Public Health G8 Summit Preparedness

&

Response Plan

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Version 1.0

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BACKGROUND

Canada holds the presidency for the 2010 G8 Summit which will be held at the Deerhurst Resort in Huntsville, Ontario, from June 25th to 26th. In addition to the G8 delegations, this event tends to attract delegations from other countries, Non Government Organizations and special interest groups.

The Group of Eight (G8) is a forum, created in 1975, that brings together the leaders of Canada, France, Germany, Italy, Japan, Russia, the United Kingdom and the United States of America. The Summit has evolved over the years into an annual informal meeting that addresses a wide range of international economic, political and social issues.

The role of chairing the G8 rotates each calendar year among the member countries in the following order: France, the United States of America, the United Kingdom, Russia, Germany, Japan, Italy and Canada. The European Union, though not part of this rotation, also participates in the G8 and is represented by the President of the European Commission and by the leader of the country that holds the presidency of the Council of the European Union at the time of the G8 Summit.

The country holding the G8 presidency is responsible for hosting and organizing the summit and a number of ministerial-level meetings leading up to the Summit. The Chair also assumes the responsibility of speaking on behalf of the G8 and of engaging non-G8 countries, non-governmental organizations and international organizations.

The host country organizes several preparatory meetings before the summit. G8 leaders' personal representatives, known as Sherpas (named after the Himalayan guides who help mountain climbers reach summits), attend these meetings to discuss potential agenda items. Their work helps leaders focus on key subjects. The Sherpas, usually high-ranking government officials, correspond directly with each other throughout the year. After the Summit, they also oversee the implementation of Leaders' commitments made at the Summit. The Sherpas are supported by networks of other senior officials who focus on major economic, financial and political issues. (Source: www.g8-gc.ca)

The Group of Twenty (G20), Finance Ministers and Central Bank Governors, was established in 1999 to bring together systematically important industrialized and developing economies to discuss key issues related to global economic stability. These discussions contribute to the strengthening of the international financial architecture and provide opportunities for dialogue on national policies and international co-operation. The membership of the G20 includes Argentina, Australia, Brazil, Canada, China, France, Germany, India, Indonesia, Italy, Japan, Mexico, Russia, Saudia Arabia, South Africa, South Korea, Turkey, the United Kingdom, the United States of America and the European Union. Canada's Prime Minister has confirmed that the City of Toronto will host the G20 summit on June 26 and 27, 2010, immediately following the G8.

The Ministry of Health and Long-Term Care (MOHLTC) has been contracted to work with health care agencies to develop health sector plans, specific to the G8/ G20 Summit. It is anticipated that both the G8 and G20 Summit will have a significant impact on health services and greatly strain the capacity of our health care system.

Public Health agencies have worked in partnership with the MOHLTC to foster the development of a generic *G8 Summit Preparedness and Response Plan*. The *G8 Public Health Subcommittee*, composed of public health stakeholders in the affected region(s), was established to facilitate a streamlined and strategic plan to support health consequence management for the G8 Summit 2010 in Deerhurst. The key objective of this committee was to develop a plan that ensures the public health sector can detect and respond to any extraordinary events that may occur in relation to the G8 Summit

Initial planning by the Public Health Subcommittee focused on planning for the G8 Summit in Huntsville. During the final stages of the planning process, it was announced that the G8 Summit would immediately be followed by the G20 Summit, in Toronto. Therefore, components within this plan have been modified to address G20 planning considerations. For the most part, this plan has been designed in preparation for and response to the G8 Summit.

The *G8 Summit Preparedness and Response Plan* identifies common hazards associated with mass gatherings and outlines potential public health mitigation and response strategies to address these risks. It also has been designed to establish a common public health emergency management framework and supporting communication systems.

Public health agencies are encouraged to use this plan as a framework to assist them locally with the further development of more comprehensive G8 and G20 plans. It is anticipated that the members of the G8 Public Health Sub-Committee will continue to plan locally with municipal, federal and community partners also involved with G8 and G20 Planning.

LEGISLATIVE AUTHORITY

Emergency Management and Civil Protection Act
http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90e09_e.htm
The Emergency Management and Civil Protection Act establishes the requirements for emergency management programs and emergency plans in the Province of Ontario. The Act specifies what must be included in emergency management programs and emergency plans. Municipal councils are required to adopt emergency plans by by-law.

Health Promotion and Protection Act (HPPA)
http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90h07_e.htm.

In Ontario, the Health Protection and Promotion Act (HPPA) requires boards of health to provide or ensure provision of a minimum level of public health programs and services in specified areas such as the control of infectious and reportable diseases, health promotion, health protection and disease prevention.

Regulations published under the authority to the HPPA assist to control the spread of communicable and reportable diseases. Regulation 569, Reports, establishes the parameters within which those who are required to report communicable and reportable diseases to the medical officer of health (MOH) must operate. The Report regulation specifies the information that must be reported for diseases listed in the regulation and under certain conditions, such additional information that the MOH may require.

Municipal and non-municipal seasonal residential water systems and those that serve public facilities other than designated facilities are also regulated under the HPPA. For these systems, Ontario Regulation 318/08 (*Transitional – Small Drinking Water Systems*) sets the basic operational requirements until an inspection and site specific risk assessment has been completed by a public health inspector (PHI). Once the system has been inspected and a directive is issued by the PHI, the operational requirements such as water testing frequency, treatment requirements, etc, will be established.

The HPPA assigns the responsibility for community health protection to the MOHs and PHIs.
Local boards of health monitor and assess local conditions and identify if appropriate action is being taken. Additional Regulations such as Regulation 319/08 (*Small Drinking Water Systems*), The Food Premises Regulation, 562/90, Public Pools Regulation 565/90, Public Spas 428/, Recreational Camps 68/908 outline requirements for other areas of public health concern. The HPPA also gives authority to the MOH and PHI inspectors to issue orders to reduce or eliminate health hazards.

A medical officer of health is authorized under Section 22 of the HPPA to issue an order under prescribed conditions to control communicable diseases. The content of these orders could include an order requiring an individual to isolate himself or herself; to place himself or herself under the care and treatment of a physician (if the disease is a virulent disease, as defined in the HPPA); or to submit to an examination by a physician.

A medical officer of health may also, under certain conditions, seek a court order under Section 35 of the HPPA to isolate an individual in a hospital or other facility for a period of up to four months.

The Ontario Public Health Standards (OPHS) establish requirements for fundamental public health programs and services, which include: assessment and surveillance, health promotion and policy development, disease and injury prevention, and health protection. The OPHS and Protocols are published by the Minister of Health and Long-Term Care, pursuant to Section 7 of the Health Protection and Promotion Act, R.S.O. 1990, c. H.7.

Personal Health Information Protection Act, 2004 (PHIPA)
http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/04p03_e.htm
PHIPA regulates the collection, use and disclosure of personal health information by health information custodians (a defined term in the Act) and includes physicians, hospitals, long-term care facilities, medical officers of health and the Ministry of Health and Long-Term Care. The Act also establishes rules for individuals and organizations receiving personal information from health information custodians.

Consent is generally required to collect, use and disclose personal health information however, the Act specifies certain circumstances when it is not required. For example, the Act permits disclosure of personal health information to the chief medical officer of health or medical officer of health without the consent of the individual to whom the information relates where the disclosure is for a purpose of the HPPA. Disclosure of personal health information without consent is also permitted for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.

Quarantine Act
http://laws.justice.gc.ca/en/Q-1/index.html
The purpose of the federal Quarantine Act is to prevent the introduction and spread of communicable diseases in Canada. It is applicable to persons and conveyances arriving in or in the process of departing from Canada. It includes a number of measures to prevent the spread of dangerous, infectious and contagious diseases including the authority to screen, examine and detain arriving and departing individuals, conveyances and their goods and cargo, which may be a public health risk to Canadians and those beyond Canadian borders.

Bill C-12, the new Quarantine Act, received Royal Assent on May 12, 2005. The new Act will not come into force until quarantine regulations have been drafted, likely by the fall of 2006. The new legislation updates and expands the existing legislation to include contemporary public health measures including referral to public health authorities, detention, treatment and disinfestation. It also includes measures for collecting and disclosing personal information if it is necessary to prevent the spread of a communicable disease.

Coroners Act
http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90c37_e.htm
Where a person dies while a resident in specified facilities, including a resident in a home for the aged or a nursing home, a psychiatric facility or an institution under the Mental Hospitals Act, the Coroners Act requires the person in charge of the hospital, facility or institution to immediately give notice of the death to the coroner. Further, if any person believes that a person has died under circumstances that may require investigation, that person must immediately notify a coroner or police officer of the facts and circumstances relating to the death. The coroner must investigate the circumstances of the death and determine whether to hold an inquest.

Occupational Health and Safety Act
http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90o01_e.htm
The Occupational Health and Safety Act is enforced by the Ministry of Labour. The Act imposes a general duty on employers to take all reasonable precautions to protect the health and safety of workers. The duties of workers are, generally, to work safely in accordance with the Act and regulations.

Public Hospitals Act:
http://www.e-laws.gov.on.ca:81/ISYSquery/IRL725B.tmp/83/doc
Hospitals are required to obtain ministry approval before using additional sites for hospital services. Cabinet is authorized to appoint a hospital supervisor on the recommendation of the Minister of Health and Long-Term Care. The Minister is then authorized to make regulations, subject to Cabinet approval, to address the safety of any hospital site and to deal with patient admissions, care and discharge.
The administrator, medical staff, chief nursing executive, staff nurses and nurses who are managers are required to develop plans to deal with: (i) emergency situations that could place a greater than normal demand on the services provided by the hospital or disrupt the normal hospital routine, and (ii) the failure to provide services by persons who ordinarily provide services in the hospital.

INTRODUCTION

OVERVIEW

Planning is a key component of emergency response. Regardless of whether the incident is man-made, health-related or environmental in nature, good planning is what separates a successful response from an unsuccessful one.

Canada will host the 2010 G8 Summit and G20 from June 24th through to the 27th. The G8 will be held at Deerhurst Resort in Huntsville, immediately followed by the G20 which will take place in Toronto. This will be a very high profile political event and will involve up to 30 international world leaders. This event will draw a large number of people into our community, and will include international visitors and their support staff plus protestors, activists and the media. Multi-agency cooperation and collaboration is required to prepare and respond to this event to ensure a safe, secure and health supportive environment while minimizing any disruptions. A coordinated public health response strategy to the G8 summit is required.

Throughout the week of June 21 to 28, 2010, a number of Internally Protected Persons (IPP) and accompanying Very Important Persons (VIP) will travel to the Huntsville and Toronto areas requiring a significant number of support staff to attend the Summit at each venue.

Planning and preparedness activities span international agencies, federal departments, provincial and municipal agencies and local community stakeholders. In an event of this size, measures will need to be taken to protect health, safety and critical services from the consequences of this event. In the context of G8 and G20 planning, *consequence management activities* are those related to *possible impacts that will* ***extend beyond*** *Deerhurst Resort and secured access zones within the Toronto area.* These activities may be related to:

- Substantial increase in "visitors" to the area, early arrival and late departure
- Possible closure of transportation routes
- Protests, civil unrest
- Different demands on the health system, including public health
- Detention centre and media centre and
- Environmental implications.

The Royal Canadian Mounted Police, the Ontario Provincial Police, Department of National Defense and the North Bay Police have formed the *Integrated Security Unit (ISU*) to provide security at the event. The ISU will work with the Summit Management Office (SMO) and other partners to provide a safe and secure environment and will be assisting with the development G8 specific Standards Operational Procedures (SOPs) for secured access zones.

AIM

The aim of the *G8 Summit Preparedness and Response Plan* is to provide a strategic approach to public health planning and response to the G8 Summit

SCOPE

This plan focuses on *consequence management components of public health response within the community* and *identifies mitigation and response strategies* related to possible impacts that could potentially extend into communities outside Deerhurst Resort and within the Greater Toronto area. This document is to serve as a guide for the local planning of each of the health units affected by the G8 and / or the G20 Summits.

To date, this plan outlines *public health concepts of operations; however, it is a work in progress*. G8 and G20 planning will continue to take place over the next several months. A variety of local, national and international factors will influence its content and future direction.

Mitigation and response activities outlined within this plan are based on planning assumptions. Identified roles and responsibilities may be modified depending on human resource availability and outcomes from budgeting discussions. In additional to this plan, public health agencies may further develop more comprehensive plans which identify localized response measures and preparedness strategies.

PLANNING AND RESPONSE ZONES

Zone 1 (Red Zone -Security Restricted Access Zones)
Deerhurst Resort and Designated Areas in Toronto – TBD (plus Pearson Airport)

- Federal responsibility; heavily protected area where dignitaries will assemble.
- Security Protected Area requiring accreditation to enter into this zone immediately preceding, during and after the Summit.
- Temporary ad hoc health infrastructure will be put in place as a precaution, coordinated between Health Canada and Emergency Health Services Board (EHSB) based on needs of Summit participants.

Zone 2 (Yellow/Interdiction/Buffer Zone)
(Estimated perimeter- Huntsville/Deerhurst Interdiction Zone- West of Grandview and East of Hidden Valley; Interdiction Zones in the Toronto Area are yet to be determined)

- A limited-access area surrounding Zone 1.
- A processing centre for persons detained by police and a media centre will be established to support the Summit; the media centre has been confirmed as being at the Toronto Congress Centre, the location of the processing centre has not yet been determined.
- Temporary ad hoc health infrastructure will be put in place as a precaution, coordinated between the G8 Integrated Security Unit (ISU) and EHSB, based on the expected needs of the security services to manage ill and injured persons related directly to the Summit. It has been confirmed that there will be an ad hoc clinic at the processing centre, and no clinic at the media centre. Other plans for any additional resources for the ad hoc structure in the interdiction zone are still underway.
- For those living in the zone who a) are receiving home care or b) are health-care providers who need to leave the zone to get to work, arrangements can be made – security checks and passes will need to be put in place.

