Full document available at:

This document has been developed to comply with the ministry’s responsibilities under the Emergency Management Act (EMA). The overall responsibility for the coordination of emergency management in the province lies with Emergency Management Ontario (EMO), under the Ministry of Community Safety and Correctional Services (MCSCS). However, the EMA and its accompanying Order in Council requires the MOHLTC to develop an emergency response plan that will address its assigned areas of responsibility: human health, disease and epidemics and health services during an emergency (see s. 3.0). This plan was prepared by the Emergency Management Unit (EMU) of the Ministry of Health and Long-Term Care (MOHLTC), using a strategic approach to emergency management. This approach involves the comprehensive assessment of potential hazards to the health of Ontarians, and the institution of procedures for communication, resource mobilization, and response that will serve as tools for the Government of Ontario to address a given incident. The MERP is in accordance with guidelines established by EMO, and provides a framework for emergency management that is consistent with the provincial emergency response plans maintained by the Ministry of Community Safety and Correctional Services. These include the Provincial Emergency Response Plan (PERP), the Provincial Nuclear Emergency Response Plan (PNERP) and the Provincial Counter-Terrorism Plan. While the MERP can function in isolation, it also supports the Provincial Emergency Response Plan.

An emergency is 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.” By its nature, an emergency often elicits an atypical response from authorities that requires them to go beyond their regular activities or procedures.

Emergencies are caused by hazards. These are described as events or conditions that have the potential to cause harm or loss to life and property, such as a tornado or a chemical explosion. 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. Emergencies are essentially local in nature. They tend to develop at the local level, with the potential to assume much larger proportions. Thus, the process of managing an emergency and executing the activities necessary to respond to the situation to protect public health and safety begins at the community or municipal level with support and assistance provided by the province. There will also be emergencies, such as a terrorist attack, for which the province’s intervention will be immediate.
3.0 LEGISLATION, ROLES & RESPONSIBILITIES
This section outlines the relevant legislation for managing emergencies in the province, the ministry’s responsibilities under that legislation and the relationships between the MOHLTC and other provincial organizations that have similar responsibilities for emergency management.

3.1 Emergency Management Act
The Emergency Management Act, R.S.O. 1990 (EMA) (now the Emergency Management and Civil Protection Act) is the principal statute governing emergencies in Ontario. The legislation provides for the declaration and termination of emergencies within a municipality or the province and directs the creation and implementation of Emergency Management Programs throughout organizations at both the municipal and provincial level. At a provincial level, the Act directs designated provincial bodies to conduct an assessment of potential hazards that could give rise to an emergency (see HIRA, s. 4.3) and to identify critical infrastructure at risk for which each designate is responsible for during an emergency (see s. 6.1). The Act further establishes the requirement of Emergency Plans for each provincial ministry or agency as part of their overall emergency management program. The legislation states that the plan is required to address the specific types of emergencies assigned to them through the Lieutenant Governor in Council.

3.2 Other Legislation

3.2.1 Health Protection and Promotion Act
The Health Protection and Promotion Act is the primary statute governing the organization and delivery of public health programs and services, the promotion and protection of the health of the people of Ontario, and the prevention of the spread of disease. This legislation requires that local Boards of Health must superintend, provide or ensure the provision of a minimum level of public health programs or services (as set out in the Mandatory Health Programs and Services Guidelines) in a number of specified areas, including the control of infectious and reportable diseases and the provision of immunization services. Provisions under this Act relevant to a human health emergency include:

• The reporting of certain diseases to medical officers of health by physicians and practitioners, laboratories, school principals, hospital administrators and others.
• Ordering persons who may have a communicable disease to do, or stop doing, anything to reduce the risk of disease transmission.
• The disclosure of information about patients who are infected with communicable diseases to the medical officer of health and from the medical officer of health to the ministry, while protecting the confidentiality of sensitive health information.
Physicians are required to report to the medical officer of health the name and residence address of any person under the care and treatment of the physician in respect of a communicable disease who refuses or does not continue the treatment in a manner and to a degree satisfactory to the physician.

Appropriate action may be taken by the Chief Medical Officer of Health to prevent, eliminate or decrease a health risk.

Premises may be required by the Minister to be used as temporary isolation facilities.

### 3.2.2 Additional Legislation with Emergency-Relevant Components

Additional pieces of legislation governing different aspects of the healthcare system may also inform the ministry’s response to an emergency. Potentially relevant legislation includes:

- **The Ambulance Act**: provisions regarding education, protection and prevention of disease transmission, including immunization of emergency medical attendants
- **Public Hospitals Act**: provisions regarding the use of additional sites, the development of emergency plans and requirements for a health surveillance program for all persons carrying on activities in the hospital
- **Other facility legislation** (e.g. Nursing Homes Act, Charitable Institutions Act and Homes for the Aged and Rest Homes Act): provisions regarding surveillance and reporting of particular communicable diseases
- **Legislation governing Regulated Health Professionals**: provisions regarding temporary registration
- **Legislation governing workplace health and safety** (e.g. the Occupational Health and Safety Act and Health Care and Residential Facilities Regulation): provisions regarding protecting the health and safety of employees
- **Legislation governing health information** (e.g. the Personal Health Information Protection Act): provisions regarding the collection, use, and disclosure of personal health information by health information custodians, including physicians, hospitals, long-term care facilities, boards of health, medical officers of health and the Ministry of Health and Long-Term Care, including disclosure to officers of health without the consent of the individuals to whom the information relates (see s. 3.2.1 above).

In the event of an emergency, appropriate branches of the ministry will be called upon to provide advice on the various rights, responsibilities, powers and authority contained in the above legislation which may be pertinent to the situation.

### 3.3 Emergency Management Program Requirements

The essential emergency management program requires the following components:

- Full-time emergency management coordinator
- Ministry emergency management program committee
- Emergency information staff
- Ministry Emergency Operations Centre
- 24/7 notification capacity
- Identification of critical infrastructure
- Emergency response plan for OIC responsibilities
- Emergency response capability
- Public awareness program for OIC responsibilities
- Business continuity plan
- Annual training
- Annual ministry exercises
- Annual evaluation of program

As indicated above, the MERP is required as part of the ministry’s essential emergency management program. The enhanced and comprehensive requirements will expand the program to incorporate prevention, mitigation and recovery strategies as well as improved training, partnerships and public education.
3.4 MOHLTC Order in Council (OIC) Responsibilities

Through the Emergency Management Act and its accompanying Order in Council, the government has assigned responsibility for specific types of emergencies to designated government ministries with the necessary expertise to deal with them. Through the Order in Council (revised in December 2004), the Ministry of Health and Long-Term Care has been assigned specific responsibility over:

- “Human Health, Disease and Epidemics”; and
- “Health Services During an Emergency”

The ministry responsibility begins at the broad level of human health, such as an incident of contamination or other emergency situation that presents a danger to, or negatively impacts on, the general health and well-being of the human population. Local outbreaks of specific diseases that require action beyond normal procedures would also be an MOHLTC responsibility, as would catastrophic health incidents such as epidemics (defined as a major incident of human illness in a community or region, caused by the transmission of a specific disease with a frequency clearly in excess of normal expectancy) or pandemics (defined as epidemics of global proportions). An influenza pandemic, as a highly contagious disease on a global scale, is one scenario that would fall within the MOHLTC’s responsibilities. The MERP must describe the process by which the ministry will respond to such situations. However, as indicated previously, the ministry also has several plans in development to address specific incidents such as a pandemic (see s. 1.1 for the list of plans). The second OIC responsibility assigns the MOHLTC a role in those emergency situations where the healthcare system is not the primary focus of the response effort, but where there may be health implications. Examples of this would be floods, earthquakes, fires/explosions, etc. While the MOHLTC would not lead the province’s responses to such incidents, the ministry would be responsible for acting to ensure the continuity and coordination of health services during the emergency. The next section (3.5) will provide greater detail on the relationships between the ministry and the other principal organizations involved in emergency management at the provincial level.

