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1.0 PREAMBLE TO BC COMMUNICABLE DISEASE CONTROL MANUAL[1]

This manual contains guidelines that have been developed by BC public health practitioners with representatives from the following groups (as appropriate): Office of the Provincial Health Officer (PHO); BC Centre for Disease Control (BCCDC); each health authority Medical Health Officers (MHOs), Public Health Nurses, Environmental Health Officers (EHOs), Infection Prevention and Control Professionals; and First Nations Health Authority (FNHA); experts in the field and others as thought necessary to review the evidence and to make recommendations about a course of action.

The purposes of these guidelines are to assist public health practitioners with decision making about specific situations, and to support consistency of provincial public health practice. Professional judgment and discretion in the application of these guidelines for decision making is necessary for specific situations.

As advances in scientific knowledge and health care practices become available, these guidelines will be routinely reviewed and updated. Although the guidelines will be updated periodically, practitioners must take responsibility to ensure they have the most recent knowledge and are using the most recent guidelines relating to the situation with which they are dealing.

These guidelines support the implementation of communicable disease control and prevention programs in BC, and the exercise of powers and duties that public health practitioners have pursuant to the *Public Health Act*, SBC 2008, c.28 (PHA)[2] and related legislation. For example, this includes such legislative issues as mandatory reporting of communicable diseases and related matters (PHA section 10 and the Communicable Disease Regulation) and the Communicable Disease Regulation); issuing of orders to people who may be infected or to deal with a health hazard (PHA sections 27-33); responding to communicable disease related public health emergencies (PHA sections 51-57); and applying for warrants, injunctions, and court orders (PHA sections 47-49).

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[1] Communicable Disease Control Manual, current version available at: http://www.bccdc.ca/health-professionals/clinical-resources/communicable-disease-control-manual

[2] The *Public Health Act* is available at: http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_08028_01

In addition to MHO general responsibilities to prevent and control communicable diseases, they have specific statutory responsibilities to determine public health threats and to direct the response to local public health threats (PHA section 81).

The MHO may give directions to deal with public health threats that vary from these guidelines, based on an assessment of a particular case or situation and their professional judgment, and as per the Protocol for Guidance about Emerging or Unusual Situations and for Varying from Existing Guidelines.

These guidelines are not legal advice and individuals should consult with their legal counsel in determining if and to what extent the PHA may apply to a particular circumstance. If there is a conflict between the guidelines and the PHA, its regulations or related legislation, the guidelines are superseded by the PHA and any of its regulations.

2.0 PROTOCOL FOR GUIDANCE ABOUT EMERGING OR UNUSUAL SITUATIONS AND FOR VARYING FROM EXISTING GUIDELINES

While the guidelines in this manual cover many situations, in practice it is not uncommon to deal with situations that are newly emerging, situations for which guidelines do not exist, or specific circumstances in which it may be appropriate to take actions that vary from these or other guidelines. The purpose of this protocol is to assist in decision making regarding these situations.

Once an MHO identifies an emerging or unusual situation with provincial implications or that warrants a significant variation from these guidelines, there must be consultation with the PHO as soon as possible. Depending on the practicality, urgency, and extent of the situation, the MHO should have a discussion with the PHO to outline the situation, list what is known and what is important but unknown, and discuss ways and means to get as much of the important missing information as possible. It would be beneficial, if time permits, for the PHO to be advised in writing about the situation and the recommended variation from guidelines, if applicable, in company with evidence and the rationale for the variation.

Significant variation from these guidelines as identified by an MHO may be necessary due to an unanticipated or unique local situation, change in the epidemiology of a disease, emergence of new evidence, particular characteristics of the population affected or at risk, or for other reasons. A significant variation from the guidelines is one which could have province wide implications; could result in confusion by other professionals, political leaders, or the public; or could result in large scale resource implications.

Although varying from provincial guidelines may be entirely appropriate to deal with local and/or individual situations, it is possible that public, professional, and political confidence in the delivery of public health services can be undermined by significant and/or ongoing inconsistencies in public health practice that are not based on justifiable variation.

The PHO may convene a discussion to assist in decision making about an emerging situation or a proposed variation from the guidelines that could include representatives of MHOs, Public Health Nurses, and EHOs from other health authorities; the BCCDC; FNHA; content experts and others as necessary to review the situation, seek consensus, and make recommendations about the course of action.

Once a decision is made about how to deal with an emerging or unusual situation or vary from an existing guideline, the decision or variation from the guideline and other details for dealing with the situation will be communicated in writing.

If appropriate, the decision will subsequently be finalized through the guideline approval process of the Communicable Disease Policy Advisory Committee (CDPAC).