Zone 3 (Community)

- Includes the surrounding area.
- Transportation routes may be closed/congested.
- Consequence management for the rest of the health-care system is being coordinated by Emergency Management Branch with the participation of EHSB for municipal emergency medical services.

This plan primarily focuses on potential planning and response activities within Zone 3, the Community Zone. Considerable planning still needs to take place for Yellow and Red Zones. Additional plans and support protocols will also be developed to support response activities within all areas of jurisdiction.

SECURITY CONSIDERATIONS

Accessibility restrictions will be applied to Zones 1 and 2. Residents and community service providers needing to enter these areas will be required to receive proper accreditation to ensure that they are able to move to, from or through these areas during the Summit. Public health personnel working within these zones will need to be identified and go through this accreditation process prior to the Summit.

PLANNING

G8 PLANNING AND RESPONSE ASSUMPTIONS:

Population Influx:
The G8 will bring a greater number of people than usual to the region:

- More than the usual summer tourist/cottager rush.
- Residents from the greater Toronto Area may congregate to the north during the weekend of the G20 Summit.
- Summit delegates and entourage: national leaders forecast to be 20 – 30; entourage numbers as yet unknown.
- Security and support staff for the delegates and the event: numbers as yet unknown.
- Media and press attendants could be as high as 2,500 – 3,000 representatives.
- The number of protesters and demonstrators is yet unknown.

General Disruption:
Influx of people and security measures will have a general impact on availability of various supplies and services

- Access routes will be closed to protect Deerhurst and Toronto venues, including:
  - Highway 60.
  - Designated no-fly zones.

- Transportation disruptions due to closure of routes for security reasons or congestion will:
  - Impact on timely delivery of supplies and equipment.
  - Impact on patient transport – pre-hospital, and between facilities.
  - Impact on travel for home-care providers.
  - Impact on patients seeking routine primary care.
  - Impact on staff – issues with timely shift change, arrival of additional staff if needed.
  - Increase in traffic on remaining routes – could create potential for more traffic accidents.

MEDICAL SCENARIO ASSUMPTIONS:

Clinical issues likely to arise:

- In the event of clashes between police/protesters:
  - Noxious anti-demonstrator substance exposure if deployed.
  - Energy weapons.
  - Blunt force trauma.
  - Penetrating trauma.
  - Dog bites if dogs deployed.

- Weather:
  - If sunny and hot: sunburn, heat related illness, dehydration.
  - If rainy/cool – slips and falls from rain, hypothermia.

- Public health Issues
  - Potential for gastrointestinal symptoms.
  - Potential for large scale outbreaks.
  - Imported illnesses from international travel.
  - Effects of pre-existing health issues based on nature of crowd: asthma, cardiac events.
  - Lost/misplaced medications.
  - Allergic/anaphylactic reactions – food, insect bites.
  - Basic needs related to mass events – hydration, food, habitation / shelter, human waste sanitation.

Public Health Planning Assumptions

- History of extreme heat - traditionally temperatures during the June 25-27 weekend have been known to reach in excess of 30 degrees Celsius which may pose dehydration and other heat-related issues.
- Food/water safety demands will increase: temporary increase in population, heightened demand for food and water, and need to compress inspection and compliance schedules that would usually be implemented on a graduated basis to the limited period of time before the summit.
    - Small Drinking Water Systems (SDWS): The safety of SDWS is a new responsibility.
    - Planned roll-out of this responsibility allowed until the end of next year for the assessment of drinking water systems in this region.
    - G8 summit requires that all SDWS in the region be not only assessed but remediated and compliance assured in a highly compressed time frame to ensure safe drinking water.
- Demands associated with increased demand for accommodation – camp site, beach safety: commercial accommodations are already highly booked, creating a "downstream" effect on facilities such as camp sites, for which public health has certain responsibilities. There is a need to compress inspection and compliance schedules that would usually be implemented on a graduated basis to the limited period of time before the summit.
- There will be a need to maintain and possibly expand routine practices; e.g. mosquito surveillance, health hazard complaints investigations.
- Health messaging for visitors unfamiliar with the region can help mitigate the occurrence of preventable injury/illness and thus demand on more acute care: e.g. extreme heat and hydration, beach safety, risk associated with insects and wild-life, hand washing and influenza prevention, particularly as pandemic activity may still be present at this time.
- Enhanced infectious diseases surveillance will be needed and rapid responses a possibility.
    - Demand for surveillance data before, during and after.
    - Need to enhance capacity for syndromic surveillance in order to rapidly identify any emerging outbreaks, particularly in a pandemic context.
    - Consequence management role as well as role within interdiction/security zones will need to be coordinated.
- Need to ensure laboratory capacity for all of above.
    - Necessary to support both environmental health and disease surveillance.
    - Plans for supplies, equipment, capacity and specimen transport may be needed; work with Ontario Agency for Health Protection and Promotion (OAHPP).

Mass Gathering Health Related Assumptions (Based on Literature Reviews):

- Mass gatherings generate more injuries and illnesses than a general population equivalent in size (i.e. a mass gathering of 30,000 people will have more injuries/illnesses than a community of 30,000 people).
- Concentrated crowds place strain on public health infrastructure and increase demands for services such as infectious disease surveillance, food, water, weather event health, and campsite safety.
- This creates a surge in demand for emergency medical services, the acute care system, and public health prevention activities.
- This also creates a "downstream" effect on other parts of the health care system such as community care (both primary and home care) and long-term care: freeing up capacity in the acute sector requires measures such as early/temporary discharge to these other levels of care, either before the event on a planned basis, or on an urgent basis during a large-scale emergency.
- Mass gatherings can also be subject to unplanned accidents or events, such as floods or acts of intentional harm, and associated with confrontations among protesters and between protesters and police/security officials.

FEDERAL PLANNING

Planning at the federal level for Red Zone (Zone 1) operations is underway. Federal agencies are working closely with local and provincial partners. Public health, together with other health system response partners will be involved with planning within Zones 1 & 2. The Royal Canadian Mounted Police, the Ontario Provincial Police, Department of National Defense and the North Bay Police have formed the Integrated Security Unit (ISU) to provide security at the event. The ISU will work with the Summit Management Office (SMO) and other partners to

provide a safe and secure environment and will be assisting with the development G8 specific Standards Operational Procedures (SOPs) for secured access zones.

PROVINCIAL PLANNING

Provincial Planning for the G8 Summit began in early 2009. Emergency Management Ontario (EMO), Ministry of Community Safety and Correctional Services (MCSCS) is responsible for overall coordination of *consequence management* activities. Emergency Management Ontario is working very closely with various ministries to ensure that planning and preparedness activities are taking place in advance to the Summit. Applicable sectors are responsible for assuring that effective plans are in plans prior to the Summit. This requires coordinated planning activities between all sectors and levels of government.

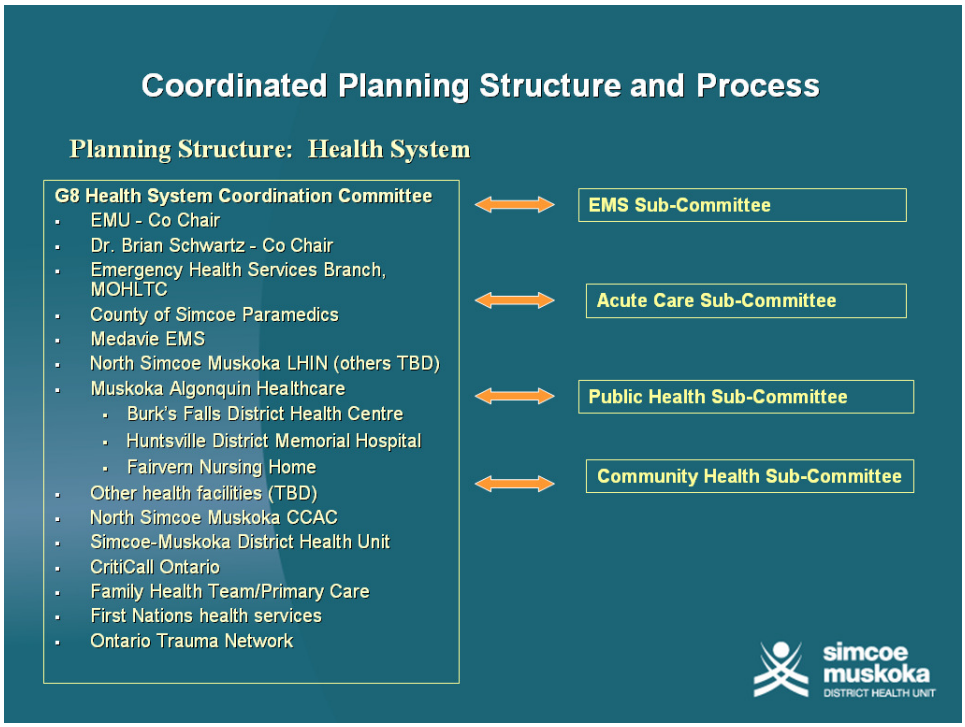
The MOHLTC's Emergency Management Branch is responsible for coordinating health sector planning for consequence management activities within Zone 3 (Community Zone). Since initial planning discussions back in January of 2009, the MOHLTC has held several planning meetings, collated cost estimates and conducted simulation exercises to test draft plans. There has been on-going liaison with health sector agencies. Although the federal government is response for overall planning within Zone 1, the MOHLTC is leading **health sector planning** for all three planning zones.

Many challenges will be faced by the health-care system for the provision of health services during the G8 and the G20. The increased demand for illness screening and medical attention will place considerable strain and pressure on the existing system. Each health agency will work to address these challenges under the leadership of the MOHLTC's Health System G8 Coordination Committee.

To facilitate the planning process, the MOHLTC has divided planning into four distinct areas of response. These four subcommittees include:

- EMS Subcommittee
- Acute Care Subcommittee
- Public Health Subcommittee
- Community Health Subcommittee.

This plan will focus on potential **public health** planning and response activities specific to the **community zone.** Mitigation and response activities outlined within this plan are based on planning assumptions. Identified roles and responsibilities may be modified depending on human resource availability and outcomes from budgeting discussions. In additional to this plan, public health agencies may further develop more comprehensive plans which identify localized response measures and preparedness strategies.



LOCAL PLANNING

Municipal and regional partners will be working together with community response agencies and all levels of government to prepare for the Summit. Throughout the local planning process, public health agencies may be involved with the development of comprehensive plans, identifying local emergency management structures, communication systems and local response measures and preparedness strategies.

PUBLIC HEALTH PLANNING

The *G8 Public Health Subcommittee*, composed of public health stakeholders in the affected region(s), was established to build strong and effective collaborative mechanisms within the public health sector and across other parts of the health-care system to facilitate a streamlined and strategic plan to support health consequence management for the G8 Summit 2010 in Deerhurst.

The key objectives of the subcommittee were:

- To develop a plan that ensures continuity of public health services during the G8 summit for current residents in the impacted areas to the extent possible.
- To develop a plan that ensures sufficient public health surge capacity to cope with anticipated demand, and coordination with other key health-care partners and the ad hoc health system/health planning for visitors and delegates.
- To develop a plan that can enhance public health services to prevent or mitigate potential impacts from the G8 Summit.
- To develop a plan that ensures the public health sector can detect and respond to any extraordinary events that may occur in relation to the G8 Summit.

The *Public Health G8 Summit Incident Preparedness & Response Plan* outlines incident management systems and frameworks, planning and response goals, planning assumptions, strategies and processes. The overall goals of the *Public Health G8 Summit Preparedness and Incident Response Plan* are:

- To enhance public health services to prevent or mitigate potential impacts from the G8 Summit.
- To coordinate public health services with other heath sector and community response partners.
- To identify key public health response functions based on prioritized risks and clarify responsibilities and capabilities of public health during planning, response and recovery.
- To ensure continuity of essential public health services to residents within G8 impacted areas, including the five critical public health functions:
    - Population health assessment (reporting on the burden of illness in a community).
    - Surveillance (detecting and monitoring cases and indicators of disease and illness).
    - Disease and injury prevention (developing strategies to reduce the risk for injury).
    - Health promotion (educating the public about steps they can take to stay healthy).
    - Health protection (identifying and managing environmental hazards that pose risks to the public health such as safe drinking water and food supplies).
- To ensure sufficient surge capacity to cope with anticipated demand, and coordination with other key health care, community response partners and the ad hoc health system/health planning for visitors and delegates.
- To ensure the health system can respond to any extraordinary events that may occur in relation to the G8 Summit.
- To identify public health's G8 emergency management structure, consistent with the Incident Management System (IMS).
- To identify communications and emergency management systems, along with supportive tools to assist with coordination of public health services during G8 response.
- To identify training need priorities and assist with G8 staff educational opportunities to enhance agency preparedness and understanding of public health response expectations.