3.5 Emergency Response Relationships within the Provincial Government

3.5.1 Emergency Management Ontario (EMO)

As previously indicated, Emergency Management Ontario, within the Ministry of Community Safety and Correctional Services, is responsible for the overall coordination and management of emergency situations in the province of Ontario. The relationship between EMO and MOHLTC depends on the type and scale of the emergency situation. For example, EMO will generally receive information concerning a potential emergency situation from first responders (police, fire, paramedics) and will inform the appropriate ministries. However, the initial alert or warning of an emergency may come from particular ministries instead based on their networks of professionals and stakeholders in the field. For example, in the case of a health-related emergency, the MOHLTC may be notified locally either through its healthcare providers (including paramedics), public health units, or regional offices. The ministry would then, in turn, inform EMO and key internal decision-makers of the event. For more information on this initial alert/warning protocol, refer to s. 5.5.1. In any event, the MOHLTC will work with EMO in responding to the emergency by liaising with its healthcare providers as well as other stakeholders involved in an effort to coordinate the provision of healthcare services wherever they are needed. This is accomplished through the collaboration of two key bodies: the Ministry Emergency Operations Centre (MEOC) located at the Emergency Management Unit (see. s. 5.3) and the Provincial Emergency Operations Centre (PEOC), located at EMO (see s. 4.2.1).

3.5.2 Other OIC Ministries

The Order in Council that accompanies the Emergency Management Act also assigns specific responsibilities to various other government ministries. For example, the Ministry of Agriculture and Food is responsible for leading the government’s response to an agricultural emergency, whereas the Ministry of Natural Resources would respond to a forest fire and the Ministry of Energy to a blackout. For a full list of the other emergency responsibilities assigned through Order in Council, see Appendix C. Similar to the MOHLTC, these other OIC ministries would also work alongside EMO in order to respond to these specific incidents should they occur within the province. These incidents may or may not require the support of the Ministry of Health and Long-Term Care to manage the emergency as well.
3.6 MOHLTC Support Role/Secondary Responsibilities
Other OIC ministries are required to deal with many emergencies that are outside of the MOHLTC’s primary OIC responsibility towards “Human Health, Disease and Epidemics”. However, these may be incidents such as floods, tornados or chemical fires where the potential for mass injury or contamination exists. In such cases, the MOHLTC, as well as fulfilling its business continuity responsibilities (Appendix M) would act in a secondary role to coordinate healthcare services for injured patients alongside local providers, while the relevant OIC ministry takes its designated primary response role. The MOHLTC may also act in a secondary role for incidents that may have a human health impact, such as an outbreak of Avian Influenza in the province’s poultry flocks. As a Foreign Animal Disease (FAD), this incident would require provincial leadership from the Ontario Ministry of Agriculture and Food (OMAF), which would direct the primary response effort of containing the outbreak within the infected group. This incident would also require a response at the federal level from the Canadian Food Inspection Agency (CFIA). If the FAD is zoonotic (i.e. transmissible to humans), the MOHLTC would be required to expand its roles and responsibilities dependent on the outbreak. The ministry’s roles and responsibilities in this regard are described in Canada and the Province of Ontario’s Foreign Animal Disease Emergency Response Plan. The relevant section is provided in Appendix Q.

Another such example of the ministry acting in a secondary role would be the release of radioactive material from one of Ontario’s many nuclear reactors. For this, the ministry’s Radiation Triage Plan (RTP), which is included in this document (see Appendix P) and is part of the larger Provincial Nuclear Emergency Response Plan (PNERP), would guide the ministry’s response. However, the ministry would still be acting in a secondary role in support of the government’s overall response to a nuclear emergency, even though MOHLTC has a significant role to play in the identification, decontamination and treatment of exposed individuals as well the supply and distribution of Potassium Iodide pills, which is the thyroid-blocking agent used in radiation emergencies. The federal government would also be involved in a response where a Canadian nuclear facility was involved. This would be done primarily through the Canadian Nuclear Safety Commission (CNSC).

3.7 MERP Testing and Evaluation
The ministry is responsible for testing and evaluating the MERP on an annual basis as required by the essential Emergency Management Program for each ministry (shown in s. 3.3).

3.7.1 Internal Testing
The Emergency Management Unit has established and will lead the following tests involving staff within the MOHLTC.
- **Notification/Fan-out**: The ministry will conduct mock fan-out drills throughout the year to a) maintain an optimum notification and response time across key ministry contacts; and b) ensure that contact lists, phone systems and voicemail standards are up-to-date and functional.
- **Ministry Emergency Response Plan**: The ministry will also hold an annual exercise to test the effectiveness of the MERP. This exercise may include activities ranging from tabletop exercises involving a limited number of key staff to larger scenarios involving the activation of the MEOC and the possible participation of other MOHLTC divisions and staff.
- **Business Continuity Plan**: The ministry will also conduct tests of its Business Continuity Plan on an annual basis similar to the tests above (see Appendix M). These tests may be held in conjunction with MERP testing in order to strengthen the interaction between the two.

3.7.2 External Testing
EMU will also conduct the following training exercises in cooperation with external organizations. The involvement of these organizations will allow the ministry to expand its testing scope and provides a more realistic emergency response scenario.
- **CBRN**: The ministry will be conducting training exercises throughout the province on a biannual basis to test the healthcare system’s developing chemical, biological, radiological/nuclear (CBRN) response capability. The exercises will be conducted in different regions in conjunction with the province’s
Emergency Medical Assistance Team (EMAT – refer to s. 7.3.2) along with local healthcare providers and first responders (police, fire, paramedics). The evaluation of these exercises will reveal the provincial response capacity to CBRN events and how this capability will function in real situations as these resources are deployed and field-tested alongside those of first responders.

- Nuclear Facility: A major exercise is conducted each year in order to test the PNERP based on a scenario involving one of Ontario’s nuclear facilities (Pickering, Darlington, Grey-Bruce and Chalk River). Ontario has 20 nuclear reactors – the most in North America. In this exercise, both the PEOC and MEOC are activated for the duration of the simulated incident and representatives from all MOHLTC divisions participate in the mock response. In addition, the Canadian Nuclear Safety Commission (CNSC) will also participate in such exercises. The evaluation of this exercise will lead to improvements in the performance of the MEOC, the functioning of the Incident Management System (refer to s. 4.2.2), as well as relationships internally within MOHLTC and externally between MOHLTC, EMO and other OIC ministries. The Fermi 2 nuclear generating station in Michigan, USA is also included in the exercise program, which allows the government to test cross-border communication and coordination with the State of Michigan.

- Canadian Pandemic Plan: The Public Health Agency of Canada is planning a series of exercises to test the federal, provincial, territorial and local response to a potential influenza pandemic.

