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INTRODUCTION

Approval and Implementation:
The Williams County Health District (WCHD) Emergency Response Plan (ERP) replaces and supersedes all previous versions of the WCHD ERP. This plan shall serve as the operational framework for responding to all emergencies, crisis situations, and major/minor/catastrophic disasters that impact the public health and medical systems in the jurisdiction. This plan may be implemented as a stand-alone plan or in concert with the Jurisdictional, Regional, or State Emergency Operations Plans when necessary.

Executive Summary:
The Williams County Health District (WCHD) Emergency Response Plan (ERP) is an all-hazard plan that establishes a single, comprehensive framework for the management of the public health response to incidents within the jurisdiction. The plan is activated when it becomes necessary to assess incidents or to mobilize the resources identified herein in order to protect the public’s health. The ERP incorporates the National Incident Management System (NIMS) as the standard for incident management.

The plan assigns roles and responsibilities to WCHD program areas and staff 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 the staff of the Williams County Health District in partnership with internal and external subject matter experts, partners, and community stakeholders. The ERP Basic Plan is intended to be used in conjunction with both the more detailed annexes, appendices, and attachments included as part of this document or with standalone guides or SOGs held by the department. Additionally, the ERP is designed to work in conjunction with the Jurisdictional, Regional, & State 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.
Statement of Promulgation:
The Williams County Health District (WCHD) Emergency Response Plan (ERP) establishes the basis for coordination of WCHD resources and response providing public health / medical services during an emergency, crisis, disaster, or event requiring public health intervention. The fundamental assumption is that a significant emergency or disaster may overwhelm the capability of public health, local government, or the healthcare system to carry out operations necessary to save lives and protect public health. Consequently, WCHD resources are used to provide public health and medical services assistance throughout the Jurisdiction of Williams County, OH.

All WCHD 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. WCHD will maintain this plan, reviewing it and reauthorizing it annually; findings from its utilization in exercises, real incidents, or review will inform updates.

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

James D. Watkins
Health Commissioner
Williams County Health District

Date: 1-9-19
Record of Changes:
The Health Commissioner or designee authorizes all changes to the Williams County Health District Emergency Response Plan (WCHD ERP). 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.

<table>
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<th>Version #</th>
<th>Change #</th>
<th>Date</th>
<th>Person's Name &amp; Title</th>
<th>Description of the Change</th>
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<td>0</td>
<td>04/27/2018</td>
<td>Michael Shultz, Preparedness Coordinator</td>
<td>New document</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>01/09/2019</td>
<td>Michael Shultz, Preparedness Coordinator</td>
<td>ERP promulgation conducted. Signed by Health Commissioner. Final ERP sent to everyone on the distribution list on page 7 of this ERP.</td>
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Record of Distribution:
A digital copy of the Williams County Health District Emergency Response Plan (WCHD ERP) is distributed to each person in the positions listed below.

<table>
<thead>
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<th>Date Received</th>
<th>Division</th>
<th>Title</th>
<th>Name</th>
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<tr>
<td>01/09/2019</td>
<td>Agency</td>
<td>Health Commissioner</td>
<td>Jim Watkins</td>
</tr>
<tr>
<td>01/09/2019</td>
<td>Nursing</td>
<td>Director of Nursing</td>
<td>Rachel Aeschliman</td>
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<tr>
<td>01/09/2019</td>
<td>Environmental</td>
<td>Director of Environmental</td>
<td>Brad Price</td>
</tr>
<tr>
<td>01/09/2019</td>
<td>Community Health</td>
<td>Director of Community Health</td>
<td>Megan Riley</td>
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<tr>
<td>01/09/2019</td>
<td>Clerical</td>
<td>Clerical Supervisor</td>
<td>Aubrey Raatz</td>
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<tr>
<td>01/09/2019</td>
<td>Public Health Preparedness</td>
<td>Emergency Preparedness Coordinator</td>
<td>Michael Shultz</td>
</tr>
<tr>
<td>01/09/2019</td>
<td>Williams County Emergency</td>
<td>Emergency Management Agency Director</td>
<td>Dawn Baldwin</td>
</tr>
<tr>
<td></td>
<td>Management Agency</td>
<td></td>
<td>Apryl McClain</td>
</tr>
<tr>
<td>01/09/2019</td>
<td>Community Hospitals and Wellness Centers</td>
<td>Emergency Management</td>
<td>Joe Schlosser</td>
</tr>
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</table>

This plan is available to all Williams County Health District staff and those occupying Command or General Staff positions within the Incident Command System via PolicyStat in electronic format. PolicyStat is accessible by all WCHD staff by logging into the PolicyStat website or upon logging onto their work computer they are automatically logged into PolicyStat. Hard copies can be found in the Emergency Preparedness Coordinator’s office (located in the bottom right drawer of Coordinator’s desk), in the Community Health Director’s office (on shelf), and in the Health Commissioner’s office (on shelf). Each hard copy is marked Williams County Health District Emergency Response Plan.
SECTION 1

1.0 Purpose:

The Williams County Health District (WCHD) has developed this Emergency Response Plan – Basic Plan (ERP) in order to support WCHD’s mission to protect and improve the health of all jurisdictional residents, visitors, workers, and businesses/county agencies at all times, even during emergencies. This plan was developed to operationalize the execution of WCHD’s mission during emergencies, crisis, or events providing the direction to plan for and respond to natural, technological, man-made, and hazardous incidents with a health impact so that negative health impacts are prevented, reversed, or minimized throughout all levels of response.

This ERP is organized in three (3) principle sections designed to guide a response at WCHD. 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 services. Section two (2) provides detailed direction in how response operations are executed at WCHD. This section covers the preliminary steps necessary for incident assessment, response activation, provides guidance on the execution of operational response, and details the processes that take place after a response. Finally, section three (3) provides guidance on development and review processes as well as, providing guidelines by which all WCHD ERPs, plans, guides, annexes, and appendices are developed.

The WCHD 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 WCHD 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 conjunction with the Jurisdictional, Regional, or State Emergency Operations Plan, other WCHD plans, annexes, documents, or appendices.

2.0 Scope and Applicability:

This plan pertains to the Williams County Health District (WCHD) and all of its offices and program areas. This plan is always in force and is activated whenever an incident impacts public health systems and/or medical systems anywhere within the jurisdiction of Williams County, Ohio and requires a response by WCHD greater than day-to-day operations.
The scope of this plan is not limited by the nature of any particular hazard, emergency, crisis, or event. This plan is written, to be applied, with equal effectiveness to hazards that impact public health and healthcare, whether they are infectious, noninfectious, intentional, unintentional, or threaten the health of jurisdictional residents, visitors, workers, or businesses/county agencies within Williams County, Ohio.

The WCHD ERP incorporates NIMS and connects agency response actions to responses at the local, regional, and state levels. This plan directs appropriate WCHD response operations to any incidents that either impact, or potentially impact, public health or healthcare within the Jurisdiction or requires WCHD to fulfill its roles described in the Williams County All Hazards Emergency Operations Plan. The Williams County All Hazards Emergency Operations Plan describes the responsibilities of all agencies in response to incidents within the Jurisdiction of Williams County, Ohio. The WCHD ERP supports the Williams County All Hazards Emergency Operations Plan through direction of WCHD response activities and provides needed detail for operations at the agency level. It describes the roles and responsibilities of WCHD areas of emergency response.

WCHD has assigned responsibilities in the Williams County All Hazards Emergency Operations Plan and functional annex section as both a primary and support agency. WCHD’s roles and responsibilities can be found in the County EOP under Annex H Public Health (digital copy of the County All Hazards EOP can be found in the Williams County Health District Emergency Response Plan folder “Stand Alone Guidance.”).

This plan does not address issues related to continuity of operations (COOP) planning at WCHD. All continuity issues are addressed through the Williams County Health District’s Continuity of Operations Plan.

Additionally the coordination of communication is not directed by this plan. Coordinated communications is directed by the Williams County Health District’s Risk / Crisis Communications Plan. However, since coordinated communications is an essential component of all incident responses, this plan identifies how the ERP interfaces with the Communications Annex to ensure that information and messaging are effectively managed and adequately support across all WCHD response activities.
3.0 SITUATION:
Geographically, Williams County, Ohio is located in the northwestern part of the state. Its western border helps form the boundary between Ohio and Indiana, and its northern border helps form the boundary between Ohio and Michigan. Williams County is also bordered by Henry, Fulton, and Defiance Counties. The county seat is Bryan, Ohio, which is the largest community in the county, with a population of 8,434 people according to the 2016 Census population estimate. Williams County is composed of 12 townships: Northwest, Florence, St. Joseph, Bridgewater, Superior, Center, Pulaski, Jefferson, Madison, Millcreek, Brady, & Springfield Townships. Total population, within Williams County, Ohio, according to the 2016 Census population estimate is 37,017. Just one percent of the county’s 422 square miles is deemed to be urban and has a mixture of rural and industrial areas.

Historically, the State has experienced a multitude of events caused by ongoing threats and hazards. The State Emergency Management Agency (State EMA) reports 47 major emergency events in the State receiving a Presidential Declaration of Disaster since 1964. These events have impacted public health and medical services in the past and continue to pose a threat to health security for State residents.

The Williams County Mitigation study reveals that Williams County, Ohio has experienced multiple events that have resulted in a Presidential Declaration of Disaster. The following are the declarations as described in the County Hazard Mitigation study:

According to the 2017 Williams County Health District Hazard Assessment we found that the Health District faces many potential threats and hazards. There are no public health hazards; rather, all hazards could lead to impacts on health, which may require WCHD 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 Jurisdiction or State
Williams County’s geographic location and accessibility places the jurisdiction within an area of risk that may become affected by incidents or events originating outside its borders. External events have the ability to directly impact both public health and medical services by causing demand for preventative and healthcare measures. Most notably, public health threats such as infectious diseases have the ability to arrive in Williams County through travel related mechanism. Threats that could originate in a neighboring jurisdiction or state and impact WCHD’s jurisdiction (combined to represent Indiana, Michigan, Henry County, Fulton County, and Defiance County) Note that “all” indicates every neighboring jurisdiction:

- Infrastructure loss (all)
- Severe Storms (Tornado, Thunderstorm, Winter Storms, etc.) (All)
- Communicable / Infectious disease (all)
- Impacts from various types of severe weather (all, 25 declarations Michigan)
- Flooding (all, 12 declarations Indiana, 11 declarations Michigan)
- Radiologic exposure (Nuclear power plants within zone: 1 Ohio, 3 Michigan)
- Transportation incidents various (border multiple state routes/highways/airports –all-)
- Supply shortages of various types/forms (all)
- Terrorism (all)
- Hazardous materials release (all)
- Pipeline failure (Henry, Defiance, Michigan)
- CBRNE (all)
- Watersheds (all)

NOTE: This is a brief list and not intended to be exhaustive.
The most current public health incident was the H1N1 crisis in 2009. Within Williams County, Points of Dispensing operations were conducted providing medication to those within the Jurisdiction. Since this event Williams County has not encountered a public health crisis or assisted another agency. Incidents directly related to public health and requiring intervention remain low with the risk still existing.

The 2013 – 2018 Williams County Hazard Mitigation Plan details and quantifies hazards from significant historic events and the hazard’s likelihood of occurrence. According to their Hazard Mitigation Plan findings Williams County, Ohio is likely to experience identified priority hazards as show in the tables below, taken from the plan directly (See plan for further information):

| Table 2-4: Risk Factor Results for Williams County and Participating Jurisdictions |
|---------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| NATURAL HAZARDS                  | PROBABILITY     | IMPACT          | SPATIAL         | WARNING         | DURATION        | RF              |
| 1 SEASONAL TEMPERATURE EXTREMES  | 1.2             | 0.6             | 0.8             | 0.1             | 0.3             | 3.0             |
| 2 SEVERE WINTER WEATHER          | 1.2             | 0.6             | 0.8             | 0.1             | 0.2             | 2.9             |
| 3 TORNADOES                      | 0.6             | 0.9             | 0.8             | 0.4             | 0.1             | 2.8             |
| 4 FLOODING                       | 1.2             | 0.6             | 0.4             | 0.1             | 0.3             | 2.6             |
| 5 DROUGHT                        | 0.6             | 0.6             | 0.8             | 0.1             | 0.4             | 2.5             |
| 6 SEVERE SUMMER STORMS           | 1.2             | 0.3             | 0.4             | 0.3             | 0.1             | 2.3             |
| 7 EARTHQUAKES/SEISMIC ACTIVITY   | 0.3             | 0.3             | 0.6             | 0.4             | 0.1             | 1.7             |
| TECHNOLOGICAL HAZARDS            | PROBABILITY     | IMPACT          | SPATIAL         | WARNING         | DURATION        | RF              |
| 1 TRANSPORTATION INCIDENT        | 1.2             | 0.6             | 0.4             | 0.4             | 0.1             | 2.7             |
| 2 TERRORISM                      | 0.6             | 0.9             | 0.6             | 0.4             | 0.1             | 2.6             |
| 3 DAM FAILURE                    | 0.3             | 1.2             | 0.4             | 0.4             | 0.2             | 2.5             |

| Table 2-39 Hazard Frequency Summary |
|-------------------------------------|-----------------|-----------------|-----------------|-----------------|
| HAZARD                              | # EVENTS ON HISTORIC RECORD | # YEARS ON HISTORIC RECORD | HISTORIC RECURRENCE INTERVAL (YEARS) | HISTORIC FREQUENCY % (CHANCE PER YEAR) |
| Thunderstorm Wind                   | 83               | 54               | 0.65            | 100%            |
| Hail                                | 32               | 38               | 1.19            | 84%             |
| Lightning                           | 2                | 62               | 31              | 3.23%           |
| Snow & Ice Extremes                 | 81               | 51               | .63             | 100%            |
| Temp. Extremes                      | 11               | 34               | 3.09            | 32%             |
| Flood                               | 31               | 37               | 1.19            | 83%             |
| Tornado                             | 11               | 54               | 4.91            | 20%             |
| Earthquake                          | 0                | 62               | N/A             | 0%              |
| Drought                             | 1                | 62               | 62              | 1.61%           |
| Dam Failure                         | 0                | 62               | N/A             | 0%              |
| Terrorism                           |                  |                  |                 |                 |
| Hazardous Materials                 |                  |                  |                 |                 |
Jurisdictional hazards have also been assessed by Williams County Health District. The 2017 Williams County Health District Hazard Assessment demonstrates hazards that the jurisdiction may face. This assessment data shown below is the result of internal, jurisdictional, regional, and state partner opinion (evidence show not exhaustive; see study for more information):
Given the size and population of Williams County, Ohio there are diverse events that reoccur yearly (i.e., Williams County Fair, Bean Days, Barn Fest, Fall Fest, Oktober Fest, Business and Industry Show, Fountain City Festival, Bryan Jubilee, Fireworks Show, Day In The Park, Bryan City Band Concert, High School Football/sporting events, Golf Scramble, & Santa Arrival Parade 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.