If a consensus decision for dealing with a situation or a proposed variation of an existing guideline cannot be reached the PHO may, pursuant to the PHA section 68 (1), establish in writing a particular course of action as a standard of MHO practice. If appropriate, the BCCDC will update the Communicable Disease Control Manual to identify the PHO decision as a standard of practice for MHOs.

Under the PHA section 81, the MHO remains responsible for directing the local response to public health threats.

3.0 CHANGING THE REPORTABILITY OF A COMMUNICABLE DISEASE UNDER THE *PUBLIC HEALTH ACT* IN BRITISH COLUMBIA

3.1 Introduction & Purpose

- Mandatory reporting is a key public health strategy to formally require the submission of information to public health officials for assessing patterns and trends of communicable diseases over time, detecting outbreaks, and assisting in the planning and evaluation of disease control programs.

- This section describes a typical pathway by which recommendations for changing the reportability status of a communicable disease come forward from CDPAC for review and action by government.
- The material in this document does not affect the authority of an MHO in relation to reporting of diseases, hazards and other matters as described in the PHA and other enactments.

3.2 Authority for Mandatory Reporting Under the *Public Health Act*

- The PHA provides the legislative authority for enacting mandatory reporting in BC.
- Certain communicable diseases must be reported to regional MHOs as well as the PHO. A current list of reportable communicable diseases in BC can be found in the Schedule of the Reporting Information Affecting Public Health Regulation.[3]
- Section 113 of the PHA enables the Lieutenant Governor to make regulations prescribing the making of reports, actions that must be taken in respect of a matter that must be reported, and diseases, health hazards and other matters that must be reported.
- The Reporting Information Affecting Public Health Regulation details the duty to report communicable diseases, specifies who must report information, and outlines the responsibilities of health officials when they receive a report.
- In urgent or emergency circumstances, the PHO can issue an order requiring the reporting of a communicable disease or health hazard to public health officials for a limited period of time (PHA s. 57, Reporting Information Affecting Public Health Regulation, s. 9). Changing the long-term reportability status of a condition in BC, however, requires amending the Reporting Information Affecting Public Health Regulation.
- A summary of the responsibilities and roles of CDPAC, PHO, BCCDC, and BC Ministry of Health is provided in Table 1.

[3] Reporting Information Affecting Public Health Regulation: https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/167_2018#Schedule

Table 1: Roles and Responsibilities of CDPAC, PHO, Ministry of Health, and BCCDC

	CDPAC	PHO	ADM, Ministry of Health PPH	BCCDC
Role/Mandate	Provide recommendations to the PHO and Ministry of Health concerning which communicable diseases should be reportable.	Provide recommendations to or endorse recommendations made by CDPAC related to the mandatory reporting of communicable diseases. Review policy recommendations brought forward from CDPAC. Support the process of developing regulations resulting from CDPAC recommendations, as needed.	Lead Ministry of Health processes to draft and seek formal government approval for regulatory changes under the PHA related to reporting of communicable diseases.	Support the work of CDPAC. Support the consultation and implementation processes, as needed.
Responsibilities	Provide scientific and operational rationale pertaining to the mandatory reporting of communicable diseases (see Appendix A/B).	Advise the Minister/ADM on the need for legislation, policies, and practices with respect to CDPAC recommendations. Provide advice concerning the implementation of regulatory changes.	Advise the Minister of Health on the need for legislation, policies, and practices. Play a leading role in the process of developing communicable disease reporting regulations and meeting all stakeholder engagement requirements. Work with Ministry of Health Legislation Branch to draft updated regulatory wording and related supporting documents.	Implement and evaluate the regulatory change as per step 5.

3.3 Regulatory Amendment Process

In the routine course of ongoing monitoring, assessing, and managing communicable diseases in BC, requests for changing the reportability of communicable diseases under the PHA are routinely brought forward from CDPAC, a provincial table of subject matter experts and leaders that includes representation from all health authorities, FNHA, the BCCDC, the Office of the PHO, and the Ministry of Health.

The key steps involved in the amendment process include:

1. Preparation of the proposal.
    - Conducting an epidemiological and public health assessment.
    - Drafting a briefing note for CDPAC.
        - Content to include in CDPAC briefing note is outlined in Appendix A.
        - The briefing notes should utilize the criteria provided in Appendix B to justify the rationale for changing the reporting status of a particular communicable disease.
        - Proposals for reportability changes from any source will be considered, however, at least one member of CDPAC must be involved in preparing the proposal and briefing note. That CDPAC member is responsible for bringing the proposal forward as an agenda item for CDPAC.
    - Following approval by CDPAC, a formal notification of the recommendation and accompanying briefing note is made by CDPAC chairs to the PHO and the Assistant Deputy Minister (ADM) of Population and Public Health (PPH) at the BC Ministry of Health. The PHO and the ADM will endeavor to acknowledge receipt of the recommendation as quickly as possible.
    - The ADM and PHO will confer about who will take the recommendation forward for consideration by the Minister of Health. Generally, the administrative escalation of the recommendation will be done by the ADM, working in close partnership with the PHO.

