Pandemic Influenza Plan

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Your Health Connection

A Message from the Medical Officer of Health and Director of Clinical Service

By Dr. Charles Gardner and Bill Mindell

We do not know when the next influenza pandemic will occur. Many have cited avian influenza as a potential source of the next pandemic; however, in truth, pandemic influenza is a random event and therefore unpredictable.

We do know that influenza pandemics have recurred throughout history, more recently at a rate of two to three times per century. Such pandemics have killed millions of people around the world, the most extreme example being the Spanish influenza of 1918 – 1919 with losses estimated at more than 50 million people. We also know that pandemic influenza will cause many people to seek health care and will greatly strain the capacity of our health care system. It may also impede the ability of society to provide for our basic needs.

To help prepare for a potential pandemic, the health units of the province have been directed by the Chief Medical Officer of Health to create agency pandemic influenza plans. They have also been directed to work with other health care agencies to develop local coordinated pandemic influenza plans.

Over the past two years, the Simcoe Muskoka District Health Unit has worked to develop its own pandemic influenza plan. This is to provide operational direction to ensure that as a public health agency we fulfill our role within the overall response to pandemic influenza in our area. This work has been facilitated through the coordinated efforts of the Pandemic Influenza Planning Advisory Committee (PIPAC), with membership from all health unit service areas and representing a wide range of disciplines and skills. The members of PIPAC and its sub-committees have done commendable work to produce our health unit pandemic plan while also working with and providing educational support to the work of other health emergency sector partners in Simcoe and Muskoka. This work would not have been possible without the overall coordination of Colleen Nisbet as our Pandemic Influenza Planner.

In a parallel process, the Simcoe Muskoka District Health Unit has worked in partnership with the County of Simcoe and the District of Muskoka through the Health Sector Emergency Planning Committee (SMHSEPC) to foster the development of an overall pandemic influenza plan for our region. We have also sought to encourage and support the development of pandemic plans for the health care and municipal agencies in keeping with our overall plan. All told, over 45 health care agencies have participated in this planning process.

Together, these two plans will help us to do our part in public health to reduce illness, death and social disruption in Simcoe Muskoka during the next influenza pandemic or other similar health emergency.

SMDHU Pandemic Influenza Plan
Executive Summary

Pandemic Planning Overview

Planning is a key component of emergency response. Regardless of whether the emergency is man-made, health-related or environmental in nature, good planning is what separates a successful response from an unsuccessful one. As the threat of a pandemic influenza grows, governments, agencies and businesses around the world are planning and preparing for this potential public health emergency.

The Simcoe Muskoka District Health Unit (SMDHU) has been engaged in pandemic influenza planning as an agency for several years. Since the fall of 2005, this work has been facilitated through the coordinated efforts of the health unit's Pandemic Influenza Planning Advisory Committee (PIPAC), with membership from all health unit service areas representing a wide range of disciplines and skills. In a parallel process, the SMDHU has worked in partnership with the County of Simcoe and the District of Muskoka through the Simcoe Muskoka Health Sector Emergency Planning Committee (SMHSEPC) to foster the development of an overall pandemic influenza plan for our region.

Although this plan is complete to date, it continues to be a work in progress. Pandemic planning does not end; rather it evolves. As circumstances around the world change, a variety of local, national and international factors will influence its content and future direction.

Part I – Planning Approach, Assumptions and Processes

Part I of the SMDHU Pandemic Influenza Plan lays the essential groundwork, including goals, assumptions, approaches and processes. The overall goals of the SMDHU Pandemic Influenza Plan are: 1) to minimize serious illness and overall deaths; and 2) to minimize societal disruption as a result of an influenza pandemic. Other essential planning components discussed in Part I include:

- pandemic planning assumptions (i.e. course of a pandemic, extent and severity of illness, access to vaccines and antivirals, etc.);
- internal and external pandemic and emergency response planning structures;
- ethical framework (i.e. decision-making principles, core ethical values);
- legislative authority (i.e. federal and provincial acts and regulations).

Part II – Pandemic Planning Framework, Components and Activities

Part II presents the basic framework of the plan which aligns the World Health Organization (WHO) pandemic phases with the local public health requirements outlined in the Ontario Health Pandemic Influenza Plan. The framework consists of the activities of seven specific pandemic planning components: (1) surveillance (2) vaccine and antivirals (3) public health measures (4) emergency response (5) communications (6) orientation and training, and (7) business continuity/ redeployment and recovery planning. Each component includes specific objectives within the framework as well as supporting documentation.

1) Surveillance

Pandemic influenza surveillance is the collection and analysis of data that determines when, where and which influenza viruses are circulating**.** It also determines those segments of the population that are at risk of illness, hospitalization and death. Surveillance information is used by decision-makers to

guide a public health response. This chapter outlines the surveillance activities that are presently taking place in Simcoe Muskoka or are currently being developed.

2) Vaccine and Antivirals

Influenza vaccination is an essential tool in preventing the harmful health effects of influenza. In a pandemic influenza situation however, vaccine will not be available until 4 to 6 months after the pandemic strain has been identified. Until such time, antivirals have been recommended for use preventively for identified groups such as healthcare workers and other essential service workers, and for early treatment of cases. This chapter describes the role of public health in the storage, handling and distribution of antivirals, as well as activities related to vaccine distribution and immunization clinics.

3) Public Health Measures

Public health measures are non-medical interventions used to decrease the number of individuals exposed to the pandemic virus, to slow the spread of disease, and to reduce illness and death caused by the pandemic. Public health measures can include, but are not limited to: providing public education; issuing travel restrictions and screening travelers; conducting case and contact management; closing schools; and restricting public gatherings. Implementing specific measures depend on several factors such as: the epidemiology of the virus; the pandemic phase and virus activity in the region; characteristics of the community; resources required to implement the measure; public acceptance of the measure; and the amount of social disruption the measure will cause. This chapter outlines health unit activities for the planning and implementation of public health measures.

4) Emergency Response

In the event of an influenza pandemic, public health authorities will lead the response. However, all health sector organizations and emergency responders will play vital roles in the provision of services and the coordination of overall emergency response. Effective emergency response requires that emergency management structures are in place, that a continuous state of readiness is maintained, and that effective communication systems are ready and able to facilitate information flow between the health unit, health sector and community emergency response partners. This chapter describes the health and social infrastructures that will assist in pandemic influenza planning and emergency response.

5) Communication

Well planned internal and external communications will be essential to supporting a coordinated and effective response to an influenza pandemic. Considerations include: providing for and responding to public and provider communication needs; educating the public about pandemic influenza and plans to minimize the impacts; and ensuring that all health and emergency sector partners and the public have access to accessible, accurate, timely information that will help them respond to challenges during each phase of the pandemic. A variety of communication channels will be used to disseminate pandemic information, including newspaper, radio, television, website, newsletters and e-mail. This chapter describes specific communications actions required of the health unit during each pandemic phase.

6) Orientation and Training

Providing an effective response to an influenza pandemic requires a knowledgeable and well trained staff. The health unit is committed to enhancing and supporting the development of public health staff

skills and capacity to respond competently in the event of a pandemic influenza emergency. This chapter identifies orientation and training activities specific to SMDHU staff.

7) Business Continuity/Re-Deployment and Recovery

In the event of an influenza pandemic it is anticipated that all businesses—private and public—will experience high employee absenteeism due to illness and/or other personal employee situations that arise as the result of an emergency. Businesses and agencies alike must plan for the negative effects a pandemic will have on its workforce and prepare business continuity plans to maintain essential services and/or functions accordingly. This chapter describes the activities of business continuity planning, particularly in reference to redeployment of staff and the return to normal business operations (recovery).

Part III – Health Services & Inter-Agency Planning

Part III of the SMDHU Pandemic Influenza Plan presents the challenges that will be faced by the health care system for the provision of health services during an influenza pandemic. The increased demand for illness screening and medical attention will place considerable strain and pressure on the existing system. In Simcoe and Muskoka, work to address these challenges will be conducted under the leadership of the Simcoe Muskoka Health Sector Emergency Planning Committee (SMHSEPC). Part III also contains relevant information regarding the Terms of Reference for health unit committees and SMHSEP planning, as well as a glossary and references used for the development of the health unit plan.

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PART I

I - 1 PANDEMIC PLANNING INTRODUCTION

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

As the threat of a pandemic influenza grows, governments, agencies and businesses around the world are planning and preparing for this potential public health emergency. The Simcoe Muskoka District Health Unit (SMDHU) has been engaged in pandemic influenza planning as an agency for several years.

In 2000, the health unit completed its first Pandemic Influenza Plan. Since then, global events such as the arrival SARS and more recently, human cases of H5N1 influenza, have demanded that public health efforts focus on planning that will direct an efficient response to an influenza pandemic. To that end, the health unit began the process of updating and revising its original pandemic plan. In 2004, the agency committed time and resources to the completion of an agency pandemic influenza plan by June 2006.

The result of this planning process is this document - a comprehensive pandemic influenza plan that provides an integrated response framework for public health services in the County of Simcoe and the District of Muskoka. This plan evolved from a collaborative effort undertaken by all service areas within the Simcoe Muskoka District Health Unit, including Clinical Service, Health Protection Service, Healthy Living Service, Corporate Service and Family Health Service.

The goals of the SMDHU Pandemic Influenza Plan are in keeping with the provincial goals that are laid out in the Ontario Health Pandemic Influenza Plan as:

1. To minimize serious illness and overall deaths.
2. To minimize societal disruption as a result of an influenza pandemic.

Similarly, the ethical and legal frameworks by which this plan was developed are based upon those articulated in the Ontario Health Pandemic Influenza Plan.

The process of preparing this plan was not only an exercise in preparing a comprehensive agency response to a pandemic, but was also used as an opportunity to educate, support and work with agencies in Simcoe and Muskoka who were developing their own pandemic influenza plans.

It must be stated at the outset that this document is a work in progress. There are outstanding gaps that need to be filled, processes and procedures that need to be developed, and a variety of unknowns that cannot yet be dealt with. Pandemic planning does not just end; rather, it evolves. As circumstances change, internal and external, local and international factors will influence its content and future direction.

As of the publication date, the SMDHU is confident that it has created the basis of a plan that will allow for a timely, coordinated, efficient response to a pandemic influenza outbreak in Simcoe Muskoka.

I - 2 PANDEMIC PLAN OVERVIEW

The content of this plan consists of three parts. **Part I** introduces the work of the health unit's Pandemic Influenza Planning Advisory Committee and its sub-committees, and defines the assumptions, processes and background information by which the Committee arrived at its planning activities.

Part II presents the basic framework of the plan which aligns the World Health Organization (WHO) pandemic phases with the local public health requirements outlined in the Ontario Health Pandemic Influenza Plan. The framework consists of the activities of seven specific pandemic planning components, including: (1) surveillance (2) vaccine and antivirals (3) public health measures (4) emergency response (5) communications (6) orientation and training and (7) business continuity/ redeployment and recovery planning. Each component includes specific objectives within the framework as well as supporting documentation.

Please note that the text provided in each framework is colour coded to indicate the readiness/completion of each activity. Text written in black indicates that the activity is complete and may be currently in use within the health unit or easily accessible. The text written in red indicates that the activity is not yet initiated, or it may be initiated but is not yet complete.

Part III contains relevant information as it relates to the Terms of Reference for health unit committees and inter-agency planning with our community partners. It also contains a glossary of terms and references used for the development of this plan.

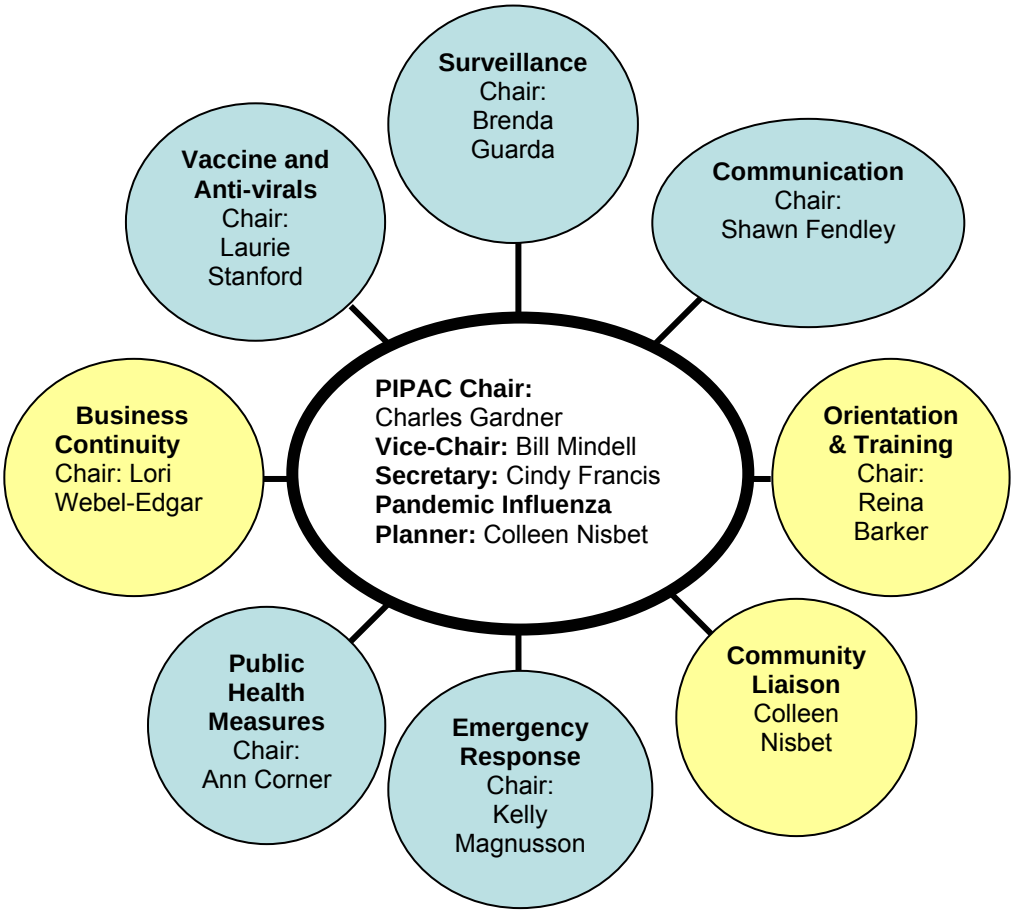
I - 3 PANDEMIC INFLUENZA PLAN ADVISORY COMMITTEE (PIPAC)

The Pandemic Influenza Planning Advisory Committee was established in December 2005 to facilitate the completion of the Simcoe Muskoka District Health Unit Pandemic Influenza Plan (SMDHU PIP).

The development of this advisory committee, led by Dr. Charles Gardner, SMDHU MOH and Bill Mindell, Clinical Service Director, built upon the work of an earlier pandemic planning committee established in January 2004 and led by former Clinical Service Director Joyce Fox.

The primary components of planning at SMDHU aligned closely with the Ontario Health Pandemic Influenza Plan (OHPIP). Five of these components (blue circles) were well established as sub-committees in the original planning group: Communication, Public Health Measures, Emergency Response, Vaccine and Antivirals and Surveillance. With PIPAC came the addition of three new components: Business Continuity/Re-deployment/ Recovery; Orientation & Training; and Community Liaison (yellow circles). The role of the Pandemic Influenza Planner included co-ordination responsibilities for PIPAC, compilation and editing of the final SMDHU PIP document.

PIPAC ORGANIZATION CHART



I - 4 PANDEMIC PLANNING ASSUMPTIONS

In order that our planning efforts remain as realistic and practical as possible certain planning assumptions must be used as a basis for planning. The SMDHU Pandemic Influenza Plan has adopted the planning assumptions contained in the Ontario Health Influenza Plan, June 2005 which are as follows:

The Course of an Influenza Pandemic

- A pandemic will be due to a new subtype of influenza A.
- A new strain is most likely to occur in Southeast Asia.
- Ontario will have little lead time between when a pandemic is first declared by the WHO and when it spreads to the province.
- An influenza pandemic usually spreads in two or more waves, either in the same year or in successive influenza seasons (i.e., October to April). A second wave may occur within three to nine months of the initial outbreak wave and may cause more serious illnesses and deaths than the first.
- In any locality, the length of each wave of illness is approximately eight weeks.

The Extent and Severity Of Illness

- Because the population will have had limited prior exposure to the virus, most people will be susceptible. Children and otherwise healthy adults may be at greater risk because elderly people may have some residual immunity from exposure to a similar virus earlier in their lives if the pandemic is caused by a recycled influenza strain.
- There will be an attack rate of 35% during the first wave.
- About 45% of people who acquire influenza will not require medical care, but they will need health information and advice; about 53% will require outpatient or primary care (e.g., treatment by a family physician); and approximately 1.5 to 2% will require hospitalization.
- More severe illness and mortality than the usual seasonal influenza is likely in all population groups.
- At least one third of deaths are likely to be in people under age 65 compared to less than 5% of deaths in interpandemic years.
- Sub-clinical infections will occur. Based on previous pandemics, some people will only experience mild illness or have no symptoms, but still be able to transmit the virus to others. This will make case identification and contact tracing more difficult.
- Individuals who recover from illness with the pandemic strain will likely be immune to infection from that strain.

Access to Vaccine and Antivirals

- A vaccine will not be available for at least four to five months after the seed strain is identified, which means it will not be available in time for the first wave of illness but may be available in time to mitigate the impact of the second wave.
- Once available, the vaccine will be in short supply and high demand. Vaccines manufactured in other countries are likely to be embargoed during a pandemic.
- In a pandemic caused by a novel virus subtype, the population will not be able to benefit from cross-protection from previous exposure to related strains, and everyone may require as many as two doses of vaccine to induce immunity.
- When vaccine becomes available, approximately 2 to 4 million doses will have to be administered per month until Ontario's population is fully immunized.
- Even with a well-matched vaccine, the effectiveness of influenza vaccine in preventing illness is approximately 70-90% in healthy adults.
- The only specific treatment option for influenza during a pandemic will be antiviral drugs, which must be started within 48 hours of the onset of symptoms. The efficacy of antivirals against the pandemic strain is unknown but, when antivirals are used to treat seasonal influenza, they have been shown to shorten the length of time people are ill, ameliorate symptoms and reduce hospitalizations.
- Prophylactic antivirals can be effective in preventing influenza and reducing the impact of outbreaks within institutions.

- Because Ontario will not have a large enough initial supply of either antivirals or vaccine for the entire population, the province will have to set priorities for who receives limited vaccine and antiviral drugs.
- Ontario will follow the recommendations of the Federal/Provincial/Territorial Pandemic Influenza Committee (PIC) for priority groups for immunization and antiviral treatment and prophylaxis. During the course of the pandemic, priority groups may change based on the epidemiology of the pandemic strain, that is, the nature of the virus and the people most affected

The Impact on the Health Care System

- During a pandemic, the availability of public health and health care workers could be reduced by up to one-third due to illness, concern about disease transmission in the workplace, and care giving responsibilities.
- During a pandemic, laboratory testing capacity will be reduced due to illness and supply shortages.
- Hospital capacity is already limited and could be further reduced because of staff illness. Inter-hospital assistance will be limited because of a rapid spread of influenza. Home care and long-term care homes will provide surge capacity by providing influenza care that will help avoid hospital admissions and allow early hospital discharges.
- Depending on the severity of the pandemic and the number of health care workers who are infected, redeployment of health care workers across sectors may not be practical. The health care system will have to use a variety of mechanisms to augment/ supplement existing health human resources.
- Non-life-threatening health services and public health programs will be significantly curtailed, consolidated or suspended completely.
- Care protocols may change and standards of practice for “normal” operating conditions may have to be adapted to meet pandemic/emergency needs.
- The MOHLTC will provide centralized purchase and distribution of certain personal protective equipment, vaccines/antiviral drugs and other clinical supplies.

Managing a Pandemic

- A provincial emergency will likely be declared early in the onset of a pandemic, and could be declared before the strain of influenza appears in Ontario.
- The overall provincial response during a declared provincial emergency will be managed from the Provincial Emergency Operations Centre, with the Emergency Management Unit, MOHLTC providing command and control services for the health care sector and the MOHLTC itself.
- The Provincial Infectious Diseases Advisory Committee (PIDAC) will be responsible for providing ongoing clinical, infection control and epidemiological advice to the MOHLTC throughout the pandemic and recovery period.

Communications

- A pandemic alert or the start of pandemic activity anywhere in Canada will become a national issue. The Public Health Agency of Canada and the federal government will coordinate inter-provincial communications. Provincial health communications strategies must be aligned with the federal communications plan.
- A pandemic will create intense public and media (local, national, international) interest. Ontario will require sophisticated streamlined communications (e.g., live news conferences using latest satellite and fibre optic technologies). Spill over media from other provinces and the United States will affect Ontarian’s perspective, reinforcing the need for a consistent communications approach among jurisdictions.

  A pandemic will also create intense pressure on health care workers. Ontario will make use of various communications channels, including websites, electronic mail and fax, to provide health care workers with information that can be useful for their own protection and for their patients/clients and to help manage broader public anxiety.

I - 5 WORLD HEALTH ORGANIZATION PANDEMIC PHASES

WHO Pandemic Periods and Phases

In 1999, to help guide response planning for an influenza pandemic, the World Health Organization (WHO) identified the phases of a pandemic. In April 2005, the WHO revised the pandemic phases (see Table 1) to reflect recent developments, including the risk to human health posed by infection in animals. The new phases focus more attention on the early phases of planning when rapid intervention may contain or delay the spread of a new influenza virus. Canada and Ontario are using the 2005 WHO pandemic periods and phases.

Delineation between pandemic phases is based on the detection of new influenza strains, the potential risk of human infection, and the spread/transmission rate of the disease.

Table 1: World Health Organization Phases of Pandemic Influenza

Period	Phase	Description
Interpandemic period	Phase 1	No new influenza subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk* of human infection is considered low.
Interpandemic period	Phase 2	No new influenza subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human diseases.
Pandemic alert period**	Phase 3	Human infection(s) with a new subtype, but no human to-human spread, or at most rare instances of spread to a close contact.
Pandemic alert period**	Phase 4	Small cluster(s) with limited human-to-human spread, but spread is highly localized, suggesting that the virus is not well adapted to humans.
Pandemic alert period**	Phase 5	Larger cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly adapted to humans, but may not yet be fully transmissible (substantial pandemic risk).
Pandemic period	Phase 6	Increased and sustained transmission in general population.
Postpandemic period		Return to interpandemic period

* The distinction between phase 1 and phase 2 is based on the risk of human infection or disease from circulating strains in animals.
** The distinction between phase 3, phase 4 and phase 5 is based on the risk of a pandemic. The world is currently in phase 3.

Source: World Health Organization, 2005

I - 6 ETHICAL FRAMEWORK

Ethical Framework for Pandemic Influenza Planning, Response and Recovery

During a pandemic, it is expected that governments will have to make some difficult decisions. The process by which these decisions are arrived at can be made easier when working within an ethical framework. Ethical considerations include honesty and transparency with clear reasons provided for decisions related to the allocation or prioritization of scarce resources (e.g. access to vaccine and antiviral medications).

There should be stakeholder involvement in the decision-making process, with clear, accurate communication. The following table, adopted from the Toronto Public Health Pandemic Influenza Plan, 2005, outlines how the Simcoe Muskoka Pandemic Influenza Plan has observed the Ethical Framework for Decision Making as outlined in the Ontario Health Pandemic Influenza Plan.

Table 2: Ethical Framework for Decision Making

Decision-Making Principle	Simcoe Muskoka Approach
Open and transparent - The process by which decisions are made must be open to scrutiny and the basis should be explained.	The SMDHU Pandemic Influenza Plan was developed by the SMDHU Pandemic Influenza Planning Advisory Committee (PIPAC), an internal committee comprised of seven sub-committees involving more than 40 public health unit staff. The planning process was communicated to all staff during a series of service area presentations and via information offered on our website and intranet. Liaison with community partners was facilitated through the Simcoe Muskoka Health Sector Emergency Planning Committee (SMHSEPC) The need for further outreach/consultation with stakeholders, in particular with community physicians, needs to be considered.
Reasonable - Decisions should be based on reasons (i.e. evidence, principles and values) and be made by people who are credible and accountable.	The Simcoe Muskoka District Health Unit Pandemic Influenza Plan (SMDHU PIP) is closely aligned with direction provided in the federal and provincial pandemic influenza plans. Decisions made, and that will be made in the future, are based on input from: • PIPAC members, • SMHSEPC Committee members, • Current literature and best practice, • Infectious disease/infection control experts, • Medical Officer of Health/Associate Medical Officers of Health
Inclusive - Decisions should be made explicitly with stakeholder views in mind and stakeholders should have opportunities to be engaged in the decision-making process.	PIPAC has adopted a model for the development of a comprehensive approach to planning, response and recovery from pandemic influenza. Input from all service areas and all staff levels of the SMDHU was solicited, primarily via PIPAC sub-committee participation and Executive Committee updates.
Responsive - Decisions should be revisited and revised as new information emerges, and stakeholders should have opportunities to voice any	SMDHU PIP will continue to be developed, enhanced and revised as new information emerges from the federal and provincial plans with on-going stakeholder input. An agency PIP Review Group has been established and

concerns they have about the decisions (i.e. dispute and complaint mechanism).	is tasked with ensuring regular review and revision of the PIP.
Accountable- There should be mechanisms to ensure that ethical decision-making is sustained throughout the pandemic.	Mechanisms will be developed to ensure accountability throughout the pandemic.

Simcoe Muskoka District Health Unit's response to an influenza pandemic will be based on the following core ethical values as outlined in the Ontario Health Pandemic Influenza Plan.

Table 3: Core Ethical Values

Core Ethical Values	Simcoe Muskoka Approach
Individual Liberty – may be restricted in order to protect the public from serious harm.	Restrictions to individual liberty will: • Be proportional to the risk of public harm • Be necessary and relevant to protecting the public good • Employ the least restrictive means necessary to achieve public health goals • Be applied without discrimination
Protection of the Public from Harm – Public measures may be implemented to protect the public from harm.	Protective measures will: • Weigh the benefits of protecting the public from harm against the loss of liberty of some individuals (e.g. isolation) • Ensure all stakeholders are aware of the medical and moral reasons for the measures, the benefits of complying, and the consequences of not complying • Establish mechanisms to review decisions as the situation changes and to address stakeholder concerns and complaints
Proportionality – restrictions on individual liberty and measures taken should not exceed the minimum required to address the level of risk or community needs	Simcoe Muskoka will: • Use the least restrictive or coercive measure possible when limiting or restricting liberties or entitlements • Use more coercive measures only in circumstances where less restrictive means have failed to achieve appropriate public health ends.
Privacy – individuals have a right to privacy, including the privacy of their health information.	Simcoe Muskoka will: • Determine whether the good intended is significant enough to justify the potential harm of suspending privacy rights (e.g. potential stigmatization of individuals and communities) • Require private information only if there are no less intrusive means to protect health • Limit any disclosure to only that information required to achieve legitimate public health goals • Take steps to prevent stigmatization (e.g. public education to correct misperceptions about disease transmission).
Equity – All patients have an equal claim to receive the health care they need, and health care institutions are obligated to ensure sufficient supply of health services and	Simcoe Muskoka will: • Strive to support health care workers in the preservation of as much equity as possible between the needs of influenza patients and

materials. During a pandemic, tough decisions may have to be made about who will receive antiviral medication and vaccinations, and which health services will be temporarily suspended.	patients who need urgent treatment for other diseases • Establish fair decision-making processes/criteria • Identify diversity and respect wherever possible ethno-cultural-faith practice
Duty to Provide Care – Health care workers have an ethical duty to provide care and respond to suffering. During a pandemic, demands for care may overwhelm health care workers and their institutions, and create challenges related to resources, practice, liability and workplace safety. Health care workers may have to weigh their duty to provide care against competing obligations (i.e. to their own health, family and friends). When providers cannot provide appropriate care because of constraints caused by the pandemic, they may be faced with moral dilemmas.	To support providers in their efforts to discharge their duty to provide care, Ontario and/or Simcoe Muskoka will: • Work collaboratively with stakeholders, regulatory colleges and labour associations to establish practice guidelines • Work collaboratively with stakeholders, including labour associations, to establish fair dispute resolution processes • Strive to ensure the appropriate supports are in place (e.g. resources, supplies, equipment) • Develop a mechanism for provider complaints and claims for work exemptions
Reciprocity – Society has an ethical responsibility to support those who face a disproportionate burden in protecting the public good. During a pandemic, the greatest burden will fall on public health practitioners, other health care workers, patients, and their families. Health care workers will be asked to take on expanded duties. They may be exposed to greater risk in the workplace, suffer physical and emotional stress, and be isolated from peers and family. Individuals who are isolated may experience significant social, economic, and emotional burdens.	Decision-makers will: • Take steps to ease the burdens of health care workers, patients, and patients' families
Trust – trust is an essential part of the relationship between government and citizens, between health care workers and patients, between organizations and their staff, between the public and health care workers, and among organizations within a health system. During a pandemic, some people may perceive measures to protect the public from harm (e.g. limiting access to certain health services) as a betrayal of trust.	In order to maintain trust during a pandemic, decision makers will: • Take steps to build trust with stakeholders before the pandemic occurs (i.e. engage stakeholders early) • Ensure decision-making processes are ethical and transparent
Solidarity – an influenza pandemic will require solidarity among community, health care institutions, public health units, and government.	Solidarity requires good communication and open collaboration within and between these stakeholders to share information and coordinate health care delivery.
Stewardship – in our society, both institutions and individuals will be entrusted with governance over scarce resources, such as vaccines, ventilators, hospital beds and even health workers. Those entrusted with governance should be guided by the notion of stewardship, which includes protecting and developing one's resources, and being accountable for public well-being.	To ensure good stewardship of scarce resources, decision makers will: • Consider both the benefit to the public good and equity (i.e., fair distribution of both benefits and burdens).

I - 7 LEGISLATIVE AUTHORITY

Actions taken during an emergency response must be guided by the legal/legislative framework that gives authority to the municipality, public health unit and others for their actions.