Williams County, Ohio currently has two hospitals and multiple health clinics. Community Hospitals and Wellness Centers operate two facilities within the jurisdiction. There are two locations, one being in Bryan, OH and the other Montpelier, OH. Neither hospital holds trauma center level recognition but offers extensive medical and surgical services to those within Williams County. There are 6 medical clinics in the jurisdiction offering walk in and appointment services of varying types.

Williams County Health District has one airport within its jurisdiction. The airport is located at 16288 Co. Rd. D, approximately 2 miles to the east of Bryan Ohio. The Airport, county owned as the name implies, was built in 1964, at the request of Governor Rhodes, governor at the time, who declared that every county should have an airport in the state of Ohio. Through the years the Williams County Regional Airport has grown to accommodate private planes, company jets and small freight companies looking to fly into Northwest Ohio. In 2005 the airport made many updates to runway lighting, runway markings and the installation of a precision approach path indicator system that gives pilots a positive visual aid on final approach when flying into the Williams County Regional Airport. The Williams County Regional Airport is open to the public so fly in or stop by and see what is new at the airport. Keep watch here as we bring you events at the airport and other updates to watch for.

In an effort to support, promote, and enhance preparedness planning and coordination the Williams County Health District participates in Region 1 Healthcare Coalition. The State of Ohio has established 8 regions, by which planning is conducted. These planning regions are derived from the State Homeland Security Regions. Each of the State’s 8 public health regions has a regional healthcare coalition that is an integral part of emergency preparedness planning and emergency response activities. Williams County Health District (WCHD) participates with the Regional Healthcare Coalition working within this community to prepare for, respond to, and recover from disasters. WCHD’s roles and responsibilities include: meeting participation,
engage in coalition planning, update the Health District, relay updates to partners, partner with coalition members in preparedness activities, & support coalition activities.

Many health related impacts are beyond the scope of the Williams County Health District alone and require involvement of other local, regional, and state partners with responsibilities for addressing incidents with impacts on health. Locally, Annex H Public Health gives direction on the Health District’s roles, responsibilities, agency coordination, and processes during an emergency or crisis. In support of Annex H Public Health other Functional Annexes are in place locally that lay the groundwork for interagency coordination.

At the Regional and State levels the Williams County Health District (WCHD) works under Emergency Support Function (ESF) – 8 Public Health and Medical Services. ESF – 8 is the involvement of other partners with responsibilities for addressing incidents with impacts on health in the state and the Ohio Department of Health is the coordinating agency for ESF – 8. Emergency Support Function (ESF) – 8 allows WCHD to partner with a wide range of organizations, including local health departments / districts (LHDs), public and private healthcare organization, the business and medical communities, and other Regional and State agencies. WCHD, Regional, and State agencies may perform response operations in either a primary or support role dependent on the incident type, severity, and scale.

In addition to ESF – 8, WCHD may also support other Emergency Support Functions during a response. Table 2, of the ESF Annexes, Introduction (January 2008) details Emergency Support Function Coordinating, and Primary and Support Agencies Designations on the FEMA website at the following web address: https://www.fema.gov/media-library-data/20130726-1825-25045-0604/emergency_support_function_annexes_introduction_2008_.pdf.

Primary & Secondary Roles Table:

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<th>AGENCY</th>
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<th>STATE &amp; FEDERAL</th>
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<tbody>
<tr>
<td>Primary:</td>
<td>Primary / Secondary:</td>
<td>State Matrix Link:</td>
</tr>
<tr>
<td>• Coordinate health &amp; medical care</td>
<td>• Agencies with primary/secondary responsibilities are spelled out in the following document utilized by Williams County EMA:</td>
<td><a href="http://www.ema.ohio.gov/Documents/Ohio_EOP/EOP_Overview/PRIMARY_AND_SUPPORT_AGENCIES.pdf">http://www.ema.ohio.gov/Documents/Ohio_EOP/EOP_Overview/PRIMARY_AND_SUPPORT_AGENCIES.pdf</a></td>
</tr>
<tr>
<td>• Food &amp; water supply inspection</td>
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<tr>
<td>• Emergency public health regulations &amp; orders</td>
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<td></td>
</tr>
<tr>
<td>• Coordinate collection, identification, &amp; interment of deceased victims</td>
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<td></td>
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<tr>
<td>• Public health crisis or emergencies</td>
<td></td>
<td></td>
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<tr>
<td>• Mass Fatality</td>
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Secondary:

- Williams County Health District is a supporting agency during emergencies involving other activated Annexes of the Williams County All Hazards Emergency Operations Plan.

At the local level, responses involving public health and medical services may differ from county to county, or city to city. Ohio is a “Home Rule” state, and deference is given to local decisions, provided that such decisions do not harm or endanger the population. In general, Williams County Health District coordinates primarily with jurisdictional agencies with support from other public health partners. Williams County Health District may partner with the following agencies during response:

- Williams County Emergency Management Agency
- Community Hospitals and Wellness Centers
- Local American Red Cross chapter
- Four County ADAMHS Board
- Fire Departments
- Law Enforcement Departments
- EMS Departments
- Local Officials
- Various City & County Departments/Offices
- Department of Aging
- Williams County Board of Developmental Disabilities
- County Coroner
- Funeral Directors
- Other non-governmental organizations acting in a supporting role

**NOTE: List not exhaustive**
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 by the Williams County Health District are shown in the CMIST Summary page, located in Section 5.3.9 of this plan, and by understanding the prevalent demographics of the jurisdiction, Williams County Health District may better assess and recommend measures to ensure health security for all jurisdiction residents/visitors. Together with local, state, federal, and various agencies, Williams County Health District has planned to respond to the whole community during an incident by identifying the services and the modes of coordination necessary to serve all within Williams County, Ohio before, during, and after an event, crisis, or emergency. Potential impacts from an incident may require Williams County Health District to respond by initiating or supporting the following activities to address an incident (list not exhaustive):

- Prophylaxis and dispensing
- Epidemiological investigation and surveillance
- Infection control
- Prevention
- Morgue management
- Medical Surge
- Mass Care
- Communications

As the Jurisdiction’s leading health agency, Williams County Health District 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 5.3.9 for additional details).

4.0 ASSUMPTIONS:

- The Williams County Health District (WCHD) is vulnerable to hazards, which may lead to emergencies or disasters anywhere in the Jurisdiction of Williams County, OH.
- A response by WCHD may be necessary to support government agencies, partners, and agencies affected by a variety of hazards and incidents.
- An incident may occur with little or no warning.
- To ensure appropriate public health response, WCHD must be prepared to respond to any incident with the ability to impact health of jurisdictional residents, visitors, and everyone within Williams County, OH.
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 within the United States, State of Ohio, Regional, and local has the potential to impact the state.

WCHD 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 in accordance with NIMS and respond as necessary to the extent of their available resources.

Responses will be different in each jurisdiction because of “Home Rule,” which is a confounding factor for response and affects the responding partners in Williams County’s jurisdiction, adjoining, or other jurisdiction.

Incidents are distinct, but they all have common elements that can be effectively managed through plans.

Plans are the best means of managing the common elements of incidents.

In addition to WCHD, 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 / necessary in / during a declared disaster, emergency, crisis, or event.

Most incidents to which WCHD responds will not result in a declaration.

Incidents can affect WHCD responders, staff, volunteers, vendors, partners, and the families of each group, impacting the agency’s ability to respond.

WCHD may have incomplete information, as it must rely on federal, state, regional, and local partners to provide some critical details during response.

WCHD may receive competing requests for support beyond its available resources.

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 WCHD has readily available.

Although great care has been taken to provide direction for WCHD response activities, it is impossible to account for all contingencies, and the leadership in the response organization must rely on their best judgement 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.

Every component of the WCHD ERP will work effectively during response, unless testing or implementation proves otherwise.
SECTION 2

5.0 CONCEPT OF OPERATIONS:

5.1 ORGANIZATION AND RESPONSIBILITIES:
All Williams County Health District (WCHD) staff has 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 (OR DESIGNEE) OFFICE:
As the Health District’s lead health official for Williams County, OH, it is under their authority that the agency responds to incidents. During incident response, the Health Commissioner or designee has the following responsibilities:

- Serve as or appoint the Incident Commander and management team.
- Act as part of Unified Command
- Establish communications, place of assembly, and provide direction/control for the Health District activities/operations during response activities.
- Maintain communication and liaison with Williams County EMA, EOC, emergency response groups, volunteer organizations, other county offices, agencies, and persons.
- Sanction release of public information.
- Set policy and guidance for WCHD and health response.
- Authorize emergency purchase of supplies and equipment.
- Monitor response progress through briefings and updates on the situation.
- Provide additional guidance and direction to WCHD response staff, as needed
- Represent WCHD in the Executive Group at the Williams County EOC, as necessary.
- Engage local, regional, state, & federal government leaders and agencies, as appropriate.
- Engage the Williams County Emergency Management Agency to request public health and medical resources on behalf of WCHD.

5.1.2 MEDICAL DIRECTOR’S OFFICE:
As the Health District’s lead health expert, the WCHD Medical Director could be engaged in any incident response. The Medical Director’s responsibilities include the following:

- Provide medical consultation to the Health Commissioner or designee, governmental officials, and response agencies/personnel.
- Inform medical policy and guidance for WCHD and jurisdictional health response.
• Engage partners regarding medical decisions and guidance.
• Represent WCHD in the Executive Group at the Williams County EOC, as necessary.
• Engage local, regional, state, & federal government leaders and agencies, as appropriate.
• Engage local, state, and federal government agencies on matters that require their consultation or clarification of existing guidance.
• Provides 24 hour medical phone coverage for consultation related to all public health emergencies and response.
• Emergency medical care procedures.

5.1.3 PUBLIC HEALTH EMERGENCY PREPAREDNESS OFFICE:
The Public Health Emergency Preparedness Office (PHEP) has the primary responsibility for coordinating emergency preparedness and response for the Williams County Health District. The Emergency Preparedness Coordinator has primary responsibility for facilitating the activation of the ERP and the Health District’s Department Operations Center (DOC). If the Emergency Preparedness Coordinator is unavailable or chooses to delegate the responsibility, activation may be successively facilitated by the Health Commissioner, designee, or Health District Director.

• Assist in coordinating public health response.
• Implement the Incident Command System.
• Serve as General or Command Staff.
• Assist in identifying appropriate ERP plans, guides, SOGs, or guidance.
• Facilitate a consistent application of the ERP and ICS in all incidents / responses

5.1.4 COMMON RESPONSIBILITIES FOR WILLIAMS COUNTY HEALTH DISTRICT:
All organizational units of the department support response and may provide response personnel for and incident or event.

All response personnel are expected to do the following:

• Follow the direction of your immediate Incident Command System (ICS) Supervisor.
• Maintain alignment with the ICS structure and processes.
• Maintain appropriate timekeeping records/documents, as prescribed by the Finance Section Chief.
• Support the overall mission of the response
• Support the Incident Commander, Incident Management Team, or Unified Command objectives and strategies by performing work assigned.
Williams County Health District

- Support the execution of the Williams County Emergency Operations Plan; the Williams County Health District responsibilities are listed in Base Plan and Annex H Public Health of the Williams County EOP.
- Support the execution of the Williams County Health District Emergency Response Plan.
- WCHD is a member of the Northwest Ohio Regional Healthcare Coalition. Their role is to support the health of the community as a whole and responsible for control of scarce supplies. WHCD may assist by:
  - Epidemiologic support
  - Investigation support
  - Support communication and outreach
  - Provide guidance on legal authorities of surveillance, investigation, enforcement, and emergency declaration
  - Support identification of abundant and scarce resources
  - Provide human resources during an incident
- During and after a response, WCHD may support the healthcare coalition through the following:
  - Information sharing and public messaging (PIO resources)
  - Public health and medical needs assessments (surveillance & surge)
  - Provide a conduit for resource attainment within Williams County
  - Assist with mass fatality management (vital statistics, LOM guidelines, investigation, protective recommendations)
  - Support emergency operation center operational needs
  - Support public health and medical information
  - Facility operations through inspections
  - Coordinate, support, and assist in demobilization and recovery operations
  - Participate in a coordinated incident response

5.2 INCIDENT DETECTION, ASSESSMENT, AND ACTIVATION:
This section describes the process for activating the ERP. The ERP may be activated in the following ways:
- The Health Commissioner or designee authorizes activation of the ERP upon determination that an incident requires implementation of one or more of the plans, guides, or strategies associated with this plan. If the ERP is activated in this way, response will begin with an incident assessment (ICS 201), which establishes the activation level and defines the incident response needs.
- Response personnel employ the entire process described in this section of the plan and present their recommendation for activation to the Health Commissioner or designee.
Barring deactivation by the Health Commissioner or designee, response personnel then complete identified response actions. Activation of the ERP marks the beginning of the response.

5.2.1 INCIDENT DETECTION:
Any WCHD staff becoming aware of an incident requiring or potentially requiring activation of the ERP is 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 Williams County Health District (WCHD) with an expectation for significant, multiagency coordination / interactions.
- 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 WCHD.
- Need for resources or support from outside WCHD.
- 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 Williams County Health District.

5.2.2 INCIDENT ASSESSMENT:
Directors, supervisors, or leadership will immediately inform the Health Commissioner or designee of any incident that they believe is likely to require activation of the ERP. Following this notification, Directors and leadership will convene within 1 hour, of the initial threat detection, to conduct an Initial Incident Assessment & Deployment Meeting (face-to-face, phone, video conference).

The Williams County Health District Board of Health will be contacted and engaged upon activation of the WCHD ERP. The Health Commissioner or designee may contact and engage the WCHD BOH for any incident where the public’s health may be adversely affected but not requiring activation of WHCD’s ERP. WCHD BOH notification will be conducted by phone, email, OPHCS, or Alert 86.

All notification is conducted by the Health Commissioner or designee. All Board members should be notified but at a minimum the WCHD BOH President or designee shall be contacted. The contact should inform the Board of the incident and/or response operations in progress or being considered.
The Initial Incident Assessment is the parallel of the “Incident Size-Up” described in ICS. It is a formal process for reviewing and evaluating an emergent incident and informs the level of activation. The assessment can be done either via 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. The Health Commissioner or designee will utilize FEMA ICS Form 201 to size up, assess, and establish incident dynamics. During this process the Health Commissioner or designee may call upon identified leadership to assist in this process. Incident Command System planning processes and methods will be utilized to size up and assess the incident.

5.2.3 ACTIVATION:
The Williams County Health District utilizes an Initial Assessment Meeting and Emergency Response Plan & Agency Activation Chart on the following page to support the completion of FEMA ICS Form 201 and determine activation level and plan/s to be activated. After determining the necessary activation level during the Initial Incident Assessment Meeting, activation of the plan/s will occur through official notice from the Health Commissioner or designee to all agency staff necessary for response efforts.

