Public Health Emergency Preparedness Protocol, 2015

Ontario

Preamble

The Ontario Public Health Standards (OPHS) are published by the Minister of Health and Long-Term Care under the authority of the Health Protection and Promotion Act (HPPA) to specify the mandatory health programs and services provided by boards of health.[1, 2] Protocols are program and topic specific documents which provide direction on how boards of health must operationalize specific requirement(s) identified within the OPHS. They are an important mechanism by which greater standardization is achieved in the province-wide implementation of public health programs.

Protocols identify the minimum expectations for public health programs and services. Boards of health have the authority to develop programs and services in excess of minimum requirements where required to address local needs. Boards of health are accountable for implementing the standards including those protocols that are incorporated into the standards.

Purpose

The purpose of this protocol is to provide direction regarding the implementation of measures that will prepare the board of health to respond to emergencies, defined in the Emergency Management and Civil Protection Act (EMCPA) as "a situation or an impending situation that constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property and that is caused by the forces of nature, a disease or other health risk, an accident or an act whether intentional or otherwise."[3]

To achieve provincial- and local-level readiness, boards of health must develop their own public health emergency preparedness and response programs to provide response capabilities in an emergency which complement the municipal, provincial and health sector emergency preparedness and response programs.

Statutory Basis

Emergency Management and Civil Protection Act

The legal basis for emergency management in the province of Ontario is in part provided for in the EMCPA.[3] The EMCPA requires ministries and municipalities to develop and implement an emergency management program consisting of emergency plans, training programs, exercises, and public education, as well as infrastructure to support emergency response.[3] An Order-in-Council (OIC) under the EMCPA identifies the specific emergency management responsibilities for ministries of the Crown.[3] The Ministry of Health and Long-Term Care, for example, has the OIC responsibility for taking a lead role in emergencies relating to *human health, disease and epidemics* and *health services during an emergency.*

Health Protection and Promotion Act

The HPPA identifies the powers and responsibilities of boards of health, medical officers of health and the Chief Medical Officer of Health (CMOH).[2] Its purpose is to "provide for the organization and delivery of public health programs and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario."[2]

Health protection is a cornerstone of the HPPA and of public health activities in the province of Ontario.[2] Boards of health have responsibility for identifying and preventing, reducing, or eliminating health hazards and addressing communicable diseases. The HPPA provides legal authority for the boards of health to respond to a public health emergency that has been determined to be a health hazard or as the result of a communicable disease.[2]

Reference to the Standards

Table 1: identifies the OPHS standards and requirements to which this protocol relates.

Standard	**Requirement**
Public Health Emergency Preparedness	Requirement #1: The board of health shall identify and assess the relevant hazards and risks to the public's health in accordance with the *Identification, Investigation and Management of Health Hazards Protocol, 2008* (or as current); the *Population Health Assessment and Surveillance Protocol, 2008* (or as current); and the *Public Health Emergency Preparedness Protocol, 2008* (or as current). Requirement #2: The board of health shall develop a continuity of operations plan to sustain the ongoing functioning of time-critical board of health services during business disruptions in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current). Requirement #3: The board of health shall develop its emergency response plan, in consultation with community partners and governmental bodies, to address the identified hazards for which the board of health and medical officer of health will have a lead role in responding to, consistent with an Incident Management System and in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current). Requirement #4: The board of health shall develop, implement, and document 24/7 notification protocols for communications with board of health staff, community partners, and governmental bodies to facilitate the sharing of information in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current). Requirement #5: The board of health shall, in collaboration with community partners, increase public awareness regarding emergency preparedness activities. Requirement #6: The board of health shall ensure the provision of emergency preparedness and response education and training for board of health staff in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current). Requirement #7: The board of health shall ensure that its officials are oriented on the board of health's emergency response plan in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current). Requirement #8: The board of health shall exercise, in whole or in part, the continuity of operations plan, emergency response plan, and 24/7 notification