PLANNING CONSIDERATIONS

4.2 Ontario Government Emergency Management Structure

This section provides a basic overview of the organization and processes that guide emergency management in the province. As shown below, the provincial organization of emergency management begins at the strategic level with the Executive Authority (the Premier of Ontario) as well as committees of Cabinet and at the Deputy Minister level. The Operations Executive Group is chaired by the Commissioner of Emergency Management and would include, in the case of a health emergency, the Chief Medical Officer of Health and the Director of the Emergency Management Unit. The operational group consists of organizations at the provincial level that are linked with organizations at the local community level and on the front lines. For the province, this includes the Provincial Emergency Operations Centre (PEOC) as well as the supporting Ministry Emergency Operations Centres (MEOCs). There would also be a staff liaison from these MEOCs at the PEOC.

4.2.1 Provincial Emergency Operations Centre (PEOC)
The Provincial Emergency Operations Centre, formerly referred to as the Provincial Operations Centre (POC), is located at EMO and is staffed by EMO personnel on a 24/7 basis. It is designed to support the Premier as the Executive Authority and is the central point from which the province coordinates its response to emergencies in conjunction with other ministries and with authorities at both the local and federal levels. At the onset of an emergency, it can be quickly expanded to incorporate staff from all provincial ministries, designated federal departments and other emergency organizations as needed.

The PEOC accommodates the Operations Executive Group. This group contains key operational decision-making personnel that serve as the command function at the PEOC. The composition of the group will change depending on the type of emergency. However, for the purposes of managing a health emergency, the Operations Executive Group may consist of the following personnel:

- Chair – Commissioner of Emergency Management
- Chief Information Officer
- Director, Emergency Operations, PEOC
- Director, Emergency Information, PEOC
- Other Deputy Ministers and Assistant Deputy Ministers, as required
- Legal Counsel, as required
- Executive Assistant to the Chair
- Administrative Assistant

MOHLTC Personnel:
- Chief Medical Officer of Health/Assistant Deputy Minister, Public Health Division
- Director, Emergency Management Unit
- Executive Director, Communications and Information Branch

4.2.2 Incident Management System (IMS)
The Incident Management System is an international emergency management structure that has been adopted by EMO as the operational framework for emergency management for the Government of Ontario. It is a standardized system that provides the basic command structure and functions that are required for the effective management of an emergency situation.

The IMS has five components: Command, Operations, Planning, Logistics and Finance & Administration. In addition, there are three support elements that report directly to command. They are: Safety, Liaison and Information. The IMS model is shown below:

The system is effective in that this structure is simple in nature and can be applied to any organization involved in emergency management, which, in turn, allows them to become interoperable with each other. This has the effect of standardizing contact information across organizations, making communication and cooperation among the groups easier and making the process of managing an emergency ultimately more efficient. Planning staff will be able to communicate directly with planning staff in other jurisdictions. The
financial group can also liaise easily with another financial group so that transactions can be processed quickly. The following diagram depicts how the IMS will be integrated within the provincial emergency management structure shown previously in s. 4.2:

An example of how IMS will function during an emergency situation can be drawn from the healthcare sector, where a key requirement in a health emergency would be to address the need for medical supplies. The mobilization and distribution of supplies from hospitals as well as from federal and provincial stockpiles to the front lines can be accomplished through communication between the Logistics group from each organization. In addition, transportation into the required area can be expedited by connecting with the Operations group of the Ministry of Transportation (MTO). The various Logistics groups at the site of the emergency (Incident Command Post, nearby hospital(s) providing treatment, etc) can then be informed that supplies are en route and be advised to prepare for their arrival and distribution.

The Ministry of Health and Long-Term Care has adopted this model within its own emergency management program. This model now serves as the organizational structure for the Ministry Emergency Operations Centre (MEOC) at EMU should it be activated to coordinate the response to an emergency situation (see s. 5.3.2 for a diagram as well as detailed descriptions of each function). Other organizations provincially and locally (such as healthcare facilities) are beginning to follow suit, which will help to increase the effectiveness and interoperability of emergency management in the province overall.

4.2.3 Response Levels
The province has adopted a three-tiered response system for emergency situations. The three levels currently in use at the PEOC level are known as: Routine Monitoring, Enhanced Monitoring and Activation. Each level prescribes the actions that should be undertaken as well as the staffing arrangements necessary to carry them out. It is expected that this system be adopted by emergency response organizations at the provincial and local level as well. Consistent with this approach, the MOHLTC has developed its own three-tiered protocol for health-related emergencies based on the above framework. Known as the Graduated Response protocol, the specifics of how this system functions can be found in s. 5.5.3.
4.2.4 Emergency Response Teams (OERT, PERT, CBRN and HUSAR)
The PEOC has the ability to dispatch two types of response teams. The Ontario Emergency Response Team (OERT) is a team that can be dispatched externally to contiguous (neighbouring) provinces or states for the purposes of providing mutual assistance and to coordinate emergency response. The Provincial Emergency Response Team (PERT) is a team made up of EMO field staff (or augmenters) and other provincial personnel dispatched internally to communities in order to coordinate the provincial emergency response, provide advice and assistance to local officials, and to ensure that critical information is exchanged between the PEOC and local communities. Both teams are under the direction of EMO and composed of EMO staff. Other specialty teams are available to deal with specific kinds of emergencies. There are three teams specially trained and equipped in the field of chemical, biological, radiological and nuclear (CBRN) events in Ontario. These teams are trained to initiate safe entry, conduct patient triage, deal with contamination, investigate, monitor, and carry out lab assessments. Located in Windsor, Toronto and Ottawa, the CBRN teams can be made available to assist other communities as necessary. The Toronto Heavy Urban Search and Rescue (HUSAR) team deals with emergencies involving collapsed structures, including the location, treatment, and removal of victims. They have a memorandum of understanding in place with the province to provide a province-wide response capacity for declared emergencies where their skills and equipment are needed and local capabilities are exceeded.

5.0 HEALTH EMERGENCY MANAGEMENT STRUCTURE

5.1 Executive Emergency Management Committee (EEMC)
The Executive Emergency Management Committee functions as the Ministry Action Group (or MAG) for the MOHLTC. It is the central, strategic decision-making body within the Ministry of Health and Long-Term Care in an emergency. The committee is activated and chaired by the Deputy Minister of Health and Long-Term Care and provides policy and operational direction to MOHLTC staff or input to the Ministry Emergency Operations Centre with respect to the management of health emergencies or providing health-related support for other types of emergencies. The EEMC may be activated in the absence of a declared provincial emergency should it be determined that such strategic direction is required for the management of a health-related emergency.

