Emergency Preparedness Planner

A Newsletter for the Health System

Emergency Management Branch, Ministry of Health and Long-Term Care Winter 2011/12

Double the Planner!

Welcome to our double issue of the Planner, bringing you highlights from autumn 2011 and into the new year!

And a jam-packed issue it is. We're bringing you additional content on two topics we've been looking at regularly over the past year -- emergency planning for Long-Term Care Homes and emergency exercises, both local and provincial. We're also providing information in response to questions from our readers on federal quarantine operations and emergency planning for mental health and addictions facilities.

We have guest articles from Huron County Health Unit and Ottawa EMS on their experiences with two of the major events we faced this past year, the Goderich tornado and the forest fire evacuations this past summer.

There are updates galore on everything from health planning for the 2015 Pan Am/Parapan Games to influenza planning and this year's Ontario Public Health Conference.

And we're pleased to introduce '*Dr. King's Corner*', a perspective from our Chief Medical Officer of Health, Dr. Arlene King, on leadership approaches and emergency management.

Whatever your role in emergency preparedness is, we're sure you'll find something of interest in this issue. Welcome and enjoy!

~ Gerilynne Carroll, Director, Emergency Management Branch

Ontario

A Tornado Leaves a Path of Lessons

~ A guest article from Huron County Health Unit

Goderich, Ontario, founded in 1827, is a beautiful historical town beside Lake Huron. It is the largest urban centre in Huron County.

On August 21, 2011 at 15:53 a powerful F3 tornado came off of Lake Huron at the Goderich Harbour, travelled through the Town of Goderich and continued into the Municipalities of Central Huron and Ashfield-Colborne-Wawanosh.

Assessment of the damage by Environment Canada's survey team estimated the winds at 280 km per hour. The most extensive damage occurred in historic downtown Goderich and included structural damage to buildings, roofs removed, numerous vehicles overturned and trees down. Electrical and natural gas services were also severely disrupted.

There was one fatality and 37 reported injuries. Very shortly after the tornado, a state of emergency was declared in the Town of Goderich.

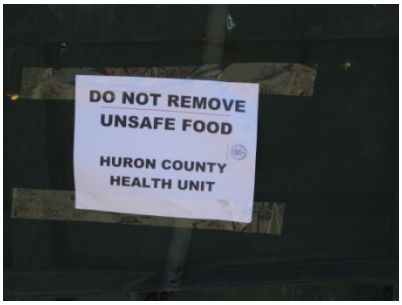
Numerous organizations responded to this devastating event. A shelter was established to assist residents and organizations.

Roles and Responsibilities for the Health Unit

"When you have many organizations responsible for many activities, you need to know and understand what others are responsible for and who has jurisdiction."
Huron County Medical Officer of Health,
Dr. Nancy Cameron

The primary role for the Huron County Health Unit was ensuring food security.

- The health unit, in its food safety role, was present at the shelter, as well as at the numerous food premises that were impacted by the tornado.
- Staff went into action assessing, organizing and cataloguing the disposal of affected food. Some of the challenges in this role included dealing with the smell of rotting food as well as the presence of bees, insects and rodents at the sites.



The health unit was also busy educating the public about their risks related to food safety and other hazards such as asbestos and injury prevention.

We worked with organizations such as the Ministry of Health and Long-Term Care, Emergency Management Branch, Public Health Ontario scientists and the Goderich Control Group to create clear-language messaging for the public about asbestos hazards, as well as injury prevention when assisting with debris clearing.

Then of course there was the need to make sure that we ourselves could continue to play these important roles – as Christina Taylor, Manager of Infectious Diseases noted, “Many staff live in Goderich and were without hydro or natural gas services. Their homes were damaged, businesses they rely on were unavailable. To complicate matters, the tornado happened during prime summer vacation time.”

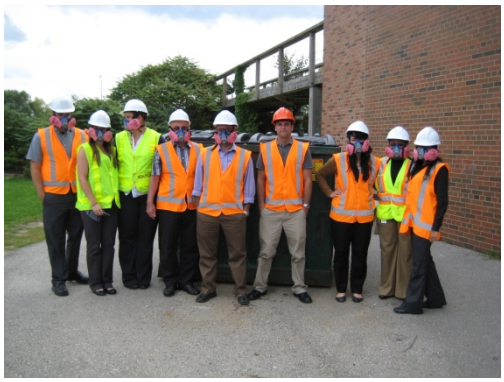
Take-Home Lessons

“There are certainly challenges to be noted and lessons to be learned when responding to a natural disaster of this magnitude.”

Emergency Co-ordinator
Donna Parsons

There were many lessons to be learned from this incident.

- The need for clarity around roles and responsibilities.
- The need for using the Incident Management System to organize a response. It became apparent that we need to enhance our IMS response to deal with large incidents that are not led by the health unit.
- Planning and preparedness ahead of time are important, and include health and safety. There are many unanticipated needs that become apparent when you face this type of situation. For example, our staff were required to wear P100 respirators, which need to be fit tested, when working at the sites due to the threat of asbestos being released from the older buildings.
- The need for a good Continuity of Operations Plan, which includes dealing with a staffing shortage. It is good practice to have a working environment that builds internal capacity and allows for cross training of staff so they can be redeployed in times of need. In a smaller rural health unit, this type of planning assists in building resiliency.