Standard	Requirement
	procedures in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current).
Foundational	Requirement #7: The board of health shall interpret and use surveillance data to communicate information on risks to relevant audiences in accordance with the *Identification, Investigation and Management of Health Hazards Protocol, 2008* (or as current); the *Infectious Diseases Protocol, 2008* (or as current); the *Population Health Assessment and Surveillance Protocol, 2008* (or as current); the *Public Health Emergency Preparedness Protocol, 2008* (or as current); and the *Risk Assessment and Inspection of Facilities Protocol, 2008* (or as current).
Infectious Diseases Prevention and Control	Requirement #7: The board of health shall ensure that the medical officer of health or designate is available on a 24/7 basis to receive reports of and respond to infectious diseases of public health importance in accordance with the Health Protection and Promotion Act; the Mandatory Blood Testing Act; the *Exposure of Emergency Service Workers* to *Infectious Diseases Protocol, 2008* (or as current); the *Infectious Diseases Protocol, 2008* (or as current); the *Institutional/Facility Outbreak Prevention and Control Protocol, 2008* (or as current); and the *Public Health Emergency Preparedness Protocol, 2008* (or as current).
Rabies Prevention and Control	Requirement #7: The board of health shall ensure that the medical officer of health or designate is available on a 24/7 basis to receive reports of and respond to suspected rabies exposures in accordance with the Health Protection and Promotion Act; the *Public Health Emergency Preparedness Protocol, 2008* (or as current); and the *Rabies Prevention and Control Protocol, 2008* (or as current).
Food Safety	Requirement #6: The board of health shall ensure that the medical officer of health or designate is available on a 24/7 basis to receive reports of and respond to: • Suspected and confirmed food-borne illnesses or outbreaks; • Unsafe food-handling practices, food recalls, adulteration, and consumer complaints; and • Food-related issues arising from floods, fires, power outages, or other situations that may affect food safety in accordance with the Health Protection and Promotion Act; the *Food Safety Protocol, 2008* (or as current); the *Infectious Diseases Protocol, 2008* (or as current); and the *Public Health Emergency Preparedness Protocol, 2008* (or as current).
Safe Water	Requirement #10: The board of health shall ensure that the medical officer of health or designate is available on a 24/7 basis to receive reports of and respond to: • Adverse events related to safe water, such as reports of adverse drinking water on drinking-water systems governed under the Health Protection and Promotion Act or the Safe Drinking Water Act;

Standard	Requirement
	• Reports of water-borne illnesses or outbreaks; • Safe water issues arising from floods, fires, power outages, or other situations that may affect water safety; and • Safe water issues relating to recreational water use including public beaches in accordance with the Health Protection and Promotion Act; the *Beach Management Protocol, 2008* (or as current); the *Drinking Water Protocol, 2008* (or as current); the *Infectious Diseases Protocol, 2008* (or as current); the *Public Health Emergency Preparedness Protocol, 2008* (or as current); and the *Recreational Water Protocol, 2008* (or as current).
Health Hazard Prevention and Management	Requirement #1: The board of health shall conduct surveillance of the environmental health status of the community in accordance with the *Identification, Investigation and Management of Health Hazards Protocol, 2008* (or as current); the *Infectious Diseases Protocol, 2008* (or as current); the *Population Health Assessment and Surveillance Protocol, 2008* (or as current); the *Public Health Emergency Preparedness Protocol 2008* (or as current); and the *Risk Assessment and Inspection of Facilities Protocol, 2008* (or as current). Requirement #5: The board of health shall ensure that the medical officer of health or designate is available on a 24/7 basis to respond to and manage health hazards in accordance with the Health Protection and Promotion Act; the *Identification, Investigation and Management of Health Hazards Protocol, 2008* (or as current); the *Public Health Emergency Preparedness Protocol, 2008* (or as current); and the *Risk Assessment and Inspection of Facilities Protocol, 2008* (or as current).