Activation levels and their associated recommended minimum staffing levels supplied from agency staff members are detailed in the tables below:

### ACTIVATION NOTIFICATION TABLE

<table>
<thead>
<tr>
<th>NOTIFICATION RESPONSIBILITY: HEALTH COMMISSIONER OR DESIGNEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency Directors (Required Notification)</td>
</tr>
<tr>
<td>Emergency Preparedness Coordinator (Required Notification)</td>
</tr>
<tr>
<td>Agency Staff (As Applicable)</td>
</tr>
<tr>
<td>Williams County Emergency Management Agency (Required Notification)</td>
</tr>
<tr>
<td>Government Officials of Impacted Jurisdiction (As Applicable)</td>
</tr>
<tr>
<td>Government Agencies i.e. police, fire, ems, etc. of Impacted Jurisdiction (As Applicable)</td>
</tr>
</tbody>
</table>

**COMMUNICATIONS UTILIZED:** OPHCS, ALERT 86, TEXT, PHONE, & CELL PHONE

**NOTIFICATION TIMEFRAME:** Within 1 hour of the Initial Incident Assessment Meeting

**INFORMATION PROVIDED:** Review of ICS Form 201, Name of IC/AC, Completed ICS Form 207, Activation Level of the Agency, Contact information ICS Form 205A, Estimated time line for first meeting to be attended (if applicable to responder), DOC or EOC activation status.
AGENCY ACTIVATION LEVELS CHART

**LEVEL 1**
Routine
- ICS may be utilized for identified events
- Agency activities routine
- Normal operations (day to day activities)
- Staff roles and responsibilities do not change
- No incident / event escalation expected

**LEVEL 2**
Awareness / Monitoring
- Single incident or limited severity, size, or actual/potential impact on health/welfare
- Agency resources involved, may require resource assistance, & becoming overwhelmed
- Organization moving outside normal routine (Escalation Expected)
- Staff, assigned with roles, pulled from regular duties (outside routine)
- Multiple moving parts
- Identified that crisis / emergency will exceed operational capacity
- Department Operations Center activated
- County Emergency Operations Center Operations Center may or may not be opened
- Called upon to respond as primary or partner agency

**LEVEL 3**
Partial Activation
- Multiagency incident or with moderate to high severity, size, or impact on health/welfare
- Multiple moving parts
- Multiple agencies resources involved
- County Emergency Operations Center opened
- Called upon to respond as a primary or partner agency
- Department Operations Center opened
- Department pulled from normal / routine (Crisis is large & escalation rapid)
- Regional and State interest generated or called upon

**LEVEL 4**
Full Activation
- Complex / Critical incident
- An incident with extensive severity, size, or actual/potential impact on health/welfare
- Multiple agencies involved (multiple jurisdiction involvement possible)
- Local resources overwhelmed
- County Emergency Operations Center opened
- Regional, State, and Federal intervention and interest plausible
- Working under a Multi-Agency Coordination System and Unified Command
## MINIMUM COMMAND FUNCTION & STAFFING RECOMMENDATIONS

| LEVEL 1 ROUTINE | Normal Staffing  
|                 | Day to day staffing  
|                 | Staffing within standard variations  
|                 | No Command or General Staff required  
|                 | Staff chooses ICS non-emergent application |
| LEVEL 2 AWARENESS/MONITORING | Response Lead / Incident Commander (1)  
|                              | Public Information Officer (1)  
|                              | Directors (5)  
|                              | Planning Section (1)  
|                              | Consider Department Operations Center |
| LEVEL 3 PARTIAL ACTIVATION | Response Lead / Incident Commander (1)  
|                            | Medical Director (1) *(If needed)*  
|                            | Public Information Officer (1)  
|                            | Backup Public Information Officer (1)  
|                            | Liaison Officer (1) *(partner engagement)*  
|                            | Planning Section (2) *(Chief & Situation Unit Leader)*  
|                            | Operations Section Chief (1)  
|                            | Logistics Section Chief (1)  
|                            | Staffing support *(as determined by Management Team)*  
|                            | Department Operations Center Activated  
|                            | County Emergency Operations Center may be activated |
| LEVEL 4 FULL ACTIVATION | Response Lead / Incident Commander (1)  
|                        | Medical Director (1) *(If needed)*  
|                        | Board of Health Members *(If needed)*  
|                        | All Command Staff (3)  
|                        | All General Staff (4)  
|                        | All staff (25)  
|                        | Other agency staffing support *(as determined by the Management Team)*  
|                        | All other functions and positions as identified by activated plans or guides.  
|                        | Department Operations Center Activated  
|                        | County Emergency Operations Center Activated |
EMERGENCY RESPONSE PLAN ACTIVATION CHART

Health Commissioner or Designee made aware of a qualifying incident. Makes contact with necessary personnel.

Contact made with necessary staff within 1 hour of detection / notification (OPHCS, ALERT 86, Text, Cell, or Phone) for the need of incident assessment meeting to determine if agency response is necessary.

Incident Detection / Notification

Implementation Incident Command System, identify IC/AC, determine command and control (if applicable).

Initial assessment meeting scheduled to be conducted within 1 hour of incident detection / notification.

Activation or no activation of the Emergency Response Plan determined. Inform / contact necessary persons and agencies (See Activation Notification Table).

Initial assessment meeting conducted & ICS Form 201 completed (to size up and assess situation) & Activation level determined (See Activation Levels Chart).
SMART OBJECTIVES CHART

| S | Specific: State exactly what you want to accomplish (Who, What, Where, Why) |
| M | Measurable: How will you demonstrate and evaluate the extent to which the goal has been met? |
| A | Achievable: stretch and challenging goals within ability to achieve outcome. What is the action-oriented verb? |
| R | Relevant: How does the goal tie into your key responsibilities? How is it aligned to objectives? |
| T | Time-bound: Set 1 or more target dates, the “by when” to guide your goal to successful and timely completion (include deadlines, dates and frequency) |

To ensure that the established objectives are appropriate, incident needs must inform the established objectives and their completion timeframes, rather than internal, agency resources 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.

Any time the Williams County Health District (WCHD) 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. Mission requests may come in 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. As needed, objectives will be revised to reflect current incident needs and the response situation.

Execution of the ERP may require staff mobilization and activation of the Williams County Health District Department Operations Center (DOC). The Williams County Health District DOC is a location where the agency’s response personnel can be brought to coordinate response activities. Activation of the DOC is described within agency DOC guidance.

5.3 COMMAND, CONTROL, & COORDINATION:
Williams County Health District 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 as described by this plan.

5.3.1 INCIDENT COMMAND & MULTIAGENCY COORDINATION:
Depending on the incident, Williams County Health District (WCHD) may either lead or support the response. WCHD uses the Incident Command System (ICS) to structure and organize response activities when leading an incident response. Similarly, when supporting an incident response, WCHD utilizes the National Incident Management System principles for a multi-agency coordination system that will coordinate response efforts with those efforts of the existing incident command structure and other supporting agencies/entities.

In large-scale responses, Ohio EMA will initiate a stat-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 ensure 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 WCHD and ODH will contribute to the establishment of these EEIs. Once finalized, WCHD will identify the POCs within the agency who will lead the implementation/identification of each EEI.

WCHD 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 WCHD 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.

Plans supporting ESF-8 and HCC interface include:

- Williams County Health Department Emergency Response Plan
- Williams County Emergency Management Agency Emergency Operations Plan
- Northwest Regional Healthcare Coalition Response Plan
- Regional Public Health Coordinator Response Plan

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

- Hospitals: provide patient care and updates related to medical surge and availability of critical medical supplies. During incidents that impact infrastructure, hospitals will support evacuation and relocation of identified CMS facility types, e.g. nursing homes.
- 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.
• Four County ADAHmS Board: provide psychological first aid to responding personnel. Serve as a connection point for care to the broader community.
• Williams County Fire & EMS: provide patient transport to care facilities. Support fit-testing for PPE and training on donning and doffing.
• American Red Cross: Facilitate setup and operations of a Family Assistance Center during mass fatality incidents.
• Williams County Board of DD: Provide support for access and functional needs community.
• Williams County Law Enforcement: Provide protection and law enforcement resources to an incident.
• Williams County Engineer’s Office: Provide maps, surveys, roadway maintenance, and heavy equipment resources.

The role of the Regional Healthcare Coordinator in local and multicounty incidents is to:
• Provide consultation, coordination, and support to NW Ohio healthcare facilities in the event of an MFI or other incident requiring resources.
• Guide the lead coordination agency in determining if the HMAC system should be activated. The activation of the HMAC system will assist local hospitals with the relocation of patients from the evacuating facility.
• Support healthcare facilities to maintain ongoing information sharing, communications, and resource support with local EMA and LHD.
• Guide the lead coordination agency in deciding if the regional OHTrac Team should be activated.
• Serve as a facilitator in organizing and accomplishing the missions, goals, and direction of HMAC during an MFI.
• Provide medical resource support
• If needed, provide representation virtually or in person at the Department Operations Center or Emergency Operations Center.

5.3.2 INCIDENT COMMANDER / AGENCY COORDINATOR:
WCHD response activities are managed by a single individual referred to as “Response Lead or Incident Commander” who serves in the command function of the response organization.

The position title is different depending on whether WCHD is leading the incident response or providing incident support. When leading the incident, WCHD uses the ICS title Incident Commander (IC); when supporting the response, WCHD uses the title Agency Coordinator (AC). 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, annex, guide, or plan) 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 / minimum command & staffing recommendations within this plan.
- The IC/AC, with designated authority, may authorize financial logistics with support of the Finance Section Chief.

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

- The IC/AC must engage the Health Commissioner or designee when staffing levels begin to approach any level that is beyond those pre-approved within this plan. The Health Commissioner or designee must authorize engagement of staff beyond those pre-approved levels.
- The IC/AC may not authorize staff to work a schedule other than their normal schedule, within the IAP directed at their response group, without prior authorization from the Health Commissioner or designee. This includes approval of overtime, changing the number of days staff works 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 WCHD regarding overtime/comp-time and should clarification on these policies or exemption be required, the IC/AC must engage the Health Commissioner.
- The IC/AC must seek approval from the Health Commissioner for incident expenditures as defined in agency policy the Health Commissioner may approve up to $15,000. Once this is met the Board of Health must be consulted for approval of more funds. This is to be understood as total incident expenditures, not just the total cost for a single transaction.
5.3.4 INCIDENTS WITH WILLIAMS COUNTY HEALTH DISTRICT AS THE LEAD AGENCY:
When leading a response, Williams County Health District (WCHD) employs the Incident Command System (ICS) and organizes the response personnel and activities in accordance with the associated ICS resources, principles, and practices.

As the lead agency, WCHD supplies the Incident Commander (IC) who is responsible for (a) protection of life and health, (b) incident stabilization, (c) property protection, and (d) environmental conservation / protection. The IC will engage local/state partners and the State Emergency Operations Center (EOC), through the Williams County Emergency Management Agency EOC as needed. Resources and support provided to WCHD for incident response will ultimately be directed by the WCHD IC, in accordance with the priorities and guidance established by the Health Commissioner or designee and the parameters established by the supplying entities.

WCHD 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 WILLIAMS COUNTY HEALTH DISTRICT IS INTEGRATED INTO AN ICS STRUCTURE LED BY ANOTHER AGENCY:
For incidents in which WCHD is integrated into an existing ICS structure led by another agency, WCHD provides personnel and resources to support that agency’s response. WCHD 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 WCHD staff may serve in various Incident Command System roles, with the possible exception of Incident Commander.

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

If such support is needed, WCHD will determine the appropriate activation level and assign an Agency Coordinator or Incident Commander to lead the integration activities. In such responses, the Planning Section Chief will track engagement of WCHD staff and resources and ensure that parameters for their utilization are communicated to both the integrated staff and the receiving Incident Commander.

Integrated staff should request that any directive, from the Incident Commander, contradicting the parameters established for their utilization notify the Agency Coordinator as to the change.
in working expectation and condition, as well as any unapproved use of WCHD resources. The Agency Coordinator will then work with the Incident Commander to determine an appropriate resolution.

5.3.6 INCIDENTS WITH WILLIAMS COUNTY HEALTH DISTRICT IN A SUPPORTING ROLE:
For incidents in which WCHD is a supporting agency, the Incident Commander is supplied by another agency. For these incidents, WCHD assigns an Agency Coordinator (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.
- Work within and support the application of the Incident Command System and supporting National Incident Management System principles.
- Support staffing needs of the incident, when possible.

If the Williams County Emergency Operations Center is activated, the Incident Commander or Unified Command, for the incident, coordinates all agency actions that support any Emergency Support Functions (ESFs)/Annexes in which WCHD has a role. In such incidents, the AC will ensure that all WCHD actions to address incidents for which the County EOC is activated are coordinated through the County EOC.

5.3.7 LEGAL COUNSEL ENGAGEMENT:
During any activation of the Emergency Response Plan, WCHD legal counsel should be engaged, regardless of the incident type. The specific topics that require targeted engagement of legal counsel include the following:

- Isolation and quarantine
- Drafting of public health orders
- Execution of emergency contracts
- Immediate jeopardy
- Any topic that requires engagement of local legal counsel
- Protected health information
- Interpretation of rules, statutes, codes, and agreements
- Other applications of the authority of the Health Commissioner or designee
5.3.8 INCIDENT ACTION PLANNING:

Every Incident Action Plan (IAP) addresses 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 1: Incident Action Plan Template. As a general 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):

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

Table 6: IAP Components and Sequence of Assembly

<table>
<thead>
<tr>
<th>Order</th>
<th>Form (FEMA-ICS Form)</th>
<th>Title</th>
<th>Required</th>
<th>Prepared by</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>200</td>
<td>Gover Sheet</td>
<td>Always</td>
<td>Planning Support Unit Leader</td>
</tr>
<tr>
<td>2</td>
<td>202</td>
<td>Incident Objectives</td>
<td>Always</td>
<td>SITL</td>
</tr>
<tr>
<td>3</td>
<td>205</td>
<td>Incident Radio Communications Plan</td>
<td>As the incident requires – Radio Use Communications Unit Leader</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>205A</td>
<td>Incident Telephone Communications Plan</td>
<td>Always</td>
<td>Resource Unit Leader</td>
</tr>
<tr>
<td>5</td>
<td>207</td>
<td>Incident Organization Chart</td>
<td>Always</td>
<td>Resource Unit Leader</td>
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<tr>
<td>6</td>
<td></td>
<td>Incident Map</td>
<td>Always</td>
<td>SITL/GIS Unit Leader</td>
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<tr>
<td>7</td>
<td>204</td>
<td>Assignment List</td>
<td>Always</td>
<td>Resource Unit Leader</td>
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<tr>
<td>8</td>
<td>220</td>
<td>Air Operations Summary</td>
<td>As the incident requires - Air Ops OSC/Air Operations Branch</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>206</td>
<td>Medical Plan</td>
<td>Always</td>
<td>Safety Officer</td>
</tr>
<tr>
<td>10</td>
<td>230</td>
<td>Meeting Schedule</td>
<td>Always</td>
<td>SITL</td>
</tr>
<tr>
<td>11</td>
<td>233</td>
<td>General Message</td>
<td>Optional</td>
<td>Any Message Originator</td>
</tr>
<tr>
<td>12</td>
<td>Other components as needed</td>
<td>Optional</td>
<td>Optional</td>
<td>Planning Support</td>
</tr>
</tbody>
</table>
5.3.9 ACCESS AND FUNCTIONAL NEEDS:
WCHD coordinates response actions with local government, Williams County Board of DD, community agencies, & access/functional need organizations to ensure that access and functional needs are appropriately addressed immediately after the incident occurs & during a response. The support available through health equity & access / functional needs reporting includes the following:

- Evaluation of research data to identify access and functional needs in the area of impact
- 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 Incident Action Plan, to include points of contact for individuals and organizations who serve individuals with access and functional needs
• Provision of just-in-time training to response personnel regarding serving individuals with access and functional needs

In all communications during incident response, WCHD will utilize person-first language as described within this document on the pages below.

