Emergency Preparedness Planner

A Newsletter for the Health System

Emergency Management Branch, Ministry of Health and Long-Term Care

Spring 2013

On the Move with the Planner

Welcome back to the Planner! Our theme in this latest issue is 'On the Move.' Here we bring you news about a conference on health care and evacuation, cross-provincial surge capacity planning, and the December fire in the Health Centre in Moosonee which led to the Emergency Medical Assistance Team's most northern deployment where they worked with the Health Centre staff to set up a temporary clinic in the local curling rink.

We also bring you some thoughts on the 2012/13 flu season which swept into Ontario early and aggressively, and a new *Dr. King's Corner*, which ponders the ongoing monitoring of the novel coronavirus in the Middle East which is being watched carefully for developments and any additional spread.

Last but not least, there are reflections on Exercise Huron Challenge. We hope you enjoy this jam-packed issue!

~ Gerilynne Carroll, Director Emergency Management Branch (EMB)

Ontario

"Healthcare Evacuation: Lessons Noted, Lessons Applied = Lessons Learned" – a Report on the Annual HEPCO Symposium

~ A guest article by Jill Courtemanche, Ottawa Public Health

Last October 26, the Hospital Emergency Preparedness Committee of Ottawa (HEPCO) hosted their 13th annual symposium. Eighty-five emergency practitioners from around the province and one from Mont Laurier, Quebec joined us for "Healthcare Evacuation: Lessons Noted, Lessons Applied = Lessons Learned".

As the title implies, the focus was on shortcomings learned from past experiences, and working corrective actions into our planning. Evacuation was chosen because aging infrastructures - both buildings and services - and changing climate patterns all raise the probability that we could be faced with the evacuation of a health care institution. Increasing patient acuity compounds the issue. Gone are the days when evacuation plans talked about "managing ambulatory patients."

We were thrilled to welcome our first keynote speaker, Dr Mark Keim from Atlanta, Georgia, where he is the Associate Director of Science with the US Centres for Disease Control (CDC). His credentials are extensive. Not only is he is trained in Emergency and Disaster Medicine, he has extensive experience consulting for dozens of emergencies around the world, including the World Trade Centre, Hurricane Katrina and the Indian Ocean Tsunami.

Dr. Keim provided statistics from an overview of hospital evacuations in the U.S. and internationally for over 30 years. This included why hospitals were evacuated, how many patients were involved, how long the evacuations lasted, and whether the evacuations were partial or complete, planned or unplanned. Of interest was the fact that the number of incidents rose exponentially over that period, lending credence to our impression that the risk is increasing. His presentation also offered many practical recommendations, such as the importance of having alternate generator back-ups -- a common failure.

The second keynote speaker came from British Columbia, where Dr. Graham Dodd's sudden propulsion into the evacuation of not only a hospital, but the town in which it was located, led him to pursue his Masters in Emergency Management. A skilled and entertaining presenter, Dr Dodd humourously noted that for some disasters you had to go no further than your daily ER, where the manual would be aptly titled "Overcrowding for Dummies."

His presentation complemented Dr Keim's with a different perspective: that of what happens when the hospital is both needed to receive disaster victims, and in turn is a victim itself. He elaborated on the criteria used when deciding to evacuate.

The next three presentations shifted the focus from hospital evacuations to receiving evacuees.

Clint Shingler, a manager with the Emergency Management Branch of the Ministry of Health and Long-Term Care (MOHLTC), provided an overview of the threat of evacuations due to forest fires in Ontario, the resources the Ministry has to assist receiving communities, and the planning initiatives developed based on past experiences to improve the response.

These included prior assessments of both evacuee health information and of the health care capacity of responding communities, facilitating sharing of information between evacuating and host communities, facilitating OHIP registrations, and webinars on particular challenges that could arise, such as opiate addictions management in an evacuation setting. All of this pre-planning helped ensure that past problems would not be repeated.

Two more presentations on Northern Evacuations rounded out the perspectives on this issue -- one from the Red Cross which managed a shelter for 500 in a small town, and the other from Ottawa Public Health (OPH) which provided shelter for a smaller number of more acute evacuees, both in 2011.

The Red Cross recommended that regular exercises in shelter operations between community based organizations and community partners would result in a smoother implementation, while OPH used their experience to enhance their development of a Health Plan for Northern Evacuations. This included extensive collaboration with their Local Health Integration Network (LHIN) for the provision of primary and specialized services, as well as with aboriginal support groups.