2. Approval by Ministry of Health to proceed.
    - Ministry PPH staff will draft a decision briefing note for government on the proposed regulatory change(s).
    - Depending on the nature of the proposed change (major/substantive/large health system implications or minor/technical/administrative), approval to proceed may lie with the Minister of Health or may be officially delegated within the Ministry of Health.

3. Development of the regulation amendment.
   - Designation of Lead
     - The ADM will identify the lead within the Ministry PPH team for working on the regulatory change. This information will be communicated to the chairs of CDPAC.
     - The drafting of the amendment to the Schedule of the regulation will be overseen by staff in the Ministry of Health's Legislation Branch.
     - The Ministry PPH lead will provide updates at each CDPAC meeting on the progress towards completion of the proposed changes whenever it is possible and appropriate to do so.
   - Consultation and engagement process:
     - The Ministry PPH lead is responsible for the planning and implementation of the consultation.
     - The process may involve a subject matter expert to provide consultative support throughout.
     - The consultation process may involve health authorities, clinicians, laboratories, First Nations, Metis Nation, impacted groups, and other key partners.
     - The process will assist in finalizing the wording of the amending order and will form the basis for a "What We Heard" report.
     - The consultation and engagement process will inform the development of a communication plan.
   - Cabinet Approval
     - The Ministry of Health's Legislation Branch compiles a package of briefing notes and other supporting documents to support decision making.
     - The Minister of Health is responsible for bringing recommended changes to Cabinet for approval.
     - Subject to Cabinet approval, an Order in Council is deposited with the Registrar of Regulations.
     - The change is published in the British Columbia Gazette Part II, which provides the first public notification.
     - The order takes effect on the date of deposit, or an alternate date as specified in the order.
     - The Ministry PPH Lead will inform the PHO, CDPAC chairs, and health authorities of the approved amendment to the regulation and implement the communication plan.

4. Communication of the regulatory change:
   - The Ministry PPH lead will coordinate the development and implementation of a communication plan.
   - The communication plan will guide the dissemination of information about the regulatory change coming into force.
   - Implementing the communication plan is a responsibility shared by all parties.

5. Implementation and evaluation of the regulatory change:
   - BCCDC will create and/or update guidelines and resources (communicable disease control guidelines, case definitions, clinical practice guidelines).
   - BCCDC will develop and coordinate training for health professionals, laboratory staff, health authority staff, and other stakeholders on testing and reporting protocols for the newly reportable disease.
   - BCCDC and health authorities will collaborate to ensure that standards and protocols for provincial public health information systems are updated to reflect the addition or removal of a disease from the reportable list.
   - BCCDC will monitor the implementation of the regulatory change, evaluate its impact and report to the PHO and Ministry of Health as requested.

3.4 Timelines

- CDPAC chairs will notify the ADM and PHO of a decision to recommend adding or deleting a disease from the reportability list within 2 weeks of the date of the meeting where the decision was made.
- There are no pre-set timelines for a regulatory change. Numerous factors beyond the control of CDPAC, the PHO, and the Ministry of Health program areas may accelerate or extend the process and timeline.

APPENDIX A: POSSIBLE COMPONENTS OF BRIEFING NOTE/PROPOSAL FOR MAKING A COMMUNCIABLE DISEASE REPORTABLE/CHANGE REPORTABILITY STATUS

A CDPAC briefing note recommending modifications to existing reporting requirements, the addition to, or deletion of a disease from the reportable list should address the items from the list below, where applicable and appropriate.

1. What – the issue, information that is currently or will be reported/collected (personal, coded, anonymous, aggregate, additional info).
2. Why – the rationale for proposing modification of, addition to, or deletion from the list of reportable diseases (see Appendix B).
3. Who is obliged to report, and to whom (Section 3, Reporting Information Affecting Public Health Regulation)?
4. How – feasibility, process for data collection, and handling.
5. When – timelines for reporting and response.
6. Other options considered.
7. Jurisdictional scan.
8. Privacy protection considerations.
9. Barriers to implementation.
10. Policies and procedures that would be needed to support the recommended change.
11. Equity considerations (in particular United Nations Declaration on the Rights of Indigenous Peoples and reconciliation considerations).
12. Summary of consultations undertaken in preparing the briefing note.
13. Implementation, including identification of potential barriers and resource implications.
14. Proposed evaluation framework.