The Health Commissioner or designee has primary responsibility for provision and coordination of these services.

In addition WCHD engages and works with other internal programs and external agencies that serve individuals with access and functional needs. These include the following:

• WIC (Women, Infants, and Children with limited financial resources)
• Injury Prevention (Physical health, wellness, exercise, and car seat)
• Williams County Board of Developmental Disabilities (offer a vast number of programs)
• Filling Home of Mercy (Main office located in Napoleon, OH)
• Williams County Department of Aging
• Williams County Senior Centers
• Family and Children First of Williams County
• Job and Family Services
• Veteran Services
• Jurisdictional nursing facilities and long term care
• Department of Medicaid
• Department of Mental Health and Addiction Services
• Ohio Emergency Management Agency
• Federal Emergency Management Agency
• Regional Healthcare Coalition
• Regional Public Health Coordination staff

NOTE: List not intended to be exhaustive.

| SUMMARY TABLE OF JURISDICTION'S ACCESS AND FUNCTIONAL NEEDS INDICATORS |
|-----------------------------|-----------------------------|-----------------------------|
| JURISDICTION                | Category                    | Value                      |
| Data Element                | General                     |                             |
| Jurisdiction population     |                             | 37120                      |
| Jurisdiction land area, in square miles |                     | 420.97                      |
| Jurisdiction population per square mile |                     | 89.4                        |
| Number of households        |                             | 15001                      |
| Persons per household       |                             | 2.42                       |
## Disability

<table>
<thead>
<tr>
<th>Description</th>
<th>Estimated Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total estimated population with a disability</td>
<td>5,025</td>
</tr>
<tr>
<td>Estimated percentage of population with a disability</td>
<td>13.80%</td>
</tr>
<tr>
<td>Estimated persons with a hearing difficulty</td>
<td>1,358</td>
</tr>
<tr>
<td>Estimated persons with a vision difficulty</td>
<td>793</td>
</tr>
<tr>
<td>Estimated persons with a cognitive difficulty</td>
<td>1,853</td>
</tr>
<tr>
<td>Estimated persons with an ambulatory difficulty</td>
<td>2,529</td>
</tr>
<tr>
<td>Estimated persons with a self-care difficulty</td>
<td>783</td>
</tr>
<tr>
<td>Estimated persons with an independent living difficulty</td>
<td>1,672</td>
</tr>
</tbody>
</table>

## Communication

<table>
<thead>
<tr>
<th>Description</th>
<th>Number of Speakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of persons aged 16+ lacking basic prose literacy skills</td>
<td>10</td>
</tr>
<tr>
<td>Ten languages with the largest number of speakers who speak English less than “very well,” in descending order by number of such speakers</td>
<td></td>
</tr>
<tr>
<td>Language 1 (Most speakers who speak English less than very well)</td>
<td>278</td>
</tr>
<tr>
<td>Language 2 (2nd-most speakers who speak English less than very well)</td>
<td>28</td>
</tr>
<tr>
<td>Language 3 (3rd-most speakers who speak English less than very well)</td>
<td>21</td>
</tr>
<tr>
<td>Language 4 (4th-most speakers who speak English less than very well)</td>
<td>19</td>
</tr>
<tr>
<td>Language 5 (5th-most speakers who speak English less than very well)</td>
<td>13</td>
</tr>
<tr>
<td>Language 6 (6th-most speakers who speak English less than very well)</td>
<td>9</td>
</tr>
<tr>
<td>Language 7 (7th-most speakers who speak English less than very well)</td>
<td>9</td>
</tr>
<tr>
<td>Language 8 (8th-most speakers who speak English less than very well)</td>
<td>9</td>
</tr>
<tr>
<td>Language 9 (9th-most speakers who speak English less than very well)</td>
<td>6</td>
</tr>
<tr>
<td>Language 10 (10th-most speakers who speak English less than very well)</td>
<td></td>
</tr>
</tbody>
</table>

## Maintaining Health

<table>
<thead>
<tr>
<th>Description</th>
<th>Estimated Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women of reproductive age (15 - 50)</td>
<td>7,947</td>
</tr>
<tr>
<td>Estimated number of pregnant women</td>
<td>448</td>
</tr>
<tr>
<td>Number of individuals who depend on electricity to maintain health</td>
<td>410</td>
</tr>
<tr>
<td>Estimated number of individuals who have had at least one prescription in the last 30 days</td>
<td>9968</td>
</tr>
<tr>
<td>Percent of persons without health insurance, under 65 years</td>
<td>0.1</td>
</tr>
</tbody>
</table>

## Safety and Support

<table>
<thead>
<tr>
<th>Description</th>
<th>Estimated Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of children (persons less than 18 years of age)</td>
<td>4,386</td>
</tr>
<tr>
<td>Estimate of persons below the poverty level</td>
<td>5,257</td>
</tr>
<tr>
<td>Estimate of the percent of population below the poverty level</td>
<td>14.5%</td>
</tr>
<tr>
<td>Median household income</td>
<td>42,455</td>
</tr>
<tr>
<td>Total number of facilities where people are incarcerated</td>
<td>2</td>
</tr>
<tr>
<td>Average number of people who are incarcerated</td>
<td>616</td>
</tr>
</tbody>
</table>

## Transportation

<table>
<thead>
<tr>
<th>Description</th>
<th>Estimated Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of households with no vehicle available</td>
<td>758</td>
</tr>
</tbody>
</table>
In all communications during incident response & within/throughout the WCHD ERP, WCHD will utilize person-first language as described in the following document:

**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).

   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.

<table>
<thead>
<tr>
<th>SAY THIS…</th>
<th>NOT THAT…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access and functional needs</td>
<td>Special needs</td>
</tr>
<tr>
<td>Access and functional need, Disability</td>
<td>Handicapped</td>
</tr>
<tr>
<td>Accessible</td>
<td>Handicapped accessible</td>
</tr>
<tr>
<td>Accessible parking/bathroom</td>
<td>Handicapped parking/bathroom</td>
</tr>
<tr>
<td>Person who uses a wheelchair</td>
<td>Confined or restricted to a wheelchair,</td>
</tr>
<tr>
<td></td>
<td>Wheelchair-bound</td>
</tr>
<tr>
<td>Disability placard</td>
<td>Handicapped sticker</td>
</tr>
<tr>
<td>Person with a disability</td>
<td>Disabled person, The disabled</td>
</tr>
<tr>
<td>Person without a disability</td>
<td>Normal person, Healthy person</td>
</tr>
<tr>
<td>Individual who is deaf, Individuals with hearing loss</td>
<td>Deaf person, The deaf</td>
</tr>
<tr>
<td>Person with a visual impairment, People who are blind</td>
<td>Blind person, The blind</td>
</tr>
<tr>
<td>Person with a congenital disability</td>
<td>Person with a birth defect</td>
</tr>
<tr>
<td>Intellectual/Cognitive/Developmental disability</td>
<td>Mentally retarded, Mentally disabled</td>
</tr>
</tbody>
</table>

---

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.
<table>
<thead>
<tr>
<th>Person with an intellectual/cognitive/developmental disability</th>
<th>Mentally retarded person, Mentally disabled person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person with an emotional or behavioral disability, Person with a mental health or a psychiatric disability</td>
<td>Mentally ill person, The mentally ill</td>
</tr>
<tr>
<td>Person who has a communication disorder, is unable/unwilling to speak, or uses a device to speak</td>
<td>Mute, Dumb</td>
</tr>
<tr>
<td>Person with limited English fluency/comprehension</td>
<td>Non(native)-English speaker</td>
</tr>
<tr>
<td>Person with limited/low literacy</td>
<td>Illiterate person, The illiterate</td>
</tr>
<tr>
<td>Person experiencing homelessness</td>
<td>Homeless person, The homeless</td>
</tr>
<tr>
<td>Person living in poverty</td>
<td>Poor person, The poor</td>
</tr>
<tr>
<td>Person with a drug addiction</td>
<td>Drug addict</td>
</tr>
<tr>
<td>Person who is incarcerated</td>
<td>Prisoner</td>
</tr>
<tr>
<td>Person with [DISEASE/CONDITION]</td>
<td>Afflicted by [DISEASE], Victim of [CONDITION], Adjective based on [DISEASE/CONDITION], e.g. Autistic</td>
</tr>
<tr>
<td>Person who is successful, productive</td>
<td>Has overcome his/her disability, is courageous</td>
</tr>
</tbody>
</table>

**References**


WCHD utilizes translation and interpretation services through Language Line. This is an outside service that offers multiple avenues of translation and language services. Access to this service
can be accomplished by signs posted throughout the health department, speaking with a public health nurse, or contacting a Director.
**SUMMARY TABLE OF JURISDICTION'S ACCESS AND FUNCTIONAL NEEDS INDICATORS**

**Directions:**
1) Complete this table after all the other tabs are filled in. Most of the information will auto-populate from the other tabs.
2) Fill in the remaining cells which are highlighted in blue.
3) For language data, copy the top 10 languages from the Language Sorting tab and then paste them into cell B27 (highlighted in blue below). If there are fewer than 10 languages with speakers who speak English less than very well, list all the languages with speakers who speak English less than very well.

<table>
<thead>
<tr>
<th>JURISDICTION</th>
<th>Data Element</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>Jurisdiction population</td>
<td>37,270</td>
</tr>
<tr>
<td></td>
<td>Total housing units</td>
<td>16,522</td>
</tr>
<tr>
<td></td>
<td>Persons per household</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>Median household income</td>
<td>45,044</td>
</tr>
<tr>
<td>Disability</td>
<td>Total estimated population with a disability</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Estimated percentage of population with a disability</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>Estimated persons with a hearing difficulty&lt;sup&gt;C&lt;/sup&gt;</td>
<td>72</td>
</tr>
<tr>
<td></td>
<td>Estimated persons with a vision difficulty&lt;sup&gt;CST&lt;/sup&gt;</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>Estimated persons with a cognitive difficulty&lt;sup&gt;CMS&lt;/sup&gt;</td>
<td>211</td>
</tr>
<tr>
<td></td>
<td>Estimated persons with an ambulatory difficulty&lt;sup&gt;ST&lt;/sup&gt;</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Estimated persons with a self-care difficulty&lt;sup&gt;S&lt;/sup&gt;</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Estimated persons with an independent living difficulty&lt;sup&gt;S&lt;/sup&gt;</td>
<td>1,000</td>
</tr>
<tr>
<td>Communication</td>
<td>Estimated percent of persons aged 16+ lacking basic prose literacy skills</td>
<td>1000.0%</td>
</tr>
<tr>
<td></td>
<td>Ten languages with the largest number of speakers who speak English less than &quot;very well,&quot; in descending order by number of such speakers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Language 1 (Most speakers who speak English less than very well)</td>
<td>Spanish or Spanish Creole:</td>
</tr>
<tr>
<td></td>
<td>Language 2 (2nd-most speakers who speak English less than very well)</td>
<td>Serbo-Croatian:</td>
</tr>
<tr>
<td></td>
<td>Language 3 (3rd-most speakers who speak English less than very well)</td>
<td>Polish:</td>
</tr>
<tr>
<td></td>
<td>Language 4 (4th-most speakers who speak English less than very well)</td>
<td>Italian:</td>
</tr>
<tr>
<td></td>
<td>Language 5 (5th-most speakers who speak English less than very well)</td>
<td>Laotian:</td>
</tr>
<tr>
<td></td>
<td>Language 6 (6th-most speakers who speak English less than very well)</td>
<td>French (incl. Patois, Cajun):</td>
</tr>
<tr>
<td></td>
<td>Language 7 (7th-most speakers who speak English less than very well)</td>
<td>German:</td>
</tr>
<tr>
<td></td>
<td>Language 8 (8th-most speakers who speak English less than very well)</td>
<td>Portuguese or Portuguese Creole:</td>
</tr>
<tr>
<td></td>
<td>Language 9 (9th-most speakers who speak English less than very well)</td>
<td>Other Slavic languages:</td>
</tr>
</tbody>
</table>
5.3.11 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 responsibility related to down-sizing the incident. Development is conducted by the Planning Section Chief by identifying processes and resources that are scaling down or are no longer needed. The Planning Section Chief will utilize appropriate WCHD Demobilization documents located in Annex 13 to develop, implement, and conduct the demobilization process. Below is a summary of the process:

- 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).

Demobilization is led by the Planning Section Chief or designee by activating a demobilization unit, which has three primary functions:

• Develop the Incident Demobilization Plan with the Planning Section Chief
• Assure completion of demobilization checkout forms by personnel and inspection of equipment as they are released from the incident
• Initiate data collection for the After Action Process

5.3.12 AFTER ACTION REPORT/IMPROVEMENT PLAN(S):
An After Action Report / Improvement Plan (AAR/IP) must be produced whenever the ERP is activated, real world event, review actions taken, identifying equipment / resource shortcomings, improving operational readiness, highlighting strengths / initiatives, or examining exercises / drills. Completion of an AAR/IP will allow the agency to review actions taken, identify equipment shortcomings, improve operational readiness, highlight strengths/initiatives, identify areas for improvement, and support stronger response.

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 Emergency Preparedness Coordinator or designee will coordinate with all involved response parties to schedule a time for the hotwash.

The Public Health Preparedness Office / Emergency Preparedness Coordinator will provide an AAR/IP coordinator for all incidents for which the WCHD ERP was activated, including incidents that the agency did not lead. The AAR/IP coordinator will be a person with general knowledge of the incident who was not directly involved in the response. If no subject matter expert is
available, an alternate subject matter expert will be identified from within WHCD or identified by the Public Health Preparedness Office.

