ACCREDITATION DOCUMENT COVER PAGE

Measure #	Required Document #	Example #	Document Date:
2.1.4	1	2	8/10/2015

Document Page #	Required Element
3-4	The various governmental agencies and departments involved in the partnership.
10	The scope of the plan and the capability areas covered which includes epidemiological investigation.
22-24	Inter-jurisdictionalrelationships for biological response.

Document Description:

This is the West Central Ohio Biological Response Plan. Pages 3 and 4 show who all is involved in the partnership for this plan which includes various government agencies across the region. Page 10 provides the legal basis for the response activities, outlines authorities and organizational relationships during a public health emergency. It describes how those activities will be coordinated. The plan represents the capabilities to respond to the needs of the victims of infectious diseases and the functional areas include health surveillance and epidemiological investigations. The inter-jurisdictional relationships are also highlighted on pages 22-24.

REGIONAL BIOLOGICAL RESPONSE PLAN v 5.0

WEST CENTRAL OHIO (WCO)

November, 2007

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Revised August 10, 2015

West Central West Central Ohio Regional Medical Response System/
Dayton Metropolitan Medical Response System
Executive Committee

Date Approved: August 27, 2015

Date Revised: August 10, 2015

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Primary Agencies: Champaign Health District, Clark County Combined Health District, Darke County General Health District, Greene County Public Health, Miami County Public Health, Public Health-Dayton & Montgomery County, Preble County Public Health, Sidney-Shelby County Health District, Oakwood City Health District, Piqua City Health District

Support Agencies:

- American Red Cross (ARC)
- Centers for Disease Control and Prevention (CDC) Community Blood and Tissue Center
- County Commissioners
- County Coroners
- County Offices of Emergency Management
- County Sheriff's Offices
- Dayton Metropolitan Medical Response System
- Department of Veterans Affairs
- Elected Officials
- Federal Bureau of Investigation (FBI)
- Greater Dayton Area Hospital Association (GDAHA)
- Hospitals within the region and support agencies
- Independent practitioners including physicians, pharmacists, veterinarians, mental health professionals
- Independent laboratories
- Local emergency medical services (EMS)
- Local fire departments
- Local law enforcement
- Miami Valley Regional Transit Authority
- Ohio Department of Health (ODH)
- Ohio Department of Public Safety, Division of EMS
- Ohio Environmental Protection Agency (OEPA)
- Ohio State Highway Patrol (OSHP)
- Prosecuting attorneys
- Public information officers
- Public works, utilities, and engineering departments
- Radio Amateur Civil Emergency Services (RACES)
- Regional Air Pollution Control Agency (RAPCA)
- WCO Regional Medical Response System
- School systems
- WCO Amateur Radio Emergency Services (ARES)
- Citizen's Corps Councils in WCO
- WCO mental health agencies
- Wright Patterson Air Force Base (WPAFB)

I. INTRODUCTION

The Regional Biological Response Plan for West Central Ohio (WCO) describes the legal basis for public health emergency response activities, outlines authorities and organizational relationships during a public health emergency and describes how those activities will be coordinated. Planning for the response and recovery of a biological emergency is coordinated through the WCO Regional Medical Response System (RMRS)/Dayton Metropolitan Medical Response System (MMRS). Regional resources and personnel are furnished under this plan when county-level resources are depleted or inadequate for response. Public Health is responsible for keeping an emergency response plan and interfacing that plan with other local and county-level agencies. The regional plan expands on this concept to describe the integration of local plans with regional and state plans.

A. Purpose

To ensure that public health preparedness and emergency response activities are coordinated throughout the West Central Region of Ohio (Ohio Homeland Security [HLS] Region 3), this plan is consistent with the concepts, principles, terminology and organizational processes in the National Incident Management System (NIMS) and the National Response Framework (NRF).

1. The Biological Response Plan of WCO identifies how Public Safety, Public Health, Health Care Services and Support Agencies will coordinate response to prevent, stop and/or eliminate the spread of human infectious disease in emergency situations.
2. Infectious diseases that pose a serious threat to humans in Ohio are diseases referenced in but not limited to Ohio Revised Code (ORC) Section 3701.23 and in Ohio Administrative Code (OAC) Sections 3701-3-02 (available: http://codes.ohio.gov/oac/3701-3-02).
3. Requests for release of information regarding infectious disease reports are subject to the requirements outlined in the Ohio Revised Code available: http://codes.ohio.gov/oac/3701-73.

B. Scope

The Biological Response Plan represents an enhanced capability to respond to the health and medical needs of victims of an infectious disease emergency whether naturally occurring or terrorism-related. Activities related to a criminal investigation, if the emergency is suspected to be terrorism-related, are addressed in local emergency response plans. In the case of terrorism, the FBI will be the lead federal agency and will assume overall responsibility for the incident, working closely with Public Health and other agencies. The response is categorized in the following functional areas:

The response is categorized in the following functional areas:

1. Detection and assessment of the incident
2. Organization, coordination, legal authority, and intra/inter-jurisdictional relationships
3. Workforce development, including Just in Time Training (JITT) and worker safety
4. Health surveillance and epidemiological investigation
5. Laboratory testing and analysis
6. Setting priorities, prevention and control recommendations and interventions
7. Information Sharing
8. Mass prophylaxis/vaccination

9. Health/medical equipment and supplies, including Personal Protective Equipment (PPE)
10. Health care personnel augmentation
11. Patient transportation and evacuation
12. Hospital care
13. Public information and warning
14. Vector control
15. Veterinary services
16. Worker health and safety
17. Environmental concerns-drinking water and waste management
18. Victim identification/mortuary services
19. Mental health care
20. Law enforcement support
21. Recovery activities

C. Community Profile

According to the U.S. Census Bureau, the West Central Region of Ohio (Ohio HLS 3) has a population of 1,122,378 as of July, 2013. The region consists of eight counties: Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble, and Shelby. The largest cities in the region are Dayton with a population of 143,365, Springfield with a population of 59,357, Kettering population 55,870, Beavercreek population 45,712, and Huber Heights population 38,142. The region is bordered to the west by the State of Indiana, to the south by the southwest region of Ohio which includes Cincinnati, to the east by the central region of Ohio which includes the capital city of Columbus and to the north, by the northwest region which includes Toledo. The region covers 3,546 square miles.

Table 1. Population of West Central Region (July, 2013)

Midyear Population Estimate (Source: U.S. Census Bureau, July, 2013)	**Population**
Champaign County	39,128
Clark County	136,554
Darke County	52,196
Greene County	163,820
Miami County	103,900
Montgomery County	533,116
Preble County	41,586
Shelby County	48,951
Total Population WCO	**1,119,251**

D. Description of Existing Health Services and Emergency Management Systems

The existing health services and emergency management system is based on the mutual cooperation between Offices of Emergency Management (EMA) and medical institutions within the region. Through the Greater Dayton Area Hospital Association (GDAHA) all area hospitals have undertaken mutual planning for biological emergencies. Hospital Biological Tier Levels are listed in Table 2. Hospitals will be tasked with the responsibility to provide care for the ill or injured according to their capabilities and to be able to expand to meet needs of surge capacity.

Hospitals, when necessary, will provide for centers of alternate care to meet the needs of surge capacity.

Hospitals will, under mutual cooperation, provide support as needed to EMAs to allow for best utilization of resources to meet the needs of any biological incidents. The use of the Hospital Incident Command System (HICS) is the management structure which will be implemented in the event of an emergency to coordinate efforts with EMA and other agencies. Hospitals within GDAHA have supplies and equipment that have been identified as shared resources through the Assistant Secretary for Preparedness and Response (ASPR). These resources may be considered a regional asset and can be requested through local Emergency Operations Centers (EOC) for redistribution when justification and need exists.

Should there be a need to move patients because the hospitals have reached capacity, EMA will be notified. Transportation will be completed as indicated in the evacuation section of this plan.

Table 2. Hospital Biological Tier Levels

Level IV Biological	***Level III Biological***	***Level II Biological***	***Level I Biological***
Perform triage and refers patients requiring critical care/airborne precautions. Limited capacity to hospitalize other categories of infected patients.	Able to triage all patients. Plan to refer patients requiring critical care/airborne precautions. Able to hospitalize other categories of infectious patients.	Able to triage and hospitalize all classes of infectious patients with referral and /or augmentation plans during an epidemic.	Able to triage and hospitalize all classes of infectious patients with augmentation plans during an epidemic.
Wayne Healthcare; Mercy Memorial Hospital	*Springfield Regional Medical Center; Upper Valley Medical Center; Wilson Memorial Hospital*	*Dayton Children's Hospital; Good Samaritan Hospital; Grandview/Southview Medical Centers; Greene Memorial Hospital; Kettering/Sycamore Medical Centers; SOIN Medical Center*	*Miami Valley Hospital*
Admit/cohort 8 patients with airborne precautions 4 critical.	Admit/cohort 15 patients (airborne precautions) 8 critical.	Admit/cohort 30 patients requiring airborne precautions 15 critical.	Admit/cohort 60 patients with airborne precautions, 30 critical.

II. POLICIES AND AUTHORITY

A. Policies

Emergencies are handled at the lowest or most immediate level of response capability. In accordance with assignment of responsibilities, each support agency will contribute to overall response but retain full control over its own resources and personnel. Copies of this regional plan are made available to RMRS/MMRS agencies, and other agencies. The regional plan should be integrated into county emergency operations plans.

1. Regional response is implemented upon request for assistance through the local EMA or directly between Public Health agencies.

2. All primary and support agencies will operate under the Incident Command/Unified Command System (ICS/UCS).
3. The county-level Joint Information Center (JIC) is the primary source of relevant public information for all officials involved in the response operation. The county-level JIC will draft press releases with incident related information after receiving authorization from command. County-level JICs will coordinate their efforts across jurisdictions. During incidents that cross county boundaries, county JICs should interface and coordinate with other involved JICs in WCO and with the ODH or Ohio EOC JIC if activated. Public Health may utilize a virtual regional JIC.
4. The *Regional Epidemiological Plan* is the source for coordinating regional statistical reports. Consistent with this plan the Regional Epidemiological Task Force (RETF) will be the primary source of combined public health statistical information, display charts, geospatial and graphic representations.
5. All agencies participating in response activities will report relevant agency/incident specific information to their counterparts in the region, and to command.

B. Authority

Appendix A contains a listing of rules and regulations in Ohio Revised Code (ORC) Chapters 3701, 3707 and 3709 and Ohio Administrative Code (OAC) Chapter 3701-3 that provides authority to local health jurisdictions with respect to human infectious diseases and addresses the following issues:

1. Reporting of diseases, unusual clusters and suspicious events
2. Identification and monitoring of exposed persons
3. Mandatory medical examinations, collecting laboratory specimens and performing tests, and mandatory vaccination and drug treatments
4. Rationing of limited stockpiles
5. Quarantine/isolation of individuals
6. Tracking/follow-up of individuals
7. Right of access to suspicious premises
8. Emergency closure of facilities
9. Temporary use of hospitals
10. Procurement or confiscation of medicines and vaccines
11. Decontamination
12. Seizure and destruction of infected property
13. Logistical authority for patient management
14. Disposal of human remains

Tab C to Emergency Support Function #8 (Public Health and Medical Services Human Infectious Disease Incident Plan) of the State of Ohio Emergency Operations Plan (EOP) has further information. The WCO Regional Biological Response Plan is consistent with Tab C of the Ohio EOP (Available: http://ema.ohio.gov/Documents/Ohio_EOP/HUMAN%20INFECTIOUS%20DISEASE%20INCIDENT%20PLAN%20-%20TAB%20C%20to%20ESF-8.pdf).