Finally, "Three Weeks in Winter" was an excellent account from the Simcoe County Emergency Manager on the experience of evacuating not one but three nursing homes in close succession in 2012. All of the homes involved evacuees with special needs, with the final event resulting in the tragic loss of four lives. These incidents highlighted the range of preparedness that can be found in private facilities. The speaker presented the plans that were developed in the aftermath, which are gold standards that could be used by other long term care facilities in developing their own plans.

Anyone with a question or who wishes to see a copy of one of these presentations can contact me, Jill Courtemanche at Ottawa Public Health.

Fire in Moosonee

On December 4, 2012 there was a fire in the storage room adjacent to the health centre in Moosonee, Ontario. The fire burned supplies in the storage room and led to significant smoke and water damage in the health centre building, rendering the structure unusable. Damage could have been worse, but for the quick thinking of one health centre employee who shut the door to the emergency bays as the building was being evacuated.

The health centre in Moosonee plays an important role in the local community and is part of the Weenebayko Area Health Authority (WAHA). The health centre provides emergency and outpatient health care services to the approximately 3,500 residents of Moosonee as well as to many of the First Nation communities along the James Bay coast. Patients who can't be treated at the health centre are transferred to the Weeneebayko General Hospital in Moose Factory, across the Moose River from Moosonee.

In response to the fire, WAHA and the Ministry of Health and Long-Term Care's Emergency Management Branch decided that the best way forward would be to deploy the Emergency Medical Assistance Team (EMAT). EMAT is a 56-bed field hospital that can be deployed to an area of the province to support health system partners who are overwhelmed or at significant risk of being overwhelmed. Unlike EMAT's traditional deployments, what WAHA required was support to set up a health clinic in a non-traditional setting, and access to some of EMAT's supplies and equipment.

EMAT deployed a small contingent to Moosonee, made up of members of their Incident Command Team and a logistics specialist. The objectives of EMAT's deployment to Moosonee were to:

- establish a clinic that provides 10 beds, including two emergency bays offering resuscitation and negative pressure, reflecting the services typically offered by the clinic;
- provide training to local staff around the use and maintenance of the equipment, caring for patients in an austere environment, patient flow issues, and functioning within an IMS structure; and
- provide transitional support to clinical staff while they gain knowledge and confidence with the new set-up

Within one week of the fire – almost to the hour - a working clinic was set up and seeing patients. The Planner team sat down with Rachel Cull, Vice President of Patient Care at WAHA to find out the lessons learned from the response.

One of the main challenges encountered in setting up a temporary health centre in Moosonee was finding a suitable location. The best option at the time was the town's curling rink due to its availability. It came as no surprise however that setting up a clinic in a curling rink has some inherent challenges.

One of the most significant challenges was heating the space. Curling rinks are not heated or insulated buildings, and the December temperature in Moosonee can drop to lows of -30^{o}C. EMAT and WAHA, including the maintenance team from the Moose Factory hospital, worked together to develop a logistics strategy for the rink. It took three days to implement the heating plan – a step that needed to take place before clinical services could begin. Along with heating, other logistical issues that needed to be overcome included expanding the phone system in the rink and setting up a back-up power supply.

Because of Moosonee's location, transportation routes into the area and to the regional hospital in Moose Factory are limited. Options were further constrained by the cold weather conditions.. Consideration of how to move patients, technical specialists, clinical providers, supplies and even EMAT itself needed to be integrated into all elements of the larger response plan. For example, moving staff and patients between the communities by helicopter could only happen during daytime hours (8am-4pm) and ice skidoo transportation was precarious as the river between Moosonee and Moose Factory was not yet frozen.

While the clinic was being set up in the curling rink, arrangements were made through a partnership with Ornge and the James Bay Ambulance Service to continue to provide emergency health care services within the region. WAHA also worked with the James Bay Ambulance Service, CritiCall, Ornge, the NorthEast LHIN and the Emergency Management Branch to develop an interim patient transportation strategy to try to reduce the need for transfers to Moose Factory.

Rachel shared some observations for others facing a similar event. The first was that when considering different candidate locations for a temporary clinic, responders should look for space in facilities with strong existing infrastructure. These types of locations will significantly shorten the time needed to open a clinic to patient care. However, getting access to such space can be difficult as temporary clinics may need to be set up for a prolonged period of time.

