of these representatives is to ensure that HCPH remains appropriately engaged to provide adequate and effective support in each of the ESFs that HCPH has responsibilities. These representatives are uniquely concerned with executing the HCPH functions related to the ESF with which they are engaged.

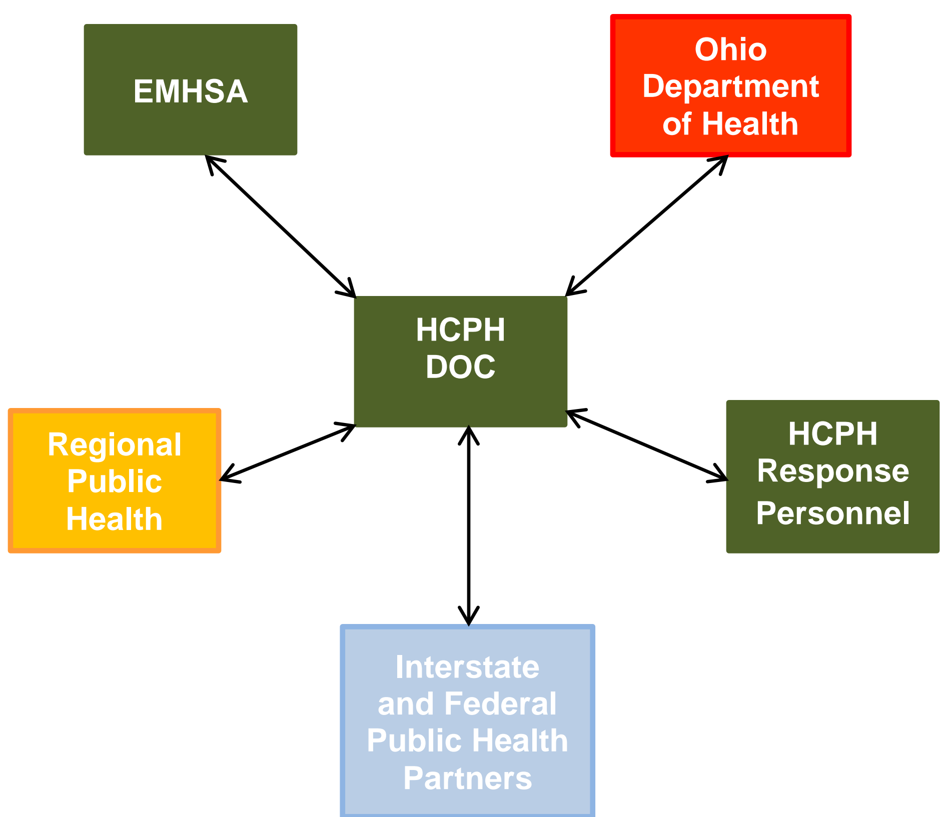
   c. HCPH ESF representatives will be activated as the incident demands. For efficiency of staffing, the ESF#8 Desk lead may be asked to also serve as the HCPH representative to other ESFs. When fulfilling this role, the ESF#8 Desk lead is acting only as the HCPH representative to the particular ESF and not as the ESF#8 Desk lead. If the demands of ESF#8 or another ESF require dedicated or expert engagement, the ESF#8 Desk lead can request that additional representatives come to the Hamilton County EOC. In the absence of a Hamilton County EOC activation, HCPH will fulfill its responsibilities in coordination with the ESF lead agency and EMHSA.

COMMUNICATION FLOW

The diagram below depicts how communication will flow when all three (3) HCPH response entities and the Hamilton County are activated. To ensure coordination, each entity should engage in confirmatory communication to verify their reports have been received.

Please note that "ESF Desk" in the diagram intentionally does not indicate ESF#8, since the HCPH DOC may communicate with any of the ESFs supported by HCPH.

Diagram 1. Communication Flow between HCPH Response Entities and the Hamilton County EOC



When activated, the Hamilton County EOC will hold regular briefings. The HCPH DOC will provide a report to the Hamilton County EOC at least one (1) hour before the scheduled briefings.

The HCPH DOC will interface directly with the ESF lead at the ESF#8 Desk for updates on missions and to provide requested information.

The HCPH DOC will provide updates via WebEOC and by sharing the developed HCPH SITREPs. Additionally, HCPH may provide 213s and 213RRs, as necessary. These may be included as attachments to the SITREPs, uploaded into WebEOC, or provided as stand-alone documents.

RESPONSE PRINCIPLES

The following principles have been developed to support the effective interface of HCPH entities engaged in response. In the event that it is unclear how to properly apply these response principles, HCPH entities are to confer with each other to determine their course of action. The response principles have been grouped by the entity to which they apply.

HCPH DOC

1) The HCPH DOC is concerned only with the actions of HCPH. The roles of other ESF partners are of concern to the applicable ESF Desk and the Hamilton County EOC, at large.
2) The HCPH DOC supports all ESFs in which HCPH has a role.
3) The HCPH DOC should monitor the HCPH assignments in WebEOC. Although valuable for situational awareness, it is not necessary for the HCPH DOC to monitor assignments to other agencies.
4) The HCPH DOC must coordinate actions with the Hamilton County EOC when taking actions that are related to incidents for which the Hamilton County EOC is activated.
5) The HCPH DOC does not need to coordinate actions with the Hamilton County EOC for actions that are related to incidents that the Hamilton County EOC is not tracking.
6) The HCPH DOC should engage the appropriate ESF Desk to coordinate its actions. Only ESF#8 actions should be coordinated through the ESF#8 Desk.
7) The HCPH DOC should not enter any data into WebEOC unless directed to do so by an ESF Desk at the Hamilton County EOC.
8) The HCPH DOC must maintain situational awareness of all HCPH response actions at all times.
9) The HCPH DOC should be prepared to provide a comprehensive report of the actions of HCPH to HCPH leadership or other stakeholders upon request.

10) The HCPH DOC must provide regular situation reports to each of the ESFs being supported by HCPH. The situation reports should group updates by the ESF to which they are related.
11) The HCPH DOC is fully authorized to execute every mission assigned to HCPH by the ESF#8 Desk. Authorization is inherent in the acceptance of the mission by the ESF#8 Desk.
12) The HCPH DOC should immediately follow up with the accepting ESF Desk if it believes the mission was improperly assigned to HCPH.
13) The HCPH DOC must maintain a common operating picture with all HCPH entities and with other response partners; confirmatory communication is essential.
14) The HCPH DOC should anticipate incident needs and initiate the execution of any action normally accomplished by HCPH, e.g. partner engagement, preparation of guidance, etc. Coordination with the Hamilton County EOC does not mean that the HCPH DOC requires Hamilton County EOC authorization to do what HCPH would normally do during incident response.
15) The HCPH DOC is intended to support and expedite emergency response actions. The HCPH DOC should never be a bottleneck to effective response.

ESF#8 Desk

1) The ESF#8 Desk is concerned only with ESF#8. The work of other ESFs and the non-ESF#8 work of HCPH are outside the purview of the ESF#8 Desk.
2) The ESF#8 Desk should monitor the ESF#8 assignments in WebEOC. Although valuable for situational awareness, it is not necessary for the ESF#8 Desk to monitor HCPH's non-ESF#8 assignments.
3) The ESF#8 Desk lead should remain aware of the activities across all ESFs and be poised to step out of the role as the ESF#8 Desk lead to represent HCPH on other ESFs.
4) The ESF#8 Desk lead should ensure that representing HCPH on other ESFs does not interfere with facilitating missions assigned to ESF#8 and should immediately notify the HCPH DOC of the need for an additional HCPH representative at the Hamilton County EOC if such a need arises.
5) When completing work as an HCPH representative in other ESFs, the ESF#8 Desk lead should differentiate such work from ESF#8 and should defer to the lead agency of the other ESF to report on and update the non-ESF#8 work of HCPH, providing additional detail only as requested.
6) The ESF#8 Desk must coordinate actions with all appropriate ESF#8 partners, not just HCPH.
7) The ESF#8 Desk should engage other ESFs for actions outside the purview of ESF#8.

8) The ESF#8 Desk is the only entity that should enter data into WebEOC; the ESF#8 Desk may request an ESF#8 partner enter data on its behalf.

9) The ESF#8 Desk should log all significant actions and events in WebEOC.

10) The ESF#8 Desk should close accept, update and close missions in a timely fashion. The ESF#8 Desk should immediately follow up with ESF#8 partners about any delays in accomplishing missions.

11) The ESF#8 Desk should confirm information with performing/providing agencies before uploading into WebEOC or reporting in a Hamilton County EOC briefing. The ESF#8 Desk should neither interpret nor add to a report; instead the ESF#8 Desk should seek clarification from the appropriate ESF#8 partner.

12) The ESF#8 Desk must maintain situational awareness of all ESF#8 actions at all times.

13) The ESF#8 Desk should be prepared to provide a comprehensive report of all the actions of ESF#8 to the Health Commissioner or other stakeholders upon request.

14) The ESF#8 Desk must participate in all Hamilton County EOC briefings and reports.

15) The ESF#8 Desk must support maintenance of a common operating picture by sharing all Hamilton County EOC reports with all applicable ESF#8 partners.

16) The ESF#8 Desk should accept every mission appropriately assigned to ESF#8. Questions about the appropriateness of a mission should be vetted with the applicable agency before accepting.

17) The ESF#8 Desk should immediately follow up with the mission-assignment Desk if a mission was improperly assigned to ESF#8.

18) The ESF#8 Desk must maintain a common operating picture with all ESF#8 partners, especially HCPH entities; confirmatory communication is essential.

19) The ESF#8 Desk should anticipate incident needs and position ESF#8 agencies to take needed actions. The ESF#8 Desk should not simply wait for an assignment from the Mission Assignment Desk, if there are needs to be addressed by ESF#8 partners.

20) The ESF#8 Desk should not circumvent the ESF#8 agency to engage the agency's partners/stakeholders on their behalf. Rather, the ESF#8 Desk should work through the ESF#8 partners to accomplish that engagement.

21) Because other partners may have questions for HCPH staff at the ESF#8 Desk, the ESF#8 Desk should maintain situational awareness of HCPH's non-ESF#8 response actions. This will be accomplished through regular review of situation reports from the HCPH DOC and active participation in the activities of the Hamilton County EOC.

22) The ESF#8 Desk is intended to support and expedite emergency response actions. The ESF#8 Desk should work with all necessary ESF#8 partners and other ESFs to accomplish the response goals. The ESF#8 Desk should never be a bottleneck to effective response.

ATTACHMENT V - INCIDENT ACTION PLAN TEMPLATE

DOCUMENT DESCRIPTION

This document serves as a template for creating an incident action plan during an emergency response. The first half of the document serves as the template, while the second half includes descriptions of the various forms utilized in the template and how best to fill them in.

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INCIDENT ACTION PLAN INTRODUCTION

The IAP is a written plan that defines the incident objectives and reflects the tactics necessary to manage an incident during an operational period. There is only one IAP for each incident, and that IAP is developed at the incident level. The IAP is developed through the incident action planning process. The IAP is a directive, “downward-looking” tool that is operational at its core; it is not primarily an assessment tool, feedback mechanism, or report. However, a well-crafted IAP helps senior leadership understand incident objectives and issues. Each page of the IAP will contain the following information:

- Date(s) of the incident;
- Name of the incident;
- Operational period;
- Name and title of the person who prepared the IAP;

The IAP will also include, but is not limited to, the following information (through the use of associated ICS forms):

Required Information	Associated ICS Form
Incident goals	ICS Form 202
Operational period objectives (major areas that must be addressed in the specified operational period to achieve the goals or control objectives);	ICS Form 202
Response strategies (priorities and the general approach to accomplish the objectives)	ICS Form 202
Organization list showing primary roles and relationships	ICS Form 203 ICS Form 204 ICS Form 207
Critical situation updates and assessments	ICS Form 202 ICS Form 208 ICS Form 213
Health and Safety plan (to prevent responder injury or illness)	ICS Form 206 ICS Form 208 (as needed)

HCPH will include a list of the current EEIs with the IAP. This list will be reviewed during IAP development and refined for each operational period. At a minimum, the IC/AC, PIO, Planning Lead, and Operations Lead will contribute to the refinement of the EEI list.

REQUIRED ICS FORMS FOR IAP

The below chart shows the required ICS forms to complete an IAP:

Order	Form (FEMA-ISC Form)	Title	Required	Prepared by:
1	200	Cover Sheet	Always	Planning Support Unit Lead
2	202	Incident Objectives	Always	SITL
3	205	Incident Radio Communications Plan	As the incident requires – Radio Use	Communications Unit Leader
4	205A	Incident Telephone Communications Plan	Always	Resource Unit Leader
5	207	Incident Organization Chart	Always	Resource Unit Leader
6		Incident Map	Always	SITL/GIS Unit Leader
7	204	Assignment List	Always	Resource Unit Leader
8	220	Air Operations Summary	As the incident requires – Air Ops	OSC/Air Operations Branch
9	206	Medical Plan	Always	Safety Officer
10	230	Meeting Schedule	Always	SITL
11	213	General Message	Optional	Any Message Originator
12	Other components as needed		Optional	Planning Support

HAMILTON COUNTY PUBLIC HEALTH
[INCIDENT NAME]
- INCIDENT ACTION PLAN

Date: ____________________

Prepared By

Name: _________________________

Position: _________________________

Title: _________________________

Operational Period:

Date From:

Time From:

Date To:

Time To:

ICS 200

1. Incident Name:

2. Operational Period: Date From: Date To:
Time From: Time To:

3. Objective(s):

4. Operational Period Command Emphasis:

General Situational Awareness:

5. Site Safety Plan Required? Yes ☐ No ☐
Approved Site Safety Plan(s) Located at:

6. Incident Action Plan (the items checked below are included in this Incident Action Plan)**:**

☐ ICS 203
☐ ICS 204
☐ ICS 205
☐ ICS 206
☐ ICS 208

☐ Map/Chart
☐ Weather Forecast/Tides/Currents

Other Attachments:
☐ ______________________
☐ ______________________
☐ ______________________
☐ ______________________

7. Prepared by: Name: ________________ Position/Title: ________________Signature: ________________

8. Approved by Incident Commander: Name: ______________________ Signature: ______________________

ICS 202 | **IAP Page** _____ | Date/Time: ______________________________________

1. Incident Name:	2. Date/Time Prepared: Date: Time:	3. Operational Period: Date From: Date To: Time From: Time To:

4. Incident communication information:

Incident Assigned Position	Name (Last, First)	Primary Number	Secondary Number	Other Method (s) of Contact (pager, email, radio, etc.)	Remarks

5. Special Instructions:

6. Prepared by (Communications Unit Leader)**:** Name: ______________________________ Signature: ______________________________

ICS 205	IAP Page _____	Date/Time: ______________________________

1. Incident Name:	**2. Operational Period:** Date From: Date To: Time From: Time To:		
3. Basic Local Communications Information:			
Section/ Division/Group	Position Assigned	Name	Method(s) of Contact (radio frequency, phone, pager, cell, etc.)
4. Prepared by: Name: ______________________	Position/Title: _______________	Signature: ________________	
ICS 205A	**IAP Page** _____	Date/Time: ____	

HCPH Department Operations Center (DOC)
Organizational Chart

- Incident Commander (IC)
  - Electronic Communications Specialist
  - Public Information Officer
  - Medical Director
  - Liaison Officer
  - Safety/Security
  - Operations Section Chief
    - Environ. Group Supervisor
    - Clinics Group Supervisor
    - Mass Dispensing Supervisor
    - Epi Division Director
      - Investigations Coordinator
  - Planning Section Chief
    - Situation Unit Leader
    - Documentation Unit Leader
  - Finance Section Chief
    - Time Unit Leader
    - Cost Procurement Unit Leader
  - Logistics Section Chief
    - Facilities Unit Leader
    - Communications Unit Leader
    - Staff Unit Leader
    - Materials Unit Leader

1. Incident Name:	**2. Operational Period:** Date From: Date To: Time From: Time To:	**3.** **Branch:** **Division:** **Group:**
4. Operations Personnel: Name:_________________________Contact Number(s):_______________ Operations Section Chief:_ Branch Director: ____ Division/Group Supervisor:_		

5. Resources Assigned:

Resource Identifier	Leader	# of Persons	Contact (e.g., phone, pager, radio frequency, etc.)	Reporting Location, Special Equipment and Supplies, Remarks, Notes, Information

6. Work Assignments:

7. Special Instructions:

8. Communications (radio and/or phone contact numbers needed for this assignment)**:**

Name/Function	Primary Contact: (cell, pager, radio frequency/system/channel)
_______________/_______________	____
_______________/_______________	____
_______________/_______________	____
_______________/_______________	____

9. Prepared by: Name: ________________ Position/Title: _______________Signature: ________________

ICS 204	**IAP Page** _____	Date/Time: ____

1. Incident Name:	**2. Operational Period:** Date From: Date To: Time From: Time To:

3. Medical Aid Stations:

Name	Location	Contact Number(s)/Frequency	Paramedics on Site?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

4. Transportation:

Ambulance Service	Location	Contact Number(s)/Frequency	Level of Service
			☐ ALS ☐ BLS
			☐ ALS ☐ BLS
			☐ ALS ☐ BLS
			☐ ALS ☐ BLS

5. Hospitals:

Hospital Name	Address	Contact Number(s)	Distance	Trauma Center	Burn Center	Helipad
				☐ Yes Level:_____	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes Level:_____	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes Level:_____	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes Level:_____	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes Level:_____	☐ Yes ☐ No	☐ Yes ☐ No

6. Special Medical Emergency Procedures:

7. Prepared by (Medical Unit Leader)**:** Name: _________________________ Signature: _________________________

8. Approved by (Safety Officer)**:** Name: ___________________________ Signature: ___________________________

ICS 206	**Page** ___	Date/Time: ____

1. Incident Name:	**2. Operational Period:** Date From: Date To: Time From: Time To:			
Date/Time	**Meeting**	**Attendees**	**Purposes/Outcome**	**Location**
Prepared by: Name: ____________________ Position/Title: ______________ Signature: ________________________		**REVIEWED BY:**		
ICS 230	**IAP Page** _____		Date/Time: _________________	

GENERAL MESSAGE		
TO:	POSITION:	
FROM:	POSITION:	
SUBJECT:	DATE:	TIME:
MESSAGE:		
SIGNATURE:	POSITION:	
REPLY:		
9. Prepared by: Name: ____________________Position/Title:_________Signature:__________________		
ICS 213	**IAP Page** _____	Date/Time: ________________________

1. Incident Name:	
3. Safety Message/Expanded Safety Message, Safety Plan, Site Safety Plan:	**2. Operational Period:** Date From: Date To: Time From: Time To:

4. Site Safety Plan Required? Yes ☐ No ☐
Approved Site Safety Plan(s) Located At:

5. Prepared by: Name: ____ Position/Title: ____Signature: ________________	
ICS 208	Date/Time: ____

ICS 202

INCIDENT OBJECTIVES

PURPOSE

The Incident Objectives (ICS 202) describes the basic incident strategy, incident objectives, command emphasis/priorities, and safety considerations for use during the next operational period.

PREPARATION

The ICS 202 is completed by the Planning Section following each Command and General Staff meeting conducted to prepare the Incident Action Plan (IAP). In case of a Unified Command, one Incident Commander (IC) may approve the ICS 202. If additional IC signatures are used, attach a blank page.

DISTRIBUTION

The ICS 202 may be reproduced with the IAP and may be part of the IAP and given to all supervisory personnel at the Section, Branch, Division/Group, and Unit levels. All completed original forms must be given to the Documentation Unit.

NOTES:

- The ICS 202 is part of the IAP and can be used as the opening or cover page.
- If additional pages are needed, use a blank ICS 202 and repaginate as needed.

Block Number	Block Title	Instructions
1	**Incident Name**	Enter the name assigned to the incident. If needed, an incident number can be added.
2	**Operational Period** • Date and Time From • Date and Time To	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	**Objective(s)**	Enter clear, concise statements of the objectives for managing the response. Ideally, these objectives will be listed in priority order. These objectives are for the incident response for this operational period as well as for the duration of the incident. Include alternative and/or specific tactical objectives as applicable. Objectives should follow the SMART model or a similar approach: **S**pecific – Is the wording precise and unambiguous? **M**easurable – How will achievements be measured? **A**ction-oriented – Is an action verb used to describe expected accomplishments? **R**ealistic – Is the outcome achievable with given available resources? **T**ime-sensitive – What is the timeframe?

Block Number	Block Title	Instructions
4	**Operational Period Command Emphasis**	Enter command emphasis for the operational period, which may include tactical priorities or a general weather forecast for the operational period. It may be a sequence of events or order of events to address. This is not a narrative on the objectives, but a discussion about where to place emphasis if there are needs to prioritize based on the Incident Commander's or Unified Command's direction. Examples: Be aware of falling debris, secondary explosions, etc.
	General Situational Awareness	General situational awareness may include a weather forecast, incident conditions, and/or a general safety message. If a safety message is included here, it should be reviewed by the Safety Officer to ensure it is in alignment with the Safety Message/Plan (ICS 208).
5	**Site Safety Plan Required?** Yes ☐ No ☐	Safety Officer should check whether or not a site safety plan is required for this incident.
	Approved Site Safety Plan(s) Located At	Enter the location of the approved Site Safety Plan(s).
6	**Incident Action Plan** (the items checked below are included in this Incident Action Plan): ☐ ICS 203 ☐ ICS 204 ☐ ICS 205 ☐ ICS 206 ☐ ICS 208 ☐ Map/Chart ☐ Weather Forecast/ Tides/Currents Other Attachments:	Check appropriate forms and list other relevant documents that are included in the IAP. ☐ ICS 203 – Organization Assignment List ☐ ICS 204 – Assignment List ☐ ICS 205 – Incident Communications Plan ☐ ICS 206 – Medical Plan ☐ ICS 208 – Safety Message/Plan
7	**Prepared by** • Name • Position/Title • Signature	Enter the name, ICS position, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).
8	**Approved by Incident Commander** • Name • Signature • Date/Time	In the case of a Unified Command, one IC may approve the ICS 202. If additional IC signatures are used, attach a blank page.