It is anticipated that the following statutes will play a role and provide legal authority to respond to pandemic influenza at the provincial and the local level:

- Health Promotion and Protection Act R.S.O. 1990 c. H. 7 (HPPA)
- Emergency Management Act R.S. O. 1990, c. E. 9
- Personal Health Information Protection Act, 2004 S.O. 2004, c. 3 Sched. A (PHIPA)
- Quarantine Act R.S.C. 1985, c. Q-1
- Coroners Act R.S.O. 1990 c. C.37
- Occupational Health and Safety Act R.S.O. 1990 c.O.1
- Public Hospitals Act R.S.O. 1990, c. C. P.40

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 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. Mandatory Health Programs and Services Guidelines published by the Minister of Health and Long-Term Care, set out minimum standards that must be met by Boards of Health delivering these public health programs and services.

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 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 Medical Officer of Health may require.
http://www.e-laws.gov.on.ca/DBLaws/Regs/English/900569_e.htm

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.

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 Health Protection and Promotion Act. 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.

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.

I - 8 SMDHU EMERGENCY RESPONSE PLAN

Emergency Response Plans

Emergency management in Ontario is governed by the *Emergency Management and Civil Protection Act*, RSO, 1990, Chapter 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.[1] 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 Simcoe Muskoka District Health Unit has developed an Emergency Response Plan to assist the agency in effectively coordinating a local response to an emergency with external emergency management officials and community partners. The SMDHU emergency response plan identifies general roles and responsibilities for each service area. It also identifies how the emergency notification system will be activated to inform and mobilize health unit staff. This plan is intended to assist the agency in response to general public health emergencies, such as long-term power outages, floods, food or drinking water quality emergencies, as well as other municipally declared emergencies in which the local municipality has requested support or assistance from the health unit. The level of response may vary depending on the type and severity of the emergency.

The Simcoe Muskoka District Health Unit Pandemic Influenza Plan (SMDHU PIP) is a sub-plan of the agency's Emergency Response Plan. It identifies specific roles and responsibilities for health unit personnel and other key community stakeholders to ensure effective management of an influenza pandemic. It also identifies local communication and emergency management structures and linkages.

Activation of SMDHU's Pandemic Influenza Plan

The Medical Officer of Health (MOH) or designate may be notified by the Public Health Branch of the Ministry of Health and Long-Term Care (MOHLTC) that pandemic influenza has entered the Province. Notification that pandemic influenza is in Simcoe County or the District of Muskoka will be made by the MOH. The SMDHU PIP will be activated in whole or in part upon direction of the Medical Officer of Health when any of the following conditions apply:

- Pandemic-relevant information is obtained from local, provincial or national sources
- Local case(s) or an outbreak of the pandemic strain of influenza is confirmed locally
- An influenza pandemic is declared by the Premier of Ontario **OR**
- The occurrence and expected impact of illness in the population will require coordinated efforts by all or most of the health unit's staff and resources.

If the MOH determines an emergency situation exceeds the ability of public health to respond effectively, the MOH may contact the Public Health Branch of the Ministry of Health and Long-Term Care to request assistance.

Activation of Local Plans/Emergency Operation Centres

Depending on the provincial situation the Province may notify municipal Community Emergency Management Coordinators (CEMC) and recommend activation of their plans. In the event of a local pandemic situation, the MOH will likely alert or activate (as described in the Simcoe Muskoka Health Sector Emergency Response Plan) the County of Simcoe and/or the District of Muskoka Emergency Operation Centres (EOC) to discuss the status of the emergency, share pandemic-relevant information and coordinate an effective response. The MOH may also request that health sector agencies and key community stakeholders activate their own emergency response plans. Each agency will be impacted

differently; therefore individual agencies may implement their plans independently or in conjunction with the Health Unit and the County and/or the District.

Individual municipalities may activate their EOCs independently depending on localized activity or upon recommendation by the Province, the County or the District to allocate resources and coordinate response locally.

It is anticipated that municipal and regional emergency plans will be activated as local conditions escalate and the need for response measures increases.

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.[2]

In an influenza pandemic situation recommendations to declare a provincial emergency will likely involve the Secretary of Cabinet, the Ministry of Health and Long-term Care, the Ministry of Community Safety & Correctional Services and the Commissioner of EMO.[3] 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 at the County or District level will be made by the Head of Council (Warden of 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 influenza pandemic situation and request assistance.

Roles and Relationships in Emergency Management

Local public health authorities are responsible for planning the local response to an influenza pandemic with direction from both the provincial and federal governments. This involves liaising with local partners (e.g. emergency responders, hospitals, mortuary services) in advance of a pandemic. It is likely that the local public health authorities, through existing or enhanced surveillance, may be the first ones to detect influenza within their community. It is essential that the lines of communication within the community and up to the Province are clear and established in advance of a pandemic.[4]

The MOH of the Simcoe Muskoka District Health Unit will lead pandemic influenza emergency response within Simcoe-Muskoka. The Health Unit will work closely with the Ministry of Health and Long-Term Care who will provide provincial leadership to the health sector through the Ministry Emergency Operations Centre. The MOHLTC may issue directives to health units, hospitals, long term care facilities and physicians.[5] The health unit will ensure that the response in Simcoe Muskoka is coordinated with the provincial response and is consistent with the directives issued by the Ministry.

The Ontario Health Pandemic Influenza Plan outlines the provincial response infrastructure for health emergencies and the relationship to the broader emergency response. These relationships are outlined in Appendix A.

In preparation for a response to a pandemic influenza, the health unit has established an inter-agency management structure which identifies relationships between all response teams (refer to Appendix B - I - 8). The roles and responsibilities for each team are identified in Appendix C - I - 8.

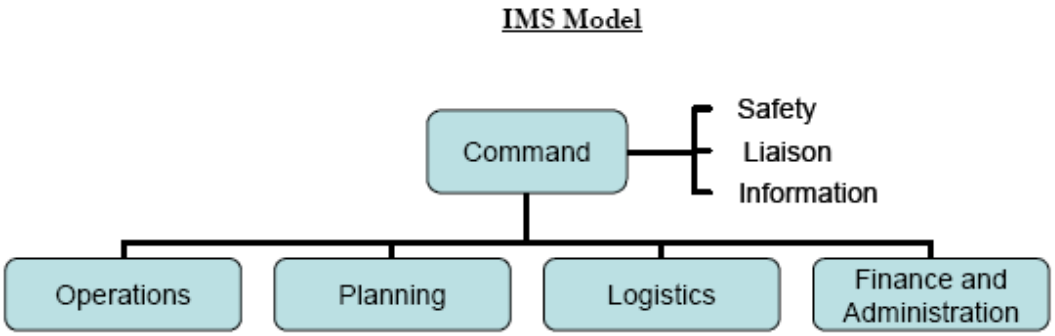
Emergency Management Systems

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 Ministry of Health and Long-Term Care will use this model for its Emergency Operations Centre at the Emergency Management Unit.[6] This structure is built around five functions: command, operation, planning, logistics and finance/administration.

Other organizations provincially and locally (such as healthcare facilities) are beginning to follow suit, which will help to increase the effectiveness and interoperability of emergency management in the province overall.[7] The health unit will adopt the IMS structure in the event of a pandemic.

Figure 1: IMS Structure



Source: Ministry of Health and Long Term Care

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 1st responder organizations participating at the same time, a **Unified Command system** should be implemented (Resulting in one single Incident Commander). In a Pandemic emergency, the **Medical Officer of Health** has been identified as the **Unified Command - 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. 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 EOC's to provide advice or assistances with response.

Potential roles of the Incident Commander may include:

- Leads the incident and deals with teams
- Coordinate 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 pandemic/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;
- Declares an Emergency/advises 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 Emergency Operations Centre (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 site
- Relay educational information to and from command
- Ensure that personnel within your 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

Community Emergency Management Coordinators (CEMC's) will play the role of the **Liaison Officer** in a local pandemic emergency. Liaison staff can be deployed to other EOC's or remain in their own and have external liaison representatives join them.

The Liaison Officer:

- Acts as a link between the Emergency Operation Centre and other organizations involved in the emergency
- Coordinates with outside agencies and other organizations involved with pandemic response
- Identifies key external contacts such as police or ambulance

- Keeps 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. Public Information Officer. 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**
- **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. Examples of operational teams established during a pandemic may include: mass vaccination and immunization clinics and Public inquiry lines.

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/pandemic influenza plan
- Assembling the CCG 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, determines what type of resources are needed to deal with the incident
- Notifies team leaders that an emergency has been declared
- Communicates directives to response team and provide feedback to Command
- Providing support to the health care sector with those of all of the other governments and agencies involved in pandemic response

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 Pandemic phase and attack rate; impacts on of municipality's services, impacts on vulnerable populations etc.)
- Need Assessments (implementation of antiviral administration arrangements; stresses on health care sector; need for reception and/or evacuation centres etc.)
- Development, dissemination and evaluation of emergency of emergency response plans up to 72 hours ahead
- Gathers information regarding incident specific impact
- Share information between all programs/teams
- Identifying alternate action to deal with emergency
- Develops the Emergency Management Team action plan
- Tracks individual/departmental services continuity plan and status
- Summarizes departmental plans for submission to senior management
- Advises Emergency Management Team of departmental service continuity plan conflicts, incongruities, overlap, etc.

Logistics

Arrange for and coordinate all materials, services, equipments and resources to manage and resolve the emergency. Logistics tracks inventory and the current location of resources.
Identifying the availability of supplies and support;

Potential roles of Logistics staff include:

- Arrange and co-ordinate materials, services, equipment and resources required to manage and resolve the emergency
- Logistics tracks usages (inventory tracking) and tracks the current location of resources
- Provides/facilitates services and staffing to deal with emergency
- Immobilizing staff
- Arranges for transportation/accommodation
- Acquires equipment and support services, office and medical supplies
- Arranges for food
- Maintains operation of the Emergency Operations Centre (EOC)
- Acquires 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

Authorizes expenditures, claims, purchases and contracts initiated during the emergency.

Finance & Administration responsibilities may include:

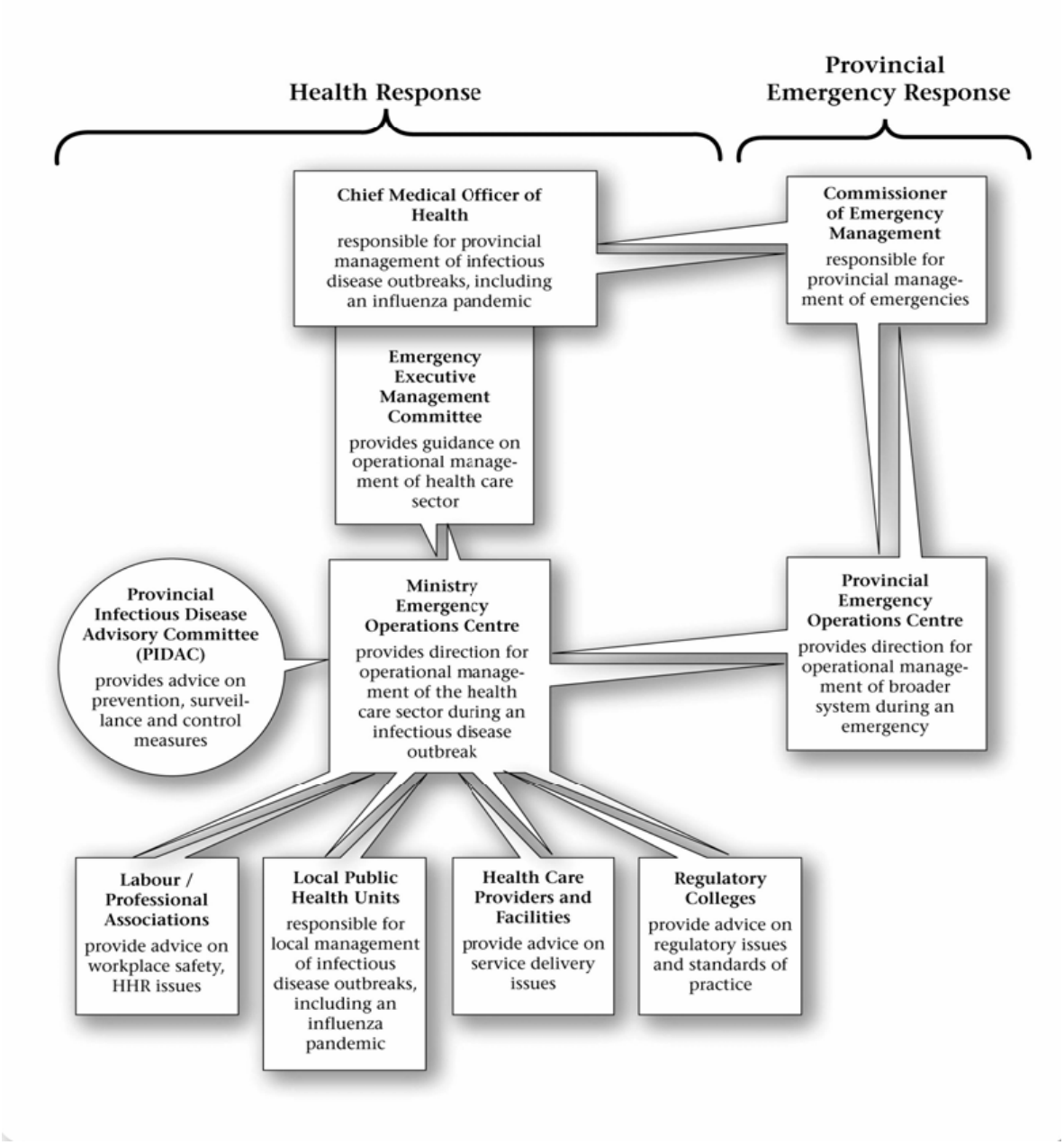
- Authorizes expenditures
- Monitors the cost associated with emergency response (expenditure tracking) for staff services, municipal/agency resources (equipment/supplies)
- Identifies cost depleted
- Emergency procurement authorization
- Claims and compensation
- Administers financial and staffing duties- incident related costs, maintenance and scheduling

EOC Operating Cycles:

Members of the ECG will gather at regular intervals to inform each other of actions taken and problems encountered. The Chief Administrative Officer (CAO) will establish the frequency of meetings and agenda items. Meetings will be kept as brief as possible thus allowing members to carry out their individual responsibilities. The Medical Officer of Health will act as Incident Commander of the pandemic emergency.

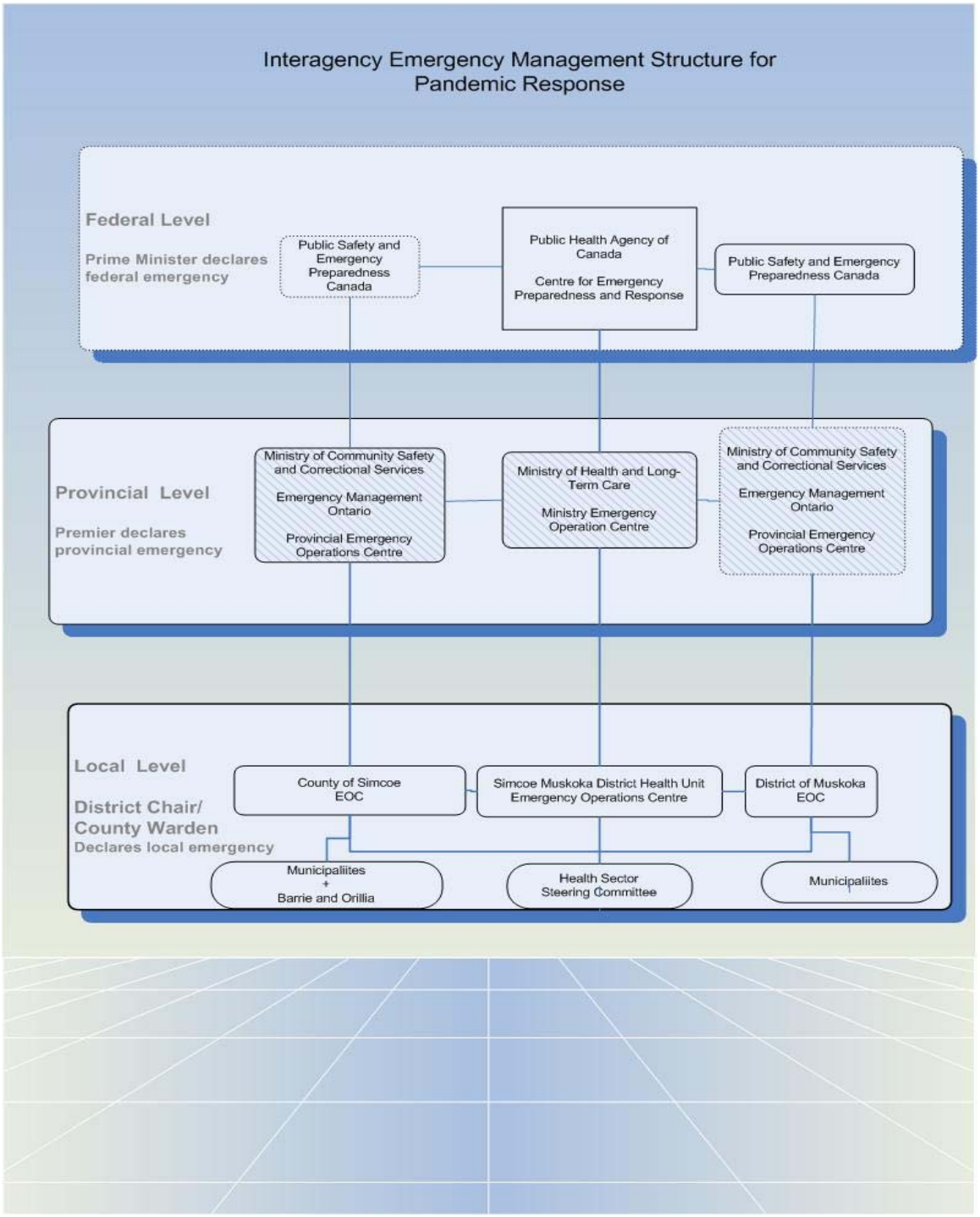
APPENDICES

APPENDIX A - I - 8: ROLES AND RELATIONSHIPS IN EMERGENCY MANAGEMENT IN ONTARIO

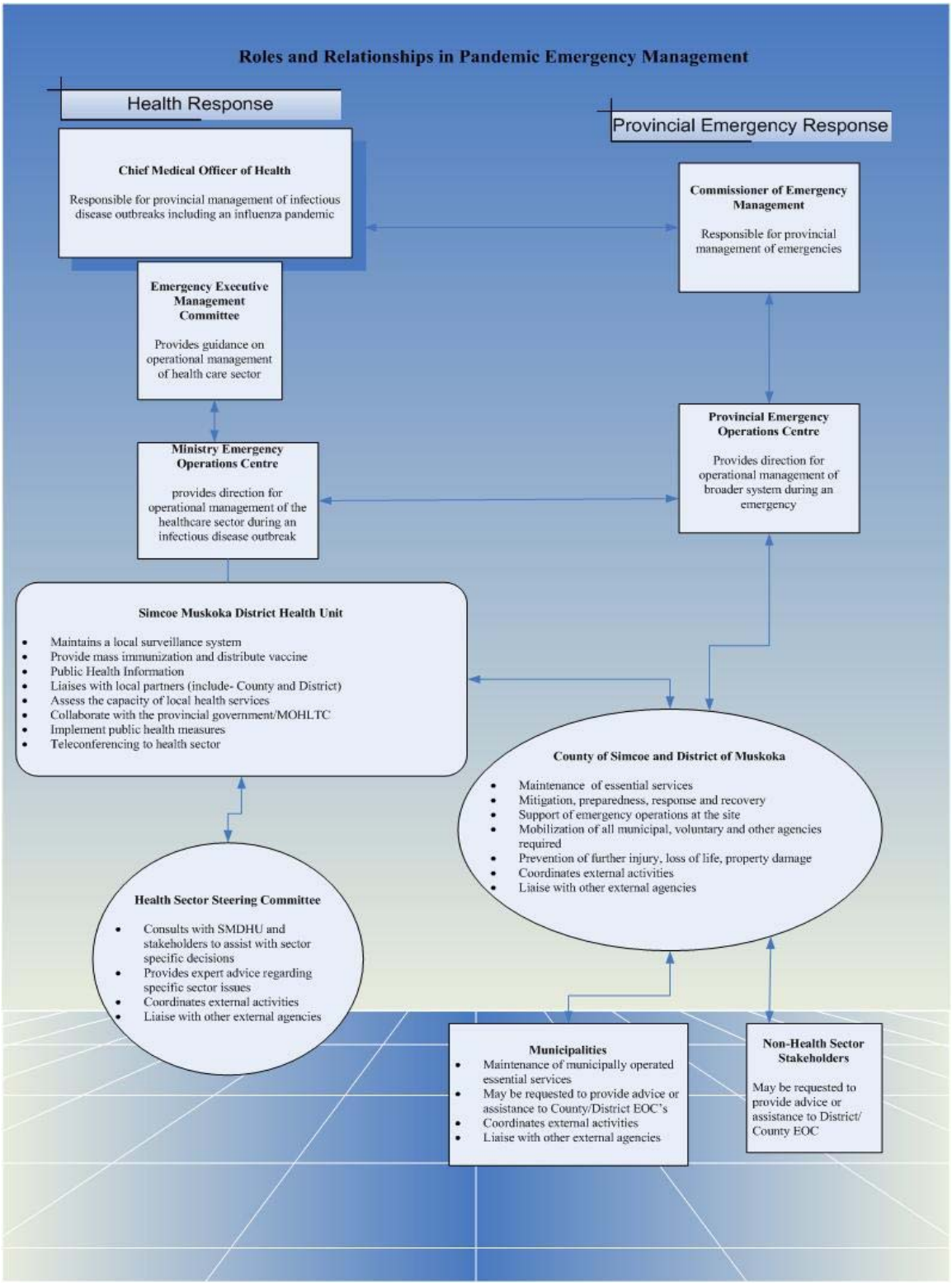


Ontario Health Plan for an Influenza Pandemic - June 2005

APPENDIX B - I - 8: INTERAGENCY EMERGENCY MANAGEMENT STRUCTURE FOR PANDEMIC RESPONSE

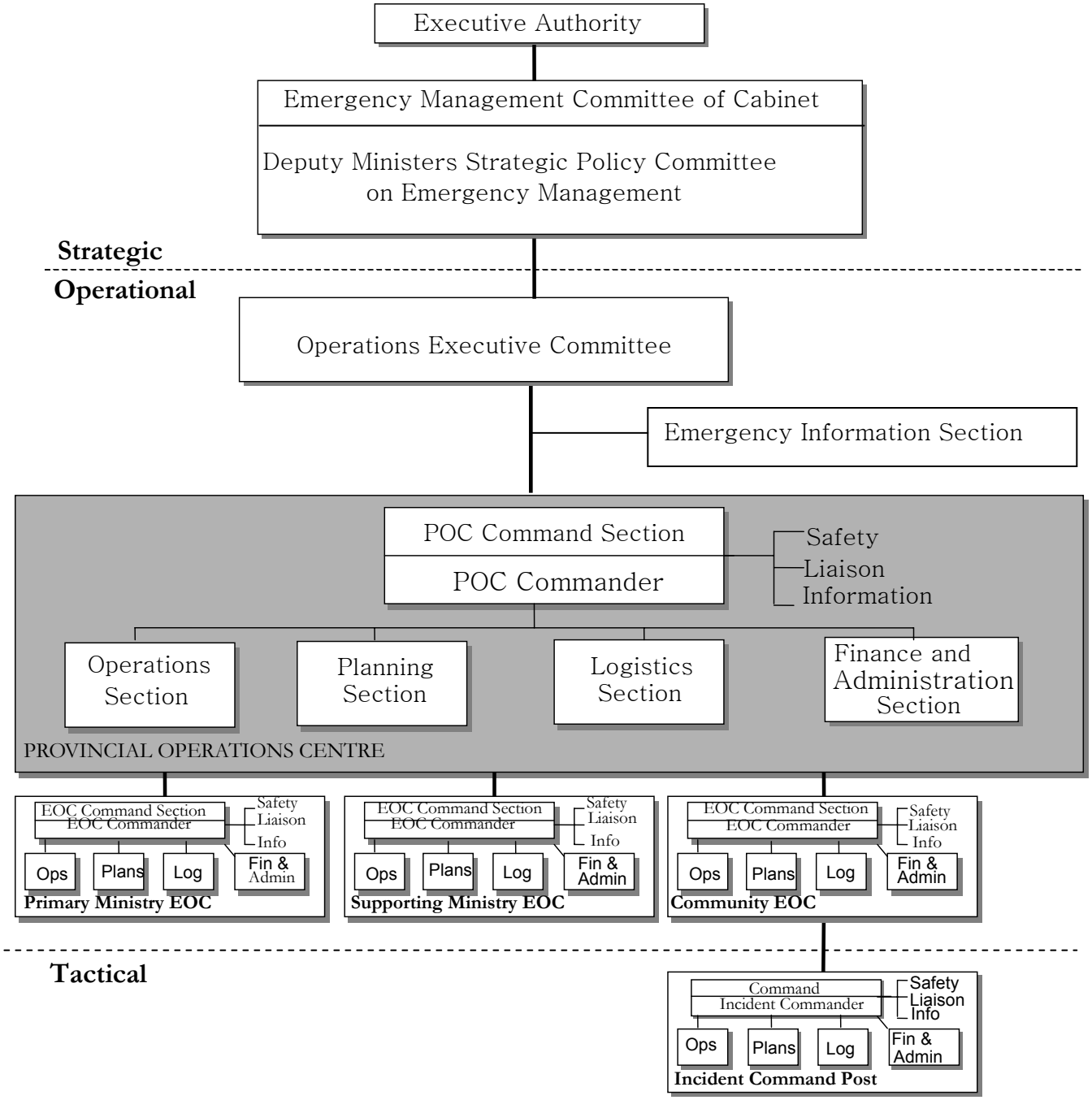


APPENDIX C - I - 8: INTER-AGENCY ROLES (RESPONSE TO A PANDEMIC)



APPENDIX D - I - 8: ONTARIO PROVINCIAL IMS MODEL

(Ministry of Health & Long Term Care, Emergency Response Plan, 2005)



PART II

II - 1 SURVEILLANCE

INTRODUCTION

Surveillance is the systematic ongoing collection, collation and analysis of data and the timely dissemination of information to those who need to know so that action can be taken.[8]

Pandemic influenza surveillance determines when, where and which influenza viruses are circulating as well as those segments of the population that are at risk of illness, hospitalization and death. All of these steps are accomplished by working through the phases of the Surveillance Cycle (Figure 1). Ultimately, the surveillance information that is disseminated is utilized by decision makers to guide a public health response. For example, surveillance data can be used to:

- determine when a pandemic begins or enters a health jurisdiction, or
- assist in the identification of high risk groups requiring antivirals or vaccinations, or
- evaluate interventions

Figure 1. Cycle of Surveillance and Examples – What May Happen At Each Phase of the Cycle

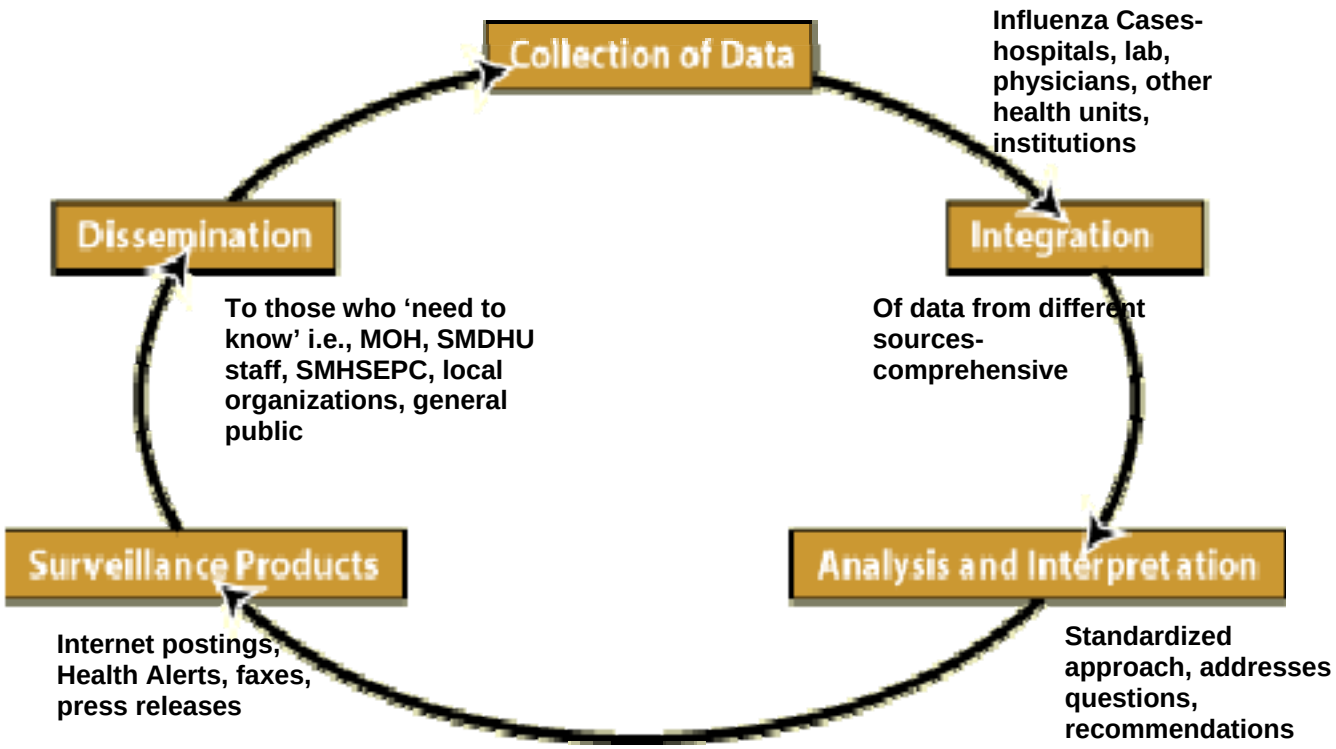


Diagram Source: Skills Enhancement for Public Health, Module 1– Basic Epidemiological Concepts

Early detection of human cases provides the greatest opportunity for preventing or delaying further spread of the pandemic influenza virus.