The Emergency Preparedness Coordinator will develop lessons learned as part of the response through a thorough analysis of response events, documentation, and the feedback provided at the hotwash. Analysis is conducted through Quality Improvement tools. This analysis will feed into the AAR/IP to provide necessary information to identify corrective actions.

The Emergency Preparedness Coordinator 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 Emergency Preparedness Coordinator or designee notifies the responsible party of the corrective action and confirms the completion date. For actions that lead to the update of an ERP component, the Emergency Preparedness Coordinator will notify WCHD Administration/Directors of the identified plan. The Emergency Preparedness Coordinator regularly follows up with the responsible party to confirm movement and, ultimately, completion of the corrective action/s.

The Williams County Health District utilizes quality improvement based upon the Plan, Do, Study, Act concept. Tools utilized would be Root Cause Analysis, Cause and Effect Diagram, 5 Whys, and the 8 Ds. The 8 Ds will be the primary methodology that will guide in tracking the completion and / or integration of corrective actions in the Emergency Response Plan. The methodology employed will be:

8D Process for Tracking Corrective Actions:
D0 – Planning phase
D1 – Develop a cross functional team of experts
D2 – Define & describe the problem
D3 – Develop, implement, & verify the containment plan
D4 – Identify & verify by root cause(s), cause and effect diagram, or 5 whys
D5 – Select permanent corrective actions for root cause, cause and effect diagram, or 5 whys
D6 – Implement & validate permanent corrective action
D7 – Ensure prevention of recurrence
D8 – Recognize efforts of the team

5.3.13 PLAN INTEGRATION:
Plan execution will be coordinated vertically within Williams County Health District and all levels of government to ensure singular operational focus.
At the local level, the WCHD ERP interfaces with the Williams County Emergency Operations through Annex H – Public Health. WCHD recognizes that all responses are local and will activate the WCHD ERP to support the actions directed by the jurisdictional response plans of the Williams County Emergency Operations Plan.

At the regional level, WCHD interfaces with Regional Public Health Coordination, which is a collective body of public health agencies in Federal Region 1. Regional Public Health Coordination support the 18 public health departments during small and large cross jurisdictional incidents by supporting agencies with resources and operational assistance. The plans produced by Regional Public Health Coordination are designed to work in concert with the plans of the member organizations and define how the agencies collaborate during responses that affect one or more of their jurisdictions.

At the state level, the WCHD ERP interfaces with the State Emergency Operations Plan (State EOP). WCHD operating within Emergency Support Function (ESF) – 8 gains specificity for how the agency will complete the actions assigned to WCHD in the State EOP. In public health WCHD interfaces with the ODH ERP. Integration with the ODH Emergency Response Plan takes place when the Williams County Health District notifies ODH or is notified of a situation by ODH causing activation of resources exceeding local / regional resources, public information support, Points of Dispensing operations support, and other critical events directed by ODH ERP.

At the federal level, WCHD interfaces with FEMA, CDC, and other agencies to support public health and medical response, respectively. Although WCHD does not review response plans from our federal partners, WCHD plans are designed to identify, access, and integrate with federal plans for support and resources made available to Williams County, Ohio. An example of such a resource is the Strategic National Stockpile (SNS). This resources and how to access it is included in the annex supporting this resource **Annex 12 SNS / Medical Counter Measures**.

**5.3.14 SITUATION REPORTS:**
In general, situational reports (SITREP) will be produced regardless of activation level; however the extent of content will vary depending on the operational complexity, scale, and length of the response. Response operations that require lower numbers of resources (both staff and materials) a short yet concise SITREP will be produced. For a larger scale response, 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 WCHD Directors, Leadership, or identified staff for their situational awareness. In addition, SITREPs will be sent electronically to all operational staff. Hardcopies of SITREPs will also be available in the WCHD DOC, if the DOC is active.

At the discretion of the WCHD Health Commissioner, designee, or Incident Commander, any SITREP may be forwarded electronically to jurisdictional (local), regional, state, or federal 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, Incident Command, Agency Coordinator, and operational staff.

<table>
<thead>
<tr>
<th>Activation Level</th>
<th>SITREP Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Situation Awareness &amp; Monitoring</td>
<td>At least daily or as necessary</td>
</tr>
<tr>
<td>Partial Activation</td>
<td>At least at the beginning and end of each operational period or deemed necessary</td>
</tr>
<tr>
<td>Full Activation</td>
<td>At least at the beginning, the middle, and the end of each staff shift or operational period, whichever is more frequent or deemed necessary</td>
</tr>
</tbody>
</table>

See **Attachment II – Situation Report Template** for a situational report template.

**5.3.15 STAFF SCHEDULE (BATTLE RHYTHM):**
WCHD Incident Command Staffing Unit will maintain staff scheduling and communicate the schedule to assigned staff utilizing an operational schedule document, such as the example below. 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 Section Chief and distributed to all response staff at the beginning of their shift, briefings, by direct supervisor, or by Section Chief.

### OPERATIONAL SCHEDULE TEMPLATE

<table>
<thead>
<tr>
<th>Date/ Time</th>
<th>Event</th>
<th>Purpose</th>
<th>Attendees/ POC</th>
<th>Location</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily/Weekly Time TBD</td>
<td>Senior Leadership Update</td>
<td>Provide summary of current situation, discuss trends and determine critical actions needed.</td>
<td>Commissioner, Senior Leadership, IC, PIO, LO, OSC, PSC and SMEs</td>
<td>Directors Conference Room. Updates are e-mailed by the IC unless a meeting is requested</td>
<td>Situational Awareness and Information Sharing</td>
</tr>
<tr>
<td>Daily/Weekly Time TBD</td>
<td>Situation Report Update</td>
<td>Ensure a common operating picture (COP) is maintained. Distribute/post ICS SITREP, Reports and Press Releases as appropriate.</td>
<td>OSC, PIO, Message Center</td>
<td>WCDH Website, District Server, &amp; Web EOC, etc.</td>
<td>Situational Awareness and Information Sharing</td>
</tr>
<tr>
<td>Daily/Weekly Time TBD</td>
<td>Operations Briefing</td>
<td>Present IAP and assignments to the Supervisors / Leaders for the next Operational Period.</td>
<td>IC, Command &amp; General Staff, Group Supervisors, and Unit Leaders.</td>
<td>Room X (TBD)</td>
<td>Situational Awareness and Information Sharing</td>
</tr>
<tr>
<td>Daily/Weekly Time TBD</td>
<td>Planning Meeting</td>
<td>Review/ identify WCDH response incident objectives and priorities for the next operational period or review and approve demobilization plan.</td>
<td>IC, PSC, Deputy PSC, RESL, SUL, &amp; FSC</td>
<td>Room X (TBD)</td>
<td>Draft ICS Form 201, 202, 203, 206, 207, 208</td>
</tr>
</tbody>
</table>
| 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 | Room X | Tactics identified will be reflected on ICS Form 204 #6 under work assignments. *May also complete ICS 215*

| Daily/Weekly Time TBD | WCHD Coordination Call/Briefing | Call with only internal SDH staff to prepare for state and local calls | All response personnel | Room X | Confirmation of action items and SitRep

| Daily/Weekly Time TBD | State Partners Call | Call with only state response partners in advance of the local call | All response personnel | Room X | Common operating picture; Updated action items

| Daily/Weekly Time TBD | LHDs Conference Call* | Event/Response title agenda item on the 1 hour LHD call | LO and OSC | Room X | Situational Awareness and Information Sharing

| Daily/Weekly Time TBD | Finalize IAP* | Review status and finalize strategies and assignments to meet Incident Objectives for the next Operational Period. | PSC | Room X | 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 | Room X | Signed IAP

| Daily/Weekly Time TBD | Update EOC | Provide an update to all ESFs supported by WCHD for EOC briefing | PSC | Room X | SitRep/Briefing document

| Daily/Weekly Time TBD | Listen to State EOC Briefing | Call in to State EOC to listen to the briefing by ESF desks | All response personnel | Room X | Situational Awareness

| Daily/Weekly Time TBD | Shift Begin | Designated ramp up time for response personnel | All response personnel | Room X | Staff check-in completed

| Daily/Weekly Time TBD | Shift End | Designated end time for response personnel | All response personnel | Room X | Staff check-out completed; documentation turned in

| Daily/Weekly Time TBD | Shift Change | Designated transition time for response personnel | All response personnel | Room X | 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 | Room X | Situational awareness; information sharing
Upon shift change, staff will be provided a shift change form utilizing Attachment III – 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 local, regional, and state levels as well as documenting response actions and outcomes. All response actions and outcomes must be documented in WebEOC for accountability and reimbursement. WCHD will also track all agency objectives, indicated in the Incident Action Plan, to ensure that they remain on track for completion. Any incidents identified as being off track/schedule will be handled by Incident Command, Unified Command, or Agency Coordinator/designee based on the type/size of response.

To aide in centralized communication, WCHD maintains a dedicated network directory for all response personnel to store incident related documentation. Further information will be compiled and analyzed in 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 (Health Commissioner / designee, Incident Commander, Agency Coordinator, Command/General Staff, Assistants, Group/Unit Leaders, & etc., of those reports at the times and disbursement schedules established. Information will be distributed digitally and in hard copy formats based upon the need and resources of the incident.

Activity Log ICS for 214 will be utilized by response staff to maintain information related to response efforts and actions. These logs will be turned in at the end of the shift as directed by their direct supervisor. ICS 214s will be collected by the Planning Section for analyze and filing.
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 the Information Tracking Document or through Incident Command ICS forms, Incident Action Plan, or other means of documentation.

5.4.2. ESSENTIAL ELEMENTS OF INFORMATION:
Essential Elements of Information (EEIs) address situational awareness information that is critical to the command and control decisions. EEIs will be defined and addressed as soon as the response begins using the following criteria:

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
Williams County Health District

- Identify support resource systems
  - Human resources

WCHD will include a list of the current EEIs with the completed ICS 201 form and with each Incident Action Plan (IAP). This list will be reviewed & defined during IAP development and refined for each operational period. At a minimum, the IC/AC, PIO, Planning Section Chief, Logistics Section Chief, and Operations Section Chief will contribute to refinement & defining of critical information (i.e. when is it needed, the type required, where it is needed from, authority required, impactful operational information, not intended to be exhaustive.

To identify sources of information for EEIs, consult the following chart:

**WILLIAMS COUNTY HEALTH DISTRICT INFORMATION POCs**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Emergency Support Function</th>
<th>Primary Agency</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direction and Control</td>
<td>Annex A</td>
<td>Williams County EMA Director</td>
<td>(419) 636-8497</td>
</tr>
<tr>
<td>Communications</td>
<td>Annex B</td>
<td>Williams County Director of 911/Communications</td>
<td>(419) 636-8497</td>
</tr>
<tr>
<td>Notification and Warning</td>
<td>Annex C</td>
<td>Williams County Director of 911/Communications</td>
<td>(419) 636-8497</td>
</tr>
<tr>
<td>Emergency Public Information</td>
<td>Annex D</td>
<td>Williams County Director of 911/Communications</td>
<td>(419) 636-8497</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>Annex E</td>
<td>Williams County Sheriff</td>
<td>(419) 636-3151</td>
</tr>
<tr>
<td>Fire Services</td>
<td>Annex F</td>
<td>Fire Services of Jurisdiction (Contact EMA)</td>
<td>(419) 636-8497</td>
</tr>
<tr>
<td>Public Works and Engineering</td>
<td>Annex G</td>
<td>Williams County Engineer</td>
<td>(419) 636-2454</td>
</tr>
<tr>
<td>Public Health</td>
<td>Annex H</td>
<td>Williams County Combined Health District</td>
<td>(419) 485-3141</td>
</tr>
<tr>
<td>Medical</td>
<td>Annex I</td>
<td>Williams County</td>
<td>(419) 636-</td>
</tr>
<tr>
<td>Annex Area</td>
<td>Annex Code</td>
<td>Contact Name</td>
<td>Contact Phone</td>
</tr>
<tr>
<td>----------------------------</td>
<td>------------</td>
<td>--------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Evacuation</td>
<td>Annex J</td>
<td>Williams County EMA Director</td>
<td>(419) 636-8497</td>
</tr>
<tr>
<td>Shelter and Mass Care</td>
<td>Annex K</td>
<td>Williams County EMA Director and American Red Cross</td>
<td>(419) 636-8497</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ARC (419) 227-5121</td>
<td></td>
</tr>
<tr>
<td>Recovery</td>
<td>Annex L</td>
<td>Williams County EMA Director</td>
<td>(419) 636-8497</td>
</tr>
<tr>
<td>Radiological Protection</td>
<td>Annex M</td>
<td>Bryan Fire Department Hazardous Materials Team</td>
<td>(419) 636-4232</td>
</tr>
<tr>
<td>Resource Management</td>
<td>Annex N</td>
<td>Williams County EMA Director</td>
<td>(419) 636-8497</td>
</tr>
<tr>
<td>Mitigation</td>
<td>Annex O</td>
<td>Williams County EMA Director</td>
<td>(419) 636-8497</td>
</tr>
<tr>
<td>Donations Management</td>
<td>Annex P</td>
<td>American Red Cross</td>
<td>(419) 227-5121</td>
</tr>
<tr>
<td>Terrorism</td>
<td>Annex Q</td>
<td>Williams County Sheriff</td>
<td>(419) 636-3151</td>
</tr>
<tr>
<td>Utilities</td>
<td>Annex R</td>
<td>Williams County EMA Director</td>
<td>(419) 636-8497</td>
</tr>
<tr>
<td>Debris Management</td>
<td>Annex S</td>
<td>Williams County EMA Director</td>
<td>(419) 636-8497</td>
</tr>
</tbody>
</table>
### WILLIAMS COUNTY HEALTH DISTRICT

### INTERNAL/INFORMATION POINTS OF CONTACT

<table>
<thead>
<tr>
<th>Topic</th>
<th>Office / Bureau</th>
<th>Program / Unit</th>
<th>Point of Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Guidance</td>
<td>Medical Director</td>
<td>Medical Director</td>
<td>Dr. Zohar Vasi 419-786-9078</td>
</tr>
<tr>
<td>Agency Commissioner</td>
<td>Commissioner</td>
<td>Health Commissioner</td>
<td>Jim Watkins (C) 419-553-9389</td>
</tr>
<tr>
<td>Public Health Nursing</td>
<td>Nursing Division</td>
<td>Director of Nursing</td>
<td>Rachel Aeschliman (H) 419-446-2277 (C) 419-906-7459</td>
</tr>
<tr>
<td>Environmental Public Health</td>
<td>Environmental Health Division</td>
<td>Director of Environmental Health</td>
<td>Brad Price (C) 419-551-7210</td>
</tr>
<tr>
<td>Community Health</td>
<td>Community Health Division</td>
<td>Director of Community Health</td>
<td>Megan Riley (C) 330-519-2976</td>
</tr>
</tbody>
</table>

#### 5.4.3 INFORMATION SHARING:

To ensure that WCHD maintains a common operating picture across all the locations response personnel are engaged, WCHD will execute the following process that defines the coordination between WCHD & local EOC when activated, along with simultaneous usage of the Emergency Response Communication Flow chart located in Section 6.0 Communications.