III. SITUATION/COORDINATION/ASSUMPTIONS

A. Situation

1. WCO is vulnerable to bioterrorism, and to unintentional or naturally emerging human infectious and communicable diseases.
2. The emergence of "new" infectious diseases and the re-emergence of "older" infectious diseases can occur at any time in the West Central Region of Ohio.
3. Some human infectious diseases are transmissible from person-to-person (communicable) and require an immediate response to prevent the spread of the disease.
4. Local public health agencies coordinate with the state public health agency, the Ohio Department of Health (ODH) located in Columbus, Ohio. There are eight county level public health agencies in the West Central Region and two city health districts (Oakwood and Piqua). In addition, there are 123 PH agencies in Ohio (88 county and 35 city health districts).
5. Regional public safety personnel consist of law enforcement, fire and emergency medical services (EMS) (Table 3).

Table 3. Regional Public Safety Count

County	Fire/EMS *By Residence*	Law Enforcement *By Availability to respond in emergencies*
Champaign	231	89
Clark	681	422
Darke	528	114
Greene	688	379
Miami	594	172
Montgomery	1812	1,385
Preble	377	122
Shelby	394	135
Total in Region	**5,305**	**2,818**

6. The Region includes 13 adult acute care hospitals, one pediatric hospital, and two Federal hospitals-Department of Veteran's Administration (VA) and the 88th Medical Center at Wright Patterson Air Force Base (WPAFB).
7. RMRS, MMRS, Public Health, and hospitals coordinate public health planning, training and exercise activities with partner agencies in WCO.

B. Emergency Condition

1. A significant human infectious disease emergency is one that may rapidly exhaust local and/or regional resources or capabilities.
2. Medical care facilities may become overwhelmed with ill patients affected by the human infectious disease emergency, as well as individuals who worry about being affected ("the worried well"). Steps may need to be taken by EMS or at community health facilities (clinics, physician's offices) to triage patients, or by diversifying with reliever facilities such as hospital alternate care sites, or state assets such as the Disaster Medical Response Unit (DMRU). The DMRU was formerly called the Acute Care Center (ACC) .

3. Operable facilities may be inundated with "worried well".
4. Due to a massive increase in demand, medical supplies and pharmaceuticals may be in short supply for the immediate care or treatment of individuals.
5. Disruption in communications may result from an overload of calls from the public or other issues.
6. Disruption in transportation may adversely affect the supply of pharmaceutical and medical equipment.
7. Routine medical care and access to pharmaceuticals and supplies may be disrupted or in short supply thereby adversely affecting the health of residents in the region.
8. Environmental issues for restoring water, sanitation and solid waste management may increase in importance.
9. Multiple deaths or reports of illness may overwhelm the medical and mental health system.
10. Movement of seriously ill patients to locations where medical care is available is coordinated with GDAHA, local EMS and hospitals.

C. <u>Assumptions</u>

1. Public Health (PH) agencies are the public health authority at the county level. PH agencies conduct an assessment of current conditions to determine the size and scope of the incident within their jurisdiction. The Regional Public Health Coordinator is the Health Commissioners' special liaison, assisting with synthesizing information from the RETF, the PH JIC, and other PH teams to share with other Regional Public Health Coordinators and ODH throughout Ohio. Local Fire/EMS, law enforcement, medical, emergency management and other support organizations are responsible for local incident management activities.
2. WCO Public Health agencies have personnel, equipment, supplies and skill sets to maximize local and regional response to a biological event.
3. Public health emergencies require extensive coordination and cooperation among diverse governmental and private agencies in order to protect residents in the region.
4. A public health emergency can occur without warning or build gradually and extend over days, weeks, months or longer.
5. Public health emergencies can occur within an isolated geographical area or expand to the region, state, nation or internationally.
6. The ***Regional Biological Response Plan of West Central Ohio*** outlines regional activities intended to minimize the human health consequences of a public health emergency. The plan is written by the RMRS/MMRS Regional Biological Plan Subcommittee membership, and maintained by the Regional Public Health Coordinator and the RMRS/MMRS Executive Committee.
7. Public Health recognizes a sentinel event through PH surveillance systems or is made aware of a local human infectious disease emergency from PH disease reporting systems.
8. Public Health staff is adequately trained and will fulfill its responsibilities in an emergency.
9. Public Health communicates with the other PH agencies and responds to request(s) for assistance.
10. The Health Commissioner or designee of the affected community requests a declaration of an emergency and identifies the need for Incident Command.

11. The Health Commissioner or designee of the affected community conducts an assessment of the incident, requests additional resources and may request activation of the local EOC.
12. The Health Commissioner or designee makes notification to support agencies and partners as the situation warrants.
13. The Health Commissioner or designee will make preparations to brief, train and implement precautions to protect the workforce and responding agencies.
14. The infectious disease emergency event may overwhelm the ability of the local/regional health jurisdictions to mount an adequate response**.**
15. Although a primary human infectious disease event may not initiate a public health emergency, secondary events stemming from the initial event may do so. Infectious disease emergencies can also occur secondary to other disaster causes.
16. Assistance in maintaining the continuity of health and medical services will be required.
17. Mobilized regional capabilities will be urgently needed to assist local health jurisdictions to prevent and control disease and medical organizations will be needed to triage and treat cases in the emergency area.
18. A large-scale public health emergency may require school closures, the cancellation of public gatherings, altered work schedules, mass immunizations/prophylaxis and the imposition of limitations on movement.
19. Disruption of sanitation services and facilities, loss of power and massing of people in shelters increase the potential for disease.

IV. ROLES AND RESPONSIBILITIES

Public Health agencies are charged with protecting the public health and welfare of residents within their jurisdictions and have the authority to implement all measures necessary to prevent, suppress, and control the spread of infectious disease within the region. Each phase of preparedness activities is outlined below:

A. Mitigation

1. Defined as, "Any action taken to eliminate or reduce the degree of long-term risk to life or property from any type of hazard" or "Taking sustained actions to reduce or eliminate long term risk to people and property from hazards and their effects."
2. Public Health promotes general health and wellness activities to their populations, encourages and provides immunizations, tracks disease outbreaks, conducts community preparedness activities, and takes numerous other steps to limit the risk and consequences of infectious disease outbreaks.
3. Public Health conducts ongoing risk assessment, modeling, and monitoring.
4. Public Health is involved in recruitment, and planning efforts for utilization of volunteers, both pre-identified and spontaneous.

B. Public Health Preparedness

1. Establishes and updates Continuity of Operations Plans (COOP) to ensure employee safety and health, protect facilities and equipment and ensure to the extent possible that essential public health services are uninterrupted. While a traditional COOP plan presupposes the causal factor is facility loss (fire, tornado, flood etc), when a biological

event triggers a COOP plan execution, chances are very good that there facility still exists, but some or all the workers may not gather together at the facility due to risk of passing the infection.

2. Establishes and updates methods for PH to notify internal/external response partners, clinicians and emergency management via email, phone, FAX, Ohio Public Health Communications System (OPHCS), or other county level notification method. Because of the potential for the cellular voice system to be overwhelmed, it is recommended that all phone tree and other communications systems include use of both cellular voice messaging and cellular text messaging.
3. Provides and updates after-hours emergency contact information to response partners.
4. Staff completes ongoing training in public health core competencies for emergency preparedness.
5. Establishes and updates procedures for recall notification of staff.
6. Adopts NIMS resolution, ICS structure, ICS forms and position checklists. Staff are trained in ICS according to their roles in an emergency.
7. Develops, updates and integrates public health preparedness plans with county level emergency operations plans (EOP).
8. Participates in regional planning process and exercises.
9. Develops and updates plans and standard operating guidelines consistent with NIMS and the National Response Framework (NRF).
10. Develops and maintains a Health Alert Network (HAN) directory of local response partners.
11. Develops rapid assessment of disease outbreaks capability for faster response.
12. Assists in the development of local communications infrastructure.
13. Develops procedures for procuring emergency supplies and equipment through the EOC.

C. Public Health <u>Response</u>

Upon determination of a human infectious disease emergency, the PH will notify the regional Public Health Coordinator, regional PH agencies, ODH and local EMA. PH in coordination with local EMA may request the activation of the local EOC and may request a disaster declaration.

1. Public Health, as the primary agency(s), is the lead for human infectious disease emergency response at the county level.
2. Regional/State public health coordination activities include public health surveillance, epidemiologic investigation, laboratory, mass prophylaxis/vaccination, public health surge capacity, hospital surge capacity, public health information and education activities and guidance on infection control practices, including PPE and isolation and quarantine.
3. Public Health liaisons assigned in the local EOCs will coordinate with response personnel and work with other support organizations in the local EOC to respond to the needs of the affected communities. Specific agency coordinators must be notified in each county by the local EOC to ensure that outreach to specific types of groups including but not limited to those with poor health status, limited health resources (disabled, elderly, pregnant women, infants, children, acute medical conditions, individuals with chronic disease, under/uninsured, persons without health insurance), low literacy, home bound, cognitively impaired, reduced mobility, and those with health vulnerabilities due to the biological event; is addressed; through such efforts, This would include contacting mental health All Hazards Coordinators to activate Behavioral Health Response Plans. Public

health requests for resources will be coordinated through the EOC as appropriate. Requests will be made in writing, or verbally with a written signed request within 72 hours.

4. Public Health agencies will function under an ICS/UCS structure.
5. Public Health will complete the Incident Assessment Form to help determine the scope of emergency.
6. Public Health will respond to requests for public health assistance and information. PH provides recommendations to the public for protective actions they may need to take. Each PH appoints a lead Public Information Officer (PIO).
7. Public Health will determine appropriate internal ICS structure based on incident needs and assign responsibilities. ICS relationships are placed on an organizational chart.
8. Public Health assignment lists are created and updated as needed.
9. Public Health documents all response activities.
10. Public Health implements demobilization plans.
11. Public Health defines operational periods.
12. Public Health will provide ongoing situation updates and assessments.
13. Public Health will provide ongoing resource status updates and assessments.
14. Public Health establishes immediate incident objectives and coordinates efforts regionally:
    a. Requests a declaration of an emergency.
    b. Collaborates with EMA on opening of EOC.
    c. Imposes limitations on movement and social distancing as needed.
    d. Determines need for mass vaccination/prophylaxis/agent specific medications.
    e. Placarding of premises.
    f. Destruction of infected property.
    g. Conducts epidemiological monitoring, investigations and studies.
    h. Laboratory sampling and submission.
    i. Interviews cases and establish contact tracing.
    j. Defines population(s) at risk.
    k. Establishes communications with first responders, health care organizations and other appropriate agencies involved with response.
    l. Coordinates with law enforcement investigations during the conduct of interviews with cases; requests security support.
    m. Conducts surveys of emergency departments, clinics, and physician offices.
    n. Obtains hospital bed availability reports from GDAHA and advises hospitals to prepare for influx of ill patients. Bed reports (using SurgeNet) and patient tracking information (using OHTrac) will be available via the Internet at EOCs and Department Operation Centers (DOCs).
    o. Advises local officials on declaration of emergency.
    p. Creates a health and safety plan.
    q. Advises on appropriate PPE.
    r. Provides guidance for health care professionals and first responders on the nature of the disease, diagnosis, treatment, infection control measures, prophylaxis/immunization and associated contraindications.
    s. Polls veterinary clinics and obtains veterinary diagnoses.
    t. Requests additional resources including the assets of the Strategic National

Stockpile (SNS) through the EOC.

u. Determines priority guidelines for chemoprophylaxis/vaccination administration and ensures access to vaccine or pharmaceuticals for identified populations.
v. Determines need for and orders closure of facilities.
w. Prohibits mass gatherings.
x. Endorses respectful disposition of deceased/mass burial.
y. Provides public education or public information for release.
z. Addresses the needs of special populations.
aa. Submits samples to ODH for laboratory testing per Ohio guidelines for submission and for analysis and obtains results.