CONCEPT OF OPERATIONS

EMERGENCY RESPONSE PLANS

Emergency management in Ontario is governed by the *Emergency Management and Civil Protection Act*, RSO, 1990, c. E.9. (*EMCPA)*. Administration of the Act is assigned to the Solicitor General of Ontario under whom the Commissioner of Emergency Management Ontario (EMO) is responsible to co-ordinate, monitor, and assist in the formulation and implementation of emergency plans.[i] The *EMCPA* provides the framework for emergency planning and preparedness in Ontario. It establishes the mandate for local municipalities to develop emergency plans, and organize the deployment of all services or resources that may be required to manage the emergency. Under the *EMCPA*, all municipalities are required to have emergency plans in place to help manage emergencies within their area of jurisdiction.

The public health agencies that will be utilizing this preparedness and response plan each has a respective emergency response plan to assist their agencies in effectively coordinating local responses to general public health emergencies or incidents.

ACTIVATION OF PUBLIC HEALTH G8 SUMMIT PREPAREDNESS AND RESPONSE PLAN

Summit preparedness activities identified within this plan will be implemented to assist with agency readiness in the months preceding the Summit. During the G8 and the G20 Summits, response plans may be activated in whole or in part upon direction of the local MOH, depending on circumstances of the event.

Mutual Assistance Agreements will be established prior to this event to address anticipated surge response needs. Public health agencies may utilize a common Mutual Assistance Agreement Template to aid in the establishment of these Agreements (See Appendix 5). If the MOH determines local response needs exceed the ability of public health to respond effectively, or an emergency event occurs during the Summit, the MOH may request assistance from neighbouring boards of health or municipalities. If surge response resources cannot be received locally, the MOH may contact the Emergency Management Branch of the MOHLTC to request additional assistance.

ACTIVATION OF LOCAL PLANS/EMERGENCY OPERATION CENTRES

Individual municipalities may activate their Emergency Operation Centre (EOC) independently depending on localized activity or upon recommendation by the Province, the County or the District to allocate resources and coordinate response to the G8 or G20 locally. Local municipalities may activate their EOC to discuss the status of response, share relevant information and coordinate an effective response.

It is anticipated that municipal and regional emergency plans and EOCs will be activated as local conditions escalate and the need for response measures increases. The MOHLTC may also request that health sector agencies and key community stakeholders activate their own emergency response plans and EOCs to assist with a coordinated health system response and to assist with the establishment of effective communication systems. Each agency will be impacted differently; therefore individual agencies may implement their plans independently or in conjunction with the health unit and the MOHLTC. Local MOHs may be represented at municipal/regional EOCs to provide public health advice and to coordinate services with other community response partners. Appendix 3 depicts the G8 Command Structure: Health Perspective.

EMERGENCY DECLARATION

Under the *Emergency Management and Civil Protection Act* only the head of council or the premier of Ontario have the authority to declare an emergency. Under the Act, the Premier of Ontario may declare that an emergency exists throughout Ontario or in any part thereof. The Premier or a designated minister may take such action as necessary to implement emergency plans and to protect the health, safety, welfare, and property of the inhabitants of the emergency area. The Premier of Ontario may require any municipality to provide such assistance, as is considered necessary, to an emergency area or part thereof that is not within the jurisdiction of the municipality and may direct and control the provision of such assistance.[ii]

In situations where recommendations to declare a provincial emergency will likely involve the Secretary of Cabinet, the MOHLTC, the Ministry of Community Safety & Correctional Services and the Commissioner of EMO.[iii] The Premier may terminate the emergency status at any time.

Locally, the head of council of a municipality may declare that an emergency exists in that municipality and may implement the municipality's emergency response plan. The Act also authorizes the head of council to do what he/she considers necessary to protect the health, safety and welfare of the residents. This allows the municipality to draw from any resource or service within the community.

A decision to declare an emergency locally will be made by the head of council (warden or district chair respectively) in consultation with other municipal emergency control group members, including the medical officer of health. The CEMC will notify the Provincial Emergency Operation Centre of a potential/actual emergency or impending situation and request assistance.

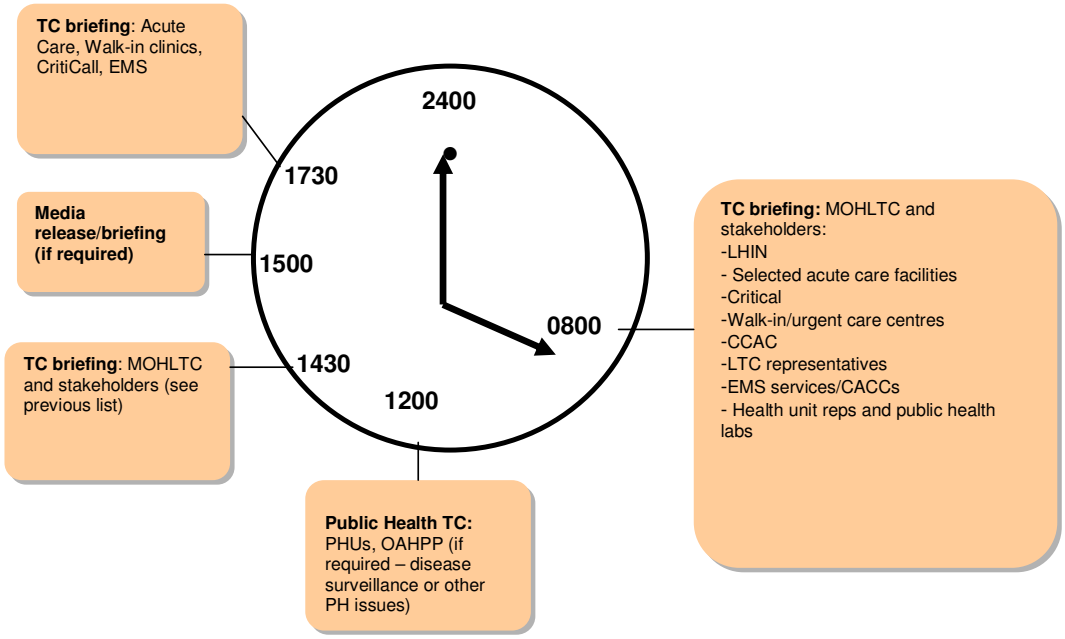
The MOHLTC will develop an inter-agency G8 Response plan which outlines the provincial response infrastructure for health emergencies and the relationship to the broader emergency response. These relationships are outlined in Appendix 3 (G8 Command Structure: Health Perspective).

EMERGENCY MANAGEMENT COMMUNICATION SYSTEMS:

Each public health agency involved in G8 and 20 response will be making decisions within their agency plans through their internal command structures and established points of contact with local partners, including the municipality, and keeping the MOHLTC informed through the existing communications cycle outlined below.
If an event escalates and the response requires additional support of guidance public health units will communicate with the MOHLTC through the MOHLTC EOC, which will be activated throughout the event, for additional guidance/decision-making.

An IMS structure will be in place within the Ministry, with the command role located with the Emergency Management Branch with support of the MOHLTC Executive Emergency Management Committee where necessary.

For issues with implications beyond health, the MOHLTC has a liaison at the Provincial Emergency Operations Centre (PEOC) through which communication takes place and issues can be raised with other ministries/levels of government.



MOHLTC Communication Cycle

PUBLIC HEALTH EOC OPERATIONS AND COMMUNICATION SYSTEMS:

Public health agencies directly impacted by the G8 and G20 Summits within their area may activate their own Emergency Operation Centres during week of Summit. Most public health agencies will adopt the Incident Management System (IMS) model as their emergency management structure.

Local communication systems will be activated to facilitate communication with municipalities, community response partners, health sector and government organizations.

- Communication cycles will mirror that of the MOHLTC- this cycle will be adopted and enhanced to included communication cycles with public health partners, local municipal and community response partners.

Public health agencies will use MOHLTC's Communication Cycle to link in with the health sector via teleconference. Other communication systems may include video conferencing, email and telephone communications.

Depending on the area of jurisdiction, the local MOH or designate may attend municipal EOCs as activated and when requested to attend.

The local MOH may attend MOHLTC/Federal EOC upon activation and request and dependent on agreements for representation prior to Summit.

Public health units may establish a command post to coordinate and manage public health services.
Additional communication processes between Red and Yellow Zone Command Sites and EOCs will be established through ongoing planning and consultation.

For a more detailed overview of the G8/G20 public health communications links between EOCs at all levels, please refer to Appendix 3. This framework provides a general overview of the local, regional and provincial components of public health communications for the G8/G20 Summits, including pre, response and post event periods.

PUBLIC HEALTH COMMUNICATION SYSTEMS AND CYCLES

Public health agencies involved in G8/G20 response may adopt the following communication cycle. The concept of having a unified communication cycle ensures that relevant, consistent and timely information is shared among all stakeholders. **Table 1** identifies the types of telecommunication systems and emergency management structures being utilized by public health agencies during the G8 and G20 Summits.

PUBLIC HEALTH COMMUNICATION CYCLE

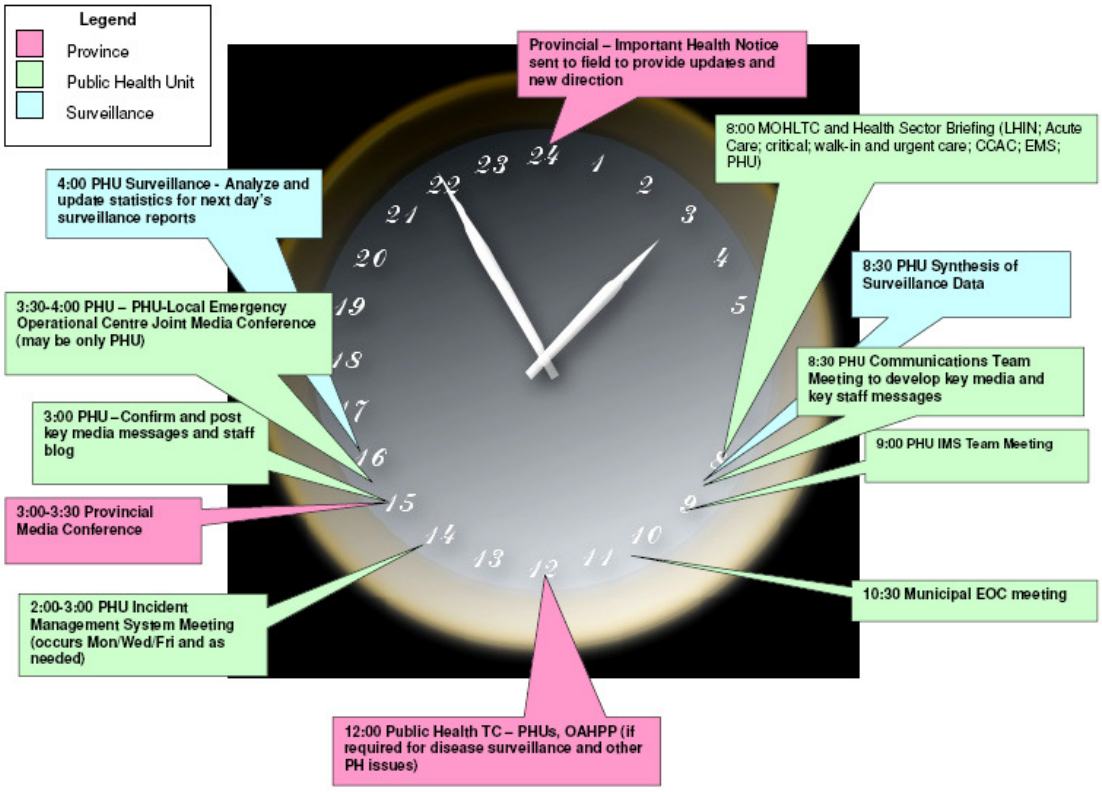


TABLE 1: INCIDENT MANAGEMENT SYSTEMS EOC OPERATIONS & COMMUNICATIONS SYSTEMS		
PUBLIC HEALTH EOC ACTIVATION	OPENING & ORGANIZATION OF EOC SETTING OF OPERATIONAL CYCLES/DELEGATION OF DUTIES/ STAFF FAN OUT NOTIFICATION INITIATED? SET OPERATIONAL CYCLES SET RESPONSE CYCLES	**PUBLIC HEALTH UNITS PLANNING TO ACTIVATE:** RENFREW SMDHU TORONTO (LIKELY)
COMMUNICATION SYSTEM ACTIVATIONS TO SUPPORT EOC	SET UP OF COMMUNICATION SYSTEMS- SUPPORT RESOURCES/TOOLS COMMUNICATION SYSTEMS GIS MAPPING?	**COMMUNICATION SYSTEMS BEING USED:** **VIDEO CONFERENCING**: NBPSDHU RENFREW SMDHU TORONTO **TELECONFERENCING:** HKPR NBPSDHU PEEL RENFREW SMDHU TORONTO YORK **CELL PHONES**: HKPR NBPSDHU PEEL RENFREW SMDHU TORONTO YORK **EMAIL:** HKPR NBPSDHU PEEL RENFREW SMDHU TORONTO YORK
MOH REPRESENTATION MOHLTC EOC		MOH/ALTERNATE TO BE AT MOHLTC/EMS EOC: SMDHU: YES, IF REQUESTED TORONTO – MOST LIKELY
MOH Representation Municipal/Regional EOC -	Direct link to HU EOC/Directors/Managers/EMC/IT/Corp Services	MOH/ALTERNATE TO BE PRESENT AT MUNICIPAL EOC: HKPR NBPSDHU- IF ACTIVATED SMDHU- YES- DISTRICT, COUNTY & HUNTSVILLE, IF ACTIVATED PEEL - YES TORONTO - MOST LIKELY YORK- IF ACTIVATED
On-Site Command Post	Dedicated, direct on site communications to public health staff. Operational Team-Headquarters Operational Leads and Incident Commander on site	**Command Sites Activations Anticipated for:** SMDHU
On-Call Support- Emergency Response (See Emergency Contact List for contact #s)	Ability to respond to emergency issues, outbreaks, recalls, extreme weather events, power outage Support for response- roll-out	On-Call Support Systems: On-Call Contact Information: SMDHU HKPR YORK TORONTO PEEL RENFREW
Enhanced Public Inquiry Lines	Activate emergency response services (At the call of SMDHU Executive)	In emergency state: Enhanced phone line SMDHU- Health Connection (HC) from 8 am - 8 pm (minimum)