ICS 204

ASSIGNMENT LIST

PURPOSE

The Assignment List(s) (ICS 204) informs Division and Group supervisors of incident assignments. Once the Command and General Staffs agree to the assignments, the assignment information is given to the appropriate Divisions and Groups.

PREPARATION

The ICS 204 is normally prepared by the Resources Unit, using guidance from the Incident Objectives (ICS 202), Operational Planning Worksheet (ICS 215), and the Operations Section Chief. It must be approved by the Incident Commander, but may be reviewed and initialed by the Planning Section Chief and Operations Section Chief as well.

DISTRIBUTION

The ICS 204 is duplicated and attached to the ICS 202 and given to all recipients as part of the Incident Action Plan (IAP). In some cases, assignments may be communicated via email/radio/telephone/fax. All completed original forms must be given to the Documentation Unit.

NOTES:

- The ICS 204 details assignments at Division and Group levels and is part of the IAP.
- Multiple pages/copies can be used if needed.
- If additional pages are needed, use a blank ICS 204 and repaginate as needed.

Block Number	Block Title	Instructions
1	**Incident Name**	Enter the name assigned to the incident.
2	**Operational Period** • Date and Time From • Date and Time To	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	**Branch** **Division** **Group**	This block is for use in a large IAP for reference only. Write the alphanumeric abbreviation for the Branch, Division and Group (e.g., "Branch 1," "Division D," "Group 1A") in large letters for easy referencing.
4	**Operations Personnel** • Name, Contact Number(s) – Operations Section Chief – Branch Director – Division/Group Supervisor	Enter the name and contact numbers of the Operations Section Chief, applicable Branch Director(s), and Division/Group Supervisor(s).
5	**Resources Assigned**	Enter the following information about the resources assigned to the Division or Group for this period:

Block Number	Block Title	Instructions
	• Resource Identifier	The identifier is a unique way to identify a resource (e.g., ENG-13, IA-SCC-413). If the resource has been ordered but no identification has been received, use TBD (to be determined).
	• Leader	Enter resource leader's name.
	• # of Persons	Enter total number of persons for the resource assigned, including the leader.
	• Contact (e.g., phone, pager, radio frequency, etc.)	Enter primary means of contacting the leader or contact person (e.g., radio, phone, pager, etc.). Be sure to include the area code when listing a phone number.
	• Reporting Location, Special Equipment and Supplies, Remarks, Notes, Information	Provide special notes or directions specific to this resource. If required, add notes to indicate: (1) specific location/time where the resource should report or be dropped off/picked up; (2) special equipment and supplies that will be used or needed; (3) whether or not the resource received briefings; (4) transportation needs; or (5) other information.
6	**Work Assignments**	Provide a statement of the tactical objectives to be achieved within the operational period by personnel assigned to this Division or Group.
7	**Special Instructions**	Enter a statement noting any safety problems, specific precautions to be exercised, dropoff or pickup points, or other important information.
8	**Communications** (radio and/or phone contact numbers needed for this assignment) • Name/Function • Primary Contact: indicate cell, pager, or radio (frequency/system/channel)	Enter specific communications information (including emergency numbers) for this Branch/Division/Group. Phone and pager numbers should include the area code and any satellite phone specifics. In light of potential IAP distribution, use sensitivity when including cell phone number. Add a secondary contact (phone number or radio) if needed. If radios are being used, enter function (command, tactical, support, etc.), frequency, system, and channel from the Incident Communications Plan (ICS 205).
9	**Prepared by** • Name • Position/Title • Signature • Date/Time	Enter the name, ICS position, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).

ICS 205

INCIDENT COMMUNICATIONS PLAN

PURPOSE

The Incident Communications Plan (ICS 205) provides contact information for all incident personnel. The ICS 205 indicates methods of contact for personnel assigned to the incident (phone numbers, pager numbers, radio frequencies, etc.) and functions as an incident directory.

PREPARATION

The ICS 205 is prepared by the Communications Unit Leader and given to the Planning Section Chief for inclusion in the Incident Action Plan. This form should be updated each operational period.

DISTRIBUTION

The ICS 205 is duplicated and attached to the Incident Objectives (ICS 202) and given to all recipients as part of the Incident Action Plan (IAP). All completed original forms must be given to the Documentation Unit. If this form contains sensitive information such as cell phone numbers, it should be clearly marked in the header that it contains sensitive information and is not for public release.

NOTES:

- If additional pages are needed, use a blank ICS 205 and repaginate as needed.
- The ICS 205 serves as part of the IAP.

Block Number	Block Title	Instructions
1	**Incident Name**	Enter the name assigned to the incident.
2	**Date/Time Prepared**	Enter date prepared (month/day/year) and time prepared (using the 24-hour clock).
3	**Operational Period** • Date and Time From • Date and Time To	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
4	**Incident Communications Information**	Enter the communications methods assigned and used for personnel by their assigned ICS position.
	• Incident Assigned Position	Enter the ICS organizational assignment.
	• Name	Enter the name of the assigned person.
	• Primary and Secondary Numbers • Other Method(s) of Contact (pager, email, radio, etc.)	For each assignment, enter primary and secondary contact number(s) to include area code, etc. If applicable, include the radio channel and frequency,
	• Remarks	Enter miscellaneous information concerning how to contact the assigned personnel
5	**Special Instructions**	Enter any special instructions or other emergency communications needs.

6	**Prepared by** • Name • Position/Title • Signature • Date/Time	Enter the name, ICS position, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).

ICS 206

MEDICAL PLAN

PURPOSE

The Medical Plan (ICS 206) provides information on incident medical aid stations, transportation services, hospitals, and medical emergency procedures.

PREPARATION

The ICS 206 is prepared by the Medical Unit Leader and reviewed by the Safety Officer to ensure ICS coordination.

DISTRIBUTION

The ICS 206 is duplicated and attached to the Incident Objectives (ICS 202) and given to all recipients as part of the Incident Action Plan (IAP). Information from the plan pertaining to incident medical aid stations and medical emergency procedures may be noted on the Assignment List (ICS 204). All completed original forms must be given to the Documentation Unit.

NOTES:

- The ICS 206 serves as part of the IAP.
- This form can include multiple pages.

Block Number	Block Title	Instructions
1	**Incident Name**	Enter the name assigned to the incident.
2	**Operational Period** • Date and Time From • Date and Time To	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	**Medical Aid Stations**	Enter the following information on the incident medical aid station(s):
	• Name	Enter name of the medical aid station.
	• Location	Enter the location of the medical aid station (e.g., Staging Area, Camp Ground).
	• Contact Number(s)/Frequency	Enter the contact number(s) and frequency for the medical aid station(s).
	• Paramedics on Site? ☐ Yes ☐ No	Indicate (yes or no) if paramedics are at the site indicated.
4	**Transportation**	Enter the following information for ambulance services available to the incident:
	• Ambulance Service	Enter name of ambulance service.

Block Number	Block Title	Instructions
	• Location	Enter the location of the ambulance service.
	• Contact Number(s)/Frequency	Enter the contact number(s) and frequency for the ambulance service.
	• Level of Service ☐ ALS ☐ BLS	Indicate the level of service available for each ambulance, either ALS (Advanced Life Support) or BLS (Basic Life Support).
5	**Hospitals**	Enter the following information for hospital(s) that could serve this incident:
	• Hospital Name	Enter hospital name
	• Address	Enter the physical address of the hospital
	• Contact Number(s)/ Frequency	Enter the contact number(s) and/or communications frequency(s) for the hospital.
	• Distance	Enter the distance in miles to the hospital.
	• Trauma Center ☐ Yes Level:_______	Indicate yes and the trauma level if the hospital has a trauma center.
	• Burn Center ☐ Yes ☐ No	Indicate (yes or no) if the hospital has a burn center.
	• Helipad ☐ Yes ☐ No	Indicate (yes or no) if the hospital has a helipad.
6	**Special Medical Emergency Procedures**	Note any special emergency instructions for use by incident personnel, including (1) who should be contacted, (2) how should they be contacted; and (3) who manages an incident within an incident due to a rescue, accident, etc. Include procedures for how to report medical emergencies.
7	**Prepared by** (Medical Unit Leader) • Name • Signature	Enter the name and signature of the person preparing the form, typically the Medical Unit Leader. Enter date (month/day/year) and time prepared (24-hour clock).
8	**Approved by** (Safety Officer) • Name • Signature • Date/Time	Enter the name of the person who approved the plan, typically the Safety Officer. Enter date (month/day/year) and time reviewed (24-hour clock).

ICS 208

SAFETY MESSAGE/PLAN

PURPOSE

The Safety Message/Plan (ICS 208) expands on the Safety Message and Site Safety Plan.

PREPARATION

The ICS 208 is an optional form that may be included and completed by the Safety Officer for the Incident Action Plan (IAP).

DISTRIBUTION

The ICS 208, if developed, will be reproduced with the IAP and given to all recipients as part of the IAP. All completed original forms must be given to the Documentation Unit.

NOTES:

- The ICS 208 may serve (optionally) as part of the IAP.
- Use additional copies for continuation sheets as needed, and indicate pagination as used.

Block Number	Block Title	Instructions
1	**Incident Name**	Enter the name assigned to the incident.
2	**Operational Period** • Date and Time From • Date and Time To	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	**Safety Message/Expanded Safety Message, Safety Plan, Site Safety Plan**	Enter clear, concise statements for safety message(s), priorities, and key command emphasis/decisions/directions. Enter information such as known safety hazards and specific precautions to be observed during this operational period. If needed, additional safety message(s) should be referenced and attached.
4	**Site Safety Plan Required?** Yes ☐ No ☐	Check whether or not a site safety plan is required for this incident.
	Approved Site Safety Plan(s) Located At	Enter where the approved Site Safety Plan(s) is located.
5	**Prepared by** • Name • Position/Title • Signature • Date/Time	Enter the name, ICS position, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).

ATTACHMENT VI - DEVELOPMENT OF AN AFTER ACTION REPORT/IMPROVEMENT PLAN AND COMPLETION OF CORRECTIVE ACTIONS

DOCUMENT DESCRIPTION

This document describes how an after action report and improvement plan is developed and the appropriate corrective actions are tracked and completed.

TABLE OF CONTENTS

DOCUMENT DESCRIPTION 1
DEVELOPMENT 2
RESPONSIBLE PARTY 2
ANALYSIS 2
CORRECTIVE ACTIONS 2
AFTER-ACTION REPORT/IMPROVEMENT PLAN (AAR/IP) 2

DEVELOPMENT

All incidents that require the use of the ERP will produce an AAR/IP. The AAR/IP development begins with a hotwash. The hotwash should occur as soon as possible but no later than three days after the conclusion of response operations. The EP Program will coordinate with all involved response parties to schedule a time for the hotwash.

RESPONSIBLE PARTY

The EP Program will provide an AAR/IP coordinator for all incidents for which the HCPH ERP was activated, including for incidents that the agency did not lead. The AAR/IP coordinator will be a planner with general knowledge of the incident who was not directly involved in the response.

ANALYSIS

The EP Program will develop lessons learned as part of the response through a thorough analysis of response events, documentation, and the feedback provided at the hotwash. This analysis will feed into the AAR/IP to provide necessary information to identify corrective actions.

CORRECTIVE ACTIONS

The EP Program is responsible for coordinating/communicating with participating response partners and stakeholders to implement corrective actions identified in the AAR/IP and for tracking completion of corrective actions. The identified items for the AAR/IP provides opportunities for future improvement upon response shortcomings and highlights the response strengths. The EP Supervisor, or designee, notifies the responsible party of the corrective action and confirms the completion date. The EP Supervisor regularly follows up with the responsible party to confirm movement and, ultimately, completion of the corrective action.

AFTER-ACTION REPORT/IMPROVEMENT PLAN (AAR/IP)

See following pages for an example After-Action Report, as provided by ODH per the PHEP grant.

[Exercise/Event Name]

AFTER-ACTION REPORT/IMPROVEMENT PLAN

[Date of Exercise/Event]

[Date AAR/IP submitted]

[Subgrantee Agency Name]

The After-Action Report/Improvement Plan (AAR/IP) aligns exercise objectives with preparedness doctrine to include the National Preparedness Goal and related frameworks and guidance. Specific to this report, the exercise objectives align with the Public Health Preparedness Capabilities: National Standards for State and Local Planning and ASPR's National Guidance for Healthcare Preparedness and the Hospital Preparedness Program Measures. Exercise information required for preparedness reporting and trend analysis is included; users are encouraged to add additional sections as needed to support their own organizational needs.

Exercise/Event Overview

Exercise/Event Name	[Insert the formal name of exercise/event, which should match the name in the document header]
Exercise/Event Dates	[Indicate the start and end dates of the exercise/event]
Scope	This is a [exercise/event type] that was [planned/occurred] for [exercise/event duration] at [exercise/event location]. Exercise/event participation was limited to [exercise/event parameters].
Mission Area(s)	[Prevention, Protection, Mitigation, Response, and/or Recovery as applicable]
PHEP Capabilities/HPP Capabilities	[List the Public Health Emergency Preparedness (PHEP) capabilities and/or Healthcare Preparedness (HPP) capabilities and the number exercised or demonstrated during the real-world event.]
Objectives	[List the exercise/event objectives]
Threat or Hazard	[List the specific threat or hazard (e.g. infectious disease, natural/hurricane, technological/radiological release, etc.)]
Scenario/Event Catalyst	[Insert a brief overview of the exercise scenario/event catalyst(s), including scenario/event catalyst impacts (2-3 sentences)]
Sponsor/Lead Agency	[Insert the name of the exercise sponsor origination or coalition, as well as any grant programs being utilized, if applicable. List the lead response agency for the real-world response.]
Participating Organizations	[List the total number of participants and participant organizations. Reference the complete list by organization type and the total number of participants by organization type in the coalition and participation level (i.e., Federal, State, local, Tribal, non-governmental organizations (NGOs), and/or international agencies) is provided in Appendix B.
Point of Contact	[Insert the name, title, agency, address, phone number, and email address of the primary exercise POC (e.g., exercise director and exercise sponsor. If a contractor was the primary POC a subgrantee POC must also be identified to answer any questions regarding the content of the report.

Executive Summary

[When writing the Executive Summary, keep in mind that this section may be the only part of the AAR/IP that some people will read. Introduce this section by stating the full name of the exercise/event and providing a brief overview of the exercise/event. This brief overview should discuss why the exercise was conducted or the event occurred; the exercise/event objectives; and what PHEP/HPP capabilities and scenario (if applicable) were used to achieve those objectives. These areas will be discussed in more detail in the subsequent sections of the AAR/IP. In addition, the Executive Summary may be used to summarize any high-level observations that cut across multiple capabilities. This section should provide a general overview of the goals, purpose and objectives of the exercise/event and a brief summary of public health, and healthcare coalition participation to include how capabilities were met.]

The purpose of this report is to analyze exercise/event results, identify strengths to be maintained and built upon, identify potential areas for further improvement, and support development of corrective actions.

[In general, the major strengths and primary areas for improvement should be limited to three each to ensure the Executive Summary is high-level and concise.]

Major Strengths

The major strengths identified during this incident are as follows:

- [Strength number 1]
- [Additional major strength]
- [Additional major strength]

Primary Areas for Improvement

Throughout the exercise/event, several opportunities for improvement in [jurisdiction/organization name]'s ability to respond to the incident were identified. The primary areas for improvement, including recommendations, are as follows:

- [Use complete sentences to state each primary area for improvement and its associated key recommendation(s).]
- [Additional key recommendation]
- [Additional key recommendation]

[End this section by describing the overall exercise as successful or unsuccessful, and briefly state the areas in which subsequent exercises conducted by these jurisdictions and/or organizations should focus.]

Analysis of Public Health Emergency Preparedness (PHEP) and/or Health Care Preparedness (HPP) Capabilities

Aligning exercise/event objectives and PHEP/HPP capabilities provides a consistent taxonomy for evaluation that transcends individual exercises and real world responses to support preparedness reporting and trend analysis. **Table 1** below includes the exercise/event objectives, aligned PHEP/HPP capabilities, and performance ratings for each PHEP/HPP capability as observed during the exercise or real world response and determined by the evaluation/AAR team. All performance measures and task ratings for the function are considered as part of the capability analysis before assigning an overall function rating. The evaluation/AAR team then considers all the function ratings for the evaluated Capability and assigns an overall Capability rating.

Table 1. Summary of PHEP/HPP Capability Performance

Objective	PHEP/HPP Capability	Performed without Challenges (P)	Performed with Some Challenges (S)	Performed with Major Challenges (M)	Unable to be Performed (U)
[Objective 1]	[Enter PHEP/HPP Capability here]				
[Objective 2]	[Enter PHEP/HPP Capability here]				
[Objective 3]	[Enter PHEP/HPP Capability here]				
[Enter more objectives as applicable]	[Enter PHEP/HPP Capability here]				

The rating scale includes four ratings:

- **Performed without Challenges (P):** The PHEP functions, tasks, and performance measures or the HPP activities, objectives, and performance measures associated with the capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws. HPP
- **Performed with Some Challenges (S):** The PHEP functions, tasks, and performance measures or the HPP activities, objectives, and performance measures associated with the capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws. However, opportunities to enhance effectiveness and/or efficiency were identified.
- **Performed with Major Challenges (M):** The PHEP functions, tasks, and performance measures and or the HPP activities, objectives, and performance measures associated with the capability were completed in a manner that achieved the objective(s), but some or all of the following were observed: demonstrated performance had a negative impact on the performance of other activities; contributed to additional health and/or safety risks for the public or for emergency workers; and/or was not conducted in accordance with applicable plans, policies, procedures, regulations, and laws.
- **Unable to be Performed (U):** The PHEP functions, tasks, and performance measures or the HPP activities, objectives, and performance measures associated with the capability were not performed in a manner that achieved the objective(s).

Note: Exercise Event review forms

The following sections provide an overview of the performance related to each exercise/event objective and associated PHEP/HPP capability, highlighting strengths and areas for improvement, a list of applicable reference documents, and capability analysis.

[Objective 1]

The strengths and areas for improvement for each [PHEP or HPP] capability aligned to this objective are described in this section **Note:** do not combine capabilities.

[Related PHEP/HPP Capability]

[List the PHEP function(s), tasks, and any performance measures or the HPP objectives, activities and any performance measures exercised or demonstrated during a real-world event, as associated with the capability here.]

Strengths

The [full or partial] capability level can be attributed to the following strengths:

Strength 1: [Observation statement]

Strength 2: [Observation statement]

Strength 3: [Observation statement]

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Area for Improvement 1: [Observation statement. This should clearly state the problem or gap; it should not include a recommendation or corrective action, as those will be documented in the Improvement Plan.]

Reference: [List any relevant plans, policies, procedures, regulations, or laws.] **Note:** be specific list the title & date of the document

Analysis: [Provide a root cause analysis or summary of why the full capability level was not achieved.]

Area for Improvement 2: [Observation statement]

Reference: [Enter reference data here i.e. plans, documents, etc.] **Note:** be specific list the title & date of the document

Analysis: [Provide a root cause analysis or summary of why the full capability level was not achieved. **Note:** The goal of data analysis is to evaluate the ability of exercised/demonstrated PHEP functions, tasks, and performance measures or HPP objectives, activities, and performance measures to perform PHEP and/or HPP capabilities successfully and in accordance with plans, policies, procedures, and agreements. For this reason, data analysis may be the most important part of the evaluation process. When conducting root-cause analysis, evaluators ask why each PHEP task or HPP activity happened or did not happen. A number of analysis tools are available for root-cause analysis. One common tool is the "why staircase." To use the why staircase, evaluators keep asking why a PHEP task or HPP activity happened or did not happen until they are satisfied that they have identified the root cause. When evaluators have identified the root cause of a problem, they can be sure that corrective action recommendations in the

Improvement Plan will actually address the problem, and not just a symptom of it. All areas of improvement must be addressed within the capability analysis.]

[Objective 2]

The strengths and areas for improvement for each [PHEP or HPP] capability aligned to this objective are described in this section **Note:** do not combine capabilities.

[Related PHEP/HPP Capability]

[List the PHEP function(s), tasks, and any performance measures or the HPP objectives, activities and any performance measures exercised or demonstrated during a real-world event, as associated with the capability here.]

Strengths

The [full or partial] capability level can be attributed to the following strengths:

Strength 1: [Observation statement]

Strength 2: [Observation statement]

Strength 3: [Observation statement]

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Area for Improvement 1: [Observation statement. This should clearly state the problem or gap; it should not include a recommendation or corrective action, as those will be documented in the Improvement Plan.]

