HURON COUNTY

Huron County Health Unit

Emergency Plan

REVISED: December, 2017

Prevent Disease Promote Wellness Protect Health

How to read / use this document

The Huron County Health Unit *Emergency Plan* is divided into *chapters* – which contain information related to a general topic / theme. The content in these chapters form the "body" of the emergency plan and outline the principles and procedures regarding emergency planning and response.

Chapters may be divided into *sections* as appropriate.

The *Emergency Plan* also includes:

- *Appendices* – include information regarding planning tools and resources and other background resource documents that may provide readers with additional information.
- *Forms* – include forms and templates developed internally and/or with community partners.
- *Confidential appendices* – contain confidential information such as personal contact information. This information is not shared outside of the Health Unit.

The appendices and resource materials are kept in a separate document for Health Unit Staff– they are arranged (and numbered) according to their corresponding chapters / sections.

For example, in the Table of Contents:

1.0 This is a *chapter* heading

1.1. This is a *section* heading

1.1 A1 – This is an *appendix* associated with section 1.1

1.1 A2 – This is the *second appendix* associated with section 1.1

1.1 F1 – This is a *form* associated with section 1.1

1.1 CA1 – This is a *confidential appendix* associated with section 1.1

2.0 Another *chapter* heading

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CHAPTER 1 – INTRODUCTION

This document was prepared by the Huron County Health Unit (HCHU) using a strategic approach to emergency management. This approach involves the comprehensive assessment of potential hazards to the health of the people of Huron County, and the institution of procedures for prevention/mitigation, preparedness, communication, response and recovery to address public health emergencies and emergencies with a public health impact

An emergency is a "situation or impending situation that constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property and that is caused by the forces of nature, a disease or other health risk, an accident or an act whether intentional or otherwise" (Emergency Management and Civil Protection Act, 1990, sec.1). By its nature, an emergency often elicits an atypical response from authorities that requires them to go beyond their regular activities or procedures. Emergency response requires a coordinated response by a number of agencies.

Emergencies are caused by hazards. Hazards are a natural or human-made event that threatens to adversely affect human life, property or activity to the extent of causing a disaster (World Health Organization, 1998). These events can be *sudden*, where they occur instantaneously, others are *gradual* and can manifest themselves progressively over time. Emergencies are sometimes predictable, but often come unexpected or without warning.

Every emergency is different. No emergency plan can describe every possible emergency; its impact; and the counter measures required to adequately respond to the emergency situation. This *Emergency Plan* recognizes this fact. It is intended to outline a standard set of principles and procedures from which Health Unit staff can monitor the incident, obtain additional support and direct a controlled response.

The plan must be flexible enough to adapt to a broad spectrum of situations and must be supported with:

- adequate personnel, equipment and expertise from the response agencies;

- familiarity with the contents of the plan by participating responders;
- training and exercises;
- awareness of the emergency plans of, and resources available from, surrounding municipalities & health units and the private sector, supplemented by prearranged agreements;
- testing of the plan on a regular basis; and
- review of the plan following any incidents or exercises where it is implemented.

The HCHU *Emergency Plan:*

- ❖ Provides the framework for a rapid and coordinated response during surge events, emerging situations and/or emergency situations.
- ❖ Can be used to guide Health Unit actions during surge events, emerging situations (up to and including un-declared emergencies) and in declared emergencies.
- ❖ In itself cannot guarantee an efficient, effective response to an emerging situation or emergency. It must be used as a tool to assist Health Unit staff and community partners in their emergency response activities.
- ❖ Is intended to be dynamic and iterative, and is updated and revised regularly based on the on-going input from Health Unit staff and our community partners and a continuous environmental scan of potential hazards relevant to the County of Huron.

1.1 GOALS AND OBJECTIVES

The aim of any emergency response is to preserve and protect life, property and the environment. As an emergency plan, this document serves as an all-hazards plan that outlines arrangements and procedures to respond to a variety of different emergencies.

Goal

- To enable and ensure a consistent and effective risk-based response to public health emergencies and emergencies with a public health impact, while maintaining continuity of priority services and functions.

Objectives are to:

- Clearly define public health roles and responsibilities in emergency response.
- Describe key roles and responsibilities and align them with the components of the Incident Management System (IMS): Command (including Safety, Liaison and Communications/Information), Operations, Logistics, Planning and Finance/Administration.
- Identify the public health impacts in relation to the Huron County Health Unit Hazard Identification Risk Assessment.
- Outline arrangements and procedures to respond to emergencies as well as supporting plans that guide the response to specific threats.
- To identify mechanisms of communication, liaison and consultation with community partners and the general public that contribute to effective emergency planning, response and recovery.
- Meet the requirements identified in the current Public Health Emergency Preparedness Protocol.

1.2 RELATIONSHIP TO OTHER PLANS

The Huron County Health Unit *Emergency Plan* is informed by, and intended to be consistent with the current versions of:

- the Ministry Emergency Response Plan (MERP), Emergency Management Unit, Ontario Ministry of Health & Long Term Care;

- The County of Huron Emergency Plan; and
- The Emergency Plans for the nine municipalities in Huron County.
- Ministry of Health and Long-Term Care - Offers Healthcare Provider Hotline and develops Important Health Notices
- Public Health Ontario - PHO is a government agency dedicated to protecting and promoting the health of all Ontarians and reducing inequities in health. During emergencies, PHO can be called upon for:
    - Scientific and technical advice
    - Surveillance data
    - Epidemiological support
    - Laboratory science and operational support

1.3 HURON COUNTY PROFILE

Huron County is located in southwestern Ontario north of the City of London and west of the Golden Horseshoe area (see map below). The County is approximately 100 kilometers long from north to south, 50 kilometers wide from east to west and covers an area of approximately 3,400 square kilometers.

Huron County's 2011 population stands at 59,100 people (Statistics Canada, 2011 census data). These residents make their home in 9 municipalities: Howick (population 3,856), North Huron (4,884), Morris-Turnberry (3,413), Huron East (9,264), Central Huron (7,591), Ashfield-Colborne-Wawanosh (5,582), Goderich (7,563), Bluewater (7,044) and South Huron (9,945).

Population centres include Wingham (approximate population 3,000), Goderich (7,500), Clinton (3,000), Seaforth (2,500), and Exeter (4,500). With a population density of just 17.7 residents

per square kilometer, and approximately 55% of County residents living in non-urban areas, the population of Huron County is one of the most "rural" in Ontario.

Huron County's population is proportionately older than the Ontario average. In fact, Huron has the third "oldest" population in Canada. In 2001, less than 40% of the population was of prime working age (25-54) while almost 30% were 55 years of age or older. Yet we have a larger proportion of youth than the provincial average. Huron County is home to approximately 5,800 business enterprises, including 2,880 farms. Farming continues to drive the local economy, despite ongoing restructuring and consolidation in the agricultural sector. Next to farming, the service sector is the next largest sector by business numbers, followed by the wholesale and retail sector.

1.4 BREASTFEEDING STATEMENT

The Huron County Health Unit is a Baby-Friendly Initiative Organization. We endeavor to support a breastfeeding culture throughout emergency preparedness and response processes. Breastfeeding remains beneficial to mothers and their babies during times of stress and emergency events.

1.5 VULNERABLE AND HIGH RISK POPULATIONS

To address the inclusion of vulnerable and high risk populations within this plan it will be assigned as a specific function under Planning within an Incident Management System Function. Further guidelines for planning considerations can be found in Chapter 13, section 6.

2.1 THE EMERGENCY MANAGEMENT CYCLE[1]

The phases of emergency management form the basis of emergency planning, as shown to the right.

The phases of emergency management can also be considered as a continuum with all emergencies displaying these phases in various proportions depending on the nature of the event. This continuum is shown below as the Emergency Management Cycle.

The phases of emergency management
- Prevention
- Mitigation
- Preparedness
- Response
- Recovery

(CSA, 2014; EMO 2010a; NFPA, 2007)

Prevention
- activities and programs intended to **stop** an emergency or potential emergency, from occurring
- actions taken **before** the emergency
- focuses on the **hazard**

Mitigation
- activities and programs intended to **reduce the impact** on the community
- actions taken **before, during, or after** the emergency
- focuses on the **hazard**

Recovery
- activities and programs designed to return a situation to an acceptable condition; a **return to normal** activities
- usually the **longest phase**
- focuses on **restoration**
- **assesses** actions taken
- **re-starts the cycle** with a review of Prevention/ Mitigation/ Preparedness Plans

Preparedness
- activities and programs intended to **maximize the efficiency** of the response through planning and preparation
- actions taken **before** the emergency
- focuses on the **plans** and resources
- includes **training** and **exercises**

Response
- activities and programs designed to **address the immediate** and short-term **effects** of an emergency
- public health activities during the Response Phase tend to be **dramatic increases** in what would otherwise be considered routine public health prevention and/or mitigation activities
- focuses on **operations**

Source: Phase definitions adapted from Gordon, 2002; and EMO, 2011a, *Glossary of Terms*.

[1] Public Health Ontario. Public Health Emergency Preparedness Workbook, July, 2015.

2.2 ROLE OF THE HEALTH UNIT IN A COUNTY EMERGENCY RESPONSE

Technically, only elected officials can declare an emergency – the heads of municipal or county council(s) and/or the Premier of Ontario. Therefore, all declared emergencies are municipal or county emergencies; a coordinated response to the emergency is facilitated by the municipal or county control group.

Where necessary, an emergency situation will be declared by the municipal or county government(s) directly involved according to their existing emergency plans. In all of these plans, the Health Unit has representation at the municipal and/or county Control Group and the roles and responsibilities of the Health Unit are set out consistent with the guidelines outlined below.