Operational Roles and Responsibilities

Assessment and Surveillance

1) Identify and assess the relevant hazards and risks to public health

a) In consultation with other relevant local government bodies the board of health shall identify and assess relevant hazards and risks to public health by:

i) Identifying the hazards relevant to public health within the health unit that may give rise to a public health emergency and/or emergency with public health impacts;

ii) Assessing the risk of the identified hazards using qualitative and/or quantitative measures of probability and consequence which, at a minimum, capture information through a risk-assessment methodology;

iii) Ranking and recording the assessed risks to public health based on qualitative and/or quantitative measures of probability and consequence. Risks shall be prioritized from high to low based on the ranking of probability and consequence;

iv) Reviewing the hazard-identification and risk-assessment at least annually and updating when required;

v) Including hazard-identification and risk-assessment materials in a confidential appendix to the board of health emergency response plan.[*] At a minimum the following shall be included:
   - Process for hazard identification;
   - Methodology for risk assessment; and
   - Results of hazard identification and risk assessment; and

vi) Identifying high-risk populations in the community relevant to specific hazards or threats and assessing potential for disproportionate health impacts to high-risk populations for relevant hazards.

b) The board of health shall include as a high priority risk any hazard of provincial significance that is identified by the CMOH.

Emergency Planning

2) Develop a continuity of operations plan

a) The board of health shall develop and maintain an up-to-date board of health continuity of operations plan. The plan shall:
   i) Identify time-critical public health services that must continue to be delivered regardless of circumstance;
   ii) Assign resources to maintain time-critical public health services;
   iii) Outline the process for recovering time-critical public health services should they be disrupted;
   iv) Be reviewed and updated on an annual basis at a minimum and as otherwise required following the completion of an exercise or incident; and
   v) Be approved by the medical officer of health.

b) At a minimum, the process for developing and maintaining the board of health continuity of operations plan shall include:
   i) Engaging the board of health senior management team;
   ii) Identifying time-critical public health services through a business impact analysis;
   iii) Identifying the dependencies upon which time-critical public health services rely;
   iv) Identifying vulnerabilities to the continued delivery of time-critical public health services;
   v) Developing recovery procedures to guide the restoration/continuation of time-critical public health services; and
   vi) A mechanism to evaluate the use of the continuity of operations plan after each use (exercise or incident) including recommendations for improvement.

[*] Note: The hazard identification and risk assessment may contain sensitive information that requires more strict controls than other elements of an emergency response plan. The board of health may choose to consult legal counsel if uncertain of controls required to maintain confidentiality of all or parts of the hazard identification and risk assessment.

3) Develop an emergency response plan

a) The board of health shall develop and maintain an emergency response plan. The emergency response plan shall:

i) Include roles and responsibilities for boards of health and medical officers of health that are, at a minimum, consistent with roles and responsibilities established in the HPPA;[2]
ii) Consist of a general plan that outlines the arrangements and procedures used to respond to a variety of different emergencies (all-hazards) and supporting plans that guide the response to specific threats identified as high-risk through the hazard-identification and risk-assessment process and identified in other standards and protocols;
iii) Align with the corresponding response plans of other government bodies, including but not limited to relevant local health sector, municipal, provincial and federal government response plans;
iv) Describe key roles and responsibilities and align them with the components of the Incident Management System (IMS): Command (which includes Safety, Liaison and Communications/Information), Operations, Logistics, Planning and Finance/Administration as per the Incident Management System Doctrine for Ontario, December 2008;[4]
v) Be reviewed and updated annually, at a minimum and as required following completion of an exercise or incident; and
vi) Be approved by the medical officer of health.

b) The board of health shall engage and collaborate with community partners in developing the emergency response plan, particularly those who have roles and responsibilities prescribed within the plan. Partners may include, but are not limited to, hospitals, community care access centres, long-term care homes, emergency medical services, Local Health Integration Networks (LHINs), community emergency management coordinator(s) (CEMC), local authorities (e.g., community police, emergency social services), and other relevant community partners.

c) The board of health general emergency response plan shall, at a minimum, include the following components:

i) Aim;
ii) Authority;
iii) Relationship to other plans;
iv) Plan activation and demobilization;
v) Notification procedures;
vi) Roles and responsibilities (aligned with the IMS);
vii) Public health emergency control group or equivalent;
viii) Emergency operations centre;
ix) Crisis communication;
x) Occupational health and safety;
xi) Arrangements for psychosocial supports for board of health staff;
xii) Coordination with other agencies; and
xiii) Tools, structures and processes to be utilized in emergency response.

d) Annexes or appendices shall accompany the plan. These shall, at a minimum, include:

i) Response plans for specific threats identified as high-risk through the hazard-identification and risk-assessment;
ii) Response plans required under other protocols and standards;
iii) Notification procedures and contact lists;
iv) Resource list(s); and
v) Mutual aid/assistance agreements.