15. Public Health prioritizes health and safety needs of assigned staff and volunteers.
16. Public Health Emergency Preparedness Coordinators and Regional Public Health Coordinator facilitate regional execution of response plans.
17. Public Health will notify response staff and request mobilization of volunteers through the EOC if needed.
18. Public Health will activate DOCs as needed to meet public health incident objectives.
19. Aspects of emergency response activities to human infectious disease impacting multiple local health jurisdictions, including surveillance and epidemiologic investigation, will be facilitated through regional coordination across the affected area under existing regional agreements and plans in order to enhance jurisdictional cooperation with state and/or federal agencies with the purpose to maximize mitigation.
20. PH prepares staging areas for coordinated receipt of state and national assistance. Such assistance will complement, not supplant, existing capabilities.
21. PH issues public health advisories:
    a. Air
    b. Water quality/potable water
    c. Food and drug safety
    d. Sheltering in place
    e. Mass sheltering facilities
    f. Health Precautions
    g. Disinfection/decontamination
    h. Wastewater and solid waste disposal
    i. Vector control

D. <u>Recovery</u>

1. Continues response phase activities as required.
2. Requests EOC assistance from support agencies for environmental surety and reimbursement activities.
3. Conducts ongoing risk assessment, modeling, monitoring, safe re-entry criteria, extent and disposition of environmental contaminants, level of decontamination, cleanup standards and methods, final disposition of affected property and ongoing vector control.
4. Other issues that will be addressed include mental health concerns for patients, their contacts, the general public and response and recovery personnel; ongoing security; issues related to mass fatality (e.g., disposal of human remains); legal issues; and economic repercussions for the region.

5. Restores essential public health services to community standards and mandated levels. This may vary from the pre-incident level.
6. Documents continued expenditures.

V. CONCEPT OF OPERATIONS

A. General

All agencies involved in disaster response will operate under the ICS/UCS organizational structure for public health emergencies. Incident or unified command will be the decision making body during a public health emergency and central support for resource appropriation is made through the county EOC(s). Multi-agency coordination entities will consist of PH Health Commissioners or designees and other representatives and liaisons to facilitate coordination in the region. Health district DOCs will be physically separate from the EOC and IC/UC. All agencies will cooperate to minimize risk, disease, and death to the regional population. An initial and ongoing needs assessment will be made to determine the scope of the emergency and the need for additional resources. An initial incident action plan will be developed. All PH agencies in WCO have adopted similar organizational structures, position descriptions and standard operating guidelines. Health district staff are instructed where to assemble and staff recall notifications will be made at the local level. Emergency volunteers will be activated as needed at the local level. Recovery activities will seek to restore essential public health services to pre-incident functioning.

B. Command

Biological events encompass a wide range of incidents. In order to effectively manage personnel and resources and to provide for the safety and welfare of personnel, the PH agencies will operate within the Incident Command System. Ohio Revised Code 3707.04 affords broad statutory authority to the local board of health to protect the public during a health crisis or epidemic. The Health Commissioner or designee, acting on behalf of a Board of Health, has both the responsibility and the authority to provide direction and control for all operations in their jurisdiction. If an event continues to grow, a representative of the PH agencies will serve as the Incident Commander within the ICS or as part of UC.

In the event that a public health infectious disease emergency is recognized in the region, all health districts will be alerted through normal channels of communication (phone or OPHCS), and appropriate personnel advised including communicable disease staff, epidemiologists, health commissioners, nursing directors, environmental health directors, and/ the regional public health coordinator as appropriate. If the event is localized geographically and/or can be handled using primarily the resources of a single public health agency then the Health Commissioner or their designee will serve as the Incident Commander.

If the event is more widespread or complex, and may require the participation of other agencies such as Law Enforcement or EMS then a Unified Command will be established incorporating agencies with responsibility and authority for incident resolution.

For events that cover multiple (or all) counties within the WCO Region, each county will utilize the Incident Command System to manage response actions within that county. Public Health coordination will be achieved across the region by the PH Incident Commanders facilitated by the Regional Public Health Coordinator.

During a biological event, Incident/ Unified Command must ensure the following functions occur:

* Ensure a strong, direct and identifiable Command is established from the onset of the incident.
* Establish an appropriate incident command structure that matches the organizational needs of the event.
* Clearly define the activities and responsibilities of both the incident commander and the other individuals operating within the ICS/UCS.
* Set objectives. Ensure tactical direction to achieve incident goals.
* Provide a system to process information to support incident management, planning and decision making. Provide situation reports (SitReps) as frequently as needed to all involved and partner agencies.
* Conduct ongoing situation assessments and adjust objectives accordingly.
* Assign resources and personnel consistent with plans and standard operating guidelines.
* Ensure incidents are properly managed, providing for equitable treatment of the public across the region. In some circumstances PH agencies may wish to involve the local/regional ethics committee. The committee can be reached through GDAHA.
* Ensure incident management objectives are met and do not conflict.
* Initiate, maintain and control the communications process.
* Consider requesting the EOC to open.
* Provide for the continuity, transfer and termination of Command.

C. Notification and Communications

Communication Infrastructure is maintained and tested in the region. County level emergency operation plans outline communication support between local, regional, state and federal organizations. The local EMA is responsible for facilitating emergency communications. Incident commander(s) should identify and prioritize communication methods, frequency and establish message triage.

1. Health care providers, laboratories and other infectious disease reporters contact PH agencies by telephone 24/7/365 to report Class A (1) diseases. PH agencies report them to ODH immediately by telephone 24/7/365.
2. Upon the occurrence of a human infectious disease emergency, PH will notify local EMA and regional partner agencies through Health Alert Network (HAN) directories or regional contact information maintained and updated by the Regional Public Health Coordinator.
3. Procedures for contacting PH agencies after-hours have been distributed to the medical community, public safety/emergency responders, local governments and the media. PH agencies in the West Central Region of Ohio are available for response 24/7/365.

Redundant communication capabilities include:

1. Intra- and Inter-agency Communications:
    a. Landline telephones
        i. Emergency Department (ED) Red Phones
    b. VOIP (Voice over Internet Protocol)
    c. Email
    d. FAX
    e. Cell phones
    f. Cellular text messaging (texting systems may be functional when cellular voice is unavailable, and vice versa)
    g. Multi-Agency Radio Communication System (MARCS)
    h. Two-way radios
    i. Automated warning and notification systems
2. Internet based
    a. Ohio Public Health Communication System (OPHCS) /Web Portal
    b. HAN (Health Alert Network)
    c. Virtual conference calls
    d. OHTrac (state-wide patient tracking)
    e. GDAHA Rerouting and bed-tracking sites (SurgeNet)
3. Community Communications
    a. Radio
    b. Newspapers
    c. Websites
    d. Warning and notification systems
    e. Local television stations
    f. Social media such as Facebook, Twitter, Nixle, Instagram, etc.
4. Alternate Communications
    a. Satellite telephone
    b. Courier
    c. Amateur Radio Operators

D. Inter-jurisdictional Relationships

1. Federal
    a. The Federal government has General Public Health Emergency Powers. The Secretary of the Department of Health and Human Services (DHHS) may declare a public health emergency to respond, conduct and support investigations into the cause, treatment or prevention of a disease or disorder. 42 U.S.C. §247d (a).
    b. A declaration of a public health emergency requires consultation with Ohio public health officials and determination of whether 1) a disease or disorder presents a public health emergency or 2) a public health emergency exists including significant outbreaks of infectious disease or bioterrorist attacks 42 U.S.C.§247d(a).
    c. Identification of resident Federal assets that could augment local assets include the Federal Bureau of Investigation (FBI, the lead agency if terrorism is suspected), U.S. Marshall's Office, U.S. Secret Service, Department of Justice, Department of Defense, Disaster Mortuary Assistance Team (DMORT) Region V, Disaster

Medical Assistance Team (DMAT), Department of Health and Human Services. Wright Patterson Air Force Base, United States Air Force, and the Department of Veterans Affairs.

2. State

An intra-state Mutual Aid Compact for emergency preparedness, and disaster response and recovery has been established pursuant to ORC Section 5502.41. This program provides for mutual assistance and cooperation among participating political subdivisions in response to and recovery from any disaster that results in a formal declaration of emergency by a participating political subdivision.

a. State agencies will coordinate with local agencies to ensure emergency needs are identified, assessed, prioritized and addressed.
b. State agencies will coordinate with federal agency peer organizations and counterpart adjacent state agencies during the emergency.
c. Identification of State assets that could augment local assets include American Red Cross Volunteer Services, Ohio Emergency Management Agency, Attorney General's Office, Ohio Department of Administrative Services, Ohio Department of Agriculture, Ohio Department of Transportation, Ohio Department of Natural Resources, Ohio Department of Mental Health, Ohio National Guard, Ohio Environmental Protection Agency, ODH, ODH DMRU, Ohio Department of Public Safety, Ohio State Highway Patrol, Ohio Medical Reserve Corps, Ohio Community Services Council, Ohio EMS, Ohio Department of Transportation, Ohio Bureau of Workers' Compensation (Division of Safety and Hygiene), Ohio State Board of Pharmacy, and Ohio Mortuary Operational Response Team.
d. In addition, ORC Section 5502.41 authorizes any participating political subdivision that is impacted by an incident, disaster, exercise, training activity, planned event, or emergency which requires additional resources to request mutual assistance or aid from any other participating political subdivision, making such requests through the emergency management agency of the political subdivision or an official designated by the chief executive of the participating political subdivision.

3. Local

The eight county level public health agencies have entered into a Mutual Aid Agreement to provide reciprocal mutual aid during a public health emergency. Recognition of a public health emergency in any county by the public health authority will invoke the provisions of the State's Intrastate Mutual Aid Compact. The health district relationships will ensure prompt and effective utilization of the combined resources of the health districts during emergencies. A similar agreement (MOU) exists between the PH agencies in the West Central and Southwest regions (Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, and Warren Counties). Memoranda of Understanding also exist between the West Central health districts for coordination of volunteer services and epidemiology.

a. Local requests for state resources and services are communicated through the local EOC to the State EOC using EOC request forms.

b. Identification of regional assets that can augment local response include: local public health emergency response teams, county Medical Reserve Corps (MRC), Dayton MMRS/RMRS, and CERT.
c. There are also mutual aid agreements (both regionally and statewide) for fire, EMS, law enforcement, and hospitals.

4. Refer to county and state level emergency response plans to see counterparts at state, federal and local levels with emergency management responsibilities for human infectious disease response and recovery. During emergencies these organizations may work together as teams in order to act as expeditiously as possible to identify, control and prevent the spread of the disease. County level public health emergency response plans contain a comparison chart of Federal, State and Local agencies to ensure that these organizations have the proper interface when activated during an emergency.

E. Limitations on Movement

Imposing limitations on movement (LOM) may be used as a disease control measure. The least restrictive method will be utilized to control the spread of disease and coordinated with regional, state and national authorities to contain and prevent the spread of disease. ORC 3707.04 through 3707.34 provide broad powers to local Boards of Health to preserve public health and prevent the spread of disease. These powers include authority to enforce the provisions of the Revised Code regarding quarantine and isolation. Isolation is utilized for ill individuals. Quarantine is used to contain well, but exposed, or suspected to have been exposed persons. The ODH issued and incorporated the Limitation on Movement and Infection Control Practices in July, 2011 available: http://www.odh.ohio.gov/PDF/IDCM/sect5.pdf.

PH agencies would collaborate when implementing and lifting LOM. PH is responsible for communicating to the EOC, ODH and local law enforcement when LOM is being implemented, its ongoing use and termination. PH agencies would be responsible for the needs of the individuals with LOM restrictions including but not limited to medical care, food, clothing, shelter and means to communicate if LOM is mandated. In most instances public health entities in the region will invoke only voluntary measures. LOM does not include the use of lethal force by Law Enforcement agencies.