In a county-wide or municipal emergency, the Huron County Health Unit is responsible for:

a) Providing advice to the Warden on any matters which may adversely affect public health. This will include, but is not limited to, providing advice on the health and safety aspects of the emergency water supplies, sanitation, shelters, food supplies, mass feeding, garbage and sewage disposal;

b) Provide representation on the County Control Group appropriate to the emergency situation;

c) Assessing the emergency situation and determining its potential impact on public health;

d) Maintaining the essential services of the Health Unit;

e) Coordinating the response to public health related emergencies or anticipated emergencies such as epidemics, according to Ministry of Health policies;

f) Liaising with the Provincial Ministry of Health and Long-Term Care, Public Health Branch;

g) Liaising with other agencies, (e.g. Public Health Ontario) and senior levels of government regarding public health matters related to the emergency situation;

h) Coordinating all efforts to prevent and control the spread of disease during an emergency. This may include providing leadership and coordinating the response to disease related emergencies or anticipated emergencies such as an influenza pandemic (i.e. act as the lead agency);

i) Providing authoritative instructions on public health matters to the public through the Media Coordinator;

j) Ensuring liaison with voluntary and private agencies, as required, for augmenting and coordinating public health resources;

k) Coordinating the emergency response activities of the Health Unit's staff;

l) Notifying the County Director of Public Works regarding the need for potable water supplies and sanitation facilities (County Emergency);

m) Liaising with the Administrator of Huron County Social Services on areas of mutual concern regarding operations in Evacuation and Reception Centers;

n) Designating an Emergency Site Manager from Health Unit personnel, if requested;

o) Participating in a debriefing of the emergency response;

p) Preparing a report outlining the Health Unit's emergency response activities and submitting a copy of the document to the County Chief Administrative Officer and the Board of Health within two weeks following an emergency termination;

q) The Health Unit does not have the authority to direct any local health care providers or services. The Health Unit / Medical Officer of Health will not be operationally involved in:

- The provision of emergency medical services, staff or supplies;
- The transportation of individuals for medical or other reasons;
- The establishment or operation of evacuation centres;

- Providing or ensuring the provision of potable water, food supplies, etc for the general public; and/or
- Providing psychosocial support to members of the public or emergency responders.

In the case of emerging or emergency situations that are primarily "public health emergencies" (e.g., pandemic influenza), the Health Unit would most likely be the agency that first calls together the control group and would be the "lead" agency for the response:

- During county or municipal emergencies, the Health Unit / Medical Officer of Health may be involved in facilitating the co-ordination of an emergency medical response. However, the Health Unit does not have the authority to direct any local health care providers or services.

2.4 THE INCIDENT MANAGEMENT SYSTEM

Emergency management at the Huron County Health Unit is organized based on the Incident Management System (IMS).

The Incident Management System is a function-driven model that provides a framework for implementing a coordinated response to any emergency situation or surge event. The Incident Management System is an established best practice model used internationally by many types of responder agencies (e.g., fire, police, military).

IMS presents standardized organizational structure, functions, processes, and terminology. The standardized organizational structure outlines the command and control chains. The standardized functions under IMS are Command, Operations, Planning, Logistics, and Finance & Administration. Two other areas of responsibility, normally associated with "command staff" include Communications and Health & Safety. The roles and responsibilities associated with each of these functions are defined further in *Chapter 7.0 – Incident Management System and Associated Appendices*.

Standardized processes allow all who respond to the same incident to formulate a unified plan to manage the incident. The use of standardized IMS plain language terminology across agencies reduces the risk of miscommunication among the many responders.

IMS is recommended for managing all incidents. The system allows response organizations to utilize only those aspects that are practically suited to a given incident, an approach referred to in the *IMS Doctrine* as the "Toolbox" concept. While the full expansion of the IMS structure may appear complex, this would occur only during complex incidents, and would serve to maintain the optimum span of control by injecting appropriate supervisory levels.

2.5 DECISION MAKING PRINCIPLES & PROCESSES

The Huron County Health Unit has adopted an ethical framework for decision making in emergency planning and response.

During emergencies, public health, governments and other responders will have to make difficult decisions, often based on incomplete information. At the Health Unit, decisions will be made by Command who, according to IMS, has the authority to make decisions to direct an effective response and the responsibility to ensure that decisions made are based on all available relevant input. Decision making during an emergency is not based on democratic or consensus models; it is hierarchical, stemming from Command.

Stakeholders are more likely to accept the difficult decisions made during an emergency if decision making processes (during emergency planning and response) are:

- *Open and transparent* – The process by which decisions are made must be open to scrutiny and the basis for decisions should be explained.
- *Reasonable* – Decisions should be based on reasons (i.e., evidence, principles, values) and be made by people who are credible and accountable.
- *Inclusive* – Decisions should be made explicitly with stakeholder views in mind and stakeholders should have opportunities to be engaged in the decision making process.

- *Responsive* – Decisions should be revisited and revised as new information emerges, and stakeholders should have opportunities to voice any concerns they have about decisions (i.e., dispute and complaint mechanisms).
- *Accountable* – There should be mechanisms to ensure that ethical decision making is sustained throughout the emergency.

The Health Unit's response to an emergency will be based on the following core ethical values (not listed in priority order). More than one value may be relevant in any given situation, and some values will be in tension with others. This tension is the cause of the ethical dilemmas that may emerge during an emergency, and reinforces the importance of shared ethical language as well as decision making processes that can assign a moral weight to each value when values are in conflict.

Individual Liberty – (i.e., respect for autonomy) is a value enshrined in our laws and health care practice.

During an emergency, it may be necessary to restrict individual liberty in order to protect *the public* from serious harm. Individual liberty can be preserved to the extent that the imposed limits and the reasons for them are transparent. Restrictions to individual liberty will:

- Be proportional to the risk of public harm;
- Be necessary and relevant to protecting the public good;
- Employ the least restrictive means necessary to achieve public health goals; and
- Be applied without discrimination.

Protection of the Public from Harm – Public health has an obligation to protect the public from serious harm.

For public health to fulfill this obligation and minimize serious illness, death and social disruption, the Health Unit may isolate people or use other containment strategies, require agencies & businesses to restrict public access to some areas or limit some services.

For these protective measures to be effective, citizens must comply with them. The ethical value of individual liberty is often in tension with the obligation to protect the public from harm; however, it is also in individuals' interests to serve the public good and minimize harm to others. When making decisions designed to protect the public from harm, the Health Unit will:

- Weigh the benefits of protecting the public from harm against the loss of liberty of some individuals (e.g., medical isolation);
- Ensure all stakeholders are aware of the medical and moral reasons for the measures, the benefits of complying, and the consequences of not complying; and
- Establish mechanisms to review decisions as the situation changes and to address stakeholder concerns or complaints.

Proportionality – Restrictions on individual liberty and measures to protect the public from harm should not exceed the minimum required to address the actual level of risk or need in the community.

The Health Unit will:

- Use the least restrictive or coercive measure possible when limiting or restricting liberties or entitlements; and
- Use more coercive measures only in circumstances where less restrictive means have failed to achieve appropriate [public health] ends.

Privacy – Individuals have a right to privacy, including the privacy of their health information. During emergencies it may be necessary to balance the right to privacy with the responsibility to protect the public from serious harm; however, to be consistent with the ethical principle of proportionality, the Health Unit will:

- Determine whether the good intended is significant enough to justify the potential harm of suspending privacy rights (e.g., potential stigmatization of individuals and communities);
- Require private information only if there are no less intrusive means to protect public health;
- Limit any disclosure to only that information required to achieve legitimate public health goals; and
- Take steps to prevent stigmatization (e.g., public education to correct misperceptions about disease transmission).

Note: Any collection, use or disclosure of personal information will be done in compliance with governing legislation, including the Personal Health Information Protection Act, 2004.

Equity – In an emergency, tough decisions may have to be made about which services to provide, to whom and, if resources are stretched, which services will be temporarily suspended. In these circumstances, the Health Unit will:

- strive to preserve as much equity as possible between the needs of those directly affected by the emergency and those with other urgent needs; and
- establish fair decision making processes / criteria.

Duty to Provide Care – Emergency responders and health care workers have an ethical duty to provide care and respond to suffering.

During an emergency, demands for care may overwhelm emergency responders (including health care workers) and their institutions, and create challenges related to resources, practice, liability and workplace safety. Emergency responders may have to weigh their duty to provide care against competing obligations (i.e., to their own health & safety, family and friends). When

providers cannot provide appropriate care because of constraints caused by the emergency, they may be faced with moral dilemmas.

Reciprocity – Society has an ethical responsibility to support those who face a disproportionate burden in protecting the public good.

During an emergency, the greatest burden falls on emergency responders. In an extended emergency (like pandemic influenza) responders may be asked to take on extended duties; they may be exposed to greater risk in the workplace, suffer physical and emotional stress, and be isolated from peers and family. Individuals who are placed in medical isolation may experience significant social, economic, and emotional burdens. Decision makers will take steps to ease the burdens of emergency responders and members of the public directly affected by the emergency.

Trust – is an essential part of the relationship between:

- government and citizens
- public health and the community
- organizations and their staff
- the public and healthcare workers, and
- among organizations within a health system

During an emergency, some people may perceive measures to protect the public from harm (e.g., limiting access to certain services / areas) as a betrayal of trust. In order to maintain trust during an emergency, the Health Unit will:

- Take steps to build trust with stakeholders before the emergency occurs (i.e., engage stakeholders early); and
- Ensure decision making processes are ethical and transparent.

Solidarity – Responding to emergencies effectively requires solidarity among community, health care institutions, public health, and government. Solidarity requires good,

straightforward communication and open collaboration within and between these stakeholders to share information and coordinate service delivery.

Stewardship – In an emergency, both institutions and individuals may be entrusted with governance over scare resources, such as food, fuel, medications, and emergency response personnel. Those entrusted with governance should be guided by the notion of stewardship, which includes protecting and developing one's resources, and being accountable for public well-being. To ensure good stewardship of scare resources, the Health Unit will consider both the benefit to the public and good equity (i.e., fair distribution of both benefits and burdens).

Family-centred Care – The Health Unit will respect a family's right to make decisions on behalf of a child, consistent with the capacity of the child. Health care providers will respect families' unique beliefs and values, and acknowledge that their choices will be informed by their beliefs and values.

Respect for Emerging Autonomy – When providing care to young people, the emergency responders will respect their emerging autonomy, and disclose age appropriate information.

Adapted from: Gibson J et al. Ethics in a Pandemic Influenza Crisis. Framework for Decision Making. Joint Centre for Bioethics. University of Toronto 2005.

2.6 SURGE CAPACITY

Definitions

The Health Unit has defined surge capacity on several levels – individual, organizational and systemic. It is:

- The ability of individual staff to work outside of their regular job function(s) (but not beyond their skills level or scope of practice) or hours of operation in order to contribute to a Health Unit response to an emerging or emergency situation;

- The ability of the health unit, as an organization, to assess an emerging or emergency situation and to re-prioritize and redeploy resources to address the unforeseen but urgent need; and
- The ability of broader public health and/or the emergency response systems (i.e., beyond the health unit) to respond in a coordinated manner to an emerging or emergency situation.

The Health Unit has defined a surge event as any sudden and unexpected circumstance that requires a coordinated assessment of the situational needs, a re-prioritization of normal work activities and a short-term redeployment of resources to adequately resolve the situation.