The SMDHU surveillance plan is organized according to the phase-specific local objectives outlined in the Ontario Health Pandemic Influenza Plan (OHPIP).[9] The surveillance sections of the Canadian Pandemic Influenza Plan (CPIP)[10] and World Health Organization (WHO) principles have also been reviewed for coherence.

The WHO outlines three priority principles for global surveillance: 1) build integrated systems, 2) concentrate surveillance efforts during the interpandemic phase 3) focus on detection of clusters of human cases.[11] Intersectoral collaboration between animal health specialists, clinicians, virologists, epidemiologists and public health professionals is strongly encouraged since the origins of pandemic influenza viruses have historically involved animal species.

The Canadian Food Inspection Agency (CFIA), Emergency Management Ontario and the Ministry of Agriculture and Food collaborated on an emergency response plan for foreign animal diseases (FAD) including highly pathogenic avian influenza.[12] Specific surveillance activities include: enhancing FAD surveillance and bio-security on farms, in veterinary practices, at livestock markets, ports of entry, slaughterhouses, feedlots, zoos, etc.; and developing and maintaining databases of producers and livestock at risk including GIS mapping capability.

Currently, local seasonal influenza surveillance activities consist of the following:

- laboratory-confirmed influenza cases are reported to the MOHLTC through the provincial reportable disease database called iPHIS
- respiratory outbreaks in hospitals, long term care facilities and other institutions such as daycares are reported to the MOHLTC through iPHIS and faxed as a preliminary and final report
- unusual clusters or travel-linked cases of febrile respiratory illness (FRI) in all health care settings are reported to the public health unit
- national influenza reports are received weekly through the FluWatch notices (Fluwatch collects influenza-like illness [ILI] data from a network of sentinel physicians, laboratory data and provincial/territorial activity)
- provincial influenza reports are received weekly via the Influenza Bulletin

The local activities outlined in each WHO phase are dependent on MOHLTC directives and correspond with the local objectives identified in the OHPIP. Changes in WHO phase would affect the surveillance activities that the health unit would undertake.

In the interpandemic phase (WHO phases 1-3), local surveillance activities ensure that existing systems are functional by educating partners and reinforcing communication. New data collection, analysis and dissemination systems are created for monitoring school absenteeism and ILI data from sentinel physicians. Baseline rates for current and future indicators must also be established.

The pandemic alert phases (WHO phases 4-5) build on interpandemic phase activities. Analysis of sentinel surveillance data begins as does enhanced communication with partners including the MOHLTC. New protocols and/or forms may need to be developed according to changes in case definition, data collection or reporting fields. Situation reports are distributed to internal staff regularly. A surveillance working group is established as is the protocol for cluster investigation. Once human-to-human transmission is present anywhere in the world, active surveillance is implemented, situation reports are disseminated to the public and surveillance group meetings are held regularly. Sentinel surveillance continues until the pandemic influenza strain is detected locally. Geographic information systems (GIS) can also be used to visualize the spread of the pandemic. For example, maps can display all suspect and confirmed influenza cases on an ongoing basis to look for clusters of illness. Also, 'hot spots' can be located by conducting weekly overlays of new cases, which will show new or changing areas of infectivity. All of these efforts can help direct interventions to areas most in need.

Once the pandemic reaches the local jurisdiction, cluster protocols are implemented, case-level information is aggregated, surveillance of vaccine efficacy and antiviral use begins and communication with partners is maintained. During the post-pandemic period, the local surveillance activities are evaluated based on the original objectives. Interpandemic activities are then resumed.

Phase 1 From WHO	Local Level Objectives From OHPIP	Public Health Unit Surveillance Activities
INTERPANDEMIC PERIOD PHASE 1		
Interpandemic Period: Phase 1 *No new influenza virus subtypes have been detected in humans*	Maintain all interpandemic surveillance activities	1. Conduct passive surveillance of global statistics on avian influenza activity (from ProMed, CIOSC, FluWatch, Ont. Influenza Bulletin, WHO, newswires i.e., CBC) and report, when necessary to Manager/Supervisor of CDSU and Director of Clinical Service 2. Develop a list of websites to use re: Pandemic Influenza statistics. Record name and URL in appropriate location. 3. Statistics on these websites to be used in the development of SMDHU surveillance reports outlined in Phases 3 thru 6 4. Receive and file weekly influenza reports from PHAC (FluWatch), MOHLTC (Influenza Bulletin). Compare to local situation. 5. Investigate all reported cases of influenza in community and institutions 6. Submit weekly reports to MOHLTC and share with internal staff (CD, MOH etc.) on community and institutional flu activity (Appendix C) 7. Submit preliminary (Appendix D) and final (Appendix E) reports of all institutional respiratory outbreaks to MOHLTC within required time frames 8. Communicate the location and status of institutional respiratory outbreaks to ICP's, EMS, other parties via password protected website ("CD Surv") 9. Track staff influenza immunization rates (LTCF and hospitals) 10. Disseminate information on influenza activity to CD team
	Maintain vigilance in FRI screening	1. Refine/Enhance Durham FRI/pandemic flu database for use in sentinel surveillance activities. Develop Users Guide and train staff - refer to Orientation and Training 2. Receive and investigate all positive FRI screens with a travel link and clusters of FRI from institutional settings in SM. Enter information in the SMDHU FRI database. 3. Educate SMDHU CD Team staff re: FRI guidelines 4. Review the effectiveness of FRI screening tool at acute care facilities in SMDHU jurisdiction 5. Improve communication re: FRI surveillance with non-acute care facilities i.e., physicians, CCAC, walk-in clinics, EMS
	Liaise with hospitals and LTC homes on FRI surveillance	1. Establish liaisons with all LTC facilities and acute care facilities in SMDHU jurisdiction 2. Provide training/direction to LTC on FRI surveillance (e.g., LTCF annual workshop or via HSEP) 3. Assist with training/direction to hospitals on FRI surveillance

Interpandemic Period: **Phase 1** *No new influenza virus subtypes have been detected in humans*	Other Activities	1. Establish contacts at sentinel schools for surveillance of absenteeism during flu season and pre-pandemic period, develop process and feedback mechanism. Work with school liaisons in this capacity 2. Recruit sentinel local physicians (above those recruited through PHAC's FluWatch system) for surveillance of ILI during pre-pandemic period, develop process and feedback mechanism. 3. Establish contact with sentinel physicians for surveillance of ILI and flu cases during flu season and pre-pandemic 4. Establish reporting protocol and data management system for sentinel sites data (school + ILI) 5. Determine minimum dataset; develop surveillance protocols, data collection and analysis methodology using MOHLTC tools. Explore the use of GIS 6. Develop evaluation framework, and data collection process for evaluating impact of pandemic influenza and response 7. Establish a clear process for the dissemination of flu information during a pandemic, following the communication time clock 8. Develop reporting relationships with First Nations Reserves, DND - Base Borden, Federal and Provincial Corrections Services. Consider memorandums of understanding 9. Design web-based tools for collection of sentinel surveillance data on-line 10. Establish and maintain links with agricultural sector (CFIA, OMAFRA)- assist in early detection of avian influenza in our jurisdiction 11. Determine all databases that will be used and data that will need to be collected from each, including sentinel surveillance database, iPHIS, BIOS, others. Create an inventory. Determine databases that must be created (i.e., tracking immunizations, staffing of clinics etc.) 12. Develop reporting templates and reporting parameters (process, frequency, content)- align with phases of the time clock and differing stakeholders. Examples - situation reports, individual epidemiological reports, aggregate epi reports, charts, tables, maps. Develop framework for post-pandemic report (incl. draft table of contents) 13. Set priorities to meet surveillance requirements during each phase of a pandemic. This includes identifying which routine activities can be suspended or reduced during a pandemic
INTERPANDEMIC PERIOD PHASE 2		
Interpandemic Period: **Phase 2** *A circulating animal influenza virus subtype poses a substantial risk of human disease*	Continues with all Phase 1 activities	
	Disseminate alerts	1. Review current information technology and information management support for tracking patients, contacts, antiviral distribution 2. Enhance the content of the SMDHU website (ex. Changes in pandemic phase or current epidemiology of the disease) 3. Communicate surveillance case definitions that are/may be developed by PHAC via SMDHU website

Interpandemic Period: **Phase 2** *A circulating animal influenza virus subtype poses a substantial risk of human disease*	Other	1. Establish baseline deaths and hospitalizations and incidence due to seasonal influenza 2. Health department to investigate and track reports from clinicians re: suspect human case of infection with an avian or animal strain of influenza or with any other novel human influenza strain - coordinate with CFIA/OMAFRA 3. Create additional databases, as required.
INTERPANDEMIC PERIOD PHASE 3		
Interpandemic Alert Period: **Phase 3** *Human infection(s) with a new subtype, but no human-to-human spread or spread to a close contact only*	Continue with all Phase 2 activities	
	Share surveillance information with stakeholders	1. Prioritize ongoing and activate additional surveillance activities (ex. school absenteeism, physicians) 2. Collaborate with local stakeholders to review, enhance surveillance activities (active surveillance) as directed by MOHLTC and/or AMOH (CD Lead) and modify plan as needed i.e., acute care, physicians 3. Communicate changes in case definitions and MOHLTC protocols to healthcare providers 4. Reinforce linkages with external organizations responsible for surveillance of diseases in animals and birds 5. Disseminate influenza situation reports to internal stakeholders (MOH, Clinical Service mgt., media, CD team) via the Intranet. On weekly basis 6. Disseminate Health faxes that include local statistics (if required) 7. Calculate estimated impact of pandemic influenza in Simcoe Muskoka
	Ensure surveillance data is being collected and forwarded to MOHLTC	1. Determine members of the surveillance/ data management/reporting work group. Set roles & responsibilities for each member and select chair. Develop meeting schedule, based on pandemic phase. 2. Review/revise standard reporting forms, data collection tools and surveillance reports, as necessary according to MOHLTC (and other) requirements 3. Continue to liaise with MOHLTC to determine iPHIS reporting protocols (if changes occur)
	Maintain vigilance in FRI screening	1. Review and confirm that all pandemic alert period surveillance activities via FluWatch and CIOSC are operating optimally
	Confirm that surveillance tools and protocols required for later phases (e.g., investigating clusters, detecting entry of the pandemic strain) are available and up-to-date	1. Develop cluster investigation protocols

	Comply with standards and protocols for collecting, storing and transporting specimens	1. Ensure a process is in place to document changes in the case definition and the definitions are consistent with the provincial/national/international definitions. Stay abreast of changes in case definitions and Health Canada, MOHLTC protocol
PANDEMIC ALERT PERIOD PHASE 4		
Pandemic Alert Period: **Phase 4** *Small cluster(s) with limited human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet by fully transmissible*	Continue will all Phase 3 activities	
	Identify surveillance/information needs should pandemic progress to next phase	1. Implement active surveillance by contacting active surveillance stakeholders/partners (hospitals, infection control professionals (ICP), general practitioners, labs, schools, coroners, etc.) 2. Recruit additional local sentinel physicians. Ensure localities represent all areas of Simcoe Muskoka 3. Enhance surveillance of worldwide situation
	Disseminate alerts about the progress of the pandemic to increase awareness and inform public health and clinical decision making	1. Disseminate change in pandemic phase to health care providers 2. Disseminate influenza situation information/alerts to general public (provide link to PHAC website re: travel advisories)
	Other Activities	1. Provide consolidated reporting of unusual cluster of ILI to MOH as needed
		2. Initiate automated, aggregate influenza situation reports and post to Intranet on weekly basis
PANDEMIC ALERT PERIOD PHASE 5		
Pandemic Alert Period: **Phase 5** *Large cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible*	Continue will all Phase 4 activities	
	Increase current surveillance activities	1. CDSU hospital liaisons attend hospital infection control meetings to discuss surveillance requirements and outcomes 2. Disseminate epidemiological summaries to characterize local outbreaks and impacts if reached SMDHU area. Data analysis and daily reporting to begin - to MOH, Intranet and health care providers. (Local stats to include # of cases by date, hospitalizations, deaths, geographic location, demographics, epidemic curves, lab information once available) 3. Disseminate influenza situation information/alerts to general public on daily basis (International/North American/Canadian stats) 4. Begin holding regular surveillance meetings with surveillance/data management/reporting group. Membership, frequency of meetings to be determined – see Phase Three activities. 5. Ensure surveillance working group lead participates in decision making process led by MOH and involving designates from all service areas

Pandemic Alert Period: Phase 5 *Large cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible*	Implement any new/updated FRI/SRI surveillance tools (especially for areas known to receive a lot of travelers from affected areas)	1. Actively search for human cases when new outbreaks of highly pathogenic H5N1 in poultry in Ontario are detected
	Review/revise information required for surveillance purposes for a potential progression to Phase 6 (pandemic)	1. Revise and update data collection forms to reflect changes in epidemiology of disease and case definitions
	Identify special study needs	1. Adopt any new MOHLTC special study needs and create necessary policies and tools required to implement special study, if applicable
	Other Activities	1. Update all on-call bags and internet/intranet with necessary forms, protocols and case definitions
PANDEMIC PERIOD PHASE 6		
Pandemic Period: Phase 6 *Increased and sustained transmission in general population*	Continue will all Phase 5 activities	
	Implement investigation protocol for clusters (i.e. geographic/school or other settings)	1. Implement investigation protocols for clusters
	Utilize active surveillance protocols to detect entry of cases of pandemic strain in Canada	1 As outlined in Phase 1 to 3 activities
	Evaluate current epidemiology of pandemic to direct priorities to high risk groups	1. Evaluate current epidemiology of pandemic to direct priorities to high risk groups. Current epidemiology of pandemic may identify priority groups to receive antivirals and or vaccines
		1. Track occurrence and progression of the pandemic. Use GIS to show geographic spread of pandemic influenza
	Adopt and implement revised case definitions as necessary	1. Communicate with internal staff and key stakeholders regarding changes to case definitions
	Provide timely data, and report to province	1. Distribute situation reports to key internal staff and external stakeholders and provinc
	Participate in special studies and establish dedicated teams to activate the studies in collaboration with other public health authorities	1. Participate in special studies
	Implement laboratory testing protocol	1. Implement changes to revised lab protocols

Pandemic Period: Phase 6 *Increased and sustained transmission in general population*	Distribute pandemic data collection forms* to appropriate pandemic stakeholders (e.g. hospitals, long-term care homes) and protocols for electronic transmission of data	1. Distribute pandemic data collection forms to appropriate pandemic stakeholders (e.g., hospitals, LTC) and protocols for electronic transmission of data
	Continue with heightened surveillance until no longer sustainable/needed to collect information on affected populations/priority groups	1. Continue with active surveillance until confirmed in HU jurisdiction. Scale back to streamlined surveillance once detected in SM
	Disseminate pandemic alerts	1. Disseminate pandemic alerts
Pandemic Period: Phase 6 *Regional and mulit-regional epidemics*	Distribute and utilize pandemic reporting tools (e.g. crude measures of morality, morbidity and ILI activity in community)	1. Ongoing communications with key stakeholders to encourage use of reporting forms and systems
	Modify definitions, activities, processes and tools as required based on direction from the province	1. Verify that new definitions, activities, processes and tools are reflected in health unit forms, data bases, and reporting mechanisms 2. Surveillance representative to attend regional/provincial teleconferences and report back to local surveillance group
	Disseminate epidemiological summaries to characterize outbreaks and impacts	1. Repeat data collection and analysis steps above and implement changes/improvements
	Continue to provide timely data and analysis	1. Ensure only aggregate data entry into iPHIS at this time 2. Provide timely data and report to province
	Maintain ongoing surveillance to detect second or later waves early	1. Maintain ongoing surveillance to detect second waves or later waves early
	Monitor vaccine efficacy, adverse reactions and coverage, once vaccine available	1. Monitor vaccine efficacy, adverse reactions and coverage, once vaccine available
Pandemic Period: Phase 6 *Pandemic Subsiding*	Work with MOHLTC to estimate burden of disease during outbreak period and develop epidemiological summaries to describe the impact of pandemic waves in Ontario	1. Provide epidemiological summary to characterize the impact of the pandemic waves in Simcoe Muskoka
	Scale down enhanced surveillance as appropriate and resume inter-pandemic response	1. Scale down enhanced surveillance as appropriate and resume inter-pandemic response
	Review/adopt case definition, evaluate the current epidemiology and decreasing levels of activity in local jurisdiction	
	Continue to implement laboratory testing protocol	

POSTPANDEMIC PERIOD		
Postpandemic Period: Return to Phase 1	Collect information required to evaluate surveillance activities	1. Implement evaluation of surveillance system
	Evaluate pandemic surveillance system performance and plan improvements as required	1. Written report and recommendations developed and disseminated to province, internally and externally as required
	Resume routine ongoing (i.e., interpandemic) laboratory and disease surveillance	1. Resume interpandemic activities

APPENDICES

APPENDIX A - II - 1: FORMS FROM OHPIP

Forms – from OHPIP

These guidelines and tools are being developed by the MOHLTC and, once released, will be added to the SMDHU Pandemic Influenza Plan

1. Health Care Reporting Forms
   - Pandemic reporting form for hospitals
   - Pandemic reporting form for LTCF
   - Primary care reporting

2. Community Reporting Forms
   - Data requirements for sporadic cases
   - Pandemic reporting form for institutional settings
   - Pandemic reporting form for community clusters

3. FRI Case Finding Protocol

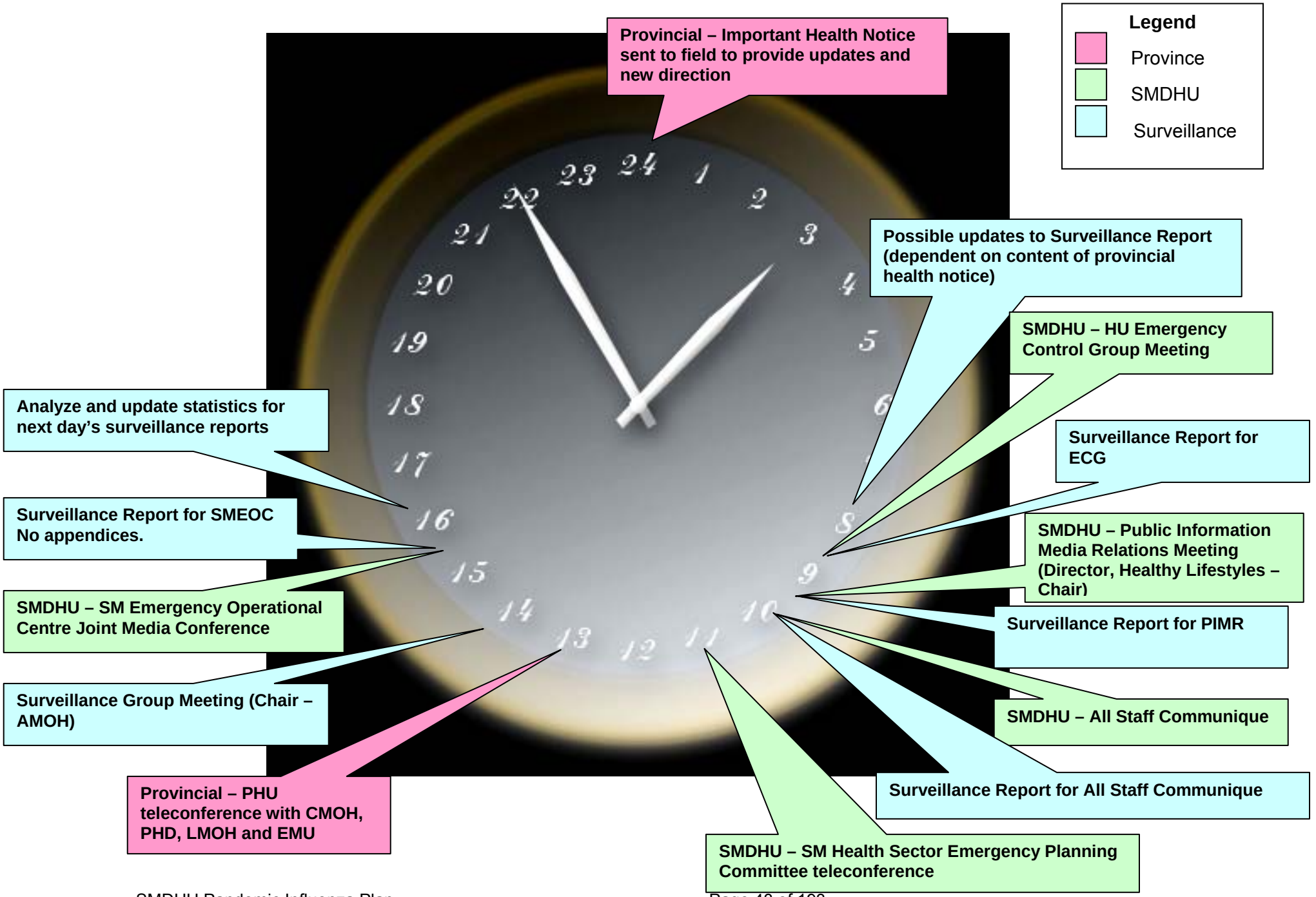
4. Sentinel Sites
   - Schools
   - Local physicians

5. Protocols for Special Studies

6. Vaccine and Antiviral Reporting Forms
   - Vaccine adverse events reporting forms
   - Vaccine uptake reporting form
   - Antiviral uptake reporting form

7. Mortality Surveillance

Source: Ontario Health Plan for an Influenza Pandemic, June 2005


Legend
Province
SMDHU
Surveillance
Provincial – Important Health Notice sent to field to provide updates and new direction
Possible updates to Surveillance Report (dependent on content of provincial health notice)
SMDHU – HU Emergency Control Group Meeting
Surveillance Report for ECG
SMDHU – Public Information Media Relations Meeting (Director, Healthy Lifestyles – Chair)
Surveillance Report for PIMR
SMDHU – All Staff Communique
Surveillance Report for All Staff Communique
SMDHU – SM Health Sector Emergency Planning Committee teleconference
Provincial – PHU teleconference with CMOH, PHD, LMOH and EMU
Surveillance Group Meeting (Chair – AMOH)
SMDHU – SM Emergency Operational Centre Joint Media Conference
Surveillance Report for SMEOC No appendices.
Analyze and update statistics for next day's surveillance reports

Simcoe Muskoka District Health Unit
Avian Influenza

For the period ending:
Date: May 29, 2006 Time: 8:00 a.m. Prepared By:

Phase: 1 - 3

International Surveillance – WHO - Human Cases of H5N1 Avian Influenza

http://www.who.int/csr/disease/avian_influenza/country/cases_table_2006_05_29/en/index.html

Country	2003		2004		2005		2006		Total	
	cases	deaths	cases	deaths	cases	deaths	cases	deaths	cases	deaths
Azerbaijan	0	0	0	0	0	0	8	5	8	5
Cambodia	0	0	0	0	4	4	2	2	6	6
China	0	0	0	0	8	5	10	7	18	12
Djibouti	0	0	0	0	0	0	1	0	1	0
Egypt	0	0	0	0	0	0	14	6	14	6
Indonesia	0	0	0	0	17	11	31	25	48	36
Iraq	0	0	0	0	0	0	2	2	2	2
Thailand	0	0	17	12	5	2	0	0	22	14
Turkey	0	0	0	0	0	0	12	4	12	4
Viet Nam	3	3	29	20	61	19	0	0	93	42
Total	3	3	46	32	95	41	80	51	224	127

Total number of cases includes number of deaths.
WHO reports only laboratory-confirmed cases.

Maps of Bird Flu Outbreaks and Confirmed Human Cases –

http://news.bbc.co.uk/2/shared/spl/hi/world/05/bird_flu_map/html/1.stm

Simcoe Muskoka District Health Unit
Avian Influenza

For the period ending:
Date: **Time:** **Prepared by:**

Phase: 4 - 5

Simcoe Muskoka Surveillance

Farmed Poultry Outbreaks	**Include: geography, numbers,**
Wild Birds Outbreaks	**Include: geography, numbers**
Confirmed Human Cases	**Include: exposure setting, geography, age & gender breakdown** **Others??**
AVE	**Include: adverse events to antivirals and vaccine, age and gender breakdown**
Quarantines, /Isolations	**Include: # quarantined, # isolated, age and gender breakdown**

Ontario Surveillance Ministry of Health and Long-Term Care

Farmed Poultry Outbreaks	**Nothing to report.**
Wild Birds Outbreaks	**Nothing to report.**
Confirmed Human Cases	**Nothing to report.**

Canada Surveillance Public Health Agency of Canada

Farmed Poultry Outbreaks	**Nothing to report.**
Wild Birds Outbreaks	**Nothing to report.**
Confirmed Human Cases	**Nothing to report.**

International Surveillance – WHO - Human Cases of H5N1 Avian Influenza

http://www.who.int/csr/disease/avian_influenza/country/cases_table_2006_05_29/en/index.html

Country	2003		2004		2005		2006		Total	
	cases	deaths	cases	deaths	cases	deaths	cases	deaths	cases	deaths
Azerbaijan	0	0	0	0	0	0	8	5	8	5
Cambodia	0	0	0	0	4	4	2	2	6	6
China	0	0	0	0	8	5	10	7	18	12
Djibouti	0	0	0	0	0	0	1	0	1	0
Egypt	0	0	0	0	0	0	14	6	14	6
Indonesia	0	0	0	0	17	11	31	25	48	36
Iraq	0	0	0	0	0	0	2	2	2	2
Thailand	0	0	17	12	5	2	0	0	22	14
Turkey	0	0	0	0	0	0	12	4	12	4
Viet Nam	3	3	29	20	61	19	0	0	93	42
Total	3	3	46	32	95	41	80	51	224	127

Total number of cases includes number of deaths.
WHO reports only laboratory-confirmed cases.

Simcoe Muskoka District Health Unit
Human H5N1 Influenza

For the period ending:
Date: **Time:** **Prepared by:**

Phase: 6 Final

Simcoe Muskoka Surveillance

cases (by case definition categories i.e., suspect, confirmed etc.) – daily figures and cumulative
- # hospitalized
- mean age
- gender breakdown
- municipality
- occupation
- exposure category
- # recovered
- # deaths

taking antivirals
vaccinated

Ontario Surveillance Ministry of Health and Long-Term Care

cases
- # hospitalized
- mean age
- gender breakdown
- PHU
- # deaths

Canada Surveillance Public Health Agency of Canada

cases
- # hospitalized
- mean age
- gender breakdown
- province
- # deaths

International Surveillance – WHO - Human Cases of H5N1 Influenza

http://www.who.int/csr/disease/avian_influenza/country/cases_table_2006_05_29/en/index.html

Country	2003		2004		2005		2006		Total	
	cases	deaths	cases	deaths	cases	deaths	cases	deaths	cases	deaths
Azerbaijan	0	0	0	0	0	0	8	5	8	5
Cambodia	0	0	0	0	4	4	2	2	6	6
China	0	0	0	0	8	5	10	7	18	12
Djibouti	0	0	0	0	0	0	1	0	1	0
Egypt	0	0	0	0	0	0	14	6	14	6
Indonesia	0	0	0	0	17	11	31	25	48	36
Iraq	0	0	0	0	0	0	2	2	2	2
Thailand	0	0	17	12	5	2	0	0	22	14
Turkey	0	0	0	0	0	0	12	4	12	4
Viet Nam	3	3	29	20	61	19	0	0	93	42
Total	3	3	46	32	95	41	80	51	224	127

Total number of cases includes number of deaths.
WHO reports only laboratory-confirmed cases.

NOTE: The WHO information will most likely be different during the pandemic. May show the number of cases/deaths by country by week.

Epidemiology of Disease – Changes or New Information
Period of communicability
Incubation Period
High risk populations
Case fatality rate
Age-specific mortality rates

Current Case Definition
As of <Date> <Time>

Simcoe Muskoka District Health Unit
Human H5N1 Influenza

For the period ending:
Date: **Time:** **Prepared by:**

SITUATION REPORT APPENDICES

1. GIS MAPS – INDIVIDUAL CASE LOCATIONS

GIS Maps

a. Confirmed cases, deaths

2. EPI CURVE

Epidemic curves

b. (e.g., by county/district, case outcome…)

Estimated Impact of Influenza Pandemic in Simcoe Muskoka District Based on 2004 Population Estimates

Gross Attack Rate*	15%			35%		
Outcome	**Min**	**Most Likely**	**Max**	**Min**	**Most Likely**	**Max**
Clinically ill (not requiring medical care)**	15,474	32,304	41,349	36,105	75,374	96,429
Require Outpatient Care	29,806	38,205	54,675	69,547	89,146	127,575
Hospitalized	301	863	1,094	752	2,015	2,552
Deaths	118	202	331	277	470	773
Total	71, 574			167,005		

Source: Outpatient, hospitalization and deaths were calculated using FluAid 2.0 Software provided by the Centres for Disease Control, National Vaccine Program Office (http://www2a.cdc.gov/od/fluaid/fluaid_page1.asp) based on Simcoe Muskoka District 2004 population estimate of 477,157 by age group, from the Provincial Health Planning Data Base, Extract November 2005. (Estimated age groups: 0-18 = 117,535; 19-64 = 293,981; 65+ = 65,641).

*Gross attack rate is the number of clinical cases of illness (not infections) caused by influenza that will have an economic impact.