1. Isolated individuals must be confined separately from quarantined individuals.
2. Quarantined individuals may pose no public health threat until their individual signs, symptoms or other conditions warrant them a threat to public health.
3. The health status of isolated and quarantined individuals must be monitored regularly.
4. Quarantined individuals who subsequently become ill or infected must be promptly moved to isolation.
5. Isolated and quarantined individuals must be immediately released when they pose no substantial risk of transmitting a contagion to others.
6. Premises used for isolation and quarantine shall be maintained in a safe and hygienic manner.

There are two instances that can affect a funeral under LOM. The first being a communicable disease that still causes illness even after death, for example Ebola. The next instance would be

something comparable to a severe pandemic; an example is the 1918 Pandemic Influenza. Specifics on if LOM would be enacted would be based on the disease and scope of the incident.

F. Mass Prophylaxis/Vaccination

1. Regional public safety pharmaceutical resource cache inventory is maintained by the MMRS. The Dayton MMRS Cache now includes antibiotic prophylaxis capability for the first three days for all fire, EMS, law enforcement, EMA, public safety dispatch, coroner and public health personnel and their families in Ohio Homeland Security Region 3.
2. A county-level SNS and Mass Prophylaxis plan has been developed in coordination with other county level plans through the public health emergency preparedness coordinator's meetings. Health districts in the region will request the SNS through the respective EOCs when local caches are inadequate to manage the human health consequences associated with a public health emergency. SNS requests are submitted in writing to the local EOC using the ODH SNS Supply requisition form. SNS assets include antibiotics, antivirals, vaccines, antidotes, medical supplies, and medical equipment to counter the effects of biological pathogens and nerve agents as well as materials for managing traumatic and other incidents.
3. Point of Dispensing (POD) facilities have been established across the region and entered into the SNS-GIS system. MOUs exist between PH agencies and POD facilities. PODs will be designated for prevention measures (individuals who are well, non-exposed, or otherwise asymptomatic), whereas hospitals/alternative care centers will provide treatment and supportive care for infected, exposed, and symptomatic individuals, except in rare circumstances.
4. Regional cooperation for opening and operating the POD sites include: a) Public Health will coordinate opening hours of operation, b) Public Health will coordinate standard hours of operation, c) PH situational status update reports on vaccine/drug supply and personnel, d) Sharing of throughput data, e) POD facilities and SNS assets are open and available to all individuals regardless of location of residency.
5. During an outbreak of an infectious, communicable disease, initial post infection control measures implemented by PH agencies will likely prioritize vaccination/prophylaxis for the following groups, or follow recommended State or Federal guidelines:
    a. Individuals directly exposed to the agent,
    b. Individuals with face-to-face or household contact with an infected person,
    c. Personnel directly involved in the evaluation, care and transport of infected persons,
    d. Laboratory personnel involved with specimen collection and testing,
    e. Others likely to have contact with infectious persons/material.
6. The above groups may include healthcare workers at clinics, surge capacity facilities, and hospitals that may receive ill patients, mortuary staff who may handle bodies, and all other essential emergency response personnel (e.g., law enforcement, firefighters, EMS, public health staff, emergency management staff, coroner, and the regional crime lab personnel, and public safety dispatchers). Vaccination/prophylaxis of immediate family members of response groups is dependent upon vaccine/drug supply.
7. In extremely large events, particularly pandemics involving highly lethal pathogens, prioritization for other critical infrastructure personnel may be necessary. Plans regarding

"Critical Infrastructure and Key Resources" (CIKR) may be found on the CDC, HHS, and Department of Homeland Security websites.

G. Crisis Communication

To ensure the public trust and proper response to potential emergency instructions, it is imperative for the dissemination of information to be accurate and timely. The regional virtual JIC may be utilized to that end.

1. PH agencies have pre-identified public information officers with appropriate training. Crisis communication plans exist in each health district that follow risk communication principles and ensure timely delivery of emergency information. Health district PIOs work with other PIOs in the region, and may select a lead PIO.
2. Emergency public information will include the status of the situation, actions the public should take, and a series of talking points targeted to the community, health care professionals, and special populations. Consistent up-to-date messaging is coordinated regionally.
3. The JIC may be led by the county PIO, PH PIOs, or PIOs from ODH. The JIC will be supported by PIOs from all other organizations having responsibilities to address the human infectious disease emergency. The JIC will ensure that maps, guidance, alerts and warnings concerning the human infectious disease emergency in the region will be widely distributed and available to the public. Duties of the PIO/JIC include:
    - Designate areas where the media may have access and where access is restricted.
    - Determine a media observation perimeter, if appropriate for gathering photos/videos.
    - Ensure all relevant media have the correct phone number of the JIC.
    - Provide media hotline, if necessary.
    - Ensure a public hotline is activated, if appropriate.
    - Ensure messages for the hotline originate with, and are approved by the JIC.
    - Prepare and disseminate emergency public information to all media sources.
    - Maintain records and documentation to support history of the incident.
    - Exchange key information with command staff on a timely basis.
    - Hold briefings/news conferences.
    - Use available media to educate the public as to the extent of the threat including social media.
    - Establish time schedule for briefings to update the media.
    - Establish and enforce media guidelines.
    - Use available media to disseminate critical information to the public:
        a. POD locations and operational hours;
        b. Casualty collection points;
        c. Medical facilities including alternate care sites and other non-hospital facilities to which victims can report for evaluation and treatment;
        d. Immediate protective, first aid, and self-decontamination measures;
        e. Evacuation instructions;
        f. Shelter in place instructions and;
        g. Phone numbers to call for further information.
4. Most PH agencies have the capability of operating toll-free information lines to respond to questions about disease entities from the general public and medical community. Some

health district staff have completed training in Joint Information Center (JIC) operations and are prepared to operate in a media command center.

H. Workforce Development

The regional RMRS/MMRS/PH/Hospital coordinators work to ensure public health, hospital, and support agency readiness through education and training. The regional coordinators ensure that participating response partners provide for on-site training sessions and guidance on the use of support documents such as NIMS, the National Response Framework (NRF), as well as the National Preparedness System, the National Preparedness Cycle, Core Competencies, the Universal Task List, and the State of Ohio NIMS Implementation Guidance.

Public health core competencies include the ODH *Strategic Plan for Public Health Preparedness Education and Training* and the Public Health Foundation's *Public Health Preparedness and Response Core Competencies.* **Orientation programs for new health district supervisors must include regional plans, including this *Regional Biological Response Plan*, *the Region 3 Plan for Response to a Radiological Emergency with Health Consequences*, and others.** Emergency Response training at the PH level is the responsibility of the Health Commissioners or their designee. Participation in all county and regional exercises, drills and training ensures seamless response across the jurisdictions and disciplines. Disciplines include law enforcement, fire, EMS, HAZ-MAT, public health, hospitals, veterinarians, the military, and other non-governmental organizations. Each PH Emergency Preparedness Coordinator is responsible for developing necessary After Action Reports (AARs). AARs are reviewed by RMRS/MMRS partners and disseminated to relevant local, state, and national agencies.

Through the Homeland Security Exercise and Evaluation Program (HSEEP), the WCO region uses exercises to examine current and required core capability levels and identify gaps. Therse exercise are consistent with the National Preparedness Goals which identifies a series of 31 core capabilities and associated capability targets across the prevention, protection, mitigation, response, and recovery mission areas. Exercises focus on assessing performance against capability-based objectives.

The Regional RMRS/MMRS/PH/Hospital Coordinators will assist RMRS/MMRS partners in meeting appropriate regional training deliverables. JITT may be a crucial component.

I. Medical Supplies/Equipment

The organizations that have responsibilities for health and medical equipment and supplies are local emergency management, health districts, hospitals, EMS, MMRS, and the American Red Cross (ARC). They are tasked to coordinate health and medical equipment and supplies, including antibiotics and antidotes, biological products, blood and blood products, and for restocking medical care facilities in the area affected by the human infectious disease emergency. A push concept is used when feasible to expedite medical re-supply to the region from pre-identified medical supply caches.

J. Health Care Personnel Augmentation

The organizations that have responsibilities for health care personnel are PH; hospitals; EMS agencies; registered Citizen Corps Councils (CCC) including Greene, Montgomery, Clark,

Miami, Preble, Darke, and Shelby; and Medical Reserve Corps Units. A biological incident will require personnel augmentation of public health agencies, hospitals, public safety and other health provider organizations and possibly surge facilities depending upon the severity of the event. Personnel augmentation will rely on current agency or organization plans. Such plans may call for existing staff to work extended hours or for recruitment of volunteers, as well as the utilization of mutual aid agreements, the Red Cross MATeam, MRC personnel, etc. PH agencies will coordinate with the EMA and appropriate agencies through the EOC to request support from various teams. Support may come from local, regional, state, or federal sources.

1. All health district staff have a visible PH issued identification badge that is shared with local law enforcement at the time of an incident.
2. All health district staff vehicles used during the emergency have PH placards on the dashboard or other visible location.
3. Special subject matter experts may be assembled to review health/medical information and provide advice on specific strategies.
4. Pre-identified emergency volunteers include the following:
    b) Pharmacists,
    c) Medical Reserve Corps,
    d) Park Rangers,
    e) Academic Nursing Coalition for Disaster Preparedness (ANCDP),
    f) Citizens Corps,
    g) ODH Disaster Medical Response Unit (DMRU),
    h) PH Emergency Response Personnel,
    i) Community Emergency Response Teams (CERT),
    j) Volunteer Organizations Active in Disasters (VOAD).
5. Minimum qualifications/certifications are required for assignments in the following areas:
    a) Environmental air and water quality, vector control, food safety, solid waste
    b) Medical Referral
    c) Medical Care
    d) Medical Transport
    e) Epidemiology and Disease Investigation
    f) Public Information
6. Credentialing
    a) All employees and volunteers will have credentials appropriate to their qualifications.
    b) Prior to issuance of identification credentials, appropriate licenses or certifications will be verified via the Ohio e-License center available: https://license.ohio.gov/lookup/default.asp or presented and approved by the issuing authority to assure that personnel meet minimum qualifications for operational assignments.
    c) Verification may be accomplished at a Volunteer Reception Center or smaller facility depending upon the magnitude of volunteer response needed to support the incident.

K. Patient Evacuation/Forward Movement

A large biological event can overwhelm a community's medical and public health resources. In most situations, disaster planning involves bringing additional resources into the area to mitigate the impacts of the incident. In public health emergencies, that may not be feasible.

Triage may need to occur at the hospital, to ensure that healthcare resources are employed as effectively as possible. Healthcare personnel must provide for the best use of resources for the patients who have the greatest potential to benefit from those resources. Criteria must be developed at the time of the incident to deal with non-distressed, vs. mild, moderate, and severe patients.

Alternative medical treatment sites may need to be established rapidly, and employed to reduce the potential for extreme hospital and emergency department overcrowding. Such alternative treatment sites may include urgent care centers, or units of the ODH DMRU. The State of Ohio has an Ohio Medical Care Coordination Plan under development which would include provisions for crisis standards of care for pre-hospital and in-hospital providers.

EMS (EMS) may need to employ atypical triage protocols during public health emergencies. Greater Miami Valley EMS Council Standing Orders include provisions for "Just in Time (JIT) Standing Orders" to cover such eventualities. Those could include EMS removals to alternative medical treatment sites (as discussed above) as well as to physician offices or urgent care centers. Non-transport of selected patients involved in the public health emergency may also need to be considered, and might require authorization from Medical Control Physicians or the chiefs and EMS medical director of various agencies. In some instances, EMS may assign a Forward Movement Manager to work under the Transport Supervisor and implement forward movement from the scene to hospitals more distant than the facilities generally used by EMS.