- The need for a strong internal communications plan. Internal e-mail updates were well received by staff but through the debriefing process it became apparent this was not sufficient. All of our staff were personally affected in some way by the tornado. It is very important to have support systems in place, such as an employee assistance program, to help staff deal with disasters such as this.

The Ottawa Paramedic Strike Team Model

~ A guest article from Robert Davidson, Commander/Special Operations, Ottawa EMS

On five occasions in recent history, the Ottawa Paramedic Service has been called upon to support the evacuation of Canadian citizens from northern communities or overseas. Paramedics provided the initial triage of arriving evacuees, treatment and transport for emergent medical conditions, and assisted our Public Health partners with health assessments at the reception centres. Often these responses were set up 'on the fly' in whatever facility was available, using only the medical equipment available in our paramedic units and emergency support units.

Based on lessons learned from our initial evacuations, the Ottawa Paramedic Service adopted a strike team model for supporting this type of response.

The basis of the strike team plan was to provide the equipment and people needed to set up a static paramedic response for on-site medical support, with the added capacity of providing our own shelter if necessary.

The first step was an evaluation of our existing mass casualty incident (MCI) and emergency shelter trailers, and identification of what additional equipment might be required. This included simple items like lighting, portable tables, chairs and privacy curtains, as well as the medications, airway equipment and sophisticated medical equipment such as monitor/defibrillators required by the paramedics. Exercises and drills prompted the adoption of wheeled shelving and standardized bins to organize and move materials during deployment.

The second step was to map out the additional skill sets and staff required to support the strike team deployment. The strike team utilizes advanced and primary care paramedics, as well as logistics technicians and communications officers within a structured response team under the command of a paramedic superintendent. Based on their specialty skills, each has a role to play within the team that supports the overall deployment, and facilitates efficient patient care, thorough patient tracking and the best use of resources.

Using our newly developed strike team concept during the Northern Fire evacuations of July 2011 was instrumental in facilitating rapid medical assessment of the evacuees. The paramedic response started with a quick triage aboard the aircraft to flag any urgent medical and mobility issues. The evacuees were then transported to the location where the paramedic strike team was staged - an airport hangar - working alongside the many City of Ottawa partners involved in managing the smooth movement of evacuees through the reception process.

When additional flights were routed to Ottawa late at night and the hangar was no longer available, we were able to test the concept of rapidly breaking down the triage site, going mobile, and setting up in a sports facility several kilometres away. The

mobility and flexibility of the paramedic strike team was a significant factor in adapting to the changing situations such a deployment can present.

The paramedic static-response strike team proved itself during the Northern Fire evacuation and is now used by the Ottawa Paramedic Service on a regular basis at major events within the national capitol region. The strike team concept works well within IMS structures, and offers a suitable model for structuring paramedic service resources in alternative deployments such as static response teams for medical support, or in FEMA-type ambulance strike teams for evacuations and mass casualty events.

For more information, contact Commander Robert Davidson.

Did you know…

In the Incident Management System, strike teams and task forces are two options for organising personnel and equipment.

- A **Strike Team** is a set number of resources of the same kind and type (e.g. in this case all EMS) that have an established minimum number of personnel and a designated leader.
- A **Task Force** is any combination of resources assembled to support a specific mission or operational need. A task force must also have a designated leader.

Long-Term Care Homes: Key Community Supports

~ A guest article from the City of Toronto's Long Term Care Homes and Services

In an emergency, the City of Toronto's divisions and community partners come together under the umbrella of Emergency Human Services to provide immediate response to people and their pets. An emergency can be a power outage, a fire or any situation where people are unable to stay in their homes.

Long Term Care Homes and Services (LTCHS) plays a key role in this response. Not only do our homes and services need to ensure their own continued operation during an emergency, but they can have an important role to play as a partner in supporting the broader community response.

Through an existing agreement among LTCHS, Toronto Emergency Medical Services (TEMS) and Community Care Access Centres (CCAC), the City provides short term care, transportation and accommodation for other displaced seniors and vulnerable adults. Two of the major activations of this voluntary agreement demonstrate the value of this role.

Keeping Warm During the 2009 Blackout

On January 16, 2009 at around 10:00 p.m., a power failure left approximately 250,000 west-end Toronto residents in the dark. With a temperature of nearly -30°C with the windchill overnight, and Toronto Hydro projecting up to 48 hours to restore power to the affected area, the City of Toronto opened seven reception centres for people to warm up.

LTCHS initiated its emergency plans to support the community. Dedicated phone lines for seniors and persons with disabilities were established to provide information about assistance in getting to one of the seven reception centres. The division utilized its Adult Day Program buses and local taxi services to assist in transporting these individuals to the reception centres. Castleview-Wychwood Towers - one of the city's Long-Term Care Homes - opened its doors as a pre-arranged reception centre and cared for a total of 97 people and 10 pets. Of those, 33 stayed overnight. Castleview-Wychwood has played a similar role during extreme heat events, providing temporary cooling centres for the frail and senior in the community, and working with Toronto Central CCAC (TCCCAC) to ensure access for some of their frail clients who needed this service.

Nancy Lew, administrator at Castleview Wychwood, noted "Being centrally located, the home has been called upon many times over the years to assist with emergency situations in the community, or host a warming or cooling centre. As a result, managers and staff are skilled at quickly establishing reception centres in the home. Staff pull together to provide a safe, compassionate and caring environment for those in need, at any time of day or night. After each situation, we evaluate our successes, as well as how we can do it better next time."