Reference: [List any relevant plans, policies, procedures, regulations, or laws.] **Note:** be specific list the title & date of the document

Analysis: [Provide a root cause analysis or summary of why the full capability level was not achieved.]

Area for Improvement 2: [Observation statement]

Reference: [Enter reference data here i.e. plans, documents, etc.] **Note:** be specific list the title & date of the document

Analysis: [Provide a root cause analysis or summary of why the full capability level was not achieved.]

[Objective 3]

The strengths and areas for improvement for each [PHEP or HPP] capability aligned to this objective are described in this section **Note:** do not combine capabilities.

[Related PHEP/HPP Capability]

[List the function(s), tasks and performance measures exercised or demonstrated during a real-world event, as associated with the capability here.]

Strengths

The [full or partial] capability level can be attributed to the following strengths:

Strength 1: [Observation statement]

Strength 2: [Observation statement]

Strength 3: [Observation statement]

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Area for Improvement 1: [Observation statement. This should clearly state the problem or gap; it should not include a recommendation or corrective action, as those will be documented in the Improvement Plan.]

Reference: [List any relevant plans, policies, procedures, regulations, or laws.] **Note:** be specific list the title & date of the document

Analysis: [Provide a root cause analysis or summary of why the full capability level was not achieved.]

Area for Improvement 2: [Observation statement]

Reference: [Enter reference data here i.e. plans, documents, etc.] **Note:** be specific list the title & date of the document

Analysis: [Provide a root cause analysis or summary of why the full capability level was not achieved.] **Note:** The goal of data analysis is to evaluate the ability of exercised/demonstrated PHEP functions, tasks, and performance measures or HPP objectives, activities, and performance measures to perform PHEP and/or HPP capabilities successfully and in accordance with plans, policies, procedures, and agreements. For this reason, data analysis may be the most important part of the evaluation process. When conducting root-cause analysis, evaluators ask why each PHEP task or HPP activity happened or did not happen. A number of analysis tools are available for root-cause analysis. One common tool is the “why staircase.” To use the why staircase, evaluators keep asking why a PHEP task or HPP activity happened or did not happen until they are satisfied that they have identified the root cause. When evaluators have identified the root cause of a problem, they can be sure that corrective action recommendations in the Improvement Plan will actually address the problem, and not just a symptom of it. All areas of improvement must be addressed within the capability analysis.]

Conclusion

[This section is a conclusion for the entire document. It provides an overall summary to the report. It should include the demonstrated capabilities, lessons learned, major recommendations, and a summary of what steps should be taken to ensure that the concluding results will help to further refine plans, policies, procedures, and training for this type of incident.

Subheadings are not necessary and the level of detail in this section does not need to be as comprehensive as that in the Executive Summary.]

Appendix A: Improvement Plan

This IP has been developed specifically for [Subgrantee Organization or Jurisdiction] as a result of [Exercise/Event Name] conducted on [date of exercise/event].

PHEP/HPP Capability	Issue/Area for Improvement	Corrective Action	Capability Element[1]	Primary Responsible Organization	Organization POC	Start Date	Completion Date
PHEP Capability 1: [Capability Name]	1. [Area for Improvement]	[Corrective Action 1]					
		[Corrective Action 2]					
		[Corrective Action 3]					
	2. [Area for Improvement]	[Corrective Action 1]					
		[Corrective Action 2]					
[Continue adding capabilities and related information as relevant.]							

[1] Capability Elements are: Planning, Organization, Equipment, Training, or Exercise.

Appendix B: Exercise/Event Participants

Participating Organizations			
Participant Type	**# in Agency/Org**	**# Participating**	**% Participation**
Federal Government			
Example: FEMA			
Example: USEPA			
State Government			
Example: ODH			
Example: Ohio EMA			
Local Government			
Example: Local Health Department			
Example: EMS			
Example: Emergency Management			
Non-government Coalition Members and Partners			
Example: Hospital			
Example: Long Term Care Facilities			
Example: Dialysis Centers			
Example: Community Health Center			
etc.			

Note: If you do not know the number of personnel in each agency put unknown. Use your exercise/event sign in sheets to get the total number of participants.

Additional Information/Comments

[Please provide any additional information or comments as indicated.]

Appendix C: Acronyms

[All acronyms referenced in the AAR/IP should be listed alphabetically and spelled out.]

Table E.1: Acronyms

Acronym	Meaning

Appendix D: Participant Feedback Summary

[Provide a summary of the Participant Feedback Form information collected, which should be distributed to exercise participants at a post-exercise/event hot wash.]

Appendix E: Exercise/Event Summary

[In formulating the analysis, the primary AAR author will assemble a timeline of key events. While it is not necessary to include this timeline in the main body of the AAR/IP, the timeline must be identified in this appendix. This section should summarize what actually happened during the exercise/event in a timeline-table format. An example of the format for the exercise/event Timeline is presented below.]

Date	Time	Event/Action
02/20/15	0900	Explosion and injuries reported at subway station 13
02/20/15	0902	Subway services stopped in accordance with protocols; notifications started
02/20/15	0915	Evacuation ordered for planning zone 2A
02/20/15	0940	Traffic at a standstill on major egress route 1 reported to players (Response generated issue because personnel to staff traffic control points were not deployed)

Appendix F: OPHCS Message Report

[The sub grantee must demonstrate the use of OPHCS in all functional and full scale exercises conducted before during and after and exercise (e.g. notification of exercise, situational awareness, and end of exercise. This section should include the OPHCS Message Report. If you utilized OPHCS during a real-world response you should attach copies of the messages here.]

To pull a message report in the OPHCS system:

1. Navigate to the “Messages” tab and select the “Sent” sub tab on the right of the screen.
2. You will now see all the messages you have sent, if you sent the message please skip step 3
3. From the drop-down menu that says “Sent by you” select “Sent by all Administrators”
4. Scroll through the list until you find the message you want to pull a report for.
5. Once the message has been selected, use the “Actions” drop down box to select “Export”
6. In the “Export Message” window check the box beside all the report options you wish to retrieve.
7. Click download
8. Congratulations you have successfully pulled an OPHCS message report.

Example OPHCS Message Report

Responses By Delivery Method - All Recipients

Delivery Method	Delivered	Delivered/ Responded	Delivered/No Response	Delivery Failed
Email	52	30	22	0
Phone	45	17	28	0
Internal	52	0	52	0

Recipient Statistics - By Containers

Recipient Containers	Recipient Count	Delivered	Responded	No Response	Failed	Not Contacted
ODH-SNS 2nd Tier Assignment	10	10	10	0	View values	0
ODH-SNS CRT Response	16	16	16	0	View values	0
ODH-SNS Response	46	46	42	4	View values	0

Advanced Delivery Options

Text Delivery Delay	0minutes
Send Time	Immediately
Message Delivery	escalation
Time this message is available for response	24 hours
Validate Recipient	Yes
Number of times to contact	3
Time between each contact attempt	10 minutes

Message Details

Sender	Ohio Public Health Communication System
Subject	SNS Responder Test Alert
Message Types	Email Internal Phone
Is this communication sensitive	No
Communication Type	Alert
Long Message	"This is an ALERT"

Appendix G: ICS FORM 205

[A completed ICS 205 form must be used for this section for the AAR to document the exercise/event radio communication plan. This information can be directly entered into the editable form below or scanned in and attached from the subgrantees ICS Form 205.]

1. Incident Name:	**2. Date/Time Prepared:** Date: Date Time: HHMM	**3. Operational Period:** Date From: Date Date To: Date Time From: HHMM Time To: HHMM

4. Basic Radio Channel Use:

Zone Grp.	Ch . #	Function	Channel Name/Trunked Radio System Talk group	Assignment	RX Freq N or W	RX Tone/NAC	TX Freq N or W	TX Tone/NAC	Mode (A, D, or M)	Remarks

5. Special Instructions:

6. Prepared by (Communications Unit Leader): Name: Signature: ______________________

ICS 205	**IAP Page**	Date/Time: Date

ATTACHMENT VII - SITUATION REPORT TEMPLATE

DOCUMENT DESCRIPTION

This document serves as the template for creation of situation reports (SitReps) during an emergency response.

TABLE OF CONTENTS

DOCUMENT DESCRIPTION 1
INCIDENT ACTION PLAN INTRODUCTION 2
CURRENT SITUATION 2

INCIDENT NAME:

START DATE (MM/DD/YYY):

END DATE (MM/DD/YYYY):

START TIME (HH:MM):

END TIME (HH:MM):

REPORT PREPARED BY (NAME, TITLE):

CURRENT SITUATION

THE INFORMATION IN THIS REPORT IS CURRENT AS OF (MM/DD/YYYY, HH:MM):

Current Issues Summary:
Current Threat Status:

Actions Completed since Last Report:
Area(s) of Operation and Status by Location:
Current Objectives and Projected Completion Time/Date:

Long-term Planning Considerations:

Functional Systems Status Summaries:

Analysis of Access and Functional Needs:
Local Health Jurisdiction(s) Status:
Health Care Facilities Status:
Epidemiology Syndromic Surveillance Summary:
Environmental Health Summary:

Public Information and Risk Communications:

Public Health and Medical Assets Deployed:

Finance and Administration Summary:

ATTACHMENT VIII - OPERATIONAL SCHEDULE FORM

DOCUMENT DESCRIPTION

The Operational Schedule Form is developed by the Planning (Support) Section Chief to notify responding staff of their supervisor's name, reporting location, reporting date, shift start time, and shift end time. This form will be provided to the entire response organization so that all participants have awareness of the response staff working an incident, the locations supporting the incident response, and the time periods when response staff is working.

TABLE OF CONTENTS

DOCUMENT DESCRIPTION 1

Operation Name:			**Operational Period: to**			
Responder Name	**Supervisor Name**	**Unit/ Section**	**Reporting Location**	**Reporting Date**	**Shift Start Time**	**Shift End Time**
Bob Doe	Kate Doe	Message Center	HCPH DOC	May 5, 2017	0800	1630
Sam Doe	Kate Doe	Situation Unit	HCPH DOC	May 5, 2017	0800	1630
Jane Doe	Lauri Doe	Epi SME	HCPH DOC	May 5, 2017	0800	1630
Julie Doe	Shirley Doe	Epi SME	HCPH DOC	May 5, 2017	1600	0030
Jim Doe	Ang Doe	BXXXX SME	HCPH DOC	May 5, 2017	0800	1630
Harry Doe	Herc Doe	HCPH EXX	Hamilton County EMA EOC ESF-8 Desk	May 5, 2017	0800	1630

ATTACHMENT IX - BATTLE RHYTHM TEMPLATE

DOCUMENT DESCRIPTION

The battle rhythm details essential command staff meetings, established reporting timelines and other necessary coordination requirements. The battle rhythm for each operational period will be created by the Planning (Support) Section and distributed to all response staff at the beginning of their shift.

The table below contains language in red font that will be customized for each response. Any meeting row can be duplicated and placed into the table in multiple locations to account for events that occur more than once per operational period.

The list of events below should be considered for each response. Unneeded events can be deleted from the battle rhythm.

TABLE OF CONTENTS

DOCUMENT DESCRIPTION 1

Incident Name : TBD			**Operational Period** Date From: TBD Date To: TBD Time From: TBD Time To: TBD		
HCPH Battle Rhythm					
Date/ Time	**Event**	**Purpose**	**Attendees/POC**	**Location**	**Expected Outcome**
Daily/Weekly Time TBD	Senior Leadership Update	Provide summary of current situation, discuss trends and determine critical actions needed.	Health Commissioner, Assistant Health Commissioners, Division Directors, Supervisors	Large Conference Room. *Updates are e-mailed by the IC unless a meeting is requested*	Situational Awareness and Information Sharing
Daily/Weekly Time TBD	Situation Report Update	Ensure a common operating picture (COP) is maintained. Distribute/post ICS SITREP and Press Releases as appropriate.	Health Commissioner, Assistant Health Commissioners, and PIO	X:Name of Incident/Situation Reports	Situational Awareness and Information Sharing
Daily/Weekly Time TBD	Operations Briefing	Present IAP and assignments to the Supervisors / Leaders for the next Operational Period.	IC, Command & General Staff, Group Supervisors, and Unit Leaders.	Small or Large Conference Room	Situational Awareness and Information Sharing
Daily/Weekly Time TBD	Planning Meeting*	Review/ identify HCPH response incident objectives and priorities for the next operational period or review and approve demobilization plan.	IC, PSC, Deputy PSC, RESL, SUL, & FSC	Small or Large Conference Room	Draft ICS Form 201, 202, 203, 206, 207, 208
Daily/Weekly Time TBD	Tactics Meeting*	Develop/review primary and alternate strategies to meet Incident Objectives, identify tactics for the next Operational Period.	OSC, Ops Group Supervisors, SO, PSC, RESL, FSC , LSC and COMM	Small or Large Conference Room	Tactics identified will be reflected on ICS Form 204 #6 under work assignments. *May also complete ICS 215*
Daily/Weekly Time TBD	HCPH Coordination Call/Briefing	Call with only internal HCPH staff to prepare for state and local calls	All response personnel	Small or Large Conference Room	Confirmation of action items and SitRep
Daily/Weekly Time TBD	County and/or ODH Call	Call with only county and/or ODH partners	Health Commissioner, Assistant Health Commissioners, and PIO	Small or Large Conference Room	Common operating picture; Updated action items

Daily/Weekly Time TBD	Finalize IAP*	Review status and finalize strategies and assignments to meet Incident Objectives for the next Operational Period.	PSC	Small or Large Conference Room	Completed ICS Form 201, 202, 203, 204s, 206, 207, 208, 215 and 215a
Daily/Weekly Time TBD	Approve IAP*	Obtain IC signature approval on the IAP for the next operational period	IC and PSC	Small or Large Conference Room	Signed IAP
Daily/Weekly Time TBD	Update State EOC	Provide an update to all ESFs supported by HCPH for Hamilton County EOC briefing	PSC	Small or Large Conference Room	SitRep/Briefing document
Daily/Weekly Time TBD	Listen to Hamilton County EMA EOC Briefing	Call in to Hamilton County EOC to listen to the briefing by ESF desks	All response personnel	Small or Large Conference Room	Situational Awareness
Daily/Weekly Time TBD	Shift Begin	Designated ramp up time for response personnel	All response personnel	Small or Large Conference Room	Staff check-in completed
Daily/Weekly Time TBD	Shift End	Designated end time for response personnel	All response personnel	Small or Large Conference Room	Staff check-out completed; documentation turned in
Daily/Weekly Time TBD	Shift Change	Designated transition time for response personnel	All response personnel	Small or Large Conference Room	New staff obtain situational awareness and status of objectives
Daily/Weekly Time TBD	Shift Briefing	Briefing about the status of the incident and to review all response objectives; typically occurs at the beginning, middle and end of shifts	All response personnel	Small or Large Conference Room	Situational awareness; information sharing
Daily/Weekly Time TBD	Submit Updates for SitRep	Response personnel send any content for the SitRep to the Situation Staff	All response personnel	Small or Large Conference Room	Updates provided; information sharing

Prepared by: TBD	**Position/Title:** Planning Section Chief	**Date:** TBD	**Time:** TBD

*If demobilization is delayed

ATTACHMENT X - SHIFT CHANGE BRIEFING TEMPLATE

DOCUMENT DESCRIPTION

The Shift Change Briefing Template will be created by the Planning Section and distributed to all responders at the beginning of their shift to foster situational awareness of the current state of the operational response activities.

TABLE OF CONTENTS

DOCUMENT DESCRIPTION 1
INCIDENT NAME 2

INCIDENT NAME

DATE (MM/DD/YYY):

TIME (HH:MM):

PREPARED BY (NAME, TITLE):

SHIFT:

CURRENT INCIDENT STATUS
Current Organization:
Status of Objectives:
Resource Assignments:

Resources Ordered and Status:
Incident Communications Plan:
Incident Prognosis:
Emergency Issues or Concerns:

Significant Activities or Developments that Occurred During Previous Shift
Information for the next shift:
Upcoming Significant Events:
Upcoming or Awaited Significant Decisions:

Priorities:
Safety Guidance:

ATTACHMENT XI – INCIDENT FISCAL RESPONSE AND RECOVERY

DOCUMENT DESCRIPTION

The purpose of this attachment is to describe how HCPH recovers the costs of funds and resources expended during emergency response operations.

TABLE OF CONTENTS

DOCUMENT DESCRIPTION 1
TABLE OF CONTENTS 1
WHAT COSTS CAN BE RECOVERED? 2
DOCUMENTATION UTILIZED BY HCPH TO SUPPORT COST RECOVERY 3
HCPH POSITION/PROGRAM AREA THAT LEADS COST RECOVERY IN THE AGENCY 3

WHAT COSTS CAN BE RECOVERED?

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 HCPH through Hamilton County EMHSA.

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.

Eligible costs/work may include:

- Labor costs – All labor hours (use of your own employees) should be documented. Depending on the funding source, only overtime/comp time may be reimbursed.
- Equipment costs – 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.
- Material costs – Costs of materials and supplies used for response/repair (from stock or purchased for purposes of completed project).
- 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.

DOCUMENTATION UTILIZED BY HCPH TO SUPPORT COST RECOVERY

In addition to the incident documentation detailed in **Attachment XII – Incident Documentation Guide**, each funding source requires completion of specific forms to access available funds. To support preparation of these forms, the agency will scan invoices, timesheets and other applicable documents and save the copies in an incident cost-recovery folder on the agency drive. At the conclusion of the incident, the list of reimbursable expenses will be compiled into a spreadsheet and saved into that same folder.

HCPH POSITION/PROGRAM AREA THAT LEADS COST RECOVERY IN THE AGENCY

These efforts are led by HCPH's Finance Officer, in coordination with personnel assigned to fiscal roles during the incident response.

ATTACHMENT XII - INCIDENT DOCUMENTATION GUIDE

DOCUMENT DESCRIPTION

This guide provides guidance in support of financial and administrative actions for the following:

a) Incident Documentation for financial and administrative actions and cost recovery activities
b) Personnel Timekeeping
c) Records Security
d) Records Retention
e) Public Records Policy.

TABLE OF CONTENTS

DOCUMENT DESCRIPTION 1
INCIDENT DOCUMENTATION 2
INCIDENT RESPONSE PERSONNEL TIMEKEEPING 3
INCIDENT RECORDS SECURITY 3
INCIDENT RECORDS RETENTION 3
PUBLIC RECORDS POLICY 4

INCIDENT DOCUMENTATION

All financial, administrative and cost-recovery activities or records will be captured daily (or incident operational period) by the Finance & Administration Section Chief/Staff Support Section (FASSS) Chief (Finance Officer, or designee) and provided to the documentation section or other HCPH representative. The documents selected for use during an incident response will adhere to the operational period time frames determined by the IC, or FASSS Chief, but will not exceed a 24 hour period.

The list below details ICS documents that could be used to support financial and administrative activities throughout an incident; whether HCPH is in an ICS or MACC structure. The forms below will be completed by all applicable staff and turned in no later than the end of each shift.

ICS Form Number	ICS Form Title	ICS Form Purpose (Administration and Finance function or use it supports)
ICS 201	Incident Briefing	Provides the basic information regarding the incident situation and the resources allocated to the incident. **(Time, Procurement, Claims and Cost)**
ICS 211	Check In List (Personnel)	Records arrival times or personnel and equipment at incident site and other subsequent locations. **(Time, Claims and Cost)**
ICS 213 RR Adapted SDH	Resource Request	Is used to order resources and track resources status. **(Procurement and Cost)**
ICS 214	Activity Log	Provides basic incident activity documentation and a reference for any after action report. **(Time, Procurement, Claims, Cost)**
ICS 221	Demobilization Check Out	Provides information on resources released from an incident. Demobilization is a planned process and this form assists with that planning. All expended resources will be tracked on this form as well. **(Time, Claims, Cost)**
SDH Procurement Summary Report	SDH Procurement Summary Report	Records all purchases executed during an incident. **(Procurement, Cost)**

INCIDENT RESPONSE PERSONNEL TIMEKEEPING

Personnel timekeeping documentation: During an incident all normal timekeeping daily/biweekly processes using the TMS website for daily timekeeping activity and leave requests. During an emergency, a special code will be set up for employees to track their time in TMS.

The ICS Forms 211 Check In List (Personnel) and ICS Form 221 Demobilization Check Out may be used by the finance and admin section to verify personnel time keeping and other associated costs.

INCIDENT RECORDS SECURITY

Records Security. During an incident HCPH will collect and receive, create and maintain a large amount of data and records. Some of this data is protected or confidential pursuant to numerous laws (e.g., R.C. 3701.17, 45 CFR Parts 160 and 164 [HIPAA Privacy Rule]), the violation of which may result in civil, criminal, or administrative penalties, as well as adverse employment action by HCPH.

HCPH requires all staff to sign a Confidentiality Statement. In the Confidentiality Statement it states the following:

> *"I understand that all client and Hamilton County Public Health employee information, records and health care information compiled, obtained, maintained, or reviewed by me in the course of my duties are confidential. I agree not to disclose or otherwise make known to any unauthorized persons any information regarding the same, unless so directed by a supervisor."*

Immediately upon discovery that there has been an unauthorized disclosure or suspected unauthorized disclosure of the information, the person who discovers the disclosure or suspected disclosure will notify his or her direct supervisor, the responsible HCPH staff supervisor and/or incident commander.