EMERGENCY MANAGEMENT SYSTEMS

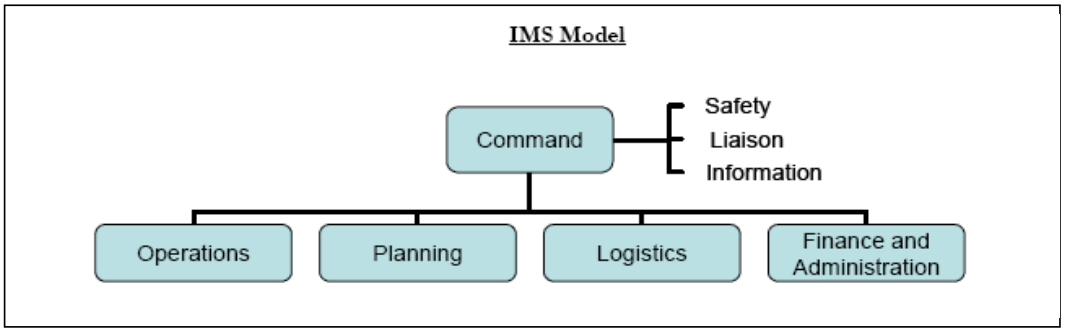
Most emergency response organizations use the Incident Management System (IMS) to permit emergency response organizations to work together effectively to manage multi-jurisdictional incidents. The Incident Management System improves communication, coordinates resources and facilitates cooperation and coordination between agencies

The IMS structure (see Figure 1) has been adopted by Emergency Management Ontario as an operational framework for emergency management for the Government of Ontario. Appendix D depicts how the IMS will be integrated within the provincial emergency management structure. The MOHLTC will use this model for its EOC at the Emergency Management Branch.[iv] This structure is built around five functions: command, operation, planning, logistics and finance/administration.

Other organizations provincially and locally (such as municipalities and health-care facilities) have adopted the IMS model to increase the effectiveness and interoperability of emergency management. The health units participating in G8 planning and response will adopt the IMS structure.

Source: Ministry of Health and Long-Term Care

Figure 1: IMS Structure



Authority is based on a top-down approach, originating from the Emergency Control Group. The four functional departments of the organizational structure (Planning, Operations, Logistics and Finance & Administration) can be activated.

The command function determines the flow of decision making and communications in the emergency setting through formal orders and directives. Command also has the overall authority to control and direct emergency resources.

Incident Commander

In a situation where there are multiple first responder organizations participating at the same time, a **Unified Command System** should be implemented (Resulting in one single incident commander).

For complex incidents, and Emergency Operations Centre (EOC) should be organized to support the incident commander, coordinate multiple incidents and interface with other agencies, organizations or levels of governments. The lead for each of the functions will be identified as representatives within the emergency control group.

Each operational response agency will identify their own incident commander who will be responsible for managing staff and resources on-site. Incident commanders from external response agencies may be requested to attend the County/District EOCs to provide advice or assistance with response.

Potential roles of the Incident Commander may include:

- Leads the incident and deals with teams.
- Coordinates response and support to other level of government or agency.
- Contingency arrangements and alternates.
- Defines the functions of various teams engaged in the emergency and specifies the roles and responsibilities for all teams members as defined within their emergency response plan.
- Determines immediate emergency response objectives and sets priorities to meet these objectives. (Coordinates activities and communicates with Program/Senior Management).

At the EOC level the Incident Commander would be responsible for:

- Coordinating with the Provincial Emergency Operation Centre (PEOC) and/or liaison through the Provincial Emergency Response Teams, especially if the response is province-wide or area specific where provincial direction/orders are given.
- Activating the pandemic plan and implementing concept of operations arrangements.
- Declaring an Emergency/advising head of council whether declaration of an emergency is recommended.
- Canceling public events or closing facilities.
- Receiving direction from health unit or province and directing local implementation of orders/advice received.
- Delivering emergency information through the media for the public.

Three functions that support command are:

- **Health & Safety**
- **Liaison, and**
- **Emergency Information.**

Health and Safety

Staff in this capacity are responsible for the monitoring, tracking and safety of all personnel working at a site or the EOC. Critical information can also be passed from command that will directly or indirectly impact emergency efforts.

Health & Safety staff:

- Monitor and track safety of personnel at the site.
- Relay educational information to and from command.
- Ensure that personnel within their department are trained and certified in safety and health practices, including the use of Personal Protective Equipment (PPE) for designated personnel.
- Coordinate with the safety officer to identify hazards or unsafe conditions associated with the incident and immediately alert and inform appropriate management and leadership personnel.

Liaison

Emergency Management Coordinators or designates **will** play the role of the **Liaison Officer**.
The Liaison Officer:

- Acts as a link between the EOC and other organizations involved in the emergency.
- Coordinates with outside agencies and other organizations involved with G8 response.
- Identifies key external contacts such as police or ambulance.
- Keeps the incident manager up-to-date with actions of other agencies and their responses.

Emergency Information/Public Information Officer

The public information officer is responsible for the development and timely dissemination of approved emergency information messages and bulletins to the media and the public. This function is responsible for coordinating all media requests for interviews and conducting regular news briefings. Please note that the incident commander may be identified as the community spokesperson.

Each response agency is responsible for identifying a public information officer for their organization. Individual agencies may already have an emergency information officer established within their organization functioning as a public information officer, media relations or communications officer.

IMS Main Functions that can be activated:
- **Planning**
- **Operations**
- **Logistics, and**
- **Finance & Administration.**

Operations

This function coordinates the operational requirements of the site and/or EOC. Resources and equipment are directed as required to fulfill assigned duties in the emergency. Operations also action decisions made by command by calling out and mobilizing staff and equipment.

A concept of operations describes the mechanism by which each organization will conduct its own operations and interact with other responding agencies. It is a key element of all emergency plans, and each agency will have its own procedures for the services that it provides to ensure that critical services are maintained.

Potential functions of Operations may include:
- Calling out and mobilizing staff and equipment.
- Notifying the head of council of an imminent and/or actual emergency.
- Activating emergency response plan.
- Assembling the control group at the EOC.
- Coordinating operations and briefing cycles of the EOC with media briefings, especially in a multi-jurisdictional response.
- Carrying out assigned duties between briefing cycles, especially for coordinating with other response organizations.
- Directing resources and equipment, determining what type of resources are needed to deal with the incident.
- Notifying team leaders that an emergency has been declared.
- Communicating directives to response team and providing feedback to command.

Planning

This function is responsible for the development, dissemination and evaluation of emergency response plans up to 72 hours ahead of time. This group gathers information regarding the incident-specific impact and identifies alternate/modified plans of action to deal with the emergency.

Potential roles of Planning Teams may include:
- Assessing the ongoing impacts (mortality and morbidity; staffing/resource needs emerging demands and requests for support/unmet needs, disease surveillance data; impacts on local area population.)
- Developing, disseminating and evaluating emergency response plans up to 72 hours ahead.
- Gathering information regarding incident-specific impact.
- Sharing information between all programs/teams.
- Identifying alternate action to deal with emergency.
- Developing the Emergency Management Team action plan.
- Tracking individual/departmental services continuity plan and status.
- Summarizing departmental plans for submission to senior management.
- Advising Emergency Management Team of departmental service continuity plan conflicts, incongruities, overlap, etc.

Logistics

This function is responsible for arranging and coordinating all materials, services, equipment and resources to manage and resolve the emergency. Logistics tracks inventory and the current location of resources and identifies the availability of supplies and support.

Potential roles of Logistics staff include:

- Arrange and coordinate materials, services, equipment and resources required to manage and resolve the emergency.
- Tracking usages (inventory tracking) and tracking the current location of resources.
- Providing/facilitating services and staffing to deal with emergency.
- Immobilizing staff.
- Arranging for transportation/accommodation.
- Acquiring equipment and support services, office and medical supplies.
- Arranging for food.
- Maintaining operation of the Emergency Operations Centre (EOC).
- Acquiring outside services, arranging for services and/or equipment from other agencies, community.
- Notifying, requesting assistance from and/or liaising with other levels of government.

Finance and Administration

This function authorizes expenditures, claims, purchases and contracts initiated during the emergency.

Finance & Administration responsibilities may include:

- Authorizing expenditures.
- Monitoring the cost associated with emergency response (expenditure tracking) for staff services, municipal/agency resources (equipment/supplies).
- Identifying costs depleted.
- Authorizing emergency procurement.
- Processing claims and compensation.
- Administering financial and staffing duties – incident related costs, maintenance and scheduling.

PUBLIC HEALTH HAZARD IDENTIFICATION RISK ASSESSMENT (HIRA)

A key challenge in the development of any health unit's emergency management program is the ability to focus resources and time in the development of emergency plans for dealing with the most significant risks. To obtain such focus, credible hazards must be identified and assessed to determine their probability of occurrence and identify potential public health consequences/impacts.

The Public Health Subcommittee for G8/G20 planning under the direction of the MOHLTC conducted a local public health risk assessment using a risk assessment grid model adopted by emergency management officials in Ontario to assist public health agencies with G8 planning. Assigning a likelihood value and an impact level to a risk and combining those two values to arrive at the level of risk completes the assessment. In general, risk with the highest assessment values should be treated first.[v]

For the purpose of this hazard assessment, **impacts (consequences) were** assessed. Three factors/components were considered when assessing overall impacts to public health units when considering the effects the G8 will have on their ability to deliver an appropriate level of service. These three areas of impact included: **the human impact, the property impact and the business impact**. An **overall impact rating** was assigned to reflect how significantly the G8/G20 would have on the ability of each agency to function.

This G8 hazard identification and risk assessment process involved four distinct steps:

1) Identifying and researching the risks/hazards, focusing on mass gathering implications.
2) Conducting a risk assessment for each hazard identified to determine probability of occurrence and public health consequences.
3) Establishing program priorities (Using a Risk Assessment Grid).
4) Developing incident specific plans for prioritized hazards.

PRIORITIZED HAZARDS

Based on a literature review and research findings eight categories of public health hazards were identified. These hazards included:

1) Food Related Hazards
2) Infectious and Contagious Diseases
3) Water Related Hazards
4) Hazardous Material Incidents
5) Bioterrorist Events
6) Environmental or Weather Related Events
7) Technological/Critical Infrastructure Failures and
8) Injury Related Events

PUBLIC HEALTH HIRA CHART

Public Health HIRA		
Hazard	**Specific Hazard**	**Rationale for Public Health Implications**
Food Related Hazards Suspect food adulteration (could be from international/domestic sources).	E-coli 157[hamburger disease] outbreak with potentially fatal results Outbreak with other organisms – salmonella, campylobacter, or hepatitis A, shigella, staph aureus, clostridium perfringens and listeria now common sources of food poisoning. Parasitic contamination of food giardia/cryptosporidium/ cyclosporiasis most common types. Gastroenteritis	High probability of illness in affected population potential exists for fatalities depending on severity and duration of illness. Children, elderly immune-suppressed most vulnerable. Contact and case management.
Infectious and Contagious Diseases Infectious and contagious diseases can either be of domestic origin or imported by persons attending the event. Note: imported diseases are not often diagnosed in the country of origin.	Out of season influenza, meningitis/meningococcal, measles, mumps, varicella, gastroenteritis, respiratory illness.	High probability of illness in affected population potential exists for fatalities depending on severity and duration of illness. High potential for multiple illness and deaths. Children, elderly immune suppressed most vulnerable. Contact and case management, staff redeployment.
Water Related Hazards Water-related issues that may arise at a mass gathering event. The occurrence may be due to contamination, malfunctioning systems, disruption or by vandalism/terrorism.	Disruption/malfunction in water treatment process. Breach of system integrity. Water main break. Loss of pressure. Vandalism/bioterrorism. Contamination of water supply (e.coli, giardia, cryptosporidium, shigella, chemical/biological contamination). Contamination of recreational water sources.	High probability of illness, long-term medical complications or death. Increase in public fear and anxiety. Hospitalization, extended medical treatment.
Hazardous Material Incidents (HAZMAT) Hazardous material explosion incident (chemical, nuclear or radiological events).	Chemical spills. Transportation incidents. Terrorists (dirty bombs, etc.)	Decontamination of exposed individuals. Evacuation of residents or surrounding areas. Shelter in place. Hospitalizations of symptomatic cases. Post exposure contact and case management. High demand on health-care services.
Bioterrorist Event (Biological Agents Only)	Bioterrorist agents: anthrax, variola virus (small pox), botulism, plague, cholera, tularemia, plus others.	Increased public fear and anxiety, stress. Potential to overwhelm health-care facilities/professional. Potential to overwhelm first responder resources.