200 Wellesley Street Fire

Then, of course, there was the fire at the Toronto Community Housing high-rise building at 200 Wellesley. As outlined in previous articles in the Planner, this fire resulted in the temporary evacuation of approximately 1,200 residents and several hundred pets. Multiple city divisions and agencies were involved in the response, including LTCHS.

A significant number of seniors living at 200 Wellesley were already receiving in-home services from the division's Homemakers and Nurses Services (HMNS) program and the TCCCAC. When the fire disrupted their normal living arrangements, intensive work was done to offer services at alternative locations within days. But in addition to addressing the needs of their existing clients, the division and its partners played an invaluable role for many of the other frail and senior residents of 200 Wellesley.

An initial reception centre was set up at the Wellesley Community Centre, but it was quickly realised that more support was needed. Within two hours of notification, both Castleview Wychwood Towers and Fudger House (another of the city's Long-Term

Care Homes), had implemented their well-rehearsed emergency response plans and were ready to receive and care for evacuees. When it became clear that additional options were required, Kipling Acres, another Toronto home, opened a temporarily closed resident unit to receive evacuees. Two community partners (St. Hilda's Towers and New Horizons Tower) also agreed to receive and care for evacuees, and LTCHS's supportive housing program arranged temporary accommodation and supportive services for some seniors at 55 Bleeker Street.

Other LTCHS staff also played various roles. Karen Thompson, the division's manager of food and dietetic services, led the City's entire food services response at the reception centre opened at the Wellesley Community Centre, an essential role. Fudger House's medical director, Dr. Terry Bates, was one of the physicians who volunteered to assist evacuees who needed medical assessment or assistance with personal care. Gregory Kolesar, LTCHS's former manager of community programs, arranged personal support services and mealtime assistance for seniors at the centre.

When LTCHS was finally able to close Fudger House, Castleview Wychwood Towers and Kipling Acres as reception centres, a number of seniors at those homes still needed temporary housing. Michael Saunders, the division's resident-client advocate, met with each senior, explaining options to ensure informed choice. Some went with friends and family, some went to alternatives arranged by the City or Toronto Community Housing, and many opted to temporarily move to New Horizons Tower. Staff collaborated with colleagues from many other City divisions and organizations to make this response successful.

Long-term care homes, along with other service providers and agencies, can play an important role in supporting their community in responding to emergency situations. As demonstrated by these examples, this support can be as simple as agreements to provide temporary shelter or more complex models that require collaborative efforts.

For more information, contact Dana Tulk, Manager of Capital and Facilities Services, at 416-392-9061.

A call for submissions!

Are you a small or rural long-term care home with an interesting experience in emergency planning or response you'd like to share with Planner readers? Let us know at Emergencymanagement.moh@ontario.ca.

You asked…

Tell me more about Quarantine Operations…

On Friday, January 20, 2012, EMB received a notification from the Public Health Agency of Canada's (PHAC) Regional Office that over the past couple of days three flights coming into Ontario had reported ill passengers aboard returning from Cuba. The symptoms that were reported had triggered a Public Health Agency of Canada Quarantine Officer response, and EMS and public health in the relevant areas were engaged.

As investigations continued over the next few days, updates and information were shared through a series of teleconferences among the impacted local public health units, the Emergency Management Branch, Public Health Ontario, and PHAC. Eventually the illness was lab-confirmed as a norovirus, and it was clear that it didn't represent a major outbreak or significant threat to the province.

Throughout this time there were many questions regarding PHAC's Quarantine Operations, and the role they play. The Planner followed up with PHAC to share with you some facts you might not know!

Q: *What's the purpose of the Quarantine Act?*

A: The purpose of the *Quarantine Act* is to protect public health by taking comprehensive measures to prevent the introduction and spread of communicable diseases into Canada. It's applicable to persons, conveyances and cargo, cadavers, body parts and other human remains arriving in or departing from Canada.

It provides measures for the screening, health assessment and medical examination of travellers to determine if they have a communicable disease; measures for preventing the spread of communicable disease; and measures such as inspection and cleansing of conveyances (e.g., airlines, ships, buses) and cargo to ensure they're not a source of communicable disease.

Q: *Under the Quarantine Act, what measures can be taken if it's determined there's a risk to public health?*

A: If it's determined that there is - or may be - a risk to public health, the following are some examples of measures that can be taken at Canadian points of entry:

- Screening Officers may conduct screening of international travellers.
- A Quarantine Officer can conduct health assessments to determine actual or potential presence of illness.
- Other measures may be ordered when a Quarantine Officer believes a traveller

poses a risk to public health. These measures include an order for a medical examination, an order to report to public health, or an order for other measures to protect public health.

- Conveyances and their contents can be stopped, inspected and ordered to be decontaminated and/or disinfected, or destroyed.
- Travellers or conveyances can be detained under the *Quarantine Act.*
- The *Quarantine Act* also authorizes the Minister to have a conveyance diverted to an alternative location, have quarantine stations or facilities established, and have people or goods from specific areas prevented from entering into Canada.