**Clinically ill cases were defined as a case of influenza that causes some measurable economic impact, such as one-half day of work lost but do not seek medical care. This definition of clinically ill excludes those that will develop mild symptoms (e.g., nausea, headache, low-grade fever), but essentially still continue their daily activities. Clinically ill cases were calculated using the following formula:[13] Number ill = (Population x gross attack rate) – (deaths + hospitalizations + outpatients)

Influenza (Seasonal Influenza) (Note that case definition may change during pandemic)
Confirmed Case = Clinically compatible signs and symptoms with:
(a) laboratory confirmation by detection or isolation of influenza virus in pharyngeal, nasal secretions or lung tissue;
or
(b) demonstration of a four-fold or greater increase in hemagglutination antibody titres to influenza between acute and convalescent sera;
or
(c) an epidemiologic link to a laboratory confirmed case.[14]

Influenza-like Illness (ILI)
acute onset of respiratory illness with fever and cough and with one or more of the following: sore throat, arthralgia, myalgia or prostration, which could be due to influenza virus. In children under 5, gastrointestinal symptoms may also be present. In patients under 5 or 65+, fever may not be prominent.[15]

Febrile Respiratory Illness (FRI)
a wide range of droplet-spread respiratory infections, such as colds, influenza, ILI and pneumonia, which usually present with symptoms of a fever of greater than 38 degrees C and new or worsening cough or shortness of breath. Note: elderly people and people who are immunocompromised may not have a febrile response to a respiratory infection.[16]

APPENDIX H - II - 1: DRAFT MOHLTC DATA COLLECTION FORMS

1. PANDEMIC DATA COLLECTION FORM FOR INSTITUTIONS FINAL REPORT

Pandemic Data Collection Form for Institutions: Final Report

Note: Document will be reformatted, Preliminary reporting form to be added

Please FAX final report to the Ministry of Health and Long-Term Care at: [to be determined]	For MOHLTC use only

Health Unit Information	**Institution Information**
Outbreak #:	Institution Master #:
Health Unit Name:	Institution Name:
Investigator Name:	Institution Address:
Contact Phone #:	City/Town of Institution:
Date Outbreak Reported to Health Unit (yyyy/mm/dd):	Postal Code of Institution:
Date Outbreak Declared Over (yyyy/mm/dd):	Date of onset of illness in first case (yyyy/mm/dd):
Date form submitted (yyyy/mm/dd):	

Institution Type					
LTCH		Hospital Operates under Public Hospitals Act?		Yes	No
Retirement Home (with more than 10 residents)		Type:	Acute Chronic Psych Rehab		
Children's Residence		Other (please specify)_____			
Facilities operating under the Developmental Services Act					

Outbreak Description		Symptoms observed related to outbreak
	Residents or Patients Staff*	Please specify by check boxes OR free text below:
Total # in institution		Abnormal Temp. (≥37.5°C or ≤35.5°C or temp. known to be abnormal for that person)
Total # cases		Cough
# cases in facility admitted to hospital attributed to outbreak		Nasal Congestion/Sneezing
# cases in facility with clinically or X-Ray confirmed pneumonia		Runny nose (coryza)
# deaths among cases attributed to outbreak		Sore throat/Hoarseness/Difficulty swallowing
		Tiredness (malaise)
		Muscle aches (myalgia)
		Loss of appetite
		Headache
		Chills
		Swollen/Tender glands in neck (cervical lymphadenopathy)
		Other Symptoms:_____
		_____

Laboratory Data			
Lab Confirmation:	□ Yes (check causative organism/s)	□ No (no organism/s identified)	□ Specimens NOT submitted
□ Influenza A	□ Influenza B	□ RSV	
□ Rhinovirus	□ Parainfluenza	□ Adenovirus	
□ Enterovirus	□ Other (specify)_____		

*Staff: All persons who carry on activities in the facility including employees, nurses, students, medical house staff, physicians, contract workers and volunteers.

Antiviral Use
If an antiviral medication was prescribed during the outbreak, please complete the chart below:

	Residents/Patients		Staff	
Antiviral Used	Oseltamivir	Other (Please specify) _____	Oseltamivir	Other (Please specify) _____
What is the number of individuals for whom a prophylactic dose of antiviral was given				
Range of length of prophylaxis (in days)				
What is the number of individuals for whom a treatment dose of antiviral was given				
If anyone contracted ILI while on prophylactic antiviral medication for over 72 hours, please indicate the number of individuals who contracted ILI				
For those who contracted ILI as per #4 above, how many had lab-confirmed influenza				
If applicable, please indicate the # of individuals who developed side effects to antiviral medication				

Please describe any severe side effects to the antiviral that led to its discontinuation.

_____

_____

_____

Source: Draft OHPIP Plan – June 9, 2006

2. PANDEMIC DATA COLLECTION FORM FOR INSTITUTIONS PRELIMINARY AND WEEKLY REPORT

In order to track the occurrence, severity and progression of the pandemic, surveillance data from institutional respiratory infection outbreaks during the pandemic must be collected. This information is usually collected by the institutions' infection control practitioner or designate. The data is sent to the facility's local health unit who in turn forward the information to the Ministry of Health and Long-Term Care. Local and provincial surveillance information will be disseminated to stakeholders.

Public health units: please FAX preliminary and updated reports to the Ministry of Health and Long-Term Care at [to be determined] within 24 hours of receiving notification of an outbreak. If new information is added, checkmark update box and write update number, e.g. Update #1 and indicate reporting period

□ Initial Notification □ Update # _____ For MOHLTC use only _____

Health Unit Information	Institution Information
For updates, reporting time period covered: ((yyyy/mm/dd) to (yyyy/mm/dd):	Institution Master #:
Outbreak #:	Institution Name:
Health Unit Name:	Institution Address:
Investigator Name:	City/Town of Institution:
Contact Phone #:	Postal Code of Institution:
Date Outbreak Reported to Health Unit (yyyy/mm/dd):	Date of onset of illness in first case (yyyy/mm/dd):

Institution Type

□ Long-Term Care Home
□ Retirement Home (with more than 10 residents)
□ Children's Residence
□ Facilities operating under the *Developmental Services Act*

Hospital: Operates under *Public Hospitals Act*? □ Yes □ No
Type: □ Acute □ Chronic □ Psychiatric □ Rehab
□ Other *(please specify)*_____

Outbreak Description

	Residents or Patients		Staff *	
	New Cases ▲	Cumulative Number §	New Cases ▲	Cumulative Number §
Total # cases				
# Cases admitted to hospital attributed to O/B				
# Cases with clinically or XR confirmed pneumonia				
# Deaths among cases attributed to outbreak				
	Residents or Patients		Staff *	
Total # in institution				

Symptoms observed related to outbreak

Please specify by check boxes OR free text below:

□ Abnormal Temp. (≥37.5°C or ≤35.5°C or temp. known to be abnormal for that person)
□ Cough
□ Nasal Congestion/Sneezing
□ Runny nose (coryza)
□ Sore throat/Hoarseness/Difficulty swallowing
□ Tiredness (malaise)
□ Muscle aches (myalgia)
□ Loss of appetite
□ Headache
□ Chills
□ Swollen/Tender glands in neck (cervical lymphadenopathy)

Other Symptoms:_____

_____

Laboratory Data

Lab Confirmation: □ Yes (check causative organism(s)) □ Pending □ Specimens NOT submitted

☐ Influenza A ☐ Influenza B ☐ RSV
☐ Rhinovirus ☐ Parainfluenza ☐ Adenovirus
☐ Enterovirus ☐ Other *(specify)*_____

** Staff*: All persons who carry on activities in the facility including employees, nurses, students, medical house staff, physicians, contract workers and volunteers.

▲ Initial Report: indicate the total number of cases
▲ Update: indicate the number of new cases since last update
§ Update/s: indicate the cumulative number of cases.
§ For initial reports enter as N/A

3. DAILY HOSPITAL REPORTING FORM

To be completed daily by all acute care hospitals in Ontario when a Pandemic has been declared in Ontario. This form is to be faxed daily to your local health unit.

Daily Hospital Reporting Form

For MOHLTC use only _____

Health Unit Information	Hospital Information
Health Unit Name:	Reporting date: (yyyy/mm/dd, 0001h-2400h)
Contact Phone #:	Hospital Master #:
Hospital Data	Hospital Name:
Total number of persons presenting to emergency department (all cause):	Hospital Address:
Total number of deaths in hospital (all cause):	City/Town of Hospital:
	Postal Code of Hospital:

Minimum Dataset by Pandemic Influenza WHO Phases

PHASES 1 – 3 (Interpandemic): For Reported Cases of Influenza

Mandatory fields (red diamond fields) in iPHIS:

- Reported Date
- Responsible health unit
- Branch office
- Disease
- Classification (and date)
- Outbreak case classification (and date)
- Disposition (and date)
- Status (and date)
- Priority

Mandatory client information (i.e., not specific to influenza):

- First and last name
- Birth date
- Gender

SMDHU additional mandatory fields:

- vaccination status
- occupation
- residential address
- telephone number
- lab results
- symptoms
- onset date

PHASES 4 – 5 (Pandemic Alert)

- mandatory fields need to be flexible and are subject to change, based on the epidemiology of the disease

1. age
2. gender
3. area of residence (street #, name, city, PC)
4. telephone #'s (home, business)
5. primary occupation
6. children (day care, school)
7. other dependents (day programs etc.)
8. medical history
9. underlying conditions
10. medications
11. smoking habits
12. prior influenza vaccination – provide timeframe
13. # of persons in household
14. contacts with pet animals

15. contacts with farmed birds
16. travel (when, where)
17. activities where contacts with animal may have occurred
18. household and non household contacts with a sick person
19. types of contacts
20. presence of symptoms
21. duration of disease (onset and recovery dates)
22. hospitalization (date of admission, hospital name, date of discharge)
23. death (date of death, cause of death)
24. antiviral use
25. laboratory results (incl. subtype) if available

PHASE 6 (Pandemic)

- to be determined (in consultation with the MOHLTC). Will not be a comprehensive list as above. Will report aggregate.

II - 2 VACCINE AND ANTIVIRALS

INTRODUCTION

Influenza vaccination is a primary means of preventing disease and death from influenza.[17] In a pandemic influenza situation however, vaccine will not be available 4 to 6 months after the pandemic strain has been identified – this may not occur until Pandemic Phase 5 or 6.

Until a vaccine is available, antivirals have been recommended for use preventively for specifically identified groups such as healthcare workers and other essential service workers, and for early treatment of cases. The role of the health unit in terms of antivirals will be to coordinate their storage, handling and distribution. Antivirals will be distributed to facilities that have been identified by the MOHLTC as those needing to provide a priority group with antivirals for either treatment or prophylaxis.

When a vaccine is available, it will be distributed to those facilities and health care providers who would normally immunize high risk groups with influenza vaccine (e.g. family physicians, acute care facilities, long tem care homes).

The health unit will implement mass immunization clinics upon the direction of MOHLTC. These clinics will be to provide influenza vaccine to the general public, as the vaccine will be available according to identification of specific priority groups.

In the early stages of a pandemic, and while the general public await access to a vaccine, specific strategies will be implemented to help minimize social disruption and care for those who are ill. These plans are outlined in the early phases of this template and include such strategies as the continuation of the Universal Influenza Immunization Program (UIIP) and promotion of pneumococcal immunization for high risk groups.

Phase 1 From WHO	Local Level Objectives From OHPIP	Public Health Unit Vaccine & Antiviral Activities
INTERPANDEMIC PERIOD PHASE 1		
Interpandemic Period: **Phase 1** *No new influenza virus subtypes have been detected in humans*	Continue to actively promote annual universal influenza immunization, particularly with NACI "high risk" groups (to reduce incidence/severity of secondary bacterial pneumonia)	1. Universal Influenza Immunization Program (UIIP) is organized and implemented by the Vaccine Preventable Diseases (VPD) Program. This annual event occurs throughout Simcoe County and the District of Muskoka offering over 100 clinics. Vaccine coverage stats are tracked and documented by VPD Team. Coverage rates hover around 40 % for the general population. Stats from RRFSS and distribution data to GP's would also support this figure. Data from long-term care facilities (LTCF) indicate that coverage rates for residents are close to 100% and staff coverage rates varies from 50 % to 100%. Stats for acute care facilities (ACF) would indicate that rates are lower and ongoing promotion of flu vaccine for Healthcare Workers is necessary. 2. The VPD team supports workplace hosted clinics providing the workplace is willing to open the clinics to the public. This information is also recorded, including the number of doses given. 3. The VPD team provides clinics for health unit staff. Supportive health unit policy encourages staff to be immunized. • The VPD team annually promotes pneumococcal vaccine to high risk groups and distribution data would indicate a good response. RRFFS data indicate the coverage rate is perhaps as low as 40%. But there may be other variables influencing these numbers (RRFSS is open to all over 18 years) • Development of all communications resources: FAQ, fact sheets. Have ready for postings to web. FAQ and fact sheet are available for UIIP vaccine and seasonal flu illness and in part for pandemic flu and vaccine. • Medical directive for pandemic flu vaccine can be created using the current medical directive for UIIP program.
	Increase annual influenza vaccine coverage rates among health care workers and emergency services workers	1. Statistics are collected and available from the CDSU team.
	Maintain up-to-date plans to acquire, store and distribute vaccine and antivirals	1. 3 large double door Revco fridges are in Barrie: each fridge has a capacity of 34,000 flu vaccine doses, leaving small amount for routine childhood vaccines. Therefore Barrie alone would have a 102,000 doses capacity on any given day. This will serve about ¼ the population of Simcoe Muskoka. Generators are in place in the Gravenhurst (GH) and Barrie offices. 2. Plans to have generators in all HU offices where vaccine is stored. 3. All other outer office locations have single door Revco fridges: Cookstown, Collingwood, Midland, Orillia, Gravenhurst and Huntsville: capacity of each of those

Interpandemic Period: Phase 1 *No new influenza virus subtypes have been detected in humans*	Maintain up-to-date plans to acquire, store and distribute vaccine and antivirals (cont.)	fridges is 17,000 doses, leaving a small amount for routine childhood vaccines. 4. As of June 2006, the direction the MOHLTC is that antivirals are to be used for treatment only. Storage requirements will be a small 10 X 8 room: suggest the small storage room off the Trillium room in GH office or another suitable location is found. 5. Depending on MOHLTC, vaccine and/or antivirals will be distributed as per the current process to physicians, long-term care and hospitals and mass immunization clinics.
	Work with stakeholders (e.g. professional organizations, labour associations) to develop plans to redeploy staff to administer vaccine and antivirals, and to provide training	1. Need agreement in place with ONA re flexible work hours and change in assignment 2. Need agreement in place with Georgian College and deployment of nursing students. 3. Need to explore with emergency responder re deployment for mass immunization 4. Need agency decision re use of volunteers. 5. Need agency decision to contract out to other volunteer agencies. 6. Explore access to staff from community nursing agencies. 7. Need to develop Orientation/Training Manual (from UIIP training manual)
	Maintain antiviral treatment and prophylaxis recommended in "A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes" (MOHLTC, 2004)	See: "A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes" (MOHLTC, 2004)
INTERPANDEMIC PERIOD PHASE 2		
Interpandemic Period: Phase 2 *A circulating animal influenza virus subtype poses a substantial risk of human disease*	Continues with all Phase 1 activities	1. Provide list of qualified immunizers to BCP
	Distribute priority group enumeration tools to health care organizations to provide estimates of demand for antivirals	1. See Emergency Response Chapter – Appendix A for estimated numbers of essential service workers. 2. Awaiting further directions regarding priority groups from the MOHLTC
	Submit estimates to MOHLTC	1. Completed 2. Enumeration process currently under review by MOHLTC
INTERPANDEMIC PERIOD PHASE 3		
Interpandemic Alert Period: Phase 3 *Human infection(s) with a new subtype, but no human-to-human spread or spread to a close contact only*	Continue with all Phase 1 activities	1. Need to complete all documents to support clinics e.g. Aftercare sheets, Vaccine and Antiviral information sheets
	Confirm that security issues associated with storing and distributing vaccine and antivirals have been addressed	1. Define the security requirements for the agency for: • storage at Health Unit offices • storage at Health Unit clinics • storage at antiviral distribution centers 2. Check with data team re: data needs for vaccine and antivirals 3. Confirm with MOHLTC re: AEFI and iPHIS

PANDEMIC ALERT PERIOD PHASE 4		
Pandemic Alert Period: **Phase 4** *Small cluster(s) with limited human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet by fully transmissible*	Confirm distribution points for vaccine, and other vaccination locations in each area	1. List of all sites noted in Appendix A (Mass Immunization Plan). Sites are designed to immunize larger groups of individuals in a rapid fashion. Unlike UIIP sites which are designed to reach as many communities over a longer period of time 2. Need Memorandum of Understanding (MOU) with schools re having access to their facilities 3. Need MOU with malls and arenas 4. Need to rate each potential location to ensure adequate facilities (using checklist for clinic location criteria) see Mass Immunization Plan, Appendix I 5. Plot clinic locations on county/district map to ensure access 6. Provide list of clinics to web master for posting on web when mass immunization clinics are implemented
PANDEMIC ALERT PERIOD PHASE 4		
Pandemic Alert Period: **Phase 4** *Small cluster(s) with limited human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet by fully transmissible*	Ensure list of currently qualified vaccinators and potential vaccinators is up to date	1. Provide to Business Continuity Plan (BCP). Currently have access to about 50 VPD casual staff. We also have access to PHN staff from other program teams who can rotate through the annual UIIP clinic to maintain immunization skill
	Review mass vaccination program	See Appendix A – Mass Immunization Plan
	Address any issues that may impede rollout of a mass immunization program	1. Large supply issues may indicate a need for a Supply Coordinator 2. Stat Sheet/Replenish List to be created for clinics
	Review/update (if necessary) educational materials on administering vaccines	1. UIIP training manual and medical directive training 2. VPD guidebook under construction 3. List of emergency #'s relevant to each clinic location will be available. Included will be information on closest door for ambulance and any other relevant information. 4. Develop Unusual Incident/Error/Vaccine Reaction Report Form
	Assess current supply of antivirals (i.e., drugs, formulations, expiry dates)	1. Await direction from the MOHLTC
	Confirm plans for distributing antivirals	1. The latest direction from the MOHLTC is that local health units will not be involved in assessments centers and the dispensing of antivirals. Main role will be in storing and distributing antivirals to health care providers and facilities. Contact to confirm – MOHLTC

PANDEMIC ALERT PERIOD PHASE 5		
Pandemic Alert Period: **Phase 5** *Large cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible*	Review and, if necessary, modify plans for storing, allocating, distributing and administering vaccine and antivirals	1. As per direction of the MOHLTC
	Review estimates of the number of people in each of the priority groups for vaccination and/or antiviral drugs (i.e. high risk groups, health care workers, emergency service workers, specific age groups) and access strategies	1. As per direction of the MOHLTC and coordinate with the surveillance group re numbers.
	Ensure staff are trained and infrastructure is in place to: • record immunizations, including requirements for a two-dose immunization program (i.e. re-call and record-keeping procedures) • track who receives antivirals for treatment or prophylaxis	1. Check with data team re-secure data base. Review Durham on site module for data entry 2. Explore options of staff working from home and access to resources/training/ schedules and clinic sites
	Work with health organizations to train non-traditional vaccinators	1. Decision needed re: use of EMS, Veterinarians, and Dentists. May need to update medical directive to include these other non traditional vaccinators
PANDEMIC PERIOD PHASE 6		
Pandemic Period: **Phase 6** *Increased and sustained transmission in general population*	Assess local capacity to provide mass vaccination (i.e., are resources required?)	1. Finalize resources needed for clinics/consents/after care / Q& A/ fact sheets
	Apply national target groups and guidelines as directed by the province	1. Implement as directed. Link with communication re target groups
	Epidemiology and available supplies, administer antiviral treatment and prophylaxis priority groups	1. Update priority groups as per direction from the MOHLTC and local HU role in distribution of antivirals. 2. Finalize resources re: Antiviral Fact Sheet FAQ/ priority groups
	If antivirals are being used, implement adverse drug reaction reporting system	1. To be entered on iPHIS
	When vaccine is available: • activate mass vaccination clinics • implement distribution and security plans	1. Obtain individual building/area maps for clinic design Implement Clinic/Client Operational Flow Chart. See Appendix A - Mass Immunization Plan.

Pandemic Period: Phase 6 *Increased and sustained transmission in general population*	• implement streamlined VAAE surveillance, in collaboration with PHAC	
	Communicate with bordering jurisdictions about vaccine and antiviral distribution plans and coordinate efforts as much as possible	1. Communicate through VPD network via Health Fax, web, teleconference – refer to Communication Framework
	Review and, if necessary, modify plans for vaccine security (i.e., during, transport, storage and clinic administration)	
Pandemic Period: Phase 6 *Regional and multi-regional epidemics*	If vaccine is available…continue to implement vaccine plan and surveillance	
	Submit reports on the total number of people immunized with one and/or two doses to MOHLTC	1. From data base or paper record
	Continue to promote strategic use of antiviral drugs and monitor/reports resistance and adverse reactions	1. Link with Communications Sub-Committee
	Monitor vaccine and antiviral supply, demand, distribution and uptake	1. Provide data entry and create reports
Pandemic Period: Phase 6 *End of first wave; pandemic subsiding*	If vaccine only becomes available at this stage…implement all Phase 6 activities above	1. An effective computer scheduling program will be needed and several admin support persons to action the scheduling of staff
	If vaccine was available and administered in earlier phases… • expand vaccine programs to cover population not yet immunized and actively promote vaccination • summarize and report coverage data (with one and/or two doses) and VAAE data • continue ongoing VAAE surveillance • restock supplies and resume routine programs	1. Continue to implement the Mass Immunization Plan

Pandemic Period: Phase 6 *End of first wave; pandemic subsiding*	Review/revise guidelines and/or protocols used during the mass vaccination campaigns	1. As needed
	Assess local stockpile/inventory of antivirals and continue to monitor availability	1. Supply coordinator to monitor
	Summarize and report: • antiviral resistance data • adverse drug reaction data	1. Link with Surveillance
Pandemic Period: Phase 6 *Second or later waves of the pandemic*	If vaccine is available…continue immunization programs focusing on non-immunized populations	
	Based on local epidemiology and available supplies, and lessons learned from previous wave(s), administer antiviral prophylaxis and treatment to priority groups	
POSTPANDEMIC PERIOD		

APPENDIX A - II - 1 MASS IMMUNIZATION PLAN

MASS IMMUNIZATION PLAN

II - 3 PUBLIC HEALTH MEASURES

INTRODUCTION

The Ontario Pandemic Influenza Plan, draft document June 2006, contains the following information from Public Health Measures and Factors to Consider when Choosing Public Health Measures.[18]

4.2 Public Health Measures
Public health measures are non-medical interventions used to reduce the spread of disease, including but not limited to:

- providing public education
- issuing travel restrictions and screening travelers
- conducting case and contact management
- closing schools
- restricting public gatherings.

4.2.1 Objectives

- To decrease the number of individuals exposed to the novel virus and potentially slow the progress of the pandemic.
- To slow disease spread and gain time for implementing medical measures (e.g., vaccine)
- To reduce the morbidity and mortality caused by the pandemic

4.2.2 Factors to Consider when Choosing Public Health Measures
The type of public health measures used during an influenza pandemic and their timing will depend on:

- the epidemiology of the virus (e.g., pathogenicity, mode/s of transmission, incubation period, attack rate in different age groups, period of communicability, susceptibility to antivirals).
- the pandemic phase and the amount of virus activity in the region (i.e., during phases 4 and 5, the focus of public health measures will be on individual measures to contain the virus (e.g., case and contact management; during phase 6, the focus will be on community measures designed to reduce risk of influenza (e.g., public education, restricting public gatherings)
- the characteristics of the community (i.e., some measures, such as school closures, may be more effective in rural than urban areas)
- public acceptance of the measures
- the resources required to implement the measure. Some measures, such as tracing contacts and active surveillance, are labour intensive and may not be effective once the virus is widespread in the community
- the amount of social disruption the measure will cause. For example, the decision to cancel public transit services would be so disruptive; it is unlikely to be used. Social isolation measures that keep people home from work could be costly to some businesses and may be applied selectively.

The following Pandemic Phases and Public Health Measures Activities have been developed from the OHPIP Section 4, June Draft 2006. The SMDHU PIP will be reviewed and updated as revised versions of the OHPIP are released.

Phase 1 **From WHO**	**Local Level Objectives** **From OHPIP**	**Public Health Unit** **Public Health Measure Activities**
INTERPANDEMIC PERIOD PHASE 1		
Interpandemic Period: **Phase 1** No new influenza virus subtypes have been detected in humans **Goal: To promote personal protective measures that reduce the risk of acquiring seasonal influenza**	Promote/disseminate practices that reduce the risk of acquiring influenza (e.g., hand hygiene, staying home when ill, covering your cough) and disseminate education materials for the general public and health care workers regarding reducing one's chances of acquiring influenza	Work with Public: 1. Media coverage – including MOH columns, interviews, work with communication groups 2. Promote use of glow germ as a teaching tool to understand hand hygiene 3. Current hand hygiene campaign – Launch Fall 2006 4. Review current teaching tools and fact sheets for public consumption 5. Review provincial and federal documents for promotion of general messages, create new tools to address gaps • http://www.influenza.gc.ca/index_e.html • http://www.simcoemuskokahealth.org/Topics/Pandemic/introduction.asp?NAV=PIP • http://www.health.gov.on.ca/english/public/program/pubhealth/flu/panflu/panflu_mn.html • http://www.pandemicflu.gov/ Work with Health Care Providers: 1. Promotion of standard precautions and use of Personal Protective Equipment (PPE) to reduce risk 2. Work with ICP's to ensure consistency in approaches to above precautions. 3. Review and promote current protocols, directives related to "best practice" link with Infection Prevention and Control Practitioner's, Occupational Health Staff in acute care and health providers to provide information – may be in form of Health Fax, meetings, teleconferences, multimedia tools, etc, 4. Link with Regional Infection Control Network to ensure best approaches and support for the work 5. Link with Webmaster for additional Website development 6. Link with Chairs of the SMHSEPC and their communications group for posting of developed materials as approved Work within this framework – Communicable Disease Surveillance Unit (CDSU) for acute care, Communicable Disease Investigation Unit (CDIU) for other facilities
	Anticipate unique needs of own community (e.g. translation requirements) and target seasonal influenza information for various stakeholders (e.g. schools, day-care, community groups)	1. Currently, the Health Status Report provides the basis of our understanding of the population within SMDHU. Additional information may be pulled from the Census data available to the Epidemiologist and Research Analyst. This will provide basis information on the diversity of our population. 2. Program staff in each office may present additional information to use in identification

		of "unique" communities. Recommend consideration of a local office meeting to discuss with staff to gather additional information. 3. Area to explore for agreements: Do we need a more formal relationship with "Welcome Centres" for new immigrants for translation purposes.
Interpandemic Period: Phase 1 *No new influenza virus subtypes have been detected in humans* **Goal: To promote personal protective measures that reduce the risk of acquiring seasonal influenza**	Follow routine (interpandemic) protocols for follow up of confirmed/suspect influenza cases and their contacts and respiratory infection outbreak management	1. CD Team receives reports for all confirmed community cases of influenza. These cases are investigated following the protocol in the CD Manual which is based on the annual surveillance information published each year by the MOHLTC. http://intranet.smdhu.net/Content/Services/Clinical/CommunicableDisease/Manual/cdindex.htm 2. Health care facilities implementing the Best Practices document - Preventing Febrile Respiratory Illnesses provides additional systems in the identification of potential illness that does not confirm any of the routine respiratory illnesses. This protocol is found at: http://www.health.gov.on.ca/english/providers/program/infectious/diseases/ic_fri.html 3. CD Team receives and responds to all reports of respiratory outbreaks within our health care facilities and day nurseries. These outbreaks are reported to the MOHLTC within a specified timeframe and entered into iPHIS for tracking of the information and for reporting purposes. The staff working in the CD Program are responsible for active follow up on a daily basis for the duration of the outbreak with the institution. At the conclusion of the outbreak a report is complete by the assigned investigator and successes and challenges are noted and shared with the facility with specific recommendations for improvement should that be required. 4. This information is disseminated to the facilities in the form of an annual education day which includes a variety of materials but reflects the past years learning's from outbreaks. New tools for monitoring are shared; lab testing materials are provided to expedite timely sample submission. 5. Each year the MOHLTC publishes amendments to the surveillance packages for outbreak management and reporting standards. This includes weekly reports for activity with our jurisdiction as well as standard reporting within iPHIS and at this point in time faxing of outbreak reports at the initiation and conclusion of the outbreak. The MOHLTC has published a guideline (2004) which is located at: http://www.health.gov.on.ca/english/providers/pub/pubhealth/ltc_respoutbreak/ltc_respoutbreak.pdf outlines the PH role in management of Respiratory Outbreaks and further directives related to communication and reporting. 6. CD Team maintains a "whiteboard" summary of outbreaks to provide a visual reporting for those working in Clinical Service and Health Connection. 7. The CD Team utilizes Health Faxes and the confidential CD Surveillance Website to communicate progress of the outbreak season to Health Care Partners 8. Consider expansion of rights/access to the CD Surveillance website to include: LTCF, Rest & Retirement Homes, Ministry Compliance Advisors, physicians, other Health Care providers

INTERPANDEMIC PERIOD PHASE 2		
Interpandemic Period: **Phase 2** *A circulating animal influenza virus subtype poses a substantial risk of human disease.* **Goal: To develop Public Health Measures (PHMs) (and communication materials related to PHMs) to be used during pandemic alert and pandemic periods**	Continue Phase 1 activities	See Above
	Community Measures Assist in the development, adopt and disseminate provincial recommendations on Public Health Measures to be implemented during a pandemic	1. Ongoing development, review and refinement of SMDHU Pandemic Plan is an ongoing process within the pandemic influenza planning structure. Staff may review the current resources and development on the Intranet site. 2. As refinements to the Ontario and Canadian Plans are finalized, SMDHU will update plans and communicate with key stakeholders the changes in recommendations and process. 3. CD team to explore Orientation and Training options regarding ongoing development and leadership of non–CS Managers and Supervisors to assist and expand the CD team during a pandemic. 4. Link with key community partners regarding implications of implementation of PH Measures: Meeting with School Boards, Day Nursery Operator Group, large event forums at health care facilities.
	Anticipate unique needs of own community (e.g. translation requirements) and target pandemic information for various stakeholders (e.g. schools, day-care, community groups)	See Above Phase 1
	Adopt education materials about public health measures that may be used during a pandemic (e.g., self isolation, school closures and social distancing) general information regarding risk reduction to introduce pandemic concepts to the general public.	See Above: 1. Review of developed resources thru shared work of the CD Team, Communications Team and the MOH office 2. Review with the Corporate Communications, information to be shared with public. 3. Review developed provincial documents on social distancing and the documents within Appendix A - II - 3 for evidence based information 4. Review protocols for case investigation and messaging for self isolation and illness monitoring. 5. Review provincial and federal documents for promotion of general messages, create new tools to address gaps • http://www.influenza.gc.ca/index_e.html • http://www.simcoemuskokahealth.org/Topics/Pandemic/introduction.asp?NAV=PIP • http://www.health.gov.on.ca/english/public/program/pubhealth/flu/panflu/panflu_mn.html • http://www.pandemicflu.gov/