Another observation Rachel had was to call the Emergency Management Branch as early as possible to start discussions with EMAT. Finally, Rachel told The Planner staff, "Working as a team was really important to our success. Because of the unique challenges of the task and our environment, we needed to pull together a lot of different types of experts who could think through and identify solutions to our specific logistical challenges."

Did you know… Spring flooding season almost over!

Spring is here officially now, and with it comes the annual spring flood season – and this year's has been an active one! In Muskoka communities such as Bracebridge and Huntsville declared emergencies. In Northwestern Ontario – home to the Moose and Albany Rivers – there have been flood-related evacuations of vulnerable community members due to sewage system failures caused by melting snowpack as well as the more usual river flooding. First Nations such as Kashechewan and Attawapiskat have been impacted, as well as the town of Moosonee.

Evacuations bring with them a variety of challenges for the health system, and health partners have been doing a great job of managing the demands. Look for more information in upcoming issues!

In the meantime, look for updates on the situation on Emergency Management Ontario's website, flood warnings on the Ministry of Natural Resource's flood information page, and information on flooding and your health on the MOHLTC website!

Dr. King's Corner

As noted in the fall 2012 issue of the Planner, MOHLTC is currently watching the developments around a novel coronavirus closely. While there have been no known cases of novel coronavirus in Canada, and a small number of known cases internationally, the complexity of the situation demands our continued attention.

This situation shares four common features of complex events as described in the Incident Management System (IMS) literature.

First is the need to coordinate response resources from many organizations and governments. Second is a diffuse geographic location and occurrence over a long time period. Third is that they unfold with a high level of uncertainty – with many poorly understood variables in the response. Fourth, complex events can incite a high degree of public interest.

Coordination of resources

Response activities for novel coronavirus are being coordinated by many organizations and governments. At the international level, the World Health Organization (WHO) is sharing information about cases through its Global Alert and Response program. This program is an integrated alert and response system for epidemics and other public health emergencies and supports the operationalization of the International Health Regulations (2005). The WHO also develops and shares guidance on surveillance and laboratory activities, infection prevention and control practices and clinical information with the international health community.

At the national level, Canada's federal government has the dual responsibility of interpreting and sharing and WHO guidance, and developing and implementing a national response. This includes processes to report newly identified cases of the novel coronavirus, a requirement of the Internal Health Regulations (2005).

At the provincial level, in Ontario, the MOHLTC is working with Public Health Ontario and the Ministry of Labour to monitor information from the Public Health Agency of Canada (PHAC), the WHO and other international governments and public health agencies to understand the risk of this situation for Ontario, to interpret guidance for the Ontario context and to share information with the people of Ontario and Ontario health workers and health sector employers.

At the local level, public health units, health care organizations, health sector employers and health workers develop regional and organizational processes to identify and report suspect cases and integrate guidance into their clinical, infection prevention & control, and occupational health & safety practices.

Other groups, such as professional organizations, colleges and unions share recommendations with members. This adds an additional layer of activity, with information moving horizontally through networks at the local, provincial, national and international levels.

Diffuse geographic location and occurs over a long time period

Novel coronavirus cases have a diffuse geographic location and have been circulating for over a year. Cases have been identified in the Kingdom of Saudi Arabia, Jordan, Qatar, United Arab Emirates, United Kingdom, Germany, and France. The first case of novel coronavirus was identified in the fall of 2012, although retrospective analysis has subsequently identified earlier cases dating back to the spring of 2012. Infections continue to be announced, and additional locations are possible. .

Evolving situation, many information gaps

A disease is labeled novel when a new type of virus or pathogen is identified. Despite the fact that coronaviruses in general are very common (think of the common cold), there is little definitive information known about this virus and its impact on humans. Unlike the common cold, this virus appears not to transmit from person-to-person easily and does appear to cause very serious disease; however, because there have only been a small number of cases, there is very limited information on the scope of disease the virus can cause. Each new case or cluster has the possibility of identifying a new piece of the novel virus puzzle. For example, the recent cases identified in the United Kingdom,France and Saudi Arabia suggest evidence of person-to-person transmission is possible; however, the cases do not signify sustained transmission among people. While pieces of the puzzle are being found, the source of infection remains unknown.

High degree of public interest

While there have only been a small number of cases identified, and the public health risk in Canada is low, the situation has garnered significant media and social media attention.