During normal business activities, the Health Emergency Management Committee (HEMC) is active. This committee similarly provides oversight and strategic direction with respect to emergency planning and preparedness within MOHLTC as well as the broader healthcare sector, and acts to ensure that emergency management structures are in place within the MOHLTC and that the roles and responsibilities between divisions are clear. This committee will stand down in the event of an emergency. In addition to the Deputy Minister as chair, the EEMC is comprised of the following members:

- Chief Medical Officer of Health/ADM, Public Health Division
- ADM, Acute Services Division
- ADM, Community Health Division
- ADM, Corporate Services and Organizational Development Division
- ADM, Health Services Division
- ADM, Integrated Policy and Planning Division
- Chief Information Officer
- Chief Nursing Officer
- Executive Director, Communication and Information Branch
- Director, Legal Services Branch
- Director, Emergency Management Unit
- Scientific Advisor (see s. 5.4.1)
- Chair of PIDAC as appropriate (see s. 5.4.2)
- Commissioner of Emergency Management (as a special advisor)
- Ministry of Labour representative

Other positions that may be invited as required:
- Medical Officer of Health of affected Public Health Unit
- Public Health Agency of Canada representative
- Provincial Emergency Operations Centre/Emergency Management Ontario
Once an emergency has been identified by the MOHLTC through alert or warning, the Deputy Minister has the option of convening a first meeting of the Executive Emergency Management Committee (see s. 8.4). The EEMC will discuss the situation and decide on the appropriate ministry response. If the ministry was notified of an emergency by the PEOC, the EEMC will confirm the role of the MOHLTC in the response effort as either a primary or secondary ministry in cooperation with EMO. At this point, the declaration of a “health emergency” would also be considered (this is an emergency with the MOHLTC and its stakeholders and not the declaration of a “provincial emergency”, which is made by the Premier). This meeting would also involve making decisions on whether to activate the MEOC, how to direct resources to manage the emergency and developing initial emergency information to be communicated to stakeholders if necessary.

5.2 Emergency Management Unit (EMU)

The Emergency Management Unit was formally created following the SARS (Severe Acute Respiratory Syndrome) crisis of 2003, in which the province’s first ever provincial emergency was declared. The vision of the EMU is to build and enhance a high performance system of integrated health emergency preparedness and response to keep Ontarians safe.

5.2.1 Mandate

The Emergency Management Unit was initially established in December 2003 with a short term mandate to: coordinate the development of an MOHLTC emergency readiness program; integrate emergency readiness into ministry business planning; identify related infrastructure requirements; and develop a quality-improvement program for emergency readiness. This mandate was later revised and expanded into the current mandate: to collaborate with stakeholders to develop, implement and maintain a comprehensive strategy to prepare for, respond to, and recover from health emergencies of known and unknown origins.

5.2.2 Functions

EMU works to develop policies, plans and procedures that will strengthen the ministry’s health emergency response capability and to ensure that this capability meets the established requirements for emergency management programs in the province. This incorporates the development of various plans such as the MERP (including the aforementioned Hazard Identification and Risk Assessment), Business Continuity Planning, and the development of incident-specific plans, such as the Ontario Health Pandemic Influenza Plan. The EMU conducts training and exercises based on these plans to test their effectiveness. EMU is responsible for activating and managing the Ministry Emergency Operations Centre (MEOC) as well as implementing the Incident Management System (IMS) and Graduated Response protocols as frameworks for the coordination and management of health emergencies within this centre (see the following section). The unit also engages stakeholders and the broader healthcare system in its emergency response planning by issuing emergency directives, guidelines and standards (e.g. for infection control and surveillance) as well as providing Important Health Notices to providers. Through such activities, the EMU also acts as an early-warning system for healthcare providers and ministry senior management. EMU also manages the content of websites for the public and healthcare providers as well as ministry staff on both the MOHLTC internet and intranet sites.

5.2.3 Organization

The normal/routine organization of the Emergency Management Unit can be expanded, consistent with its Graduated Response Protocol and Incident Management System, to accommodate representatives throughout MOHLTC divisions as well as other designated staff as required to respond effectively to the situation (see the “Virtual Team”, s. 7.5). At this stage, EMU effectively becomes the Ministry Emergency Operations Centre. The EMU also is responsible for ensuring that the PEOC, when activated, has a roster of staff from the ministry to occupy the MOHLTC desk within the PEOC when it is required by EMO.

5.3 Ministry Emergency Operations Centre (MEOC)

The Ministry Emergency Operations Centre becomes the central command centre from which emergency situations facing the healthcare system or emergencies requiring MOHLTC support will be coordinated. It is the focal point where operational decisions for the healthcare system will be carried out by MEOC staff in
conjunction with the PEOC at Emergency Management Ontario and following strategic policy direction provided by the EEMC. In addition to EMU personnel, the MEOC can be comprised of staff from across every MOHLTC division along with the additional external advisors and support staff necessary to fulfill the required elements of an effective ministry response. This staff complement may be adapted depending on the size, type or location of the emergency. In order to provide for the necessary complement and reserve of ministry staff, the EMU has created a “Virtual Team” within the ministry that will help staff the MEOC in the event of an emergency.

5.3.1 Emergency Features
Once activated, the MEOC will be able to house approximately 30 staff and is equipped with the following resources with redundant capability where required.

5.3.2 IMS in the MEOC
As mentioned previously, the MOHLTC has adopted the Incident Management System; the international protocol adopted by EMO as the operational framework for emergency management for the province (see s. 4.2.2). EMU has since added additional detail to the basic IMS structure to tailor it to healthcare emergencies and provide additional clarity regarding roles and responsibilities.

The following provides an overview of each major IMS element:
• Command – The command and control function for the MEOC rests with the Director of the Emergency Management Unit. The Command function has the authority to direct the ministry’s emergency response efforts (including the necessary resources) to manage the emergency. This role is supported by three elements:
  Safety – Safety is tasked with monitoring and ensuring the safety of personnel involved in the response effort, including staff at the MEOC.
  Liaison – Acts as a link between Command and other organizations involved in the management of the emergency. Such staff can be deployed to the PEOC or other Emergency Operations Centres as required to coordinate the response.
  Communications – Responsible for the development and timely dissemination of approved emergency information messages to health stakeholders, the public, media, etc.
• Operations – ‘Ops’ staff direct resources as required to fulfill the ministry’s emergency response requirements. As such, this group would be required to link with local healthcare providers, public health labs, etc. in order to carry out the decisions disseminated from Command. This group also staffs the 24/7 EMU Healthcare Provider Hotline (see s. 7.4.1), responding to inquiries about the emergency from the health sector.
• Planning – Planning staff are responsible for the interpretation, dissemination and evaluation of the necessary emergency response plans that are relevant to the type of incident being faced. The group is required to link between all elements of the IMS to ensure that the ministry’s plans are being carried out appropriately. This group must also modify such plans, should changes become necessary. The Planning group also contains the technical expertise required to respond to the emergency (see consultative/advisory bodies, s. 5.4) and engages in data collection activities to ensure that all relevant emergency data is available for Command and Operations staff.

• Logistics – This group’s primary function is to mobilize the province’s available resources for the response. Logistics coordinates and directs the necessary supplies, equipment, services or other resources that are required to resolve the emergency. This may include liaising with provincial and federal stockpile sources (see, s 7.2.1), if necessary, in order to access stores of emergency supplies and dispatch them to the appropriate location(s). In addition to these tasks, this group may also be responsible for ensuring the continuity of ministry operations during the emergency, which will require the MEOC to lead Business Continuity measures where the emergency has a ministry wide impact (see Appendix M for the Business Continuity Plan). Logistics is also responsible for managing the increased amount of teleconferencing traffic that becomes typical of emergency situations and is vital to the communication and sharing of information and ultimately to the success of the emergency response effort.

• Finance & Administration – Lastly, an F&A group will be required to perform the meticulous administrative duties in support of the ministry’s emergency response that are vital to the successful functioning of the MEOC, thus allowing it to execute decisions in a timely and efficient manner. This includes all necessary human resource and financial transactions, scheduling and technical support as well as the exhaustive documentation and record-keeping activities required to capture the comprehensive history of decisions, actions and other details that are needed to recount the ministry’s response to the event.