Surge events are normally of a short duration and localized – meaning that they do not warrant a declaration of an "emergency" but do require that staff from several programs (and perhaps several teams) come together to respond to the situation. Possible examples of surge events include large community outbreaks, food recalls, spills events.

The implementation of "surge capacity" is supported by the Health Units Continuity of Operations Plan.

STAFF TRAINING

The Health Unit provides staff with opportunities for training regarding emergency response in the following ways:

1. Training opportunities for staff (collectively or individually) as identified by the Emergency Management Advisory Group.
2. Upon starting at the Health Unit, staff will be orientated to all emergency plans used by the Health Unit.
3. Staff are encouraged to be familiar with this emergency response plan as well as other supporting plans including the continuity of operations plan, hazard specific plans and the Health Units internal emergency plan.

During surge events:

1. A Control Group may be established (based on the IMS framework) and holds meetings as required to co-ordinate the Health Unit response.
2. Staff are advised that the Health Unit is responding to a surge event and will be up-dated as appropriate.
3. Any Health Unit staff person may be asked to:
    a. Set aside regularly planned work and participate in resolving the situation;
    b. Perform duties that are not part of their regular day-to-day work; and/or
    c. Work extended hours.
4. Staff asked to assist will be provided with support and guidance appropriate to the situation. No staff person will be required to work beyond their skill level or to perform duties that may endanger themselves or others.

DEBRIEFING

Ensures an opportunity to provide staff with support and on-going training regarding individual and collective surge capacity. It also provides feedback regarding components of the *Emergency Plan*.

1. Debriefing of staff involved in the surge event may begin while the situation progresses.
2. As soon as possible after the surge event has ended, debriefing opportunities will be provided for:
    a. The Control Group;
    b. All staff who participated in addressing the situation; and
    c. All Health Unit staff who were not involved in the event. (This may be done with all staff present or in a separate group.)

At the end of a surge event:

1. All records regarding the surge event, including debriefing notes, are collected and collated.
2. The Emergency Management Advisory Group reviews the material to see how it may inform revisions to the Emergency Plan.

SYSTEMIC SURGE CAPACITY

The Health Unit contributes to, and may draw from, the surge capacity of the provincial public health system and/or county/municipal emergency response system(s) as a whole.

Where a surge event (or declared emergency) requires a response that surpasses the ability of the Huron County Health Unit to respond, it may call upon others (e.g., neighbouring health units, local governmental emergency response workers) for assistance. Similarly, the Health Unit may be called upon for assistance by others responding to emerging or emergency situations.

To contribute to systemic surge capacity, the health unit:

1. Bases its emergency planning on principles consistent with county, provincial and government emergency plans and approaches;
2. Maintains (informal and formal) mutual assistance agreements with neighbouring health units (see chapter 14);
3. Actively co-ordinates emergency planning with the County of Huron and all nine local municipal “emergency management” programs (i.e., participates on the Huron County Emergency Management Committee);
4. Maintains an awareness of other resources available to assist during surge events and emergency situations (e.g., PHO resources to access scientific advisors or field epidemiologists);

5. Is prepared to provide staff and expertise to contribute to local and regional responses to public health emergencies or emergencies with a public health impact; and
6. Continually assesses resources available and priorities during surge events and emergencies with a view to the need to call upon others for assistance.

2.7 OCCUPATIONAL HEALTH & SAFETY

Health & Safety considerations for health unit staff, are paramount.
Although the *Emergency Management and Civil Protection Act (EMCPA)* provides special powers, the *Occupational Health & Safety Act (OHSA)* cannot be overruled in any emergency because worker safety is paramount. All roles, responsibilities, duties, and authority outlined in the OHSA remain intact during an emergency, and the OHSA prevails to the extent of any conflict with the *Emergency Management and Civil Protection Act*.
From the *Emergency Management & Civil Protection Act*:

> *Despite subsection (4), in the event of a conflict between this Act or an order made under subsection 7.0.2 (4) and the Occupational Health and Safety Act or a regulation made under it, the Occupational Health and Safety Act or the regulation made under it prevails. [EMCPA, Section 7.02(8)].*

The Health Unit Control Group includes a "Health & Safety Officer" so that health and safety considerations are taken into account in all decisions made regarding health unit staff response.

The Health Unit has developed a "Health and Safety Handbook" for staff. The Handbook addresses components of health and safety which are also relevant during surge events and emergency situations. The handbook can be found on the HU Intranet "Wave" and the HU general drive/health and safety working group/H&S handbook. A hardcopy has also been provided to each team in a central location.

The Role of the Ministry of Labour (MOL) is to enforce the OHSA. The MOL responds to all emergencies (e.g. natural disasters). The Health Unit collaborates and cooperates with the MOL.

The Health Unit can also contact Public Services Health and Safety Association (PSHSA) for support and resources during any phase of an emergency. They can be reached at 519-858-8400.

CHAPTER 3 – AUTHORITY

3.1 UNDER THE HEALTH PROTECTION & PROMOTION ACT, RSO 1990

The *Health Protection & Promotion Act, RSO 1990* is the main provincial legislation governing Health Units. The HPPA gives the Board of Health and the Medical Officer of Health many powers to protect the health of the public:

http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h07_e.htm

Very generally (see the HPPA for specifics), the Medical Officer of Health has the right to intervene where there are reasonable and probable grounds that there is a risk to the health of the public related to:

- food safety;
- safe (drinking) water;
- health hazards related to occupational and/or environmental health; and/or
- infectious disease.

In the above cases, s/he has varying rights to:

- enter private and public places to inspect, examine, take samples, make enquiries regarding and test for public health risks; and
- prepare and deliver orders to individuals and owners / operators of institutions regarding:
    - placarding, closure, evacuation of buildings and places; and
    - prohibiting, regulating or requiring certain activities to eliminate the risk to public health.

The HPPA also provides the Chief Medical Officer of Health (of Ontario) with powers to address risks to public health:

If the Chief Medical Officer of Health is of the opinion that a situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons, he or she may investigate the situation and take such action as he or she considers appropriate to prevent, eliminate or decrease the risk. [Section 77.1(1)].

3.2 TO CALL TOGETHER A MUNICIPAL OR COUNTY CONTROL GROUP

The Health Unit has representation on the Control Groups for all local municipalities and the County of Huron.

Consistent with these plans, the Health Unit has the authority to call together any of these Control Groups to assess and respond to potential risks to public health.

3.3 DURING A DECLARED EMERGENCY

During a declared emergency, the Health Unit participates as a member of the applicable municipal or County Control Group. The Health Unit therefore shares in the authority and powers of the Control Group as outlined in the *Emergency Management & Civil Protection Act:*

> *The head of council of a municipality may declare that an emergency exists in the municipality or in any part thereof and may take such action and make such orders as he or she considers necessary and are not contrary to law to implement the emergency plan of the municipality and to protect property and the health, safety and welfare of the inhabitants of the emergency area. [EMCPA, Section 4.1]*

Furthermore:

> *Subject to subsection (3), the Lieutenant Governor in Council or the Premier, if in the Premier's opinion the urgency of the situation requires that an order be made immediately, may by order declare that an emergency exists throughout Ontario or in any part of Ontario. [EMCPA, Section 7.01(1)]*

Such a declaration would result in extra-ordinary powers being given to the Lieutenant Governor in Council, powers that may be implemented through – or delegated to – the local Control Group:

In accordance with subsection (2) and subject to the limitations in subsection (3), the Lieutenant Governor in Council may make orders in respect of the following: [EMCPA, Section 7.01(4)]

1. *Implementing any emergency plans formulated under section 3, 6, 8 or 8.1.*
2. *Regulating or prohibiting travel or movement to, from or within any specified area.*
3. *Evacuating individuals and animals and removing personal property from any specified area and making arrangements for the adequate care and protection of individuals and property.*
4. *Establishing facilities for the care, welfare, safety and shelter of individuals, including emergency shelters and hospitals.*
5. *Closing any place, whether public or private, including any business, office, school, hospital or other establishment or institution.*
6. *To prevent, respond to or alleviate the effects of the emergency, constructing works, restoring necessary facilities and appropriating, using, destroying, removing or disposing of property.*
7. *Collecting, transporting, storing, processing and disposing of any type of waste.*
8. *Authorizing facilities, including electrical generating facilities, to operate as is necessary to respond to or alleviate the effects of the emergency.*
9. *Using any necessary goods, services and resources within any part of Ontario, distributing, and making available necessary goods, services and resources and establishing centres for their distribution.*
10. *Procuring necessary goods, services and resources.*
11. *Fixing prices for necessary goods, services and resources and prohibiting charging unconscionable prices in respect of necessary goods, services and resources.*

12. *Authorizing, but not requiring, any person, or any person of a class of persons, to render services of a type that that person, or a person of that class, is reasonably qualified to provide.*
13. *Subject to subsection (7), requiring that any person collect, use or disclose information that in the opinion of the Lieutenant Governor in Council may be necessary in order to prevent, respond to or alleviate the effects of the emergency.*
14. *Consistent with the powers authorized in this subsection, taking such other actions or implementing such other measures as the Lieutenant Governor in Council considers necessary in order to prevent, respond to or alleviate the effects of the emergency. 2006, c. 13, s. 1 (4).*

See the *Emergency Management & Civil Protection Act* for full details:

http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90e09_e.htm

3.4 ACTION(S) PRIOR TO DECLARATION

When an emergency exists, but has not yet been declared to exist, Health Unit employees are authorized to take such action(s) under this *Emergency Plan* as may be required to respond to the emergency.

CHAPTER 4 – PLAN ACTIVATION

During times of disasters or emergencies, there is always potential for negative health effects. There are a number of events where public health is expected to play a central role in the response. An example would be incidents that involve the occurrence of an infectious disease.

The Health Unit Emergency Plan may be activated in whole or in part in the case of:

- A surge event – i.e., any sudden and unexpected circumstance that requires a coordinated assessment of the situational needs, a re-prioritization of work normal activities and a short-term redeployment of resources to adequately resolve the situation.
- An emerging situation – i.e., a situation or impending situation caused by the forces of nature, an accident, an intentional act or otherwise that constitutes a danger of major proportions to life or property (a "potential" emergency).
- A declared emergency – i.e., when an official state of emergency has been declared by local or provincial governments.

Any member of the Health Unit Control Group may be instructed to initiate the activation procedure by the Medical Officer of Health or alternate.