Crisis Communications and Public Awareness

4) Develop, implement and document 24/7 notification protocols

a) The board of health shall have a 24 hours per day, 7 days per week (24/7) notification protocol. At a minimum, the notification protocol shall include a telephone capability for:
   i) Two-way communication with board of health staff;
   ii) Two-way communication with key community partners including, but not limited to, hospitals, community care access centres, long-term care homes, emergency medical services, LHINs, CEMCs, local authorities (e.g., community police, emergency social services), and any other relevant community partners;
   iii) Two-way communication with government bodies;
   iv) Access to the medical officer of health or designate during and after business hours; and
   v) Receiving, notifying, and responding to reports of:
      - An incident or emergency;
      - A potential health hazard; and
      - A reportable disease including institutional outbreaks.

b) To support the development and maintenance of the notification protocol, the board of health shall:
   i) Assign a senior management representative who is accountable for the notification protocol;
   ii) Have an up-to-date on-call schedule or rota for performing on-call duties;
   iii) Retain contact lists for board of health staff, which shall be reviewed quarterly and updated as required;
   iv) Retain contact lists for community partners and government bodies, which shall be updated quarterly;
   v) Have a fan-out mechanism in place for mass notification of staff, community partners, and government bodies (e.g., a call tree); and
   vi) Have a back-up communications capability for mass notification of staff, community partners, and government bodies.

5) Increase awareness regarding emergency preparedness activities

Public awareness of emergency preparedness activities may lead to increased preparedness for individuals and families. A process of community engagement may also build networks among individuals and families that promote increased preparedness for public health threats. Boards of health may choose to raise awareness regarding emergency preparedness activities on their own or engage and plan activities with other governmental and/or community partners.

Education, Training and Exercises

6) Deliver emergency preparedness and response education and training for board of health staff

a) The board of health shall provide at least one education session annually on components of the public health emergency preparedness standard which includes all board of health staff, and which at a minimum:
   i) Identifies the risks to public health in the public health unit as identified through the hazard identification and risk-assessment process;
   ii) Describes key elements of the board of health continuity of operations plan;
   iii) Describes key elements of the board of health emergency response plan; and
   iv) Describes the roles of key officials and staff in the aforementioned plans, as aligned with the IMS.

b) The board of health shall maintain a record of board of health staff who have attended education sessions.

7) Ensure that officials are oriented on the board of health's emergency response plan

a) The board of health shall provide orientation to officials (board of health members and board of health staff) on the emergency response plan. Orientation shall:
   i) Be delivered by the medical officer of health or designate;
   ii) Include, at a minimum, the public health emergency control group or other equivalent decision-making roles as aligned with the IMS;
   iii) Be completed at least once annually for existing board of health members;
   iv) Be included in the workplace orientation for new board of health members and board of health staff; and
   v) Be documented in an appendix to the plan once the orientation is completed. The documented information shall include the name of the individual oriented, the date the orientation was completed, and the components of the plan on which the individual received orientation.

8) Exercise the continuity of operations plan, emergency response plan and 24/7 notification protocol

a) The board of health shall conduct an exercise at least once annually that tests all or some components of the:
   i) Board of health continuity of operations plan;
   ii) Board of health emergency response plan; and
   iii) 24/7 notification protocols.

   Note: If a board of health activates its emergency plan, continuity of operations plan, or 24/7 notification protocols, then the requirement to conduct an exercise is not required that year.

b) In the planning and delivery of an exercise or exercises, the board of health shall ensure there are:
   i) Exercise objectives that are linked to the plan and protocols being tested;
   ii) Scenario(s) that include a high-risk hazard that the board of health has identified through the hazard identification and risk-assessment process;
   iii) Post-exercise debrief(s) with exercise participants; and

iv) Reports that outline key lessons learned from the exercise or exercises and inform amendments to the plan and future requirements for training.

c) The board of health shall engage and collaborate with community partners and governmental bodies, including, but not limited to, hospitals, community care access centres, long-term care homes, emergency medical services, LHINs, CEMCs, local authorities (e.g., community police, emergency social services) and any other relevant community partners; who have prescribed roles in the plan during the planning and implementation of the exercises.

References

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