INCIDENT RECORDS RETENTION

Records Retention. During an incident all staff will abide by the HCPH Records Retention Policy. The HCPH Records Retention Policy provides direction to HCPH employees regarding the required timeframe documentation is kept/retention periods, transfer and destruction methods for HCPH records.

During the response, an incident folder will be created on the HCPH X:SHARED drive. It will be the responsibility of the Planning Section Chief/Planning Support Unit to ensure all information is categorized correctly using the following steps.

a) Establish Incident Response Folder on the X:SHARED drive.

b) Establish files for the response folder.

c) Inform response personnel of the location of file.

d) Each incident supervisor will be responsible for the organization and orderliness of their respective file (e.g., Operations, Logistics, Administration)

e) Reminders of recordkeeping and locations of files will be reviewed during each change of shift brief.

f) Response Folders will be backed up daily according to normal server backup protocols.

g) Location of any documents associated will be kept initially in a secure location in the HPCH office and maintained by the administrative section or designated representative.

h) After incident documents (hardcopies) and any external hard drive storage will be kept and managed in the HCPH office located at the 250 William Howard Taft Road location and maintained by the documentation unit or other designated representative. All incident documents (hardcopies), etc will be retained, stored and kept by the agency for an indefinite period of time, or until the Health Commissioner declares the documents can be properly discarded.

i) At the end of a response, all hardcopy records as well as any external hard drives will be stored in the main HPCH office located at 250 William Howard Taft Road. HCPH staff will have access to all records/logs/documents or computer storage devices.

PUBLIC RECORDS POLICY

The Hamilton County General Health District maintains various records that are utilized to support the accountability of the Government. In accordance with Ohio Revised Code 149.38 and the Hamilton County Records Commission, the Hamilton County General Health District has adopted Schedules of Records and Retention and Disposition (RC-2) that identify these records. These schedules identify records that are stored on a fixed medium (paper, computer, film, etc.) that are created, received or sent under the jurisdiction of the Health District which document the organization, functions, policies, decisions, procedures, operations or other activities of the agency. The Board of Health of the Hamilton County General Health District has adopted a Public Records Policy to ensure all Public Records responsive to the request are promptly prepared and made available for inspection to any person at all reasonable times during regular business hours.

ATTACHMENT XIII - SWOPHR MUTUAL AID AGREEMENT

DOCUMENT DESCRIPTION

This is the Southwest Ohio Public Health Regional Mutual Aid Agreement (updated December 6, 2018).

TABLE OF CONTENTS

DOCUMENT DESCRIPTION 1

SOUTHWEST OHIO PUBLIC HEALTH REGION (SWOPHR)
MUTUAL AID AGREEMENT (MAA)

Whereas, Section 5502.29 of the Ohio Revised Code states that "Political Subdivisions, in collaboration with other public and private agencies within this state, may develop mutual aid assistance or aid agreements for reciprocal emergency management assistance or aid for purposes of preparing for, responding to, and recovering from an incident, disaster, exercise, training activity, planned event or emergency, any of which requires additional resources; and

Whereas, city, general and combined health districts are political subdivisions created by ORC Section 3709; and

Whereas, Section 5502.41 of the Ohio Revised Code created the intrastate mutual aid law known as "the intrastate mutual aid compact" to complement existing mutual aid agreements in the event of a disaster that results in a formal declaration of emergency by a participating local political subdivision and defines the requirements under this program; and

Whereas, public health emergencies, such as large naturally occurring outbreaks of infectious disease or acts of bioterrorism, may require resources beyond the capacity of a health district in order to effectively respond; and

Whereas, the participating health districts deem it to be sound public health and in the best public interest to cooperate among themselves and to provide mutual assistance and mutual exchange of public health support;

Therefore, the participating boards of health identified in Schedule A have each reviewed this Agreement, and by affirmative motion at a public meeting, approved this Agreement and do authorize their respective Health Commissioners to sign this Agreement to provide mutual aid assistance under the following provisions:

ARTICLE 1

Participating health districts may request assistance of other participating health districts in response to and recovery from a public health emergency or disaster during formally declared emergencies or in disaster-related exercises, testing, or other training activities. Requests for assistance shall be through the health commissioner or incident commander designated by the health commissioner of the participating health district from which the assistance is requested. Requests may be verbal or in writing. If verbal, the request shall be confirmed in writing within seventy-two hours after the verbal request is made. Requests shall provide the following information:

A. A description of the emergency or disaster situation;
B. A description of the assistance needed;

C. An estimate of the length of time the assistance will be needed;

D. The specific place and time for staging the assistance and a point of contact at that location;

ARTICLE 2

A participating health district requesting assistance must have either declared a state of emergency by resolution of its health commissioner or scheduled disaster-related exercises, testing, or other training activities.

ARTICLE 3

A responding health district may withhold resources necessary to provide for its own protection.

ARTICLE 4

Personnel of a responding participating health district shall continue under their local command and control structure, but shall be under the operational control of the appropriate officials within the incident management system of the participating health district receiving assistance.

ARTICLE 5

Personnel of a responding health district who suffer injury or death in the course of, and arising out of, their employment while rendering assistance to another participating health district under this MAA, are entitled to all applicable benefits under Chapters 4121 and 4123 of the Ohio Revised Code.

Personnel of a responding participating health district shall be considered, while rendering assistance in another participating health district under this MAA, to be agents of the participating health district receiving assistance for the purposes of tort liability and immunity from tort liability under the law of this state.

A responding participating health district and the personnel of that health district, while rendering assistance or while in route to or from rendering assistance in another health district under this MAA, shall be deemed to be exercising governmental functions as defined in 2744.01 of the Ohio Revised Code, shall have the defenses to and immunities from civil liability provided in sections 2744.02 and 2744.03 of the Ohio Revised Code, and shall be entitled to all applicable limitations on recoverable damages under section 2744.05 of the Ohio Revised Code.

A participating health district requesting assistance and the personnel of that health district, while requesting or receiving assistance from any other participating health district under this MAA, shall be deemed to be exercising governmental functions as defined in section 2744.01 of the Ohio Revised Code, shall have the defenses to and immunities from civil liability provided in sections 2744.02 and 2744.03 of the Ohio Revised Code, and shall be entitled to all applicable limitations on recoverable damages under section 2744.05 of the Ohio Revised Code.

ARTICLE 6
If a person holds a license, certificate, or other permit recognized and/or issued by a participating health district evidencing qualifications in a professional or other skill, and if the assistance of that person is asked for by a participating health district receiving assistance under this MAA, the person shall be deemed to be licensed or certified in or permitted by the participating health district receiving the assistance to render the assistance, subject to any limitations and conditions the health commissioner of the participating health district receiving the assistance may prescribe by executive order or otherwise.

ARTICLE 7
Any participating health district rendering assistance in another health district under this MAA shall be reimbursed by the participating health district receiving the assistance for any loss or damage to, or expense incurred in the operation of, any equipment used in rendering the assistance, for any expense incurred in the provision of any service used in rendering the assistance, and for all costs incurred in responding to the request for assistance. However, a participating health district rendering assistance may assume in whole or in part the loss, damage, expense, or costs, or may loan the equipment or donate the service to the participating health district receiving the assistance without charge or cost. Any two or more participating health districts may enter into agreements establishing a different allocation of loss, damage, expense, or costs among themselves; and expenses incurred for injury or death of responding personnel are not reimbursable.

ARTICLE 8
Any participating health district requesting use of regional equipment owned by another health district under this MAA shall be responsible for the cost of fuel to operate vehicles or equipment, cost to replace and/or repair damaged, lost or otherwise rendered inoperable equipment, supplies and vehicles. This responsibility will be in effect from the time the equipment, supplies and vehicles are picked up from the health district owning the equipment and until equipment, supplies and vehicles are returned to that location.

ARTICLE 9
This MAA does not preclude a participating health district from entering into a mutual aid or other agreement with another health district; and does not affect any other agreement to which a participating health district may be a party or any request for assistance that may be made, under any other mutual aid agreement.

ARTICLE 10
This Agreement shall become effective upon signature of all parties hereto and shall continue in full force and effect and remain binding on the parties. The Board of Health of any party to this Agreement may request termination of their participation in the Agreement at any time having no effect on the continuation of the agreement of the other parties. In so doing, the health commissioner shall provide the other parties (health districts) to this Agreement a written notice of termination within thirty days prior to termination of this Agreement. Said notice shall be mailed to the health commissioner of each party to this Agreement. This agreement shall continue in full force and effect and remain binding on all other parties.

BE IT FURTHER RESOLVED, that any previous resolution, rule, or policy adopted by the Board of Health of the __________________ for mutual aid agreements that in any way conflicts in part or in whole with this resolution, is hereby rescinded and repealed in part or in whole to the extent of any conflict; and

BE IT FURTHER RESOLVED, by this Board of Health of the __________________, that this Board finds and determines that all formal actions relative to the passage of this resolution were taken in an open meeting of this Board and that all deliberations of this Board and of its committees, if any, which resulted in formal action were taken in meetings open to the public, in full compliance with the applicable legal requirement, including Sections 121.22 of the Ohio Revised Code.

_________________________ moved and _________________________________seconded the Resolution. Upon roll call, the vote was as follows:

___________________, President ______
___________________, Vice President ______
____________________________ ______
____________________________ ______
____________________________ ______

Board of Health of the ______________________________________

____________________, President

ATTEST: ________________________________ Date: _________________

________________________________, Secretary to the Board
Health Commissioner

This resolution was approved as to form by Prosecuting Attorney, ________________________.

______________________________ Date: __________________
Signature

SCHEDULE A

SWOPHR MAA Signature Page

William Hablitzel, MD – Adams County

Kyle Arn, RS -Brown County

Jennifer Bailer, RN MS – Butler County

Melba R. Moore, MS, CPHA-City of Cincinnati

Julianne Nesbit, RS, MPH-Clermont County

Pam Walker-Bauer, RS MPH-Clinton County

Timothy Ingram, MS RS-Hamilton County

Kay Farrar, RN BSN-City of Hamilton

Jared Warner, MEM RS-Highland County

Jackie Phillips, RN MPH-City of Middletown

Frank Perrino, MD-City of Norwood

Matthew Clayton, BS-City of Springdale

Duane Stansbury, RS MPH-Warren County

ATTACHMENT XIV – IMAC/EMAC REQUEST SOG

DOCUMENT DESCRIPTION

The purpose of this attachment describes the process by which HCPH provides resources in response to an IMAC/EMAC request from another jurisdiction/state.

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DOCUMENT DESCRIPTION 1
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PROCESS FOR DISSEMINATING THE REQUEST INTERNALLY........ 2
INTERNAL APPROVALS NEEEDED TO SEND RESOURCES 2
ENTERING INTO AN INTERGOVERNMENTAL AGREEMENT WITH OHIO EMA........ 3

INTRODUCTION

This SOG describes the process by which HCPH provides resources in response to an IMAC/EMAC request from another jurisdiction or state.

The IMAC process is facilitated by Hamilton County EMHSA; the EMAC process is facilitated for the State of Ohio by Ohio EMA. Any and all local public health engagement in IMAC/EMAC will be facilitated by local/state EMA, respectively.

Within jurisdictions, public health agencies may receive requests for available resources that could be provided to address IMAC/EMAC requests from other jurisdictions. These could be for general resources that the agency may have or for public-health-specific resources that the agency is likely to have. The purpose of this SOG is to position HCPH to have internal processes that allow the agency to quickly provide available resources in support of the broader response community.

This SOG will:

- Describe the position that coordinates the provision internally to the agency.
- Describe the process for disseminating the request internally.
- Describe the internal approvals needed to send resources.
- Describe how, in an EMAC situation, HCPH will enter into an intergovernmental agreement with Ohio EMA.

POSITION THAT COORDINATES THE PROVISION INTERNALLY

Internal processing of the IMAC/EMAC requests is led by the Health Commissioner or his/her designee.

PROCESS FOR DISSEMINATING THE REQUEST INTERNALLY

Following approval, the Health Commissioner or designee will query for available resources within HCPH and will collaborate with Human Resources (HR) to query internal databases, institutional knowledge centers and the various HCPH inventory systems for the required resource. As needed, HR will engage the Division Director(s) of the Division(s) where the potential resource exists.

INTERNAL APPROVALS NEEEDED TO SEND RESOURCES

Upon receipt of the request, the Health Commissioner or designee in coordination with HR, with obtain pre-approval from the Health Commissioner or designee to query available resources that would meet the request.

If such resources are identified, provision of those resources is at the discretion of the applicable Division Director, in consultation with HR and the HCPH Finance Officer.

ENTERING INTO AN INTERGOVERNMENTAL AGREEMENT WITH OHIO EMA

Context - *Receiving states will only accept resources from the State of Ohio. For local resources to qualify as State resources, the providing agency (ie, HCPH) must enter into an intergovernmental agreement with Ohio EMA.*

The content that follows reflects guidance from Ohio EMA for LHDs to enter into such an agreement.

Once the provision of the resource has been approved by the Health Commissioner, Ohio EMA will begin dialogue with the requesting state, in collaboration with HCPH. If the requesting state accepts the resource(s) offered by HCPH, Ohio EMA will execute an intergovernmental agreement with HCPH. Receiving states will only accept resources from the State of Ohio. An intergovernmental agreement with Ohio EMA will allow HCPH's resources to be designated as State of Ohio resources.

HCPH staff deployed through this mechanism will be paid, e.g. compensation, travel reimbursement, etc., by HCPH 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 HCPH 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 HCPH.

Upon completion of the intergovernmental agreement, Ohio EMA, the receiving organization and HCPH 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.

APPENDIX 1 – HAMILTON COUNTY DISASTER HISTORY

DOCUMENT DESCRIPTION

This appendix details historic disaster declarations in Hamilton County. Information obtained from the State of Ohio Enhanced Hazard Mitigation Plan.

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Document Description....1
Disaster Declaration Table....2

DISASTER DECLARATION TABLE
HAMILTON COUNTY, OHIO

Disaster Declaration Number	Date Declared	Incident Type
DR-167	3/24/64	Heavy rains and flooding
DR-243	6/5/68	Heavy rains and flooding
DR-390	6/4/73	Mudslides
DR-421	4/4/74	Tornadoes and high winds
DR-870	6/6/90	Severe storm, tornadoes and flooding
DR-1097	1/27/96	Ohio River flooding
DR-1122	6/24/96	Severe storms and flooding
DR-1164	3/4/97	Flash flooding on inland rivers/streams and Ohio River flooding
DR-1390	8/8/01	Flooding
EM-3198	1/1/05	Snow Removal and Response
DR-1805	10/24/08	Severe wind storms associated with Tropical Storm Depression IKE

Note: Information taken from Appendix A to State of Ohio Enhanced Hazard Mitigation Plan (updated as of 1/14/11)

APPENDIX 2 – ROLES OF COUNTY AGENCIES IN EMERGENCY SUPPORT FUNCTIONS

DOCUMENT DESCRIPTION

This appendix provides an overview of the Emergency Support Function (ESF) structure, common elements of each of the ESFs, and the basic content contained in each of the ESF Annexes. The appendix includes a series of annexes describing the roles and responsibilities of County departments and agencies as ESF coordinators, primary agencies, or support agencies.

TABLE OF CONTENTS

Document Description..1

Overview of Emergency Support Functions 2

Human Services

This includes both public and private human service organizations.

- Assisting in the provision of food, shelter, food assistance, and financial services to those left homeless due to a disaster.
- Identifying functional needs populations, and assisting with unmet needs.
- Referring disaster victims to appropriate social service agencies for unmet needs.

Finance, Budget, and Purchasing (All jurisdictions)

- Maintain records of financial transactions, personnel hours and purchases that deviate from normal procedures during a disaster.
- Establish and maintain a separate account of expenditures for the disaster.
- Assist in ROC with resource management.
- Develop procedures for the procurement and delivery of essential resources and supplies for emergency situations.

School Districts

- Provide shelter facilities per agreements with the American Red Cross.
- Provide access to school district resources when appropriate and available – coordinated through the ROC.
- Coordinate evacuation and transportation operations for students during emergency situations.

SORTA

- Provide mass transit vehicles and drivers for emergency evacuation.

Direction, Control, and Coordination

All emergencies begin and end locally. It is only after a jurisdiction identifies that the event will exceed their capacity that mutual aid resources are requested. Once local emergency response resources are exhausted or if the county does not possess the needed capability to address the incident, then state resources can be requested.

The National Incident Management System (NIMS) establishes a clear progression of coordination and communication from the local, regional, state, and national level. Local incident command structures are responsible for directing on-scene emergency management and maintaining command and control of on-scene incident operations. The ROC will provide a central location for operational information sharing and resource coordination in support of on-scene efforts. The ROC will aid in establishing priorities among the incidents and associated resource allocations, resolving agency policy conflicts, and providing strategic guidance to support incident management activities. In accordance with NIMS, emergency response resource and policy issues are addressed at the lowest organizational level.

Emergency Support Functions (ESF)

Each ESF in the EOP has one-or-more primary agencies and several support agencies. The Primary Agency provides overall coordination of the functional activities of their assigned ESF.

ESF-1 - Transportation addresses emergency-related transportation issues including:

- Assessing damage to, restoring, and maintaining land, air and water transportation routes; during emergencies in coordination with governmental and private organizations as required;
- Transportation of personnel, materials, goods, and services to emergency sites; and

- Supporting evacuation and re-entry operations for threatened areas.

ESF-2 – Communications ensures the provision of communication to support local, county, state and federal communications efforts. ESF-2 coordinates with communications assets available from local/regional agencies, voluntary groups, the telecommunications industry, and the state and federal government.

ESF-3 – Engineering/Public Works addresses most engineering concerns that are not related to transportation systems. Missions could include:

- damage inspection and assessment;
- demolition and stabilization missions;
- reconnaissance; emergency repairs;
- temporary and permanent construction; and
- debris management.

ESF-4 – Fire and Rescue agencies and departments are responsible for fire suppression in rural, urban, and wild land settings that result from naturally-occurring, technological or man-made emergency incidents. Local jurisdictions have the responsibility of providing basic fire service protection.

ESF-5 – Emergency Management manages the collection, processing, and analysis of information for dissemination to operational elements. It responds to the information requirements of assessment, response, and recovery personnel. It supports the identification of overall priorities for emergency activities by conducting planning, research, and development of briefing materials as directed by the EOC Director. Assists with the development of Incident Action Plans, mission assignments, and financial management

ESF-6 – Mass Care addresses, coordinates with partner volunteer agencies and reports on the emergency mass care activities of organizations responsible for sheltering, feeding, counseling, first aid, pet and assistance animal care, social services and welfare activities required to assist disaster survivors.

ESF-7 – Resource Management provides logistical and resource support to state and local entities involved in emergency response and recovery. This support includes locating, procuring, and issuing resources including equipment, supplies, and services required by emergency responders and disaster survivors. Coordinates donations management with partner volunteer agencies.

ESF-8 – Public Health and Medical addresses public health and medical services concerns during emergency events or incidents.

Public health concerns can include:

- Assessment and surveillance of health needs of the affected communities;
- Provision of health related services and supplies;
- Identification of areas where health problems could occur;
- assistance in assessing potable water and wastewater/solid waste disposal issues and coordination/equipment;
- Testing of products for public consumption; and
- Environmental testing.

Medical services concerns can include:

- Logistical support for health personnel in the field;
- Supply and restocking of health-related equipment and supplies;
- Testing and/or disposal of food, medicine and related products affected by the disaster;
- Assessment of medical and mental health needs of the affected communities, coordination with emergency medical personnel;
- Provision of medical-related services and supplies that support the affected communities; and
- Assistance and support for mass fatality and triage sites.

ESF-9 – Search and Rescue provides for the guidance and organization of agencies that may be employed during Search and Rescue (SAR) operations. SAR operations include, but are not limited to, the location, recovery, and extrication of victims who become lost or entrapped as the result of a major disaster or life-threatening emergency.

ESF-10 – Hazardous Materials provides for a coordinated response to actual or potential oil and hazardous materials incidents. Hazardous materials include chemical, biological, and radiological substances, whether accidentally or intentionally released.

ESF-11 – Food and Agriculture addresses concerns regarding agriculture functions during natural disasters. These concerns could include:

- Assessment and surveillance of agriculture needs of affected areas;
- Provision of agriculture related services and supplies;
- Testing of products for public consumption;
- Identification of food assistance needs;
- Identification and application of appropriate agriculture assistance programs

ESF-12 – Energy coordinates with energy utilities and related governmental and private organizations to provide information for assessment, response and recovery operations related to fuel shortages, power outages, and capacity shortages that may impact Ohio citizens during disasters. The ESF-12 Team also provides information available on the transportation of fuel, sources for the provision of emergency power to support immediate response operations and the restoration of normal energy supplies to energy-affected communities.

ESF-13 – Law Enforcement response and recovery activities can include the following:

- Maintaining law and order within legal authority;
- Assisting with the dissemination of alerts, warnings and notifications;
- Coordination of law enforcement activities;
- Staffing - roadblocks, traffic control points and other sites;
- Providing evacuation/relocation support;
- Providing communications to support agencies;
- Supporting the relocation and temporary detention of persons confined to institutions; and
- Maintaining and protecting logs, records, digests and reports essential to government and emergency operations.