Q: *How does the role of the Quarantine Officer (QO) relate to the role of Health Canada's Environmental Health Officers (EHO) and the Border Service Officers?*

A: The role of the Quarantine Officer focuses on international travellers, (including any who may die en route), cadavers, body parts and human remains.

Health Canada's EHOs are responsible for cargo and conveyances. They're involved in the inspection of conveyances and cargo, and can detain or take other measures regarding conveyances and their contents.

Border Services Officers act as Screening Officers under the *Quarantine Act.* Screening is a preliminary review of travellers' health to determine if there's a risk they may have a communicable disease.

Q: *What triggers a Quarantine Officer response?*

A: A conveyance operator, who is required to report if there is an ill traveller aboard, may notify a Quarantine Officer directly or indirectly. Additionally, Screening Officers may encounter a traveller who self-reports an illness, or the Screening Officer may identify a traveller who may have a communicable disease. The Screening Officer uses the following syndromal case definition to make this determination:

- Appearing obviously unwell
- Cough with blood
- Fever with any of the following:
    - shortness of breath, or difficulty breathing
    - repeated coughing
    - diarrhea
    - headache
    - recent confusion
    - skin rash
    - bruising or bleeding without previous injury

It's not uncommon for people to return from holiday destinations with symptoms like gastro-intestinal upset. For those travelers who cannot be screened out, a health assessment is done by a Quarantine Officer to determine whether or not these symptoms are related to a communicable disease listed in the Act.

Q: *Do Quarantine Officers play an ongoing role once travellers have arrived?*

A: A Quarantine Officer's authorities pertain to persons and conveyances arriving in, or in the process of departing from, Canada. Therefore they're exercised at Canada's points of entry. Once travellers leave the point of entry, they fall under the provincial or local public health authority responsible for the location where the travellers have entered, unless they've been placed under the authority of the *Quarantine Act* by a Quarantine Officer. If the travellers have been placed under the authority of the *Quarantine Act,* Quarantine Officers will play an ongoing role until the travellers are released from the authority of the Act.

In cases where travellers do not fall under the authority of the *Quarantine Act*, Quarantine Officers will cooperate with public health authorities to the extent possible.

Q: *Are there Quarantine Officers at every international airport in Ontario?*

A: No. There are Quarantine Officers at 2 international airports in Ontario – Ottawa and Toronto. Quarantine Officers are also located in Vancouver, Calgary, Montreal and Halifax. These six international airports account for nearly 94% of international flights arriving in Canada. All other points of entry are covered remotely in collaboration with Screening Officers.

Tell me more about emergency planning in mental health …

We've written about a number of different hospital experiences with emergency preparedness and response over the years, but we received some interesting questions lately about emergency planning at mental health and addictions facilities. To learn more, we sat down with Marisa Tacconelli Termine, the former director of risk management, quality and patient safety at Toronto's Centre for Addiction and Mental Health.

Q: *What do you think is most different about emergency preparedness in an addiction and mental health setting?*

A: I've had questions over the years with a lot of focus on Code Whites - how we manage violent incidents – and also regarding CAMH's work in the area of prevention and management of violence. And while we do groundbreaking work around preventing and managing aggressive behaviour, I've always been a little uncomfortable with the assumptions behind that focus. I want to say up front that it's a mistake to think of our environment and the people we serve as somehow 'worse' than what general hospitals deal with. Our clients have often had unimaginable experiences living with the multiple effects of their illnesses and associated challenges, and it's important that we don't stigmatize them even further in these types of discussions.

We work with people facing distressing symptoms and life situations, trying to do the best with the skills they have. Like any specialized service, we have to address the specific challenges faced by the populations we serve. So part of our work is to support CAMH staff in sustaining best practices and in continuous improvement, supporting safety for all, and contributing to a desired culture.

When it comes to aggressive behaviour, there are measures that can help prevent these situations from developing or escalating. Early client assessment, intervention and prevention are what we focus on to address challenging behaviour, and we make tools available to support assessment and intervention.

Other tools supporting prevention include formal risk assessments, individualized safety plans, room and furniture standards and environmental assessments. Our approach for this is client centered; this means engaging the clients in their own care, recognizing that they're the experts about themselves, and building a good therapeutic relationship. Partnering with patients and with other team members is crucial.

Our main focus CAMH-wide is on prevention. A program called Partnering to Prevent Aggressive Behaviour (PPAB) is mandatory for all clinical staff. This includes modular monthly sessions on topics from ethical and legal accountability to healthy teams and care planning. Emphasis is on prevention through core clinical competencies & partnerships between clients and the care team.

PPAB supports another program, the Prevention of Restraint and Seclusion Initiative. CAMH has successfully concluded a three-year initiative for reduction of seclusion and restraints, and we're proud of the outcomes: the Canadian Institute for Health Information report compared CAMH's rate of 1.6% for mechanical restraint very favourably to our peers across the province!

For select roles or areas (e.g. security staff or some in-patient units), felt to be at higher risk of encountering unpredictable and possibly aggressive behavior we offer training to manage aggression - Prevention and Management of Aggressive Behavior (PMAB), an ever-evolving program. This training is specific to containment. Staff are further supported through PMAB coaches, who receive intensive train-the-trainer training, including theoretical aspects as well as practical techniques. Mock team exercises further support readiness and safety for all.