For many in Ontario, the emergence of this novel coronavirus is likely to bring back memories of Severe Acute Respiratory Disease (SARS) in 2003. SARS was also a novel coronavirus; however, this new coronavirus is not SARS and has not demonstrated the same epidemiological pattern as SARS.

MOHLTC actions

The MOHLTC has worked with public health units, partner ministries and Public Health Ontario to develop a plan to respond should cases be identified in Ontario. The MOHLTC has focused efforts on ensuring that health workers, health sector employers have situational awareness of the evolving situation. In addition to the two Important Health Notices that have been issued, the MOHLTC has developed a website to share information and recommendations about the novel coronavirus. This website is being updated as needed.

As always, if health workers or health sector employers have questions, they are encouraged to call the Health Care Providers Hotline at 1-866-212-2272.

Exercises

A Pan-Canadian Exercise in Mutual Aid

In 2009, the Ministers of Health across Canada signed a Memorandum of Understanding (MOU) on sharing health resources during emergencies with major

health impacts. In the intervening years, work at the Federal/Provincial/Territorial level with the Public Health Agency of Canada (PHAC) has gone into developing a draft Operational Framework, meant to provide a suite of common protocols or approaches that could make this MOU operational. The first focus has been on the sharing of nurses and physicians across provincial borders. A 'distributed tabletop' exercise with the provinces and PHAC was held on February 7 to examine the assumptions and basic processes that are currently being proposed.

As anyone who has looked at the question of sharing staff – even between institutions - knows, the considerations can be complex. When you add in the complications of travel outside of their home province, even more complexities are introduced. How do you identify interested health care providers? How do you address licensure and credentials which vary province to province? Who do they report to and who provides oversight? How can volunteers be supported away from their homes and usual work environments? There are further questions of workplace safety and insurance, as well as pay.

The Draft Operational Framework has begun to flesh out a picture of how this sort of sharing could work. The current version looks at approaches to notification, formal requests across provincial boundaries, and licensure mechanisms.

The distributed table top model involved a webinar hosted by PHAC, in which a basic scenario, injects and discussion questions were presented to all provinces in a plenary session. Provinces then held their own separate facilitated discussion sessions, with facilitators provided by PHAC and Health Canada, followed by a report-back plenary in which all provinces shared highlights from their guided discussions.

The Ontario session included both the ministry and representation from the College of Physicians and Surgeons of Ontario (CPSO), College of Nurses of Ontario (CNO) and Emergency Management Ontario (EMO).

The discussion validated the basic notification and request approaches suggested, identified some key roles and responsibilities, and identified a number of areas where specific protocols and mechanisms must be developed. Excitingly, options for the issuing of temporary licenses to practice in Ontario in an emergency are well underway, with the CPSO using the short duration class license as the underlying principle, and the CNO having a new Emergency Assignment class certificate of registration. The details of the processes still need to be worked through, but the foundations are in place.

A number of important areas – including workplace safety and insurance - require further discussion, but this is a new and important step in making our health system more resilient in Ontario and beyond!

Exercise Huron Challenge: Participants Reflect

In October 2012, the Huron Challenge Exercise Program culminated in the three-day, multi-agency, full-scale exercise Trillium Resolve. Led by Emergency Management Ontario, in close co-operation with Bruce Power, the exercise was a combination of 'boots on the ground' activities plus table-top, discussion-based and functional

Emergency Operations Centre focused exercises. More than 50 organizations - and approximately 1,000 participants – were involved.

Inspired by the 2011 earthquake and tsunami, and the impact they had on the Fukushima Daiichi nuclear plant in Japan, the exercise looked at an overall severe weather scenario in which storms and tornadoes triggered a series of other events. These events ranged from power outages to road accidents and spills to impacts on operations at the Bruce Nuclear plant. This scenario offered participants a sense of what it would be like to experience a truly complex scenario in which they were responding to numerous individual crises making up an ever-changing larger picture.

The health sector's participation was coordinated by the Emergency Management Branch (EMB), Ministry of Health and Long-Term Care (MOHLTC), and involved more than a dozen different agencies or facilities. For this issue, the Planner reflected on some of the ministry experiences and talked to two of the participating hospitals: Alexandra Marine & General Hospital (AMGH) in Goderich and Grey Bruce Health Services (GBHS), a six-hospital corporation in the Grey Bruce area, including Southampton, Markdale and Owen Sound sites. Neither hospital had participated in a large provincial exercise before.