Environmental/ Weather Related	Extreme heat, severe storms, tornadoes, lightening strikes.	Serious injuries, illness and potential for deaths (tornado) Dehydration. Large scale evacuations. Vulnerable populations, elderly, COPD (Chronic Obstructive Pulmonary Disease), mobility impaired]. Shelter in place. Impacts to local health care. Cooling centres, evacuation centres.
Technological/Critical Infrastructure Failure	Energy supply disruption (power, natural), mechanical failure at water treatment and sewage. Water and Sewage System disruptions/malfunctions. Road closures. Information technology. Communication system.	Impacts on the vulnerable populations long-term care residents. Restoration of essential services, evacuation, food premises food suppliers, retail. Economic impact for business and other agencies.
Injury Related_ Public Safety hazards Community health issues – substance abuse (alcohol/drug related injuries) Sprains/fractures, slips, falls. Heat related dehydration, exhaustion and strokes. Medication related concerns.	Alcohol abuse. Drug use. Slips/falls. Heat related. Medication related.	Increase risk of heat-related illness (headache, fatigue, sunburn, insect bites). Dehydration. Medication concerns for individuals not traveling with vital medications. Implications of sprains/fractures.
Air plane incident – hazardous material incident and/or rodent control.	The release of hazardous materials from the cargo (e.g. chemicals, pharmaceuticals) and the plane itself.	Water quality monitoring. Decontamination of exposed individuals. Evacuation of residents or surrounding areas. Shelter in place. Hospitalization of symptomatic cases. Post exposure contact and case management. High demand on health-care services. Rodent control of the area itself, depending upon the nature of the accident.

G8 RISK ASSESSMENT GRID:

A Risk Assessment Grid depicts assessment values for each hazard. In general, risks were further assessed and given a scoring based on their likelihood of occurrence and severity of impact/consequence. The overall impact considered effects on public health resources and personnel, local business, critical infrastructure and the general community. Based on this further assessment, G8/G20 priority planning hazards were identified. (See Appendix 1)

Public Health Emergencies (Priority Planning Hazards)

a) **Infectious and Contagious Diseases**. These types of hazards are common at mass gathering events and have significant impacts to the population as a whole.

b) **Food Related Hazards** have the potential to happen at any time during the year and are common at mass gathering events. These hazards can be directly related to power outages/winter and summer. Large scale foodborne illness outbreaks and large scale food recalls [Maple Leaf Meats] are associated with poor food handling practices and with mass gathering events have been linked to illegal operations.

c) **Environmental/Severe Weather Emergencies** can happen at any time during the year and have the potential to cause food, water, human health and technological emergencies. The most common issue associated with this category is heat-related incidents.

d) **Injury Related & Health & Safety Hazards** are common at mass gathering events. Research findings indicate that most of these incidents are associated with substance abuse (alcohol and drugs).

e) **Drinking Water Emergencies** can occur at any time during the year and although large-scale emergencies are rare, the consequences and impact can be severe.

Less Likely Events – Lower Planning Priority for Public Health

a) **Technological and Infrastructure Emergencies** such as road closures due to accidents, or bridge collapses due to aging infrastructure, are fortunately rare. The province-wide power outage that occurred in the summer of 2003 directly resulted in food, water and human health emergencies. As the infrastructure ages and the demand for electricity increases, the potential for more of these emergencies exists.

b) **Hazardous Material Emergencies** and **Bioterrorist Events**
HAZMAT incidents are fortunately few in number given the volume of hazardous materials that are transported via road and rail on a daily basis in this country. Highly trained specialist teams would normally respond to such an emergency with public health being used in an advisory role and not as first responders. Bioterrorism emergencies can happen at any time and the impact and consequences can be catastrophic. Fortunately they are very rare and usually happen only in areas of political or religious significance or in areas of high population density. This type of incident ranked low as a public health planning priority, however, for security and safety purposes, federal officials consider this type of hazard as a high priority issue.

IDENTIFICATION OF MITIGATION & RESPONSE STRATEGIES FOR PRIORITIZED HAZARDS

The risk assessment grid process identified emergencies that have been ranked with the highest priority. Public health units have used this ranking to make decisions on program planning priorities. Each public health agency impacted by the G8/G20 Summit established mitigation and strategies to address the assessed risks. This plan identifies these strategies, however, each public health unit may need to develop more comprehensive plans to address local and agency specific needs. Local emergency management structures, systems and resources may also be included within comprehensive plans.

PUBLIC HEALTH MITIGATION AND RESPONSE STRATEGIES

Public Health Activities Based on Risk Assessment Priorities2	Mitigation and Response Strategies	Timelines and Responsibilities
Food Safety & Security Hazards Community Zone		
Heightened Surveillance/Compliance Monitoring ***Food Handler Training Health Promotion*** ***Enteric Outbreak Response***	Meeting inspection frequency and scheduling as outlined in Ontario Public Health Standards and Protocols. Food Safety Education and Awareness - Community operators. Heightened food-borne illness and complaint investigations. Enhanced face-to-face food handler training to food handlers. Review housekeeping practices at local hotels/motels (glasses, laundry, ice buckets).	**Timelines:** 2010 - Jan & February high & medium risk inspections. May - June - 1 additional Inspection **Health units assuming responsibilities:** HALIBURTON KAWARTHA PINE RIDGE (HKPR) SMDHU ORONTO YORK
Temporary/"Rogue" Food Vendors & Event Permits	Review existing permit process for municipalities. Establish requirements and processes. Liaise with municipality to establish process as needed. Temporary/"rogue" food vendors - action plan for restricting. Enforcement.	**Timelines:** 2010 - April – June. **Health units assuming responsibilities**: HKPR NORTH BAY PARRY SOUND DISTRICT HEALTH UNIT (NBPSHU) PEEL –(GREEN ZONE) SMDHU TORONTO YORK
Food Safety General Planning	Development of work plans. Identification of food-related issues and response strategies. On-going negotiations with community partners. Development of key food safety messages/resources and protocols. Establishment of MOUs with external response/support agencies.	**Timelines:** Dec 2009 – May 2010 **Health units assuming responsibilities**: HKPR SMDHU PEEL TORONTO YORK

Water Hazards- Community Zone		
Drinking water- Assessments and Compliance Monitoring (Note: Compliance monitoring over and beyond 2010 scheduled)	Identify regulated premises within community zone and targeted facilities/vulnerable populations. Complete pre-assessment contact and notification including information package. Complete formal assessment with MOHLTC of the RCat tool. Issue directives for small drinking water systems. Monitor water quality with public works department where applicable.	Timelines: Oct 2009 - June 2010 – pre-assessments. October 2009- June 2010- enhanced assessments, sampling and operational compliance. **Health units assuming responsibilities:** HKPR NBPSHU SMDHU TORONTO YORK
Recreational Camp inspection/Transient Campgrounds	Inspection of recreation camps/transient camps prior to Summit. Determine and assess operation of recreation camps during the event and determine impacts to routine operations and public health emergencies. Communicate and discuss with operators the level of operation during the affected period, changes in operations and/or clients to determine impacts and service needs. In transient camps do community sanitation assessments - portable toilets, garbage and sewage disposal, pest management.	Timelines: May - June 2010 **Health units assuming responsibilities:** SMDHU YORK
Environmental/Severe Weather		
Extreme Heat Assessment & Response	Part 1: Work with G8 planning partners to establish public education and awareness strategies for delivery of education packages/information. Identify list of impacted vulnerable populations. Identify heat and dehydration health implications. Implement public education strategy, public health measures, public awareness, media e.g., information related to heat-related illness (headache, fatigue, sunburn, insect bites). Part 2: Environmental Planning & Response: Develop criteria for issuing 'extreme alert' notice. Develop extreme heat response plan. Assessing previous year's weather history. Implement consequence management strategies to address extreme heat. Issue 'extreme heat alert' notice. Implement extreme heat response plan. Work with community partners (municipalities) to establish community-based cooling shelters/water depots. Ensure sufficient locations of drinking water for attendees and ensure water quality meets standards. Monitor for poor outdoor air quality. Respond to heightened complaint investigation response.	Timelines: **Part 1** Planning - March - May 2010. Implementation - May - June 2010. **Part 2** **Health units assuming responsibilities:** HKPR NBPSHU SMDHU YORK (monitoring system already established)

WNv/Lyme Disease Surveillance	Surveillance of larval/adult mosquito populations. Lyme surveillance as per MOHLTC protocol. (Note: Vector-borne surveillance not routinely completed for area.)	**Timelines:** May -June 2010 **Health units assuming responsibilities**: SMDHU PEEL
Injury Related & Health and Safety Hazards		
Trips Falls/Road Safety	Community health issues – sprains/fractures, slips, falls, road safety. Communication with local municipal planners - re: ensuring safety issues considered, street furniture not impeding foot traffic, road traffic control measures, car rental agents - channel for messaging. Incorporate surveillance systems through emergency department(s).	Timelines: Planning- March - May 2010 Implementation - May - June 2010 **Health units assuming responsibilities** SMDHU PEEL – usual activities only
Tobacco: Exposure to Second-Hand Smoke	Maintain enforcement of SFO requirements for smoke-free environments in all indoor public and workplaces. Conduct surveillance/education visits to public places/workplaces over the 4 months in advance of the event. Respond to complaints Provide education to public.	**Timelines:** March - June 2010 **Health units assuming responsibilities** SMDHU PEEL – Usual activities
Alcohol Consumption /Drug & Substance Abuse	Ensure availability/provision of Smart Serve training opportunities in preparation for the event. Deliver alcohol awareness resources. Work with HP Specialist to develop public messaging drug/alcohol. Work with community partners to identify and ensure facilities provide for proper, secure needle disposal for diabetics/illicit drug users. Work with sexual health to deliver needle exchange containers. Address medication related concerns.	**Timelines:** Planning- April - May 2010 Implementation - June 2010 **Health units assuming responsibilities** SMDHU PEEL – usual activities
Mental Health	Provide support to local community in regards to mental health through communication of community resources - coping with strangers, security, fear, disruption to routine activity, heightened sensitivity to crisis event.	**Timelines:** Planning- May- June 2010 Implementation - June 2010 **Health units assuming responsibilities** SMDHU PEEL – usual activities
General Public Health Communications Planning		
Health Promotion Resources	Provide enhanced promotion focused on all food handlers within Huntsville area. Develop public health-related literature for those target populations identified. Address access to health information and care: hydration: shade, hats, location of cooling stations and water depots, swimming areas/ pools; sprains/ fractures, slips, falls, road safety drug/alcohol abuse, moderating alcohol consumption; handwashing; mosquito control - use of insect repellant; SFO legislative requirements; healthy food choices; insect presence (black flies/ mosquitoes) and use of insect repellant; condom use, walking in the woods - safety - animals, ticks, poison ivy; Provide promotion of literature regarding responsible drinking, public safety. Develop public messaging re: stocking supplies for family needs for a week-long period (food supply, water, formula/baby food/ medications/BC/personal care	**Timelines:** March - June 2010 - resource development **Health units assuming responsibilities** SMDHU PEEL – usual activities

	products), safety to be broadcast in advance of the Summit. Develop appropriate signage re: blood-borne infections and communicable diseases, needle sharing and exchange and site availability.	
Crisis Communication Planning	Develop health unit crisis communication plan. Establish communication systems. Coordinate with different levels of government and community partners. Form G8 writing teams to create ready-made fact sheets, press releases and other resources as required.	**Timelines**: May- June 2010 **Health units assuming responsibilities**: SMDHU PEEL
Public Inquiry Lines: Access to Public Health Information/Referral	Ensure availability of public health inquiry lines by extending hours the week of the Summit and through the weekend of event to assist in receipt of complaints or questions about/reports of CD (if needed) and environmental/health hazard complaints	**Timelines:** June 2010 **Health units assuming responsibilities** SMDHU
Technological and Infrastructure	Conduct business impact assessments/business continuity planning	**Timelines:** January - May 2010 **Health units assuming responsibilities**: SMDHU
HAZMAT/Bioterrorist Events	Review current policies on CBRN. Clarify roles and responsibilities on CBRN response expectations, decontamination procedures and health impact assessments (for biological agents). Identify G8-related complaint response process. Develop decision-making algorithm - syndromic surveillance - i.e. With health care, first aid stations etc. Determine communication protocols (consider external partners). Conduct lab planning including expedited delivery forms and couriers for high priority samples. Conduct contact tracing, case management Heighten environmental surveillance to assure environmental surety. Implement "CBRN Emergency Response Guidelines for Health Care Providers". Monitor Health Connection (call center operations) for increased call volumes. Implement public education. Make recommendations for joint training and preparedness opportunities.	**Timelines:** March-June 2010 **Health units assuming responsibilities**: SMDHU PEEL TORONTO YORK
Infectious and Contagious Diseases		
Disease Surveillance (Active, Passive and Syndromic Surveillance)	Working within the existing health-care sites for the provision of reporting trends of illness or reportable diseases. **Active Surveillance** prior to and including the time of the G8 Summit **Passive surveillance** from health-care providers **Syndromic Surveillance -** Identify and discuss potential disease investigation and surveillance issues to ensure routine infectious disease surveillance activities are implemented and conducted efficiently.	**Timelines:** Planning - March - June 2010 Implementation - June 2010 **Health units assuming responsibilities:** HKPR NBPSHU PEEL SMDHU TORONTO YORK

Disease Reporting Mechanisms	Identify, develop or enhance reporting mechanisms required to address surveillance needs. Establish syndromic surveillance and reporting expectations.	**Timelines:** Planning - March - June 2010 Implementation - June 2010 **Health units assuming responsibilities:** HKPR NBPSHU Peel SMDHU Toronto York
Outbreak Response	Ensure on call support prepared - CD Investigators on standby to provide ready outbreak response as required.	**Timelines:** June 2010 **Health units assuming responsibilities:** HKPR NBPSHU PEEL SMDHU TORONTO YORK
Case and Contact Management	Ensure CD investigators action any reports of illness generated as a result of the Summit. Provide advice and support to Detention Centre regarding Infection prevention and control (IPAC) interventions.	**Timelines:** June 2010 **Health units assuming responsibilities:** HKPR NBPSHU PEEL SMDHU TORONTO YORK

PUBLIC HEALTH BUSINESS CONTINUITY AND RECOVERY

The identification and prioritization of potential public health hazards within our communities can also assist with business continuity planning. Impacts on pre-identified essential services by these hazards can be assessed to determine potential surge impacts on each service area. Once assessed, staff redeployment plans and specialized training can be provided.