Q: *As a facility you must also deal with some of the challenges that all facilities do, like fire drills and emergency evacuations. Do you face any different challenges on this front?*

A: We hold regular fire drills and other mock codes, as well as regular reviews of Emergency Codes. Annual training on the 10 Emergency Codes is mandatory for all staff, and is available via e-learning. We also work closely with partners like the Toronto Fire Department to ensure the excellence of our plans. Our redevelopment on the Queen Street Campus has been an interesting opportunity to address some of that planning in a very proactive way.

Any considerations for clients/patients who may have 'special circumstances' are reflected in our policies and procedures. For instance, with evacuation:

- Appropriate Personal Protective Equipment use is dictated in our procedures for the movement of clients/patients who are on Infection Prevention and Control additional precautions.
- The evacuation of clients/patients who are a current risk of harm to others, in seclusion or restraints are addressed, consistent with the techniques taught in the PMAB Training Program.

We have accommodated special considerations within our fire (Code Red) and evacuation (Code Green) plans. For example, evacuation plans for the Law and Mental Health Program (the program for people with mental illness who have come into contact with the law) specifies that they exit into the outside yards or dining area, which are both secure areas.

But even with special considerations like these, the people who use our services can expect what any patient in Ontario should be able to expect – safe facilities, high quality emergency plans, and a staff well-prepared to meet their needs.

For more information, contact the Office of Quality and Patient Safety (QPS) at CAMH, at (416) 535-8501 x1919.

What's New at EMB?

Ontario Health Plan for an Influenza Pandemic (OHPIP)

As discussed in previous issues of the Planner, the current round of pandemic planning underway at the ministry is unique. It's the first time we have the experience of an actual 21st century pandemic on which to reflect. Based on this experience and, as always, the input of the dedicated stakeholders who contribute to the OHPIP, some big changes are afoot in provincial influenza planning.

One of the challenges that our experience with H1N1 and subsequent flu seasons highlighted is that influenza is the only emerging infectious disease that reoccurs every year. Some seasonal influenza strains may cause greater morbidity and mortality than pandemic influenza strains. Each year, there is the potential for at-risk populations to experience severe illness and death.

While each flu season comes with a certain degree of unpredictability, there is an opportunity to apply the attention, rigour and lessons learned from pandemic planning and response to seasonal influenza. Strengthening this response will only strengthen the health system's response to an influenza pandemic!

Over the next year or so, steps will be taken to transition planning from the OHPIP (a large pandemic-focused document) to more operational tools that can be used in either a seasonal or pandemic context.

The first step in this process was the incorporation of lessons from H1N1 into a new edition of OHPIP, currently underway. The first chapters slated for release are already in the final stages of stakeholder feedback, and the entire revised plan is expected out in the summer of 2012.

The second step was the release of the *2011/2012 Seasonal Influenza Blueprint.* Distributed in January 2012, this blueprint currently focuses on provincial-level activities. Future versions will provide operational guidance for health providers/ organizations at the local level.

Following the summer of 2012, the ministry will work with our partners to integrate strategies from the *Seasonal Influenza Blueprint* with the OHPIP to develop the *Ontario Influenza Response Plan*. This integrated and comprehensive plan will include stratified, scalable response strategies to inform the health system's response to all types of influenza – both seasonal and pandemic. It is anticipated that the *Ontario Influenza Response Plan* will be released after the 2012/2013 influenza season.

For more information on the *2011/12 Seasonal Influenza Blueprint*, go to the Ministry's website. For more information on the OHPIP, stay tuned!

Health Sector Preparedness for the Pan Am Games

With the Pan Am Games in the Greater Golden Horseshoe on the horizon for 2015, a group of observers from the municipal, provincial and federal levels had the unique opportunity to participate in the Official Observer Program for the 2011 Pan Am Games in Guadalajara, Mexico. This group included two representatives from the Ministry of Health and Long-Term Care.

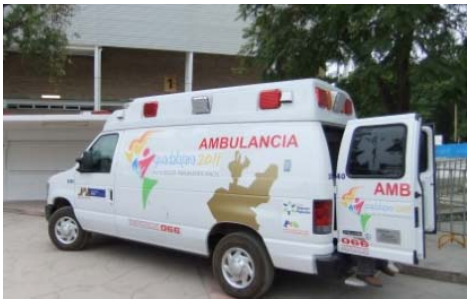
"We got to see first-hand some of the challenges an event like this can create for the health system," commented Geri Carroll, director of the Emergency Management Branch. And while there are many differences between Mexico's health system and Ontario's, both the 2015 games organizing committee (TO 2015) and the broader health system can expect to face some of the same planning questions:

- Imagine the importance of food safety not only for the 10,000 athletes, coaches and officials who are expected, but for the up to 20,000 volunteers as well! Mexico had a particular challenge in making sure that none of the meat provided to athletes contained the drug Clenbuterol, which is a banned substance for athletes – regulations regarding its use in animals intended for human consumption is different in Mexico than in jurisdictions like the U.S. and Canada.

- Infectious disease prevention and surveillance with athletes and officials coming from more than 40 countries are also key – including preparations to

prevent any risk that the host country might present to visitors, scanning globally in advance of the games to determine if there are issues of particular significance that might be imported, and systems to identify and report any signs of outbreaks during the games.