At the provincial level, one of the immediate challenges was maintaining accurate situational awareness. With updates coming from a variety of sources at a variety of sites and levels, events evolving quickly, and multiple task groups required to address different issues, simply tracking exactly what had happened where became complicated. This reinforced the importance of the briefing cycle in the Incident Management System (IMS), and the need for dedicated attention in the planning and operations sections to maintain the full operational picture.

This experience was echoed by the hospitals. "We've participated in county, town, and industry exercises," noted Richard Bedard, CIO/Director of Clinical Support at AMGH. "We routinely practice emergency preparedness through regular mock exercises. In addition, we've responded to two actual events, including a cyclone and recently, a tornado. For the Huron Challenge exercise, we found the sheer volume of information highly challenging."

As a multi-site hospital, GBHS exercised some of their own communication and coordination processes. On one day they used a "hub" approach, in which key decision-makers gathered at one site. The next day they moved to a video conference-facilitated structure. "It was challenging having lots of information coming in through many different channels - email, phone and video-conference," noted Sonja Glass, Chief Quality Officer at GBHS. "As a facilitator, I couldn't monitor all of those sources on my own. And we certainly learned the value of the Liaison Officer role when so many partners are involved – in some cases you may need more than one LO."

One difference in an exercise, of course, is that regular business is expected to continue as usual in the background, whereas in a real emergency, priorities change. Both hospitals acknowledged that participation in an exercise on this scale was resource-intensive. "We had over one hundred participants playing throughout the exercise," said Glass. "On a multi-day exercise, that's a big commitment."

“We’re strongly committed to emergency preparedness here at AMGH,” said Bedard. “As part of our exercise program, we coordinate a monthly unannounced code exercise, with the responsibility for design and control rotating through different staff, so most of us have experience in both design and play. We’re no stranger to the work involved with putting together many components into an exercise - for instance we completed a Code Purple exercise a couple of months ago that had a SWAT team move through the entire hospital, not just the hostage area. This allowed the exercise to mimic a real situation for much of the organization as well as our external participants (police). Planning for Huron Challenge was very demanding and I’d recommend watching for scope creep to anyone getting involved in a major exercise like this – it’s very easy to get carried away with adding new players and additional objectives.”

But there are also unique opportunities to an exercise on this scale. “We certainly engaged with new and different partners,” said Bedard. “There were so many different levels involved in all of this – not just the municipality and county, but the various provincial ministries, the technical experts and so forth.”

“We became much more aware of some of the resources that were available to us,” noted Glass, “and we’d never had this extent of external engagement from other EOCs, from the county EOC to the Ministry MEOC and the Provincial PEOC. It was a gap we had identified for ourselves, and the exercise really allowed us to address it. And this happened not just during play, but in the training that preceded it where we interacted with other players.” The interaction with other players provided some interesting insights into GBHS’s IMS structure.

“We instituted IMS in 2006/2007,” Glass explained. “We’ve used it extensively – and not just through regularly planned mock exercises. We’ve had partial evacuation at some of our sites – once due to the Chapman’s Ice Cream factory fire, where we left only the Emergency Department capacity in place to be prepared to meet the needs of any first responders, and a couple of times due to onsite issues like broken water mains or a fire in one of our clinical units. But when we put our system in place, we were using Incident Command System resources from California. We learned quickly that we needed to update to reflect the Ontario-specific IMS materials that have since been developed. We needed to make sure our job action sheets and language reflected what everyone else was using, so we could connect with the municipality and first responders more effectively. We’ve already begun updating them. We’ve also started making closer connections with our municipality, and we’re reviewing the local Hazard Identification and Risk Assessment with them to make sure we’re planning in alignment.”

Both hospitals agreed that the exercise highlighted some CBRN questions for them. “I’m so proud of our team,” said Glass. “From first notification that a patient needed decontamination to full set-up of the CBRN tent, it took 32 minutes. But I really wonder about Code Brown readiness and sustainability at smaller rural hospitals. One of our sites only has four people in the emergency department overnight, so a response would essentially use that whole capacity until more staff can come in.”

“The core equipment we were provided with needed supplementing for our setting, and we only figured out what we really needed once we started using the equipment during exercises carried out in past years,” noted Bedard. “But exercising also causes wear

and tear on equipment. It's a challenge for hospitals to build staffing for exercises and replacement of capital equipment into budgets with current financial pressures."