ESF-14 – Recovery supports jurisdictions in the restoration of communities damaged by disasters. Recovery efforts include:

- Coordination with state field personnel,

- Interaction and cooperation with information and planning (ESF -5) personnel, and the Federal Emergency Management Agency (FEMA) for damage assessment and information gathering in order to
- Develop disaster-specific recovery plans and to
- Direct interaction with state and local officials for recovery efforts.
- Social and economic community impact assessment
- Analysis and review of mitigation program implementation

ESF-15 –Emergency Public Information ensures accurate, coordinated, and timely information is communicated to affected populations, governments, legislators and the media. Other duties include:

- Emergency Public Information
- Protection action guidance
- Media and community relations

Table 1: Designation of County-level ESF Primary and Support Agencies

P = Primary S = Support Emergency Support Function Agency	#1 –Transportation	#2 – Communications	#3 - Engineering	#4 -Fire & Rescue	#5 – Emergency Management	#6 - Mass Care	#7- Resource Management	#8 - Public Health and Medical	#9 – Search and Rescue	#10 – Hazardous Materials	#11 – Food & Agriculture	#12 – Energy	#13 – Law Enforcement	#14 – Recovery	#15 – Emergency Public Info.
Hamilton Co. ADAMHS								S							
Hamilton Co. Administration					S		S							P	
Hamilton Co. Auditor					S		S								
Hamilton Co. Board of County Commissioners															S
Hamilton Co. Coroner’s								S					S		
Hamilton Co. Disability Services						S		S						S	
Hamilton Co. Educational Services						S								S	
Hamilton Co. Emergency Communications Center		P			S										
Hamilton Co. EMHSA		S		S	P	S		S	S	S	S			S	P
Hamilton Co. Engineers	P		P	S			S	S	S	S		P		S	
Hamilton Co. Enviro. Services										P		S			S
Hamilton Co. Facilities Mgmt.	S		S	S			S					S		S	
Hamilton Co. Fire Chiefs				P											
Hamilton Co. Job & Family Services						P	S							S	S
Hamilton Co. LEPC									S						
Hamilton Co. Mental Health Board														S	
Hamilton Co. Metro Sewer			S							S					
Hamilton Co. Park District								S							
Hamilton Co. Plan & Develop			S												
Hamilton Co. Prosecutor			S										S	S	
Hamilton Co. Public Health			S			S		P			S			S	
Hamilton Co. Purchasing			S				P								
Hamilton Co. Risk Mgmt.					S										
Hamilton Co. Sheriffs	S					S	S	S	S			S	P		
Hamilton Co. Solid Waste														S	
Hamilton Co. Task Force 1									P						
Ohio State Extension											P				
The Health Collaborative								P							

APPENDIX 3 – HCPH CMIST PROFILE

DOCUMENT DESCRIPTION

This appendix includes the CMIST Profile for Hamilton County Public Health (HCPH) service jurisdictions, in addition to the cities of Norwood and Springdale.

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DOCUMENT DESCRIPTION 1

HCPH CMIST PROFILE 2

HCPH, CITY OF NORWOOD AND CITY OF SPRINGDALE-COMBINED CMIST PROFILE 5

HCPH CMIST PROFILE

HCPH recognizes a population may have diverse needs, especially during an emergency. As such, HCPH ensures the inclusion of HCPH jurisdiction residents by utilizing the CMIST framework to address access and functional needs. The CMIST framework defines the components of access and functional needs: Communication, Maintaining Health, Independence (the goal), Services and Support, and Transportation.

The CMIST components are further defined below:

- **C**ommunication – Refers to limitations in both receiving and providing information [e.g., only speaking a language other than English, not being able to read or write (well), or being unable to speak].
- **M**aintaining Health – Refers to needs associated with managing health conditions that require observation or ongoing treatment (e.g., requiring dialysis or administered oxygen, needing IV therapy or tube feeding, relying on power-dependent equipment to sustain life, or needing medication to maintain optimal levels of health).
- **I**ndependence –Maintaining independence is the goal of CMIST.
- **S**afety and Support – Addresses individuals who may have lost the support of assistants, attendants, family, or friends; or may be unable to cope in new or strange environments (i.e., people with Alzheimer's or individuals who experience stressors beyond their ability to cope, people who function adequately in a familiar environment but become disoriented in an unfamiliar environment, children who are unaccompanied, or people who are incarcerated).
- **T**ransportation – Refers to needs related to travel (e.g., not having a vehicle or driver's license, needing specialized transportation, or being unable to navigate existing transportation options).

Individuals with access and functional needs may:

- Have a disability
- Require medical care
- Have a temporary medical condition, like pregnancy or an injury
- Live in institutional settings
- Use prescription drugs to maintain health
- Be children
- Have limited English proficiency
- Not have access to transportation

SUMMARY TABLE OF HCPH JURISDICTIONS ACCESS AND FUNCTIONAL NEEDS INDICATORS

Category	Data Element	Value
General	Jurisdiction population	477,287
	Jurisdiction land area, in square miles	319.86
	Jurisdiction population per square mile	1,492.2
	Number of households	187,635
	Persons per household	2.54
Disability	Total estimated population with a disability	54,743
	Estimated percentage of population with a disability	11.56%
	Estimated persons with a hearing difficulty	14,433
	Estimated persons with a vision difficulty	8,539
	Estimated persons with a cognitive difficulty	20,403
	Estimated persons with an ambulatory difficulty	27,077
	Estimated persons with a self-care difficulty	10,282
	Estimated persons with an independent living difficulty	19,025
Communication	Estimated percent of persons aged 16+ lacking basic prose literacy skills	7.0%
	Ten languages with the largest number of speakers who speak English less than "very well," in descending order by number of such speakers	Number of Speakers
	Spanish or Spanish Creole:	3,336
	African languages:	727
	Chinese:	660
	Russian:	570
	Vietnamese:	525
	Korean:	464
	Other Indic languages:	430
	French (incl. Patois, Cajun):	401
	German:	331
	Hindi:	304

Maintaining Health	Women of reproductive age (15 - 50)	106,241
	Estimated number of pregnant women	4,428
	Number of individuals who depend on electricity to maintain health	5,090
	Estimated number of individuals who have had at least one prescription in the last 30 days	244,111
	Percent of persons without health insurance, under 65 years	1.8%
Safety and Support	Total number of children (persons less than 18 years of age)	114,968
	Estimate of persons below the poverty level	48,434
	Estimate of the percent of population below the poverty level	10.3%
	Median household income	60,685
	Total number of facilities where people are incarcerated	Not applicable
	Average number of people who are incarcerated	Not applicable
Transportation	Number of households with no vehicle available	10,814
	Percentage of households with no vehicle available	5.8%

By understanding the prevalent demographics of HCPH's service jurisdictions, HCPH may better assess and recommend measures to ensure health security for all County residents. Together with local, state, federal and non-profit partners, HCPH has planned to respond to the whole community during an incident by identifying the services and the modes of coordination necessary to serve all Hamilton County residents before, during and after an event.

HCPH, CITY OF NORWOOD AND CITY OF SPRINGDALE-COMBINED CMIST PROFILE

SUMMARY TABLE OF HCPH, CITY OF NORWOOD AND CITY OF SPRINGDALE JURISDICTIONS ACCESS AND FUNCTIONAL NEEDS INDICATORS

Category	Data Element	Value
General	Jurisdiction population	507,954
	Jurisdiction land area, in square miles	327.97
	Jurisdiction population per square mile	1,548.8
	Number of households	200,686
	Persons per household	2.53
Disability	Total estimated population with a disability	58,876
	Estimated percentage of population with a disability	11.69%
	Estimated persons with a hearing difficulty	15,481
	Estimated persons with a vision difficulty	9,185
	Estimated persons with a cognitive difficulty	22,062
	Estimated persons with an ambulatory difficulty	29,365
	Estimated persons with a self-care difficulty	11,494
	Estimated persons with an independent living difficulty	20,680
Communication	Estimated percent of persons aged 16+ lacking basic prose literacy skills	7.0%
	Ten languages with the largest number of speakers who speak English less than "very well," in descending order by number of such speakers	Number of Speakers
	Spanish or Spanish Creole:	4,716
	African languages:	744
	Chinese:	676
	Russian:	570
	Vietnamese:	543
	French (incl. Patois, Cajun):	496
	Korean:	477
	Other Indic languages:	430
	German:	331
	Hindi:	304

Maintaining Health	Women of reproductive age (15 - 50)	113,621
	Estimated number of pregnant women	4,716
	Number of individuals who depend on electricity to maintain health	5,264
	Estimated number of individuals who have had at least one prescription in the last 30 days	259,130
	Percent of persons without health insurance, under 65 years	2.5%
Safety and Support	Total number of children (persons less than 18 years of age)	121,828
	Estimate of persons below the poverty level	54,739
	Estimate of the percent of population below the poverty level	10.9%
	Median household income	59,651
	Total number of facilities where people are incarcerated	Not applicable
	Average number of people who are incarcerated	Not applicable
Transportation	Number of households with no vehicle available	12,538
	Percentage of households with no vehicle available	6.2%

By understanding the prevalent demographics of HCPH, City of Norwood and the City of Springdale service jurisdictions, HCPH may better assess and recommend measures to ensure health security for all County residents. Together with local, state, federal and non-profit partners, HCPH has planned to respond to the whole community during an incident by identifying the services and the modes of coordination necessary to serve all Hamilton County residents before, during and after an event.

APPENDIX 4 – HCPH CMIST PARTNER LIST

DOCUMENT DESCRIPTION

The purpose of this appendix summarizes HCPH’s access and functional needs partners list.

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DOCUMENT DESCRIPTION 1
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HCPH CMIST PARTNER LIST 2

HCPH CMIST PARTNER LIST

This information will be filled in once PHEP Core Deliverable 6.1 is completed in BP2.

APPENDIX 5 – THE PLANNING PROCESS

DOCUMENT DESCRIPTION

This appendix includes a graphical representation of the Planning Process used for Emergency Response Planning.

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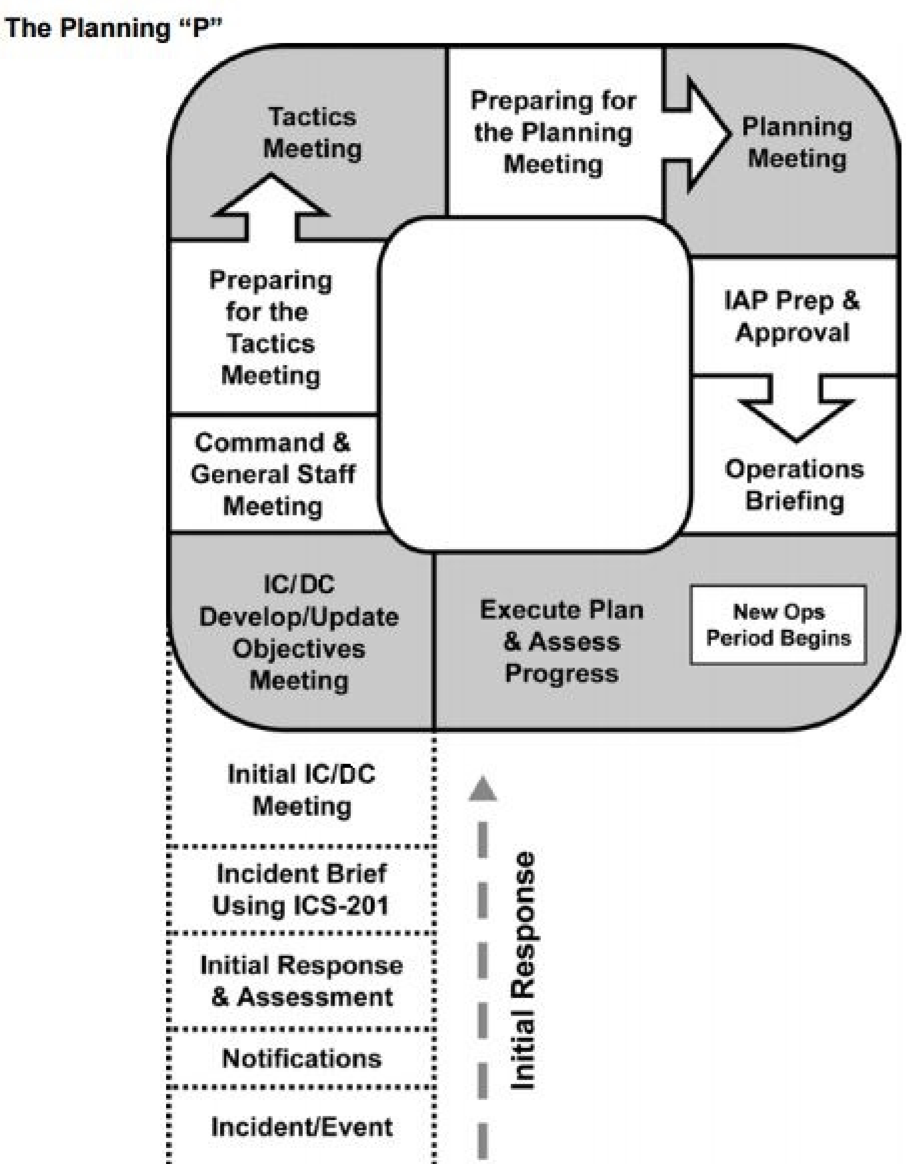
DOCUMENT DESCRIPTION 1

THE PLANNING PROCESS 2

THE PLANNING PROCESS



The Planning "P" is a guide to the process and steps involved in planning for an incident. The leg of the "P" describes the initial response period: Once the incident/event begins, the steps are Notifications, Initial Response & Assessment, Incident Briefing Using ICS 201, and Initial Incident Command (IC)/Unified Command (UC) Meeting.

At the top of the leg of the "P" is the beginning of the first operational planning period cycle. In this circular sequence, the steps are IC/UC Develop/Update Objectives

Meeting, Command and General Staff Meeting, Preparing for the Tactics Meeting, Tactics Meeting, Preparing for the Planning Meeting, Planning Meeting, IAP Prep & Approval, and Operations Briefing.

At this point a new operational period begins. The next step is Execute Plan & Assess Progress, after which the cycle begins again.

APPENDIX 6 – COMMUNICATING WITH AND ABOUT INDIVIDUALS WITH ACCESS AND FUNCTIONAL NEEDS

DOCUMENT DESCRIPTION

This appendix includes provides guidelines for communicating with and about individuals with access and functional needs.

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Document Description....1
Using People-First Language in Plans....2

Ohio Department of Health

People-First Language in Plans

Updated January 2016

Using People-First Language in Plans

People-first language is the practice of literally putting "people" ahead of their needs. When communicating in plans about a person/people with access and functional needs:

1. Begin with a word that affirms human dignity, e.g. person, individual, population, etc.;
2. Follow with a brief statement that respectfully captures the access and functional need (CMIST[1]).
    a. Current terms for selected access and functional needs are listed in the "**SAY THIS…**" column; they are contrasted with terms that are no longer recommended for use in plans.

SAY THIS…	NOT THAT…
Access and functional needs	Special needs
Access and functional need, Disability	Handicap
Accessible	Handicap accessible
Accessible parking/bathroom	Handicap parking/bathroom
Person who uses a wheelchair	Confined or restricted to a wheelchair, Wheelchair-bound
Disability placard	Handicap sticker
Person with a disability	Disabled person, The disabled
Person without a disability	Normal person, Healthy person
Individual who is deaf, Individuals with hearing loss	Deaf person, The deaf
Person with a visual impairment, People who are blind	Blind person, The blind
Person with a congenital disability	Person with a birth defect
Intellectual/Cognitive/Developmental disability[2]	Mentally retarded, Mentally disabled
Person with an intellectual/cognitive/developmental disability[2]	Mentally retarded person, Mentally disabled person
Person with an emotional or behavioral disability, Person with a mental health or a psychiatric disability	Mentally ill person, The mentally ill
Person who has a communication disorder, is unable/unwilling to speak, or uses a device to speak	Mute, Dumb
Person with limited English fluency/comprehension	Non(native)-English speaker
Person with limited/low literacy	Illiterate person, The illiterate
Person experiencing homelessness	Homeless person, The homeless
Person living in poverty	Poor person, The poor
Person with a drug addiction	Drug addict
Person who is incarcerated	Prisoner
Person with [DISEASE/CONDITION]	Afflicted by [DISEASE], Victim of [CONDITION], Adjective based on [DISEASE/CONDITION], e.g. Autistic
Person who is successful, productive	Has overcome his/her disability, is courageous

[1] CMIST: Communication, Maintaining Health, Independence, Support/Services/Self-Determination, and Transportation

[2] The developmental disability definition requires substantial functional limitations in three or more areas of major life activity. The intellectual disability definition requires significant limitations in one area of adaptive behavior. Definitions of cognitive disability vary but are generally broad and include difficulties with mental tasks or processing.

References

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People First Language

Style Guide

A reference for media professionals and the public

What is People First Language?

People First Language (also referred to as "Person First") is an accurate way of referring to a person with a disability. This style guide offers an alphabetical list of standard terms that balance the need for clarity and sensitivity by focusing on the person instead of the disability. It is not a complete list but a general representation of terms people with disabilities commonly find respectable.

Why People First Language?

Words have a profound impact on shaping attitudes and perceptions. Incorporating People First Language demonstrates people are unique and their abilities or disabilities are part of who they are, not a definition of who they are. People First Language is sensitive and accurate. It helps break down community barriers to foster acceptance, mutual respect and open lines of communication.

Tips for Incorporating People First Language

Some disability groups object to different phrases for varying reasons. Even among people with disabilities and their families, a variety of terms are used and accepted. It is best to ask the person which words or phrases are acceptable to them.

Avoid using descriptions that connote pity, such as "afflicted with" or "suffers from," because these terms carry the assumption that the person with a disability is living a reduced quality of life. It is preferable to use neutral language when describing a person with a disability.

When writing or speaking about people with disabilities, it is best to emphasize abilities rather than limitations, and focus on a person's accomplishments, creative talents or skills. That doesn't mean you should avoid mentioning a disability or describing the impact it has had on the person's life. Always refer to the person and the disability he or she has respectfully and accurately.

Refer to the Quick Guide on the back page for an overview of common words to use and avoid.

For additional information or resources, contact:

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10600 Springfield Pike
Cincinnati, OH 45215
(513) 771-4800
www.cincinnatigoodwill.org

Attention Deficit Hyperactivity Disorder (ADHD). Involves learning and behavioral challenges that do not have any serious underlying physical or mental causes. It is characterized by difficulty in sustaining attention, impulsive behavior and excessive activity.

> ***DO USE:*** *child with ADHD*
> ***DON'T USE:*** *hyperactive*

Autism. A developmental disability originating in infancy. Autism and autism spectrum disorder (ASD) are general terms for a group of complex disorders of brain development characterized by difficulties in social interaction, language dysfunction and repetitive behaviors.

> ***DO USE :*** *child with autism, she has autism, "on the spectrum"*
> ***DON'T USE***: *autistic child*

B

Blind. Describes a person with complete loss of sight. For others, use terms such as visually impaired or person with low vision.

> ***DO USE:*** *person with visual impairments, boy who is blind*
> ***DON'T USE:*** *the blind, blind person*

Brain injury. A temporary or long-term disruption in brain function resulting from injury to the brain. Difficulties with cognitive, physical, emotional and/or social functioning may occur.

> ***DO USE:*** *person who has a brain injury, woman who sustained a brain injury, boy with an acquired brain injury*
> ***DON'T USE:*** *brain damaged, suffers from brain damage*

C

Cerebral palsy (CP). Refers to a number of neurological disorders that appear at birth, in infancy or early childhood and permanently affect body movement and muscle coordination, but don't worsen over time.

> ***DO USE:*** *a person with cerebral palsy, he/she has cerebral palsy*
> ***DON'T USE:*** *cerebral palsy victim, cerebral palsied, spastic, a CP*

Congenital disability. A disability present since birth.

> ***DO USE:*** *has a congenital disability, was born with a disability, has had a disability since birth*
> ***DON'T USE:*** *birth defect, defective*

D

Deaf. Describes a person with profound or complete hearing loss. Language often develops differently from those who have hearing. Many people who are hearing impaired have mild to moderate hearing loss that may or may not be corrected with amplification. There is no uniform terminology, so it is best to ask the person which term is suitable.

> ***DO USE:*** *Hearing impaired, woman who is deaf, boy who is hard of hearing, partially deaf*
> ***DON'T USE:*** *deaf and dumb, deaf mute*

Developmental disabilities. An intellectual or physical disability that occurs at birth or before age 22, is expected to be life-long and affects one or more major life activities. It is an umbrella term.

> ***DO USE:*** *an individual with: a disability, autism, epilepsy, a brain injury, etc.*
> ***DON'T USE:*** *retarded, disabled, handicapped, autistic, epileptic, brain damaged*

Disability. A general term used for a functional limitation that can interfere with a person's ability to walk, lift, hear, see, learn, comprehend or complete other tasks. It may be physical, sensory or intellectual. Disability and people with disabilities are not monolithic. Avoid referring to "the disabled" as a singular group.

> ***DO USE:*** *person with a disability*
> ***DON'T USE:*** *handicapped, the mentally or physically disabled, special, retarded, mental retardation*

Down syndrome. Describes a chromosomal irregularity that results in a delay in physical, intellectual and language development.

> ***DO USE:*** *person with Down syndrome*
> ***DON'T USE:*** *Mongol, Mongoloid, Down's baby*

Handicap. Should not be used when describing a disability. In recent years, advocates have been successful in removing the word "handicap" from parking signs and other public areas. "Accessible" is the preferred term in those situations.