Non-standard transport procedures might also be needed, including the potential of utilizing mass transit vehicles (e.g., buses) to move patients from multiple sites. In events where the potential for external contamination exists, it is the responsibility of EMS to decontaminate those victims. Only decontaminated patients will be delivered to alternative treatment sites, EDs, or casualty collection points.

Once the area's healthcare resources have been exhausted, the potential for "Forward Movement of Patients" would need to be explored. Local EOCs will coordinate resources for the movement of seriously ill patients from the area affected by a human infectious disease emergency to locations where definitive medical care is available.

There are numerous transportation assets that would be potentially useful in a Forward Movement scenario. Those assets differ depending on the location and scenario, and are not under the control of any one agency. The EOC will coordinate allocation of these assets.

Transportation assets could include any or all of the following:

- Basic Life Support Ambulances and Advanced Life Support Medic Units operated by area Fire Departments and EMS who would respond under our existing Mutual Aid

agreement. Law enforcement agencies also are able to respond under existing Mutual Aid agreement.

- Basic and Advanced Life Support Ambulances operated by hospitals and private ambulance companies.
- EMS helicopters from the entire tri-state area.
- Military support, including patient transport buses from Wright Patterson Air Force Base Medical Center and military aircraft.
- Public transit buses operated by the Miami Valley Regional Transit Authority and other area transit providers (e.g. Greene CATS).
- Additional Basic and Advanced Life Support Ambulances, as well as fire apparatus with trained EMS personnel, can respond from more distant areas of the state under the Ohio Fire Emergency Response Plan (ERP).
- Additional law enforcement resources can respond from more distant areas of the state under the Law Enforcement Response Plan (LERP).
- Large trucks with tie-downs for makeshift liters.
- When local EMAs have contacted Ohio EMA and in-state resources are exhausted or projected to be exhausted, OEMA could consider requesting out of state fire, EMS, law enforcement, and other resources through the Emergency Assistance Compact (EMAC).
- Commercial aircraft (may be used for ambulatory patients, or it is possible to reconfigure for transport of litter patients in as little as two hours).
- AMTRAK rail cars, particularly "sleeper" cars (although no passenger trains that currently route through Dayton, there have been in the past, and there is a site where loading can take place).
- Private transportation assets as available.

As the decision is made to request National Disaster Medical System (NDMS) assistance to move patients out to other metropolitan areas, a notification will be made to the community's international airport, Dayton International Airport. The Airport Fire Department will arrange patient staging areas and delivery/exit routes for local ambulances. Aircraft landing areas are pre-designated and well secured. Alternative airfields are listed in the table below.

The following airports are close to the Dayton Metropolitan area. They could potentially be used as landing sites for military or commercial patient transport aircraft. The airports are listed in order of most likely use. There are also smaller airports in Miami Township (Montgomery County, Moraine, Piqua, Sidney, Urbana and New Carlisle that could be used for small aircraft and rotary craft.

Airport	Maximum Runway Length (feet)
Dayton International (DAY)	10,910
Greene County Airport	4,500
Wright-Patterson AFB (FFO)	12,600
Wilmington (Airborne Express) (ILN)	10,710
Middletown (MWO)	6,100
Springfield	9,009
So. Dayton / Wright Bros. (MGY)	4,980
Lunken Airport (LUK)	6,101

Butler County Regional Airport Hogan Field (HAO)	5,500 (Plus 750' Overrun West End)
Cincinnati-Northern Kentucky Int'l (CVG)..	12,000

The following are the most commonly used aero-medical evacuation aircraft currently employed by the U.S. Air Force. Patient capacity and minimum runway requirements are shown to aid in determining number of aircraft that may be needed and which airports in the Dayton area could be used as landing fields.

Aircaft	**Patient Capacity**	**Minimum Runway for Landing**
C-135	Litter Patients on cargo floor	8,000 feet
C-17	36-48 Litter Patients, or 54 Ambulatory Patients + 36- 48 Litter Patients	3000 Feet (only on military airvields) (Some Sources Recommend 7000 Feet)
C-130	74 Litter Patients (97 Litters in the C-130J-30)	7,000 feet
B-767 (Civilian)	87 Litter + 33-48 Ambulatory	6000 Feet

Rather than setting a number that would activate a Forward Movement plan, this plan allows the decision-makers in the EOC to determine that need based on multiple factors. Considerations will include all of the following:

- Number of victims.
- Extent and need for decontamination.
- Number of available hospital beds.
- Acuity of the patients.
- Ages of the patients.
- How rapidly the disaster develops.
- How rapidly area forces are able to "gear up".
- How rapidly patients present to area hospitals.
- The availability or unavailability of medical and hospital staff.
- The extent of the danger area.
- Whether the danger area involves area hospitals.
- Need for quarantine of the victims/patients.
- Need for area-wide quarantine.
- How widespread the scenario is; degree of involvement in other geographic areas

Any vehicle used for Forward Movement will be appropriately staffed with EMS personnel, nurses, or physicians. The staffing and equipment sent on Forward Movement vehicles will be dictated by patient conditions.

L. In-Hospital Care

Hospitals provide medical care to victims who become seriously ill as a result of the emergency.

GDAHA member hospitals operate under HICS and have established disaster plans. Elective surgeries may be cancelled and emergency dismissal plans would be implemented. Closed wings may be reopened for additional space, providing staff is available to care for victims. Moderately ill patients may be removed to alternate care facilities if they are available. In addition, transported patients may be diverted to alternate triage and treatment facilities to ease the burden on emergency departments. Additional surge facilities may be requested by the local EOC to the state EOC.

Each hospital has a system of triage and tracking of patients that come to the facilities. Line lists of cases and contacts of cases are maintained by PH agencies. Further, the statewide Mass Casualty Incident (MCI) patient tracking system (OHTrac) has the potential to be used by all hospitals, coroner's offices, EMAs, PH agencies, EMS, the ARC, and others.

Activation of the NDMS forward movement of patients will allow increased numbers of patients to be treated. Patients may be managed in-hospital or at a unit of the DMRU.

M. Vector Control and Environmental Surety

Local public health agencies, municipal governments, Ohio Department of Health, Ohio Department of Natural Resources, Ohio Department of Agriculture, and specific federal agencies may have varying jurisdiction for oversight and coordination of vector control. Coordination of vector control activities will include assessing the threat of vector-borne diseases related to the human infectious disease emergency through surveillance; providing technical assistance and consultation on prevention activities regarding those diseases; providing technical assistance for sampling and testing, and consultation on the medical treatment of victims of vector-borne diseases. In this region, environmental surety is provided by four primary agencies: the Ohio Environmental Protection Agency (OEPA), regional HAZ-MAT, PH, and RAPCA. Federal EPA also has assets which can be brought to the region on request.

N. Epidemiology and Surveillance

Identification of any biological incident will require the combined efforts of the regional health districts, and cooperation with local hospitals, laboratories and other health care networks. Epidemiology response team members have developed the *Regional Public Health Epidemiology Response Plan,* and disease protocols, and have received training on how to respond to and limit the impact of the event. This includes case identification; surveillance, isolation, monitoring and confinement procedures of cases and contacts; treatment and prophylaxis with pharmaceuticals and vaccines; and case, contact and public education.

Depending upon the extent of any event, additional epidemiological support is expected from other local health departments, the ODH, and the Centers for Disease Control and Prevention. Local medical facilities and universities may also provide additional sources for epidemiological support.

O. Mental Health Care

It is crucial that responders be aware of the psychological and emotional issues surrounding many incidents, as well as the physical issues. For Mental Health issues during large scale incidents affecting multiple organizations or jurisdictions (e.g., natural disasters, terrorism, or epidemics) or emotionally significant events (e.g., suicide at a school or business, accidents or the death of a child that impacts a community), or at the discretion of an on scene Incident

Commander, contact your county Emergency Management Agency to request Mental Health Services.

P. Law Enforcement Support

Public health emergencies pose special challenges for law enforcement, whether the threat is manmade (e.g., the anthrax terrorist attacks) or naturally occurring (e.g., flu pandemics). During a public health emergency, law enforcement will need to quickly coordinate its response with public health and medical officials—people with whom they seldom work. PH agencies will initially request the support of local law enforcement agencies in case of an incident.

Law enforcement's role may include the following:

1. Enforcing public health orders (e.g., quarantines, travel restrictions, suspension of public gatherings);
2. Securing the perimeter of contaminated areas;
3. Securing health care facilities, such as clinics and hospitals;
4. Controlling crowds;
5. Investigating scenes of suspected biological terrorism;
6. Protecting or transporting national stockpiles of vaccines or other medicines, as well as transporting local and regional resources;
7. Providing security at Points of Dispensing (PODs).

Policing styles, strategies, and priorities will vary depending on the type of situation and level of the threat, as will the potential risk to the responding officers. Law enforcement personnel will not be asked to perform duties beyond their scope or authority.

Biological events that reach a regional scale will be accompanied by an appropriate "Declaration of Emergency" from each affected jurisdiction, county Emergency Management Authority (EMA), the State of Ohio, or appropriate federal authorities.

Law enforcement relies on mutual aid to augment their numbers in response to an incident. The more widespread the incident, the less mutual aid will be available. There are few "force multipliers" for law enforcement assets; therefore they will be used judiciously throughout the region. It is assumed that:

- All law enforcement resources will operate under Unified Command;
- Force multipliers may need to come from outside the region from law enforcement agencies not specifically tasked with local law enforcement, such as the Ohio Highway Patrol, the National Guard, and federal agencies;
- County or state law enforcement personnel may support or assist the local law enforcement organizations within the scope of their jurisdiction and authority;
- Regional law enforcement assets will be requested from county-level EMA to the region under mutual aid compacts.

Coordination of all requests shall be handled by the local EMA. If the region has exhausted all law enforcement resources, and mutual aid law enforcement is not available, then the county EOC will make a request to Ohio EMA for additional law enforcement support. The request

must have an appropriate emergency declaration. Another option is for the local sheriff or police chief to request law enforcement resources through LERP.

Law enforcement resources *may* be balanced across the region by consultation and consensus through the County Unified Commands. If resources have been requested from throughout the state and additional law enforcement assets are still required, each county can petition the State of Ohio for State Highway Patrol assets or the National Guard.

All counties in WCO region are covered by the OSP Piqua – District 5 except Greene County which is served by OSP Wilmington – District 8. Only the Governor of Ohio can activate the Ohio National Guard. Federal assets to augment local law enforcement include the Federal Bureau of Investigation, Immigrations and Customs (ICE), the United States Marshal's Office, and the United States Secret Service. Use of federal assets (among others) is coordinated through Ohio EMA.

Q. Legal Support

The Prosecuting Attorney of each county provides legal advice to local agencies and departments concerning human infectious disease issues, including limitation on movement (e.g., quarantine orders), indemnification, and human resource issues, as needed. Agencies that do not have a Prosecuting Attorney as their legal advisor should consult their designated legal advisor with regard to these issues.

R. Veterinary Support

Additional support from the Ohio Department of Natural Resources may be utilized for coordinating activities that affect the health of wild animal populations. Local level support may come from dog wardens, local veterinarians, animal control, humane societies or animal shelters. Activities may include:

1. Coordinate with PH if a zoonotic condition exists.
2. Provide surveillance information for disease in animals.
3. Coordinate with PH on food safety issues.
4. Provide relevant information and support rumor control efforts by providing relevant information to the JIC.
5. Provide epidemiological support to PH as requested during an emergency.
6. Provide personnel to assist in response and recovery operations as needed.
7. Provide recommendations to PH concerning potential effects on animal health.
8. Provide recommendations to PH concerning potential effects on food safety.
9. Coordinate animal disposal activities as needed.
10. Coordinate food disposal activities as needed.