OTHER FACTORS IMPACTING ON BUSINESS OPERATIONS:

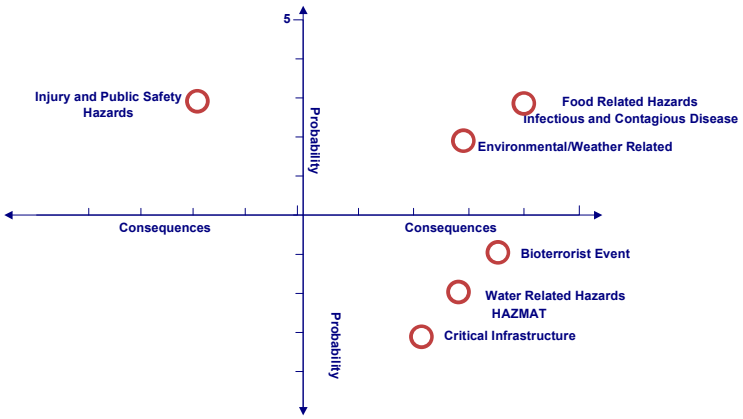
- Business continuity – surge capacity and redeployment plan required.
- Occupational health & safety issues.
- Travel restrictions: highway closures restricting provision of essential services.
- Capacity issues- credentials – specialized skills required to conduct assessment (staff designation required), numbers of staff, may require redeployed or MOU with public health agencies to support service delivery.
- Information technology – communication capabilities between field staff and command and security protected areas.
- Community partnerships – coordination/planning with other government organizations, community partners and health sector required.
- Logistics – on-site accommodations may be required during event..
- Human resource policies – reviewing after-hours response, vacation requests & scheduling, shift lengths.
- Accreditation of staff into Zone 1 & 2 required.

Pre-established agreements will be established between boards of health to provide for mutual aid and assistance between the public health units when the resources normally available to a board of health within a municipality are not sufficient to cope with a situation which may require public health action as a result of the Summit. The health and wellbeing of a community will best be protected through the concerted efforts of multiple public health agencies providing assistance to one another. The promotion and coordination of this assistance through these agreements is desirable for the effective and efficient provision of mutual aid and assistance.

APPENDICES

APPENDIX 1: RISK ASSESSMENT GRID

G*8 Specific Public Health RISK ASSESSMENT GRID				
PROBABILITY	***4***		***Food Related Hazards*** ***Infectious and Contagious Diseases***	
	3	***Environmental/ Weather Related*** ***Critical Infrastructure Failures***	***Water Related Hazards***	
	2	***Injury Public Safety Hazards***	***Hazardous Material Incidents***	
	1		***Bioterrorist Events (Biological Agents Only)***	
	1 Negligible	***2 Low***	***3 Moderate***	***4 High***
	CONSEQUENCES			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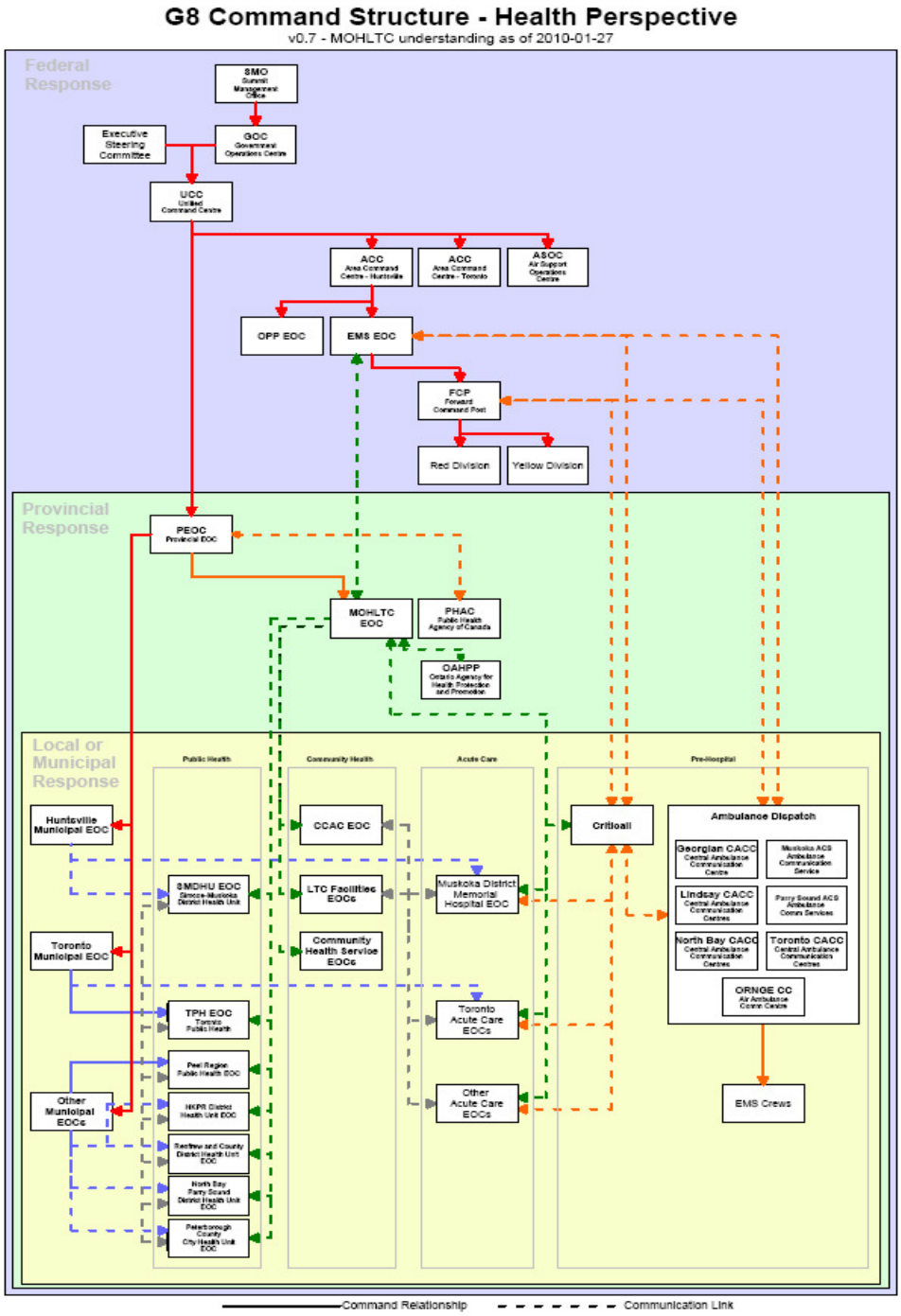
Injury and Public Safety Hazards
Probability
Food Related Hazards
Infectious and Contagious Disease
Environmental/Weather Related
Consequences
Consequences
Bioterrorist Event
Water Related Hazards
HAZMAT
Critical Infrastructure
Probability

APPENDIX 2: PUBLIC HEALTH UNITS' EMERGENCY CONTACTS

Public Health Units	Name	Position	Telephone
City of Toronto	**Incident Commander** (IC)– Ron De Berger **Emergency Management Contact:** Marco Vittiglio	Director of Healthy Environments Manager, Emergency Planning and Preparedness	Daytime: (416) 338-7953 After hours: (416) 690-2142 Daytime: (416) 338-8187 After hours: (416) 690-2142
Haliburton, Kawartha, Pine Ridge District	**Incident Commander:** Atul Jain Standby- Dr. Lynn Noseworthy **Emergency Management Contact** Younous Manjoura	Assistant Director (A), Environmental Health MOH Public Health Emergency Preparedness Coordinator	Daytime: (905) 885-9100 ext. 418 Daytime (cell: 905- 373-6885 After hours: 1-888-255-7839 After hours: 1-888-255-7839 Daytime:- (905) 885-9100 ext. 478 After hours: 1-888-255-7839
North Bay Parry Sound District Health Unit	**Emergency Management Contact:** Greg Rochon	Emergency Preparedness Manager	Daytime: (705) 474-1400 ext. 2205 Cell: (705) 498-3352 After hours: (705) 474-1400
Region of Peel	**Incident Commander:** **Emergency Management Contact**: Andre Luc Beauregard	 Manager, Regional Emergency Management	Daytime: (905) 791-7800 ext. 4132 After hours: (905) 791-7800
Simcoe Muskoka District Health Unit	**Incident Commander:** Dr. Charles Gardner **Alternate IC**: Ted Devine **Emergency Management Contact:** Kelly Magnusson	MOH Director of Health Protection Manager, Emergency Management	Daytime: (705) 721-7520 ext 7219 After hours: 1-888-225-7851 Daytime: (705) 721-7520 ext 7524 After hours: 1-888-225-7851 Daytime: (705) 721-7520 ext 7289 After hours: 1-888-225-7851
York Region	**Incident Commander** – or likely to be Director of Health Protection or Infectious Disease **Emergency Management Contact**: Sandra Vessel	MOH Manager of Health Emergency Planning	Daytime: (905) 830-4444 ext. 4012 After hours: 1-800-361-5653 (through on-call staff) Daytime: (905) 830-4444 ext. 4103 After hours: (905) 830-3375

			(905) 830-3370 1-800-361-5653
Renfrew County	**Incident Commander**: Dr. Michael Corriveau **Alternate I.C** – Bob Schreader **Emergency Management Contact**	MOH Acting Manager, Environmental Health	Daytime: (613) 735-8654 ext 503 After-hours –:(613) 732-2811 through local hospital operator Day-time: (613) 735-8654 ext. 535 After-hours: (613) 732-2811

APPENDIX 3: G8 COMMAND STRUCTURE – HEALTH PERSPECTIVE



APPENDIX 4: G8/G20 SUMMIT PUBLIC HEALTH COMMUNICATIONS FRAMEWORK

G8/G20 SUMMIT PUBLIC HEALTH COMMUNICATIONS FRAMEWORK

BACKGROUND

Canada will host the 2010 G8 Summit from June 24-25 at the Deerhurst Resort in Huntsville and the G20 Summit from June 26-27 in Toronto. These summits will be very high profile political events that will involve 40 or more international world leaders. This event will draw a large number of people into the Simcoe Muskoka District Health Unit area and the health unit jurisdictions in the GTA, particularly Toronto. It will include international visitors and their support staff plus protestors, activists and the media. Multi-agency cooperation and collaboration is required to prepare and respond to this event to ensure a safe, secure and health-supportive environment while minimizing any disruptions. A coordinated public health response strategy to the G8/G20 Summits is required.

ISSUE/ACTION

This communications framework provides a general overview of the local, regional and provincial components of public health communications for the G8/G20 Summits, including pre, response and post event periods.

GOAL AND OBJECTIVES

The **goal** of this communications framework is:

1. To provide a communications framework that will guide the creation of comprehensive, coordinated communications plans to address key public health issues and concerns related to the G8 and G20 Summits in Huntsville and Toronto, Ontario in June 2010.

This goal will be reached through the implementation of the following **objectives**:

1. Determine clear roles and responsibilities/authority of each sector involved in public health communications related to the G8/G20 Summits.
2. Develop a comprehensive timeline of key activities that will ensure the provision of factual, timely and accurate public health information to the general public, vulnerable populations, media, public health staff, stakeholders and partners regarding all public health issues, and delivery of services before, during and after the G8/G20 Summits in June 2010.
3. Create a collaborative process with public health and other G8/G20 partner agencies for the development and implementation of a joint public health communications strategy, including the development of key messages for specific target audiences, as well as specific plans for different public health jurisdictions.
4. Ensure that a coordinated communications system and process are in place and are fully operational.

APPROACH

This communications framework incorporates the following approaches and concepts:

- Clarity of processes for timely approval and message dissemination.
- Clear responsibility and authority for public health communications activities and message dissemination.
- Collaborative communication activities with local, regional, provincial and federal partners.
- Consistency in messaging across the region and the province.
- Emphasis on the dissemination of critical and timely public health information to the media, general public, vulnerable populations, public health staff and stakeholders and partners as required.
- Opportunity for dialogue and information sharing on public health issues related to the G8/G20 Summits between public health and key stakeholders and partners.
- Communications activities are underpinned by the following principles:

- Dissemination of information should be timely and transparent in order to build public trust and confidence.
- Key messages should be clear and consistent.
- In a health crisis situation, people need accurate, clear, succinct information about how to protect their health and the health of others.
- Information presented should minimize speculation and misinterpretation.
- Rumours, myths and misconceptions need to be dealt with immediately.
- Systems are in place to track and respond to media and public inquiries.

COMMUNICATION LEVELS

There are three levels of public health communications that must be planned for this event. It is essential that a coordinated approach to communication systems and processes be planned within and between all three levels.