> ***DO USE:*** *person with a disability, accessible entrance*
> ***DON'T USE:*** *she is handicapped, a handicap parking space*

L

Learning disability. Anything that permanently affects how a person processes, retains and expresses information.

> ***DO USE:*** *a child with a learning disability, she has learning disability*
> ***DON'T USE:*** *slow, slow learner, retarded*

Little people/person. Refers to people of short stature, below 4 feet 10 inches. Groups focusing on this issue are often divided between using "little person" or "dwarf," as some people are offended by those terms and others are not.

> ***DO USE****: ask the person who is being written or talked about*
> ***DON'T USE****: midget, vertically challenged*

M

Mental retardation. A term no longer accepted, even as a medical diagnosis. It should not be used. Advocates have been successful in getting this phrase removed from federal and state laws.

Mental illness. An umbrella term for different conditions that affect how individuals act, think, feel or perceive the world. Specific disorders are types of mental illness and should be used whenever possible. Do not describe an individual as mentally ill unless it is clearly pertinent to a story and the diagnosis is properly sourced.

> ***DO USE****: She has depression, he was diagnosed with schizophrenia*
> ***DON'T USE:*** *insane, crazy/crazed, nuts, deranged, lunatic*

Mute. Generally considered a derogatory term referring to a person who physically cannot speak because it implies people who do not use speech are unable to express themselves. Others with speaking difficulties are speech impaired. A person who does not use speech may be able to hear, and they may use written language or sign language.

> ***DO USE:*** *child who uses augmentive/assistive communication, she uses sign language, he does not speak*
> ***DON'T USE:*** *mute, dumb*

S

Seizure. An involuntary muscular contraction, a brief impairment or loss of consciousness resulting from something neurological like epilepsy or brain injury.

> ***DO USE:*** *person with a seizure disorder, person who had a seizure*
> ***DON'T USE:*** *fit, spastic, epileptic*

Spinal cord injury. Occurs when there has been permanent damage to the spinal cord. Quadriplegia is a substantial or significant loss of function in all four extremities. Paraplegia refers to substantial or significant loss of function in only the lower part of the body

> ***DO USE:*** *person with a spinal cord injury, person who has quadriplegia or paraplegia*
> ***DON'T USE:*** *quadriplegic, paraplegic*

Stroke. Caused by interruption of blood to the brain. Paralysis of one side, or hemiplegia, may result.

> ***DO USE:*** *person who had a stroke*
> ***DON'T USE:*** *stroke victim*

Wheelchair. People use wheelchairs for independent mobility and the equipment is considered part of their personal space. People who use wheelchairs have widely different disabilities and varying abilities.

> ***DO USE:*** *wheelchair user, person who uses a wheelchair*
> ***DON'T USE:*** *wheelchair-bound, confined to a wheelchair.*

DO USE	DON'T USE
She has autism	Autistic child
Congenital disability	Birth defect
He is blind/visually impaired	Blind person
Person served/supported	Client/Consumer
She is deaf/hard of hearing	Deaf person
He has a disability (specify which one, if able)	Disabled, retard, handicapped, cripple
She has Down syndrome	Downs, Mongoloid
He has epilepsy	Epileptic
Accessible parking	Handicap parking
Little person/dwarf (ask the person his/her preference)	Midget
She doesn't speak/uses assistive communication	Mute/dumb
Uses a wheelchair	Wheelchair-bound

This style guide, updated in 2017, is produced by Hamilton County Developmental Disabilities Services and Ohio Valley Goodwill Industries. It aligns with definitions in the Associated Press Stylebook and the guide produced by the National Center on Disability and Journalism at the Walter Cronkite School of Journalism and Mass Communication at Arizona State University.

APPENDIX 7 – HCPH PROFILE OF ACCESS AND FUNCTIONAL NEEDS

DOCUMENT DESCRIPTION

The purpose of this appendix is to 1) identify a map showing the floodplains within HCPH's jurisdictions and 2) identifies all social vulnerability index (SVI) scores for each census tract in HCPH's service jurisdictions.

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MAP OF FLOODPLAINS WITHIN HCPH JURISDICTIONS

The following map identifies the floodplains within the agency's service jurisdictions.

Hamilton County, OH Floodplain Map

Map Legend

National Flood Hazard Layer - Flood Hazard Zones, FEMA 2016

- Floodway
- 1% Annual Chance (100 Year) Flood Zone
- 0.2% Annual Chance (500 Year) Flood Zone
- Area with Reduced Risk Due to Levee
- Future Conditions 1% Annual Chance
- Area of Undetermined Hazard
- Water

Community Commons, 8/16/2018

SOCIAL VULNERABILITY INDEX SCORES

The following SVI scores are from census tracts within HCPH service jurisdictions.

State	County	FIPS	Location	Socioeconomic Score	Housing Composition and Disability Score	Minority Status and Language Score	Housing and Transportation Score	Overall SVI Score
OHIO	Hamilton	39061004000	Census Tract 40, Hamilton County, Ohio	0.5843	0.9092	0.7735	0.8622	0.8383
OHIO	Hamilton	39061004500	Census Tract 45, Hamilton County, Ohio	0.111	0.5339	0.1003	0.1358	0.0906
OHIO	Hamilton	39061004602	Census Tract 46.02, Hamilton County, Ohio	0.2479	0.2001	0.6595	0.3995	0.3132
OHIO	Hamilton	39061004603	Census Tract 46.03, Hamilton County, Ohio	0.145	0.0823	0.2391	0.526	0.1525
OHIO	Hamilton	39061004604	Census Tract 46.04, Hamilton County, Ohio	0.446	0.7067	0.7048	0.4726	0.5798
OHIO	Hamilton	39061004605	Census Tract 46.05, Hamilton County, Ohio	0.1519	0.0796	0.2932	0.2538	0.1004
OHIO	Hamilton	39061004702	Census Tract 47.02, Hamilton County, Ohio	0.8233	0.4274	0.3415	0.4781	0.6309
OHIO	Hamilton	39061004800	Census Tract 48, Hamilton County, Ohio	0.0014	0.067	0.1881	0.0177	0.0017
OHIO	Hamilton	39061005000	Census Tract 50, Hamilton County, Ohio	0.0674	0.0752	0.7673	0.4672	0.2125
OHIO	Hamilton	39061005200	Census Tract 52, Hamilton County, Ohio	0.1733	0.0238	0.7701	0.4917	0.1971
OHIO	Hamilton	39061005400	Census Tract 54, Hamilton County, Ohio	0.2482	0.018	0.7575	0.555	0.2271
OHIO	Hamilton	39061005500	Census Tract 55, Hamilton County, Ohio	0.6255	0.819	0.4452	0.7591	0.7259
OHIO	Hamilton	39061005600	Census Tract 56, Hamilton County, Ohio	0.5604	0.1283	0.3983	0.3984	0.382
OHIO	Hamilton	39061005701	Census Tract 57.01, Hamilton County, Ohio	0.4195	0.1752	0.8483	0.4029	0.4419
OHIO	Hamilton	39061005702	Census Tract 57.02, Hamilton County, Ohio	0.3041	0.0606	0.9344	0.4199	0.3592
OHIO	Hamilton	39061005800	Census Tract 58, Hamilton County, Ohio	0.5485	0.8972	0.8609	0.7686	0.8025
OHIO	Hamilton	39061005900	Census Tract 59, Hamilton County, Ohio	0.462	0.3372	0.6612	0.6005	0.5233
OHIO	Hamilton	39061006000	Census Tract 60, Hamilton County, Ohio	0.6422	0.3699	0.8599	0.9418	0.8052
OHIO	Hamilton	39061006100	Census Tract 61, Hamilton County, Ohio	0.7892	0.7135	0.9639	0.7656	0.8839
OHIO	Hamilton	39061006300	Census Tract 63, Hamilton County, Ohio	0.5652	0.8207	0.5194	0.3743	0.5941
OHIO	Hamilton	39061006400	Census Tract 64, Hamilton County, Ohio	0.8842	0.9289	0.5221	0.8425	0.9169
OHIO	Hamilton	39061007000	Census Tract 70, Hamilton County, Ohio	0.4249	0.2974	0.3861	0.687	0.4593
OHIO	Hamilton	39061007300	Census Tract 73, Hamilton County, Ohio	0.7273	0.5954	0.9371	0.6478	0.7875
OHIO	Hamilton	39061008000	Census Tract 80, Hamilton County, Ohio	0.9673	0.7349	0.7847	0.6645	0.9023
OHIO	Hamilton	39061008100	Census Tract 81, Hamilton County, Ohio	0.7538	0.6778	0.9874	0.6958	0.8505
OHIO	Hamilton	39061008201	Census Tract 82.01, Hamilton County, Ohio	0.4406	0.5502	0.4582	0.5897	0.5148
OHIO	Hamilton	39061008202	Census Tract 82.02, Hamilton County, Ohio	0.7303	0.4083	0.4565	0.7186	0.6755

State	County	FIPS	Location	Socioeconomic Score	Housing Composition and Disability Score	Minority Status and Language Score	Housing and Transportation Score	Overall SVI Score
OHIO	Hamilton	39061008300	Census Tract 83, Hamilton County, Ohio	0.7378	0.5863	0.9537	0.8064	0.8451
OHIO	Hamilton	39061008501	Census Tract 85.01, Hamilton County, Ohio	0.9309	0.755	0.9643	0.9228	0.9792
OHIO	Hamilton	39061009700	Census Tract 97, Hamilton County, Ohio	0.919	0.9544	0.8741	0.8459	0.9758
OHIO	Hamilton	39061009901	Census Tract 99.01, Hamilton County, Ohio	0.605	0.4627	0.617	0.1878	0.4556
OHIO	Hamilton	39061009902	Census Tract 99.02, Hamilton County, Ohio	0.7283	0.3933	0.3381	0.6791	0.6299
OHIO	Hamilton	39061010100	Census Tract 101, Hamilton County, Ohio	0.7753	0.769	0.8136	0.9633	0.9387
OHIO	Hamilton	39061010201	Census Tract 102.01, Hamilton County, Ohio	0.744	0.8564	0.3469	0.7581	0.7651
OHIO	Hamilton	39061010300	Census Tract 103, Hamilton County, Ohio	0.9636	0.7754	0.3741	0.6751	0.8362
OHIO	Hamilton	39061010400	Census Tract 104, Hamilton County, Ohio	0.6112	0.7635	0.1646	0.4553	0.5295
OHIO	Hamilton	39061010500	Census Tract 105, Hamilton County, Ohio	0.6582	0.6193	0.2929	0.1834	0.4379
OHIO	Hamilton	39061010600	Census Tract 106, Hamilton County, Ohio	0.3592	0.6693	0.1531	0.1735	0.2588
OHIO	Hamilton	39061010700	Census Tract 107, Hamilton County, Ohio	0.6071	0.4423	0.8901	0.3978	0.6214
OHIO	Hamilton	39061010800	Census Tract 108, Hamilton County, Ohio	0.3105	0.0333	0.7772	0.2838	0.2237
OHIO	Hamilton	39061010900	Census Tract 109, Hamilton County, Ohio	0.826	0.5202	0.7765	0.3794	0.7211
OHIO	Hamilton	39061011000	Census Tract 110, Hamilton County, Ohio	0.8543	0.969	0.8721	0.9129	0.9796
OHIO	Hamilton	39061011100	Census Tract 111, Hamilton County, Ohio	0.2213	0.3613	0.6874	0.2004	0.2717
OHIO	Hamilton	39061020401	Census Tract 204.01, Hamilton County, Ohio	0.4818	0.493	0.1156	0.444	0.3667
OHIO	Hamilton	39061020403	Census Tract 204.03, Hamilton County, Ohio	0.0984	0.0572	0.0541	0.0735	0.0089
OHIO	Hamilton	39061020404	Census Tract 204.04, Hamilton County, Ohio	0.1532	0.0953	0.0827	0.1603	0.0494
OHIO	Hamilton	39061020501	Census Tract 205.01, Hamilton County, Ohio	0.2274	0.5781	0.1282	0.3076	0.221
OHIO	Hamilton	39061020502	Census Tract 205.02, Hamilton County, Ohio	0.1205	0.2048	0.7068	0.163	0.1617
OHIO	Hamilton	39061020504	Census Tract 205.04, Hamilton County, Ohio	0.0695	0.1262	0.8245	0.0456	0.081
OHIO	Hamilton	39061020505	Census Tract 205.05, Hamilton County, Ohio	0.4259	0.5315	0.8228	0.2096	0.4494
OHIO	Hamilton	39061020601	Census Tract 206.01, Hamilton County, Ohio	0.159	0.1946	0.1558	0.0942	0.0575
OHIO	Hamilton	39061020602	Census Tract 206.02, Hamilton County, Ohio	0.2121	0.3423	0.3588	0.0929	0.126
OHIO	Hamilton	39061020701	Census Tract 207.01, Hamilton County, Ohio	0.4838	0.5417	0.7929	0.7969	0.6922
OHIO	Hamilton	39061020705	Census Tract 207.05, Hamilton County, Ohio	0.649	0.6039	0.382	0.8761	0.7235

State	County	FIPS	Location	Socioeconomic Score	Housing Composition and Disability Score	Minority Status and Language Score	Housing and Transportation Score	Overall SVI Score
OHIO	Hamilton	39061020707	Census Tract 207.07, Hamilton County, Ohio	0.0831	0.1269	0.0912	0.2494	0.0579
OHIO	Hamilton	39061020741	Census Tract 207.41, Hamilton County, Ohio	0.6868	0.8646	0.7082	0.3392	0.7034
OHIO	Hamilton	39061020742	Census Tract 207.42, Hamilton County, Ohio	0.5666	0.4583	0.9241	0.4471	0.6306
OHIO	Hamilton	39061020761	Census Tract 207.61, Hamilton County, Ohio	0.5386	0.6635	0.8891	0.6414	0.7133
OHIO	Hamilton	39061020762	Census Tract 207.62, Hamilton County, Ohio	0.7205	0.3692	0.8463	0.477	0.6806
OHIO	Hamilton	39061020802	Census Tract 208.02, Hamilton County, Ohio	0.2499	0.131	0.4105	0.1671	0.145
OHIO	Hamilton	39061020811	Census Tract 208.11, Hamilton County, Ohio	0.333	0.5944	0.8561	0.9296	0.7232
OHIO	Hamilton	39061020812	Census Tract 208.12, Hamilton County, Ohio	0.1559	0.5107	0.1898	0.3671	0.2145
OHIO	Hamilton	39061020901	Census Tract 209.01, Hamilton County, Ohio	0.5795	0.6301	0.6952	0.3409	0.5812
OHIO	Hamilton	39061020902	Census Tract 209.02, Hamilton County, Ohio	0.745	0.4624	0.5741	0.621	0.6854
OHIO	Hamilton	39061021001	Census Tract 210.01, Hamilton County, Ohio	0.4488	0.8071	0.451	0.5441	0.5638
OHIO	Hamilton	39061021002	Census Tract 210.02, Hamilton County, Ohio	0.2588	0.7785	0.0616	0.0157	0.0895
OHIO	Hamilton	39061021003	Census Tract 210.03, Hamilton County, Ohio	0.3401	0.4587	0.2252	0.1694	0.2176
OHIO	Hamilton	39061021101	Census Tract 211.01, Hamilton County, Ohio	0.0943	0.0674	0.285	0.198	0.0644
OHIO	Hamilton	39061021102	Census Tract 211.02, Hamilton County, Ohio	0.0589	0.3202	0.2844	0.0789	0.0569
OHIO	Hamilton	39061021201	Census Tract 212.01, Hamilton County, Ohio	0.0075	0.2171	0.2316	0.0109	0.0044
OHIO	Hamilton	39061021202	Census Tract 212.02, Hamilton County, Ohio	0.1879	0.3454	0.1412	0.2879	0.1498
OHIO	Hamilton	39061021302	Census Tract 213.02, Hamilton County, Ohio	0.1563	0.2862	0.3503	0.4134	0.2223
OHIO	Hamilton	39061021303	Census Tract 213.03, Hamilton County, Ohio	0.1485	0.3004	0.3272	0.2089	0.1447
OHIO	Hamilton	39061021401	Census Tract 214.01, Hamilton County, Ohio	0.6932	0.5393	0.5806	0.5645	0.6544
OHIO	Hamilton	39061021421	Census Tract 214.21, Hamilton County, Ohio	0.1736	0.0735	0.0667	0.0082	0.0034
OHIO	Hamilton	39061021422	Census Tract 214.22, Hamilton County, Ohio	0.5308	0.4253	0.6054	0.3256	0.4671
OHIO	Hamilton	39061021501	Census Tract 215.01, Hamilton County, Ohio	0.2404	0.6499	0.9078	0.8571	0.665
OHIO	Hamilton	39061021504	Census Tract 215.04, Hamilton County, Ohio	0.443	0.1657	0.9871	0.394	0.5022
OHIO	Hamilton	39061021505	Census Tract 215.05, Hamilton County, Ohio	0.5305	0.9374	0.9707	0.4753	0.7528
OHIO	Hamilton	39061021506	Census Tract 215.06, Hamilton County, Ohio	0.6592	0.8996	0.9942	0.8071	0.8958
OHIO	Hamilton	39061021508	Census Tract 215.08, Hamilton County, Ohio	0.24	0.4485	0.7759	0.3127	0.3704

State	County	FIPS	Location	Socioeconomic Score	Housing Composition and Disability Score	Minority Status and Language Score	Housing and Transportation Score	Overall SVI Score
OHIO	Hamilton	39061021509	Census Tract 215.09, Hamilton County, Ohio	0.7324	0.9718	0.4194	0.822	0.841
OHIO	Hamilton	39061021571	Census Tract 215.71, Hamilton County, Ohio	0.5216	0.4804	0.4514	0.6597	0.5577
OHIO	Hamilton	39061021572	Census Tract 215.72, Hamilton County, Ohio	0.5907	0.7343	0.9803	0.543	0.744
OHIO	Hamilton	39061021602	Census Tract 216.02, Hamilton County, Ohio	0.7865	0.9367	0.9493	0.5907	0.8873
OHIO	Hamilton	39061021603	Census Tract 216.03, Hamilton County, Ohio	0.6568	0.82	0.7558	0.1187	0.57
OHIO	Hamilton	39061021604	Census Tract 216.04, Hamilton County, Ohio	0.6973	0.9684	0.4626	0.4427	0.7245
OHIO	Hamilton	39061021701	Census Tract 217.01, Hamilton County, Ohio	0.4705	0.8744	0.7139	0.9813	0.8488
OHIO	Hamilton	39061021702	Census Tract 217.02, Hamilton County, Ohio	0.6735	0.8499	0.901	0.9871	0.9547
OHIO	Hamilton	39061021801	Census Tract 218.01, Hamilton County, Ohio	0.617	0.4502	0.768	0.8268	0.7324
OHIO	Hamilton	39061021802	Census Tract 218.02, Hamilton County, Ohio	0.5206	0.8125	0.4092	0.5284	0.5928
OHIO	Hamilton	39061022000	Census Tract 220, Hamilton County, Ohio	0.2823	0.2457	0.7037	0.2297	0.2918
OHIO	Hamilton	39061022101	Census Tract 221.01, Hamilton County, Ohio	0.1832	0.443	0.6364	0.1317	0.2142
OHIO	Hamilton	39061022102	Census Tract 221.02, Hamilton County, Ohio	0.2281	0.3059	0.6497	0.4927	0.3561
OHIO	Hamilton	39061022200	Census Tract 222, Hamilton County, Ohio	0.2469	0.2637	0.3459	0.5515	0.3037
OHIO	Hamilton	39061022301	Census Tract 223.01, Hamilton County, Ohio	0.7327	0.8557	0.9762	0.9394	0.9537
OHIO	Hamilton	39061022302	Census Tract 223.02, Hamilton County, Ohio	0.2598	0.1011	0.8476	0.6951	0.4321
OHIO	Hamilton	39061022400	Census Tract 224, Hamilton County, Ohio	0.0861	0.2201	0.6813	0.1848	0.1542
OHIO	Hamilton	39061022601	Census Tract 226.01, Hamilton County, Ohio	0.014	0.3831	0.6888	0.1041	0.112
OHIO	Hamilton	39061022602	Census Tract 226.02, Hamilton County, Ohio	0.0558	0.3348	0.7531	0.084	0.1236
OHIO	Hamilton	39061022700	Census Tract 227, Hamilton County, Ohio	0.9322	0.8357	0.8068	0.6244	0.9081
OHIO	Hamilton	39061023001	Census Tract 230.01, Hamilton County, Ohio	0.4164	0.557	0.9112	0.9731	0.7899
OHIO	Hamilton	39061023002	Census Tract 230.02, Hamilton County, Ohio	0.2343	0.5298	0.6582	0.4284	0.396
OHIO	Hamilton	39061023100	Census Tract 231, Hamilton County, Ohio	0.0119	0.0963	0.652	0.0194	0.0242
OHIO	Hamilton	39061023201	Census Tract 232.01, Hamilton County, Ohio	0.8325	0.5539	0.7027	0.8084	0.8318
OHIO	Hamilton	39061023210	Census Tract 232.10, Hamilton County, Ohio	0.364	0.0541	0.767	0.8744	0.5179
OHIO	Hamilton	39061023222	Census Tract 232.22, Hamilton County, Ohio	0.4614	0.621	0.5905	0.6203	0.5778
OHIO	Hamilton	39061023300	Census Tract 233, Hamilton County, Ohio	0.0197	0.3913	0.7422	0.0262	0.0712