4.1 ACTIVATION / NOTIFICATION PROCEDURES

1. If the Medical Officer of Health or designate, determines the Health Unit Control Group should meet, or be put on stand-by, s/he / they will:
    a. Put the health unit on alert and activate the Health Unit Emergency Plan.
    b. Activate the Health Unit Emergency Operations Center.
    c. Determine the time and location of the Control Group Meeting.
    d. Arrange teleconferencing as needed. (See 4.1 CA1 – Teleconferencing Instructions)

e. Notify the Control Group members or alternates and provide them with the following information:

   i. The nature of the emergency situation;

   ii. The time of the initial meeting of the Control Group and details of the meeting including:

   - Location if there is to be a face-to-face meeting; or
   - Phone numbers and access codes if the meeting is to be a teleconference.

f. If incident is after hours, notify staff as required using a fan-out process which is supported by a list containing staff names and phone numbers and is accessible by the Public Health Managers. This process is described in the Health Unit policy GA 3.08 – *Staff Notification of Emergencies / Surge Events (included as appendix 4.1 CA2).*

g. Document the date and time that each member of the Control Group (or alternate) was contacted.

2. During regular business hours, the Communications lead or designate will notify all Health Unit staff that the Control Group has been called together (i.e., that the Health Unit is "in surge") by email

CHAPTER 5 – DECLARATION OF AN EMERGENCY

1. The Health Unit does not have the legal authority to declare a state of "emergency". Only elected officials can "declare" an emergency – the "heads" of municipal or county council(s) and/or the Premier of Ontario.

   The head of council of a municipality may declare that an emergency exists in the municipality or in any part thereof and may take such action and make such orders as he or she considers necessary and are not contrary to law to implement the emergency plan of the municipality and to protect property and the health, safety and welfare of the inhabitants of the emergency area. [EMCPA, Section 4.1] Therefore, all declared emergencies are municipal or county emergencies; officially declared as per the relevant emergency plan. A coordinated response to the emergency is facilitated by the municipal or county Control Group. The Health Unit has representation on all municipal and the county Control Groups.

2. The Medical Officer of Health, or their designates, may declare that the Health Unit is "in surge" – meaning that the Emergency Plan is, in part or in whole, being implemented to respond to some surge event, emerging or emergency situation (as per *Chapter 4.0 – Plan Activation*).

3. Where the Health Unit has been declared to be "in surge" and/or a state of emergency has been declared by a local municipality or the County of Huron, the Health Unit will notify the following, as appropriate:

   a. Surrounding / adjacent health units;

   b. The Huron County Board of Health;

   c. The Chief Medical Officer of Health;

   d. The Ontario Ministry of Health & Long Term Care;

   e. Public Health Ontario

f. The Ministry of Children & Youth Services;

g. The Chief Administrative Officer of the County of Huron;

h. The Warden of the County of Huron;

i. Municipal staff and elected officials;

j. The local Member of Parliament; and/or

k. The local Member of Provincial Parliament

l. Local Healthcare partners

CHAPTER 6 – EMERGENCY OPERATIONS CENTRE

The Emergency Operations Centre (EOC) is a central facility or head-quarters from which the Control Group directs, co-ordinates, communicates and supports emergency operations within the Health Unit's jurisdiction. It must have appropriate technological and telecommunications systems to ensure effective communication in an emergency.

The EOC will include:

- A meeting room for Control Group deliberations with the equipment required for effective meetings (e.g., white board, flip charts, teleconferencing capabilities); and
- A communications room with access to the equipment and supplies necessary to:
    - communicate the decisions made by the Control Group;
    - co-ordinate response activities; and
    - consolidate related files and paperwork.

  (e.g., white board, flip charts, telephones, fax machines, file systems, maps).

The Logistics Lead (or alternate) will establish the Emergency Operations Centre (EOC) when the Control Group is initially called together.

The primary location for the Health Unit Emergency Operations Centre (HUEOC) is located in room # 2 at the Health and Library Complex (alternate locations are listed in 6.0 CA1). Features of the Huron County Health and Library Complex include:

- A permanent backup generator.
- Heated by natural gas.
- Supplied with water from the Municipality of Central Huron. In the event of a power outage, the Municipality has a backup generator able to supply water to their service area, including the

Health and Library Complex. In the event that the back-up generator malfunctions, a precautionary boil water advisory will be issued for The Health Unit Complex.

- A limited supply of bedding and toiletries and an on-site shower for use by the Control Group and other emergency responders. These items are stored in the Health and Library Complex Basement. Key access is at front reception. Staff are able to access the basement by use of their key cards. A list of these supplies can be found in 6.0 CA2 (On-Site Emergency Control Group Supplies).
- telephones, maps, communications equipment and various supplies. These items are stored in locked cupboards in room #2. See also 6.0 CA3 (H&LC Telephone Systems); 6.0 CA4 (Back-up Fax Machines); 6.0 CA5 (Control Group Kits); and 6.0 CA6 (Office-in-a-box kits).
- On-site (and on-call) Property Services and IT support.
- Supplies to assist with a Health Unit response such as mass immunization clinics can be found in the emergency supplies room in the basement of the Health and Library Complex. This list can be found on 6.0 CA7 (On-Site Emergency Supplies)

As part of the Corporation of the County of Huron, the Health Unit EOC / Control Group has emergency access to the emergency re-fueling centre(s). See *8.5 CA9 – Emergency re-fueling centre location(s)*.

CHAPTER 7 – THE IMS FRAMEWORK ADAPTED TO THE HCHU

7.1 IMS OVERVIEW

The Incident Management System (IMS) is a model for emergency response that provides a way of coordinating the efforts of agencies and resources by using a common organizational structure that can expand or contract based on the scope of response. The more complex the situation becomes, the more critical it is for every agency involved to co-ordinate their own efforts as well as integrate their activities with those other responding agencies. IMS design makes that possible, as it uses a consistent approach, standardized terminology and communication systems, consolidated action plans, pre-designated facilities, and an all-hazards approach appropriate for all types of emergencies.

IMS is considered "best practice" and is used in governments and responding agencies across Canada. The Huron County Health Unit has adopted the Incident Management System (IMS) to manage emergency response efforts within the Health Unit.

7.2 IMS STRUCTURE

IMS consists of organizational structures and components that can be utilized and adapted to suit each incident response and operational needs.

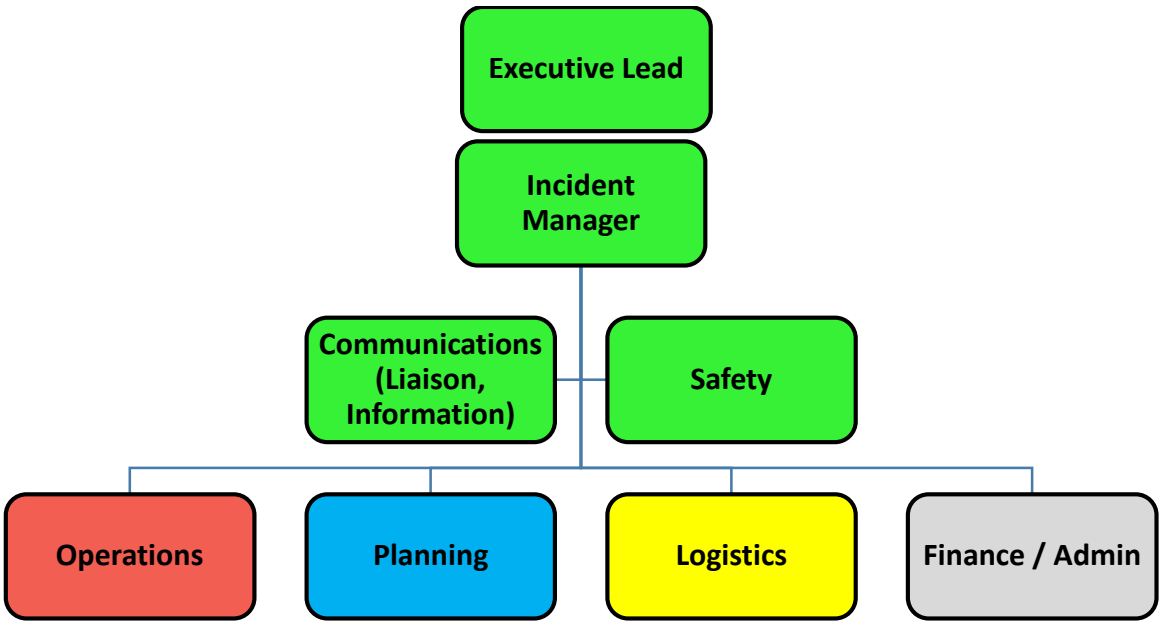
The IMS structure is built around five major management activities or "functions":

- Command (Executive Lead, Incident Manager, Communications and Safety)
- Operations
- Planning
- Logistics
- Finance/Administration

IMS uses a "toolbox" concept and may utilize only those functional roles that are practically suited to a given incident for which the HU Control Group has become activated. Regardless of the number of staff available at the HU Control Group, all major IMS functions need to be addressed.

In large and complex incidents a single staff may be assigned to lead individual functional roles. In smaller and less complex incidents, one person may be assigned to multiple IMS functions. Role specific IMS Guidelines for the Huron County Health Unit can be found in Chapter 7.0 Appendices from 1-8.

Huron County Health Unit IMS structure is illustrated below:



7.2.1 Control Group Composition (as many as required for specific response):

- MOH (Executive Lead)
- Health Unit Managers
- Senior Staff
- Executive Admin (scribe)
- Communication Coordinator
- Online Coordinator
- Epidemiology
- Emergency Management Coordinator
- Other staff or alternates as assigned

7.2.2 Control Group Responsibilities:

- Set priorities and strategic direction
- Direct response and recovery activities
- Ensure essential services are maintained
- Information collection, collation, evaluation and dissemination
- Management of resources
- Manage internal / external communications
- Monitor recovery progress

7.2.3 Control Group Initial Response Activities (checklist 7.2.3 A1)

- Identify and call together Control Group Members;
- Assess the situation;
- Assess the public health implications by creating an incident or situational HIRA
- Public health responsibilities and actions;
- Develop the Incident Action Plan;
- Appoint IMS Leads;
- Initiate communication strategies;
- Establish communications with key partners;
- Attend/participate at County/Municipal EOC if appropriate;
- Operational period length and start time

7.2.5 CHOOSING STAFF FOR IMS FUNCTIONAL TASKS (SEE CONTROL GROUP BLANK TEMPLATE 7.0A3)

When activating the HU Control Group and IMS structure, focus needs to be placed on what needs to be done and who has the expertise/knowledge to carry out required tasks. Knowledge, training, authority and/or experience should be the primary factors in determining individuals who are assigned to specific IMS functions. All staff at the Huron County Health Unit fill out a Public Health Skills Inventory which is a valuable tool to assist with assigning IMS functions. The Public Health Skills Inventory is completed electronically and can be arranged though the Health Unit Program Evaluator. The most up to date copy of the staff results can be found in 7.2.5 A2.