When activated, the EOC holds briefings every four (4) hours. The Williams County Health District (WCHD) DOC will provide a report to the Williams County EOC every four hours, at least one (1) hour before the scheduled briefings. If this schedule is revised, WCHD will update the frequency of information exchange, continuing to provide a report one (1) hour before scheduled briefings.

WCHD DOC will interface directly with at least two Points of Contact types at the Williams County EOC:

- Incident Commander and/or Unified Command for incident overview information and to provide situational updates;
- Annex leads at each of the Annex Desks supported by WCHD for updates on missions and to provide requested information.
6.0 COMMUNICATIONS:
As Williams County, Ohio’s lead health agency, WCHD is responsible for maintaining communication with local, regional, state, federal, private, and non-profit partners during an incident requiring activation of this plan.

WCHD Annex 4 – Information and Communications operates in concert with the Williams County All Hazards Emergency Response Plan Annexes B, C, & D throughout ongoing response activities in order to ensure accurate and efficient communication with internal and external partners. When engaged in a response, WCHD will ensure the dissemination of information and maintain communication with the following entities to ensure continuity of response operations:

- Staff & employees, as applicable
- County EOC, as applicable
- State EOC, as applicable
- WCHD DOC, as applicable
- Local hospitals
- Other local health departments
- Regional Public Health Coordinators
- Regional Healthcare Coordinators
- City, county, state, and federal officials
- Non-government partners
- Other support systems, agencies, and/or organizations involved in the incident response.

NOTE: List not intended to be exhaustive.

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
- Cell phones
- Email & messaging
• Secure fax
• Web meeting
• Web-based applications, including Alert 86 and Ohio Public Health Communication System (OPHCS).

**NOTE: List not intended to be exhaustive.**

There are four (4) alert levels employed by WCHD 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 the message
- **Important**, which requires a response within four (4) hours of receipt of the message
- **Standard**, which requires a response within eight (8) hours of receipt of the message

Notifications and alerts will be drafted with input from applicable and identified subject matter experts and utilizing pre-drafted messages / information within public information files in coordination with staff, Public Information Officers, and Health Commissioner or designee engaged in the incident. In addition to the content itself, the developing group will assign the appropriate alert level to the message. Incident staff receiving alerts will be expected to take the prescribed actions within the timeframe prescribed. WCHD’s process for notification or alert begins with incident notification and detection. When this has been confirmed the Health Commissioner or designee will initiate contact methods consisting of cell phone, group text, agency phones, Alert 86, and OPHCS. Incident staff receiving alerts will be expected to take the prescribed actions within the timeframe described.

When notifications or alerts must be sent, WCHD utilizes Alert 86 or OPHCS. Alert 86 and OPHCS are reliable and secure web-based messaging and alerting systems used to communicate incident information to relevant groups via email, fax, phone, pagers, text, and other messaging modalities to support notifications on a 24/7/365 basis. This system is used by WCHD and various partners, but is not available to the general public. OPHCS operates under two messaging levels, these levels include:

- Messages
- Alerts

OPHCS communications sent as messages do not receive priority; whereas, communications sent as alerts are prioritized over messages that may be in queue for dissemination. These communication levels may be designated when drafting an OPHCS communication.
In the event that WCHD communication resources become overburdened or destroyed, redundant or back-up communication equipment and methods utilized include:

- Alert 86
- Governmental Emergency Telecommunication Service (GETS) card
- Multi-Agency Radio Communications (MARCS) radios
- Cell, landline phones, and fax lines
- Ohio Public Health Communications System (OPHCS)

GETS card has been made available to Directors and Emergency Preparedness Coordinator. GETS card consists of phone numbers that receive priority over regular calls; thereby greatly increasing the probability a wired call is received. GETS cards also have numbers that allow access through Verizon, AT & T, & Sprint wireless allowing access and prioritized processing greatly increasing the probability of call completion.

WCHD maintains Multi-Agency Radio Communications (MARCS) by housing a base station and two portable MARCS radios. WCHD conducts monthly & quarterly MARCS radio checks with hospitals, Emergency Management Agency, & regional health departments to verify MARCS radios are operational for emergency use. Both GETS and MARCS radios are maintained and managed by WCHD's Emergency Preparedness Coordinator.

WCHD may engage primary and redundant methods of communication both at the programmatic, DOC and local/regional level. When responses require the engagement of the County EOC WCHD assumes its role at the Annex-4 desk. When operating within a state framework WCHD assumes its role in ESF-8. From the desk, WCHD may require additional collaboration with other ESFs, local, state, and federal partners. The Annex-H / 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 below.
For a list of partner point of contacts, please refer to Appendix 1 – External POCs.

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

- Incident summary
- Current operations summary
- Response lead / Incident Command type (individual or unified)
- Objectives to be completed by agency as stated in the Incident Action Plan
- Planned public information activities
- Other engaged agencies
- Important situational awareness information

6.1 PUBLIC COMMUNICATIONS:
WCHD maintains a Public Information Officer (PIO) and Back Up Public Information Officer to plan and review communications and messaging activities outlined in the WCHD Risk Crisis Communications Plan. This plan will be active during all response activities of WCHD and describes protocols by which public information will interface with the WCHD response.

7.0 ADMINISTRATION AND FINANCE:

7.1 GENERAL:
Focused, deliberate / conscientious administration efforts, recordkeeping, and accounting are vital to ensure a successful response, demobilization, and recovery supporting the full scope of activities. During an incident it becomes everyone’s responsibility for proper documentation and recordkeeping. Collaboration vertically and horizontally between sections is key.

- In a WCHD led ICS response, finance and administration duties may be delegated by the Incident Commander to the Finance and Administration Section Chief.
- When WCHD is engaged in coordination, these duties may be delegated by the Agency Coordinator to the appropriate staff member or unit.

7.2 COST RECOVERY:
Cost recovery for an incident includes all costs reasonably incurred by WCHD 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. Cost recovery documentation is completed by tracking receipts, time sheets, invoices, and other applicable documents. These are then applied to agency fiscal processes with all information saved on agency fiscal server. All cost recovery is led by the Health Commissioner in coordination with the agencies Fiscal Officer or designated staff.

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 Williams County Health District through the Williams County Emergency Management Agency. Established funding streams through which reimbursement may be available include the following:

- **State Disaster Relief Program (SDRP)** – Administered by the Ohio Emergency Management Agency (Ohio EMA), Disaster Recovery Branch. The SDRP is designed to provide financial assistance to local governments and eligible non-profit organizations impacted by disasters. These funds are intended to SUPPLEMENT NOT SUPPLANT an applicant’s resources and therefore, applicants must demonstrate the disaster has overwhelmed local resources and that other avenues of financial assistance have been exhausted prior to requesting assistance through the SDRP. The SDRP is implemented at the governor’s discretion, when federal assistance is not available. Local governments and eligible non-profit organizations must apply, through a written letter of intent, to the program within 14 days of the Program being made available. The supplemental assistance is cost shared between Ohio EMA and the applicant.

- **FEMA Public Assistance (PA) Program** – administered through a coordinated effort between the FEMA, Ohio EMA, and the applicants. While all entities must work together to meet the overall objective of quick, efficient, effective program delivery, each has a different role. FEMA’s primary responsibilities are to determine the amount of funding, participate in educating the applicant on specific program issues and procedures, assist the applicant with the development of projects, and review the projects for compliance. The FEMA PA Program provides supplemental Federal disaster grant assistance for debris removal, emergency protective measures, and the repair, replacement, or restoration of disaster-damaged, publicly owned facilities. The PA Program also encourages protection of these damaged facilities from future events by providing assistance for hazard mitigation measures during the recovery process. The Federal share of assistance is not less than 75%
of the eligible cost for emergency measures and permanent restoration from major disasters or emergencies declared by the President.

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

Examples of eligible / recovery costs / work to be considered for incident may include:

- **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.

- **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.
## MOU / MAA / CONTRACTS TABLE

<table>
<thead>
<tr>
<th>Document Name</th>
<th>Document Type</th>
<th>Resources/Support Provided</th>
<th>Cost for Utilization</th>
<th>POC to Activate</th>
<th>POC Primary Contact Info</th>
</tr>
</thead>
<tbody>
<tr>
<td>NW Ohio Mutual Aid Agreement</td>
<td>MAA</td>
<td>Public Health Response</td>
<td>No cost; Resources as available</td>
<td>Regional Public Health Wood County</td>
<td>(419) 352-8402</td>
</tr>
<tr>
<td>Epi Service</td>
<td>MOU</td>
<td>Epidemiologic Services</td>
<td>Ongoing quarterly payments</td>
<td>Fulton County Health District</td>
<td>(419) 337-0915</td>
</tr>
<tr>
<td>Language Line</td>
<td>MOU</td>
<td>Language and translation services</td>
<td>No cost</td>
<td>Williams County 911/Communications</td>
<td>(419) 633-5001</td>
</tr>
<tr>
<td>Veterans Memorial POD MOU</td>
<td>MOU</td>
<td>POD location</td>
<td>No cost</td>
<td>Veterans Memorial</td>
<td>(419) 737-2188</td>
</tr>
<tr>
<td>Bryan Schools POD MOU</td>
<td>MOU</td>
<td>POD location</td>
<td>No cost</td>
<td>School Superintendent</td>
<td>(419) 636-6973</td>
</tr>
<tr>
<td>Montpelier Schools POD MOU</td>
<td>MOU</td>
<td>POD location</td>
<td>No Cost</td>
<td>School Administrator</td>
<td>(419) 485-6700</td>
</tr>
</tbody>
</table>
7.3 LEGAL SUPPORT:

WCHD legal counsel will work in collaboration with the incident command/management 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 WCHD General 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 laws, rules, statutes, & ordinances are recognized and being adhered to.

WCHD General Counsel may also support the execution of Memorandums of Understanding (MOUs), Mutual Aid Agreements (MAAs) and requests for resources through the Emergency Management Assistance Compact or other documents of agreement.

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 / input for creation of IAPs, and (e) development / input for the creation of AAR/IPs. 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. Incident documentation will be collected and organized by the Planning Section.

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).
Legal matters may arise following a disaster response activities. This makes documentation important so the operational picture can be built and understood. All documentation will be collected before, during, and after operational periods/shifts. Documentation will be checked and organized by the Planning Section so as to assure accuracy and understanding.

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 and provided to the Planning Section or Planning section 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.

It is the policy of the Williams County Health Department that openness leads to a better informed citizenry, which leads to better government and better public policy. It is the policy of the Williams County Health Department to strictly comply with the Ohio Public Records Act. Many of the records the Williams County Health Department creates and maintains fall under the requirements of the act. Conversely, some records are strictly confidential and exempt from public record. All exemptions to openness are to be construed in their narrowest sense and any denial of public records in response to a valid request will be accompanied by an explanation, which cites legal authority, as outlined in the Ohio Revised Code, if the request is in writing, the explanation must also be in writing. This policy provides general guidelines for compliance with the Ohio Public Records Act.

The Williams County Health Department, in accordance with the Ohio Revised Code, defines records as including the following: Any document - paper, electronic (including, but not limited to, e-mail), or other format - that is created or received by, or comes under the jurisdiction of a public office that documents the organization, functions, policies, decisions, procedures, operations, or other activities of the office. All records of the Williams County Health Department are public unless they are specifically exempt from disclosure under the Ohio Revised Code.

The Williams County Health Department, in accordance with Ohio law, will maintain records in an organized manner and in a way that facilitates good business practice, so that the records
are readily available for inspection and copying (See Section 4 for the e-mail record policy). Additionally, a copy of the current record retention schedule shall be updated regularly and posted prominently for public inspection. All records resulting from a response activity will follow the Record Retention Schedules of the Williams County Health District. Example: “Activity reports – reports compiled to detail financial, statistical, and/or operational data (2 years paper or digital).”

All records resulting from response efforts of the Williams County Health District will be kept in paper form in the records room and any digital records will be kept on the health department’s secure server on the Master Drive. The Health Commissioner and Directors are the only individuals with direct access to any records from response efforts. Any person needing access to these documents must be granted permission from the Health Commissioner or designee.

<table>
<thead>
<tr>
<th>ICS Form Number</th>
<th>ICS Form Title</th>
<th>ICS Form Purpose (Administration and Finance function or use it supports)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICS 201</td>
<td>Incident Briefing</td>
<td>Provides the basic information regarding the incident situation and the resources allocated to the incident. (Time, Procurement, Claims and Cost)</td>
</tr>
<tr>
<td>ICS 211</td>
<td>Check In List (Personnel)</td>
<td>Records arrival times or personnel and equipment at incident site and other subsequent locations. (Time, Claims and Cost)</td>
</tr>
<tr>
<td>ICS 213 RR</td>
<td>Resource Request</td>
<td>Is used to order resources and track resources status. (Procurement and Cost)</td>
</tr>
<tr>
<td>ICS 214</td>
<td>Activity Log</td>
<td>Provides basic incident activity documentation and a reference for any after action report. (Time, Procurement, Claims, Cost)</td>
</tr>
<tr>
<td>ICS 221</td>
<td>Demobilization Check Out</td>
<td>Provides information on resources released from an incident. Demobilization is a planned process and this form assists with that planning. All expended</td>
</tr>
</tbody>
</table>
7.5 EXPEDITED ADMINISTRATIVE AND FINANCIAL ACTIONS:

Expeditied actions can occur in the forms of approvals for personnel actions and procurement of resources. All expeditied actions will be initially approved by the Finance & Administration Section Chief or appointed Fiscal Officer and provided to the IC/AC for approval. 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 Williams County Health District Health Commissioner or designee.

- **Expedited Financial Actions:** All expeditied financial actions will be coordinated by the Financial Section Chief or appointed Fiscal Officer in consultation with Williams County Health Commissioner or designee (request may be made for General Counsel or other necessary person). No funding will be obligated or committed without the consent of the Health Commissioner or designee.

- **Expedited Procurement Actions:** Expenditure and emergency processes will follow the above actions unless an expeditied action is necessary. In this situation the Health Commissioner has the authority to authorize spending to a designated limit. “The Health Commissioner is authorized by the Board of Health to approve purchases up to $15,000.00 in emergency expenditures…”

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:

- 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.
• 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, WCHD will expedite the approval process through the Health Commissioner and will work directly with key stakeholders to obtain approval of the contract relationship and support availability of additional funds. The Board of Health has authorized the Health Commissioner to receive funds, which allows the Health Commissioner to enter into contracts or receive funds on behalf of the agency during emergencies, without prior BOH approval.