S. Emergency Management Support

Local Emergency Management Agencies (EMAs) support PH agencies by providing regional coordination during infectious planning, response, and recovery efforts. Each EMA incorporates regional biological response plans into their County Emergency Operations Plan (EOP). Based on these planning efforts, exercises are developed to test the response and refine the plan.

Each EOC will make available the means for local leadership to:

1. Conference.
2. Determine the best means of communication (e.g., telephone, VOIP, radio).
3. Set objectives.
4. Determine scope of an incident.
5. Provide follow-up for future conferencing.
6. Manage resource procurement and allocation.

Response and recovery coordination is achieved by communications among EOCs. The EMAs within the region may designate an EOC as the regional hub. This designation would allow for the routing of essential communications to all Counties in the region.

Currently there is no established authority to designate one EOC as a regional hub. To implement this part of the plan, authority must be established and protocols must be developed for implementation. Despite any such regional designation, each County's EOC will communicate directly with the State EOC in Columbus. Each County EOC will call the State EOC for additional resources as needed.

Each EOC will also facilitate the dissemination of public information. All information given to the public should be coordinated throughout the region through the Joint Information Centers. The individual County EMAs will implement the local EOP through the County EOC. Situation Reports and After Action Reports are written by County EOC staff in collaboration with partner agencies. The Situation Reports are sent to elected officials in the County, the State EOC and other agencies as appropriate as a means of keeping all appropriate parties apprised of the status within the County. The After Actions Reports are prepared to capture lessons learned during the response and recovery phase. These lessons are then incorporated into future planning, training, and exercise activities.

T. Examination, Care and Disposition of Human Remains

The Coroner, in accordance with ORC 313.12 has the responsibility to investigate the cause of death resulting from violent, suspicious and unusual or sudden death, accidents or in other situations where someone in good health dies. The Coroner has ultimate authority of all remains in most mass fatality situations. However, this may not be the case in some biological incidents (e.g., pandemic influenza), since such deaths are categorized as natural deaths. EOCs coordinate fatality management in the local jurisdictions including communications with coroners and funeral home directors.

Should the event result in more than 50 estimated or actual fatalities in the region, the EOCs should refer to the appropriate mass fatality plan for the local jurisdiction. Montgomery County Coroner's Office (MCCO) has developed an extensive mass fatality plan, which is available for use by other counties as a template. MCCO also has numerous assets such as mass fatality trailers, which are available to assist throughout the region.

Should augmentation of available resources be necessary, storage facilities may be needed in temporary storage/refrigeration units. Additional assistance may be requested from the state

Dental Association Mass Disaster ID team, or OMORT. These teams are activated by the Coroner or highest ranking official with jurisdiction over the incident through the EMA.

County Coroners request augmentation through their offices or other channels as appropriate for assistance. The OMORT will establish additional temporary morgue facilities. Remains can be recovered and evacuated to the temporary morgues for identification purposes and safeguarding of personal effects.

Infection control precautions are required for all personnel who handle remains of infected persons. Body substance isolation precautions will be followed when performing post-mortem care on deceased individuals and a biohazard label will be affixed to potentially affected remains.

The release of remains to family members for final disposition in accordance with religious preferences and customs is extremely important for the psychological and emotional recovery of the community. Local clergy and other religious groups will coordinate support services for family members of the deceased. Due to the persistence of some infectious agents such as anthrax or plague or special hazards associated with embalming, special emphasis on cremation may be desirable.

The Coroner and Health Commissioner will jointly discuss the need for any mass burial. Personnel issues to transport and handle bodies will be a daunting task and will require significant resources to manage the situation.

1. Coroners may coordinate local resources for collection, identification and disposition of deceased persons and human tissue.
2. Coroners may assist in selecting sites for temporary morgue facilities.
3. Coroners may coordinate services of funeral directors, EMS, pathologists, Family Assistance Centers, dentists and x-ray technicians.
4. Family Assistance Centers, operated by the ARC will care for next of kin and survivors of deceased when public gatherings are permitted.

Definitions

Biological- relating to life and living organisms**,** microorganisms
Bioterrorism-Intentional release of a biological agent
Communicable Disease-A disease that can be transmitted directly or indirectly person to person
Confinement-To restrain in a place
Contagious-Communicable pathogen that is transmitted readily from person to person
Cordon Sanitaire- Literally a "sanitary cord" or line around a quarantined area guarded to prevent the spread of disease by restricting passage into and out of an area.
Decontaminate-Rendering an object, person, or area free of a contaminating substance such as bacteria, chemicals, poison gas, or a radioactive substance
Environmental surety-Actions taken prior to, during and after an incident to ensure that resulting conditions placed upon the environment do not pose a health threat to the public, the environment or agriculture
Epidemiology-Science concerned with defining and explaining the relationships of factors that determine disease frequency and distribution
Epidemiological investigation-An endeavor or study into the relationships of factors that determine disease frequency and distribution
Infectious Disease-Any disease caused by growth of pathogenic organisms in the body which may or may not be contagious
Isolation-The physical separation and confinement of an individual or groups of individuals who are reasonably believed to be infected with a contagious or possibly contagious disease from non-isolated individuals, to prevent or limit the transmission of the disease to non-isolated individuals
LOM-Limitation on movement pertains to a public health response to an outbreak of a communicable disease where a form of quarantine, isolation, and/or cordon sanitaire is implemented. The implementation can be through voluntary or mandatory means
Pharmaceuticals-Medications available for dispensing
Prophylaxis-Observance of rules necessary to prevent and/or control the spread of disease
Quarantine-The physical separation and confinement of an individual or groups of individuals, who are or may have been exposed to a contagious or possibly contagious disease and who are asymptomatic from non-quarantined individuals, to prevent or limit the transmission of the disease to non-quarantined individuals
Surge Capacity- The increased need of personnel (clinical and non-clinical), support functions (radiological and laboratory), physical space (beds, alternate care facilities), and logistical support (clinical and non-clinical supplies) in a coordinated fashion.
Surveillance-Monitoring
Terrorism-The calculated use of violence or threat of violence to cause fear among the public and instill a feeling of community powerlessness
Triage-Screening and classifying of sick or injured persons to determine priority needs for efficient use of health care resources
Vector Borne Diseases-Diseases carried by arthropods or insects that transmit causative organisms of disease from infected to non-infected individuals
Vector Control-Methods to prevent or control the spread of vector borne diseases

Acronyms

AAR- After Action Report
ARC-American Red Cross
ASPR – Assistant Secretary for Preparedness and Response
CDC-Centers for Disease Control and Prevention
COOP- Continuity of Operations Plan
DHS-Department of Homeland Security
DHHS-Department of Health and Human Services
DMAT-Disaster Medical Assistance Team
DMHS-Department of Mental Health Services
DMORT-Disaster Mortuary Operational Response Teams
DMRU-Disaster Medical Response Unit
GDAHA-Greater Dayton Area Hospital Association
ED-Emergency Department
EMS-Emergency Medical Services
EOC-Emergency Operations Center
EOP-Emergency Operations Plan
FBI-Federal Bureau of Investigation
HAN-Health Alert Network
HICS-Hospital Incident Command System
HLS – Homeland Security
HSEEP- Homeland Security Exercise and Evaluation Program
ICS-Incident Command System
JIC-Joint Information Center
JITT – Just in Time Training
PH-Public Health
MARCS-Multi-Agency Radio Communications System
MMRS – Metropolitan Medical Response System
NDMS-National Disaster Medical System
NIMS-National Incident Management System
NRF – National Response Framework
ORC- Ohio Revised Code
OAC-Ohio Administrative Code
ODH-Ohio Department of Health
EMA-Office of Emergency Management or Emergency Management Agency
OEPA- Ohio Environmental Protection Agency
OPHCS-Ohio Public Health Communications System
OSHP – Ohio State Highway Patrol
PIO-Public Information Officer
POD-Point of Dispensing
PPE-Personal Protective Equipment
RACES - Radio Amateur Civil Emergency Services
RAPCA-Regional Air Pollution Control Agency
RMRS-Regional Medical Response System
SNS-Strategic National Stockpile
UCS-Unified Command System

VA-Veterans Administration
WCO- West Central Ohio
WPAFB-Wright Patterson Air Force Base

APPENDIX A
List of Selected Authorities: Ohio Revised Code and Ohio Administrative Code

Ohio Department of Health: Ohio Revised Code

O.R.C. 3701.03:	General Duties of the Director of Health
O.R.C. 3701.04:	Powers of the Director of Health
O.R.C. 3701.06:	Right of Entry to Investigate Violations
O.R.C. 3701.13:	Powers of Department of Health
O.R.C. 3701.14:	Special Duties of Director of Health
O.R.C. 3701-146	Duties and powers regarding tuberculosis
O.R.C. 3701.16:	Purchase, Storage and Distribution of Medical Supplies
O.R.C. 3701.17	Protected Health Information
O.R.C. 3701.201	Rules for reporting bioterrorism or pandemic
O.R.C. 3701.22	Public Health laboratory
O.R.C. 3701.23:	Report as to Contagious or Infectious Diseases
O.R.C. 3701.248	EMS worker or funeral services worker request of test results
O.R.C. 3701.25:	Occupational Diseases; Report by Physician to Department of Health
O.R.C. 3701.342	Minimum Standards
O.R.C. 3701.352:	Violation of Rule or Order Prohibited
O.R.C. 3701.56:	Enforcement of Rules and Regulations
O.R.C. 3701.58	Prosecutions and Proceedings
O.R.C. 3701.81	Exposing others to contagion

Ohio Department of Health: Ohio Administrative Code

3701-3	Infectious Disease Prevention and Control

Public Health: Ohio Revised Code

O.R.C. 3707.01:	Powers of Board; Abatement of Nuisances
O.R.C. 3707.02:	Proceedings When Order of Board is Neglected or Disregarded
O.R.C. 3707.02.1:	Noncompliance; Injunctive Relief
O.R.C. 3707.03:	Correction of Nuisance or Unsanitary Conditions on School Property
O.R.C. 3701.04:	Quarantine Regulations
O.R.C. 3707.06:	Notice to be given of Prevalence of Infectious Disease
O.R.C. 3707.07:	Complaint Concerning Prevalence of Disease; Inspection by Health Commissioner
O.R.C. 3707.08:	Isolation of Persons Exposed to Communicable Disease; Placarding of Premises.
O.R.C. 3707.09:	Board May Employ Quarantine Guards.
O.R.C. 3707.10:	Disinfection of House in Which There Has Been a Contagious Disease
O.R.C. 3707.12:	Destruction of Infected Property
O.R.C. 3707.13:	Compensation for Property Destroyed

O.R.C. 3707.14:	Maintenance of Persons Confined in Quarantine House.
O.R.C. 3707.16:	Attendance at Gatherings by Quarantined Person Prohibited
O.R.C. 3707.17:	Quarantine in Place other than that of Legal Settlement
O.R.C. 3707.19:	Disposal of Body of a Person Who Died of Communicable Disease
O.R.C. 3707.23:	Examination of Common Carriers by Board during Quarantine.
O.R.C. 3707.26:	Board Shall Inspect Schools and May Close Them
O.R.C. 3707.27:	Board may Offer Vaccination Free or at Reasonable Charge; Fee Payable to State
O.R.C. 3707.31:	Establishment of Quarantine Hospital
O.R.C. 3707.32:	Erection of Temporary Buildings by Board of Health; Destruction of Property
O.R.C. 3707.33:	Inspectors, Other Employees
O.R.C. 3707.34:	Board May Delegate Isolation and Quarantine Authority to Health Commissioner
O.R.C. 3707.48:	Prohibition against Violation of Orders or Regulations of Board.
O.R.C. 3709.20:	Orders and Regulations of Board of City Health District
O.R.C. 3709.21:	Orders and Regulations of Board of General Health District
O.R.C. 3709.22:	Duties of Board of City or General Health District
O.R.C. 3709.36:	Powers and Duties of Board of Health
O.R.C. 5502.41	Intrastate Mutual Aid compact