State	County	FIPS	Location	Socioeconomic Score	Housing Composition and Disability Score	Minority Status and Language Score	Housing and Transportation Score	Overall SVI Score
OHIO	Hamilton	39061023400	Census Tract 234, Hamilton County, Ohio	0.5563	0.6363	0.4728	0.637	0.6142
OHIO	Hamilton	39061023501	Census Tract 235.01, Hamilton County, Ohio	0.079	0.0701	0.8793	0.2514	0.1767
OHIO	Hamilton	39061023521	Census Tract 235.21, Hamilton County, Ohio	0.206	0.2038	0.7565	0.5584	0.3701
OHIO	Hamilton	39061023522	Census Tract 235.22, Hamilton County, Ohio	0.1726	0.3484	0.766	0.6638	0.4256
OHIO	Hamilton	39061023600	Census Tract 236, Hamilton County, Ohio	0.3613	0.3338	0.4827	0.3181	0.3323
OHIO	Hamilton	39061023702	Census Tract 237.02, Hamilton County, Ohio	0.2955	0.2344	0.501	0.1446	0.1978
OHIO	Hamilton	39061023800	Census Tract 238, Hamilton County, Ohio	0.5145	0.2671	0.8803	0.7414	0.6445
OHIO	Hamilton	39061023901	Census Tract 239.01, Hamilton County, Ohio	0.0892	0.5379	0.8622	0.6856	0.4654
OHIO	Hamilton	39061023902	Census Tract 239.02, Hamilton County, Ohio	0.0174	0.3181	0.5384	0.6094	0.2486
OHIO	Hamilton	39061024001	Census Tract 240.01, Hamilton County, Ohio	0.2012	0.5162	0.6099	0.5689	0.4072
OHIO	Hamilton	39061024100	Census Tract 241, Hamilton County, Ohio	0.0446	0.2753	0.5313	0.623	0.2608
OHIO	Hamilton	39061024200	Census Tract 242, Hamilton County, Ohio	0.1668	0.6356	0.3466	0.5281	0.3442
OHIO	Hamilton	39061024301	Census Tract 243.01, Hamilton County, Ohio	0.128	0.1939	0.8789	0.1351	0.1927
OHIO	Hamilton	39061024303	Census Tract 243.03, Hamilton County, Ohio	0.2932	0.4437	0.6405	0.2314	0.3235
OHIO	Hamilton	39061024321	Census Tract 243.21, Hamilton County, Ohio	0.0099	0.1912	0.7075	0.5175	0.2182
OHIO	Hamilton	39061024322	Census Tract 243.22, Hamilton County, Ohio	0.0092	0.0898	0.5776	0.0347	0.0221
OHIO	Hamilton	39061024400	Census Tract 244, Hamilton County, Ohio	0.0354	0.4944	0.6429	0.1038	0.1318
OHIO	Hamilton	39061024700	Census Tract 247, Hamilton County, Ohio	0.3313	0.2885	0.4915	0.1307	0.2179
OHIO	Hamilton	39061024800	Census Tract 248, Hamilton County, Ohio	0.0129	0.212	0.3068	0.5961	0.1593
OHIO	Hamilton	39061024901	Census Tract 249.01, Hamilton County, Ohio	0.6156	0.2055	0.2463	0.2872	0.349
OHIO	Hamilton	39061024902	Census Tract 249.02, Hamilton County, Ohio	0.0579	0.281	0.2037	0.0827	0.0446
OHIO	Hamilton	39061025001	Census Tract 250.01, Hamilton County, Ohio	0.2455	0.4855	0.616	0.1939	0.2904
OHIO	Hamilton	39061025002	Census Tract 250.02, Hamilton County, Ohio	0.1709	0.4393	0.0789	0.0245	0.0388
OHIO	Hamilton	39061025101	Census Tract 251.01, Hamilton County, Ohio	0.0126	0.1184	0.5918	0.0031	0.0075
OHIO	Hamilton	39061025102	Census Tract 251.02, Hamilton County, Ohio	0.1825	0.2981	0.6844	0.4151	0.318
OHIO	Hamilton	39061025103	Census Tract 251.03, Hamilton County, Ohio	0.1811	0.6679	0.4459	0.3838	0.3388
OHIO	Hamilton	39061025104	Census Tract 251.04, Hamilton County, Ohio	0.078	0.2028	0.0619	0.2188	0.0596

State	County	FIPS	Location	Socioeconomic Score	Housing Composition and Disability Score	Minority Status and Language Score	Housing and Transportation Score	Overall SVI Score
OHIO	Hamilton	39061025200	Census Tract 252, Hamilton County, Ohio	0.7191	0.4798	0.5905	0.8503	0.7504
OHIO	Hamilton	39061025300	Census Tract 253, Hamilton County, Ohio	0.6241	0.0861	0.7218	0.7516	0.5996
OHIO	Hamilton	39061025401	Census Tract 254.01, Hamilton County, Ohio	0.3834	0.3579	0.602	0.9544	0.6476
OHIO	Hamilton	39061025402	Census Tract 254.02, Hamilton County, Ohio	0.3922	0.1194	0.2367	0.0732	0.1069
OHIO	Hamilton	39061025500	Census Tract 255, Hamilton County, Ohio	0.7011	0.4542	0.3228	0.8431	0.6905
OHIO	Hamilton	39061025600	Census Tract 256, Hamilton County, Ohio	0.6176	0.1055	0.6531	0.588	0.524
OHIO	Hamilton	39061025700	Census Tract 257, Hamilton County, Ohio	0.8815	0.2113	0.8408	0.4828	0.7266
OHIO	Hamilton	39061025800	Census Tract 258, Hamilton County, Ohio	0.554	0.3171	0.3173	0.8833	0.6101
OHIO	Hamilton	39061026001	Census Tract 260.01, Hamilton County, Ohio	0.0712	0.0749	0.3167	0.1473	0.0514
OHIO	Hamilton	39061026002	Census Tract 260.02, Hamilton County, Ohio	0.285	0.1899	0.1177	0.7479	0.3017
OHIO	Hamilton	39061026101	Census Tract 261.01, Hamilton County, Ohio	0.3459	0.4178	0.3915	0.3141	0.3204
OHIO	Hamilton	39061026102	Census Tract 261.02, Hamilton County, Ohio	0.3902	0.7193	0.0344	0.4627	0.3626
OHIO	Hamilton	39061026200	Census Tract 262, Hamilton County, Ohio	0.7293	0.7241	0.2711	0.6676	0.6885
OHIO	Hamilton	39061027300	Census Tract 273, Hamilton County, Ohio	0.0776	0.1273	0.1354	0.0082	0.0031
OHIO	Hamilton	39061027400	Census Tract 274, Hamilton County, Ohio	0.8607	0.5158	0.9653	0.953	0.9517

APPENDIX 8 – ESSENTIAL ELEMENTS OF INFORMATION REQUIREMENTS

DOCUMENT DESCRIPTION

This appendix includes a list of Essential Elements of Information (EEI's) which may be used during the response cycle.

TABLE OF CONTENTS

DOCUMENT DESCRIPTION 1

HCPH CMIST PROFILE 2

EEI REQUIREMENTS

STATUS: INITIAL RESPONSE (IMMEDIATE)

- What is the scope of the incident and the response?
- How will it affect service delivery?
- Where are the impacted communities?
- What population is impacted?
- What is the anticipated medical surge?
- Determine communication means
- Evaluate healthcare organization, staff and supplies
    - Healthcare facility status
    - Consider healthcare facility incident command status
- Determine health department status
- Identify who need to know
- Identify resources to be deployed
- Consider healthcare facility decompression initiatives

STATUS: ONGOING RESPONSE

- Projections for healthcare organization, staff and supplies:
    - Identify additional resources
    - Responder safety and health
    - Identify capabilities by specialties
    - Prioritize routine health services
- Forecast duration of incident
- Update response partners
- Status of critical infrastructure (i.e., hospitals, urgent care, EMS service, long term-care, public health department, behavioral health)
- Status of interoperable communication systems
- Status: RECOVERY
- Prioritize essential functions
- Identify support resource systems
    - Human resources
    - Infrastructure resources

- Identify documentation
- Address regulatory requirements for reimbursements
- Assess functional staff (i.e., physical, mental screening, vaccinations)

APPENDIX 9 – EXTERNAL POINTS OF CONTACT

DOCUMENT DESCRIPTION

This appendix includes a list of External Points of Contact (POCs) that can provide HCPH with incident external points of contact (POC) specific information or situational awareness.

TABLE OF CONTENTS

DOCUMENT DESCRIPTION 1

EXTERNAL POINTS OF CONTACT 2

EXTERNAL POINTS OF CONTACT

Topic	Emergency Support Function	Primary Agency	Phone Number
Transportation	ESF #1	Hamilton County Engineers	
Communications	ESF #2	Hamilton County Communications Center	
Engineering & Public Works	ESF #3	Hamilton County Engineers	
Firefighting	ESF #4	Hamilton County Fire Chiefs	Call Hamilton County EMHSA for current contact
Information & Planning	ESF #5	Hamilton County Emergency Management & Homeland Security Agency (EMHSA)	
Mass Care	ESF #6	Hamilton County Job & Family Services	
Logistics & Resource Support	ESF #7	Hamilton County Purchasing	Call Hamilton County EMHSA for current contact
Public Health & Medical Services	ESF #8	HCPH The Health Collaborative	
Search & Rescue	ESF #9	Hamilton County Task Force 1	Call Hamilton County EMHSA for current contact
Hazardous Materials	ESF #10	Hamilton County Environmental Services	
Agriculture	ESF #11	Ohio State Extension	Call Hamilton County EMHSA for current contact
Energy	ESF #12	Hamilton County Engineers	
Law Enforcement	ESF #13	Hamilton County Sheriffs	Call Hamilton County EMHSA for current

			contact
Recovery & Mitigation	ESF #14	Hamilton County Administration	Call Hamilton County EMHSA for current contact
Emergency Public Information & External Affairs	ESF #15	Hamilton County EMHSA	
Volunteer Reception Center	N/A	Tri-State Community Organizations Active in Disasters (COAD)	
Elderly populations	N/A	Council on Aging of Southwestern Ohio	
Developmental Disability support	N/A	Hamilton County Developmental Disabilities Support	
Coroner	N/A	Hamilton County Coroner	
Salvation Army	N/A	Salvation Army Greater Cincinnati & Northern Kentucky	
Shelters, shelter populations	N/A	American Red Cross (ARC)	
Mental/behavioral health & Addiction services	N/A	Hamilton County Mental Health and Recovery Services	
Donations Management	N/A	Hamilton County EMHSA	
Federal Assistance - U.S. Environmental Protection Agency	N/A	U.S. EPA Emergency Response Branch Steve Renninger - OSC	
SPCA	N/A	Hamilton County Society for the Prevention of Cruelty to Animals (SPCA)	
Southwest Ohio Regional Transit Authority (SORTA)	N/A	SORTA	

APPENDIX 10 – INTERNAL HCPH DIVISION AND PROGRAM POINTS OF CONTACT

DOCUMENT DESCRIPTION

This appendix includes a list of Internal Points of Contact (POCs) that can provide specific information or situational awareness.

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DOCUMENT DESCRIPTION 1

INTERNAL POINTS OF CONTACT 2

INTERNAL POINTS OF CONTACT

Topic	Division or Program	Program	Point of Contact
Medical Guidance	Medical Director	Medical Director	P – Dr. Steve Feagins, M.D.
Death Certificates	Customer Service	Vital Statistics	P – Denise Comeau - Supervisor
Immunizations STDs HIV	Disease Prevention	Nursing	P – Laura McCreadie - Director S – Serenity Millow – TB Office Manager
Educations	Health Promotion & Education	Health Promotion & Education	P – Rebecca Stowe – Director S – Mary Ellen Kramer – Supervisor
Tuberculosis	Disease Prevention	TB Clinic	P – Serenity Millow – TB Office Manager S – Laura McCreadie – Director
Disease Investigation Communicable Disease Surveillance	Epidemiology	Epidemiology	P – David Carlson – Director S – Tom Boeshart – Supervisor
Emergency Preparedness Planning Emergency Preparedness Outreach	Emergency Preparedness	Emergency Preparedness	P – John Sherrard – Supervisor S – Kelsie Bobo - Emergency Preparedness Specialist
Restaurants – Food Safety Housing and Nuisance Inspections	Environmental Health	Sanitarian	P – Jeremy Hessel - Director S – Tucker Stone -

Public Swimming Pools and Spas School Inspections Campground Inspections Public Accommodation Inspections Manufactured Home Parks Inspections Rabies Prevention & Control			Supervisor S-Scott Puthoff - Supervisor
Waste Disposal Lead Poisoning and Prevention	Waste Management	Waste Management	P – Chuck DeJonkheere – Director
Sewage Treatment Systems Private Water Systems Stormwater	Water Quality	Stormwater	P – Chris Griffith – Director S – Greg Cassiere - Supervisor S – Ryan Wuest – Supervisor S – Felicia Erwin – Tech Supervisor
Plumbing Inspections Backflow Prevention	Plumbing	Plumbing	P – Lisa Humble – Director S – Sean Moore - Supervisor

Note: “P” indicated the Primary POC, “S” indicates the Secondary POC

APPENDIX 11 – HCPH AGREEMENTS AND CONTINGENT CONTRACTS

DOCUMENT DESCRIPTION

The purpose of this appendix identifies existing memoranda of agreements (MOAs)/memoranda of understanding (MOUs) and/or contingency contracts which HCPH can access in the event of an emergency response.

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DOCUMENT DESCRIPTION 1

TABLE OF CONTENTS 1

EXISTING MOAs, MOUs AND CONTINGENCY CONTRACTS 2

EXISTING MOAs, MOUs AND CONTINGENCY CONTRACTS

The following table identifies HCPHs existing MOAs, MOUs and contingency contracts which can provide resources and support in the event of an emergency.

Document Name	Document Type	Resources/ Support Provided	Cost for Utilization	POC to Activate	POC Primary Contact Info
Cincinnati Public Library trucks MOU	MOU	Library to supply 5 trucks and drivers at the CDS to be used to distribute MCMs from CDS	None	The Public Library of Cincinnati and Hamilton County	Holbrook Sample, Chief Technology and Logistics Officer office cell
Community Services for the Deaf	Contract	Interpreting services for the deaf	See contract	Community Services for the Deaf	Jennifer Lloyd, Scheduling Coordinator
Psychological First Aid Support	MOU	Supply 1-5 skilled nurses to provide psychological first aid and mental health support to Hamilton County residents affected by a disaster	None	Compassus™ Hospice & Palliative Care	Elizabeth Grinkemeyer, Executive Director
Psychological First Aid Support	MOU	Supply 1-5 skilled nurses to provide psychological first aid and mental health support to	None	Heartland Hospice Care	Amy Misch Administrator

		Hamilton County residents affected by a disaster			
Psychological First Aid Support	MOU	Supply 1-5 skilled nurses to provide psychological first aid and mental health support to Hamilton County residents affected by a disaster	None	Hospice of SW Ohio	Lori Revis Director of Education
Resolution endorsing the participation of county employees in assisting with responding and recovering during a declared emergency and/or points of dispensing	County Resolution	Up to 400 county employees will serve during a declared disaster and/or serve as volunteers at PODs	None	Board of County Commissioners	Current Board Chair
United Language Group	Contract	Translation and interpreting provider for over 200 major languages	See contract	United Language Group	https://unitedlanguagegroup.com/
Utilization of Consolidated Analytical Systems (CAS) as a County Drop Site (CDS)	MOU	Tisch Properties agreement to allow HCPH use the CAS Facility as a CDS	None	W. John Tisch – Co-owner CAS	

Utilization of Great Parks of Hamilton County Rangers and Vehicles	MOU	5 Great Parks of Hamilton County Rangers will escort delivery vehicles from HCPH distribution nodes to open PODs. Rangers will use Great Parks of Hamilton County vehicles	None	Great Parks of Hamilton County	Current Ranger Chief

APPENDIX 12 – HCPH PLAN STYLE GUIDE

DOCUMENT DESCRIPTION

This appendix outlines the ERP plan style guide.

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DOCUMENT DESCRIPTION 1

PLAN STYLE GUIDE 2

PLAN STYLE GUIDE

- Arial 26pt for Title
- Arial 12pt for Body Text, single spaced, left aligned
- Arial 18pt for Table of Contents header
- Arial 18pt for Section Headers (such as Section I)
- Arial 14pt for Section Subheaders (such as Section 1.0)
- Arial 13pt for Section Sub-Subheaders (such as Section 5.1.1)
- 6pt, single space After every paragraph
- 12pt, single space After every last paragraph before a header or subheader, etc.
- 12pt, single space After every header or subheader, etc. before the first paragraph is started
- Footer will include the following
    - Page number: Arial 10pt; aligned center
- Header will include the following:
    - Plan name; aligned center
- Arial 10pt for headers at top of page
- Hyperlinks are denoted by **blue color** font
- When referenced, ***plans*** are designated with **bold**, *italicized*, underlined font.
- When referenced, **attachments** are designated with **bold** font
- When referenced, ***appendices*** are designated with **bold**, *italicized* font.
- When referenced, **annexes** are designated with **bold**, underlined font.

APPENDIX 13 – NATIONAL INCIDENT MANAGEMENT SYSTEM (NIMS) 2017 REFRESH

DOCUMENT DESCRIPTION

The purpose of this document is to provide a high-level summary of changes made to the NIMS as part of the 2017 refresh.

The 2017 update to the National Incident Management System (NIMS) clarified roles and responsibilities for tactical level responders as well as coordination and support personnel operating from Emergency Operations Centers (EOCs), Multiagency Coordination Groups (MAC Groups) and Joint Information Centers (JICs).

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DOCUMENT DESCRIPTION 1
TABLE OF CONTENTS 1
INTRODUCTION 2
RESOURCE MANAGEMENT 2
COMMAND AND COORDINATION 3
COMMUNICATION AND INFORMATION MANAGEMENT 6
RESOURCES 7

INTRODUCTION

The 2017 NIMS refresh eliminates the preparedness component to avoid redundancy with the National Preparedness System and Goal. Fundamentals for the NIMS now include a component on unity of effort as a guiding principle. The addition of unity of effort emphasizes the importance of coordination among all responding organizations while maintaining specific jurisdictional responsibilities to support each other.

NIMS 2017 refresh defines three (3) components that are a consolidation of the 5 components that comprised the 2008 version (see Figure1).

FIGURE 1 – NIMS COMPONTENT COMPARISION

2008

1. Preparedness
2. Communications and Information Management
3. Resources Management
4. Command and Management
5. Ongoing Management and Maintenance

2017

1. Resource Management
2. Command Coordination
3. Communications and Information Management

RESOURCE MANAGEMENT

Resource management is clarified in the refresh to include pre-incident guidance for resource management during an incident and illustrates how resources are managed in mutual aid scenarios.

The need for pre- incident, resource typing and credentialing of incident personnel, terms and definitions was addressed in the 2017 refresh to establish standardization.

These resource types include the following:

- **Capability**- the core capability for which the resource is most useful
- **Category**- the function for which a resource would most likely be used
- **Kind**- a broad classification such as personnel, teams, facilities equipment and supplies
- **Type**- a resource's level of minimum capability to perform its function based on size, power, capacity (for equipment) or experience and qualifications (for personnel or teams)

Credentialing has also been newly defined as the responsibility lead by the authority having jurisdiction.

COMMAND AND COORDINATION

Contrary to the 2008 version, the 2017 NIMS refresh defines the NIMS management characteristics and provides a description for the four (4) NIMS command and control structures (see Figure 2).

FIGURE 2 – NIMS COMMAND AND CONTROL STRUCTURES

NIMS Command and Control Structures

- Incident Command System
- Emergency Operations Centers
- Multiagency Coordination Group
- Joint Information System

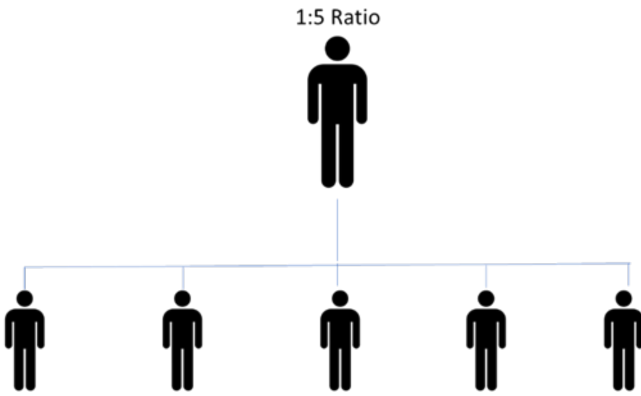
The NIMS refresh discusses the fourteen (14) NIMS Management Characteristics, these characteristics were formally known as ICS Management Characteristics (see Table 1).