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

During normal operations, purchases over $15,000 and the entering into contracts require BOH approval. The BOH may allowing the Health Commissioner to apply funds as needed to address “an imminent or critical public health incident.”

Additionally, the agency’s policy of at least three interviews before hiring will be suspended. During an emergency, emergency staff may be installed after an interview with their direct supervisor. The employee will be able to begin work after passing the background check.

All expedited actions will be briefed during the incident operational briefings and also during shift change briefs. These actions will be tracked in the operational activity log ICS 214 form or chronology of events document and reviewed with the Financial Section Chief as needed. All necessary agency forms will also be completed, in addition to the incident forms.

8.0 LOGISTICS AND RESOURCE MANAGEMENT:

8.1 GENERAL:

WCHD has a limited amount of materiel and personnel staffing resources available for incident response, and shortfalls are most likely in these commodities. The following six (6)
levels of sourcing have been identified to fill potential resource shortfalls and minimize any time delays in acquiring the asset:

- **Source 1: WCHD internal human resource/personnel and inventory management.** All resources will be queried internally prior to engaging any partner or stakeholder. When all WCHD requires resources that are not on-hand or have been exhausted the agency will pursue with local, regional, & state agency partners for resources.

- **Source 2: Local, Regional, & State agency resources.** When WCHD resource avenues have been exhausted, the acting Logistics Section Chief will work through the Williams County EMA to engage local, regional, & state partners to secure a resource. Local EMA may choose to activate the Emergency Operations Center (may request State EOC assistance) and associated Support Annex or Emergency Support Function (ESF) partners to identify and secure a resource (e.g. ESF-1, ESF-7).

- **Source 3: MOUs and MAAs.** When a required resource is needed, the Finance Section Chief will refer to existing MOUs or MAAs to fulfill resource shortfalls. Assistance will be sought from Legal, as necessary.

- **Source 4: Emergency Purchasing and Contracts.** Special provisions have been made allowing the Health Commissioner or designee authority for emergency procurement (MOU, MOA, Agreement/s, or Contract/s). The Williams County Health District Health Commissioner or designee has access to these documents which are located in the Health Commissioner’s office.

- **Source 5: Emergency Management Assistance Compact (EMAC).** When a resource for WCHD use is not available and cannot be found in state, the Logistics Section Chief will work through the County EOC/EMA who will reach out to the State EOC/EMA to request interstate resources using the EMAC Process.

- **Source 6: Federal Assets.** Specialized federal assets to include subject matter experts and material may be required to support state incident response. Federal agencies that support WCHD responsibilities include but are not limited to the Centers for Disease Control (CDC), Department of Health and Human Services (HHS) and the Department of Energy (DOE). These assets range from requests from the CDC for Strategic National Stockpile (SNS), Medical Countermeasures (MCM), and the Department of Energy for radiation incidents.
8.2 WCHD RESOURCES:
WCHD has identified three resource priorities to fill during an incident:
- Personnel
- Supplies/materials
- Transportation

8.2.1 PERSONNEL RESOURCES:
The Planning Section Chief will work with WCHD Administration, Logistics Section Chief, & Financial Section Chief to fill these shortfalls. If there are insufficient WCHD personnel (staffing assets) available internally, WCHD will engage the staffing pools/options in section 9.3 of this plan.

8.2.2 MATERIAL RESOURCES:
In an effort to fulfill material resource gaps the acting Logistic Section Chief will research for the asset internally (resources of WCHD not utilized) using WCHD’s current inventory system (overseen by WCHD Clerical Supervisor) to locate the required asset or resource. If the resource is located it may be pulled and utilized for response efforts.

If the resource is not found the Logistic Section Chief or designee may indicate the need to Incident / Unified Command; upon which a request will be made to the Williams County Emergency Management Agency for location of needed resources. If available, the resource may be released and assigned for the duration of the incident. A copy of the form will be kept and submitted to the Planning Section. Request for medical countermeasures will follow guidance and plans for Medical Counter Measures.

8.2.3 TRANSPORTATION RESOURCES:
WCHD transportation assets are limited for both personnel and material transportation. During an incident response, the Logistics Section Chief or designee will collaborate with the Health Commissioner or designee to determine available WCHD vehicle and transportation assets for use in the form of personnel transport vehicles and cargo transportation vehicles to meet transportation requirements. Any transportation needs that remain unmet after this engagement will be addressed through interactions with the Williams County Emergency Management Agency who will coordinate resource discovery and acquisition.
8.3 MANAGEMENT AND ACCOUNTABILITY OF RESOURCES:

8.3.1 MANAGEMENT OF WCHD INTERNAL RESOURCES:

The management of WCHD internal resources and assets used in support of an incident response will be tracked in compliance with agency practices for inventory management. Assets and resources used to assist in the response will be tracked utilizing agency inventory management forms and procedures for supplies and material managed/distributed by regional, state, or federal partner caches.

The Logistic Section Chief or designee will manage all internal and external resources and will log the following minimum information for all WCHD material assets involved in response activities:

- Asset tag number
- Serial and model number
- Equipment custodian (owner) name
- Description of asset (name/identifier)
- Asset storage location
- Asset assigned location
- Noted damage or state of the asset

8.3.2 MANAGEMENT OF EXTERNAL RESOURCES:

Upon receipt of an external resource, the WCHD Incident Commander or Agency Coordinator in collaboration with the Logistic Section Chief will accept responsibility of the asset, by entering relevant information into the designated tracking system and log the minimum information for all assets as listed in 8.3.1 (if applicable). For equipment, supplies, or MCMs received by the RSS warehouse responders will use the documents provided by the Ohio Department of Health for resource management 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 may be assigned to external assets 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:

Williams County Health District (WCHD) is responsible for managing the internal resources that belong to their agency. When a WCHD asset or resource is requested, for an internal or external response, WCHD will use the pre-determined inventory system and asset/resource transfer and receipt documentation to appropriately manage utilized resource. It is then the responsibility of the response lead to account for/track the resource, its use, sustainment, and demobilization.

- When an individual WCHD employee responds or deploys to an incident with a WCHD asset, that employee becomes the equipment custodian of the asset throughout the response and demobilization phases unless asset is transferred to another custodian as agreed upon by the Incident Commander / Agency Coordinator.
- During a response, an update of all resources deployed from WCHD (internal and external) will be compiled at the beginning of and end of each operational period. Report resource update to Agency Coordinator, Incident Commander, direct Supervisor, or designee according to Incident Command System structure throughout the response and demobilization phases.
- Internal processing of IMAC/EMAC requests are handled by the Health Commissioner or designee. A Director or the Emergency Preparedness Coordinator may receive a request and move it to the Health Commissioner or designee.
- Following approval by the Health Commissioner or designee, assigned staff will begin a resource search within WHCD. All WCHD Divisions will research databases and inventory systems for resource request at all WCHD agency locations. Once completed all resource information will be submitted to the Health Commissioner or designee for deployment.
- All IMAC/EMAC approvals, to send resources, reside with the Health Commissioner or designee in consultation with the BOH.
- 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 WCHD. If the requesting state accepts the resource(s) offered by WCHD, Ohio EMA will execute an intergovernmental agreement with WCHD. Receiving states will only accept resources from the State of Ohio. An intergovernmental agreement with Ohio EMA will allow WCHD’s resources to be designated as State of Ohio resources.
- WCHD staff deployed through this mechanism will be paid, e.g. compensation, travel reimbursement, etc., by WCHD 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 WCHD 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 WCHD.

Upon completion of the intergovernmental agreement, Ohio EMA, the receiving organization and WCHD 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.

The following Incident Command System (ICS) forms (as needed / if applicable) may be used to assist in resource accountability tracking and post incident cost recovery along-side agency documentation resources established in this plan:

<table>
<thead>
<tr>
<th>ICS Form Number</th>
<th>ICS Form Title</th>
<th>ICS Form Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICS 204</td>
<td>Assignment List</td>
<td>Block #5. Identifies resources assigned during operational period assignment.</td>
</tr>
<tr>
<td>ICS 210</td>
<td>Resource Status Change</td>
<td>Record status change information received on resources assigned to the incident.</td>
</tr>
<tr>
<td>ICS 211</td>
<td>Check In List (Personnel)</td>
<td>Records arrival times or personnel and equipment at incident site and other subsequent locations.</td>
</tr>
<tr>
<td>ICS 213 RR (if applicable)</td>
<td>Resource Request</td>
<td>Is used to order resources and track resources status.</td>
</tr>
<tr>
<td>ICS 215</td>
<td>Operational Planning Worksheet</td>
<td>Communicates resource assignments and needs for the next operational period.</td>
</tr>
<tr>
<td>ICS 219</td>
<td>Resource Status Card (T-Card)</td>
<td>Visual Display of the status and location of resources assigned to the incident.</td>
</tr>
<tr>
<td>ICS 221</td>
<td>Demobilization Check Out</td>
<td>Provides information on resources released from an incident.</td>
</tr>
</tbody>
</table>

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 WCHD
assets or resources used in an incident, full accountability of equipment returning to WCHD will be completed in collaboration with health department representative and Incident Commander/Agency Coordinator or designee. The asset will be inventories and matched against the asset tag or identifier/number, serial number, then inspected for new damage, serviceability, and cleanliness. If all equipment serviceability and cleanliness requirements are met, the assets or resources will be transferred to WCHD representative and returned to normal service. ICS Form 221 Demobilization Check-out Form may be used to facilitate this process.

- If the equipment or resource deployed is lost, damaged, or does not meet serviceability requirements, WCHD Agency Coordinator or designee, stakeholder, or appointed equipment custodian will collaborate with necessary agencies and WHCD Fiscal Officer to determine 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 OHIO INTRASTATE MUTUAL AID COMPACT (IMAC) & EMERGENCY MANAGEMENT ASSISTANCE COMPACT (EMAC):
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.

5502.29 Mutual emergency management assistance or aid agreements.

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. More information is available at www.emacweb.org.

Williams County Health District may/will use IMAC and EMAC to support a Public Health Emergency at the local level or assist at the regional level. Resources may come in many forms such as: personnel, equipment, PPE, transportation, and other identified response resources (not meant to be exhaustive). WCHD will work with and make requests through the Williams County Emergency Management Agency and Public Officials when utilization of the enacted Revised State Code IMAC and Federal Public Law EMAC are required / necessary. IMAC and EMAC will be called upon when resources are stressed or exhausted and will support the above mentioned resources.

8.6 MEMORANDUMS OF UNDERSTANDING, MUTUAL AID AGREEMENTS, AND OTHER AGREEMENTS:

- Memoranda of Understanding (MOUs) and Mutual Aid Agreements (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 management, 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 a MOU/MAA.

- These agreements (MOU/MAA) expand the capacity of WCHD 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 Williams County Prosecutor/Legal Counsel and WCHD Health Commissioner or designee.

- Established WCHD MOUs and MAAs are retained by the Williams County Health District Health Commissioner. The Health Commissioner retains the compilation of original/official agreements. Additionally, WCHD Division Leadership retains copies of MOUs or MAAs specific to their program. Those with financial commitment are retained by the WCHD Health Commissioner. Directors have access to the location, of MOUs and MAAs, within the Health Commissioner’s office. MOUs and MAAs are reviewed based upon the original document of the agencies entering into the agreement. Some documents are yearly, biyearly, and others stand until rescinded by agency request.

- Upon an incident response, it is incumbent upon the Logistic Section Chief to inquire with the appropriate leadership or authorized designee to determine whether any MOUs or MAAs are applicable to the response activities.

- If an MOU or MAA is determined to be needed during an incident, the Incident Commander / Agency Coordinator or designee, and appropriate leadership will collaborate on execution of the MOU/MAA.

- The request for IMAC or EMAC resources is an executive level decision. The Health Commissioner or designee, Williams County Emergency Management Agency Director or designee, or public official with authority over the jurisdiction being impacted dictate if IMAC or EMAC assistance will be sought. The Williams County EMA follows the Ohio EMA utilizes their forms and follows its processes. To request EMAC resources there must be a Governor’s declaration in State.

- IMAC & EMAC Process: All IMAC & EMAC requests will follow State EMA instructions and procedures with assistance coming from Williams County EMA in applying the request. All IMAC & EMAC requests will be developed by the Logistics Section Chief or designee, and provided to Williams County EMA after WCDH Health Commissioner or designee approval. At a minimum, representatives from the Williams County Health District, Williams County EMA, and public official with jurisdiction authority will be involved in the IMAC & EMAC processes. Once approved by these officials the request will be processed and executed.
<table>
<thead>
<tr>
<th>Document Name</th>
<th>Document Type</th>
<th>Resources/ Support Provided</th>
<th>Cost for Utilization</th>
<th>POC to Activate</th>
<th>POC Primary Contact Info</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buckton Regional Public Health MOU</td>
<td>MOU</td>
<td>Public Health Response Personnel</td>
<td>No cost; staff provided as available</td>
<td>George Regionford</td>
<td>555-MOU-HELP</td>
</tr>
<tr>
<td>Buckton Regional MAA</td>
<td>MAA</td>
<td>Staff and resources from other governmental agencies in the region</td>
<td>Costs vary by resource type</td>
<td>Jill Coordination</td>
<td>555-MAA-SEND</td>
</tr>
<tr>
<td>Vector Control Contingent Contract</td>
<td>Contract</td>
<td>Vector Control services in response to vector-borne disease outbreak</td>
<td>$12,000 if activated; full coverage of impacted area</td>
<td>Vicky Vector</td>
<td>555-BUG-STOP</td>
</tr>
<tr>
<td>Vaccine Staffing Contract</td>
<td>Contract</td>
<td>RNs, LPN, EMTs and phlebotomists, at an hourly rate</td>
<td>RN: $40/hr</td>
<td>Stan Staffer</td>
<td>555-STAFFERS</td>
</tr>
<tr>
<td>Critical IT Supplies</td>
<td>Contract</td>
<td>Laptops, printers, servers and other, critical IT supplies.</td>
<td>Costs vary by resource type</td>
<td>Ingrid Tockland</td>
<td>555-LAPTOPS</td>
</tr>
</tbody>
</table>
9.0 STAFFING:

9.1 GENERAL:
All WCHD employees are designated as public health responders and can be called upon to fulfill response functions during an incident. The role assigned to any WCHD employee in an incident is dependent upon the nature of the incident, skill/knowledge required, and the availability of staff to respond. With approval of WCHD Health Commissioner or designee, 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 Administration. All staffing considerations will revolve around needs of the incident and skills/knowledge/capability necessary to effectively and safely accomplish and complete the job or work assigned. At no point will an employee be purposely placed in an unsafe position or position they are not trained for.