APPENDIX B: FRAMEWORK FOR PROPOSING CHANGES TO MANDATORY REPORTING[4]

Category	Details	Criteria
Diseases of Interest to Organizations to Inform Prevention and Regulatory Programs	This criterion addresses whether diseases are of interest to organizations, such as regulatory authorities, for disease surveillance data to inform prevention or regulatory programs.	0 no national/international regulatory/prevention program interest 1 interest to regulators and/or World Health Organization Department of Communicable Disease Surveillance and Response (but not internationally notifiable) 2 emerging disease - there is potential to develop national prevention programs if data available (and data would not otherwise be available and/or timely) 3 directly prevented though notification (otherwise recognition of a problem would not be timely enough for action).
Incidence in Canada (5-year Average incidence)	The 5-year average incidence divided into quartiles and "critical incidence", where just one case would be significant (e.g. Smallpox). Anchor points are based on maximum 5-year average rate of current notifiable diseases (data from reporting provinces/territories only).	0 no cases reported 1 more than 0 but less than or equal to 0.02/100,000 per year 2 more than 0.20 but less than or equal to 0.38/100,000 3 more than 0.38 but less than or equal to 5.62/100,000 4 more than 5.62/100,000 5 "critical incidence"
Severity	This criterion combines the formerly separate Morbidity, Mortality, and Case-Fatality Rate criteria. Available data will be collected and summarized to support the rating scheme. Informed expert opinion will be used to create and apply the scoring structure for this criterion.	1 short-term illness, and/or complete recovery in majority of cases, and/or case-fatality = 0% 2 short or longer-term illness, and/or lengthy recovery in some cases, and/or case-fatality = 0 to 1% 3 long term disability, and/or recovery rare, and/or death more likely, and/or case-fatality = 1 to 10% 4 severe illness, and/or death is most likely outcome, and/or case fatality = 10 to 100%
Communicability / Potential Spread to the	Based on efficiency of transmission from person to person, animal to human or food/water/environment to human	0 not communicable 1 low communicability 2 low-medium communicability 3 medium communicability

[4] Final report and recommendations from the National Notifiable Diseases Working Group. March 31, 2006 - Canada.ca

Category	Details	Criteria
General Population		4 highly communicable
Potential for Outbreaks	Based on ability to cause outbreaks. Consider size of outbreak and number of outbreaks.	0 no potential to cause outbreaks 1 at least one past outbreak documented in the literature 2 small infrequent outbreaks possible. Low transmissibility, low rate of exposure 3 large or frequent outbreaks possible. Readily transmissible, large proportion of the population is potentially exposed and susceptible 4 potential to cause large, widespread, ongoing, devastating outbreak. Very readily transmissible, long period of communicability, potential for widespread exposure, high level of susceptibility
Socioeconomic Burden	Diseases/conditions subjectively ranked considering costs to society associated with each case of disease including, immunization programs, long-term disability, non-hospital care, years of potential life lost.	1 low cost to heath care system, no disability 2 low to medium costs, disability rare to somewhat common 3 medium to high costs, disability more likely 4 high costs to health care system and severe disability
Preventability	Subjectively ranked, based on the efficacy (including risk/benefit) of available preventative measures including, but not restricted to vaccines.	0 no preventative measure 1 preventative measure available but low efficacy 2 preventative measure with moderate efficacy/high side effects 3 preventative measure with moderate efficacy/low side effects 4 preventative measure with high efficacy/low side effects
Risk Perception	Subjectively ranked, based on various aspects of perception of risk to personal health associated with having the disease, including: media attention, immediacy of the effect of disease, level of fear, unknown or unclear disease mechanism, dreaded versus familiar, affecting mainly children, “identifiable victims”, not controllable by the public. This criterion is not measuring public perception of the chance of acquiring the disease; this is ranked in the preventability and communicability criteria.	1 no to low perception of risk 2 low to medium perception of risk 3 medium to high perception of risk 4 high perception of risk/perceived ‘crisis’ situation when cases identified

Category	Details	Criteria
Necessity for Public Health Response	Subjectively ranked, based on the need and efficacy of a response by Public Health to prevent other cases of the disease, e.g. case and contact management.	0 not important for public health to know about a case 1 case reporting important for describing trends only 2 case reporting important for detecting outbreaks that require investigating 3 case reporting important to detect outbreaks of cases and investigate contacts that require immediate intervention to prevent fatalities or severe outcomes 4 a single case can be considered an outbreak and requires immediate follow-up
Appearing to Increase in Incidence or Change Patterns Over the Past Five Years	Subjectively ranked, based on how the disease appears to be emerging or is re-emerging, and whether the disease is anticipated to change or has ongoing change. Consider the following: newly appeared disease, unexpected/unusual event, changes in demographics, rapid spreading capacity, resistance to antibiotics, appearance/reappearance of the disease, vulnerable groups/susceptible people accumulations, environment/climate factors, and changes in ecology of vectors.	0 has been stable over past 5 years 1 exhibiting slow changes over past 5 years 2 exhibiting medium degree of change over past 5 years 3 exhibiting dramatic changes over past 5 years 4 new, emerging disease of high public health importance