Interpandemic Period: Phase 2 *A circulating animal influenza virus subtype poses a substantial risk of human disease.* **Goal: To develop Public Health Measures (PHMs) (and communication materials related to PHMs) to be used during pandemic alert and pandemic periods**	Adopt and disseminate information about personal protective measures to be used by cases and their contacts	1. As information is developed, this will be shared with cases and their contacts. Currently the MOHLTC website has these recommendations for prevention: 2. Once a case of novel viral influenza is identified within Ontario/Canadian borders, recommendations for containment strategies will be made by public health officials. 3. In considering the initial cases and their contacts dissemination of control and preventive measures will be of top priority for staff assigned to the CD Program. Persons presenting with influenza like illness or confirmed influenza should be isolated. Isolation location will be based on the severity of the symptoms. Plans should be developed to assist the individuals with personal protective measures to limit spread of illness to others including: • how to self-isolate within the home setting • work with admitting institution should the case be institutionalized to ensure routine precautions are in place (documents that would provide assistance see reference18F[19], [20] and in addition, reference.20F[21] These reference documents would assist as well as the routine Infection Prevention and Control Documents found at the Public Health Agency of Canada and the Centers for Disease Control in Atlanta. • hand washing and use of hand sanitizers • respiratory etiquette practices, covering mouth when coughing, disposal of tissues, etc. • use of surgical masks when attending outside appointments or contact with well individuals in the home For contacts of cases: • Self monitoring for symptoms • Reporting on symptoms as they develop • hand washing and use of hand sanitizers • respiratory etiquette practices, covering mouth when coughing, disposal of tissues The following sites provide basic information on personal protective measures: Hand washing and the use of sanitizers http://www.ccohs.ca/oshanswers/diseases/washing_hands.html Respiratory Hygiene http://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm General information on personal and family preparedness http://www.pandemicflu.gov/plan/tab3.html

INTERPANDEMIC PERIOD PHASE 3		
Pandemic Alert Period: **Phase 3** *Human infection(s) with a new subtype, but no human-to-human spread or spread to a close contact only* **Goal: To mitigate the effects of a novel strain, should one be detected in Ontario**	Continue Phase 2 activities	See Above
	Individual-Based Measures when novel virus activity is occurring outside of Ontario	
	Disseminate educational materials for health care workers during a pandemic	1. As the province releases key documents, work with communications group to disseminate the material / protocols via approval channels. 2. Current key resources to assist health care providers include: PIDAC Best Practices document - Preventing Febrile Respiratory Illnesses provides additional systems in the identification of potential illness that does not confirm any of the routine respiratory illnesses. This protocol is found at: http://www.health.gov.on.ca/english/providers/program/infectious/diseases/ic_fri.html The Canadian Pandemic Plan includes Annex F which is devoted to Infection Control and Occupational Health Guidelines During a Pandemic Influenza in traditional and Non-Traditional Health Care Settings, February 2004, found at: http://www.phac-aspc.gc.ca/cpip-pclcpi/pdf-cpip-03/cpip-appendix-f.pdf WHO has also published a document that provides background infection and prevention guidelines for Health Care Workers. http://www.wpro.who.int/NR/rdonlyres/EA6D9DF3-688D-4316-91DF-5553E7B1DBCD/0/InfectionControlAIinhumansWHOInterimGuidelinesfor.pdf
	Follow routine (interpandemic) protocols for follow up of confirmed/suspect influenza cases and their contacts and respiratory infection outbreak management	See Phase 1
	Individual-Based Measures when novel virus activity is occurring within Ontario	

Pandemic Alert Period: **Phase 3** *Human infection(s) with a new subtype, but no human-to-human spread or spread to a close contact only* **Goal: To mitigate the effects of a novel strain, should one be detected in Ontario**	Isolate individuals suspected/confirmed to be ill with the novel strain in hospital with highest priority for those for whom hospital treatment is clinically indicated. Isolate at home if there is no hospital capacity for less clinically severe cases. Adults recommended for self-isolation at home should stay there for a minimum of 5 days after onset of symptoms or until symptoms have resolved, whichever is longer.	CD team routinely works acute care partners and the local public health laboratory in the identification of unusual illnesses. Individuals presenting to a health care facility with influenza like illness may fail the "FRI" screening which would be the first surveillance tool to indicate the individual has a respiratory illness not yet diagnosed. While laboratory tests to confirm illness (currently there are no rapid tests for avian influenza, however, there is a shell vial culture test which is now available and will provide a culture result in under 72 hours) are being performed the individual suspected of the illness should: 1. Be isolated if in a health care facility if illness warrants this level of care 2. If discharged home or sent home the individual should remain in isolation and monitored by the assigned CD investigator for a period of not less than five days for resolving symptoms and that the individual has limited their contact with others a. if the CD investigator is concerned that the individual is not maintaining voluntary isolation, this should be reviewed with the program supervisor and manager for next steps b. if the manager supports, the situation is reviewed with the Clinical Service Director and the assigned MOH to determine if a Section 22 Order is the next option for case manager – See Appendix B – Preparing and Servicing a Section 22 Order c. Manager and assigned investigator will draft the order for review by the Director and MOH d. Order will be served by assigned staff. e. CD investigator will monitor compliance with the order by phone or home visit as required f. if compliance is not secured further discussion with the MOH and Director will be required for next determining next steps 3. CD investigator assigned should determine household and other contacts, what personal protective measures need to be put into place to protect others in the home and those providing care 4. CD investigator in discussion with the case should identify other contacts who may have had close contact defined as those with face to face (1 meter) contact of a suspect or confirmed case
	Advise contacts* of cases to restrict contact with others for 3 days (or for duration of incubation period of novel strain) * For the purpose of this document, a contact is an individual who had face-to-face contact (within 1 metre) of a suspect or confirmed case.	1. Once the case has been interviewed and the contact list developed, the investigator will review the contacts with their assigned manager or supervisor. In consultation with the MOH office it will be decided whether the individuals will be asked to restrict contact with others for 3 days. 2. Check with Surveillance/Data Group regarding tool creation for use in monitoring and contact management. Responsibility for development - CDSU epidemiologist and research analyst.

Pandemic Alert Period: **Phase 3** *Human infection(s) with a new subtype, but no human-to-human spread or spread to a close contact only* **Goal: To mitigate the effects of a novel strain, should one be detected in Ontario**	Implement quarantine and active surveillance for contacts of cases for symptoms of illness for 3 days or duration of incubation period of novel virus, whichever is longer. Consider asking contacts to defer travel for duration of surveillance period.	1. Assigned Investigator will contact the case contacts for 3 consecutive days to determine onset of symptoms should they develop 2. Utilizing the appropriate collection tool, this information is entered into the specific data base and reports will be generated on a daily basis – Link with Surveillance/Data Group to confirm development of such a tool as above. Currently may be able to adapt SARS forms see: S:\Health Unit\Health Protection\Sars\Forms S.C. & Others a. if the CD investigator is concerned that the individual is not maintaining voluntary quarantine, this should be reviewed with the program supervisor and manager for next steps b. if the manager supports, the situation is reviewed with the Clinical Service Director and the assigned MOH to determine if a Section 22 Order is the next option for case investigator – See Appendix B – Preparing and Serving a Section 22 Order c. Manager and assigned investigator will draft the order for review by the Director and MOH d. Order will be served by assigned staff. e. CD investigator will monitor compliance with the order by phone or home visit as required f. if compliance is not secured further discussion with the MOH and Director will be required for determining next steps
	Educate cases and contacts about methods to reduce disease transmission [for cases isolated at home] (e.g. frequent and thorough hand hygiene, respiratory hygiene), and what to do if illness progresses (cases) or develops (contacts\	• Self monitoring for symptoms • Reporting on symptoms as they develop • Hand washing use of hand sanitizers • Respiratory etiquette practices, covering mouth when coughing, disposal of tissues 1. Develop checklist that will assist investigator in education provision; - CD Team/ Communications Responsibility
	Community Measures when novel virus activity is occurring outside of Ontario	
	Adopt revised provincial Public Health Measures	1. CDSU assigned staff will monitor the key websites and documents to identify changes in provincial recommendations for action. 2. CD Team will respond and update plans as new recommendations are provided.
	Disseminate educational materials for health care workers during a pandemic	As Above 1. As the province releases key documents, work with communications group to disseminate the material / protocols via approval channels. See Communications framework. 2. Current key resource to assist health care providers include: PIDAC Best Practices document - Preventing Febrile Respiratory Illnesses provides additional systems in the identification of potential illness that does not confirm any of the routine respiratory illnesses. This protocol is found at: http://www.health.gov.on.ca/english/providers/program/infectious/diseases/ic_fri.html

	Disseminate educational materials for health care workers during a pandemic (cont.)	The Canadian Pandemic Plan includes Annex F which is devoted to Infection Control and Occupational Health Guidelines During a Pandemic Influenza in traditional and Non-Traditional Health Care Settings, February 2004, found at: http://www.phac-aspc.gc.ca/cpip-pclcpi/pdf-cpip-03/cpip-appendix-f.pdf WHO has also published a document that provide background infection and prevention guidelines for Health Care Workers, found at: http://www.wpro.who.int/NR/rdonlyres/EA6D9DF3-688D-4316-91DF-5553E7B1DBCD/0/InfectionControlAlinhumansWHOInterimGuidelinesfor.pdf
Pandemic Alert Period: Phase 3 *Human infection(s) with a new subtype, but no human-to-human spread or spread to a close contact only* **Goal: To mitigate the effects of a novel strain, should one be detected in Ontario**	Identify and train additional staff in case management and contact tracing to ensure expertise and resources are available for business continuity for outbreak and pandemic management	See Business Continuity Planning. 1. CD Manager and Supervisors to work with HR/Corp S and Orientation and Training co-ordinator to set out a work plan for training development related to surge capacity. Identification of staff will be based on our Emergency Response Plan. 2. Currently there are PowerPoint presentations on: • PPE • Hand washing • CD Manual is a resource on standards for Intake, Investigation Process • SARS Training Modules provide an introduction to Epi and Surveillance that could be modified to a self-training package SEE: S:\Health Unit\Pandemic Flu Planning\Pandemic General Files\40_Pandemic_Influenza_Planning_Advisory_Committee\510_Public Health Measures\Documents_Resources\SARS Training 2. As per the Emergency Response Plan, CD Manager and Supervisor to assess who will be reassigned to CD, their current level of knowledge and learning need
	Community Measures when novel virus activity is occurring within Ontario	
	Attend teleconferences among affected health unit/s, MOHLTC, PHAC and other relevant stakeholders should laboratory-confirmed cases be identified in Ontario	1. Determine best person (CD Team assignment) to assist in attending teleconferencing, preparing report to brief management and MOH office as required and document actions/changes in process 2. As required update stakeholders via the web or other communication methods. See Communications Framework
	Monitor/track compliance with public health/containment measures until no longer sustainable; report compliance to MOHLTC	1. Working with Surveillance/Data Group, ensure documents that are developed, and utilized to track information to assist in determining compliance 2. Determine how the MOHLTC seeks to receive the reports

PANDEMIC ALERT PERIOD PHASE 4		
Pandemic Alert Period: Phase 4 *Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans (Could we have a definition of what a small cluster would be?* **Goal: To mitigate the effects of a novel strain, should one be detected in Ontario**	Continue Phase 3 activities	
	Individual-Based Measures when novel virus activity is occurring outside of Ontario	
	As per phase 3	
	Individual-Based Measures when novel virus activity is occurring outside of Ontario	
	Implement measures 1, 2, 3, 4 as per phase 3 above **KEY DECISION** Individual case management by local public health authorities may need to be discontinued in health units that are heavily impacted during the alert periods.	See Appendix A
	Community Measures when novel virus activity is occurring outside of Ontario	
	Ensure business continuity plans/strategies are updated, relevant and ready for implementation.	See Business Continuity Planning.
	Advise MOHLTC what particular business continuity plans/strategies are if situation escalates.	See Business Continuity Planning.
	Community Measures when novel virus activity is occurring outside of Ontario	
	Collaborate with PHAC and MOHLTC to implement exit screening if required.	1. Consider implications and confirm process expected and involved in “exit” screening – CDSU to Follow-up
PANDEMIC ALERT PERIOD PHASE 5		
Pandemic Alert Period: Phase 5	Continue Phase 4 activities	
	Review/update local plans for pubic health measures based on national/ provincial guidelines and unique needs of own community (e.g. rural vs. urban)	1. CD Team to review and modify PHM as required based on current surveillance and epidemiological trends. Based on WHO, Health Canada and MOHLTC recommendations/directives

Pandemic Alert Period: **Phase 5** *Large cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible* **Goal: to mitigate the effects of a novel strain, should one be detected in Ontario**		
	Individual-Based Measures when novel virus activity is occurring within Ontario	
	Implement measures 1, 2, 3, 4 as per phase 3 above.	See Phase 3
	Recommend contacts defer travel for duration of surveillance period.	1. Build this into a communication and case / cont 2. act management strategy for case investigator to recommend 3. Consider this to be part of a FAQ, Fact Sheet Development for Corporate Communications
	Community Measures when novel virus activity is occurring within Ontario	
	Continue with phase 4 activities	See Phase 4.
	Activate local information hotline	See Communication Planning
	Community Measures when novel virus activity is occurring within Ontario	
	Activate local information hotline for frequently asked questions	See communication planning.
	Activate local pandemic plans	1. Under the leadership of the MOH office and the Emergency Response Team, decision to activate plans will be considered
PANDEMIC PERIOD PHASE 6		
Pandemic Period: **Phase 6** *Increased and sustained transmission in general population* *Limited virus spread within Canada*	Individual case management by local public health authorities will likely not be sustainable and consideration should be given to discontinue at this phase based on local activity and health unit capacity.	1. Working with the Surveillance/Data Group, determine minimal data sets information required to report status to the MOHLTC Outcomes of reporting: • basic demographics • severity- morbidity and mortality effects • impacts to health care • ability to carry on priority services • identify slowing down of infections
	Isolate individuals suspected to be ill with the novel strain in hospital if clinically indicated, otherwise isolate at home	1. CD Team to work with health care providers to ensure that individuals diagnosed with influenza are self-isolated for the required time period based on the epidemiology of the virus

		2. Work with Communications Team to disseminate developed self care messages including self-isolation requirements 3. With the expanded team determine levels of monitoring that would be required for diagnosed cases
	Contacts of cases to self monitor for symptoms for 3 days after last exposure to case or for duration of incubation period, whichever is longer	1. Work with Communications Team to disseminate developed self care messages including self-monitoring for illness
Pandemic Period: Phase 6 *Increased and sustained transmission in general population* *Limited virus spread within Canada*	Provide contacts with information about how to report symptoms of influenza-like illness (ILI), when isolation is indicated, and when to seek medical care	1. Work with Corporate Communications to ensure that case contacts have easy access to information on self monitoring and reporting 2. Consider methods of self reporting to enable staff to monitor the stages of individuals with ILI. Work with staff in CDSU and the Surveillance/Data Group to consider data requirement and methods – consider online, telephone, call centres. Link concepts with Assessment Centres 3. Consider distribution methods of self monitoring – posted to web site, work place settings, doctor's offices, hospitals, "mailings" etc
	Community Measures	
	Implement provincial pandemic PHM as conventional (i.e., individual case and contact management) *measures may no longer be sustainable due to spread of virus*	As in Phase 2. 1. Currently the MOHLTC website has these recommendations for prevention: 2. Persons presenting with influenza like illness or confirmed influenza should be isolated. Isolation location will be based on the severity of the symptoms. Plans should be developed to assist the individuals with personal protective measures to limit spread of illness to others including: • how to self-isolate within the home setting • work with admitting institution should the case be institutionalized to ensure routine precautions are in place (documents that would provide assistance see reference[22] and in addition, reference).22F[23] These reference documents would assist as well as the routine Infection Prevention and Control Documents found at the Public Health Agency of Canada and the Centres for Disease Control in Atlanta. • hand washing and use of hand sanitizers • respiratory etiquette practices, covering mouth when coughing, disposal of tissues, etc • use of surgical masks when attending outside appointments or contact with well individuals in the home

Pandemic Period: Phase 6 *Increased and sustained transmission in general population* *Limited virus spread within Canada*		1. For contacts of cases: a. Self monitoring for symptoms b. Reporting on symptoms as they develop c. hand washing use of hand sanitizers d. respiratory etiquette practices, covering mouth when coughing, disposal of tissues 2. The following sites provide basic information on personal protective measures: Hand washing and the use of sanitizers: http://www.ccohs.ca/oshanswers/diseases/washing_hands.html Respiratory Hygiene http://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm General information on personal and family preparedness http://www.pandemicflu.gov/plan/tab3.html
Pandemic Period: Phase 6 *Increased and sustained transmission in general population* *Limited virus spread within Canada* **Goal: Communicate to public about risk reduction strategies**	**"KEY DECISION" **** Consider implementation of community-based PHMs based on epidemiology of novel strain (e.g. affected age group/s, severity of illness), risk of virus acquisition and unique characteristics of jurisdiction	See Appendix A
	Communicate about issues pertaining to individual preparedness/protection, curtailment of other public health services/functions,	1. See Communication planning.
Pandemic Period: Phase 6 *Regional and multi-regional epidemics Widespread novel virus activity in Canada*	**Continue Phase 6 activities**	
	Individual-Based Measures	
	Isolate individuals suspected to be ill with the novel strain in hospital if clinically indicated, otherwise isolate at home.	As above

Pandemic Period: Phase 6 *Regional and multi-regional epidemics Widespread novel virus activity in Canada*	**Community Measures**	
	Disseminate public education messages designed to heighten awareness of personal protective measures, self-care and illness reporting; include advice to contacts (as entire population will now be considered potential cases) [broad messaging, rather than individual-based instructions, e.g. self monitor for ILI]	1. See Communication planning 2. Review of current documents, considering modifying based on analysis of current trends
	General Measures	
	Disseminate any revised provincial PHM directives	1. CDSU assigned staff will monitor the key websites and documents to identify changes in provincial recommendations for action. 2. CD Team will respond and update plans as new recommendations are provided.
	Provide feedback on effectiveness of interventions to the provincial level	1. Effectiveness of interventions to be monitored by Data Team
Pandemic Period: Phase 6 End of First Pandemic Wave; Pandemic Subsiding	Prepare for the next wave:	
	Evaluate the effectiveness of public health measures	1. Linking with the Surveillance/Data Group consider use of PHM 2. Determine methods of Evaluation – to be discuss with Research Consultant as early as possible in the planning cycle.
	Document and report lessons learned to the MOHLTC	1. Review minutes, reports, staffing analysis, link with other groups to provide information to the Ministry as request.
	Restore depleted physical and human resources Implement psycho-social programs for staff	See Business Continuity Planning.
	Communicate with general public to prepare for next wave	See Communication Planning

POSTPANDEMIC PERIOD		
Postpandemic Period: Return to Phase 1	Return to interpandemic influenza prevention and control measures	See phase 1
	Evaluate and develop lessons learned to help prepare for next wave	1. Workings with the leadership of SMDHU, at service and team levels, consider methods to review and propose methods to improve implementation of PHM. Share results with all staff.

* *Key decisions indicate where a major decision is required of the local Medical Officer of Health*

APPENDICES

APPENDIX A - II - 3: BACKGROUNDER FOR MOH KEY DECISIONS

In the June, 2006 draft of the Public Health Measures section of the Ontario Health Pandemic Influenza Plan (OHPIP), there are two key public health actions highlighted which denote a major decision required by the local Medical Officer of Health. This appendix is designed to provide the MOH office with the most current information that is available to help guide the decision making process related to these two key public health activities.

MOH Key Decision from OHPIP	PHM	Recommendations from PHAC & WHO	Comments
Key Decision # 1 - Individual case management by local public health authorities may need to be discontinued in health units that are heavily impacted during the alert periods	Case Management & Contact Tracing	• PHAC & WHO recommend aggressive case management and contact tracing be implemented until no longer feasible (generally cited as phase 3-5).	• Based on limited historical evidence, active tracing of contacts leading up to and during pandemics is not shown to be practical[24] • WHO findings state that quarantine and contact tracing measures during a pandemic will not be as successful as social distancing strategies at potentially reducing the spread of virus[25] • A large amount of Public Health resources and staffing would be required for questionable benefits[26] • WHO Phase 4 –Small cluster refers to less than 25 cases lasting less than 2 weeks and WHO Phase 5 –Large cluster refers to 25-50 cases lasting two to four weeks[27]

Key Decision #2 – Consider implementation of community-based PHMs based on epidemiology of novel strain (e.g. affected age group/s, severity of illness), risk of virus acquisition and unique characteristics of jurisdiction	Closures of Schools & Daycares	• PHAC & WHO recommend this PHM be considered most likely not before phase 4.	• Although there is limited scientific evidence of the effectiveness of these measures, anecdotal reports indicate they can limit influenza outbreaks and mathematical modeling suggests that they can flatten the epidemic curve and reduce the disease – particularly if schools are closed long enough early in the pandemic.[28] • Depends on the epidemiological context of the virus – the extent to which these settings contribute to transmission.[29] • When considering school/daycare closures, need to consider other venues that may arise for children to be mixing with their peers (other activities, make shift daycare sites etc.). Need to ensure that this measure is actually working to reduce the mixing of children.[30] • Consider the economic and societal disruptions of prolonged school/daycare closures.[31] • Unique characteristics of the community should be taken into account when decisions about school/daycare closures are being made[32]
	Restriction of Public Gatherings	• PHAC & WHO do not recommend this PHM for broad implementation. Consider if high risk gatherings can be identified.	• This measure is frequently supported, but limited scientific evidence to support its success. (Global Consulting, March 2006) • If the epidemiology of the pandemic suggests higher morbidity and/or mortality in a specific group of individuals then canceling events known to attract this specific high-risk group should be considered. (PHAC Annex M, March Draft)

APPENDIX B - II - 3: PREPARING AND SERVING A HPPA SECTION 22 ORDER

FROM THE HEALTH PROTECTION AND PROMOTION ACT, SECTION 22

"**22.** (1) A Medical Officer of Health, in the circumstances mentioned in subsection (2), by a written order may require a person to take or to refrain from taking any action that is specified in the order in respect of a communicable disease. R.S.O. 1990, c. H.7, s. 22 (1).

Condition precedent to order

(2) A Medical Officer of Health may make an order under this section where he or she is of the opinion, upon reasonable and probable grounds,

(a) that a communicable disease exists or may exist or that there is an immediate risk of an outbreak of a communicable disease in the health unit served by the Medical Officer of Health;

(b) that the communicable disease presents a risk to the health of persons in the health unit served by the Medical Officer of Health; and

(c) that the requirements specified in the order are necessary in order to decrease or eliminate the risk to health presented by the communicable disease. R.S.O. 1990, c. H.7, s. 22 (2); 1997, c. 30, Sched. D, s. 3 (1).

Time

(3) In an order under this section, a Medical Officer of Health may specify the time or times when or the period or periods of time within which the person to whom the order is directed must comply with the order. R.S.O. 1990, c. H.7, s. 22 (3).

What may be included in order

(4) An order under this section may include, but is not limited to,

(a) requiring the owner or occupier of premises to close the premises or a specific part of the premises;

(b) requiring the placarding of premises to give notice of an order requiring the closing of the premises;

(c) requiring any person that the order states has or may have a communicable disease or is or may be infected with an agent of a communicable disease to isolate himself or herself and remain in isolation from other persons;

(d) requiring the cleaning or disinfecting, or both, of the premises or the thing specified in the order;

(e) requiring the destruction of the matter or thing specified in the order;

(f) requiring the person to whom the order is directed to submit to an examination by a physician and to deliver to the Medical Officer of Health a report by the physician as to whether or not the person has a communicable disease or is or is not infected with an agent of a communicable disease;

(g) requiring the person to whom the order is directed in respect of a communicable disease that is a virulent disease to place himself or herself forthwith under the care and treatment of a physician;

(h) requiring the person to whom the order is directed to conduct himself or herself in such a manner as not to expose another person to infection. R.S.O. 1990, c. H.7, s. 22 (4); 1997, c. 30, Sched. D, s. 3 (2).

Person directed

(5) An order under this section may be directed to a person,

(a) who resides or is present;

(b) who owns or is the occupier of any premises;

(c) who owns or is in charge of any thing; or

(d) who is engaged in or administers an enterprise or activity,

in the health unit served by the Medical Officer of Health. R.S.O. 1990, c. H.7, s. 22 (5).

Class orders

(5.0.1) An order under this section may be directed to a class of persons who reside or are present in the health unit served by the Medical Officer of Health. 2003, c. 1, s. 15 (1).

Notice to class

(5.0.2) If a class of persons is the subject of an order under subsection (5.0.1), notice of the order shall be delivered to each member of the class where it is practicable to do so I n a reasonable amount of time. 2003, c. 1, s. 15 (1).

Same, general notice

(5.0.3) If delivery of the notice to each member of a class of persons is likely to cause a delay that could, in the opinion of the Medical Officer of Health, significantly increase the risk to the health of any person, the Medical Officer of Health may deliver a general notice to the class through any communications media that seem appropriate to him or her, and he or she shall post the order at an address or at addresses that is or are most likely to bring the notice to the attention of the members of the class. 2003, c. 1, s. 15 (1).

Information in notice

(5.0.4) A notice under subsection (5.0.3) shall contain sufficient information to allow members of the class to understand to whom the order is directed, the terms of the order, and where to direct inquiries. 2003, c. 1, s. 15 (1).

Hearing for class member

(5.0.5) Where a class of persons is the subject of an order under subsection (5.0.1), any member of the class may apply to the Board for the purposes of requiring a hearing under section 44 respecting that member. 2003, c. 1, s. 15 (1).

Health Care Consent Act, 1996

(5.1) The *Health Care Consent Act, 1996* does not apply to,

(a) a physician's examination of a person pursuant to an order under this section requiring the person to submit to an examination by a physician;

(b) a physician's care and treatment of a person pursuant to an order under this section requiring the person to place himself or herself under the care and treatment of a physician. 1996, c. 2, s. 67 (1).

Additional contents of order

(6) In an order under this section, a Medical Officer of Health,

(a) may specify that a report will not be accepted as complying with the order unless it is a report by a physician specified or approved by the Medical Officer of Health;

(b) may specify the period of time within which the report mentioned in this subsection must be delivered to the Medical Officer of Health. R.S.O. 1990, c. H.7, s. 22 (6).

Reasons for order

(7) An order under this section is not effective unless the reasons for the order are set out in the order. R.S.O. 1990, c. H.7, s. 22 (7)."

In writing a Section 22 order please consider the following:

The "Health Protection and Promotion Act", Section 22, sets out the parameters including scope of the orders that a Medical Officer of Health may serve upon an individual. It is incumbent upon the writer of the order to include:

- Reasonable and probable grounds:
  - A communicable disease exists or may exist and there is a risk of an outbreak
  - The disease presents a risk to others
  - The requirements are necessary to decrease or eliminate the risk to health
- Inclusions/actions described in the Order:
  - Closures of part a premise
  - Placarding of a premise to give notice of the other
  - Isolation of an individual who has or may have a communicable disease
  - Cleaning/disinfecting of a premise or thing (must be specific)
  - Destruction of the matter or thing (must be specific)
  - An individual to submit for examination by a physician and deliver a report of this examination to the Medical Officer of Health to confirm whether or not a person has a communicable disease or is infected with the agent of a communicable disease
  - An individual infected with a virulent communicable disease to place himself or herself under the care and treatment of a physician
  - An individual to conduct himself or herself in such a manner to not expose anyone else to the infection

- The order may be directed to a person (within the health unit jurisdiction) who:
  - Resides or is present
  - Who owns or occupies the premise
  - Who owns or is in charge of any thing
  - Who is engaged or adminsiters a enterprise or activity

Consideration in writing a class order:

- Class orders may be directed to a class of persons residing or are present in the health unit jurisdiction
- If a class of persons is directed under the order, a notice of the order must be delivered to each member of the class if practical to do so in a reasonable amount of time
- If the delivery of the notice will cause a delay which under the opion of the Medical Officer of Health, significally increases the risk of health of any individual, a general notice to the calss may be made via any communications media which seems appropriate to the Medical Officer of Health. In addition, a posted notice at the address or addresses to bring the order to the attention to the members of the class should be undertaken
- The notice should include information to allow the members of the class understand to whom the order is directed, terms of the order and to whom to direct inquires
- Any member of the class may apply to the Board for purposes of a hearing under section 44.

APPENDIX C - II - 3: SAMPLE ORDERS – INDIVIDUAL AND CLASS

Sample Order Individual:

ORDER OF THE MEDICAL OFFICER OF HEALTH

Section 22

Health Protection and Promotion Act, RSO 1990, c. H.7

TO:

I, <insert MOH/AMOH name and title> for the Simcoe Muskoka District Health Unit, order you to take the following actions:

1. <insert actions>
2.
3.

The purpose of this order is to <insert purpose>

THE REASONS for this ORDER are that:

1. <inset reasons>
2.
3.

As a result, I am of the opinion, based on reasonable and probable grounds that:

a. a communicable disease exists or may exist or there is an immediate risk of an outbreak of a communicable disease in the health unit served by me;

b. the communicable disease presents a risk to the health of persons in the health unit served by me; and

c. the requirements specified in this order are necessary in order to decrease or eliminate the risk to health presented by the communicable disease.

NOTICE

TAKE NOTICE THAT you are entitled to a hearing by the Health Services Appeal and Review Board if you deliver to me at the Health Unit and to the Health Services Appeal and Review Board, Health Boards Secretariat, 151 Bloor Street West, 9th Floor, Toronto, Ontario, M5S 2T5, notice in writing requesting a hearing within 15 days after service of this Order.

AND TAKE FURTHER NOTICE THAT although a hearing may be requested, this Order takes effect when it is served upon you.

FAILURE TO COMPLY with this Order is an offence for which you may be liable, on conviction, to a fine of not more than $5,000.00 for every day or part of each day on which the offence occurs or continues.