COMPONENT	PROVINCIAL	REGIONAL/MUNICIPAL	LOCAL
Jurisdiction	Ontario	District of Muskoka/Town of Huntsville City of Toronto	Huntsville Toronto
Public Health Lead	Provincial G8 Public Health Subcommittee – Communications Work Group	Simcoe Muskoka District Health Unit (SMDHU) Toronto Public Health (TPH)	SMDHU TPH
Communications Team	Communications Leads from: • SMDHU • TPH • Peel Public Health • MOHLTC	Communications Leads from: • Simcoe Muskoka District HU • District of Muskoka - EOC • Town of Huntsville • TPH • City of Toronto	• MOH (or designate) • Director, Corporate Service • Health Promotion Specialist, Corporate Service • Media Coordinator
Primary Activities and Responsibilities	• Communicate with Ontario public health units – pre, during and post event. • Communicate with federal contacts. • Coordinate communication systems and processes with provincial partners and federal counterparts. • Develop provincial public health communications framework. • Develop processes for approvals and key spokespeople. • Clarify media relations and management systems and processes. • Discuss development and dissemination of key public health messages.	• Develop regional public health communications plan, including crisis communication plan, that reflects the provincial public health communications framework. • Develop processes for approvals and key spokespeople. • Clarify media relations and management systems and processes. • Coordinate key public health message development and dissemination to targeted audiences in specific health unit jurisdictions.	• Develop health unit public health communications plan, including crisis communication plan, that reflects the provincial public health communications framework. • Disseminate key messages to public and other targeted audiences in G8/G20 affected areas (Huntsville and Toronto and surrounding areas). • Communicate to SMDHU and TPH staff and boards. • Ensure communication systems and processes are in place for agency communication response. • Develop agency processes for approvals and key spokespeople. • Clarify media relations and management systems and processes.

COMMUNICATIONS STAGING PERIODS

There are four designated periods in which public health communications will be staged:

1. Early Pre-event – 1 August 2009 to 31 March 2010
2. Late Pre-event – 1 April 2010 to 23 June 2010
3. Event – 24-27 June 2010
4. Post-event – 28 June to 4 July 2010

The chart below provides suggested key communication activities within these stages:

STAGING PERIOD	PROVINCIAL	REGIONAL/MUNICIPAL	LOCAL
Early Pre-event (1 August 2009 to 31 March 2010)	• Form Public Health Communications Work Group of Provincial G8/G20 Public Health Subcommittee. • Develop public health communications plan in collaboration with partners/ stakeholders, including federal counterparts. • Create crisis communications plan in collaboration with partners/ stakeholders. • Communicate G8/G20 planning structure and processes to all health units in province. • Establish contact with communication leads of key partners and stakeholders. • Initiate coordination of communication processes and systems. • Initiate key public health message development. • Partake in table-top exercise (Dec 7-11). • Plan for required staffs training needs related to communications. • Plan for G8/G20 accreditation for required communication staffs. • Clarify media relations/key contacts/ spokespeople/ approval processes.	• Establish contact with communication leads of key partners and stakeholders. • Prepare communication components of EOC operations with SMDHU & TPH. • Partake in table-top exercise (Dec 7-11). • Develop public health communications plan in collaboration with public health and other relevant partners/ stakeholders, including federal counterparts. • Create crisis communications plan in collaboration with public health and other relevant partners/ stakeholders. • Plan for required staffs training needs related to communications. • Plan for G8/G20 accreditation for required communication staffs. • Clarify media relations/key contacts/ spokespeople/ approval processes.	• Develop health unit communications plan in collaboration with partners/stakeholders. • Create crisis communications plan in collaboration with partners/stakeholders. • Establish contact with communication leads of key partners/stakeholders. • Partake in table-top exercise (Dec 7-11). • Plan for required staff training needs related to communications. • Plan for G8/G20 accreditation for required communication staffs. • Clarify media relations/key contacts/spokespeople/ approval processes.
Late Pre-event (1 April 2010 to 23 June 2010)	• Have key messages finalized and prepared. • Have all communications	• Have EOC communications systems readied.	• Develop all necessary resources and templates. • Have all communication

	systems and processes in place and tested. • Partake in table-top exercise (Apr 12-14). • Have all pre-event key messages disseminated. • Monitor and track media activity, public inquiries, feedback and response of issues and concerns. • Ready spokespeople.	• Partake in table-top exercise (Apr 12-14). • Have all pre-event key messages disseminated. • Monitor and track media activity, public inquiries, feedback and response of issues and concerns. • Ready spokespeople.	systems and processes in place and tested. • Partake in table-top exercise (Apr 12-14). • Have all pre-event key messages disseminated. • Monitor and track media activity, public inquiries, feedback and response of issues and concerns. • Ready spokespeople.
Event (24-27 June 2010)	• Disseminate key messages as required. • Partake in press conferences as required. • Implement crisis communication plan if required. • Monitor and track media activity, public inquiries, feedback and response of issues and concerns.	• Disseminate key messages as require. • Partake in press conferences as required. • Implement crisis communication plan if required. • Monitor and track media activity, public inquiries, feedback and response of issues and concerns.	• Disseminate key messages as required. • Partake in press conferences as required. • Implement crisis communication plan if required. • Monitor and track media activity, public inquiries, feedback and response of issues and concerns.
Post-event (28 June to 4 July 2010)	• Debrief communication activities and structures.	• Debrief communication activities and structures.	• Commence evaluation of communications plan. • Debrief communication activities and structures.

TARGET AUDIENCES and COMMUNICATION CHANNELS

Public health communications and information will be targeted at a variety of different audiences. Key message dissemination and the mechanisms for the delivery of public health information to specific audiences will be the responsibility of the three different levels identified in this framework. The chart below provides a general overview of key audiences, their information requirements and potential channels/vehicles for information delivery.

AUDIENCE	INFORMATION REQUIREMENTS	CHANNELS/VEHICLES
General Public • Residents of area (full time & seasonal). • Visitors to area (tourists). • Protestors & activists.	• Current and timely information pertaining to issues of public health concern (routine and emergency) before, during and after the event. • Reassurance that public health systems/measures are in place for routine matters and potential public health emergencies. • What public health services will be impacted by the event. • Points of access for information (where you go for what information). • Systems for transferring information (referrals, etc.).	• The media. • Distribution of resources (pamphlets, fact sheets, notices). • Internet. • E-mail. • Information centres. • Telephone system (pre-recorded messages). • Public information sessions. • Newspaper ads/inserts. • PSAs. • Call-in shows. • Radio advertising. • Public announcements at public events. • Social media (videos, blogs, wikis, etc.). • Posters, banners. • Text messaging.
Vulnerable Populations • Seniors • Homeless • Others?	• Current and timely information pertaining to issues of public health concern (routine and emergency) before, during and after the event. • Reassurance that public health systems/measures are in place for routine matters and potential public health emergencies. • What public health services will be impacted by the event. • Points of access for information (where you go for what information). • Systems for transferring information.	• The media. • One-to-one contact. • Mobile/outreach services. • Home visits. • Distribution of resources. • Telephone calls. • Posters, banners.
Media	• Current, accurate and timely information on all issues of public health importance.	• Regular press releases. • PSAs. • One-on-one interviews with spokespeople. • Press conferences. • Taped television/radio shows. • Local health unit web sites. • Provincial website. • Social media (videos, blogs, wikis, etc.). • Seminars. • Text messaging.

Public Health Stakeholders • Ontario Public Health Units - board & staff • MOHLTC • OAHPP • PHAC	• Current, accurate and timely information on all issues related to public health operations, systems and processes. • Impacts of G8/G20 event on public health resources/staffing. • Coordination of planning for a public health response to the G8/G20 event. • Use of normal strategies for communication. • Points of access of information. • Systems for transferring information.	• Email. • Internet, websites & portals. • Faxes. • Meetings. • Teleconferences. • Social media (videos, blogs, wikis, etc.). • Electronic newsletter & discussion boards. • Resources. • Webinars, training events, seminars.
Other Partners & Stakeholders • Town of Huntsville/District of Muskoka/other local municipalities • County of Simcoe • City of Toronto • Pertinent federal departments • Pertinent provincial ministries • Pertinent G8/G20-related committees • Police (OPP, Toronto Police Services, RCMP, military) • Local fire/ambulance • Local hospitals • Local physicians • Local social service/health agencies • NGOs (i.e. Red Cross, St. John's Ambulance, etc.) • School boards • Businesses/workplaces • Chambers of commerce/Business Improvement Areas • Campgrounds • Summer camps • Resorts • Summit venues	• Detailed, up-to-date information on G8/G20 event status/ statistics/surveillance/risk assessments, MOH/ MOHLTC public health directives, systems and procedures, public health measures.	• Email. • Internet, websites & portals. • Faxes. • Meetings, teleconferences. • Social media (videos, blogs, wikis, etc.). • Electronic newsletter & discussion boards. • Resources. • Webinars, training events, seminars.

MEDIA RELATIONS

PRESS RELEASES

As per process identified in each public health agency's communications plan.

Joint Release: on as needed basis – with direction from MOHLTC.

JOINT MEDIA CENTRE(s)

To be determined by each health unit with their EOCs and other pertinent partners and identified in each agency's communications plan.

PRESS CONFERENCES

As per process identified in each public health agency's communication plan.

PUBLIC HEALTH EMERGENCY RESPONSE COMMUNICATIONS (channels to use with partners)

A) Emergency Meetings.
B) Tele/video conferencing – as per communication clocks.
C) Website – local health units & MOHLTC.
D) White board communications/portals.
E) Notices (multi-media).

COMMUNICATION DISTRIBUTION (who it goes out to and how)

A) Provincial Public Health Subcommittee membership – Access to website.
B) Other key partners and stakeholders - Access to website.
C) Email distribution – communication contact list.
D) Other?

INFORMATION SOURCES (CENTRES, PHONE & WEBSITE)

A) Call Centers:
    i) SMDHU: 1-877-721-7520 or 721-7520 (Health Connection)
    ii) District of Muskoka
    iii) TPH
    iv) City of Toronto
    v) MOHLTC
    - To publicize call center #'s for public inquiry.

- To communicate “Key Messages”.
- To refer callers to specific municipalities and/or organizations as required.

B) Local Municipal Information Centers:

- To provide contact information for ALL municipal information centers.

C) Public Health Communication Contacts:

- Established contact information for each public health unit (communication representative/public inquiries).

D) Web Site Communication:

- G8/G20 planning framewor..
- Membership contact information.
- Repository for related information (policies, publications, tools, etc.).
- Links to SMDHU, TPH, MOHLTC & other related websites.
- GIS emergency database (E-Map).
- Portal/white board communications.

IDENTIFIED PUBLIC HEALTH ISSUES AND KEY MESSAGES

PUBLIC HEALTH ISSUE	KEY MESSAGES	AUDIENCE
Environmental/weather (extreme heat, severe storms, lightning strikes, tornadoes).	To be developed	
Food related hazards (food recalls, food adulteration, food poisonings, gastro-illness).		
Water related hazards (water system malfunction/disruption, water contamination).		
Infectious & contagious diseases (respiratory illness, asthma, influenza, etc.).		
Critical infrastructure failures (electricity & natural gas disruption, telecommunications, sewage & water treatment disruption, road closures).		
Hazardous material incidents (chemical, nuclear, radiological, chemical spills, transportation, terrorist).		
Bioterrorist events (biological agent).		

Public safety/injury hazards (alcohol, drug, sun safety, sprains/fractures, heat, dehydration, medication).		

EVALUATION OF G8/G20 PUBLIC HEALTH COMMUNICATION PLANS

It is important that proper evaluation is conducted of each communication plan developed through this framework, including formative, process, impact and outcome components. The evaluation ideally will include:

- Tracking of all media-related occurrences:
  - Number of press conferences.
  - Number of releases and PSAs released and published/broadcast
  - Number of interview requests.

- Tracking of all public enquiries:
  - Number of calls to *Health Connection*, number of calls to information centres.
  - Number of website hits (health unit, MOHLTC).
  - Number of email enquiries (*Health Connection*).

- Tracking of partner-related communications:
  - Number of those participating in meetings/teleconferences/videoconferences.
  - Number of postings to porta.l

These evaluations will be shared amongst groups and may be compiled into one final evaluation report for the province.

Prepared by Megan Williams, Health Promotion Specialist
Simcoe Muskoka District Health Unit

APPENDIX 5: MUTUAL ASSISTANCE AGREEMENT TEMPLATE

THIS MUTUAL AID AGREEMENT made this day of , 20__

BETWEEN:

INSERT NAME OF HEALTH UNIT

OF THE FIRST PART

- and -

(NTD: INSERT NAME OF OTHER PARTY)

OF THE SECOND PART

WHEREAS the parties wish to provide for mutual aid and assistance to each other through the provision of personnel, services, equipment or materials to one or the other in a time of an Emergency.

Comment [s1]: Consider adding and the support of Large Scale Incident Response

NOW THEREFORE in consideration of the mutual covenants herein contained, the parties agree as follows:

1. Definitions

1.1 In this Agreement,

1.1.1 "Assisted Public Health Unit" means the Public Health Unit receiving aid or assistance pursuant to this Agreement;

1.1.2 "Assisting Public Health Unit" means the Public Health Unit providing aid or assistance pursuant to this Agreement;

1.1.3 "Emergency" means an event arising from forces of nature, disease outbreak, an accident, intentional act or technological hazards that constitute a danger of major proportion to life or property.

1.1.4 "Emergency Control Group" means the organization's team or group responsible for directing and controlling the Assisted Public Health Unit's response to an Emergency.