5.4 Consultative/Advisory Bodies
This section provides the titles and descriptions of individuals and committees that would be called upon during an emergency to provide scientific and operational advice to the ministry on the appropriate emergency response activities that can be undertaken for their respective areas of expertise. The current persons and/or committees with whom the ministry consults with for emergency advice are as follows:

5.4.1 Scientific Advisor/Scientific Response Team (SRT)
The Scientific Advisor is a crucial position within the Emergency Management Unit where complex decisions regarding appropriate response actions during a crisis must be evidence-based, incorporating the current body of scientific knowledge on the type of incident being faced and reflecting current best practices within the healthcare system. This individual supports strategic and operational decision-making within the MOHLTC, reporting to the Director of EMU and working collaboratively with EMU staff to provide expert advice on a wide variety of issues. Such requirements could include: information on health effects associated with CBRN (chemical, biological, radiological/nuclear) events as well as knowledge concerning best practices in responding to CBRN events. The Scientific Advisor will also act to chair the Scientific Response Team (SRT). This team will be activated during an emergency for the purpose of providing scientific advice in situations where it becomes necessary to expand the advisory capacity in order to either encompass a wider, more general body of scientific knowledge or to focus on a targeted body of scientific knowledge necessary to deal with the event.

5.4.2 Provincial Infectious Disease Advisory Committee (PIDAC)
In an emergency caused by an infectious disease, the Provincial Infectious Diseases Advisory Committee will function as the Scientific Response Team for that particular emergency. PIDAC will provide advice to the Chief Medical Officer of Health (CMOH) on the prevention, surveillance and control measures necessary to protect Ontarians from the disease through the provision of scientific expert advice and the development of evidence-based materials. More specifically, PIDAC will recommend provincial standards and guidelines for infection control and advise the CMOH on infection control research priorities and emergency preparedness measures in relation to outbreaks and immunization programs. PIDAC’s membership includes broad expertise from across the healthcare sector as well as relevant MOHLTC representation:

• Chair/Co-Chairs of the Committee
• Chief Medical Officer of Health, /Associate Chief Medical Officer of Health or designate Representative from Hospitals Branch, Acute Services Division
• Director, Emergency Management Unit
• Representative from Long-Term Care Facilities Branch, Community Health Division
• Representative from Laboratories Branch
• Nine (9) other members chosen for their expertise in the following areas:
  □ Epidemiology
  □ Public Health
  □ Infection control
  □ Medical Microbiology
  □ Adult infectious disease
  □ Paediatric infectious disease
  □ Occupational health and safety
  □ Zoonotic disease
  □ Primary care
• Other representatives as required

The Chair or Co-Chairs of the committee are not employees of the Government of Ontario. In addition, where Co-Chairs are appointed, one of these positions shall be chosen from Public Health Units and one shall represent institutional health care

5.5.3 Graduated Response
The MOHLTC Graduated Response Protocol is based on the province’s three-tiered approach in place at the PEOC (see s. 4.2.3). This protocol provides a framework for steps to be taken, including notifications, across the ministry in response to the mounting emergency. EMU may carry-out these actions either independently of or in concert with the response level adopted by the PEOC, depending on the nature of the emergency. The ministry may elevate or reduce its response level depending on the circumstances of the emergency. Such action would be based on the information the ministry receives concerning the status of the incident and how it is (or is not) developing within the province or its neighbouring jurisdictions. The following provides a detailed description of each response level:
• Routine: During routine status the Emergency Management Unit will continue to plan, develop and implement mitigation strategies and preparedness initiatives, conduct ongoing exercises, work with stakeholders, as well as undertaking testing and evaluation activities in preparation for a potential emergency. The ongoing monitoring and surveillance of reportable diseases by Public Health Division will also continue, as will monitoring of known threats such as Avian Influenza, and of relevant media to obtain forewarning of other potential emergency situations.
• Enhanced: The ministry may move to this level once an emergency has been detected and is at the early stages of development. However, it may also choose to do so if it has been warned of an impending hazard that has yet to materialize within the province. It is also possible to proceed to the Enhanced stage to monitor an emergency that has occurred beyond the province’s borders (e.g. in a contiguous state). Activities at the Enhanced level are meant to “ramp up” or prepare the ministry for a large-scale emergency, but also to attempt to mitigate the emergency at its early stage of development as much as possible. Generally, activities at this stage involve a higher level of external surveillance and communication between providers/stakeholders at the local level and within the ministry itself. The MEOC may be partially activated to facilitate these activities and the ministry will begin to take steps to identify the potential diseased (if a disease has been identified as the cause of the emergency). A first meeting of the Executive Emergency Management Committee (EEMC) may also be convened (see s.8.4 for details). In addition, as mentioned above, EMU will issue “quiet alerts” to key areas of ministry senior management as appropriate to provide them with a heads-up on the status of the situation. This will include notifying the Duty Officer at the PEOC if the initial alert or warning was given to MOHLTC directly. Ministry staff and response resources (e.g. EMAT - see s. 7.3.2) may be placed on standby, as will elements of the healthcare system itself. Increased staffing at the MEOC may be required at this level in order to effectively monitor the developing situation and to communicate efficiently both internally and externally. The EMU may utilize its divisional contacts within the ministry to fulfill this role.
• Emergency: At this stage, an emergency situation has been confirmed by the EEMC. The Emergency Management Unit will activate its fan-out list and begin to mobilize the MEOC towards full activation status
At full activation, this will incorporate the staff from the EMU itself, its divisional contacts and members of the Virtual Team who will be contacted as needed to augment and supplement the composition of the MEOC. The MEOC will implement the IMS and establish an operating cycle to manage the emergency, depending on the scope of the incident, and will implement shifts where necessary in order to have 24-hour coverage. At the emergency level, the MEOC, of course, begins to take the appropriate action consistent with the MERP to respond effectively to the emergency as well as ensuring the continuity of critical government operations (i.e. Business Continuity). The range of possible response actions and resources are noted in the sections below.

The MEOC can be fully mobilized in the Emergency stage even without the declaration of a provincial emergency by the Premier.

**Recovery:** As an emergency situation ends or begins to de-escalate, the ministry will initiate recovery activities, intended to return the government and the healthcare system to normal operations. At this point the ministry will endeavour to wind down operations at the MEOC, but will continue to direct resources to reestablish routine business. Financial purchases will also continue to be monitored and tracked within this phase at least until the end of the fiscal year. The Recovery stage of the emergency management cycle is not detailed in this document, and will be planned for in greater detail in future. It should be noted, though, that there is no clear distinction between the impact and recovery phases of an emergency, as they often overlap each other. Detailed charts of the graduated response levels as well as the divisional roles and responsibilities within the ministry to be carried out at each level can be found in s. 8.2. In addition, EMU maintains an alert notification status message on its public and provider websites (see s. 7.4.2).

### 6.2 Healthcare Providers & Partners

The management environment of a health emergency is also characterized by the complex, interlinking, and critical roles played various healthcare providers and other partners within the healthcare sector, an environment in which linkage and communication is key.

- **Hospitals:** Public hospitals are required by the Public Hospitals Act to develop plans to deal with emergency situations, and all hospitals are encouraged to do so in alignment with provincial planning. Hospitals may also be the site where the existence of an emergency such as an outbreak or epidemic first becomes apparent, and they have important responsibilities in surveillance and reporting.