The MOHLTC After Action Report is currently being prepared and will capture the valuable lessons learned for the MOHLTC and its health sector partners.This includes the need to continue strengthening relationships established during the exercise, and working to enhance understanding within and across organizations and sectors.

From a provincial perspective, having stakeholders willing and able to play in large scale exercises like these adds an aspect of realism that can't be manufactured in any other way, and provides an invaluable frontline perspective. We'd like to take this opportunity to thank our health system partners for all their hard work and insight!

Did you know? Insights into a Hospital Exercise Program

The Planner asked Alexandra Marine and General about their monthly code exercise program. What's the key to maintaining this level of commitment?

"Well, you really need a vision," commented Rick Bedard. "Emergency preparedness must be seen as important across the whole organization and treated as a priority. We can have plans and procedures that look great on paper, but I truly believe that if we do not do practice runs of the plans, we will not know if they'll work. Our program has really taught us this, and we have a group of people who see the value and have a vested interest. We have successfully responded to a cyclone and tornado.

To be successful, I believe mock exercises need to be taken seriously. We always complete a debriefing and review afterwards, and take corrective action – it's not enough to address something on paper. During an emergency, it's challenging to ask people to take on new roles – people gravitate towards known and familiar functions. Our staff appreciate and value regular mock exercises. It makes them feel much more familiar and comfortable with emergency processes and roles. Living them through an exercise changes the dynamic and makes them real, as well as pointing out the practical supports that are necessary for processes to work."

One way AMGH has managed the demands of regular exercise design is by rotating the design and control responsibility among different people. And this has had another advantage: "Not only do we get a range of people with experience, but a little friendly competition helps keep the quality high. No one wants to be outdone by last month's exercise!" The spirit of fun clearly helps keep people invested in the program.

Would you like to learn more about the AMGH exercise program? Contact Richard Bedard, CIO/Director of Clinical Support.

What's New in Health Emergency Management?

What's new at Public Health Ontario (PHO)?

PHO has hosted a series of the following special presentations relevant to Emergency Preparedness. Keep your eye on the Public Health Ontario website for upcoming sessions at:

http://www.publichealthontario.ca/en/LearningAndDevelopment/Events/Pages/default.aspx#.Ub9Wb-dJ5wA

- Last September visiting speaker Dr. Daniel Barnett examined research on the willingness of health providers to respond to public health emergencies. He noted how perceptions of threat and efficacy influence response willingness. He also explored policy considerations for disaster surge capacity among local public health agencies.
- In October, PHO hosted the session "A Gale of Two Cities," comparing and contrasting responses to tornadoes in Alabama and Ontario in 2011. Dr. Sarah Nafziger of Alabama emphasized the need for advance planning and making full use of volunteers. Donna Parsons from Goderich, Ontario stressed the importance of updating internal plans and clarifying roles with partners before disasters.
- In November, Dr. Robin Williams, Ontario's acting ACMOH, and Loretta Chandler, Toronto's Director of Emergency Management discussed the challenges in integrating emergency response in public health with health care delivery and non-health organizations. Their comparison of Niagara Region and Toronto highlighted emergency management governance structures and potential areas of collaboration.
- In January, we collaborated with PHO Research and Ethics Services to hosted Dr. Matthew Hunt from McGill University, who discussed disaster research in terms of scientific validity, the need for informed consent, critical examination of who is doing and funding the research, and fair selection of study populations. While there are ethical concerns about disaster research, it may be unethical *not* to do research after disasters to inform future preparedness and mitigation activities.
- In February, PHO's own Drs. Jonathan Gubbay and Doug Sider presented the etiology, chronology and laboratory detection of the novel coronavirus discovered in Europe and the Middle East in 2012. Although we have learned a great deal since the last novel coronavirus epidemic (SARS 2003), there is still more to learn about effective notification strategies and rapid response to evolving global outbreaks.
- Finally, in May, Dr. Laura Rosella, scientist at Public Health Ontario and assistant professor at the Dalla Lana School of Public Health, presented a paper about how Canadian decision-makers set public health policy during pandemic H1N1, The presentation highlighted the study's main findings and key recommendations for improving the integration of evidence into decision-making about public health actions and policies during a pandemic.

What's new at Emergency Management Branch?

In December 2012 the health system began to see indications that seasonal influenza activity was starting early. While influenza is a notoriously unpredictable disease, evidence of early virus activity raised concerns at the Emergency Management Branch (EMB).