1.1.5 "Medical Officer of Health" means the person appointed by a Board of Health under s. 62 of the *Health Protection and Promotion Act.*

1.1.6 "Mutual Aid Agreement" means this Agreement and the attached Schedule(s) which embody the entire Agreement between the parties;

1.1.7 "Public Health Unit" means a public health unit defined in Ontario Regulation 553 under the *Health Protection and Promotion Act.*

1.1.8 "Requesting Party" means the Public Health Unit asking for aid, assistance or both pursuant to this Agreement;

2 Authorization to Request/Offer Assistance

2.1 Each party hereby authorizes its Medical Officer of Health ("MOH") to request assistance, accept offers to provide, or to offer to provide assistance pursuant to this Agreement on behalf of that party.

3 Requests for Assistance

3.1 The parties agree that in an Emergency, a Requesting Party may request assistance in the form of qualified personnel, services, equipment, or material from the other party.

3.2 The request for assistance shall be made, in writing, by the MOH of the Requesting Party to the MOH of the other party.

3.3 The written request shall set out in detail the specific personnel, services, equipment or material that has been requested as assistance.

3.4 The MOH may make the initial request for assistance orally. However, any request for assistance made orally shall be confirmed in writing by the Requesting Party within 3 days of the initial oral request.

3.5 The Assisting Public Health Unit may provide assistance to the other party upon receipt of the oral request.

3.6 The request for assistance shall be confirmed in writing by the Requesting Party in accordance with Schedule "A" attached hereto.

3.7 The Assisting Public Health Unit may request such reasonable additional information from the Requesting Party as it considers necessary to confirm the existence of the Emergency and to assess the type, scope, nature and amount of assistance to be provided.

3.8 The Assisting Public Health Unit shall respond to the request within 1 day, and may, in its sole discretion, determine the type and scope, nature and amount of assistance it will provide.

3.9 The Assisting Public Health Unit shall confirm in writing the assistance it has agreed to provide.

3.10 The parties may, by mutual agreement, amend the scope, type, nature or amount of assistance to be provided to the Assisted Public Heath Unit under this Agreement. Such amendments shall be confirmed in writing by the Requesting Party within 3 days of being agreed upon.

4 Limitations on Assistance Provided

4.1 Nothing in this Agreement shall require or obligate or be construed to require or obligate a party to provide assistance. Each party shall retain the right to refuse the request to provide assistance, and the right to offer alternatives to the assistance that has been requested.

4.2 No liability shall arise against the Assisting Public Health Unit if it fails, for any reason whatsoever, to respond to a request for assistance made under this Agreement.

4.3 When assistance has been offered or provided by the Assisting Public Health Unit, the Assisting Public Health Unit shall not be obligated to provide any further assistance or to do anything or take any action beyond that which is specifically agreed to by the acceptance of the request for assistance.

4.4 Nothing in this Agreement shall prevent the Assisting Public Health Unit, in its sole discretion, from withdrawing any or all assistance provided to the Assisted Public Health Unit. Any withdrawal of assistance by the Assisting Public Health Unit shall be made only upon at least 48 hours notice to the Assisted Public Health Unit, unless the Assisting Public Health Unit is responding to an actual or pending Emergency within its own geographical boundaries, in which case it may withdraw assistance from the Assisted Public Health Unit without notice.

4.5 The Assisted Public Health Unit may determine in its sole discretion that its requirement for assistance has ceased and shall notify the Assisting Public Health Unit of this in writing.

4.6 Nothing in this Agreement affects a Public Health Unit's statutory responsibilities under the *Health Protection and Promotion Act*, its regulations, and the Ontario Public Health Standards.

5 Term and Termination

5.1 This Agreement shall be in effect from the date on which the second Party signs the Agreement.

5.2 Despite any other section of this Agreement, either party may terminate this Agreement upon at least 60 days' written notice to the other parties.

6 Costs

6.1 Unless otherwise agreed upon, in writing, between the parties, each Public Health Unit shall be responsible for all of the costs incurred by it, whether or not the costs are incurred for the purpose of assisting the Assisted Public Health Unit.

6.2 The costs in section 6.1 above include direct and indirect costs for personnel, services, equipment, machinery or material furnished, including but not limited to costs of fuel, repairs, parts and any an all other items directly or indirectly attributable to the operation of equipment and machinery, services and material furnished as assistance to the Assisted Public Health Unit under this Agreement.

6.3 The costs referred to in paragraph 6.1 above shall also include all wages, salaries, overtime, shift premium, Canada Pension Plan, Employment Insurance, OMERS contributions, and/or contributions made to life insurance, health, dental and/or disability plans or policies, and similar charges and expenses incurred in providing the assistance including those wages, salaries, overtime and shift premium charges incurred resulting from staffing requirements in its home jurisdiction during the period of the assistance.

6.4 The Assisting Public Health Unit shall remain responsible for all statutorily required deductions, contributions and/or payments, such as Employment Insurance, Canada Pension Plan etc.

7 Employment Relationship

7.1 Despite that the employees, contractors, servants and agents (collectively "the workers") of the Assisting Public Health Unit may be assigned to perform duties for the Assisted Public Health Unit, the workers of the Assisting Public Health Unit shall retain their employment or contractual relationship with the Assisting Public Health Unit. The parties acknowledge and agree that the Assisted Public Health Unit is not to be deemed the employer of the Assisting Public Health Unit's employees, contractors, servants or agents, under any circumstances or for any purpose whatsoever.

8 Powers and Rights

8.1 Unless otherwise specified, the Assisted Public Health Unit shall afford to the personnel of the Assisting Public Health Unit, operating within the Assisted Public Health Unit's jurisdiction, the same powers and rights as are afforded to like personnel of the Assisted Public Health Unit.

9 Indemnity

9.1 The Assisted Public Health Unit shall indemnify and save harmless the Assisting Public Health Unit from all claims, costs, all manner of action or actions, cause and causes of action, accounts, covenants, contracts, demands or other proceedings of every kind or nature whatsoever at law or in equity arising out of this Agreement and out of assistance provided pursuant to this Agreement. The indemnity herein provided shall include all costs, including but not limited to duties, dues accounts, demands, penalties, fines and fees.

10 Insurance

10.1 During the term of this Agreement, each party shall obtain and maintain in full force and effect, general liability insurance issued by an insurance company authorized by law to carry on business in the Province of Ontario, providing for, without limitation, coverage for personal injury, public liability and property damage. Such policy shall:

10.1.1 Have inclusive limits of not less than Five Million Dollars for injury, loss or damage resulting from any one occurance;

10.1.2 Contain a cross-liability clause endorsement and severability of interests clause of standard wording;

10.1.3 Name the other party as an additional insured with respect to any claim arising out of the Assisted Public Health Unit's obligations under this Agreement or the Assisting Public Health Unit's provision of personnel, services, equipment or material pursuant to this Agreement; and

10.1.4 Upon request of the other party, provide proof of insurance if so required in a form satisfactory to the other party's MOH.

10.1.5 Include a Non-Owned Automobile endorsement.

10.2 During the term of this Agreement, each party shall obtain and maintain in full force and effect, automobile liability insurance in the amount of Five Million Dollars for injury, loss or damage resulting from any one occurrence.

10.3 In the case of any conflict between the provisions of this document and any other provisions speaking to contractual indemnity or insurance clauses, the provisions of this Agreement will govern.

11 Collective Agreements

11.1 Each Party agrees to review the provisions of this Agreement with its appropriate local bargaining units for the purpose of seeking amendments to the local agreements, if necessary, to reflect the terms of this Agreement. Each party further agrees to advise the other party as soon as practically possible if it becomes aware of any impediments or obstacles imposed by local agreements to meeting its obligations under this Agreement.

12 Liaison and Supervision

12.1 The Assisting Public Health Unit shall have the right, to be exercised in its sole discretion, to assign an employee or agent (the "Liaison Officer") of the Assisting Public Health Unit to the Emergency Contol Group of the Assisted Public Health Unit. The Liaison Officer shall provide a liaison between the Assisting Public Health Unit and the Emergency Control Group of the Assisted Public Health Unit.

12.2 The parties acknowledge that the purpose of the Liaison Officer shall be to permit communication between the Assisted and the Assisting Public Health Units. Subject to the *Freedom of Information and Protection of Privacy Act,* the Liaison Officer shall be permitted to inform the Assisting Public Health Unit on the status of the Emergency and the actions taken by the Assisted Pubic Health Unit.

12.3 The Liaison Officer shall have the right to obtain information about the Emergency and the use of the assistance provided in order to report to the Assisting Public Health Unit during and after the duration of the assistance provided and the Emergency.

12.4 The Assisting Public Health Unit shall keep confidential and not disclose any information concerning the Emergency or the assistance provided without the prior consent of the Assisted Public Health Unit.

12.5 The Assisting Public Health Unit shall assign its personnel to perform tasks as directed by the Emergency Control Group of the Assisted Public Health Unit. The Assisting Public Health Unit shall have the right to assign supervisory personnel to operate or supervise the operation of any of the Assisting Public Health Unit's personnel and or equipment furnished as assistance to the Assisted Public Health Unit. Such supervision shall be in accordance with the instructions of the Emergency Control Group.

13 Information Sharing

13.1 Subject to the *Freedom of Information and Protection of Privacy Act*, the parties agree to share with each other, information lists or databases detailing the amount, type, capability, and characteristics of personnel, services, equipment or material in possession of each party, which may be available to the Requesting Party under this Agreement. Such sharing of information shall occur upon the execution of this Agreement and the parties, on mutual agreement, shall update these information lists from time to time.

14 Notice

14.1 If not otherwise provided in this Agreement, written notice given pursuant to this Agreement must be addressed,

in the case of notice to ---------- Health Unit, to:

The Medical Officer of Health
(Public Health Unit)
(address)
(city), Ontario
(postal code)
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-and-

in the case of notice to (INSERT NAME OF PARTY), to:

The Medical Officer of Health
(Public Health Unit)
(address)
(city), Ontario
(postal code)

14.2 If hand delivered, the notice is effective on the date of delivery; if faxed, the notice is effective on the date and time the fax is sent; if sent by electronic mail, the notice is effective on the date sent; and if mailed, the notice is deemed to be effective on the fifth business day following the day of mailing.

14.3 Any notice given shall be sufficiently given if signed by the MOH or by a person authorized by or acting under the direction or control of the MOH.

15 Rights and Remedies

15.1 Nothing contained in this Agreement shall be construed as restricting or preventing either party from relying on any right or remedy otherwise available to it under this Agreement, at law, or in equity in the event of any breach of this Agreement.

16 Binding Effect

16.1 This Agreement shall ensure to the benefit of, and be binding upon the parties and their respective successors, administrators, and assigns.

16.2 This Agreement shall not be construed as or deemed to be an agreement for the benefit of any third parties, and not third party shall have any right of action arising in any way or manner under this Agreement for any cause whatsoever.

17 Incorporation of Schedules

17.1 This Agreement and the attached Schedule "A" embody the entire Agreement and supersede any other understanding or agreement, collateral, oral or otherwise, existing between the parties prior to or at the date of execution

18 Provisions Surviving Termination

18.1 Sections 4.2, 6, 7, 9, 10, 14, 15, 18, 19 and 20 of this Agreement shall survive termination of this Agreement.

19 Governing Law

19.1 The parties agree to be governed by the laws of the Province of Ontario and Canada.

20 Arbitration

20.1 The Parties herein agree that in the event of any dispute arising under or pursuant to this Agreement, which dispute cannot be resolved by the mutual agreement of the Parties' MOHs, the MOHs shall refer the dispute to the respective Chairs of the Boards of Health of the parties for resolution. In the event that the Boards of Health cannot resolve the dispute, either party may, on providing 90 days' written notice to the other, refer the dispute to a third party arbitrator of their mutual choice for resolution. Such arbitration shall be conducted pursuant to the *Arbitration Act*, 1991, S.O. 1991 c. 17, as amended.

IN WITNESS WHEREOF the parties have executed this Agreement.

SIGNED SEALED AND DELIVERED In the presence of	)	**THE SIMCOE MUSKOKA DISTRICT HEALTH UNIT**
_____ Witness	)	_____ Chair
	)	_____ Vice Chair
_____ Witness	)	**(INSERT NAME OF THE OTHE PARTY**) _____ Chair
	)	_____ Vice Chair

SCHEDULE “A”

Mutual Aid Agreement

I, _____, Medical Officer of Health of the _____, duly authorized to do so by the Board of Health of _____, do hereby request of the _____, to provide assistance in the form of:

___ PERSONNEL
___ SERVICES
___ EQUIPMENT
___ MATERIAL

AS IS MORE PARTICULARLY SET OUT IN DETAIL AS FOLLOWS:

The above confirms the assistance verbally requested on _____, and which assistance _____ ___ has agreed to provide.

Dated at _____ this _____ day of _____, ___.

_____
Medical Officer of Health of

REFERENCES

[i] Halton Region Health Department. Halton region pandemic influenza response plan: a toolkit for business continuity. 2006. Available from: URL: http://www.halton.ca/Pandemic%20Influenza%20Response%20Plan.pdf

[ii] IBID

[iii] Griffiths M. Coordination of the provincial emergency response to an influenza pandemic. Ontario Association of Law Enforcement Planners, editor. April 19, 2006.

[iv] Ministry of Health & Long-Term Care. Ontario Health Plan for an Influenza Pandemic. 2008. Available from: URL: http://www.health.gov.on.ca/english/providers/program/emu/pan_flu/pan_flu_plan.html

[v] Emergency Management Workbook; A tool for Emergency Management Practitioners, Emergency Management Ontario, FEBRUARY 2006, Page 29