- **Pre-Hospital:** In some emergencies the pre-hospital system (i.e. paramedics, ambulances), may be the first healthcare workers to handle patients, and may be engaged in direct patient contact throughout the duration of the emergency. They must be kept informed of developments during an emergency in order to take adequate actions to respond appropriately and protect themselves and others. The transfer of patients between healthcare facilities during an emergency is also a key role for the pre-hospital system. The Ontario Air Ambulance Base Hospital Program operates the Patient Transfer Authorization Centre, a patient tracking system that monitors the transfer of patients with Febrile Respiratory Illness between healthcare facilities (see s. 7.1.2). Ambulance services in Ontario include:
  - **Land Ambulance:** Partially funded by the ministry and contracted for or directly delivered by municipalities/delivery agents, the land ambulance service is responsible for providing timely response, pre-hospital emergency care and patient transport to those with immediate medical needs, as well as transport of non-emergency patients to and from medical facilities. Ambulance service is coordinated across the province through the Central Ambulance Communications Centres.
  - **Air Ambulance:** Supporting the land ambulance system, the air ambulance program, provides transport for critically ill patients or those in remote areas of the province to hospital, as well as to specialized medical teams. Air ambulance service is coordinated through the ministry’s Medical Air Transport Centre.

- **Long-Term Care Homes (LTCHs):** Designed for people who require the availability of 24-hour nursing care and supervision, Long-Term Care Homes may not be faced with providing care to the most acute patients in an emergency, but their populations may be particularly vulnerable to infectious diseases and/or interruptions in power or other services. They also play an important role in surveillance and reporting of diseases. They must be prepared to deal with their own populations in an emergency, and may also be required to accommodate transfers from acute care facilities in order to free capacity for critical care.
• Community Care Access Centres (CCACs): Coordinators of services for seniors, people with disabilities and people who need health care in the community, CCACs are key in identifying capacity should transfers to LTCHs or into the community be necessary. They too have vulnerable populations to plan for, and obligations to comply with ministry directives, including any regarding surveillance for communicable diseases.

• Community Health Centres (CHCs): Providers of primary care and health promotion to individuals and communities, CHCs have the standard responsibilities regarding surveillance and reporting that belong to primary care, and may also play a role in mitigation and prevention through promoting practices such as infection control for the public.

• CritiCall: This emergency referral service for physicians caring for seriously and critically ill patients can play a key role in coordinating care. For further description of Criticall, see section 7.3.4.

• Public Health Units: Public Health Units, the official health agencies established by regulation under the Health Protection and Promotion Act, and which are governed by boards of health comprised of municipal members and members appointed by the Lieutenant Governor in Council, have significant responsibilities regarding infectious disease surveillance, response, and planning at local levels. They carry out the mandate of the HPPA (see s. 3.2.1), and offer the programs and services set out in the Mandatory Programs and Services Guidelines, including: receiving reports of, investigating, and providing ongoing monitoring of reportable diseases; receiving, investigating, ensuring public health management of and contact tracing for communicable diseases; provision of information regarding infectious diseases to health care professions, institutions and the community, including emergency service workers. They play a major role in local emergency planning, and in planning and delivering vaccination programs.

• Public Health Agency of Canada (PHAC): The Public Health Agency of Canada:
  - develops national plans and frameworks which influence planning at the provincial and territorial level;
  - liaises with other national and international organizations;
  - plays a major role in vaccine procurement, allocation and distribution to provinces and territories;
  - communicates with provinces and territories regarding urgent policy and operational issues; and
  - activates their own national emergency response plans and teams as required.

Within the PHAC, the Centre for Emergency Preparedness and Response (CEPR) acts as the coordinating point for dealing with health emergencies. PHAC is responsible for the National Emergency Stockpile System (NESS) (see s. 7.2.1).

• Professional Associations and Regulatory Colleges: All of the above activities require trained health care workers, and regulatory colleges and professional associations play an important role in health human resources during an emergency.
  - Regulatory Colleges: The 21 regulatory colleges in Ontario set standards and guidelines for their members and practice, ensure that training and educational standards are met, develop programs to help members improve their skills and knowledge, and address concerns about the conduct of practice of their members. In addition to dealing with temporary registration of certain health care workers in an emergency, regulatory colleges can also support emergency preparedness and response through implementing the infection control and surveillance standards and guidelines for febrile respiratory illness developed by the ministry, as well as offering appropriate opportunity for skills improvement in other related topics.
  - Professional Associations: represent the interests of their members (e.g. doctors, nurses), and work through education, research and advocacy to help shape practice and influence public policy decisions. They may work with government and institutions to ensure that their members are adequately protected in their work during an emergency. Through their research, education, and knowledge transfer activities they can improve their members’ emergency response skills and offer best practice guidelines on relevant topics. They may also engage their members in a culture of emergency awareness, and offer resources such as volunteer lists or, working with the regulatory colleges, suggestions regarding redeployment of staff during emergencies.
7.1.2 Patient Transfer Authorization Centre (PTAC)

The Provincial Transfer Authorization Centre (PTAC) was created to mitigate infectious disease outbreaks by screening all patient transfer requests, identifying patients with infectious disease symptoms and preventing the disease from spreading between healthcare facilities. PTAC is a patient tracking system designed to monitor the transfer of patients between healthcare facilities for patients with Febrile Respiratory Illness (FRI). It is a surveillance measure that is vital to preventing the spread of infectious disease within the province while ensuring the safety of both patients and healthcare workers. PTAC is currently located at and operated by Ornge (previously known as the Ontario Air Ambulance Base Hospital Program). A transfer authorization is accomplished either through faxing the necessary data into PTAC or through PTAC’s web-based authorization system. The web-based system collects and analyzes patient transfer requests, detecting any inquiries from hospitals that require quick transfers of patients due to potential infectious disease exposure. The PTAC website can be found at: https://www.hospitaltransfers.com/transfer/. PTAC scrutinizes each patient transfer to ensure that:

- the transfer will not compromise containment measures;
- appropriate protective measures are taken by facilities involved as well as transfer agents;
- the patient’s clinical needs are dealt with promptly; and
- documentation is recorded should transfers need to be traced or referred to in the future.

7.2 Preparedness Resources

7.2.1 Stockpiles/Emergency Medical Supplies

The province must be prepared to equip healthcare providers with emergency supplies, should facility stocks be exhausted when faced with a particular emergency scenario that could potentially overwhelm or overstretch available resources (e.g. a large-scale emergency, multiple small-scale emergencies or a small-scale emergency of long duration). Not only must the province and the broader healthcare system have access to medical supplies that can treat patients (possibly contaminated with chemicals or radiation or infected with a communicable disease), but stores of protective gear must also be on hand in order to protect healthcare workers at the front line who are directly involved in the emergency response. The province has access to two emergency stockpile systems should local resources be in danger of depletion. One is provincially-managed; the other is federally-managed. The decision to release medical supplies and equipment from the stockpiles will be made by the Director of the EMU in consultation with the relevant MOHLTC Regional Office and affected healthcare providers.

Provincial Stockpile/Ontario Government Pharmacy – A two-month contingency stockpile of personal protective equipment (PPE), sufficient to support the healthcare needs of a community the size of Toronto, has been established through the Ontario Government Pharmacy and Medical Supplies Services (OGPMSS). The supply currently consists of a host of items such as N95 masks, surgical masks, isolation gowns, gloves, goggles, face shields, hand sanitizer and virucide liquid (see s. 9.7.1 for the protocols to access this stockpile).