Public Health Ohio Administrative Code:

3701-3-02:	Diseases to Be Reported
3701-3-02.2	Air- and blood borne diseases reasonably likely to be transmitted to EMS workers
3701-3-03:	Reported Diseases Notification
3701-3-04:	Laboratory Result Reporting
3701-3-05:	Time of Report
3701-3-06	Reporting to department
3701-3-08	Release of patient's medical records
3701-3-13	Isolation requirement
3701-3-15	Reporting requirements pharmacies or pharmacists

APPENDIX B

West Central Ohio – Public Health Emergency Preparedness Contact List

COUNTY	CONTACTS	OFFICE	FAX	CELL PHONE	24 HOUR PHONE	TWO-WAY PHONE	PAGER	EMAIL
REGIONAL	**Bill Burkhart** PH Coordinator	(937) 224-8091	(937) 496-7468	(937) 672-8442	(937) 672-8442	N/A	N/A	wburkhart@phdmc.org
REGIONAL	**Pat Bernitt** Regional Hospital Coordinator	(937) 424-2364	(937) 228-1035	(937) 307-0399	(937) 307-0399	N/A	N/A	pbernitt@gdaha.org
REGIONAL	**Tim Kernan** Director Health initatives	(937) 424-2361	(937) 228-1035	(937) 620-8746	(937) 620-8746	N/A	N/A	tkernan@gdaha.org
REGIONAL	**David Gerstner** MMRS/RMRS Coordinator, Emergency Preparedness Planner	(937) 333-4551	(937) 333-4561	(937) 776-4410	(937) 776-4410	N/A	(937) 227-8705	david.gerstner@daytonohio.gov
REGIONAL	**Steve Jez** Healthcare Preparedness Program Coordinator	(937) 424-2362	(937) 228-1035	(937) 479-4399	(937) 479-4399	N/A	N/A	jez@gdaha.org
CHAMPAIGN	**Jeff Webb** Health Commissioner	(937) 484-1547	(937) 484-1622	(937) 869-6277	(937) 869-6277	N/A	N/A	jwebb@champaignhd.com
	Dr. Barry Paxton Medical Director	N/A	(937) 484-3520	(937) 896-9111	(937) 896-9111	N/A	N/A	N/A
	Karla Green Director of Nursing	(937) 484-1619	(937) 484-1622	(937) 869-6273	(937) 869-6273	N/A	N/A	kgreen@champaignhd.com
	Gabe Jones Epidemiologist	(937) 390-5600	(937) 390-5626	(937) 925-5956	(937) 925-5956	N/A	N/A	gjones@ccchd.com
	Andy Russell Public Information Officer Director of Environmental Health	(937) 484-1608	(937) 484-1622	(937) 869-6012	(937) 869-6012	N/A	N/A	arussell@champaignhd.com
	Shelley Jackson Communicable Disease Nurse	(937) 484-1645	(937) 484-1622	(937) 508-5161	(937) 508-5161	N/A	N/A	sjackson@champaignhd.com
	Jeanne Bowman Emergency Preparedness Coordinator, MRC Coordinator	(937) 484-1675	(937) 484-1622	(937) 974-0968	(937) 974-0968	N/A	N/A	jbowman@champaignhd.com
	CONTACTS	**OFFICE**	**FAX**	**CELL PHONE**	**24 HOUR PHONE**	**TWO-WAY PHONE**	**PAGER**	**EMAIL**
CLARK	**Charles Patterson** Health Commissioner	(937) 390-5600	(937) 342-5500	(937) 925-5959	(937) 925-5959	N/A	N/A	cpatterson@ccchd.com
	Dr. Laura Thompson Medical Director	(937) 390-5600	(937) 390-5626	(937) 475-2453	(937) 475-2453	N/A	N/A	laurabboehmer@yahoo.com
	Susan Bayless Director of Nursing	(937) 390-5600	(937) 390-5626	(937) 925-5957	(937) 925-5957	N/A	N/A	sbayless@ccchd.com
	Larry Shaffer Director of Environmental Health	(937) 390-5600	(937) 390-5625	(937) 925-5954	(937) 925-5954	N/A	N/A	lshaffer@ccchd.com
	Christina Conover Emergency Preparedness Coordinator	(937) 390-5600	(937) 390-5626	(937) 925-5958	(937) 925-5958	N/A	N/A	cconover@ccchd.com
	Gabe Jones Epidemiologist	(937) 390-5600	(937) 390-5626	(937) 925-5956	(937) 925-5956	N/A	N/A	gjones@ccchd.com
	Vince Carter Public Information Officer	(937) 390-5600	(937) 390-5626	(937) 536-5942	N/A	N/A	N/A	vcarter@ccchd.com
	Anita Biles Public Information Officer	(937) 390-5600	(937) 390-5626	(937) 244-4408	(937) 244-4408	N/A	N/A	abiles@ccchd.com
	Kitty Smith Infectious Disease Nurse	(937) 390-5600	(937) 390-5625	(937) 925-5926	N/A	N/A	N/A	gsmith@ccchd.com
	Sandy Miller MRC Coordinator	(937) 390-5600	(937) 390-5626	(937) 925-5924	(937) 925-5924	N/A	N/A	smiller@ccchd.com
DARKE	**Dr. Terrence Holman** Health Commissioner, Public Information Officer	(937) 548-4196 ext. 201	(937) 548-9128	(937) 459-8080	(937) 459-8080	N/A	N/A	terrence.holman@odh.ohio.gov
	Dr. William Osterbur Medical Director	(937) 548-1700	(937) 548-8263	N/A	(937) 548-1141	N/A	(937) 548-1141	N/A
	Jennifer Barga Director of Nursing	(937) 548-4196 ext. 213	(937) 548-9128	(937) 623-5077	(937) 459-8054	N/A	N/A	jennifer.barga@odh.ohio.gov
	Roberta Mangen Director of Environmental Health	(937) 548-4196 ext.203	(937) 548-9654	(937) 459-8040	(937) 459-8040	N/A	N/A	roberta.mangen@odh.ohio.gov
	Kari Shuttleworth Infectious Disease Nurse, Accreditation Coordinator	(937) 548-4196 ext.232	(937) 548-9128	N/A	N/A	N/A	N/A	Kari.shuttleworth@odh.ohio.gov
	Dennis Wein Emergency Preparedness Coordinator, Communicable Disease Nurse, MRC Coordinator, Epidemiologist	(937) 548-4196 ext.202	(937) 548-9128	(937) 459-8013	(937) 459-8013	N/A	(937) 548-4196	dennis.wein@odh.ohio.gov

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GREENE	**Melissa Branum** Health Commissioner	(937) 374-5630	(937) 374-5675	(937) 241-5672	(937) 241-5672	N/A	N/A	mbranum@gcchd.org
	Dr. Robert Dilliplain Medical Director	(937) 374-5600	(937) 374-5675	(937) 623-0084	(937) 623-0084	N/A	N/A	rpdmdinc@gcph.info
	Robyn Fosnaugh Community Health Services Director	(937) 374-5615	(937) 374-5675	(937) 478-9462	(937) 478-9462	N/A	N/A	rfosnaugh@gcph.info
	Debbie Leopold Director of Environmental Health, Emergency Preparedness Coordinator	(937) 374-5604	(937) 374-5675	(937) 603-1463	(937) 603-1463	N/A	N/A	dleopold@gcph.info
	Amy Schmitt Biological (Secondary), Communicable Disease Nurse	(937) 374-5638	(937) 374-5675	(937) 477-9881	(937) 477-9881	N/A	N/A	aschmitt@gcph.info
	Don Brannen, PhD Epidemiologist, MRC Coordinator	(937) 374-5660	(937) 374-5675	(513) 532-3846	(513) 532-3846	N/A	N/A	dbrannen@gcph.info
	Laurie Fox Public Information Officer	(937) 374-5669	(937) 374-5675	(513) 475-2804	(513) 475-2804	N/A	N/A	lfox@gcph.info
	Shernaz Reporter Assistant Public Information Officer	(937) 374-5617	(937) 374-5675	(513) 238-1499	(513) 238-1499	N/A	N/A	sreporter@gcph.info
	Sheryl Wynn Emergency Preparedness Planner	(937) 374-5670	(937) 374-5675	(937) 781-6753	(937) 781-6753	N/A	N/A	swynn@gcph.info
MIAMI	**Dennis Propes** Health Commissioner, PIO (Primary)	(937) 573-3505	(937) 573-3501	(937) 405-5449	(937) 405-5449	N/A	N/A	dpropes@miamicountyhealth.net
	Dr. James Burkhardt Medical Director	(937) 778-6893	(937) 773-9810	(937) 214-7266	N/A	N/A	N/A	jburkhardt@miamicountyhealth.net
	Deb French Director of Nursing	(937) 573-3521	(937) 573-3503	(740) 361-0454	(740) 361-0454	N/A	N/A	dfrench@miamicountyhealth.net
	Jeff Koehl Director of Environmental Health	(937) 573-3536	(937) 573-3502	(937) 418-7671	(937) 418-7671	N/A	N/A	jkoehl@miamicountyhealth.net
	Lori Ptak Epidemiologist, Communicable Disease Nurse, Emergency Preparedness Coordinator, MRC Coordinator	(937) 573-3509	(937) 573-3501	(937) 572-2692	(937) 572-2692	N/A	N/A	lptak@miamicountyhealth.net
	Nate Bednar PIO (Secondary)	(937) 573-3537	(937) 573-3502	(937) 524-6689	(937) 524-6689	N/A	N/A	nbednar@miamicountyhealth.net
MONTGOMERY	**Jeff Cooper** Health Commissioner	(937) 224-8090	(937) 496-3070	(937) 271-1540	(937) 271-1540	N/A	N/A	jacooper@phdmc.org
	Barbara Marsh Assistant to the Health Commissioner	(937) 225-1543	(937) 496-3070	(937) 620-0569	(937) 620-0569	N/A	N/A	bmarsh@phdmc.org
	Dr. Thomas Herchline Medical Director	(937) 496-7313	(937) 224-8853	(937) 985-1213	(937) 985-1213	N/A	(937) 681-6547	therchline@gmail.com
	Yevetta Hawley Director of Nursing	(937) 225-4477	(937) 224-8078	(937) 238-4560	(937) 238-4560	N/A	N/A	yhawley@phdmc.org
	Jennifer Wentzel Director of Environmental Health	(937) 225-4429	(937) 496-3072	(937) 608-7805	(937) 608-7805	N/A	N/A	jwentzel@phdmc.org
	Melissa Bullis Communicable Disease Nurse/Epidemiologist	(937) 225-4508	(937) 224-8853	(937) 266-8758	(937) 266-8758	N/A	N/A	mbullis@phdmc.org
	Caren Stevens Communicable Disease Nurse/Epidemiologist	(937) 496-7699	(937) 224-8853	(937) 266-3369	(937) 266-3369	N/A	N/A	cstevens@phdmc.org
	Heather Hall TB Communicable Disease Coordinator	(937) 496-3394	(937) 224-8853	(937) 597-0251	(937) 597-0251	N/A	N/A	hhall@phdmc.org
	Bill Wharton Public Information Officer	(937) 225-4403	(937) 496-3074	(937) 266-0150	(937) 266-0150	N/A	N/A	bwharton@phdmc.org
	Larry Cleek Emergency Preparedness Coordinator MRC Coordinator	(937) 225-4483	(937) 496-7468	(937) 543-9961	(937) 543-9961	N/A	N/A	lcleek@phdmc.org
	Tracy Clare Planning & Exercise Specialist	(937) 225-5713	(937) 496-7468	(937) 430-6491	(937) 430-6491	N/A	N/A	tclare@phdmc.org
	Dawn Ebron Epidemiologist	(937) 496-6533	(937) 496-7468	(937) 361-9383	(937) 361-9383	N/A	N/A	debron@phdmc.org