- Good planning around onsite health services at games venues is not only important to the games experience, but will also help lessen the demands a large event can place on local primary care and emergency departments.
- Large events can have major traffic impacts, and this can have implications not only for Emergency Medical Services, but for Continuity of Operations Planning for health services delivered at home and in the community.
- Ensuring that health and security have good channels of communication is also important, so that information about risks or incidents can be shared quickly and effectively, though the Pan Am games tend to present less of a risk than the Olympic games.
- And, of course, planning to ensure a quick and effective response to any potential emergency during the games is important. This includes not only emergencies that might be associated specifically with the games themselves, but other emergencies that might coincidentally occur at the same time, as those who experienced tornadoes, earthquakes, and flash floods during the G8 and G20 summits can attest!

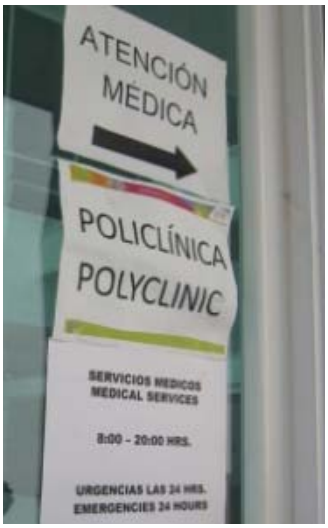


Luckily Toronto 2015 is well positioned to begin developing the Games Medical and Health Services Plan with the appointment of their Chief Medical Officer (CMO), Dr. Julia Alleyne. The scope of planning for the TO2015 CMO includes health and medical services for the athletes, officials, games workforce, and spectators at games venues. This involves, among other tasks:

- Health and medical services at the Athletes' Village – from the development of a multi-disciplinary 'polyclinic' to food safety, water safety and surveillance

- Other onsite health services at various venues
- Work with hospitals designated to receive any games-related individuals who require hospital-level care (specific hospitals for Ontario have not yet been identified)
- Emergency medical services arrangements at venues
- The games anti-doping program

Dr. Alleyne has significant experience in this arena – she has been part of the medical staff for Canadian Olympic teams in Salt Lake City, Torino, Beijing and Vancouver, and will be Chief Medical Officer for the Canadian team at the London 2012 Olympics. She is also a past President of the Canadian Academy of Sport and Exercise Medicine (2003). As Dr. Alleyne commented, "We definitely get the best athlete performance when we have healthy athletes, and that's where early and quick intervention for emergency health services is critical for success."



Planning to address those areas where the TO2015 planning overlaps with readiness in the broader health system is just beginning. The EMB will be leading work on developing a coordination and communication structure for this broader system planning. We'll look at issues like capacity, continuity of operations, coordination of emergency preparedness and communication. We hope to have an update for you soon.

Congratulations to a Key Partner!

The Planner would like to congratulate Rob Burgess, senior director at the Sunnybrook Centre for Prehospital Medicine, and lead on the operation of the provincial Emergency Medical Assistance Team (EMAT) program. Rob was one of the three recipients this year of Sunnybrook's Leo N. Steven Excellence in Leadership Award.

Rob practiced as an Advanced Care paramedic, receiving the EMS Exemplary Service Medal from the Governor General of Canada, and the Rubes Award recognizing excellence in paramedicine. He is a past president of the Ontario Paramedic Association.

Rob has also been instrumental in the review and renewal of the EMAT program over the past three years. His contributions have been key to the new, more flexible EMAT format, and he has led two successful deployments over the past two years – one to support Huntsville District Memorial Hospital during the G8 Summit in 2010, and one this past summer to support the forest fire evacuations in the northwest.

This award is more than deserved, and the EMB looks forward to continuing work with one of our most dedicated partners!

What's New at Public Health Ontario?

The Ontario Public Health Conference

Public Health Ontario (PHO), together with the Ontario Public Health Association (OPHA) and the Association of Local Public Health Agencies (alPHa), were pleased to present the Ontario Public Health Convention (TOPHC) for the second year on April 2 - 4, 2012 at the Sheraton Centre Downtown Toronto Hotel. This year's theme was "Staying Ahead of the Curve," and the program included cutting edge presentations on all aspects of health promotion, knowledge translation and, of course, health protection and public health system resilience in emergencies.

In response to last year's feedback, PHO also conducted an interactive and practical tabletop exercise focussing on five broad issue areas: 1) the Incident Management System and multi jurisdictional management of events 2) risk communication 3) risk assessment 4) resource management and 5) continuity of operations. Look for lessons from this exercise in future updates!

PHO has also been developing an incident management system (IMS) course for use as a training tool in health emergency preparedness, based on Emergency Management Ontario (EMO)'s IMS-200 course. The course is aimed at the public health and greater healthcare sectors.

After an initial testing phase, the course was delivered as a pilot in three public health units (Peel, KFL&A and Porcupine) this past December and January. Feedback indicated that there was a much greater working knowledge of IMS than assumed and that it was too long at 1.5 days duration. Participants asked for more highly focused public health scenarios to illustrate key applications of IMS. It also became clear that the needs of the public health sector are so different from the greater healthcare sector that separate tools are required.

PHO is now designing the next phase of this project in a single-day format with a focus on public health; separate courses may be developed later for the greater healthcare sector. With the IMS-100 as a pre-requisite, key concepts will be reviewed and applied in highly-developed public health scenarios which will highlight the most relevant aspects of IMS in the public health context to assist public health practitioners in managing public health incidents.