National Emergency Stockpile System (NESS) – The federal NESS program consists of two major components: 1) Pre-positioned supplies and equipment; and 2) Federal reserve warehouses. The pre-positioned emergency supplies and equipment are stored in strategic locations within Provinces and Territories, while a small number of federal reserve warehouses containing much larger quantities of emergency supplies and equipment are also located across the country. The locations of the pre-positioned materials are determined by the province, however precise locations are not made public. The NESS also contains a pharmaceutical stockpile, which includes the necessary supplies to deal with CBRN events.

The NESS also has a number of units (now under review):

- Emergency Hospital – providing acute and short-term medical care
- Advanced Treatment Centre – early medical and limited surgical procedures in the field
- Casualty Collecting Unit – providing immediate first aid, movement of patients/evacuees
- Reception Centre Kit – provides materials to set up evacuation centres/shelters
- Mobile Feeding Unit – emergency feeding capability in a field environment
- Trauma Kit – first aid, intubation, IV to support first line response and triage-pt. staging
• Mini Clinic – supplements existing medical care facilities that are overwhelmed
NESS equipment and supplies are held by the Office of Emergency Services, Public Health Agency of Canada, and can be made available to the province on a loan basis (see s. 9.7.3 for the protocols to access the NESS).

7.3 Response Resources

7.3.1 Land and Air Ambulance
Previously discussed under Pre-Hospital in s. 6.2.

7.3.2 Emergency Medical Assistance Team (EMAT)
The Emergency Medical Assistance Team was launched in January of 2004 in an effort to equip the province with a specially-trained and equipped response capability for major health emergencies. EMAT is a self-sufficient, 56-bed, acute-care field unit with its own medical equipment supplies, refrigeration, communications, water and electricity. It is also equipped with an independent outdoor isolation and triage unit; a three-part tent system dubbed a ‘tripod’. These resources are stored within a custom-designed tractor-trailer, which can be dispatched to any area of the province that has road access (up to 3,200 km without re-fueling). The tractor-trailer unit is stationed at Sunnybrook and Women’s College Health Sciences Centre where it is managed by the Ontario Air Ambulance Program. EMAT’s function in an emergency is to provide surge capacity to communities in which local healthcare resources have become overwhelmed due to an emergency. The team is also trained to deal with chemical, biological, radiological and nuclear (CBRN) events. The unit is staffed by a volunteer team of professional healthcare providers, including physicians, paramedics, nurses, radiology technologists and respiratory therapists. This staff is specially-trained to function and operate effectively in the EMAT environment and is oncall to travel to the site of an emergency by air or vehicle. The volunteer team members come from a variety of locations across the province to ensure that no particular area is depleted of vital health human resources. EMAT can be on-site within 24 hours of dispatch and can be fully operational between four to six hours after arrival. The unit can be set up in such locations as a local community centre, arena or school gymnasium. The aforementioned ‘tripod’ unit can also be setup in an outdoor location. EMAT provides a staging and triage base for the evaluation and management of patients prior to their transfer to hospital. It also has the capability of isolating up to 20 patients with infectious disease. The unit is equipped with its own independent oxygen and filtration systems and possesses a range of personal protective equipment (PPE) to handle a variety of incidents. EMAT can operate independently in this manner, without re-supply, for a period of 72-hours. EMAT information can be found on the ministry’s website: http://www.health.gov.on.ca/english/providers/program/emu/emerg_prep/emat.html

The process for deploying EMAT to respond to an emergency and the criteria under which the deployment decision is made is discussed further under s. 9.5.4.

7.3.3 Rapid Response Teams
The ministry’s Public Health Division created Rapid Response Teams to increase local public health response capacity in the province. These teams can be deployed on short notice to assist local public health units and other related institutions in the event of an infectious disease outbreak or other public health emergency where the health units may not possess sufficient resources to deal with the situation. The province currently has two (2) such teams at its disposal to help manage a public health emergency. Each team is comprised of a supervisor/lead, epidemiologist, public health nurse, public health investigators and administrative assistant. Each team consists of up to seven (7) members. The protocol to deploy RRTs can be found in s. 9.5.3.

7.3.4 CritiCall
CritiCall’s provides an emergency referral service for physicians caring for seriously and critically ill patients. Its toll-free operation 1-800-668-HELP(4357) provides a 24-hour callcentre for hospitals, allowing them to contact on-call specialists and arrange for appropriate hospital bed access from anywhere in the province and to facilitate urgent triage for patients. The CritiCall database is able to identify and direct the
caller to the nearest available hospital bed and can also advise hospitals as to the availability of negative pressure rooms (used in the treatment of infectious diseases) across the province by region, site, and facility type. It will be an important resource to coordinate care and treatment for patients affected by an emergency. Its flexible web-based program can be used for data collection and information sharing in an emergency.

7.4.1 Telecommunications

Health Stakeholders:

- **EMU Healthcare Provider Hotline:** 1-800-212-2272 or mohltc03@moh.gov.on.ca The EMU Healthcare Provider Hotline is a toll-free hotline for healthcare providers across the province that is in operation, with the support of the Public Health Call Centre, 24 hours a day, seven days a week. The hotline can be used to alert the ministry of any potential or existing emergencies, and for enquiries regarding ministry directives, standards and Important Health Notices
- **Public Health Call Centre (PHCC):** 416-212-6361 / 6362

The PHCC was established to serve as an information relay center for public health units and also to provide assistance to the PHD’s on-call physicians in dealing with a public health emergency outside of business hours. The responsibilities of the Call Centre have since increased to include: assisting in the management of West Nile Virus cases, water quality and boil water advisories, collecting information for institutional respiratory infection outbreaks and answering calls at the above Provider Hotline on behalf of Emergency Management Unit (EMU) during weekends and after hours.

- **Regional Office General Inquiry Lines:** Each regional office maintains an on-call roster to ensure accessibility to local health-care providers.

Public:

- **Telehealth Ontario - 1-866-797-0000** Telehealth Ontario is a free, confidential telephone service through which the public can access health advice or general health information from a Registered Nurse. Based on a series of assessment questions, callers are provided with advice regarding self care, a recommendation for a visit to an appropriate health care provider, or given contact information for community resources. Telehealth does not replace 911, but in the event of a health emergency it can help in providing accurate health information to the public and in encouraging appropriate use of the health care system.

- **INFOline - 1-800-268-1154 / 416-314-5518 or infoline@moh.gov.on.ca** The MOHLTC INFOline provides information regarding ministry services and programs. It does not provide medical advice.

- **Media Line - 1-888-414-4774 / 416-314-6197 or by email at media@moh.gov.on.ca** The media line answers media enquiries on behalf of the ministry to ensure appropriate spokespeople and consistent messaging.

- **Employer’s Hotline - 1-866-331-0339** The EMU Employer’s Hotline is a toll-free number at which managers can obtain information from the ministry on the health aspects of emergency management and business continuity for the benefit of their employees and the operation of their business in the event of emergencies such as a pandemic. The hotline is operational during regular business hours.

7.4.2 Websites


EMU website, Information for Health Care Professionals:

The public MOHLTC website provides information on ministry programs and services and other healthcare topics, targeted as appropriate to the public, healthcare providers, and the media. Information includes updates on current healthcare, news releases and important documents such as the Ontario pandemic influenza plan and the SARS commission reports. In an emergency it will be used to communicate important information and ensure that the ministry response remains transparent to Ontarians. The public website also includes the EMU website, which provides more detailed emergency management information for both the public and health care providers, including information regarding specific threats such as pandemic influenza, general emergency preparedness information, health
and travel advisories, and, for health care professionals, access to infection control standards and important health notices.