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

Psychological first aid will be made available during and after the incident. WCHD works with the Four County ADAMhS Board and other counseling services identified by the ADAMhS Board. They will be engaged early in the response to allow for deployment. Mental health professionals from organizations will be deployed to strategic areas. Staff will have immediate access before, during, and after the deployment and incident. Contact numbers and information will be distributed to all responders during or after a shift.

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

- Mass fatality incidents, natural or man-made disasters, infectious disease
- Incidents with significant impact on children or family
- Incidents that require extended use of PPE
- Incidents with significant public demonstration with limited supply.
9.2 STAFFING ACTIVATION LEVEL:
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 to support response activities. Staffing levels will be evaluated in development of the IAP, updated for each operational period, if identified during an operational period, and through ongoing situational assessment of response activities and needs.

WCHD will utilize the necessary plan to inform how staff is reallocated from their day-to-day activities to incident response. This will be done as needed, as ERP activation does not automatically activate other plans.

9.3 STAFFING POOLS / OPTIONS:
WCHD offices and divisions will be engaged to provide staffing for incidents that can be effectively supported by their staff. The Health Commissioner or designee has the capability to query for specially qualified personnel as needed. The following WCHD staff pools could be considered for fulfilling command and public health staffing requirements:

- Qualified Division/Program staff
- Division/Program staff with special skill, knowledge, or ability
- Specific roles for program personnel that may be defined in functional annexes or incident specific preparedness documents included in this plan
- Incident Commander / Agency Coordinator role may be filled by the Health Commissioner or designee

Other potential partner staffing pools include the following:

- Staffing agreements in Mutual Aid Agreements or Memorandums of Understanding
- Staff request through the Ohio Intrastate Mutual Aid Compact
- Staff request through the Emergency Management Agency Compact
- Staff request through Regional Public Health Coordinator
- Staff request through Williams County Emergency Management Agency
- Federal entities
- Staff requests thorough surrounding MRC or CERT teams
- 6-PACT partners (Defiance, Paulding, Putnam, Fulton, & Henry)
- Community Hospitals and Wellness Centers
- Other volunteer pools: Williams County Health District Medical Reserve Corp., American Red Cross, Ministerial Association, United Way and Community Emergency Response Team are available volunteer options (NOTE: Volunteers can be used in any position,
provided they do not exceed their scope of practice or verified skills for the duties they are assigned. Limitations on volunteers is determined by the Health Commissioner or designee upon time of deployment as there are no specific limitations.

WCHD Health Commissioner or designee and staff identified by the Health Commissioner or designee will be engaged, as appropriate, prior to outreach efforts to these alternate staffing pools.

9.4 MOBILIZATION ALERT AND NOTIFICATION:
The Planning Section Chief will prepare a mobilization message for dissemination to response personnel (reviewed by IC & PIO prior to release). The Planning Section Chief or designee holds responsibility for contacting staff from staffing pools during a response. This message will be shared with the appropriate Director as to their staff that has been engaged. Staff notified for mobilization/deployment will follow these instructions:

- **Where to report**: All personnel alerted for mobilization/deployment, for an incident, will report to the WCHD DOC, unless otherwise specified.
- **When to report**: Staff alerted will report within the required time established by the IC/AC. The goal for initiating deployment is within 30 – 60 minutes of notification; arrival times may vary depending on the distance the staff must travel.
- **Whom to report to**: The staff alerted will report to the Planning Section Chief or designee. The Incident Commander or designee will review the responsibilities of assigned staff and consult with the Planning Section Chief to ensure the Planning Section is able to receive and process responding personnel.

Upon reporting to the DOC, EOC, or Incident Command Post (will be established in notification message) the staff will be received, checked in, provided an incident summary upon check-in (if applicable), assigned and integrated into their role where incident summary may be given by their direct supervisor. 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 WCHD 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 WCHD STAFF MEMBER WILL SELF-DEPLOY TO AN INCIDENT, EMERGENCY, or EVENT RESPONSE.**
10.0 DISASTER DECLARATIONS:

10.1 NON-DECLARED DISASTERS:
WCHD may respond to an incident as set forth in law and/or outlined in this plan without formal declaration of a disaster or state of emergency with the expectation that local resources will be used and that reimbursement of costs will be reviewed by the Health Commissioner with other agency administration. The Health Commissioner or designee may redirect and deploy agency 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 or 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 department, 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 local, regional, and 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 the local agency.

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 LOCAL DECLARATION OF DISASTER EMERGENCY:
Declaration of disaster emergency is done by the Williams County Board of Commissioners at the request/recommendation of EMA, elected official, or political entity. Should it ever be
needed, the State EMA template may be utilized by the Williams County EMA to assist in this declaration process.

The Health Commissioner or designee determines that the situation has or is elevating to a level requiring a disaster declaration. Upon verification of the situational assessment the Health Commissioner or designee will contact the jurisdictional authority for that impacted area. The Williams County EMA will also be contacted and informed of the declaration intent request. Coordination of the declaration will be conducted by those authorities involved in the process with messages being distributed by the PIO to necessary individuals and agencies. Further coordinating activities may be conducted by the jurisdictional authority, Health Commissioner, Incident / Unified Command, or designee/s granted authority.

Furthermore, WCHD’s role in the emergency declaration process is to provide subject matter expertise and situational information. WCHD cannot declare an emergency or disaster; only the jurisdictional authority tasked with this responsibility. WCHD may be asked to weigh in by Williams County EMA on the effects of a disaster and its public health implications. The Health Commissioner and any WCHD staff member that the jurisdictional authority deems necessary to include may act as consultants, with Health Commissioner approval, to the jurisdictional authority and inform Williams County EMA led disaster declaration process.

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 exist. 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 PH does not require a formal request from state or local authorities.

SECTION 3

11.0 PLAN DEVELOPMENT AND MAINTENANCE:

11.1 PLAN FORMATTING:
All plan components will align with the definitions, organization, and formatting described below. Additionally, WCHD uses both appropriate terminology for access and functional needs and person first language throughout the ERP, consistent with the standards indicated on pages 37 – 38 of this plan.

Plan: A collection of related documents used to direct response activities.
- Plans may include up to four types of documents, which are the following: Basic Plan, Attachment, Appendix, Annex, Internal Processes, SOGs, and Stand Alone Guides.
- When referenced, plans are designated with bold, italicized, or underlined font.

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

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 **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.

**11.2 REVIEW AND DEVELOPMENT PROCESS:**

- Planning shall be initiated and coordinated by the Public Health Emergency Preparedness Office. Planning shall address revisions to the ERP Basic Plan, as well as revisions or development of any other ERP components. The Public Health Emergency Preparedness Office will form a collaborative planning team to include the following staff/groups/individuals:
  - Health Commissioner
  - Health Department Directors
  - Public Health Nurses
  - Health Educator
  - Sanitarians
  - Senior Centers, Specialized Care Facilities, Cultural groups (Access/Functional Needs)
  - Hospital Emergency Management
  - Williams County Emergency Management Agency
  - Williams County Board of DD (Access and Functional Needs)
  - Subject Matter Experts (SME’s) from both within WCHD and outside of the agency
Revisions will be determined on an annual revision schedule and by identifying gaps and
lessons learned through exercises and real-world events, or by the direction of the
WCHD Health Commissioner or Public Health Preparedness Office. 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 WCHD planning teams 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 the
planning team 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, WCHD
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 obtained through the following hyperlink:

- Emergency Response Plan Meeting Minutes

Below are the established plan, annex, attachment, and appendix review schedules. The
planning team 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.

<table>
<thead>
<tr>
<th>Plan</th>
<th>ANNUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annex</td>
<td>ANNUAL</td>
</tr>
<tr>
<td>Attachment</td>
<td>ANNUAL</td>
</tr>
<tr>
<td>Appendix</td>
<td>ANNUAL</td>
</tr>
<tr>
<td>Stand Alone</td>
<td>ANNUAL</td>
</tr>
</tbody>
</table>

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

11.3 REVIEW AND ADOPTION OF THE ERP – BASIC PLAN AND ITS ATTACHMENTS:

The basic plan and its attachments shall be reviewed by Directors and endorsed by the
Health Commissioner or designee. 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.

- Administration, Directors, or Emergency Preparedness Coordinator may initiate changes
to the basic plan and its attachments by submitting the proposed changes for review by
Health Commissioner and Directors during the annual review.
- Proposed changes may be approved for use in response activities by the Williams
County Health District before adoption by the Health Commissioner or designee; such
approval is only valid until the annual review, after which the Health Commissioner or
designee must have adopted the proposed changes for their continued use in response
activities to be allowable.

11.4 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 Emergency Preparedness Coordinator or
designee. The Health Commissioner/designee or Director may initiate changes to
appendices by submitting the proposed changes to the ERP. All appendices should be
reviewed by WHCD Health Commissioner/designee or Directors upon inclusion, revision,
or expansion, but it is not necessary, at any time, for the Health Commissioner/designee
or Directors to approve appendices.

11.5 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 Public Health Preparedness Office and conducted
by a review team, which will comprise the previously stated in 11.2 Review and
Development Process. The review committee will be led by a chair, who will be the
Emergency Preparedness Coordinator or designee with the greatest responsibility for
execution of the annex; 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 Health
Commissioner or designee.
- The Health Commissioner/designee, Directors, or Emergency Preparedness Coordinator
may initiate changes to annexes and its attachments by submitting the proposed
changes to the ERP for presentation to the previously stated in 11.2 Review and
Development Process. Please note that if an attachment is an SOG or directive, then
that attachment must be updated through the existing SOG / directive policy.
Proposed changes may be approved for interim use in response activities by the Williams County Health District 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.

11.6 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 Health Commissioner/designee, Directors, or Emergency Preparedness Coordinator at any time. Any of the three named positions 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.

11.7 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 with 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.

11.8 PLAN FORMATTING:
WCHD Plan Style Guide:
- Calibri 28pt for Title
- Calibri 12pt for Body text
- Calibri 24pt for Headers
- Calibri 11pt for footnotes
- Multiple 1.5 before and after paragraphs
- Multiple 1.5 spaced.
11.9 PLAN PUBLISHING:
The Emergency Response Plan – Basic Plan will be made available for review by the public online on the WCHD website under Preparedness. The Public Health Preparedness Office will communicate to WCHD’s Public Information Officer (PIO) when the emergency response plan has been revised and a new version is available for public publishing. All other plan documents will be made available to the public upon request. The Emergency Response Plan – Basic Plan will be distributed to partners with other plan documents being made available upon request. The Basic Plan will be posted on the Williams County Health District website for public view. Areas of the public plan/s that require redaction will be overseen by the Health Commissioner or designee prior to publishing in any format. Public comment on the ERP will be accepted via email and tabled in addition to the proposed changes between revision cycles for consideration. All public comments submitted will be acknowledged and a return email sent to verify receipt of comments.

12.0 DOCUMENT DEFINITIONS AND ACRONYMS:
Definitions and acronyms related to the WCHD ERP Base Plan are in Appendix 2 – Definitions & Acronyms.
13.0 AUTHORITIES:

The following list of Authorities and References includes Executive Orders, Agency Directives, Statutes, Rules, Ordinances, Plans, and Procedures that provide authorization and operational guidelines for the allocation and assignment of local, regional, state, and federal resources in response to emergencies:

13.1 FEDERAL:
- National Plan for Telecommunications Support in Non-Wartime Emergencies
- Executive Order 12148, Formation of the Federal Emergency Management Agency
- Executive Order 12656, Assignment of Federal Emergency Responsibilities
- Presidential Policy Directive 8 (PPD-8), National Preparedness, 2011
- Uniform Administrative Requirements for Grants and Cooperative Agreements to state and Local Governments, 44 CRF Parts 13 and 206.

13.2 STATE:
State authorities are detailed in Appendix 14 – SHD Authorities. They include:
- Infectious Disease Control
- Emergencies
- Management of People
- Monetary
- License and Regulatory Authority
- Support Services
- Registries & General Confidentiality

13.3 LOCAL:
Ohio Administrative Code:
- 3701-3-13: Isolation Requirement

Ohio Revised Code:
- 3701.13: Department of health – powers
- 3701.17 Protected health information
3701.28 Power of department when local authorities fail to act
3701.56 Enforcement of rules and regulations
3707 Board of Health
3707.04 Quarantine regulations
3707.05 Board must secure approval of department of health in certain cases
3707.08 Isolation of persons exposed to communicable disease, placarding premises
3707.09 Board may employ quarantine guards
3707.14 Maintenance of persons confined in quarantined house
3707.17 Quarantine in place other than that of legal settlement
3707.19 Disposal of body of person who died from communicable disease
3707.20 Admission of person suffering from a contagious or infectious disease to certain institutions
3707.21 Disease in public institution – temporary building
3707.22 Removal of affected or exposed persons from public institution to hospital
3707.31 Establishment of quarantine hospital
3707.32 Erection of temporary buildings by board – destruction of property
3707.34 Quarantine and isolation policies
3707.48 Prohibition s against violation of orders or regulations of board
370749 Violation by a corporation – forfeiture
707.53 Deposit for costs not required in prosecutions - fines

14.0 References:

14.1 FEDERAL:
• National Response Framework (NRF), 2016
• The National Incident Management System (NIMS), 2008

14.2 STATE:
• State Department of Health Continuity of Operations Plan, 2014
• State Department of Health Emergency Communications Plan, 2013
• State Emergency Operations Plan, 2016
• State Hazard Analysis and Risk Assessment, 2013
• State Hazard Mitigation Plan, 2014
OTHER DOCUMENTS OF REFERENCE:

- Williams County Health District 2017 Hazard Assessment
- Williams County Emergency Management Agency 2013 – 2018 Hazard Mitigation Study
- PHAB Standards and Measures Version 1.5_10.01.15
- PPHR-Criteria-Version-8.1
- CDC-RFA-TP17-1701 Revised FOA

- Annex 1: Chemical Emergencies
- Annex 2: Natural Disasters, Communicable Diseases and Biological Emergencies
- Annex 3: Volunteer Management Plan
- Annex 4: Crisis and Emergency Risk Communication Plan
- Annex 5: Direction and Control
- Annex 6: Disaster Mental Health Response
- Annex 7: Laboratory Response
- Annex 8: Mass Casualty Care (Medical Surge)
- Annex 9: Mass Fatalities Plan
- Annex 10: Radiological, Nuclear and Explosive Protection
- Annex 11: Pandemic Influenza Plan
- Annex 12: SNS / Medical Counter Measures
- Annex 13: Disaster Recovery/Demobilization
- Attachment I – Incident Action Plan Template
- Attachment II – Situation Report Template
- Attachment III – Shift Change Briefing
- Appendix 1 – External POCs
- Appendix 2 – Definitions & Acronyms
- Appendix 3_National Incident Management System (NIMS) 2017 Refresh
- Appendix 4_Access and Functional Needs Partner List (Place Holder)