<Insert MOH name and credentials>
Medical Officer of Health
Simcoe Muskoka District Health Unit
15 Sperling Drive
Barrie, Ontario L4M 6K9

Served Upon: _____

Time: _____

Date: _____

Hand Delivered By: _____

Sample Order, Class:

ORDER OF THE MEDICAL OFFICER OF HEALTH

Section 22

Health Protection and Promotion Act, RSO 1990, c. H.7

TO: <insert the class of individuals being ordered>

<insert addresse(s) of site or location known to be common location of the class i.e. workplace, known meeting place>

I, <insert MOH/AMOH name and title> for the Simcoe Muskoka District Health Unit, order you to take the following actions:

4. <insert actions>
5.
6.

The purpose of this order is to <insert purpose>

THE REASONS for this ORDER are that:

4. <inset reasons>
5.
6.

As a result, I am of the opinion, based on reasonable and probable grounds that:

d. a communicable disease exists or may exist or there is an immediate risk of an outbreak of a communicable disease in the health unit served by me;

e. the communicable disease presents a risk to the health of persons in the health unit served by me; and

f. the requirements specified in this order are necessary in order to decrease or eliminate the risk to health presented by the communicable disease.

NOTICE

TAKE NOTICE THAT you are entitled to a hearing by the Health Services Appeal and Review Board if you deliver to me at the Health Unit and to the Health Services Appeal and Review Board, Health Boards Secretariat, 151 Bloor Street West, 9th Floor, Toronto, Ontario, M5S 2T5, notice in writing requesting a hearing within 15 days after service of this Order.

AND TAKE FURTHER NOTICE THAT although a hearing may be requested, this Order takes effect when it is served upon you.

FAILURE TO COMPLY with this Order is an offence for which you may be liable, on conviction, to a fine of not more than $5,000.00 for every day or part of each day on which the offence occurs or continues.

<Insert MOH name and credentials>
Medical Officer of Health
Simcoe Muskoka District Health Unit
15 Sperling Drive
Barrie, Ontario L4M 6K9

Served Upon: _____

Time: _____

Date: _____

Hand Delivered By: _____

II - 4 EMERGENCY RESPONSE

INTRODUCTION

Public health authorities will lead the response in an influenza pandemic. Health sector organizations and emergency responders will play vital roles in the provision of services and the coordination of overall emergency response.

The objectives of emergency response are:

1. To ensure that effective emergency management structures are in place to allow for the collaboration between the health sector, emergency service personnel and public health to ensure that the planned pandemic response is coordinated
2. To ensure a continuous state of readiness through education, testing and revision of plans
3. To minimize societal and economic impacts by ensuring that emergency and essential services are maintained and
4. Ensuring that effective communication systems are in place to facilitate information flow between the health unit, health sector and community emergency response partners.

Effective emergency response requires cooperation between many agencies to coordinate resources and services during all stages of an emergency. This chapter will describe the health and social infrastructures that will assist in pandemic influenza planning and response.

During the preparedness stages of an emergency, activities will include the development of plans and the conduct of simulation exercises to test these plans. It also includes the identification of communication systems and emergency management structures which will assist in local “readiness” to respond.

Contact information for key decision makers and essential service providers such as the health sector, emergency first responders (e.g. police and firefighters), utility services (e.g. Hydro and telecommunications workers), and social service providers has been identified and will be periodically reviewed.

To ensure that the consequences of a pandemic remain manageable, effective mitigation activities and resource allocation is required by those agencies responsible for providing services to the community. The Simcoe Muskoka District Health Unit has identified the approximate numbers and types of these service providers and agencies, and will work toward encouraging the agencies to develop business continuity plans which ensure the continued delivery of their services during a pandemic.

Ongoing efforts are also required to ensure that health care organizations, essential service organizations, and other employers within Simcoe Muskoka receive information about pandemic influenza, prevention and infection control strategies, and business continuity planning. This information can be delivered via printed material, material posted on web sites, in person meetings, and group presentations/forums and workshops. The health unit will be working with municipalities and other community partners to ensure that these agencies have access to information on business continuity to assist them with their business continuity planning.

EMERGENCY REPSONSE ACTIVITIES

Phase 1 **From WHO**	**Local Level Objectives** **From OHPIP**	**Public Health Unit** **Emergency Response Activities**
INTERPANDEMIC PERIOD PHASE 1		
Interpandemic Period: **Phase 1** *No new influenza virus subtypes have been detected in humans*	Develop/maintain emergency response/business continuity plans	**Internal** 1. Establish internal pandemic planning committee to develop Agency Influenza Pandemic Response Plan (Emergency Response Manager/Clinical Services Director) 2. Hire a Pandemic Influenza Planner (PIP) to oversee and coordinate pandemic planning and write overall plan (CS Director) 3. Establish key working groups in the areas of: • Public Health Measures • Communications • Emergency Response • Training and Orientation • Surveillance • Vaccine and Antivirals and • Business Continuity 4. Assign chairs for each working group (MOH/PIP Planners) 5. Working groups to develop content for specified chapters within the plan 6. Establish a communications coordinator (Information Management Lead) to oversee and support the communications process/materials, etc. during the pre-pandemic period. 7. Establish a communications liaison link with each of the pandemic planning workgroups **External** 1. Establish Health Sector Emergency Planning Committee as per recommendation by Ministry of Health & Long Term Care to assist in the development of the plan (County/District/MOH) 2. Develop and complete a coordinated, inter-agency pandemic influenza plan for the health sector of Simcoe County and the District of Muskoka (PIP Planner/County/District/Health Sector Planners) 3. Establish working group is assist with planning and identify opportunities to coordinate response 4. Ensure key stakeholders within the plan understand their identified roles (PIP Planner/MOH) 5. Ensure County/District plans are current and have been reviewed routinely

		6. Work with community stakeholders to develop business continuity plans 7. See Business Continuity Chapter for Business Continuity Planning Activities/Timelines and Responsibilities
Interpandemic Period: **Phase 1** *No new influenza virus subtypes have been detected in humans*	Conduct simulation exercises to test emergency response plans during a pandemic	**External** 1. Set up simulation exercise development committee- external committee (to plan for a pandemic simulation exercise at the County/District Level) (County EMC/District EMC, HPS,EMT, CS, CD Manager, AMOH (CS assigned AMOH, Content Specialist) 2. Hire a consultant to develop and facilitate simulation exercise (County/District) 3. Identify goals and objectives and methods of evaluation (Simulation Exercise Committee) 4. Introduce concept of exercise to Health Sector Emergency Planning Committees (County EMC) 5. Gain acceptance/approval of HSEP committee to proceed with development and conduction of exercise and expand (County/District/Public Health) 6. Extend committee membership to include health expert representatives 7. Review previously conducted simulation exercises and findings 8. Identify Key Stakeholders to be involved as a participants in the exercise 9. Develop Exercise 10. Communicate Invitation to participate to key stakeholder and request inputs 11. Identify sites for consideration for conduction of exercise 12. Site selection 13. Conduct exercise 14. Conduct “hot wash” 15. Conduct formal debriefings and evaluate exercise and plans 16. Evaluate exercise/existing Plans 17. Communicate findings 18. Modify Plans **Timelines** Development of Committee – May, 2006 Hire Consultant – June, 2006 Exercise Development and Communications – June/July/August, 2006 Conduction of Exercise – November, 2006

Interpandemic Period: Phase 1 *No new influenza virus subtypes have been detected in humans*	Conduct simulation exercises to test emergency response plans during a pandemic (cont.)	**Internal** 1. Communicate the need for a simulation exercise development committee to executive (HPS, ER Manager – May, 2006) 2. Set up Internal simulation exercise development committee to develop and conduct a pandemic simulation exercise prior to County/District Exercise (HPS, E.R Manager, C.S, CD Manager, C.S AMOH, C.S, S.H Manager, VPD staff, Health Communication staff, Family Health Staff) – June, 2006 3. Consider involvement of Key Response Partners (June, 2006) 4. Review previously conducted simulation exercises and findings (June, 2006) 5. Determine exercise format and develop Exercise (July/August, 2006) 6. Consider 2 phases of delivery to address "Command" and "Deployment" responsibilities 7. Communicate Invitation to participate to staff and identified key responders (August, 2006) Conduct Exercise (September/October, 2006) 8. Conduct debriefing (October, 2006) 9. Evaluate exercise and plan (October, 2006) 10. Modify Plan (October, 2006)
Interpandemic Period: Phase 1 *No new influenza virus subtypes have been detected in humans*	Promote annual influenza immunization to all emergency and other essential workers	See Vaccine & Antiviral and Communications Framework 1. Annual influenza immunization promotion to all emergency and essential service providers to be included as vital component of business continuity planning
	Revise plans if necessary	**Internal** 1. Integrate agency ER plan into Pandemic Plan (HPS, ER Manager, February, 2006) 2. Provide Orientation to PIPAC on ER Framework, Business Continuity, emergency declaration processes, requesting assistance from the province, Communications Protocol (HPS, ER Manager) 3. Review SMDHU ER plan (HPS, EMP) 4. Consider adoption of IMS system for emergency response as per provincial recommendations to health units and acute care facilities (HPS, EMP, Executive) 5. Review plans using similar IMS system (HPS, EMP-April/May, 2006) 6. Determine if IMS system is being adopted by the province and the Ministry of Health (HPS , EMP- April/May, 2006) 7. Contact other health units to determine if this model is being used (HPS–EMP, April 2006) 8. Develop a proposed IMS Response Framework (HPS, EMP–May/June, 2006) 9. Review IMS with Executive to determine if agency wants to adopt similar model (HPS – ER Manager/EMP – May, 2006) 10. Develop an orientation and implementation plan (HPS -EMP, July/Aug, 2006) – See Orientation and Training Framework 11. Integrate the IMS structure into the general agency's emergency response plan/framework (HPS, EMP – September/October, 2006) 12. Receive Plan Approval from Executive (HPS, EMP -October, 2006)

Interpandemic Period: **Phase 1** *No new influenza virus subtypes have been detected in humans*	Revise plans if necessary	13. Train staff on IMS structure (HPS, EMP - September-December, 2006) 14. Notify ER partners of key changes to the plan **External** 1. Meet with key external planning partners (District/County) to ensure that our proposed emergency response structure is consistent with their response framework (HPS, EMP – June- September, 2006) 2. Ensure that Health Unit response restructure and emergency notification systems are compatible with other health sector agency plans (HPS, EMP – June – September, 2006) 3. Ensure that emergency response structure and notification systems are compatible with the Ministry of Health and provincial reporting protocols (HPS, EMP May-September , 2006) 4. IMS structure training/recommendation for use by health sector agencies (County, HPS, EMP – June, 2006)
	Conduct risk assessments to determine appropriate precautions and educate emergency responders and workers who provide essential services about influenza, appropriate protective personal practices and the tools for determining who would have priority access to vaccine and antivirals	See Public Health Measures for infection control measures and assessed risks Public Health Measures Plan to identify/develop educational materials/resources and tools for first responders and identify methods/forms of communication See Vaccine/Antiviral Chapter - CS, VPD to identify priority groups for vaccine access
Interpandemic Period: **Phase 1** *No new influenza virus subtypes have been detected in humans*	Maintain up-to-date estimates of: • the impact of an influenza pandemic on emergency responders and workers who provide essential services • the number of emergency responders and other workers required during a pandemic who should receive priority access to vaccine and antivirals • the emergency resources required during a pandemic to assist with transporting medical supplies and equipment, securing vaccine and antiviral supplies and providing health services	**Number of Emergency Responders receiving vaccine** 1. Collect and collate information identified within enumeration tools (HPS, EMP, HPS Program Assistant) 2. Collect and obtain information from enumeration tools 3. Compile a list of estimate numbers of essential services providers (See Appendix A – Impacts on Essential Service Providers) 4. Establish a process for maintenance and storage of this information (HPS, EMP, C.S VPD Team) (Information obtained from enumeration tools is for emergency service providers only Police, Fire, LTC's, Hospitals, Physicians, Ambulance and CCAC) 5. Link with Municipalities to determine key municipal infrastructure and essential service providers (HPS, EMP) See Vaccine/Antiviral Chapter CS, VPD to identify priority access groups for vaccine **Impact of Influenza on essential Service Emergency Responders** 1. Calculate the impact of Influenza on essential service responders using the following Ministry of Health impact assumptions: • 35% attack rate • 20% absenteeism rate (HPS, EMP – June, 2006)

	Maintain up-to-date estimates of: • the impact of an influenza pandemic on emergency responders and workers who provide essential services • the number of emergency responders and other workers required during a pandemic who should receive priority access to vaccine and antivirals the emergency resources required during a pandemic to assist with transporting medical supplies and equipment, securing vaccine and antiviral supplies and providing health services (cont.)	Calculation more specific impacts using CDC's FluAid 2.0 and FluSurge 2.0 software program (HPS, EMP – June, 2006) See Surveillance Framework Appendix F for details: • 75% infected • 15 - 35% clinically ill • 6.8% - 17% outpatient care • .1% - .3% will require hospitalization • .01% - .1% deaths (See Appendix A - Impacts on Essential Service Providers. Estimated impacts were calculated using CDC's FluAid 2.0. These estimations are intended for calculating predicted impacts on general populations. It cannot be predicted if impacts on essential service providers may differ from those of the general population). **Emergency Resources required to assist with transport of medical supplies** 1. Encourage local response agencies to address the need for continuity of the transport of medical supplies for their agency (such as PPE) (Health Sector Planning, Health Services, C.S, PIP)
Interpandemic Period: **Phase 1** *No new influenza virus subtypes have been detected in humans*	Identify vulnerable populations (e.g. elderly living on own, homeless) and develop strategies for support in the event of a pandemic	1. Identify a Human & Social Service lead agency to be responsible for identifying vulnerable population needs and "coordinating" services (Health Unit, HPS, EMP, FHS, County/District CEMC's, Social Services/CCAC) – June-September, 2006 2. Approach lead agency to get agreements in place (FH , HPS ,EMP, County/District CEMC's, June- September, 2006) 3. Lead Agency to: • Develop a mechanism to coordinate with each other agencies to maximize resources and reduce duplication of response (come together to coordinate casework, service delivery, identify and resolve gaps in service) • Allow for cross training, familiarity with existing programs so that appropriate referrals can be made (FH/HPS, County/District to link with Lead Agency) 4. Compile a contact directory for Human & Social Service Agencies (FH, HPS in conjunction with District/County, May-September, 2006) 5. Ensure that these groups understand how to access emergency management authorities and coordinate response and service delivery (understanding roles) (County/District CEMC's, HPS, EMP, Corp S, Health Communication Team, FHS) 6. Identify how information will be relayed(County/District CEMC's, HPS, EMP, Corp S, Health Communication Team, FHS) 7. Ensure that a process in is place for identifying persons requiring assistance (FHS, Human and Social Service Lead Agency) 8. Quick orientation of the emergency management structure and organizations 9. Promote Business Continuity Planning, Pandemic Preparedness (HPS, EMP, County/District, FHS) 10. Make Arrangements with Lead Human Service Agency to Act as link between County/District Emergency Control Groups out to supporting agencies (HPS, EMP, County/District CEMC's) 11. Lead Agency to educate Emergency Responders to strengthen their awareness and understanding of disability, aging and vulnerable population needs & services

Interpandemic Period: Phase 1 *No new influenza virus subtypes have been detected in humans*	Identify vulnerable populations (e.g. elderly living on own, homeless) and develop strategies for support in the event of a pandemic (cont.)	12. Develop strategies for support (support and referral services, how to communicate to vulnerable population, public educations and awareness campaigns to educate) 13. Coordinates with external agencies to provide residents with: • health assessment, support and referral • public health information and links to community networks • counseling and group sessions related to emotional coping strategies (FHS) 14. Collaborate with emergency response agencies to assist community residents confined to home to access food, shelter and other daily necessities (FHS, Lead Agency, Social Services, CCAC) 15. Provide sessions to the public related to emotional stressors and coping strategies (FHS)
INTERPANEMIC PERIOD PHASE 2		
Interpandemic Period: Phase 2 *A circulating animal influenza virus subtype poses a substantial risk of human disease*	Distribute priority group enumeration tools to organizations responsible for essential community services	1. Obtain relevant mail-out information from Outlook contact directory (CS PIPlanner) 2. Use MOHLTC template to develop a letter of explanation, the appropriate form and completion instructions (MOH, PIP) 3. Identify a lead/contact person responsible for collection and maintenance of information (CS, PIP) (Appendix B – Enumeration Letter)
	Review plans to: • provide emergency back-up for essential community services (i.e. if regular workers become ill) • provide back up services required and the organizations responsible for providing them • the dispatch and service plans for the continuous supply of essential service delivery items (e.g. fuel, food, accommodation, drugs, oxygen, biomedical engineering services, repairs) • provide food, medical and other emergency social services for people confined to their homes • ensure smooth easy access to fuel supplies for providers delivering, life sustaining services as well as hospitals and other staff who must travel by car to work	1. Consult with essential service providers to verify that these agencies have a business continuity plan in place, offer advice/assistance on infection control strategies to assist in the prevention of the spread of influenza in house , screening tools for ill/potential cases, offer business continuity planning resources and tools (HPS, EMP, County/District CEMC's, EMO, Community Officer) 2. Liaise with Director of Public Utilities/Small Waterworks Operators within Simcoe-Muskoka municipalities to ensure continuation of service/provision of potable water, community sanitation, maintenance/sanitary facilities in event of Pandemic(HPS) 3. Develop contracts with essential service providers (fuel, food, supplies) (Corp S, Human Resources) 4. Work with essential service providers to develop business continuity plans (HPS, EMP, County/District CEMC's, EMO, Community Officer) 5. Provide forums for discussions around Pandemic Flu and Business Continuity planning (HPS/FH, FHS June-December,2006) 6. Confirm plans to provide food, medical and emergency social services for persons confined to their homes (FHS, Lead Agencies (Social Services, CCAC) 7. Collaborate with emergency response agencies to assist community residents confined to their homes to access food, shelter and other daily necessities (FHS) 8. Coordinate with external agencies to provide back-up support services to ensure that residents are provided with: • health assessment, support and referral • public health information and links to community networks • counseling and group sessions related to emotional stressors and coping strategies (FHS) (Refer to SMDHU ER Plan)

INTERPANDEMIC PERIOD PHASE 3		
Interpandemic Alert Period: **Phase 3** *Human infection(s) with a new subtype, but no human-to-human spread or spread to a close contact only*	Notify local emergency service manager of virus report and current monitoring activity	See Communications Framework for Details 1. Set up intranet/internet/extranet structure for information/tools to include the following: (and post as information available): (Corp S) • Situation reports (global, national, provincial & local) • Health Faxes/Alerts to be communicated to family physicians, hospitals, etc) 2. Ensure fax numbers are up-to-date (Corp S, Assigned Program Assistant) 3. CDIU to notify paramedic services of positive influenza cases and recommend prevention and infection control strategies 4. CDSU to inform hospitals of positive influenza cases and recommend prevention and infection control strategies
	Ensure essential community services have up-to-date information on infection control precautions	See Public Health Measures Framework for details 1. Identify Essential Service providers within our communities (See Appendix C for assigned responsibilities + Municipal Partners Emergency Response Plans) 2. Build awareness of pandemic planning via regular media/public vehicles (MOH Columns, Health Matters, website etc) (C.S, Corp S) 3. Develop an Inter-Agency Emergency Framework identifying key response structure, roles and channels of communication, include this information within the Inter-Agency Plan (HPS, EMP, County/District, Corp S, Communication Team) 4. Communicate disease process to enhance understanding for communicability and transmission risks through extranet and other public communication vehicles (Corp S). 5. Communicate to Municipal Emergency Management Coordinators to identify their role in delivery of key messages out to essential service providers (HPS, EMP, County/District) 6. Orient external ER partners to pandemic flu plan (CS) 7. Develop a communication plan, including crisis communication plan, key messages, media/communication outlets, etc. (Corp S, CS) 8. Collaborate with Health Sector Emergency Planning Committee 9. Remind ER partners via email/Health Fax to refer to County/District ER website on pandemic flu plan and situation updates (MOH, CS, HPS, EMP, Corp S) 10. Plan for a Joint Media Centre and establish key partners and location 11. Gather Emergency Contact numbers for media in surrounding HUs (Corp S) 12. Establish a communications coordinator to oversee and support the communications process/materials, etc. during the pre-pandemic period. (Corp S) 13. Notify Telehealth of local pandemic activities and services (CS)
	Collect and collate completed enumeration tools	1. Obtain mail-out information from Outlook contact directory (CS, PIP) 2. Establish template letter of explanation and completion instructions (MOH, PIP) 3. Identify a lead/contact person responsible for collection and maintenance of information (CS, PIP) 4. Collate information and provide estimate numbers of ES Workers (HPS, EMP)

PANDEMIC ALERT PERIOD PHASE 4		
Pandemic Alert Period: **Phase 4** *Small cluster(s) with limited human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet by fully transmissible*	Review results of any previously conducted simulation exercises, confirm that corrective actions were taken, and identify any significant changes since the exercise that might affect emergency response	1. Establish contact information for other health unit/health sector representative who may have been involved in simulation exercises (HPS, EMP, CS) 2. Compile exercise results and review findings 3. Make recommendations for plan revision based on exercise findings (HPS, EMP, CS, PIP)
	Update all staff about an influenza pandemic	1. Orientate staff to pandemic flu plan at all staff levels or area service meetings, include a component for new staff orientation program (CS) 2. Set up intranet/internet structure for information/tools (Corp S) 3. Pandemic Influenza Planner to provide staff orientation on Pandemic Planning 4. CS to assist with transfer of information related to disease/infection control, directives from the Ministry, Ministry Fact sheet/resources 5. PIP to convene meeting with Executive/managers, EMC's, CD supervisors/consultants to report and discuss change in status, review agency pandemic flu plan and ERP and determine action steps required. 6. Update intranet with change in status refer staff to intranet/internet and 7. orient all staff to public education materials/resources (Corp S) 8. Provide Staff briefing by email and teleconference with update and actions required of staff (MOH, CS) 9. Updating staff on current protocols/directives/PPE measures 10. Provide staff training for staff redeployment or potential redeployment (Program Directors) 11. Set up intranet/internet structure for information/tools to include the following: (and post as information available): • WHO alert phases • Links to Pandemic Flu plans (global, national, provincial & local) • Legislation on PH role • Situation reports (global, national, provincial & local) • FAQs • Public Education Materials (i.e., fact sheets, media releases & other SMDHU, provincial, federal resources) • Information for health professional & emergency response partners • Directives (with archived files for outdated directives) • Vaccine coverage stats, vaccine storage and handling, vaccine security • Databases of priority groups to receive vaccine/antivirals • Infrastructure (description of roles and responsibilities) and link to policies and procedures • Surge capacity/IC units/negative pressure rooms • Emergency Housing and Feeding stations • Staff briefings/updates (Corp S)

Pandemic Alert Period: Phase 4 *Small cluster(s) with limited human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet by fully transmissible*	Update all staff about an influenza pandemic (cont.)	12. Information Management Lead (IML) to: • Communicate status of emergency to all agency staff at the time of emergency (Coordinates all public health messages/information sent out to staff and public • Establishes systemic approach to receiving, storing and disseminating information • Establishes electronic storage and retrieval that is accessible to users who need the information • Informs all staff of methods to access information so that staff are kept up-to-date on the status of the emergency and public health implications • Maintains information and ensures it is accurate and up-to-date • Identifies and communicates critical information that will directly/indirectly impact on the safety of the response team • Liaises with Coordinators to receive and disseminate current/critical emergency information) (Existing ER Plan)
PANDEMIC ALERT PERIOD PHASE 5		
Pandemic Alert Period: Phase 5 *Large cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible*	Ensure list of essential community services (and corresponding personnel) whose absence would pose a serious threat to public safety or would significantly interfere with the ongoing response to the pandemic, is up to date and available for distribution	1. Develop contact lists for all essential community services 2. Assign staff to be responsible for list development and maintenance (Corp S, HPS, EMP) (See Appendix C for assigned responsibilities) 3. Consider V, I and Low Priority timelines compiled over a month period beginning September, 2006) • Vital – compiled by November, 2006 • Important- compiled by February 2007 • Low Priority compiled by April 2007 4. Identify a process for information storage and maintenance (Corp S) 5. Provide further training for staff on use of right fax/mass faxing (Corp S) 6. Contact municipalities to determine if they already have these lists compiled (HPS, EMP) 7. Post Contact Information to Intranet and develop electronic databases (Outlook Directory) and identify responsibilities for maintenance (Corp S) 8. Develop List Serve or group fax numbers for external partners and facilities. (Corp S) 9. Ensure that maintenance schedule for contact directory is reviewed and updated every 6 months (Corp S) 10. Ensure that communication tools exist (Health Fax, Health Alert) (Corp S) Activities 5 – 10 refer to Communications Framework
	Confirm/update estimates of numbers of emergency services workers including health care workers, funeral services, and leaders (political leaders< managers of response teams) essential to pandemic response are current and prepare lists for dissemination	1. Collect and collate information identified within enumeration tools (HPS, EMP, HPS Program Assistant) 2. Compile a list of estimate numbers of essential services providers (See Appendix A) 3. Establish a process for maintenance and storage of this information (HPS, EMP, C.S VPD Team) Information obtained from enumeration tool is for emergency service providers only Police, Fire, LTC's, Hospitals, Physicians, Ambulance and CCAC 4. Link with Municipalities to determine key municipal infrastructure and essential service providers (HPS, EMP)

	Consider activation of local plans	1. Under leadership of MOH office, ECG and ERT determine if conditions warrant activation of local plans (See Phase 6 for plan activation activities).
PANDEMIC PERIOD PHASE 6		
Pandemic Period: Phase 6 *Increased and sustained transmission in general population*	Activate local emergency response plans	**Internal** 1. Determine criteria and rationale for ER and Pandemic Plan activation (HPS, EMP, CS, MOH) 2. Activate this plan when: • An influenza pandemic is declared by the Premier of Ontario or the MOHLTC OR • A local case(s) or outbreak of the pandemic strain of influenza is confirmed. • The occurrence and expected impact of illness in the population will require coordinated efforts by all of most of the health unit's staff and resources (MOH) *Increased and sustained transmission in general population* 3. Conduct on-going assessment of current local pandemic activity (CS, MOH) 4. Activate Health Unit Emergency Control Group/EOC (MOH) 5. Conduct group discussions to determine if current situation fit criteria to activate Pandemic Plan (MOH, Program Directors) 6. Activate Agency Pandemic Influenza Plan (MOH) 7. Initiate staff fan-out and provide direction for staff response (MOH/Program Directors) 8. If the emergency escalates beyond the health unit's capacity to respond, request assistance from the Ministry (MOH) 9. Contact Public Health Branch Medical Consultant/On-Call Physician (MOH) 10. Establish meeting schedules with exec/managers, ERC, CD supervisors/consultants to report and discuss change in status (Corp S, MOH) 11. Implement agency pandemic flu plan and ER communications plan (MOH) 12. Conduct regular staff briefings by email and teleconference with update and actions required of staff (MOH) **External** 1. Conduct discussions/agreement prior to recommendation to activate that outline criteria and rationale (HPS, EMP, MOH, CS) 2. Ensure messages developed explaining the rationale for activation (CS, Corp S, MOH) 3. Establish a process for communicating with external CEMC's (HPS, EMP, Corp S) 4. When response requires elaborate coordination and support from external health agencies, recommend the activation of local County/District EOC's (wi*th or without the issuance of a Provincial declaration (MOH)* 5. Recommend the activation of County/District/local emergency response plans (MOH) 6. Notify appropriate emergency service partners to remain on standby and be prepared to implement their own Emergency response plans (MOH) 7. Identify a process to communicate with other health sector representatives to coordinate response (District/County/MOH, Corp S, HPS, EMP)

Pandemic Period: Phase 6 *Increased and sustained transmission in general population*	Confirm plans to provide food, medical and emergency social services for persons confined to their homes as directed by public health	1. Identify a Human & Social Service lead agency to be responsible for identifying vulnerable population needs and "coordinating" services (Health Unit, HPS, EMP, FHS, County/District CEMC's, Social Services/CCAC) – June-September, 2006 2. Approach lead agency to get agreements in place (FH , HPS ,EMP, County/District CEMC's, June- September, 2006) 3. Lead Agency to: • Develop a mechanism to coordinate with each other to maximize resources and reduce duplication of response (come together to coordinate casework, service delivery, identify and resolve gaps in service • Allow for cross training, familiarity with existing programs so that appropriate referrals can be made (FH/HPS, County/District to link with Lead Agency) 4. Compile a contact directory for Human & Social Service Agencies (FH, HPS in conjunction with District/County, May-September, 2006) 5. Maintain list of Community Service Providers (HL, FH, HPS, EMP) 6. Identify a process for identifying persons requiring assistance (FH, Lead Social Service Agency, CCAC) 7. Identify a process for providing these services (FH, Lead Social Service Agency, CCAC, County/District) 8. Link with community service providers to ensure that plans are in place (FH) 9. Review plans to ensure continuation of services (FH) 10. Identify a location and access to plans (FH, Lead Agency, County/District) 11. Ensure Coordination of Plans (FH, Lead Agency) 12. Coordinates with external agencies to provide residents in shelter with: • health assessment, support and referral • public health information and links to community networks • counseling and group sessions related to emotional stressors and coping strategies (staff) (FH) 13. Collaborate with emergency response agencies to assist community residents not in shelters to access food, shelter and other daily necessities (FH) 14. Provide sessions to the public related to emotional stressors and coping strategies (FH) 15. Ensure the Health Connection staff to be kept up to date on community resources, social service plans to provide/how they will provide in event that Public Health receives calls for assistance from the community (FH, HL) 16. Post location of Emergency Housing and Feeding Stations on internet (Corp S)
	Assist with preparation and operation of alternate care sites, and other "over-flow" facilities	1. Meet with community health sector representatives to determine local course of actions, roles and responsibilities (Health Services, MOH, Pandemic Planner, Director of Clinical Services) 2. Establish pre-arranged agreements with CCAC, Red Cross and other Home Care Providers (Hospitals, LTC's, MOH, Pandemic Planner, CS Director) 3. Establish a process for identifying care facilities in operation.(Hospitals, LTC's, MOH, Pandemic Planner, CS Director) 4. Establish a process for determining staff to service these facilities.(Hospitals, LTC's, MOH, Pandemic Planner, CS Director)