Dr. King's Corner

The Planner sat down this month with Dr. Arlene King, Ontario's Chief Medical Officer of Health, to talk about the National Preparedness Leadership Initiative (NPLI) and its application to the discipline of emergency management.

The NPLI is an initiative of the Centers for Disease Control and Prevention (CDC), the Harvard School of Public Health (HSPH) and the JFK School of Government (KSG). Its goal is to build crisis response capacity in senior leadership to address terrorism and other large scale disasters that threaten the public's health. Our own Dr. King was one of the first Canadians to participate in the NPLI in 2007. As Dr. King noted, "The program provided tremendous networking opportunities, and an opportunity to reflect on leadership during crises – such as SARS."

The NPLI program starts with two key assumptions. The first is that bad leadership can be in and of itself a risk factor for public health, and the second is that a specific type of leadership is required to address large scale incidents and 'incidents without precedent' - like complex emergencies.

The type of leadership taught through the NPLI is called meta-leadership. Meta-leadership refers to the guidance, direction and momentum across organizational lines that develop into a shared course of action – even among organizations that appear to do very different work. The qualities of meta-leaders include:

- 'Big thinking', a willingness to take on large and complex problems and search broadly for solutions
- A flexible leadership style that adopts the leadership approach (authoritative/democratic/coaching) that best suits the situation Personally demonstrates leadership attributes such as honesty, competency and inspiration,
- High scores in emotional intelligence, and
- Stamina!

The application of meta-leadership is key in health emergency management, given the need to work effectively across the health sector. Within the health sector there are many different disciplines that have their own scope of activities; however, during an emergency, these sectors need to find ways to work collaboratively. For example, during last summer's evacuations due to the forest fires in northern Ontario, the health sector in the province took on many different response roles from medical transportation to inspection of food premises in the temporary evacuation centres and the direct provision of health care services to evacuees. While each of these activities is very different and is performed by different organizations, they all supported the same goal of ensuring the health and safety of evacuees.

Meta-leadership is also consistent with Incident Management System leadership principles, like the unity of command and the coordination of a range of response activities (operational tasks) towards a common goal.

Said Dr. King: "Meta-leadership provides a structured way to think about the various paradigms in which we work during an emergency. However, its application extends beyond that of emergency management to the many complex issues – the wicked problems – we address everyday."

For more information about meta-leadership and its five dimensions please see:

- Marcus LJ, Dorn BC, Henderson JM, Meta-leadership and national emergency preparedness: A model to build government connectivity. Biosecur Bioterror. 2006;4(2):128-34.
- http://www.hsph.harvard.edu/npli/meta-leadership/
- http://www.youtube.com/watch?v=eCFIdNAizGM

Training and Exercises

Operation Plugged In

In October 2011, Simcoe County conducted a major tabletop exercise focused on a winter storm and an extended power outage scenario: Operation Plugged In. With 170 participants from a wide variety of disciplines, including both public and private sectors, discussion ranged widely.

The exercise Design Team - which consisted of representatives from County of Simcoe Emergency Management, Town of Innisfil Fire Services, and the Simcoe Muskoka District Health Unit – put together this large and ambitious exercise based on findings from Simcoe's earlier exercise experiences, such as the 2006 pandemic exercise "Operation Fever Phix." These previous experiences made it clear that any extended emergency response would engage multiple partners across the whole community, and that discussions should involve diverse agencies and roles.

Objectives for Operation Plugged in included promoting a common business continuity planning template and lexicon, promoting the Incident Management system, clarifying roles and responsibilities among a wide range of agencies, and identifying vulnerabilities in existing plans.

This exercise also made an effort to address two aspects of emergency management that sometimes don't get as much attention as preparedness and the immediate emergency response.

One aspect was the inclusion of a module on the recovery phase. This module included a focus on human needs, such as how to handle emergency shelter for people who may not be able to return to their homes for up to three weeks, including vulnerable individuals who may have ongoing support needs, and how to deal with a widespread need for crisis counseling. It also looked at business needs, such as dealing with employees who may have been significantly impacted, and at issues like data loss and insurance plans.

The second was a focus on psychosocial support, and the various caring professions involved in providing it. Experience has taught us the importance this question quickly assumes in an emergency.

While perspectives and concerns were diverse, some common concerns were identified:

- The importance of planning in an integrated, system-based way, rather than in silos. It was pointed out that multiple separate plans sometimes relied on the same resources, without the coordination to make sure that there weren't duplicated expectations. It's also important to make sure that the resources you're relying on know they're in your plan! This was a particular focus at the health table, where it was both recognised that better coordination between health and other sectors is key, and that the health system itself could improve coordination among its various parts.
- An important example of a common resource is fuel. There was great concern that in an extended power outage all sectors would be relying on a limited supply of fuel for everything from keeping hospital generators running to the transport of key supplies.
- Participants agreed that compassion fatigue support for response personnel and volunteers, as well as an awareness of the impacts of decision fatigue for Emergency Operations Centre teams, is critical at all phases of an emergency event.

To access the full exercise materials and videos, including the After Action Report with summary recommendations, visit www.simcoemuskokaemergency.ca. Click on the County of Simcoe logo at the bottom and follow the link for Emergency Management Program.

For more information on Operation Plugged In please contact Cathy Clark, CEMC, Simcoe County.