• Healthy Ontario: http://www.healthyontario.com
Health Ontario is a website intended to provide Ontarians with reliable information on health and health services, including medical information, health assessment tools, and information on healthcare services available in Ontario. It has already been used to provide information on current topics such as influenza, and to promote campaigns such as the flu shot. In a health emergency, it could be used to promote preparedness, provide the public with a source of accurate health information and advice, and to encourage appropriate use of the health care system.

• INFOweb Intranet Site: http://intra.moh.gov.on.ca
The MOHLTC Intranet is accessible to OPS staff, and can be used to share important information with ministry employees regarding the ministry emergency response, business continuity, program area planning for emergencies, personal preparedness planning, and information about services (e.g. flu shot clinics) available to OPS employees.

8.0 EMERGENCY RESPONSE PROCEDURE: WARNING/IMPACT PHASES

8.1 Alert/Warning System
The following diagram shows the paths of communication between organizations through which the EMU will be informed of the presence of either a potential or actual emergency:

8.1.1 General Emergencies
Upon being notified of a particular incident within the province, Emergency Management Ontario will act based on the nature of the incident and the response capacity at the local level. For example, the Duty Officer at the PEOC may opt for a partial activation of the PEOC simply to monitor the developing situation.
However, if the incident escalates into a larger-scale emergency, the PEOC may proceed to full activation in order to begin coordinating resources to manage the emergency. Should the situation potentially require a response from the MOHLTC (consistent with its OIC responsibilities), the Duty Officer at the PEOC will inform the ministry through the Emergency Management Unit.

8.1.2 Health-Related Emergencies
MOHLTC may receive information on a health-related emergency (including an outbreak of infectious disease) from its own healthcare providers prior to EMO or in parallel with EMO. In such a situation, the ministry would inform EMO of the emergency as part of its initial notification procedure. In such a situation, the Director of EMU may opt to activate the MEOC prior to the PEOC. The ministry may activate its MEOC independent of action taken at the PEOC by Emergency Management Ontario. Upon receiving information identifying a health-related emergency in the province, the Emergency Management Unit may issue either a quiet alert to key ministry staff or it may choose to activate its full fan-out procedure depending on the nature of the emergency. Similarly, activation of the MEOC would likewise be partial or full depending on the situation. The type of action taken by EMU will be dependent on the necessary level of response as prescribed in the Graduated Response Protocol. The section below describes this protocol in detail.

9. COMMUNICATIONS
9.4.3 Important Health Notices (IHNs)
The following process is used to develop an Important Health Notice to providers and/or stakeholders:

9.5.1 Issuing Directives
Depending on the nature of the emergency, operational guidance and/or direction may be issued by the MOHLTC in consultation with PIDAC or the SRT. The following is the ministry protocol for developing and issuing such operational guidance/direction to the healthcare system:
9.5.2 Management/Deployment of Healthcare Resources
The MEOC Operations group will manage healthcare resources (i.e. Hospitals, Long-Term Care Homes, Community Care Access Centres, etc.) at a provincial level in collaboration with the Regional Offices and local healthcare providers.

9.5.3 Deploying Rapid Response Teams (RRTs)

1. The initial request for assistance will come from the local medical officer of health, who will contact the RRT manager at Public Health Division. After normal business hours, this request would come through the Public Health Call Centre (PHCC).
2. A teleconference will be held with the public health unit to determine what resources are overwhelmed at the local level, the specific level of support that is required and what resources are available at the provincial level to provide assistance.
3. RRT(s) is/are dispatched to render assistance to the local public health unit.
4. EMU is notified of RRT deployment.

9.5.4 Deploying EMAT
The criteria and process for deploying the Emergency Medical Assistance Team are as follows:
1. Local hospital and regional acute care resources overwhelmed by emergency, defined by:
Labour availability inadequate to meet requirements.
>10% over normal sick calls, which compromises the ability to provide acute care services to emergency related patients.
AND
Chief Nursing Officer identifies staffing levels as compromising patient/staff safety.
AND
Staff unavailable to meet needs of emergency-related patients.
OR
Physical resources overwhelmed
>100% of emergency capacity (to be defined provincially in consultation with hospitals Spring, 2004) in use for >24 hours.
AND
20% of inpatient beds dedicated to emergency.
AND
Specialty beds, as defined by the emergency are at full capacity for >18 hours.
OR
Other mitigating factors:
- Single hospital community
- Length of emergency and impact on local health services and resources
- Community infrastructure unable to meet demands (i.e. Community Care Access Centres, public health unit)

2. Local hospital and regional acute care resources physically incapacitated by emergency and unable to care for current and/or anticipated in-hospital acute care patients:
- Volume of patients cannot be managed
- Patients have been discharged as appropriate
Process:
Local hospital contacts the ministry’s Emergency Management Unit (EMU) 24 hour hotline: 1-866-212-2272.

Executive Emergency Management Committee (EEMC) approves EMAT deployment in consultation with EMAT medical director/program manager, CEO of Ornge, local hospital and public health unit included in discussion. Meeting to occur within three hours of initial call.

9.5.5 Establishing Screening Clinics
Screening clinics may be important tools in communities affected by a health emergency to allow those who are unsure of their symptoms to be assessed in an environment which is practicing heightened infection/contamination control precautions. Siting of a screening clinic will be driven by:
- location(s) of the emergency;
- ability to provide a safe environment; and
- availability of appropriate staff
- siting of the regional hospital.

The MEOC will recommend siting of screening clinics to the EEMC for approval in consultation with Regional Offices and local healthcare providers.

9.5.6 Multiple Fatalities/Managing the Deceased
One of the responsibilities of the MOHLTC in an emergency, as stated in the Provincial Emergency Response Plan, is to maintain a list of hospitalized casualties for conditions specifically related to the incident itself. Depending on the type of emergency, this task must be managed by Operations staff in collaboration with the Office of the Chief Coroner (under the Ministry of Community Safety and Correctional Services), which administers the Provincial Multiple Fatality Plan. The Provincial Multiple Fatality Plan will be implemented if the magnitude of the multiple fatality incident is such that extraordinary provincial resources are required for the effective investigation, reporting, recovery, identification, examination and disposition of human remains to minimize evidence loss and contamination. This plan also
includes specific jurisdiction for such activities within First Nation communities, both organized and unorganized.

Pursuant to S. 10 of the Coroner’s Act, 1995, a coroner must investigate all unnatural deaths such as those where foul play, suicide, accident, negligence and malpractice are suspected. Certain natural deaths are also investigated such as those occurring suddenly and unexpectedly or from illness not under treatment by a qualified physician. A coroner may also be involved when questions concerning the death can only be answered after an investigation. It is therefore likely that all multiple fatality incidents occurring within the Province of Ontario will fall within the jurisdiction of the Office of the Chief Coroner. When the Provincial Multiple Fatality Plan is activated (in full or in part), a Coroner’s Control Group and necessary teams, may be established to oversee the investigation, reporting, recovery, identification, examination and disposition of human remains. Additional information can be found within the plan itself, which can be obtained from the Office of the Chief Coroner, Ministry of Community Safety and Correctional Services.