Keep in mind the following questions:

- What is the task to be performed?
- What is the authority to perform the task? (The person must have requisite authority to do what is required under the assignment)
- Knowledge or skill set required? (Staff must have the knowledge, skills and abilities required for the duties assigned. If not completed prior to deployment, training or cross training may have to be completed)
- What is the anticipated length of time for the activation of the EOC? (Will staff need to be rotated? Assess impact on HU essential services)

7.3 INCIDENT ACTION PLAN(S)

An Incident Action Plan (IAP) informs the work of public health in preparation for and throughout events or emergencies.

The purpose of the IAP is to:

- Maintain situational awareness
- Consolidate information
- Streamline the documentation process

- Track progress of the event or emergency over time

Other supporting materials can be attached to an IAP, such as maps, assignment lists and communication plans. An IAP should be signed by the Planning Lead and the Incident Manager.

IAPs are developed for each operational period. Control Group members and IMS leads contribute towards developing the IAP by providing input and information specific to their areas of responsibility. The IAP is traditionally compiled by the Planning Lead. See 7.3 A1 New Incident Action Plan Form.

7.4 OPERATIONAL PERIOD

The length of time set by the HU Control Group to achieve a given set of objectives. These objectives are specified in the IAP. Operational periods can be various lengths although usually not over 24 hours.

7.5 PLANNING MEETINGS

Another critical part of successfully managing an emergency is conducting emergency planning cycles involving key personnel. The emergency planning cycle provides a framework that the Incident Manager and other IMS leads can take to plan and develop emergency response measures, and for service and support planning. It is the Planning Lead's responsibility to establish the planning cycle for the Incident Commander and to facilitate the meetings. The meetings are held as needed throughout the duration of an incident. The Planning Lead is also responsible for developing agendas, identifying meeting locations and times as well as attendees, and ensuring all necessary information is available.

7.6 BRIEFINGS

Provide the HU staff, external agencies or media with vital information they need to function effectively and efficiently. Briefings can be held to:

- Review policies and operational guidelines;
- Establish priorities and objectives;
- Keep staff informed of the current situation and impact on their daily work

- Approve action plans

The HU Control Group briefings can be held as often as necessary to support response operations and present changes in management direction. During these briefings Control Group Staff (IMS Leads) should be prepared to report on:

- Current situation relevant to their functional role
- Unmet needs
- Future activities
- Public information needs
- Resource requests

All HU staff must forward all incident situation information and feedback to the Planning Lead for discussion at Control Group Meetings.

7.7 EMERGENCY MANAGEMENT ADVISORY GROUP (EMAG) (FOR COMPLETE TERM OF REFERENCE SEE GA 2.03.02)

Purpose: To provide a forum to discuss Health Unit emergency management plans and activities

Objectives are to:

- Provide feedback and opinion on Health Unit emergency plans and emergency management activities
- Provide emergency management training and education for members to enhance and support the Health Unit emergency management process
- Support all staff learning opportunities to enhance the preparedness of the health unit to be able to response adequately and appropriately during emergencies.
- Discuss lessons learned after an emergency or surge event and support the creation and implementation of action plans

Membership

The Health Unit Emergency Management Advisory Group membership consists of individuals who bring unique knowledge and skills in their area of expertise which complement the advisory capacity of the group in terms of emergency management plans and activities.

Includes:

- Medical Officer of Health
- Health Unit Managers
- Senior Staff
- Executive administration

Those representing the following Health Unit programs and services:

- Epidemiology
- Communications
- Online Communications
- Social determinants of health
- Emergency Management

CHAPTER 8 – COMMUNICATION

8.1 CRISIS AND RISK COMMUNICATIONS

Most public health professionals perform some kind of risk communication as part of their daily routine — helping people understand the nature and seriousness of a risk so that each person can make an informed decision about how to deal with the risk.

In a crisis, the Health Unit performs similar risk communications, as part of providing situational information to the public and directive actions required to be taken by the public. See 8.1 A1 Tips for Interviews with Media.

When deciding whether and how to communicate about an issue, we use the Peter Sandman risk communications model:

risk = hazard (actual danger) + outrage (public perception/feeling about the event).

- When both hazard + outrage are high, we communicate.
- When hazard is high but outrage is low, we communicate.
- When hazard is low but outrage is high, we still communicate! This means that a relatively low-risk aspect of an emergency may still require messaging.

8.2 HEALTH UNIT'S ROLE

The Health Unit's role in any given crisis will depend on whether the crisis is a public health emergency (such as an outbreak) or an emergency with a public health component (such as a tornado or ice storm).

As a credible source of health information, the Health Unit will assist in managing crisis communications by providing information on public health issues in either situation. However, our role during an emergency with a public health component focuses more on collaboration and exchanging information with the designated emergency command. See 8.2 A1 Public Information Release.

8.3 HEALTH UNIT COMMUNICATION ACTIVITIES IN A PUBLIC HEALTH EMERGENCY

In a **public health emergency**, the Health Unit communications activities will:

- Ensure there is a primary contact for anyone who wants emergency information about the incident and the response to it.
- Advise Command on issues related to media/public emergency information dissemination and media relations.
- Co-ordinate with emergency information staff from other organizations or levels of response to ensure that clear and consistent emergency information is issued.
- Consult with Command and Planning regarding any constraints on the release of emergency information to the media and public.
- Establish key messages for spokespersons and media products.
- Advise on the most effective mediums for message dissemination
- Obtain emergency information from the community, the media, and others, and provide that emergency information to Command, as appropriate.
- Define internal communication needs.
- Send updates to internal staff on a regular schedule.
- Establish an emergency information centre or media area away from incident operations and a safe distance away from any hazard.
- Broadcast emergency information and instruction to the public, if requested/required (e.g., evacuation or shelter orders).
- Arrange media tours of incident sites and incident facilities (where feasible), media interviews with spokespersons and technical experts, and a media inquiry hotline.

- Establish a public inquiry hotline.

- Document and track media coverage, while monitoring media to counteract rumours or misinformation.

- Being spokesperson in the early stages of an incident or emergency until designated spokespersons are identified.

- Gather information about organizations involved with the incident. This includes obtaining from their representatives, information about standard and specialized resources they might have, or special support that they might need, and whether there are considerations or restrictions that may impact how such resources may be used.

- Serve as a coordinator for organizations not represented in Command.

- Provide briefings to organization representatives about the operation.

- Maintain a list of supporting and co-operating organizations, and keeping it updated as the incident evolves.

- Ensure Health Unit staff have been notified that the Control Group has been called together.

- Ensure reception has a communication log that records what the public questions are and comments being made by public.

8.4 HEALTH UNIT COMMUNICATION ACTIVITIES IN AN EMERGENCY WITH A PUBLIC HEALTH COMPONENT

In **an emergency with a public health component**, communications activities may include:

- Co-ordinate with emergency information staff from other organizations or levels of response to ensure that clear and consistent emergency information is issued.
- Consult with Command and Planning regarding any constraints on the release of emergency information to the media and public.
- Obtain emergency information from the community, the media, and others, and forwarding that emergency information to Command, as appropriate.
- Establish key public health messages for spokespeople and products.
- Media monitoring, to counteract rumours or misinformation related to public health messaging.
- Gather information about organizations that are involved with the incident. This includes obtaining from their representatives, information about standard and specialized resources they might have, or special support that they might need, and whether there are considerations or restrictions that may impact how such resources may be used.
- Advise on the most effective mediums for message dissemination
- Define internal communication needs.
- Send updates to internal staff on a regular schedule.
- Document and track media coverage.
- Maintain a list of supporting and co-operating organizations, and keeping it updated as the incident evolves.

8.5 INTERNAL COMMUNICATIONS

Health Unit staff must be informed with timely, up-to-date and accurate information regarding an emergency. This helps staff know how they may be impacted by the emergency, as well as helps staff manage questions and comments they may hear from the community.

Information to staff includes:

- Current situation and who is involved
- When they'll get regular updates
- How they'll get regular updates
- Staffing changes/impacts
- Key messages they can share with others (public, family, etc.)
- How to direct media inquiries
- Encouragement for staff to share any questions/information with their manager or Incident Management System (IMS) Lead
- Confidentiality statement at the top of all internal communications

8.5.1 IMMEDIATE NOTIFICATION TO STAFF

If the emergency is declared during working hours, a Public Address Announcement will be made to staff through the phone system. Administration staff will contact staff who are not at work. Notification after working hours will be made through the Emergency Fan Out Network. Our current notification system for staff is ERMS (Emergency Mass Notification System). It is internet based and accessible to Managers and Staff Administrators. As a contingency plan, Managers have access to staff phone lists and will assign calling as appropriate.

8.5.2 ELECTRONIC UPDATES FOR STAFF

Staff will receive an email immediately after the first Control Group meeting. The email will include:

- The details of the emergency situation and who declared the emergency; or an update of the emergency.
- A summary of the public health issues related to the emergency.
- The activities of Health Unit Control Group.
- Public advisories, fact sheets and public service announcements that have been released.
- News releases and media kits that have been released, as well as where to direct media inquiries.
- Other pertinent information.
- How further communication will be handled (how often to expect emails/updates, etc.).

This same information will be posted on WAVE, the Health Unit's intranet, where all subsequent information related to the emergency will be posted.

8.5.3 Internal Hotline

During an emergency, staff may be directed to check for updates by calling the Health Unit number and pressing a certain extension. The voice mail message will include any new information about the emergency as well as any action items for staff.

8.5.4 Texting

Texting to staff cell phones may be used as a way to update.

8.5.5 Staff Briefings

It may be necessary for the MOH or designate from the Control Group to provide staff with more information or details regarding an emergency. This may be done through staff briefings in order to provide direct responses to their questions. The need to hold a staff briefing will be determined by the MOH or designate.

8.5.6 Periodic Updates

As events and information may change quickly, periodic updates to staff will be necessary between HU Control Group meetings. Communications will work with the HU Control Group to determine the need.

The lunchroom bulletin board may be used as a central spot for posting information. Copies of all updates will also be available on WAVE, the Health Unit's intranet.