With the support of Public Health Ontario and the Emergency Department Syndromic Surveillance system, it was estimated that influenza activity would peak across the province over the holiday season and into the first weeks of January. Because of this timing, influenza season was likely to peak over the period of time when many people

would be traveling and getting together for the holidays – a great way to spread the virus – and when the health system's capacity would be decreased as health providers themselves took time to be with friends and family.

While health providers had different experiences, the overall consensus was that this was a busy influenza season. Many organizations used plans and strategies developed as part of their emergency management programs to respond to the event. At the ministry, this was the first time that our Emergency Operations Centre has been activated to respond to seasonal influenza. For us, this experience reinforces the value of leveraging emergency management tools to respond to events that are not formal 'emergencies' as defined in the Emergency Management and Civil Protection Act, but that do carry a high degree of risk to human health or to the integrity of the health system.

We have developed a lessons learned process to collect the experiences of health providers and organizations as well as the strategies that were used to respond to influenza this year. This information will be used to inform influenza response plans and programs. Look out for our surveys and feel free to share additional written submissions with the ministry by emailing: emergencymanagement.moh@ontario.ca .

This year's influenza season also reinforces the value of the severity-based approach that has been used to update the Ontario Health Plan for an Influenza Pandemic (OHPIP). This approach recognizes that a range of response measures to a given hazard could be appropriate and that the final decision about what measures are most appropriate cannot be known until the severity of the event is understood. In the case of influenza, this also means that approaches generally used to respond to seasonal influenza may be applicable in a pandemic scenario and, conversely, pandemic strategies may be applicable to a given seasonal influenza response depending upon the impact of the virus. We are happy to share with you that the updated OHPIP has been released and is posted on the ministry's website. .

What's new at the Public Health Emergency Planners Nework?

~ A guest article by Connie Verhaeghe, City of Hamilton - Public Health Services

The Public Health Unit Emergency Planners met late November 2012 at the City of Hamilton Emergency Operations Centre. Difficulty parking and technical problems hampered telephone conferencing resulting in a rather chaotic start to the meeting. It was however a great meeting for sharing, networking and understanding how our colleagues tackle preparedness and response issues within health units.

Updates from the Emergency Management Branch presented by Gerri Carroll included the plans for the 2013 release of the Ministry of Health Emergency Response Plan, the Ontario Influenza Response Plan, the Radiation Health Response Plan, the Health Evacuation Plan and the Health System Emergency Response Plan. The Ministry also provided a brief update on preparing for the Pan /Parapan AM Games and the legacy opportunities presented by hosting these games.

Dr. Brian Schwartz, Chief of Emergency Preparedness with Public Health Ontario (PHO), provided an enlightening presentation highlighting the Order-in-Council responsibilities of the MOHLTC during an emergency which includes services for

human health, disease and epidemics and ensuring health services during an emergency.

PHO focused on the Incident Management System, demonstrating the importance of this framework for response. Many health units have received PHO's IMS training course and have been impressed with the content and implementation of this course for health units. A new direction was proposed to develop a 'Train the Trainer' course to assist with the implementation of IMS in health units throughout the province. Brian also highlighted the Health Emergency Preparedness and Response Triad among public health units, emergency management and our healthcare delivery system. A relationship to be fostered and harnessed!

Brian concluded with the Public Health Unit's Needs Assessment Survey. This survey invites PHUs to provide feedback to PHO regarding their needs on emergency preparedness training. The survey also reveals current IMS training practices and uncovers the perception of IMS usefulness for PHUs.

Oxford, Huron, Hamilton, London and North Bay provided updates and lesson learned from their recent public Hhalth exercises. Common themes focused around communication, clarifying leadership roles and allocation of resources during an emergency.

The afternoon was spent networking and sharing preparedness and response strategies within health units. Discussion focused around standards of documentation during an emergency, health risk assessments, need for a Continuity of Operations Plan and a data base for skills inventory.

The Public Health Emergency Planners volunteered to provide input into revisions for the Ontario Public Health Standards: Emergency Preparedness Protocols. They also volunteered to work with PHO to develop a train the trainer program for IMS training.

For more information, contact Connie Verhaeghe or Pat Simone.

Do you have a health emergency management network that you would like to highlight? To let us know Nwhat your network has been working on, write to: emergencymanagment.moh@ontario.ca

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