TABLE 1 – NIMS MANAGEMENT CHARACTERISTICS

NIMS Management Characteristics	
Common Terminology	Integrated Communications
Modular Organization	Establishment and Transfer of Command
Management by Objectives	Unified Command
Incident Action Planning	Chain of Command and Unity of Command
Manageable Span of Control	Accountability
Incident Facilities and Location	Dispatch/Deployment
Comprehensive Resource Management	Information and Intelligence Management

The NIMS refresh clarifies that the incident command system is used for on-scene management of incidents. Revisions to the incident command system which includes revised guidance on what a manageable span of control is. In 2008, NIMS doctrine described the idea of span of control to a range from 3 to 7 subordinates with 5 being the ideal number of subordinates. However, in the 2017 refresh, the recommended ratio of 1:5 (see Figure 3) is established as a guideline for incident personnel with supervisors using their best judgement as to determine the best staffing for the incident or EOC activation.

FIGURE 3 – EXAMPLE OF 1:5 RATIO



There is also clarification and use of the term Incident Management Team (IMT) as a reference to a team of pre-rostered emergency management professionals that may be assigned to an incident. Incident Management Assistance Teams (IMAT) provide emergency management personnel to support on scene or at the state, regional, and national level.

While the incident command system structure has not changed, additional functions have been added to incorporate the function of intelligence gathering for incidents that may require intelligence gathering or investigative activities. This function may exist within the planning, operations, command or general staff section or alternately be a combination of these locations.

Additionally, the revision to the ICS concepts includes the inclusion of legal counsel, medical advisors and an access and functional needs advisor as possible command advisors.

Terms such as "resource team" has also been revised to replace the law enforcement term of "strike team."

Incident Action Planning also had revisions in the 2017 refresh, primarily, changes have been made to the planning "P." The planning "P" now includes an agency administrator briefing (if applicable) as well as a strategy meeting/command and general staff meeting (if necessary). Additionally, the understanding of the situation as an ongoing action is now at the center for the graphic (see Figure 4).

FIGURE 4 – 2017 NIMS REFRESH PLANNING "P"

The 2017 NIMS refresh provides guidance on EOC structures and activation levels. Standard EOC functions include information management, resource management and communication of policy decisions.

The role of the Emergency Operations Center (EOCs) has been clarified as an offsite support center for on-scene ICS operations.

EOC teams may comprise multiple agencies with staff of various disciplines who exchange information for decision making, coordination and communication.

EOCs may activate for a variety of reasons to provide support to an incident. EOC activation levels allow for a scalable response and coordination. NIMS 2017 has defined EOC activation levels (see Table 2).

TABLE 2 – NIMS EOC ACTIVATION LEVELS

Level	Activation Level Title	Description
3	Normal Operations/ Steady-State	Activities that are normal for the center, when no incident or specific risk or hazard has been identified, are underway. This includes routine watch and warning activities if the center normally houses this function.
2	Enhanced Steady State/Partial Activation	Certain EOC Team members/ organizations are activated to monitor a credible threat, risk or hazard and/or to support the response to a new and potentially evolving incident.
1	Full Activation	EOC team is activated, including personnel from all assisting agencies, to support the response to a major incident or credible threat.

Multiagency Coordination Groups (MAC Groups) comprise agency decision makers such as administrations or senior leaders, leaders from non-governmental organizations (NGOs) or designees. The update defines MACS as the overarching term for NIMS command and Coordination systems e.g., ICS, EOCs, MAC Groups/policy groups and JICs. This shift is overarching rather than defined as components of MACS which were understood to be as EOCS and MAC Groups.

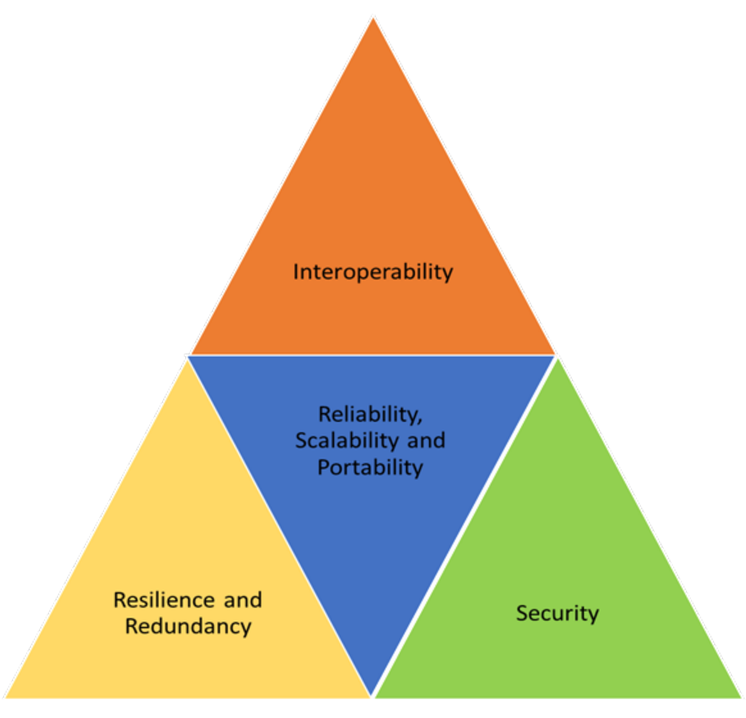
The MAC Group may be referred to as the “policy group.” The purpose of a MAC Group is to provide strategic policy guidance to support the decision making of elected or appointed officials and determine scare resource allocation. MAC Group participants do not perform incident command functions.

COMMUNICATION AND INFORMATION MANAGEMENT

The refresh has restructured the concepts for communications and information management

Because of the vulnerability of personal, identifiable information and other sensitive material gathered and utilized during response, the 2017 refresh adds security as one of the four key principles of communications (see Figure 5).

FIGURE 5 – NIMS COMMUNICATIONS KEY PRINCIPLES



RESOURCES

Federal Emergency Management Agency (FEMA).(2017). National Incident System. Retrieved from https://www.fema.gov/media-library-data/1508151197225-ced8c60378c3936adb92c1a3ee6f6564/FINAL_NIMS_2017.pdf

FEMA.(2017). National Incident System (NIMS) 2017 Learning Materials. Retrieved from https://training.fema.gov/nims/docs/nims.2017.instructor%20student%20learning%20materials.pdf

APPENDIX 14 – DEFINITIONS AND ACRONYMS

DOCUMENT DESCRIPTION

This appendix contains definitions and acronyms to the ERP plan.

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DOCUMENT DESCRIPTION 1

EMERGENCY RESPONSE PLAN DEFINITIONS 2

EMERGENCY RESPONSE PLAN ACRONYMS 9

EMERGENCY RESPONSE PLAN DEFINITIONS

Agency: An agency is a division of government with a specific function, or a nongovernmental organization (e.g., private contractor, business, etc.) that offers a particular kind of assistance. In ICS, agencies are defined as jurisdictional (having statutory responsibility for incident mitigation) or assisting and/or cooperating (providing resources and/or assistance).

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.

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 referenced, annexes are designated with bold, underlined font.
- 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.

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.

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

Cache: A pre-determined complement of tools, equipment, and/or supplies stored in a designated location, available for incident use.

Check-In: The process whereby resources first report to an incident. Check-in locations include: Incident Command Post, Incident Base, Camps, Staging Areas, Helibases, and Supervisors (for direct line assignments).

Command Staff: The Command Staff consists of the Public Information Officer, Safety Officer, and Liaison Officer. They report directly to the Department Commander. They may have an Assistant or Assistants, as needed.

Coordination: The process of systematically analyzing a situation, developing relevant information, and informing appropriate command authority of viable alternatives for selection of the most effective combination of available resources to meet specific objectives. The coordination process (which can be either intra- or interagency) does not involve dispatch actions. However, personnel responsible for coordination may perform command or dispatch functions within the limits established by specific agency delegations, procedures, legal authority, etc.

Delegation of Authority: A statement provided to the Incident Commander by the Agency Executive delegating authority and assigning responsibility. The Delegation of Authority can include objectives, priorities, expectations, constraints, and other considerations or guidelines as needed. Many agencies require written Delegation of Authority to be given to Incident Coordinator(s) prior to their assuming command on larger incidents.

Disaster: Any imminent threat or actual occurrence of widespread or severe damage to or loss of property, personal hardship or injury, or loss of life that results from any natural phenomenon or act of a human.

DOC Manager: HCPH staff member responsible for management of the HCPH DOC and DOC support staff.

Emergency: Any incident, human-caused or natural, that requires responsive action to protect life or property. Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, an emergency means any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States.

Emergency Management Assistance Compact (EMAC): The Emergency Management Assistance Compact (EMAC) is the first national disaster-relief compact since the Civil Defense and Disaster Compact of 1950 to be ratified by Congress. Since ratification and signing into law in 1996 (Public Law 104-321), 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands have enacted legislation to become EMAC members. EMAC offers assistance during governor-declared states of emergency through a mutual aid framework that allows states to send personnel and equipment to help disaster relief efforts in other states. EMAC establishes a firm legal foundation for interstate mutual aid deployments. Once the conditions for providing

assistance to a requesting state have been set, the terms constitute a legally binding contractual agreement that makes affected states responsible for reimbursement. The EMAC legislation solves the problems of liability and responsibilities of cost and allows for credentials, licenses, and certifications to be honored across state lines.

Emergency Operations Center (EOC): The physical location at which the coordination of information and resources to support domestic incident management activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, and medical services), by jurisdiction (e.g., Federal, State, regional, county, city, tribal), or some combination thereof.

Emergency Operations Plan (EOP): The plan that each jurisdiction has and maintains for responding to appropriate hazards.

Event: A planned, non-emergency activity. ICS can be used as the management system for a wide range of events, e.g., parades, concerts, or sporting events.

Federal: Of or pertaining to the Federal Government of the United States of America.

Finance/Administration Section: The Section responsible for all incident costs and financial considerations. Includes the Time Unit, Procurement Unit, Compensation/Claims Unit, and Cost Unit.

Hazard: Something that is potentially dangerous or harmful, often the root cause of an unwanted outcome.

Incident: An occurrence or event, natural or human-caused, which requires emergency response to protect life or property. Incidents can, for example, include major disasters, emergencies, terrorist attacks, terrorist threats, wildland and urban fires, floods, hazardous materials spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, war-related disasters, public health and medical emergencies, and other occurrences requiring an emergency response.

Incident Commander/Agency Commander (IC/AC): The individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources. The IC/AC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations.

Incident Action Plan (IAP): An oral or written plan containing general objectives reflecting the overall strategy for managing an incident. It may include the identification of operational resources and assignments. It may also include attachments that provide direction and important information for management of the incident during one or more operational periods.

Incident Command System (ICS): A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a

common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations. Incident Communications Center: The location of the Communications Unit and the Message Center.

Incident Objectives: Statements of guidance and direction necessary for the selection of appropriate strategy(ies), and the tactical direction of resources. Incident objectives are based on realistic expectations of what can be accomplished when all allocated resources have been effectively deployed. Incident objectives must be achievable and measurable, yet flexible enough to allow for strategic and tactical alternatives.

Intrastate Mutual Aid Compact (IMAC): The Ohio Intrastate Mutual Aid Compact (IMAC), Ohio Revised Code Section 5502.41, was updated on July 3, 2012. IMAC is mutual aid agreement through which all political subdivisions can request and receive assistance from any other political subdivisions in the state; many of the administrative and legal issues are resolved in advance of an incident. All political subdivisions are automatically part of IMAC. The definition of political subdivision is broad and includes not only counties, municipal corporations, villages and townships, but also port authorities, local health districts, joint fire districts, and state institutions of higher education.

Joint Information Center (JIC): A facility established to coordinate all incident-related public information activities. It is the central point of contact for all news media at the scene of the incident. Public information officials from all participating agencies should collocate at the JIC.

Joint Information System (JIS): Integrates incident information and public affairs into a cohesive organization designed to provide consistent, coordinated, timely information during crisis or incident operations. The mission of the JIS is to provide a structure and system for developing and delivering coordinated interagency messages; developing, recommending, and executing public information plans and strategies on behalf of the Incident Commander; advising the Incident Commander concerning public affairs issues that could affect a response effort; and controlling rumors and Inaccurate information that could undermine public confidence in the emergency response effort.

Jurisdiction: A range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority. Jurisdictional authority at an incident can be political or geographical (e.g., city, county, tribal, State, or Federal boundary lines) or functional (e.g., law enforcement, public health).

Local Government: A county, municipality, city, town, township, local public authority, school district, special district, intrastate district, council of governments (regardless of whether the council of governments is incorporated as a nonprofit corporation under State law), regional or interstate government entity, or agency or instrumentality of a local government; an Indian tribe or authorized tribal organization, or in Alaska a Native village or Alaska Regional Native Corporation; a rural community, unincorporated town or village, or other public entity.

Logistics Section: The Section responsible for providing facilities, services, and materials for the incident.

Military Installation: A base, camp, post, station, yard, center, or other activity under the jurisdiction of the Secretary of a Military Department or, in the case of an activity in a foreign country, under the operational control of the Secretary of a Military Department or the Secretary of Defense.

Mitigation: The activities designed to reduce or eliminate risks to persons or property or to lessen the actual or potential effects or consequences of an incident. Mitigation measures may be implemented prior to, during, or after an incident. Mitigation measures are often formed by lessons learned from prior incidents. Mitigation involves ongoing actions to reduce exposure to, probability of, or potential loss from hazards. Measures may include zoning and building codes, floodplain buyouts, and analysis of hazard-related data to determine where it is safe to build or locate temporary facilities. Mitigation can include efforts to educate governments, businesses, and the public on measures they can take to reduce loss and injury.

Mobilization: The process and procedures used by all organizations (Federal, State, and local) for activating, assembling, and transporting all resources that have been requested to respond to or support an incident.

Multiagency Coordination Systems (MACS): Multiagency coordination systems provide the architecture to support coordination for incident prioritization, critical resource allocation, communications systems integration, and information coordination. The components of multiagency coordination systems include facilities, equipment, emergency operations centers (EOCs), specific multiagency coordination entities, personnel, procedures, and communications. These systems assist agencies and organizations to fully integrate the subsystems of the NIMS.

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

Operational Period: The period of time scheduled for execution of a given set of operation actions as specified in the Incident Action Plan. Operational Periods can be of various lengths, although usually not over 24 hours.

Operations Section: The Section responsible for all tactical operations at the incident, includes; Includes Branches, Divisions and/or Groups, Task Forces, Strike Teams, Single Resources, and Staging Areas.

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.

Planning Meeting: A meeting held (as needed throughout the duration of an incident), to select specific strategies and tactics for incident control operations, and for service and support planning. On larger incidents, the Planning Meeting is a major element in the development of the Incident Action Plan (IAP).

Planning Section: Responsible for the collection, evaluation, dissemination of information related to the incident, in addition to the preparation and documentation of Incident Action Plans. The Section also maintains information on the current and forecasted situation, and on the status of resources assigned to the incident; which includes the Situation, Resources, Documentation, and Demobilization, as well as Technical Specialists.

Preparedness: The range of deliberate, critical tasks and activities necessary to build, sustain, and improve the operational capability to prevent, protect against, respond to, and recover from domestic incidents. Preparedness is a continuous process. Preparedness involves efforts at all levels of government and between government and private-sector and nongovernmental organizations to identify threats, determine vulnerabilities, and identify required resources. Within the NIMS, preparedness is operationally focused on establishing guidelines, protocols, and standards for planning, training and exercises, personnel qualification and certification, equipment certification, and publication management.

Prevention: Actions to avoid an incident or to intervene to stop an incident from occurring. Prevention involves actions to protect lives and property. It involves applying intelligence and other information to a range of activities that may include such countermeasures as deterrence operations; heightened inspections; improved surveillance and security operations; investigations to determine the full nature and source of the threat; public health and agricultural surveillance and testing processes; immunizations, isolation, or quarantine; and, as appropriate, specific law enforcement operations aimed at deterring, preempting, interdicting, or disrupting illegal activity and apprehending potential perpetrators and bringing them to justice.

Reporting Locations: Location, or facilities, where incoming resources can check-in at the incident. (See Check-In.)

Resources: Personnel and major items of equipment, supplies, and facilities available or potentially available for assignment to incident operations and for which status is maintained. Resources are described by kind and type and may be used in operational support or supervisory capacities at an incident or at an EOC.

Recovery: The development, coordination, and execution of service- and site-restoration plans; the reconstitution of government operations and services; individual, private-sector, nongovernmental, and public-assistance programs to provide housing and to promote restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental, and economic restoration; evaluation of

the incident to identify lessons learned; post-incident reporting; and development of initiatives to mitigate the effects of future incidents.

Resource Management: Efficient incident management requires a system for identifying available resources at all jurisdictional levels to enable timely and unimpeded access to resources needed to prepare for, respond to, or recover from an incident. Resource management under the NIMS includes mutual-aid agreements; the use of special Federal, State, local, and tribal teams; and resource mobilization protocols.

Response: Activities that address the short-term, direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs. Response also includes the execution of emergency operations plans and of mitigation activities designed to limit the loss of life, personal injury, property damage, and other unfavorable outcomes. As indicated by the situation, response activities include applying intelligence and other information to lessen the effects or consequences of an incident; increased security operations; continuing investigations into nature and source of the threat; ongoing public health and agricultural surveillance and testing processes; immunizations, isolation, or quarantine; and specific law enforcement operations aimed at preempting, interdicting, or disrupting illegal activity, and apprehending actual perpetrators and bringing them to justice.

Span of Control: The number of individuals a supervisor is responsible for, usually expressed as the ratio of supervisors to individuals. (Under the NIMS, an appropriate span of control is between 1:3 and 1:7.)

Staging Area: Location established where resources can be placed while awaiting a tactical assignment. The Operations Section manages Staging Areas.

Standard Operating Procedure (SOP): Complete reference document or an operations manual that provides the purpose, authorities, duration, and details for the preferred method of performing a single function or a number of interrelated functions in a uniform manner.

State: When capitalized, refers to any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and any possession of the United States.

Strategy: The general direction selected to accomplish incident objectives set by the Incident Coordinator.

Strategic: Strategic elements of incident management are characterized by continuous long-term, high level planning by organizations headed by elected or other senior officials. These elements involve the adoption of long-range goals and objectives, the setting of priorities, the establishment of budgets and other fiscal decisions, policy development, and the application of measures of performance or effectiveness.

Tactics: Deploying and directing resources on an incident to accomplish incident strategy and objectives.

Threat: An indication of possible violence, harm, or danger.

Unified Command: An application of ICS used when there is more than one agency with incident jurisdiction, or when incidents cross political jurisdictions. Agencies work together through the designated members of the Unified Command, often the senior person from agencies and/or disciplines participating in the Unified Command, to establish a common set of objectives and strategies and a single Incident Action Plan.

Vital Records: The essential agency records that are needed to meet operational responsibilities under national security emergencies or other emergency or disaster conditions (emergency operating records), or to protect the legal and financial rights of the government and those affected by government activities (legal and financial rights records).

EMERGENCY RESPONSE PLAN ACRONYMS

ACRONYM	DESCRIPTION
AAR	After-Action Report
AAR/IP	After-Action Report / Improvement Plan
ARC	American Red Cross
ATSDR	Agency for Toxic Substances and Disease Registry
CDC	Centers for Disease Control & Prevention
CHS	Community Health Services
CMIST	Communication, Medical, Independence, Supervision, & Transportation services
COAD	Community Organizations Active in Disasters
COOP	Continuity of Operations Plan
CRI	Cities Readiness Initiative
DOC	Department Operations Center
DOE	U.S. Department of Energy
DPC	Disaster Preparedness Coalition
EEI	Essential Elements of Information
EMAC	Emergency Management Assistance Compact
EMHSA	Hamilton County Emergency Management & Homeland Security Agency
EMS	Emergency Medical Services
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
EP	Emergency Preparedness
ERP	Emergency Response Plan - Basic
ESF	Emergency Support Function
ESF-8	Emergency Support Function #8 (Public Health and Medical Services)
FEMA	Federal Emergency Management Agency
GETS	Governmental Emergency Telecommunication Service
HCPH	Hamilton County Public Health

HHS	U.S. Department of Health & Human Services
HIPAA	Health Insurance Portability & Accountability Act of 1996
HPP	Hospital Preparedness Program
IAP	Incident Action Plan
IC/AC	Incident Commander / Agency Commander
ICS	Incident Command System
IMAC	Intrastate Mutual Aid Compact
IMATS	Inventory Management Asset Tracking System
IP	Improvement Plan
IRMS	Inventory Resource Management System
LHD	Local Health Department
MAA	Mutual Aid Agreements
MACC	Multi-agency Coordination Center
MARCS	Multi-Agency Radio Communication System
MCM	Medical Countermeasures
MOU	Memorandum of Understanding
MSA	Metropolitan Statistical Areas
NIMS	National Incident Management System
NRF	National Response Framework
OPHCS	Ohio Public Health Communications System
PHE	Public Health Emergency
PHS	Public Health Service Act of 1944
PIO	Public Information Officer
POC	Points of Contact
PSC	Planning Section Chief
RPHC	Regional Public Health Coordinator
SITREP	Situation Report
SME	Subject Matter Expertise
SNS	Strategic National Stockpile
THIRA	Threat and Hazard Identification & Risk Assessment
SWOPHR	Southwest Ohio Public Health Region
U.S. EPA	United States Environmental Protection Agency
UC	Unified Command
VOAD	Voluntary Organizations Active in Disasters
VoIP	Voice over Internet Protocol
WIC	Women, Infants and Children
WPS	Wireless Priority Service