8.6 COMMUNICATING WITH PUBLIC AND STAKEHOLDERS

8.6.1 Website and Social Media Management

Online channels, such as websites and social media platforms have changed the way people access and share information. During a public health emergency, websites can be used to share information as it becomes available, while social media platforms can be used actively to share information and engage in online conversations, or passively to obtain information and monitor conversations about the situation.

8.6.1.1 Website

In a public health emergency, our goal is to issue the first communication as quickly as possible, with regular updates as needed.

- Communications will either post information to the health unit's website homepage as it becomes available, or designate a staff member trained to work on the website to do this.
- Information will be provided to the County's Communications Coordinator for cross-posting on the County's website; s/he will identify a main contact person to work with to post information to their website.
- Identify support staff to do calendar postings, if needed.
- Ensure all information is uploaded ASAP.
- Meet regularly with the advisory group throughout the emergency to build necessary web pages.

- Monitor RSS feeds from Ministry, PHAC, CFIA or other appropriate sources for updated and relevant information; share findings with the advisory group.

Communications will assume responsibility for overseeing the following, when necessary:

- Replace the homepage of the Health Unit's website with a "lite" homepage with limited navigation and other features; this page will serve as a primary source of updates, linking from there to other pages with detailed information.
- Alert banners or Hot Topics will be posted as required.

8.6.1.2 Social Media

Top priority during an emergency situation is to ensure that all pre-scheduled posts across all channels, organic and paid, are cancelled immediately. Communications have access to all native social channels and tools to do this, and are trained on how to deactivate advertising and pre-scheduled organic posts.

Depending upon the situation, Communications will quickly identify the needs and use of social media (blogs, Twitter, Facebook, Instagram, YouTube, etc.). Priority will be given to use of existing channels/platforms. Different levels of engagement on different social media platforms may be used.

Observer: monitoring social media channels without actively creating content. This allows monitoring of public opinion, and gathering of information on event; there's no involvement in conversations, nor opportunity to correct misinformation or direct to authoritative sources.

Broadcaster: selecting one social media platform/account to post public information (e.g. copy and paste from media releases). No engagement in conversation will be done, so necessary to state broadcast nature of platform in profile information and direst users to the platform where you are more actively engaged, if present.

Dabbler: an account for posting comments where not otherwise engaged in order to correct misinformation. Direction to platforms where more actively engaged is provided.

Fully immersed: an account where staff are involved fully, engaging with community, responding to questions and comments, having conversations, and providing information during the emergency response. Requires highest level of staff resourcing, but provides highest level of community benefit.

Posting access will be assigned to staff who are familiar with the Health Unit's existing codes of conduct surrounding social media.

Social media presence and level of engagement will be limited to what can easily be maintained throughout the emergency situation.

8.6.2 Hotline for Public

This is a way for the public to get up-to-date information on the emergency. This could be a hotline with a pre-recorded message or simply a number that directs to a designated staff member's extension. IT can help set up either configuration.

- Determine if there is a need for a hotline in this particular emergency:
    - Are main reception and/or the lead team finding themselves overwhelmed with the number of phone calls and overhead pages? (outrage)
    - Is the public currently at risk? (hazard)
    - If the risk is over do we need to get information to the public?

Pre-recorded hotline procedure:

- Decide who will update the message.
- Decide how often the message needs to be updated.
- Create a template for the messages (to include date and time of message)
- Plan advertising/announcement of the hotline.

Hotline directed to a staff member's extension:

- Decide which staff member will answer hotline inquiries, taking into account staff member's knowledge about the particular situation, as well as their time and schedule.
- Decide how calls will be documented.
- Plan advertising/announcement of the hotline.

8.6.3 Hotline for Stakeholders

A way for stakeholders to get specific information on the emergency with a recorded message.

- Determine if there is a need for a stakeholder hotline in this particular emergency.
- Decide who will update the message.
- Decide how often the message needs to be updated.
- Create a template for the messages (to include date and time of message, how to deal with forms etc.).

8.6.4 Public Information Sessions

Depending on the type of emergency, the Health Unit Control Group will determine when a Public Information Session is needed. A Public information Session is basically a town hall meeting.

Communication will make the arrangements for a Public Information Session with direction from the HU Control Group.

The location of the Public Information Session will be determined by where the issue has occurred. For example, if residents in a particular neighbourhood are concerned about ground water safety, the Public Information Session should be held in that neighbourhood.

The Control Group will select an appropriate location.

Communications will help publicize the Public Information Session through various public communications formats – web site, news release to media, etc.

Ideally, all stakeholders concerned with a particular issue will be notified of a Public Information Session. To ensure as many are notified as possible, Communications will consult with the HU Control Group to identify stakeholders and notify them using the fastest, most convenient methods available.

Post information from Public Information Session to website ASAP.

Depending on the nature of the emergency and the reaction of the public, it may be important to consider:

- Security at the public information session
- Separate entrance for speakers
- Independent facilitator/moderator

A crisis does not always get picked up by the media immediately. During a public health emergency, the HU Control Group may have to decide when to contact the media about an issue.

These triggers are prompts to begin media communications:

- Risk to public has or will become high enough to require risk/crisis communications.
- Increased calls/emails from public.
- Increased social media/online chatter from public about issue.
- Contact from community partner/stakeholder indicating increased chatter in community.
- Media contacts us.
- Issue appears in media without our input.

START HERE: CRISIS COMMUNICATIONS CHECKLIST

- ☐ Identify if this is a public health emergency or an emergency with a public health component.
- ☐ Start filling out a crisis communications plan (see appendix 8.6.5 A1). For an emergency with a public health component, fill out the top row indicating who will be the lead agency, who that agency's communications contact is and their contact info. For a public health emergency, make that row "N/A".
- ☐ When meeting with the EOC/HCHU control group, get a description of current situation.
- ☐ Get a summary of all audiences. Use the pre-listed audiences in the crisis communications plan as prompts.
- ☐ For the current situation: determine key messages for each audience, methods of distribution (how you will get the information to the audience) and who is responsible for each.
- ☐ Brainstorm three escalating scenarios that would require a ramped-up communications response. EOC/Control group may want to brainstorm key messages, audiences and timelines for the first escalation scenario.
- ☐ Begin performing key tasks according to plan. Seek out and note new information. Update plan regularly with EOC/HCHU control group

8.7 COMMUNICATING ACCESSIBLE EMERGENCY INFORMATION

In an emergency, information becomes critical. The Huron County Health Unit strives to provide information to everyone in an emergency, including people with a variety of disabilities, people with English as a second language and people with low literacy.

Given its capacity, the Health Unit focuses on making emergency information accessible and understandable to vulnerable populations through the use of:

- Plain language
- Simple layout and presentation
- Simple design

In addition, the HCHU can make use of these alternative formats:

- Electronic Text
- Large print

If an emergency is on a large enough scale, additional alternative formats or translation into different languages may be available from provincial leaders or our larger urban counterparts:

- Middlesex London Health Unit
- Region of Waterloo
- Toronto Public Health
- Public Health Ontario
- MOHLTC

The use of volunteers to provide interpretation services, whether verbally into another language or through ASL, in a **mass communication format** (such as a media conference, media release or radio interview) during an **emergency situation** is **strongly discouraged**. There is the **risk of misinformation** going out to vulnerable populations due to these possible risks of using non-professional interpreters: may be fluent for everyday language but not for technical concepts and terminology, no assessment of skills, no formal interpreting education, not bound by any professional code of conduct.

Volunteer interpreters may be considered in a one-on-one scenario where the person seeking information can clarify the information with the person who is interpreting. This policy and process would be in keeping with Health Unit Communications Policy 7.01 Translation and Interpretation Services.

Sources:
Making Sure People with Communication Disabilities Get the Message: A Checklist for Emergency Public Information Officers, Disability Alliance BC

Emergency Response Interpreters: Presentation
THE ARIZONA COMMISSION FOR THE DEAF AND THE HARD OF HEARING

CHAPTER 9 – STAFF SUPPORT AND TRAINING

Staff can expect that the management of an emergency may be significantly different from the regular work of most positions within the Health Unit. Individuals responding to an emergency will operate in an environment of command and control that is sometimes fast-paced and overwhelming, and at other times, slow-paced and routine.

Staff may be assigned a role within the Health Unit's response structure. The IMS concept of emergency management provides an organizational framework that exists separately from the routine operations of an organization. When an individual is asked to take on any role under an Incident Management System, it is based on their particular skill-set and is not necessarily based on seniority or routine reporting relationships within the Health Unit.

When participating in the response, staff report to the lead for their section (e.g. the Operations Lead) and to the Incident Manager. This does not replace normal reporting relationships, but is in addition to routine business.

Below are some other examples of what can be expected:

- The flow of information will increase well beyond normal rates, leading to challenges in remaining up-to-date.
- Staff may be directed to perform seemingly routine, but necessary tasks. On the other hand, staff may experience entirely new tasks they had not performed before.
- Response activities must be well documented. Staff can expect the level of documentation to be significantly increased.
- Staff may be required to communicate or liaise with organizations they have never dealt with before. During emergencies, relationships are developed with a variety of organizations (sometimes working together for the first time during an emergency).

9.1 STAFF TRAINING REGARDING EMERGENCY PLANNING & RESPONSE

Staff who have been provided with training regarding emergency planning and response will be more prepared, practically and psychologically, for the atypical working conditions experienced during a surge event or emergency response.

The Health Unit provides staff with opportunities for training regarding emergency response in the following ways:

1. All staff are introduced to the Health Unit *Emergency Plan* during workplace orientation.
2. At a minimum of twice a year, there is "emergency planning and surge capacity" agenda item at All Staff Meetings.
3. Staff participate in exercises / tests of the emergency plan and the debriefing of these events.
4. Staff participate in debriefing opportunities regarding actual surge events and emergency situations.
5. Individual staff may request (or be encouraged to undertake) other training and professional development that will increase their ability to participate in addressing surge events and emergency situations.
6. Other training opportunities for staff (collectively or individually) may be identified by the Emergency Management Advisory Group.

9.2 STAFF PERSONAL EMERGENCY PREPAREDNESS

Staff who are personally prepared at home to deal with emergency situations will be better able to participate in emergency response at the Health Unit. Knowing that the home situation is well prepared and, in an emergency, attended to reduces levels of stress and allows staff to focus on needs of the workplace.

The Health Unit provides all staff with information regarding personal emergency preparedness.

9.3 HOT WASH AND DEBRIEFING OPPORTUNITIES FOR STAFF

A hot wash is an informal discussion after an exercise, surge event or emergency response. It is the same day as the event and allows for immediate feedback.