Trillium Navigate Launches New Collaboration!

In November 2011, a day-long provincial tabletop exercise took place in Toronto, carried out in association with a national emergency exercise series focusing on urban mass transit. Led by Emergency Management Ontario (EMO), Exercise Trillium Navigate focused on suspicious explosions taking place on transit in Hamilton and Toronto.

Ambitious exercises are, as contributions to this newsletter have proven, nothing new to Ontario. Local health facilities, agencies and services participate in a variety of local and regional exercises. The Ministry of Health and Long-Term Care (MOHLTC) participates each year in a provincial exercise led by EMO, and the provincial Emergency Medical Assistance Team (EMAT) carries out a live deployment exercise in partnership with one of Ontario's hospitals approximately every 18 months.

However, this year's exercise presented a chance for us here at the MOHLTC to try something new. We invited a number of local health care

stakeholders from two major urban centres, Hamilton and Toronto, to participate as both designers and players in a major provincial exercise.

Discussions during the morning were broken into six subject groups - CBRNE (Chemical, Biological, Radiological, Nuclear, and Explosive) Response, Emergency Information & Communications, Social Services, Continuity of Operations and, of course, Health – a group of more than 35 stakeholders! Health group participants represented EMS, hospitals and public health from the Greater Toronto Area (GTA) and Hamilton, other health agencies such as Community Care Access Centres and CritiCall, non-government organizations (NGOs) such as St. John Ambulance, and Canadian Blood Services. Health Canada and the Public Health Agency of Canada also participated, as did representatives from related areas such as fire services, law enforcement and the Office of the Chief Coroner.

Discussion ranged widely as the group worked through the complexities of roles, responsibilities, and plans in a scenario including both mass casualty and CBRNE responses. Connections were made, assumptions re-examined, and important questions raised.

Despite the logistical challenges in coordinating such a large health group in the context of a larger exercise, it was undoubtedly useful. In fact, one of the primary suggestions for improvement at the debrief was that the exercise could have gone longer!

"I learned a lot and the questions raised were useful," noted one participant as the day wound up, "but we only scratched the surface – we could have spent a whole other day working through the answers!"

A special thanks is due to those local stakeholders who contributed to the design process, including major hospitals in Hamilton and the GTA, Public Health and EMS from Toronto and Hamilton, the Toronto Central CCAC, and others! As Alastair Hodinott, who participated on behalf of the Hospital for Sick Children, noted, "I think this provided a fantastic opportunity to participate with our colleagues from all disciplines in a disaster exercise, and provided clarity and insight into the roles and responsibilities of each."

Other exercises using the scenario developed for this day will continue into 2012, including EMAT's semi-annual live deployment exercise, in partnership with St. Joseph's Healthcare Hamilton and Hamilton Health Sciences, and other tabletop exercises involving Hamilton area health stakeholders.

We're hopeful that this experience lays the groundwork for greater health sector participation in other large provincial exercises in future.

For more information about the exercise contact the Emergency Management Branch.

Upcoming Events

HEPCO Conference – a focus on evacuation

The Hospital Emergency Preparedness Committee of Ottawa (HEPCO) will be hosting a day-long conference on Friday October 26, 2012.

HEPCO, previously featured in the Spring 2011 edition Of the Planner, is made up of emergency managers from the health sector, first responders and the City Office of Emergency Management. The theme of this year's symposium is evacuation, and the goal is to provide a broad spectrum of presentations for all sectors. The northern forest fire evacuations in summer 2011 will be one focus, including the roles that public health, the municipality, community partners and the ministry played. Speakers with a wealth of experience with hospital evacuations are coming from the CDC and from British Columbia. Finally, there is a presentation from long-term care, where tough lessons are to be learnt. "Evacuations, Lessons to be Learned" will be at Ben Franklin Place, Ottawa on October 26, 2012. Registration information is forthcoming shortly.

For more information on HEPCO and their conference, please contact Jill Courtemanche at Ottawa Public Health.

Public Health Emergency Planners Group

The Public Health Emergency Planners Group has an upcoming meeting on Friday, May 4th in the Toronto area. For more information, contact Pat Simone at Middlesex-London Health Unit.

Critical Incident Stress Management training

Middlesex-London Health Unit is also running two upcoming Critical Incident Stress Management training sessions. These courses will prepare participants to understand a wide range of crisis intervention services, and provide several interventions. The Level I course will familiarize participants with providing demobilizations after large scale traumatic incidents, small group defusing and the group intervention known as Critical Incident Stress Debriefing (CISD). The Level II course will broaden the knowledge base concerning critical incident stress interventions as well as post- traumatic stress disorder, with an emphasis on advanced defusing and debriefing in complex situations. Both courses will be taught by Mr. Murray Firth, who has been actively involved internationally in the delivery of critical incident stress management education and services for over 15 years.

The training is open to all, and is relevant to human resources, mental health and other medical professionals, public safety personnel,

and a range of other emergency response workers.

- Level 1 will be on May 23 and 24
- Level 2 will be offered on June 27 and 28.

Further details are available on the Middlesex-London Health Unit website.

Not on the Emergency Planner Distribution List?

If you would like to be added to the Emergency Preparedness Planner's distribution list or would like to update your current registration, please contact Emergencymanagement.moh@ontario.ca or call 416-212-0822.