Pandemic Period: Phase 6 *Increased and sustained transmission in general population*	Assist with preparation and operation of alternate care sites, and other "over-flow" facilities	5. Identify a process for communicating issues related to these facilities(Hospitals, LTC's, MOH, Pandemic Planner, CS Director) 6. Identify a process for activation of facilities .(Hospitals, Physician's, LTC's, MOH, Pandemic Planner, CS Director) 7. Establish availability of alternate care facilities for ill families, childcare, staff/healthcare, and emergency feeding where needed (e.g. seniors - living independently (Acute Care facilities, Social services, FHS, County/District CEMC's, Lead Agency) 8. Negotiate Agreements re. service provision & site use (Acute Care facilities, Social services, FHS, County/District CEMC's, Lead Agency) 9. Ensure that agreements are in place to provide food, water, medical supplies etc.
Pandemic Period: Phase 6 *Increased and sustained transmission in general population*	Reduce services that can be curtailed during a pandemic and implement pandemic staffing plans (i.e., redeploy workers to provide essential community and health services)	1. Implements the agency's Business Continuity Plan (MOH) 2. Determine which services can be curtailed in the event of a Pandemic (Service Area Directors, MOH) 3. Modify/cut public health services (Program Directors) 4. Establishes a contact person for staff inquiries and ensures a listing of the availability of staff and contact information is maintained (Corp S) 5. Manages equipment/supplies resources (Corp S) 6. Receives requisitions for additional supplies through Coordinators and ensures that identified resources are provided (Corp S) 7. Manages staff resources. Receives requests for additional staff resources from Coordinators. Monitors current response capabilities and redeploys staff (Corp S) (ER Plan) See Business Continuity Framework
	Promote inter-agency cooperation at the local level to maintain essential services	1. Establish Health Sector Emergency Planning Committee as per recommendation by Ministry of Health & Long Term Care to assist in the development of an inter-agency plan (County/District/MOH) 2. Develop and complete a coordinated, inter-agency pandemic influenza plan for the health sector of Simcoe County and the District of Muskoka (PIPlanner/County/District/Health Sector Planners) 3. Establish working group is assist with planning and identify opportunities to coordinate response 4. Determine the process/tools to be used for external ER partners to be oriented and kept up to date on pandemic flu situation (Corp S) 5. Ensure key stakeholders identified within the inter-agency plan are oriented to the plan and have a clear understanding of their identified roles (MOH, CS Director) 6. Ensure County/District emergency response plans are current and have been recently reviewed 7. Work with community stakeholders to develop business continuity plans (HPS, EMP) 8. Development of the ER extranet website - communications/webmaster (HU & county/district) 9. Plan for a Joint Media Centre and establish key partners and location 10. Ensure compatibility of Municipal/provincial and county/district planning stakeholders pandemic plans with inter-agency pandemic plan (County/District, PIP, MOH)

Pandemic Period: Phase 6 *Increased and sustained transmission in general population*	Continue to implement local emergency response plan to provide essential services	1. Establish on-going assessment of the emergency situation (County/District ECG's) 2. Identify additional resource requirements needed for emergency response (County/District ECG's) 3. Maintain ongoing list of activated municipal and health sector pandemic ER plans 4. Post pandemic plans on intranet (Corp S) 5. Identify an internal process for liaising with municipalities individually (HPS, EMP, Corp S, MOH)
	Work with the province to determine whether conditions warrant declaring a local state of emergency	**Internal** 1. Assign key health unit contact to respond to MOHLTC requests for updates/needs assessments and receive directives and resources. 2. Designate individual from each service area response team to receive and provide information to/from HU/MOHLTC contact (Service Area Directors) 3. Provide daily debriefings and updates to HU emergency control (MOH) 4. Conduct local surveillance and service delivery status (Agency Directors/MOH) 5. Determine if pandemic emergency situation exceeds agency's ability to respond to local conditions effectively (MOH/ECG) 6. Contact Public Health Branch Medical Consultant/On-Call Physician if health unit resources cannot meet community demand (MOH) 7. (Based on provincial situation assessment, Premier in consultation with the MOHLTC) will determine if conditions warrant provincial emergency declaration) (See Part 1 – SMDHU Emergency Response and Emergency Activation. **External** 1. Recommend activation of upper tier EOC's to discuss situation current situation and coordinate response 2. Invite key health sector stakeholders to participate in situation assessment (Upper tier ECG) 3. Request the area municipalities to activate their emergency plans and operations centres 4. Determine if conditions warrant emergency declaration locally (ECG) 5. Recommend declaration local emergency when: • An influenza pandemic is declared by the Premier of Ontario or the MOHLTC OR • Local case(s) or outbreak of the pandemic strain of influenza is confirmed (with County/District-wide epidemics) • The occurrence and expected impact of illness in the population will require coordinated efforts by all of most of community resources (MOH consultation with County/District ECG) 6. Notify Province of local emergency declaration (Upper Tier CEMC's)
	Evaluate need to request additional security assistance with provincial stockpile system and distribute supplies as needed	See Vaccine & Antiviral Framework 1. Request supportive resources from Province through County/District Emergency Operation Centre's for OPP assistance (MOH through upper tier EOC)

Pandemic Period: Phase 6 Regional and multi-regional epidemics	Evaluate need to request additional security assistance with preparation and operation of alternate care sites, and other "over-flow" facilities	1. Set up Memorandum of Understanding with local police services (Health Sector) 2. Request supportive resources from Province through County/District Emergency Operation Centre's (Health Sector through upper tier EOC)
	Assess need for ongoing local state of emergency (if applicable) and criteria for ending the local emergency	1. Set criteria for termination of an pandemic emergency (MOH in consult with County/District ECG and Ministry of Health) 2. Recommendation to local EOC (County/District Head of Council) 3. Terminate emergency (County/District Head of Council) (Provincial emergency will be terminated by the Premier upon recommendation by MOHLTC. Criteria for termination of emergency at provincial level to be determined by MOHLTC)
	Evaluate local stockpile system and restock supplies as available	See Vaccine & Antiviral Chapter (VPD & CDIU, CDSU)
	Evaluate need for ongoing security assistance with operation of alternative care sites	1. Set up Memorandum of Understanding with local police services (Health Sector) 2. Request supportive resources from Province through County/District Emergency Operation Centre's (Health Sector through upper tier EOC)
Pandemic Period: Phase 6 *End of first wave; pandemic subsiding*	Review/revise local plan for an influenza pandemic as required	1. Establish a forecast planning team to: (EOC Chair in consultation with Health Unit ECG) • Ensure that appropriate information is available to develop plans that forecast 72 hours ahead of current situation. (AMOH and Forecast Planning Team) • Assess the incident on a continual basis and project possible contingencies and alternative courses of action (AMOH + Forecast Planning Team) 2. Identify a process for collecting information needed for evaluation (Corp S) 3. Conduct a debriefing and evaluate information (EOC Chair, ECG) 4. Evaluate and develop lessons learned to help prepare for the next emerging disease (Corp S/CS) 5. Develop a process for communicating lessons learned (Corp S) 6. Review and revise plans to include recommendations (CS) 7. Conduct Emergency Notification Testing and Conduct simulation exercises (HPS, EMP, CS) 8. Debrief with staff and key stakeholders - emergency service workers, essential service workers, school boards, other highly affected groups (MOH) 9. Evaluate the internal/external response. (Upper Tier ECG, Corp S, all staff)
POST PANDEMIC PERIOD PHASE 1		
Post pandemic Period: Return to Phase 1	Review/activate local aftercare/recovery plans/guidelines	See Business Continuity Chapter for Activities/Timelines and Responsibilities 1. Conduct emergency debriefings (MOH)

Post pandemic Period: **Return to Phase 1**	Retur to pre-emergency activity level	See Business Continuity Chapter for Activities/Timelines and Responsibilities
• **Other Tasks/ Assignments** • **Inter-Agency Planning**	Develop an Inter-Agency Mass Fatality Plan	**External** Develop an Inter-Agency Mass Fatality Plan (MOH, CS, HPS, involve municipalities/funeral directors/hospitals/District Coroners) **Internal** 1. Maintain Funeral Home Contact information (HPS) 2. Develop list of Cemeteries within Simcoe/Muskoka (Funeral Directors Pandemic Planning Survey, Ontario Funeral Services Association of Canada, Disaster Plan Survey - See Appendix) 3. Consult with funeral home directors/hospitals on morgue capacity (Funeral Home Survey Results, Funeral Services Association of Canada- See Appendix D and E) 4. Develop Safe Handling and Disposal Guidelines (CS, HPS) 5. Identify burial site locations and capacities (HPS) 6. Discuss handling of mass body disposal with funeral directors and cemeteries and crematoria (MOH, CS, HPS) 7. Propose communication strategies to lead agency to clarify expected roles (MOH, CS Director) 8. Provide Public Health Educational forums for Funeral Directors to clarify expected roles and responsibilities (HPS, CS) 9. Communicate with municipalities regarding enhanced needs for death registration requests and burial permits (HPS) 10. Communicate with the chief Coroner in Ontario regarding activation of surveillance for deceased and need to conduct respiratory tract specifics/lung tissue for culture/direct antigen testing (MOH, CS) 11. Conduct Public health surveillance for deceased- conduct respiratory tract specifics/lung tissue for culture/direct antigen testing (CS) 12. Identify process and responsibility- permission from next of kin for post mortem testing (CS) **External** 1. Develop a mass fatality planning committee (involving Health Service Agencies) to: • Identify Pronouncement Protocols (who can pronounce death, assistance from paramedic • Issuance of Death Certificates (physicians, but RN, extended class may also issue • Expedite the process for issuance of burial permits (needed for burials and cremations) • Consider temporary storage facilities for bodies

APPENDICES

APPENDIX A - II - 4: IMPACTS ON ESSENTIAL SERVICE PROVIDERS
(from Enumeration of Essential Workers Data, SMDHU 2005)

Table 1: Essential Emergency & Health Care Workers in Simcoe Muskoka District

Group	# of Essential Workers
Police	816
Fire	1373
EMS (Ambulance)	444
Hospitals	3983
CCAC (Community Care Access Centre)	126
Long-Term Care	2621
Health Unit	383
Total	9746

Table 2: Estimated Rates of Illness Hospitalization and Death for Different Gross Attach Rates

Rates	Low	Middle	High
Attack	15%	25%	35%
Hospital	0.02%	0.1%	0.3%
Deaths	0.003%	0.004%	0.01%

Table 3: Estimated Impact of Pandemic Influenza on Essential Service Workers in Simcoe Muskoka

Police			
Numbers	**Low**	**Middle**	**High**
ILL	122	204	286
Hospitalizations	0.2	1.2	2.2
Deaths	< 0.1	< 0.1	< 0.1
Fire			
Numbers	**Low**	**Middle**	**High**
ILL	206	343	481
Hospitalizations	0.2	2.0	3.8
Deaths	< 0.1	< 0.1	0.1
EMS			
Numbers	**Low**	**Middle**	**High**
ILL	66	111	155
Hospitalizations	< 0.1	0.6	1.2
Deaths	< 0.1	< 0.1	< 0.1
Hospitals			
Numbers	**Low**	**Middle**	**High**
ILL	597	996	1394
Hospitalizations	0.7	5.8	10.9
Deaths	< 0.1	0.1	0.4
CCAC			
Numbers	**Low**	**Middle**	**High**
ILL	18.9	31.5	44.1
Hospitalizations	< 0.1	0.2	0.3
Deaths	< 0.1	< 0.1	< 0.1
LTCF			
Numbers	**Low**	**Middle**	**High**
ILL	393	655	917
Hospitalizations	0.5	3.8	7.2
Deaths	< 0.1	< 0.1	0.2
HU			
Numbers	**Low**	**Middle**	**High**
ILL	57.45	95.75	134.05
Hospitalizations	< 0.1	0.6	1.1
Deaths	< 0.1	< 0.1	< 0.1
Total			
Numbers	**Low**	**Middle**	**High**
ILL	1462	2436	3411
Hospitalizations	1.8	14.3	26.8
Deaths	0.2	0.4	0.9

APPENDIX B - II - 4: LETTER FOR SMDHU TO COMMUNITY AGENCIES RE: ENUMERATION PROCESS

November 24, 2005

Dear:

RE: Enumeration Process for the Planning For Antiviral/Vaccine Distribution during an Influenza Pandemic

I would like to take this opportunity to introduce myself as Medical Officer of Health for the Simcoe Muskoka District Health Unit. The Health Unit has enjoyed a positive and productive working relationship with its partner health care agencies, preventing and controlling infectious diseases. More recently this has including working to develop district and institutional pandemic influenza plans. I am very pleased to join in these collective efforts, both in order to protect the health of our citizens and patients, and as an opportunity to become more familiar with the health care providers of Simcoe County and Muskoka District.

During the first wave of an influenza pandemic (expected to last 8 weeks), vaccine will not be available and the focus of containment will be on the use of antiviral medications for prevention and early treatment of influenza cases. In order to facilitate this, the province has adopted national priority groups for receiving antivirals and vaccine during an influenza pandemic.

This package contains information regarding the Ministry of Health and Long-term Care's pandemic influenza planning-related enumeration process for the national priority groups. An enumeration tool has been developed to count the number of people in the province who fall within the designated priority groups for preventive treatment with antiviral medications. Please note, based on the epidemiologic data collected during the pandemic, these priority groups may be adjusted.

The Simcoe Muskoka District Health Unit and the province continue to work on enhancing local and Ontario preparedness for a pandemic. The plans to date include that a portion of the stockpile of antivirals to be made available to previously identified priority groups for prophylaxis.

In order for your organization to be included in the planning process for the distribution of antiviral medication/vaccine, we are asking you to determine how many people within your organization meet the criteria for these priority groups. Please use the tools in the package to assist you in this process. The most appropriate individuals in your organization to complete these forms may be those already involved in emergency preparedness or business continuity planning.

For your reference, we have attached supplementary fact sheets and other information that might assist you in this enumerative process. We are aware that this is a challenging process with a tight timeline, and that the information collected will need to be repeatedly refined and updated. It is anticipated that this data may be updated as frequently as every six months.

Please complete the enumeration tools by **December 8, 2005**. The completed documents should be sent to:

Colleen Nisbet
Pandemic Influenza Planner
Simcoe Muskoka District Health Unit
5 Pineridge Gate
Gravenhurst, ON P1P 1Z3

Fax: 705-684-9959.

If you have any questions about this procedure or our local planning efforts, please contact Colleen directly at 705-684-9090, ext. 253.

We have also made pandemic influenza planning information and web links available on our website at www.simcoemuskokahealth.org or by going directly to http://www.simcoemuskokahealth.org/Topics/Pandemic/introduction.asp .

Thank you for your co-operation and your prompt attention to this request.

Sincerely,

Charles Gardner, MD, CCFP, MHSc, FRCPC
Medical Officer of Health

CG:BM:lp

Attachments:
1. Agency Enumeration Tool
2. Instruction Sheet for Enumeration Tool with a Sample Completed Tool
3. Fact Sheets on Pandemic Influenza, Vaccines and Antivirals
4. Fact Sheet on Ethical Decision Making
5. Pandemic Influenza Preparedness Power Point Presentation (hardcopy)
6. Ministry of Health and Long Term Care Website Resource List

APPENDIX C - II - 4: MANAGEMENT - KEY CONTACT LIST FOR ESSENTIAL SERVICE PROVIDERS

Lists to be Reviewed/Updated every 6 Months

Timelines for Key Contact List Completion:
Vital – compiled by November, 2006
Important- compiled by February 2007
Low Priority- compiled by April 2007

Provider	Where Key Contact Can be Found	Progress to Date June 2006	Responsible Program/Service Area	Timeframe for Completion
Police Officers	ER Manual	Completed	HPS, EMC	Nov 2006
Firefighters (Fire)	ER Manual	Completed	HPS, EMC	Nov 2006
Sheriff (Provincial Courts)	Phase One Contact List	Partially Completed	HL, TEO	Apr 2007
Bailiff (Provincial	Phase One Contact List	Partially Completed	HL, TEO	Apr 2007
Correctional officers (Federal Contacts)	Phase One Contact List	To be Completed	HPS, EMC	Feb 2007
By Law Enforcement (Municipalities)	Phase One Contact List	Muskoka Partially Complete	HPS	Feb 2007
Probation/parole (Provincial/Federal)	Phase One Contact List	Muskoka Partially Complete	HPS	Feb 2007
RCMP (Federal)	Phase One Contact List	Completed	HPS	Nov 2006
Red Cross/St.John's (Social Services)	ER Manual	Completed	Corp Service	Nov 2006
CFB Base Commander/ Federal Jurisdiction		To be Completed	Clinical Service	Apr 2007
Funeral directors	CISS	Completed	HPS, EMC	Nov 2006
public transport operators (Municipal)	Raccoon Rabies Contingency Plan	Partially Completed	HPS	Feb 2007
public works/maintenance, water works and gas maintenance workers,	MOE –water works	To be Completed	HPS	Feb 2007
computer/network/web technicians		To be Completed	Corp S	Feb 2007
food suppliers/operators	CISS database	Completed	HPS	
marine transport operators, railway traffic/marine traffic controllers		To be Completed	HPS	Apr 2007
air pilots, flying engineers/instructors, air traffic controllers		To be Completed	HL, TEO	Apr 2007
mail/postal clerks		To be Completed	HL, TEO	Apr 2007
judges		To be Completed	HL, TEO	Apr 2007
education	Outlook	Completed	FH	Feb 2007
social and community services	Outlook	Completed	Corp Services	Feb 2007
government managers-health & social policy development & program administration	Outlook	To be Completed	HL	Feb 2007

APPENDIX D - II - 4: OFSA FUNERAL SERVICES DISASTER PLAN SURVEY

alPHa Association of Local PUBLIC HEALTH Agencies

Ontario Funeral Service Association

OFSA
FUNERAL SERVICE
DISASTER PLAN SURVEY

INTRUCTIONS: Please complete the survey using accurate, current information and numbers pertaining to your company. Funeral Homes/ Cemeteries and Crematoriums with more than one location should fill out one survey per site, indicating the total resources at a particular location. Regarding equipment; values should represent the minimum inventory available at all times. Please complete all survey sections where applicable.

NAME OF FUNERAL HOME(S) / TRANSFER SERVICE / CEMETERY / CREMATORIUM :

MAIN ADDRESS: (INCLUDING TOWN, POSTAL CODE AND REGION)

CONTACT PERSON:

TELEPHONE: **FAX:** **E-MAIL:**

SURVEY SECTION FOR CEMETERY AND CREMATORIUM USE ONLY:

TOTAL CREMATORIUM OPERATORS: _____ TOTAL CEMETERY GROUNDS PERSONS AVAILABLE: _____
MAXIMUM CREMATIONS PER 8 HOUR PERIOD: _____ MAXIMUM BURIALS PER 8 HOUR PERIOD: _____
ESTIMATE OF NUMBER OF PLOTS AVAILABLE FOR BURIAL: _____ WINTER BURIAL AVAILABLE: YES____ NO: _____
WINTER VAULT STORAGE FACILITY AVAILABLE: YES_____ NO_____ IF YES, PLEASE SPECIFY TOTAL SPACE AVAILABLE FOR CASKETS: _____
REFRIDGERATED STORAGE AVAILABLE: YES ____ NO_____ IF YES, PLEASE SPECIFY TOTAL SPACE AVAILABLE FOR CASKETS: _____

SURVEY SECTION FOR FUNERAL HOME / TRANSFER SERVICE USE ONLY:

TOTAL FUNERAL DIRECTORS / EMBALMERS: _____ MAXIMUM NUMBER OF EMBALMING PERFORMED PER 8 HOUR PERIOD: _____
TOTAL OF NON-LISCENSED AUXILLIARY PERSONNEL (PREPARATION ROOM ASSISTANTS / REMOVAL & TRANSFER STAFF): _____
TOTAL OF REMOVAL VEHICLES (EXCLUDE FUNERAL COACHES): _____ AVERAGE CAPACITY OF REMAINS PER VEHICLE: _____
TOTAL FUNERAL COACHES: _____
TOTAL 1-MAN STRETCHERS: _____ TOTAL 2-MAN STRECTCHERS: _____
REFRIDGERATED STORAGE AVAILABLE: YES ____ NO_____ IF YES, PLEASE SPECIFY TOTAL SPACE AVAILABLE FOR CASKETS: _____
MINIMUM BODY BAGS AVAILABLE AT ALL TIMES (REGULAR VINYL TYPE): _____ (HEAVY DUTY DISASTER TYPE): _____
HERMETICALLY SEALED METAL TRANSFER CASES AVAILABLE: _____ FUNCTIONAL EMBALMING TABLES: _____ OTHER TABLES (DRESSING /BACKBOARDS): _____
FUNCTIONAL EMBALMING MACHINES: _____ FUNCTIONAL ASPIRATORS: ELECTRO-ASPIRATORS: _____ HYDRO-ASPIRATORS: _____

PROTECTIVE GEAR AND EMBALMING FLUIDS:

BOXES OF LATEX GLOVES: S____M____L_____ DISPOSABLE COVERALLS: _____ FACE MASKS: _____ FACE SHIELD / VISORS _____
DISPOSABLE APRONS: _____ DISPOSABLE HEAD COVERS: _____ DISPOSABLE SHOE/BOOT COVERS (PAIRS): _____
CASES OF ARTERIAL EMBALMING FLUIDS: _____ CASES OF CAVITY FLUIDS: _____ CASES OF ACCESSORY FLUIDS/POWDERS: _____

Do you anticipate any bottlenecks in your area during a mass fatality event (i.e. death certificates, burial etc)? ANSWER ON BACK of PAGE

Do you, in your community or region, have any mutual aid agreements? ANSWER ON BACK of PAGE

Once completed, please promptly fax to OFSA at (416) 695-3583 by April 15, 2006.

It is important that this survey be filled with most accuracy, so that we may establish local/provincial needs or deficiencies, plan all options and resources available and locate emergency supplies, suppliers, support personnel and equipment.

Once again, thank you for your cooperation.

Tom Flood

President

OFSA thanks the Ottawa and District Funeral Directors for their help.

APPENDIX E - II - 4: FUNERAL DIRECTORS, PANDEMIC INFLUENZA PLANNING SURVEY

Instructions: Please complete the survey using current information and numbers pertaining to your company. Funeral homes/cemeteries, and crematoriums with more than one location should fill out one survey per site, indicating the total resources at each location. Please return completed surveys by FAX to 416-595-0030 or by mail to alPHa, 425 University Avenue, Suite 502, Toronto, ON M5G 1T6. Completed surveys will be sorted by Local Public Health Unit and forwarded to them. Health Units will use the information in their own planning and may provide aggregate information to the Ontario Ministry of Health and Long-term Care, as requested.

CONTACT INFORMATION	
Business Name (i.e., Funeral Home, Cemetery, Crematorium, Transfer Service):	
Telephone No: ( )	Fax No: ( )
Contact Person:	
Email Address:	
Preferred method of communication: Phone ☐ Email ☐ Fax ☐ Doesn't matter ☐	
Business Address:	
Name of Local Public Health Unit:	
CAPACITY INFORMATION (Circle N/A if not applicable)	
1. Total number of Funeral Directors licensed to embalm:	N/A
2. Maximum number of embalmings possible in an 8-hour period:	N/A
3. Number of embalming equipment sets on site:	N/A
4. Number of embalming rooms:	N/A
5. Maximum number of surface embalmings possible per 8-hour period:	N/A
6. Total number of non-licensed support staff (please list by job classification or title):	
7. Refrigerated storage space available: YES ☐ NO ☐	If YES, specify maximum capacity (caskets):

8. Off-site emergency refrigerated storage secured: YES ☐ NO ☐	If YES, specify maximum capacity (caskets):	
9. Access to Winter Vault Storage: YES ☐ NO ☐	If YES, state location:	
10. Minimum number of body bags available at all times:	Regular vinyl type: _____ Heavy duty type: _____	N/A N/A
11. Maximum number of viewing rooms:		N/A
12. Number of vehicles available for transporting deceased persons:		N/A
13. Average capacity of vehicles:		N/A
14. Total number of staff who can operate a crematorium:		N/A
15. Maximum cremations per 8-hour period:		N/A
GENERAL INFORMATION:		
16. Have you seen/read the Ontario Pandemic Plan or the Canadian Pandemic Plan (applicable sections)?		YES ☐ NO ☐
17. Do you have a pandemic contingency plan?		YES ☐ NO ☐
18. Have you stockpiled supplies specifically for a pandemic i.e., extra stock beyond normal quantities? YES ☐ NO ☐ If YES, circle all that apply: gloves, masks, gowns, body bags, embalming fluids, hand antiseptics, hand soap, disinfectants, paper towels, other (specify)		
19. Would you like more information on infection prevention and control? YES ☐ NO ☐		
Comments and questions		

alPHa is a not-for-profit Association representing the 36 Public Health Units across Ontario.

II - 5 COMMUNICATION

INTRODUCTION

Effective and timely internal and external communications provide the backbone for a coordinated response to an influenza pandemic.[33] Communication is critical before, during and after an influenza pandemic.

Our communication objectives are:

- To be sure that we are prepared to respond to public and provider communication needs
- To educate people about pandemic influenza and our plans
- To provide consistent, coordinated and effective public and provider communications
- To ensure that all health and emergency sector partners and the public have access to transparent, accessible, accurate, real-time information that will help them respond to challenges during each phase of the pandemic

The information needs of internal and external stakeholder audiences have been assessed to determine the appropriate information structures, processes, protocols, messages and strategies that need to be in place in each pandemic phase. This section of the SMDHU PIP describes specific actions required during each of the pandemic phases.

Appendix A-II-5 contains the Crisis Communication Plan for Pandemic Influenza articulating the risk communication goals, objectives, approaches, audiences, key messages, activities and evaluation plan.