A debriefing is an opportunity to reflect on experiences and challenges and to give some direct feedback about the health unit's surge response and identifies lessons learned. Debriefing includes an in-depth view of what went well and what did not go well as well as what we need to change. Debriefing notes taken will assist with creating an after action report.

Group debriefing sessions should be held as soon as possible after the surge / emergency situation. Where a time-lag is expected, at the very least staff should be informed ASAP regarding when the debriefing meeting(s) can be expected and directed to their managers for more immediate support as needed.

Group Debriefing guidelines can be found in Appendix 9.3 A1.

9.4 AFTER ACTION REPORT

This report includes lessons learned and makes recommendations for improvement to emergency plans, processes and procedures. It allows for assessment of emergency response capabilities and includes an Action Plan to move forward.

To be effective, the Action Plan identifies staff members responsible for follow up with action Items. Timelines for action items, dissemination of information and information and report storage decisions are also required.

The After Action Report Executive Summary Template can be found in Appendix 9.3 A2.

DATA AND DOCUMENTATION PROCESS:

9.5 ACCESS TO EXTERNAL PSYCHOSOCIAL SUPPORTS

Many staff at the Health Unit (according to their collective agreements) have access to an Employee Assistance Program (EAP). This program may be extended to non-participating staff during / after emergency response.

In a County-wide emergency situation, the County of Huron Human Resources Department is responsible to source and co-ordinate the provision of Critical Incident Stress Debriefing services for County Staff including the Health Unit. See 9.5 CA1 Employee Assistance Program

CHAPTER 10 – TERMINATION OF AN EMERGENCY

The Health Unit cannot officially "declare" a state of emergency according to the related legislation. Therefore, the Health Unit has no role in "terminating" a state of emergency.

Where the Director of the Health Unit and/or the Medical Officer of Health have named the Health Unit to be "in surge" is response to a surge event, emerging or emergency situation, they, or their alternates, may end the "surge" status of the Health Unit.

a. All staff will be advised that the Health Unit is returning to normal operations as per the procedures set out in 4.1 Activation / Notification Procedures.

b. External stakeholders (as identified by the Control Group and in 4.1 Activation / Notification Procedures) will be advised as appropriate.

CHAPTER 11 – PLAN DEVELOPMENT & MAINTENANCE

11.1 PLAN APPROVAL

The Health Unit Emergency Plan is approved by the Executive Lead (i.e., the Medical Officer of Health) based on the recommendation of the Emergency Management Advisory Group. This includes revisions to the Emergency Plan.

The EMAG is informed of, but does not need to "approve", up-dates / revisions to the appendices of the Emergency Plan.

11.2 TESTING / EXERCISES

The Emergency Plan, or some component of the Plan, is tested at least annually.

Exercises to test the emergency plan will:

- have specific goals and objectives;
- include observation, and a report, by a third party if available;
- be recorded in confidential appendix 11.2 CA1 – Emergency Exercise dates;
- result in a summary report prepared within a reasonable time period; and
- inform review and revision of the Emergency Plan.

11.3 REVIEW & REVISION

The Emergency Plan is maintained and reviewed in whole or in part:

- At least annually by the Emergency Management Advisory Group;
- After every surge event or emerging or emergency situation; and
- After every exercise intended to test some component of the Plan.

Review and revision dates are recorded as part of the policy manual and can be found at the end of the document.

CHAPTER 12 – PLAN DISTRIBUTION

1. Current copies of the Health Unit *Emergency Plan* are:
    - made available in the Administrative Area of the Health Unit;
    - kept in the IMS response kits located in the Emergency Supplies Cupboards in Rm 2;
    - included in:
        - The Health Unit General Drive/Emergency Response;
        - CARRs files and on the WAVE (including confidential appendices); and
        - the “on call” manual(s) (including confidential appendices);
    - referenced in staff orientation materials;
    - posted to the Health Unit web-site; and
    - electronically shared with partners as requested.
2. Up-dated chapters / versions of the Emergency Plan are distributed as necessary.

CHAPTER 13 – HAZARD IDENTIFICATION RISK ASSESSMENT

13.1 HAZARD IDENTIFICATION RISK ASSESSMENT (HIRA)

A HIRA is a risk assessment tool that can be used to assess which hazards pose the greatest risk in term of how likely they are to occur and how great their potential impact may be. It is not intended to be used as a prediction tool to determine which hazard will cause the next emergency

13.2 THE HAZARD IDENTIFICATION & RISK ASSESSMENT PROCESS

The HIRA process used by the Huron County Health Unit follows 6 steps:

1. Hazard Identification – using a master list (compiled from York Region Health Unit) and a public health lens, identify hazards most relevant to Huron County. These will be included in the risk assessment.
2. Assess Frequency – Examine past occurrences and the likelihood of the hazard impacting people, property, the environment or critical infrastructure

Frequency		
Rating	Description	Percent Chance
1. Remote	Occurs on average >100 years and includes hazards that have not occurred in the County but are reported to likely occur in the near future.	Less than a 1% chance of occurrence in any year
2. Very Unlikely	Occurs on average every 20-50 years and included hazards that have not occurred but are reported to be more likely to occur in the near future	Between 1-2% chance of occurrence in any year
3. Unlikely	Occurs on average every 20-50 years	Between 2-10% chance of occurrence in any year

4. Possible	Occurs on average every 5-20 years	Between 10-50% chance of occurrence in any year
5. Likely	Occurs on average every 5 years or less	Between 50-100% chance of occurrence in any year
6. Almost Certain	Annual on average occurrence of the hazard	100% chance of occurrence in any year

3. Assess Consequence Using the Hazard Category Impact description table below, determine the consequence rating for each hazard identified in Step 1.

Consequence		
Consequence		Description
Public Health Impacts		The direct negative consequences of the occurrences of a hazard to public health (PH) and/or the public health system
Hazard Category Impact Descriptions		
1. Minor	Public Health	Not likely to cause injury/illness/death outside of the normal progression of the hazard; not know to be transmitted person-to-person or endemic to the population
	Public Health Unit	No impact on the PH system
	Broader Health System	May or may not have an impact on the health and human health system (health system outside of PH may be overwhelmed, while there is little to no effect on PH).
	Media Attention	No media attention

2. Slight	Public Health	Sporadic/slight activity of a disease/hazard that has the potential to cause injury/illness/death outside of the normal hazard progression; not likely to be transmitted person-to-person
	Public Health Unit	Not likely to have an impact on PH staff and/or resources; however, monitoring of the situation may be required (within normal day-to-day operations).
	Broader Health System	Slight impact on the human health system (required active monitoring by PH).
	Media Attention	Local and/or Regional media attention on general health hazards
3. Moderate	Public Health	Localized disease which has the potential to cause higher than average rates of injury/illness/death than normal hazard progression; may be transmitted person-to-person
	Public Health Unit	Minor to moderate impact on PH system; monitoring of the situation is required. Minor impact on PH staff and/or resources outside of day-to-day operations; however, can still be managed by each respective Division
	Broader Health System	Moderate impact on the human health system; may require guidance/resources from the Provincial level.
	Media Attention	Local and/or County media attention on a specific health hazard
4. Severe	Public Health	Widespread disease/hazard which has the potential to cause a high rate of injury/illness/death outside the normal hazard progression
	Public Health Unit	Severe impact on the PH system; required enhance monitoring by PH staff and support at the Team level

	Broader Health System	Severe impact on the human health system; required intervention by PH staff and/or requires resources from other Health Unit Departments
	Media Attention	County media attention on a specific health hazard; or international media attention on a general health hazard
5. Very Severe	Public Health	Widespread disease/hazard which has the potential to cause a significantly high rate of injury/illness/death rate; outside of the normal hazard progression
	Public Health Unit	Very severe impact on the PH system; requires intervention by PH staff and support at the Departmental level with possible involvement from multiple levels of government
	Broader Health System	Very severe impact on the human health system; requires intervention by PH staff and/or requires resources from the Department and/or County level
	Media Attention	National media attention on a specific health hazard; or international attention on a general health hazard
6. Catastrophic	Public Health	A large scale epidemic/pandemic or widespread event involving an environmental hazard resulting in extremely high rates of injury/illness/death outside of normal hazard progression
	Public Health Unit	Extensive draw on PH staff and resources; requires coordination with external health sector partners and multiple levels of government
	Broader Health System	Human health system unable to cope with influx of patients surging health care systems

	Media Attention	National and international media attention on a specific health hazard

4. Assess Changing Risk – Using the table below, assess if the risk is increasing, decreasing or remaining the same. By assessing the hazards identified in Step 1, we can try to account for the change in the risk that the hazards pose.

Changing Risk
Is the number of reported occurrences of the hazard increasing?
Is human activity (e.g. population expansion, altering of drainage flow patterns) likely to lead to more interaction with the hazard or an increase in frequency?
Is there an environmental reason (e.g. climate change) why the frequency of this hazard may increase?
Are human factors such as business, financial, international practice more likely to increase or decrease this risk? (e.g. international business travel)
Is a large percentage of the population vulnerable to this hazard or is the number of people vulnerable to this hazard increasing?
Are response agencies practiced or prepared to respond to this hazard? (e.g. do emergency plans exist for this?)
Are prevention/mitigation measures currently in use for this hazard? (e.g. immunizations, infection prevention and control practices)
Does the Ministry of Health and Long-Term Care consider this an emerging risk?

5. Calculation of Risk – Applying the formula: **Risk = Frequency X Consequence**

Overall Risk Rating		
Rating	**Score** **F X C**	**Descriptor**
Extreme	31-36	Immediate action is required. Health and life safety of people is currently at risk. Very severe consequences are almost certain if mitigation and preparedness action are not taken immediately
Very High	21-30	Health and life safety of people will be impacted, and very severe consequences would probably occur if this hazard were to materialize. Mitigation and preparedness actions should be in place and exercised to ensure response will meet the needs of the community when required
High	15-20	Health and safety of people could be impacted, and severe consequences would probably occur if this hazard were to materialize. Mitigation and preparedness actions are required.
Moderate	8-14	Health and life safety of people may be impacted, and moderate consequences may result if this hazard were to materialize. Specific mitigation and preparedness actions should be considered
Low	1-7	The risk posed by this hazard is very minimal and can be managed by routine procedures and operations. This risk should not require much attention and only needs to be reviewed if there are indications that the risk is increasing in frequency or consequence. The frequency and consequence of this hazard will have limited to no impact on the community.