	CONTACTS	OFFICE	FAX	CELL PHONE	24 HOUR PHONE	TWO-WAY PHONE	PAGER	EMAIL
PIQUA	**Amy Welker** Director of Health	(937) 778-2060	(937) 778-0050	(937) 606-0688	(937) 606-0688	136*16405*27	N/A	awelker@piquaoh.org
	Chris Boeke Emergency Preparedness Coordinator	(937) 778-2060	(937) 778-0050	(937) 606-0690	(937) 606-0690	N/A	N/A	cboeke@piquaoh.org
	Mary Jo Koenig Health Nurse	(937) 778-2058	N/A	N/A	N/A	N/A	N/A	healthnurse@piquaoh.org
PREBLE	**Erik Balster** Health Commissioner	(937) 472-0087 ext. #215	(937) 456-6382	(937) 830-0642	(513) 456-2997	N/A	N/A	erik@preblecountyhealth.org
	Suzy Cottingim Emergency Response Coordinator MRC Coordinator	(937) 472-0087 ext.# 207	(937) 456-6382	(937) 533-6905	(937) 533-6905	N/A	N/A	suzy@preblecountyhealth.org
	Dr. Mark Vosler Medical Director	(937) 472-0087 (937) 456-8300	(937) 456-6382 (937) 456-8341	N/A	N/A	N/A	N/A	pcdh@preblecountyhealth.org
	Nan Smith Director of Nursing, Communicable Disease	(937) 472-0087 ext. #239	(937) 456-6350	(937) 684-7203	(937) 684-7203	N/A	N/A	nan@preblecountyhealth.org
	Roger McCampbell Director of Environmental Health	(937) 472-0087 ext. #212	(937) 456-6382	(937) 533-0837	(937) 533-0837	N/A	N/A	roger@preblecountyhealth.org
	Shana Roberts Prenatal Coordinator/SIDS Coordinator/ Communicable Disease Nurse	(937) 472-0087 ext. #243	(937) 456-6350	(513) 533-1363	(513) 533-1363	N/A	N/A	shana@preblecountyhealth.org
	Anita Stoner Public Information Officer	(937) 472-0087 ext. #242	(937) 456-6350	(937) 620-0837	(937) 620-0837	N/A	N/A	anita@preblecountyhealth.org
	Scott Wilford Epidemiologist	(937) 472-0087 ext. #217	(937) 456-6382	N/A	N/A	N/A	N/A	scott@preblecountyhealth.org
SHELBY	**Steven Tostrick** Health Commissioner	(937) 498-7338	(937) 498-7013	(937) 726-1134	(937) 726-1134	N/A	N/A	steven.tostrick@shelbycountyhealthdept.org
	Dr. Paul Weber Medical Director	(937) 440-8687	(937) 440-9235	(937) 307-8671	(937) 307-8671	N/A	(937) 635-2383	pweber@uvmc.com
	Margie Eilerman Director of Nursing, Public Information Officer	(937) 498-7341	(937) 498-7013	(937) 726-1322	(937) 726-1322	N/A	N/A	margie.eilerman@shelbycountyhealthdept.org
	Kent Topp Director of Environmental Health, Public Information Officer	(937) 498-7479	(937) 498-7013	(937) 538-6779	(937) 538-6779	N/A	N/A	kent.topp@shelbycountyhealthdept.org
	Lou Ann Albers Emergency Preparedness Coordinator, Communicable Disease Back-Up, MRC B/U	(937) 498-7958	(937) 498-7013	(937) 538-6784	(937) 538-6784	N/A	N/A	louann.albers@shelbycountyhealthdept.org
	Scott Wilford - Epidemiologist	(937) 472-0087 ext. 217	(937) 456-6382	N/A	N/A	N/A	N/A	scott@preblecountyhealth.org
	Deb Graham Communicable Disease Nurse	(937) 498-7339	(937) 498-7013	(937) 726-2338	N/A	N/A	N/A	deb.graham@shelbycountyhealthdept.org
	Kathy Cavinder MRC Coordinator	(937) 498-7249	(937) 498-7013	(937) 726-1513	(937) 726-1513	N/A	N/A	kathy.cavinder@shelbycountyhealthdept.org

APPENDIX C
West Central Ohio – American Red Cross Contact List

COUNTY	CONTACTS	ADDRESS	TELEPHONE	FAX	EMAIL
Cincinnati Dayton-Area Region	**John Bernard** Regional Disaster Officer	2111 Dana Avenue Cincinnati, OH 45207	(513) 675-0894	(513) 579-3064	john.bernard@redcross.org
	Alayne Chapman Senior Disaster Program Manager	2111 Dana Avenue Cincinnati, OH 45207	(513) 384-1482	(513) 579-3064	alayne.chapman@redcross.org
DAYTON AREA CHAPTER **Greene, Montgomery, Preble**	**Randy Earl** Disaster Program Manager	370 West First Street Dayton, OH 45402	(937) 232-1065	(937) 445-0577	randy.earl@redcross.org
	Maria Carroll Disaster Program Specialist	370 West First Street Dayton, OH 45402	(937) 416-2654	(937) 445-0577	maria.carroll@redcross.org
	Greg Kambitsch Disaster Volunteer Chair	370 West First Street Dayton, OH 45402	(937) 231-3473	(937) 445-0577	greg.kambitsch@gmail.com
	Laura Seyfang Chapter Executive Director	370 West First Street Dayton, OH 45402	(937) 430-6688	(937) 445-0577	laura.seyfang@redcross.org
CLARK COUNTY CHAPTER (Springfield)	**Mike Larson** Executive Director	1830 North Limestone St. Springfield, OH 45503	(937) 399-3872	(937) 399-6111	mlarson@clarkcountyarc.org
	James Wagner Administrative Assistant	1830 North Limestone St. Springfield, OH 45503	(937) 399-3872	(937) 399-6111	jwagner@clarkcountyarc.org
DARKE COUNTY CHAPTER (Greenville)	**Lynn Gump** Executive Director	130 Martz St., Suite #6 Greenville, OH 45331	(937) 548-1002	(937) 548-2030	gumpl@darkecounty.redcross.org
MAD RIVER CHAPTER Champaign,and Logan Counties (Urbana and Bellefontaine)	**TBA**				
	Sheri Timmers Champaign Office Manager for Mad River Chapter	Mad River Chapter 105 N. Detroit St. West Liberty, Oh 43357	(937) 650-5000	(937) 650-5003	stimmerslc@ctcn.net
NORTHERN MIAMI VALLEY CHAPTER Darke, Champaign, Clark Logan, Miami, Shelby	**Marc Cantrell** Disaster Program Manager	1314 Barnhart Road Troy, OH 45373	(937) 418-0269	(937) 332-1441	marc.cantrell@redcross.org
	John Wright Disaster Volunteer Chair	1314 Barnhart Road Troy, OH 45373	(937) 623-2698	(937) 332-1441	wrighj@hotmail.com
	Lynne Gump Chapter Executive Director	1314 Barnhart Road Troy, OH 45373	(937) 459-0628	(937) 332-1441	lynne.gump@redcross.org

APPENDIX D

West Central Ohio – Emergency Management Association Contact List

COUNTY	CONTACTS	ADDRESS	TELEPHONE	FAX	EMAIL
CHAMPAIGN	**Craig Evans** Director	Champaign County EMA 1512 S. R. 68, Suite C103 Urbana, OH 43078	(937) 484-1642	(937) 484-1641	ema@co.champaign.Oh.us
CLARK	**Lisa D'Allessandris** Director	Clark County EMA 3130 East Main Street, Suite 1E Springfield, OH 45505	(937) 521-2175	(937) 327-3862	ldallessandris@clarkcountyohio.gov
DARKE	**Mindy Saylor** Director	Darke County Office of Homeland Security & Emergency Mgmt. 5183 County Home Rd. Greenville, OH 45331	(937) 548-1444	(937) 547-4617	mindy@darkecountyema.org
GREENE	**Rosanne Anders** Director	Greene County EMA 45 N. Detroit Street Xenia, OH 45385	(937) 562-5994	(937) 562-5995	randers@co.greene.oh.us
MIAMI	**Kenneth Artz** Director	Miami County EMA 210 Marybill Drive Troy, OH 45373	(937) 332-8560	(937) 440-6009	kartz@miamicountyema.org
MONTGOMERY	**Jeff Jordan,** CEM Director	Montgomery County OEM 117 S. Main St., Ste 721 Dayton, OH 45422	(937) 224-8936	(937) 224-8881	jordanj@mcohio.org
PREBLE	**David Anderson** Director	Preble County EMA 6818 U.S. 127 North Eaton, OH 45320	(937) 456-5647	(937) 456-6371	danderson@prebleema.org
SHELBY	**Cheri Drinkwine** Director	Shelby Co EMA 800 Fair Road Sidney, OH 45365	(937) 492-5635	(937) 492-8507	ShelbyCountyEMA@gmail.com

APPENDIX E
West Central Ohio – Sheriff's Contact List

COUNTY	SHERIFF	ADDRESS	TELEPHONE	FAX	EMAIL
CHAMPAIGN	Matt Melvin	204 E. Main Street Urbana, OH 43078	(937) 653-3409	(937) 652-3622	mmelvin@co.champaign.oh.us
CLARK	Gene Kelly	120 N. Fountain Ave. Springfield, OH 45502	(937) 521-2056	(937) 328-2515	sheriff@clarkcountyohio.gov
DARKE	Toby Spencer	5185 County Home Rd. Greenville, OH 45331	(937) 548-2020	(937) 548-9235	tspencer@darkecountysheriff.org
GREENE	Gene Fischer	120 E. Main Street Xenia, OH 45385	(937) 376-5111	(937) 562-4880	adminassist@miamicountyso.com
MIAMI	Charles A. Cox	201 West Main Street Troy, OH 45373	(937) 440-6085	(937) 440-3524	adminassist@miamicountyso.com
MONTGOMERY	Phil Plummer	345 W. Second St. P. O. Box 972 Dayton, OH 45422	(937) 225-4357	(937) 496-7975	plummerp@mcohiosheriff.org
PREBLE	Michael Simpson	1139 Preble Drive Eaton, OH 45320	(937) 456-6262	(937) 456-6353	msimpson@preblecountysheriff.org
SHELBY	John Lenhart	555 Gearhart Rd. Sidney, OH 45365	(937) 498-1111	(937) 498-7845	john.lenhart@shelbycountysheriff.com

APPENDIX F
Quick Links

Regional Resources:

Champaign Health District: www.champaignhd.com
Clark County Combined Health District: http://www.ccchd.com
Darke County General Health District: www.darkecountyhealth.org
Greene County Public Health: www.gcchd.org
Miami County Combined Health District: www.miamicountyhealth.net
Public Health- Dayton and Montgomery County: www.phdmc.org
Preble County General Health District: www.pcghd.net
Sidney-Shelby County Health District: www.shelbycountyhealthdept.org
Dayton MMRS/RMRS: http://www.daytonmmrs.org/
Greater Dayton Area Hospital Association: http://www.gdaha.org/
Greater Miami Valley EMS Council: https://www.gmvemsc.org/

State Resources:

ODH: www.odh.ohio.gov

Infectious Disease Control Manual:
http://www.odh.ohio.gov/healthResources/infectiousDiseaseManual.aspx

Listing of all Ohio Health Districts
http://odhlogin.sso.odh.ohio.gov/PHdirectory/NetMgr/ODHList.aspx

OHTrac: www.OHTrac.org

Ohio EMA: http://ema.ohio.gov/

Federal Resources:

CDC: http://www.cdc.gov/