6. Determine Vulnerabilities

Vulnerable populations in the context of emergency preparedness can be defined as “any individual, group or community whose circumstances create barriers to obtaining or understanding information or the ability to react as the general population”[1].

Vulnerability in the same context can be defined as the "diminished capacity of an individual or group to anticipate, cope with, resist and recover from the impact of a natural or man-made hazard"[2].

Vulnerabilities change as factors impacting risk change. Vulnerabilities can change seasonally and are not equally distributed but vary across regions and are different across hazards zones. The ability to predict relative vulnerability is complex and diverse. "Identifying, communicating with, responding to, or engaging some high risk groups is difficult due to fear, stigma and protection of privacy"[3] (p. 11).

To determine people's vulnerability, two questions need to be asked:

1. To what threat or hazard are they vulnerable?
2. What makes them vulnerable to that threat or hazard?[2]

During times of emergencies or disasters, anyone can be considered or become "vulnerable". There are however factors and circumstances that provide individuals with fewer resources and reduced capacity to be able to handle emergency situations.

Factors to Consider:

- psychological status– ability to think, behave and express appropriately in relation to emotions[4]
- mental status
- available social networks
- lack of monetary resources (or lack of access to resources)
- physical status – limited physical mobility
- health capacity – chronic illnesses, unstable health
- cognitive status – two way communication and appropriate decision making
- access to information – language barriers, technology literacy, physical disability, sensory difficulties
- stigma for equitable access – access to resources, deserving versus undeserving poor, culture, ethnicity, LGBTQ
- unstable or precarious housing
- other limiting barriers – transportation,

To better assist vulnerable populations and reduce the negative impact of emergencies on people at risk and communities as a whole, common difficulties of many at risk individuals can be considered within the following five key areas:

- ❖ Communication needs
- ❖ Maintaining functional independence

- Medical needs and supports
- Psychosocial supports
- Supervision needs
- Transportation needs[5]

Using these guidelines the Huron County Health Unit will:

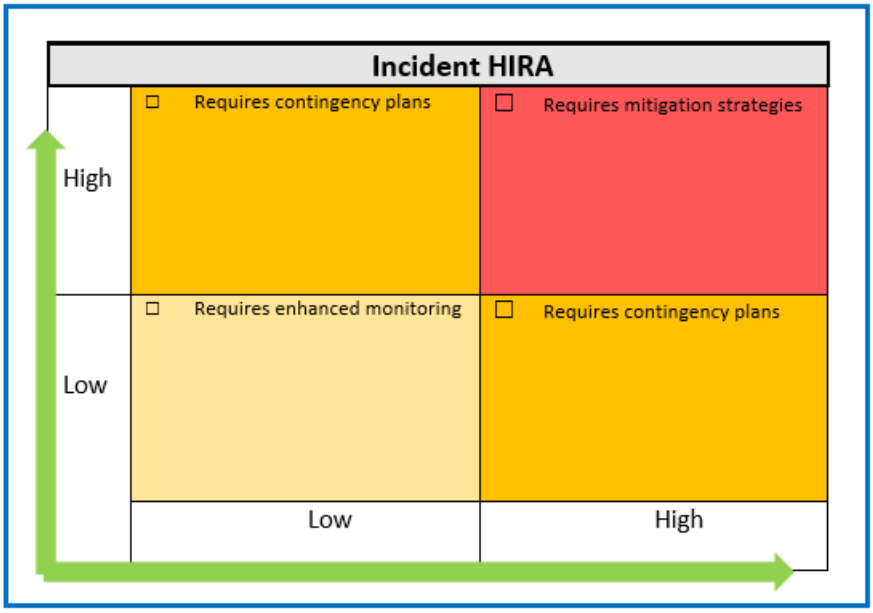
- incorporate planning for vulnerable populations within public health sub plans where applicable.
- counteract vulnerability by reducing the impact of the hazard where possible through mitigation, preparedness and planning efforts, assisting to build capacity where possible to cope with hazards and continuing to challenge some root causes of vulnerability such as poverty, health inequities, discrimination and unequal access to resources within our Health Unit programs
- include the issue of vulnerable populations in Emergency Operations Centre agendas to ensure an appropriate response

References

1. Public Health Advisory Committee. (January 25, 2006). IOWA Public Health Preparedness Program. http://www.idph.iowa.gov/Portals/1/Files/DisabilityHealthProgram/emergency_planning.pdf
2. International Federation of Red Cross and Red Crescent Societies. (2016). Online: http://www.ifrc.org/en/what-we-do/disaster-management/about-disasters/what-is-a-disaster/what-is-vulnerability/
3. Canadian Red Cross. (2007). Integrating Emergency Management and High-Risk Populations: Survey Report and Action Recommendations. Online: http://www.redcross.ca/cmslib/general/dm_high_risk_populations.pdf
4. Balboa Horizons. (2016). What is the difference between mental health and psychological health. Online: http://www.balboahorizons.com/difference-mental-illness-psychological-health/
5. Centre for Emergency Preparedness and Response Public Health Agency of Canada & BC Coalition of People With Disabilities. (2008). Checklist to Facilitate Health Emergency Planning for At Risk People. Online: http://www.icid.com/files/Marg_Pop_Influenza/9_Checklist_Health_Emergency_Planning_for_At_Risk_People_BCCPD_.pdf

13.3 INCIDENT HIRA

During emergencies or surge capacity incidents such as a Mass Gathering Event an Incident HIRA can be completed to prioritize public health concerns. This process is used to identify potential hazards and determine the risk of each hazard (probability X impact).



CHAPTER 14 – MUTUAL AID & ASSISTANCE AGREEMENTS

Some emergency situations may require a response that is beyond the capacity of the individual agency or institution (e.g., health unit of local government). In these cases, systemic surge capacity provides the resources needed to appropriately respond to the situation.

Where a surge event (or declared emergency) requires a response that surpasses the ability of the Huron County Health Unit to respond, it may call upon others (e.g., neighbouring health units, local governmental emergency response workers) for assistance. Similarly, the Health Unit may be called upon for assistance by others responding to emerging or emergency situations.

Mutual aid/assistance agreements ensure aid required to effectively manage an emergency. Aid provided may include services, personnel, equipment and materials. Mutual aid/assistance agreements enable the health unit, in advance of an emergency, to set the terms and conditions of the assistance which may be requested or provided. Health units (or municipalities) requesting and providing assistance are therefore not required to negotiate the basic terms and conditions of the request at the time of an emergency and may request, offer or receive assistance according to the predetermined and mutually agreeable arrangements.

To contribute to systemic surge capacity, the Health Unit:

- maintains an awareness of other resources available to assist during surge events and emergency situations;
- is prepared to provide staff and expertise to contribute to local and regional responses to surge events and declared emergencies;
- continually assesses resources available and priorities during surge events and emergencies with a view to the need to call upon others for assistance; and
- enters into mutual aid and mutual assistance agreements as appropriate.

14.1 MUTUAL AID AGREEMENTS

The Huron County Health Unit has (informal and unwritten) mutual aid agreements in place with:

- The Middlesex-London Health Unit;
- The Perth District Health Unit; and
- The Grey-Bruce Health Unit.

The Huron County Health Unit has provided assistance to, or received assistance from, these health units in the past and may continue to do so in the future. Requests for or offers of assistance are normally made through the Medical Officer of Health or designate.

A record of the use of mutual aid agreements is maintained as appendix 14.1 CA1 – Mutual Aid Agreement Implementation Records.

14.2 MUTUAL ASSISTANCE AGREEMENTS

Mutual Assistance Agreements are pre-negotiated, written agreements between potential response agencies to set out the terms and conditions of assistance which may be provided or requested. They often include stipulations that:

- the “assisted” agency will reimburse the “assisting” agency for services, staff and materials provided during the emergency response – either as outright payment or, more often, in the case that provincial or federal emergency funding becomes available; and
- the “assisting” agency has a right to determine what resources it has available to provide, based on its own current operational needs.

The Huron County Health Unit does not currently have any mutual assistance agreements in place.

A template for the development of mutual assistance agreements is included as appendix 14.2 A1 – Mutual Assistance Agreement Template.

14.3 THE HEALTH UNIT AS PART OF THE CORPORATION OF THE COUNTY OF HURON

The Health Unit is a "department" of the Corporation of the County of Huron.

As such, it is included in the Emergency Management Program of the County of Huron and participates structurally in any emergency response activities undertaken by the County of Huron.

As well, the Health Unit is included in the Mutual Assistance Agreements between the Corporation of the County and:

- the nine municipalities included in the County of Huron; and
- any other mutual assistance agreements entered into by the County of Huron.

14.4 OTHER EXTERNAL SOURCES OF ASSISTANCE DURING EMERGENCY RESPONSE

As part of the "public health system" in Ontario, the Health Unit also has access to surge and emergency supports provided at the provincial and federal levels. These include:

- The *Public Health Branch*, Ministry of Health & Long Term Care
- The *Emergency Management Unit* of the Ministry of Health & Long Term Care, contacted through the Public Health Call Centre at 416-212-6361 or 416-212-6362
- The Canadian Field Epidemiology Program, Public Health Agency of Canada – request assistance from the Ontario Ministry of Health and Long-Term Care who will contact the Field Epidemiologist on our behalf
- Public Health Ontario which has 3 functions during an emergency:
    1. **provide laboratory services and science**
    2. **provide surveillance and epidemiology services**
    3. **provide scientific and technical support (internal and external experts)**

In emergency preparedness and response, public heath units may access these services through Public Health Ontario:

Emergency Preparedness and Incident Response

epir@oahpp.ca

- Main switch board, after hours on-call system 24/7
- During an emergency, MOHLTC Emergency Management Branch will involve PHO – Emergency Preparedness and Response Branch, when scientific/technical advice and support is required.

Chapter ***Review and Revision Log***

Manual Section	Review Date	Revision Date	Reviewed By	Approved By
Chapter 1	June 2, 2016	June 2, 2016	EMAG	EMAG
Chapter 13	June 2, 2016	June 28, 2016	EMAG	EMAG
Chapter 7	June 2, 2016	June 28, 2016	EMAG	EMAG
Chapter 8	June 2, 2016	June 28, 2016	EMAG	EMAG
9.3	April 27, 2017	Sept 28, 2017	EMAG	EMAG
Manual	June 28, 2017			Dr. Bokhout MOH
8.7	Sept 28, 2017	Sept 28, 2017	EMAG	EMAG
9.4	Sept 28, 2017	Sept 28, 2017	EMAG	EMAG
Manual	August 24, 2018			Dr. Bokhout MOH