COMMUNICATION ACTIVITIES

Phase 1 **From WHO**	**Local Level Objectives** **From OHPIP**	**Public Health Unit** **Communication Activities**
INTERPANDEMIC PERIOD PHASE 1		
Interpandemic Period: **Phase 1** *No new influenza virus subtypes have been detected in humans*	Work with professional organizations and labour associations to actively promote UIIP to the public and health care workers	**External** Health Care Workers 1. Educate/Awareness Universal Flu • promote development of health care facility UIIP policies, personal protection equipment and measures via health network contacts i.e., Infection Control (CD, CD) • promotion of UIIP via media, web, fact sheet/poster, newsletters, Health Fax (VPD/Corporate Communication) • one-to-one contacts with health care partners (VPD) • promotion of pneumococcal vaccine for high risk through physicians, LTC, Rest &Retirement Homes (VPD) Public 1. Education/ Awareness Universal Flu • personal prevention promotion via media, web, fact sheet/poster, letter to employers, newsletter (VPD/Corporate Communication) • one-to-one phone and clinic contacts/respond to RFS (Health Connection, VPD) 2. Education/Awareness of pneumococcal vaccine for people over 65 • via media, web, fact sheets, newsletter (VPD/ Corporate Communication) • one-to-one phone and clinic contact/respond to RFS (Health Connection, VPD)
	Ensure all educational materials for the public, heath care workers & stakeholders on influenza is accurate, up-to-date and accessible (i.e., languages, literacy levels)	1. Annual implementation of UIIP communication strategy including web, print, media accessing Ministry materials as required to meet language needs (VPD/ Health Communication) 2. Annual review of UIIP web content (VPD/Corporate Communication)
	Continue to reinforce the importance of prevention/mitigation activities	**External** Links/partners 1. Education/Awareness – introduction to Pandemic Influenza, PIP, personal protection measures & vaccine/Antivirals, required resources/services, business continuity planning • presentations at meetings of SMHSEPC (PIP/ PIPAC chairs) • presentations to County of Simcoe and District of Muskoka EMCs and related groups (ER/PIPAC members)

Interpandemic Period: **Phase 1** *No new influenza virus subtypes have been detected in humans*	Continue to reinforce the importance of prevention/mitigation activities (cont.)	• standing item on agendas of SCICN, CDSN, Hospital IC & PAC LTCH (CD Team) • enhanced CD Surveillance website to include pandemic educational resources (CD Team) • HealthFax to Physicians, acute care facilities, LTCH and Rest & Retirement Homes (CD Team) • Education Strategy for Essential and Emergency Service Workers (EMP) 1. Education/Awareness – reporting requirements • routine confirmation of reporting requirements (case definitions) and outbreak reporting for LTCH and acute care (CD Team) via LTC education workshop and SMIPACN (Infection Prevention and Control Network) **External** Public 1. Education/Awareness Pandemic Flu • via media, web, newsletter, Health Connection (Corporate Communication/Health Connection) • Community presentations via requests for service (Health Connection) 2. Education/Awareness PI Personal Protection • via media, web, newsletter, Health Connection (Corporate Communication/Health Connection) • Community presentations via requests for service (Health Connection)
	Continue to work to improve the communication/information infrastructure (MOHLTC and Community Partners)	**External** MOHLTC/Provincial Networks 1. Participate on ministry pandemic-related planning groups (A/MOH, CD Mgr, CS Dir, ER Mgr) 2. Participate on pandemic-related regional planning networks i.e., GTA Pandemic Planners, GTA Communicators, GTA VPD Managers (Health Communications TL/VPD Mgr) 3. Establish links with the MOHLTC Communications Branch (Corporate Communications) Links/partners 1. Maintain databases of health sector contacts including • Acute care (CD Team) • LTCH (CD Team) • Daycares (CD Team) • Physicians (CD Team) • Pharmacists (CD Team through the Pharmaceutical Association) • Occupational Health (?) • Allied Health Professionals (e.g. respiratory tech, personal support

Interpandemic Period: **Phase 1** *No new influenza virus subtypes have been detected in humans*	Continue to work to improve the communication/information infrastructure (MOHLTC and Community Partners) (cont.)	workers: SMHSEPC) 2. Maintain databases of emergency response sector contacts including: • EMC (EMP) • Police & Fire (EMP) • SC & MD Emergency Management (EMP) • Ambulance/Paramedics (EMP) 3. Develop key contacts list for Essential Service Workers (ESW) including: • funeral directors/embalmers • public transportation operators • public works, water works & gas • computer/network web technicians • pilots/flying engineers/instructors • mail/postal clerks • judges • managers of COMSOC, education, government managers (health & social program admin) • food suppliers/operators (process to collect/post & maintain) (EMP) 4. Develop key contact list of Emergency Service Workers (EMS) including: • sheriffs, bailiffs • correctional service officers • bylaw enforcement officers et al • other protective service occupations • probation/parole officers • RCMP • Red Cross (employees & volunteers) • St. John's (First Aid, respiratory volunteers & youth members) • CFB (EMP) 5. Maintain linkages with Health Sector Emergency Planning partners (SMHSEPC) via • Committee meetings (DCS, MOH, other staff) • Email distribution list (ER Mgr) • Extranet (ER Mgr) 6. Maintain linkages with Infection Control Network via meetings, email and web log of outbreaks (CD Team). Refer to Public Health Measures Framework. 7. Maintain linkages with Emergency Response Coordinators Network via meetings, and Extranet and through upper tier EOC's. (EMP) 8. Develop and utilize electronic communication methods for ongoing communication & updates with Health Sector including: • Health Fax to Physicians and LTCH, Emergency Room, Infection Control Practitioners (CD Team) • SMHSEPC email distribution list (ER Mgr) • SMHSEPC extranet (ER Mgr)

Interpandemic Period: Phase 1 *No new influenza virus subtypes have been detected in humans*	Continue to work to improve the communication/information infrastructure (MOHLTC and Community Partners) (cont.)	9. Develop electronic communications methods to exchange information with Emergency SW • fax, listserve & web based (Corp S) 10. Develop electronic communications methods to exchange information with Essential SW • fax, listserve & web based (EMP/HPS/Corp S)
	Use results of the pandemic simulation exercise to refine Crisis Communication Plan for PIP	**Internal/External** 1. Simulation Exercise • prep & communicate, participate, debrief, report/recommendations (PIPAC) • follow through & communicate with SMHSEPC 2. Draft a health unit crisis communications plan (Corporate Communication)
	Work with MOHLTC and HU to establish procedures to ensure all information is accurate at the time it is released	1. Develop/review/update/revise and communicate policies and procedures to ensure accuracy of all information released related to communicable infectious disease (CS/Corporate Communication)
Interpandemic Period: Phase 1 **INTERNAL Communications**	Establish internal structures to support pandemic planning and implementation	**Internal** 1. PIPAC – Structure, meetings/minutes (PIP, MOH) 2. PIP Committees – structure, meetings/minutes & plans (PIPAC Chairs)
	Develop information management systems to ensure all staff are kept informed of pandemic planning and implementation	1. Develop Intranet information management system to include: (Corp S, Corporate Communication, PIP/secretary) • pandemic plans (local, provincial, federal) • WHO Phases • FAQs • Monitoring/Tracking (& Analysis) • Public Education Materials • Media Communications • PIP – SMDHU planning structure • Training Materials • Key Agency Contacts/databases • Surveillance Tools • Staff Briefing/updates • Priority Groups – vaccines & antivirals • Medical Directives • Situation Reports

Interpandemic Period: Phase 1 **INTERNAL Communications**	Establish policy & protocols to support pandemic planning and implementation	**Internal** 1. Protocols/processes for communicating current world and local developments including • MOH Team • Executive/Managers • CD/CD Team • VPD Teams • Health Connection • Corporate Communication Team • Health Information Team • All staff VIA email, intranet, team meetings, emergency information access i.e. web based (Corporate Communication, CD Team) 2. Surveillance • Develop clear protocol for when and what to report to key external stakeholders i.e. health care professionals, emergency response partners (CD/EMP) • Train staff on protocols (CD, EMP)
Interpandemic Period: Phase 1 **INTERNAL Communications**	In cooperation with the Training and Orientation Lead, develop training and orientation programs to support pandemic planning and implementation	Internal 1. Training & Orientation • introductory PIP i.e. what, when, responsibilities/roles, planning, info access, protection, priority groups, infection control & public health measures (including importance of Annual Influenza Vaccination) via presentations, intranet, resources and new staff orientation. (PIP) 2. Training & Orientation • prepare staff "team" to provide on-site presentations to respond to RFS. (Health Connection) 3. Ensure staff is informed of SMDHU ER plan and ER structure (EMP)
INTERPANDEMIC PERIOD PHASE 2		
Interpandemic Period: Phase 2 *A circulating animal influenza virus subtype poses a substantial risk of human disease*	Work with professional organizations and labour associations to actively promote UIIP to the public and health care workers	Continue activities from phase one
	Ensure all educational materials for the public, heath care workers & stakeholders on influenza are accurate, up-to-date and accessible (i.e., languages, literacy levels)	Continue activities from phase one

Interpandemic Period: **Phase 2** *A circulating animal influenza virus subtype poses a substantial risk of human disease*	Continue to reinforce the importance of prevention/mitigation activities	**External** Links/partners 1. Undertake enumeration process – explain rationale and direct partners to complete enumeration tools VIA letter and personal contact (CD) 2. Education/Training • to support pandemic planning at organization level • orient to local planning • orient to communication channels including extranet • surveillance/reporting VIA meetings (SMHSEPC, EMC Network), workshops/presentations, PowerPoint presentations (SMHSEPC, EMC) **External** Public 1. Education & Awareness • introduction to PIP in collaboration with County of Simcoe and District of Muskoka planners • introduction to PI – what it is/isn't, potential risks, public health measures, personal protection measures, how to access information, FAQ, Pandemic stages via web and media interviews VIA: • PSAs, press releases & interviews (SC & SMDHU media coordinators/SMHSEPC Chairs) • Web content (Corporate Communication) • Health Connection • Newsletter/Health Matters (Corporate Communication)
Interpandemic Period: **Phase 2** *A circulating animal influenza virus subtype poses a*	Continue to work to improve the communication/information infrastructure (MOHLTC and community partners)	**External** 1. Links/partners • establish protocols/procedures for communicating world developments & local actions • establish communications system for Health Sector & ER partners i.e. email/listserve, extranet, fax, rounds/professional groups meetings • communicate updates and directives as per P&P • establish protocols/procedures for communicating world developments & local actions to non SMHSEPC partners i.e. Emergency Service Workers, Essential Service Workers

substantial risk of human disease **Interpandemic Period:** **Phase 2** *A circulating animal influenza virus subtype poses a substantial risk of human disease*	Continue to work to improve the communication/information infrastructure (MOHLTC and community partners) (cont.)	• establish partners, functions, locations, protocols/processes for joint media centre (SMHSEPC – Joint Communications Committee) 2. Develop and Maintain SMHSEPC extranet – partner with the County of Simcoe to create, promote and maintain web site to include: • World Developments/ Alert status • FAQ • Pandemic Plans (local, provincial & federal) • Definitions • Local Status/surveillance • Key contact databases • Human Resources – rosters/skills • Legislation – roles & responsibilities • Directives • Infection Control/Public Health measures • Vaccine & Antiviral priority groups • Tracking tools/checklists • Education materials – including personal protection measures (e.g. handwashing, cough etiquette) • Media communications • Vaccine/antiviral storage & security 3. Media Preparation • determine HU spokesperson(s) for pandemic • determine Health Sector Planning Committee spokesperson(s) • determine media contacts for County of Simcoe, District of Muskoka and SMDHU • establish media contacts network to support media planning & public communications • establish HU staffing for joint media centre location(s) • determine training needs – provide media training for spokespersons (SC, District of Muskoka & SMDHU media coordinators) 4. Maintain a database and identify community partners, including media, requiring alerts, notification and updates on community action and resources (all contact database managers)
	Use results of the pandemic simulation exercise to refine Crisis Communication Plan for PIP	**External** 1. Undertake a Simulation Exercise in collaboration with SMHSEPC • prep & communicate • participate • debrief • report/recommendations

		• follow through • communicate (all MOHs, Directors, Mgrs, Corp S and appropriate staff) 2. Draft crisis communications plan in collaboration with the SMHSEPC (Corporate Communication)
Interpandemic Period: Phase 2 **INTERNAL Communications**	Work with SMDHU staff to establish procedures to ensure all information is accurate at the time it is released	1. Continue activities from phase one 2. Develop FAQ • post to intranet • review & update process as per international, national and provincial updates (Corporate Communication)
	Establish and maintain internal structures to support pandemic planning and implementation	**Internal** 1. PIPAC maintain communication through meetings, emails, intranet 2. PIP Committees continue to maintain communication through meetings, emails, intranet
	Develop and use information management systems to ensure all staff are kept informed of pandemic planning and implementation	**Internal** 1. Communicate change in alert status as per protocols – to include PIPAC, MOHs, directors and managers via intranet, email 2. Intranet – updates to all current sections and add: • Surge capacity info (acute care, infection control units & negative pressure rooms) • List of qualified vaccinators. • List of clinic sites • Antivirals & Vaccines – storage and handling, etc. • Emergency media contacts • Fact Sheets • Surveillance Tools • Business Continuity Plan – including surge capacity, and personal preparedness (family contingency planning) • Emergency housing and feeding info (Managers & PIPAC secretary/Corporate Communication/Corp S) 3. Extranet Site Development – develop site to keep staff informed from locations outside the agency (PIP/Corporate Communication/Corp S) 4. Staff updates through presentations 5. New phone system and cell phone system has been implemented (Corporate Services) 6. Establish emergency response media partners (Corporate Communication)

	Establish policy & protocols to support communications in pandemic planning and implementation	**Internal** 1. Develop P&P to direct staff on ER communications, i.e. access, reporting (ERM/ER Information Management Lead)
Interpandemic Period: **Phase 2** **INTERNAL Communications**	Develop and provide training and orientation programs in communications to support pandemic planning and implementation	**Internal** 1. Training & Orientation • Surveillance (principles & forms) for CD unit and backup 2. Communicate Business Continuity Plan: • essential services • training & orientation plan • alternate decision making process • work reporting procedure • info access outside the office • Family Contingency Plan i.e. stress management Via: Team meetings, email & intranet (Corp. S. + Program directors)
INTERPANDEMIC ALERT PERIOD PHASE 3		
Interpandemic Alert Period: **Phase 3** *Human infection(s) with a new subtype, but no human-to-human spread or spread to a close contact only*	Work with professional organizations and labour associations to actively promote UIIP to the public and health care workers	Continue Phase 1 and 2 activities
	Ensure all educational materials for the public, heath care workers & stakeholders on influenza are accurate, up-to-date and accessible (i.e., languages, literacy levels)	Continue Phase 1 and 2 activities
	Continue to reinforce the importance of prevention/mitigation activities	**External** Links/partners 1. Distribute PI print/electronic resources (MOHLTC , PHAC resources) to all partners for distribution to patients/clients/families and the public (Program Teams and Corporate Communications) Public 1. Staff to share key messages about public health measures with the public whenever health teaching opportunities arise. (all staff) 2. Distribute resources (MOHLTC, PHAC) about public health measures to community agencies where the public can access, including HU office reception areas (Program Teams and Corporate Communications) 3. Post public health measures information to health unit website (Corporate Communication)

		4. Share information on public health measures through the media via press release, PSA, MOH column, interviews). (Spokespersons, media coordinators) 5. Share information on potential public health measures for community outbreaks (isolation, contact tracing, etc.) via media outlets and posted to the website (Corporate Communications). See Public Health Measures Framework
Interpandemic Alert Period: **Phase 3** *Human infection(s) with a new subtype, but no human-to-human spread or spread to a close contact only*	Continue to work with SMHSEPC and Community Partners to improve the communication/information infrastructure	**External** 1. Activate Health and ER sector joint communications network to confirm: • understanding of current situation • local status • public health measures • key messages • direction for media inquiries • situation updates process (teleconference, web, etc.) (SC/MD & Corporate Communication) 2. Establish Joint Media Centre (with electronic links between Simcoe and Muskoka) • determine key spokespersons, key messages, media access to information (phone, interview, web) • develop crisis communication plan (SMHSEPC Joint Communications Committee) 3. Forward information for posting to SMHSEPC Extranet: • mass vaccination program • vaccine and antiviral priority groups (& numbers) when available/known • vaccine clinic supply locations (VPD Manager)
	Use results of pandemic simulation exercise to refine Crisis Communications Plan for PIP	Repeat of Phase 1 and 2 activities
	Work with MOHLTC and SMHSEPC to establish procedures to ensure all information is accurate at the time it is released	**External** 1. Establish protocol and procedures for information created from joint media centre (SMHSEPC Joint Communications Committee) 2. Establish a communication link with Central East health units for consistent public messages and cross-promotion of immunization program and vaccine access (Corporate Communication)
	Review and, if necessary, refine local communication plans; confirm when and what to communicate to the public health care workers, workplaces, and other audiences, focusing on existing influenza	**External** Links/partners 1. Communicate change in alert status as per protocols, plus required public health measures, access to antiviral & vaccine, surveillance requirements (case definitions) and REMINDER of communication channels/protocols via

	prevention messages and WHO/PHAC updates Review and, if necessary, refine local communication plans; confirm when and what to communicate to the public health care workers, workplaces, and other audiences, focusing on existing influenza prevention messages and WHO/PHAC updates	email list serve and extranet (CS, Corporate Communication) 2. Forward info for updating SMHSEPC extranet to include: • Estimated impacts based on viral activity and high-risk groups i.e. infected, clinically ill, o/p care hospitalized and deaths • Local surveillance data (link to national/provincial data) • Infection control/public health measures • Antiviral and vaccine access (priorities based on viral activity and supply) • Clinic schedules • Emergency supports i.e. alternate care, housing, food (Corporate Communication) • Communicate with Emergency Service Workers and Essential Service Workers via list serve to include: • World Developments/ Alert Status • Surveillance protocols/procedures and tools (where appropriate) • Local surveillance data • Estimated impacts based on viral activity and high-risk groups • Public health measures • Antiviral & vaccines access (priorities based on viral activity and supply) • Clinic schedules • Emergency supports i.e. alternate care, housing, food 3. Work with SMHSEPC to develop appropriate communication tools to share information with partners and community agencies and service providers. (Corporate Communication) **External** Public Education & Awareness: via media and web • situation update/ alert status • local viral activity • viral pattern & high-risk groups, • public health measures • directions for flu assessments and access to a antiviral/vaccines (MOHLTC, VPD) • information access Health Connection (phone & web) • reassurance (coordinated planning), emergency response measures/supports, business continuity measures (as appropriate) • (Corporate Communication, Corporate Service) Vulnerable populations • determine community agencies/partners links (including CCAC and Social Services) with vulnerable population and how best to communicate information related to access of community supports (EMP) • - communicate with other key stakeholders re: the nature of support, agencies providing support. (Corporate Communication.)
Interpandemic Alert Period: **Phase 3** *Human infection(s) with a new subtype, but no human-to-human spread or spread to a close contact only*		

	Review and, if necessary, update pandemic contact list	Continue from phases 1 and 2 activities
Interpandemic Alert Period: **Phase 3**	Establish and maintain internal structures to support pandemic planning and implementation	Review structure used previously for PIPAC for the ongoing requirements identified that fit with SMDHU ER structure (Executive Committee)
Interpandemic Alert Period: **Phase 3** **INTERNAL Communications**	Develop and use information management systems to ensure all staff are kept informed of pandemic planning and implementation	**Internal** 1. Communicate change in Alert Status as per protocols (email & intranet) (Corporate Communication, CS) 2. Update information for SMDHU staff on the intranet regularly i.e. • Current SMDHU PIP • FAQs, fact sheets (public health measures) • WHO Levels/pandemic situation update • HPPA closures process, etc. (MOHTLC) • Vaccines and antivirals – priority group numbers, mass vaccination plan, supplies, list of qualified vaccinators and potential vaccinators, training manual, medical directives, flu assessment centres (Managers, Corporate Communication) 3. Communicate with all staff the vaccine and antiviral priority groups via management team/team meetings, intranet, email (VPD manager, managers) 4. Review and finalize PIP Crisis Communications Plan with emphasis on: • Key message development • Communications Plan • Development of new prevention/information resources if necessary. (Corporate Communication)
	Establish policy & protocols to support pandemic planning and implementation	**Internal** 1. Establish a Surveillance communication meeting process/schedule/protocol to include CD, AMOH/MOH and Epidemiologists (MOH/AMOH) See Surveillance Framework – Phase 3 2. Establish internal communications group including MOH office, CD, VPD, HC, Corporate Communication, reception, epidemiologists, Public Information and Media Relations Coordinator and Information Management Lead (EMP) • determine meeting schedule/protocols/communication methods • assign responsibilities within a 24 hour information cycle • Including MOH updates, manager updates, all staff updates, team updates, etc.
	Develop and provide training and orientation programs to support pandemic planning and implementation	1. Vaccination (including mass vaccination plan), CD investigation, CD follow up, phone response (appropriate service/team) 2. Provide training related to media and media monitoring, key message response for telephone inquiries, voice messaging (Corporate Communication)

PANDEMIC ALERT PERIOD PHASE 4		
Pandemic Alert Period: **Phase 4** *Small cluster(s) with limited human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible*	Work with professional organizations and labour associations to actively promote UIIP to the public and health care workers	Continue Phase 1, 2 and 3 activities
	Ensure all educational materials for the public heath care workers/stakeholders on influenza is accurate, up-to-date and accessible (i.e., languages, literacy levels)	Continue Phase 1, 2 and 3 activities 1. Develop signage to support the implementation of mass immunization clinics (Corporate Communication) Develop the vaccination information tools required for clinics and web posting (VPD, Corporate Communication)
	Continue to reinforce the importance of prevention/mitigation activities	**External** Links/Partners – continue phase 3 activities Public – continue phase 3 activities
	Continue to work with MOHLTC, SMHSEPC and Community Partners to improve the communication/information infrastructure	**External** MOHLTC 1. Participate in all meetings, teleconferences, etc related to PIP (MOH, PIP, CD & VPD managers, Corporate Communication) Links/Partners - continue all Phase 1, 2 & 3 activities 1. Continue of Phases 1, 2 and 3 activities 2. Communicate active surveillance procedures with all identified partners via email and post to the extranet (CD)
	Run annual pandemic simulation exercise and use results to refine Crisis and Risk Communications Response Plan	Repeat of phases 1,2 and 3
	Work with MOHLTC and SMHSEPC to establish procedures to ensure all information is accurate at the time it is released	Continue Phases 1,2 and 3 activities
	Confirm local spokespeople and back up personnel for a pandemic and provide crisis communication training	**External** Links/Partners 1. Confirm spokespeople and backup personnel for joint media centre 2. Provide crisis communications training for identified spokespersons for SMHSEPC, ERC and HSER media network (Corporate Communication)

Pandemic Alert Period: Phase 4		
	Confirm that local health facilities have up-to-date pandemic plans in place	1. Confirm pandemic plan in local health facilities through ICP contacts via meetings, email and phone contact (CD)
Pandemic Alert Period: Phase 4 **INTERNAL Communications**	Verify lists of stakeholder and media contacts	1. Confirm database updates and functionality – see phases 1 and 2 (SMHSEPC and Corporate Communication)
	Confirm translation requirements	1. Determine translation requirements, communication channels, distribution methods, accessible resources, etc. (H Communications)
	Establish and maintain internal structures to support pandemic planning and implementation	Continue phase 2 & 3 activities
	Develop and use information management systems to ensure all staff are kept informed of pandemic planning and implementation	1. Communicate health unit emergency response status i.e. pre-ER via email from MOH or designate to all staff and post to intranet (Corporate Communication) 2. Pandemic situation updates posted weekly to the intranet (CD) 3. Provide executive summary of Mass Immunization Plan on intranet
	Establish policy & protocols to support pandemic planning and implementation	1. Review, finalize and implement agency pandemic policies and protocols (Executive) 2. Communicate procedures for health facilities, closures, orders under HPPA via email, team meeting and post to intranet (CD)
	Develop and provide training and orientation programs to support pandemic planning and implementation	1. Provide ongoing media/ and media monitoring training as required (H Communications)
PANDEMIC ALERT PERIOD PHASE 5		
Pandemic Alert Period: Phase 5	Work with MOHLTC to develop public education messages, and define the role of spokespersons	1. Participate in MOHLTC communication teleconferences, events, etc. (Corporate Communication)
	Participate in Crisis Communication network	1. Confirm who participates locally (Corporate Communication) 2. Report CC network updates to SMHSEPC and HS/ER media network, and to internal stakeholders (Corporate Communication) 3. Update health unit Crisis Communications Plan accordingly (Corporate

	Participate in Crisis Communication network	Communication) 4. Update JMC Crisis Communications Plan, review training needs and provide training as needed (Corporate Communication)
Pandemic Alert Period: **Phase 5** *Large cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible*	Implement plans to communicate with all relevant audiences, including the media, key opinion leaders, stakeholders, and employees Implement plans to communicate with all relevant audiences, including the media, key opinion leaders, external stakeholders, and employees	**External** Links/Partners 1. Advise partners of pandemic situation updates (daily), health/travel alerts, clinics, access to vaccine and antivirals via email, extranet and Health Fax (CD/VPD, Corporate Communication) 2. Stakeholder meetings/forums (if appropriate given transmission status, etc.) (Corporate Communication) Public 1. Activate automated VOIP messages (Corporate Communication) 2. Advise public of pandemic situation updates, health/travel alerts via press release/PSAs, media interviews and post daily to the web site (Corporate Communication) 3. Public meetings/forums (if appropriate given transmission status, etc.) • to explain health unit and regional plans to contain/combat the disease, to provide factual, credible information and reassure the public (MOH, CS Director, Corporate Communication) Staff 1. Activate emergency response media contacts – situation status, requirements, roles, processes (Corporate Communication) 2. Advise staff of situation status, public health measures, health/travel alerts, clinics, vaccine and antiviral updates, emergency response readiness, etc via teleconference, email , team meetings and post to the intranet (MOH, Corporate Communication)
Pandemic Alert Period: **Phase 5** **INTERNAL Communications**	Establish and maintain internal structures to support pandemic planning and implementation	1. Establish processes that reflect the ER planning structure 2. Undertake volunteer training to support communications functions. (Corporate Communication)
	Develop and use information management systems to ensure all staff are kept informed of pandemic planning and implementation	1. Update all staff via email, teleconference and the intranet on the following: • Business Continuity Plan and redeployment expectations • Estimate impact numbers i.e. infected, clinically ill, o/p care, hospitalization • Health and travel alerts • Directives (MOHLTC & EMO) • Antiviral & vaccine access, clinics etc. • Surveillance data/forms, protocols and case definitions • Policies – e.g. mandatory isolation order • Staff reporting mechanisms • Out-of-office information access (web & radio) • Updates to all sections on intranet as appropriate

Pandemic Alert Period: **Phase 5** **INTERNAL Communications**	Develop and use information management systems to ensure all staff are kept informed of pandemic planning and implementation (con't)	(MOH, Corporate Communication) 2. Activate the web-based information source for staff (intranet duplicate) and inform staff of process for access via email and team meetings. (Corp S, Corporate Communication, Managers) 3. Apprise Emergency Control Group of hot issues as a result of media coverage. (Corporate Communication)
	Establish policy & protocols to support pandemic planning and implementation	1. Review internal communications processes/protocols, etc and follow as appropriate.
	Develop and provide training and orientation programs to support pandemic planning and implementation	
PANDEMIC PERIOD PHASE 6		
Pandemic Period: **Phase 6** *Increased and sustained transmission in general population*	Activate Crisis Communication Plan	**External** 1. Activate crisis communication plan (see appendix A, B and C) (Corporate Communication) 2. Post revised main web page with focus on pandemic (Corporate Communication) 3. Activate process evaluation of crisis communications plan (Corporate Communication)
	Distribute fact sheets	**External** 1. Distribution of education materials (prevention, mitigation, personal protective measures, personal protective equipment, etc) i.e., • fact sheets, brochures via HU offices, HU staff contacts with the public, health and emergency sector partners, libraries, community recreation centres and halls, social service agencies, schools, etc. (Corporate Communication)
	Continue regular communication with communication partners	**External** Links/Partners 1. Work with Joint Media Centre to implement joint crises communications components • Joint press conferences – postings to extranet site • Joint press releases • Ongoing media contacts (MOH and Corporate Communication) 2. Maintain regular contact with HS/ER media network via teleconference (Corporate Communication)

Pandemic Period: Phase 6 *Increased and sustained transmission in general population*	Provide information in real time to health care workers, media and the public regarding Ontario's: • level of readiness • possible decreases in service • alternative care sites	**External** Links/Partners 1. Notify SMHSEPC partners of need/rationale to "stand-by" and be ready to activate their emergency response plan via list-serve and extranet (MOH or alternate) 2. Notify SMHSEPC partners via list-serve and extranet that the health unit has activated its emergency response plan.(MOH or alternate, ER Info Management Lead) 3. Notify Simcoe County and the District of Muskoka EOC's and municipal heads of council that the HU emergency response plan has been activated.(MOH) 4. Communicate request from MOH to County/District heads of council (faxed letter) to activate their Emergency Operations Centres. (MOH) 5. Communicate request from MOH to County/District municipal councils (faxed letter) to activate their emergency response plans. (MOH). 6. Remind key partners of the surveillance reporting process/tools via email/extranet (CD, Corporate Communication) Public 1. Notify public via media (press release & press conference with JMC) of activation of the ER plan including rationale and post to the web site (Corporate Communication & Corp S) • respond to media inquiries via interview/press conference (MOH and Corporate Communication)Public Links/Partners & Public 1. Advise partners and public of change in service delivery, including the provision of essential services, via press release, website and Health Connection. (Corporate Communication & Corp S) 2. Advise public that trained volunteers/helpers in place to support pandemic activities via joint media centre. (press release, press conference & interviews) (Corporate Communication) 3. Assist in notification to partners and public of alternate health services and care sites through Health Connection. (Corporate Communication) 4. Advise partners and public of vaccine security measures, mass immunization clinic plans, including priority groups and sites via Health Fax, extranet, Joint Media Centre (press releases and press conferences), website and Health Connection. (VPD, Corporate Communication) 5. Inform partners and public of food, emergency and medical services available for people confined to home via Joint Media Centre (press releases and press conferences), extranet, website and Health Connection.(EMP, Corporate Communication) 6. Advise partners and public of infection control measures, isolation and quarantines, travel restrictions, community facility/school closures, event cancellations, etc. via Health Fax, extranet, Joint Media Centre (press releases

Pandemic Period: Phase 6 *Increased and sustained transmission in general population*	Provide information in real time to health care workers, media and the public regarding Ontario's: • level of readiness • possible decreases in service alternative care sites (cont.)	and press conferences), website and Health Connection. (CD, Corporate Communication) 7. Advise partners and public of pandemic situation updates daily (or more often as required) via Health Fax, extranet, Joint Media Centre (press releases and press conferences), website and Health Connection. (CD, Corporate Communication)
	Provide regular updates to Joint Health and Safety Committees and receive updates from them as appropriate	
	Update annual multimedia campaign promoting UIIP, adding information about current influenza activity	**External** 1. Continue activities from phases 1, 2, 3, 4 and 5 (VPD, Corporate Communication)
Pandemic Period: Phase 6 **INTERNAL Communications**	Establish and maintain internal structures to support pandemic planning and implementation Establish and maintain internal structures to support pandemic planning and implementation (cont.)	1. ER daily briefing (teleconferences) meetings to include (Emergency Control Group) • Surveillance update • Travel restrictions, restrictions, cancellations, quarantines, isolations, closures (schools, daycares, business, centres, etc.) • Staff deployment/ staffing issues • Deployment of volunteers • Mass clinic plan update • Public Communications/public response • Update to go to staff 2. Implement daily communications briefings with Internal Communications Group to include (Emergency Response Public Information and Media Relations Coordinator (PIMRC), Info Management Lead (IML) • Health Connection – public response/information needs • Media response/tracking/information needs • Internal information needs (surveillance, public health measures, community health service and social supports, staff deployment) • Ministry directives 3. Implement all daily communications protocols to management, all staff, teams, etc. (IML)

Pandemic Period: Phase 6 **INTERNAL Communications**	Develop and use information management systems to ensure all staff are kept informed of pandemic planning and implementation	Provide situation update to staff via teleconference followed by email and intranet/extranet posting, to include (teleconference updates - frequency to be determined as situation unfolds): (PIMRC & IML): 1. Global/Provincial/local situation update, including surveillance reports 2. Standby for activation of the emergency response plan 3. Activation of the emergency response plan 4. Public Health Measures in place 5. Access to antivirals/vaccine 6. Implementation of the business continuity plan - current stage 7. Process to access password protected extranet for situation updates, staff schedules/assignments, etc. 8. Process for staff to report to work/report absence on a daily basis 9. Emergency information media stations for urgent staff PSAs 10. Hours of expanded Health Connection service 11. Role of trained volunteers Keep staff informed of local emergency response/resources via the intranet/extranet (IML, Corp S) 1. Current priority groups for antivirals, access points 2. Current Mass clinic plans, including priority groups, sites and staff schedules, VAER results (as required) 3. Current vaccine supply/access for non-priority groups 4. Infection control procedures including mandatory isolation orders, stay at home if ill, restrictions (including travel), cancellations, closures 5. Assessment and alternate care sites (activation and deactivation) 6. Food, medical and emergency social services for those confined to their homes 7. Social and support services for the public 8. Burial locations 9. Available support resources for staff and how to access
	Establish policy & protocols to support pandemic planning and implementation	1. Activate the Crisis Communications Plan (see appendix A, B and C) 2. Post revised protocols for mass immunization clinics to intranet (VPD) 3. Post vaccine security procedures to the intranet (VPD) 4. Communicate policy and procedures related to mandatory isolation orders (CD) 5. Activate Internal Communications Group including MOH office, CD, VPD, HC, Corp. Communications Team, PIMRC, IML, Reception, Surveillance/Epidemiologist. • determine meeting schedule/protocols/communication methods • assign responsibilities (PIMRC)

	Develop and provide training and orientation programs to support pandemic planning and implementation	1. Train staff related to revised contact tracing/case management procedures/surveillance and investigating via multimedia and workshop (CS) 2. Phone response training via manual and multimedia workshop with PowerPoint (HLS) 3. Training for vaccination via manual, PowerPoint and workshop (CS) 4. Continue to orient all staff to new public education materials and community resources. (refer to intranet for information) 5. Apprise staff of support services available to staff (Corp S)
Pandemic Period: Phase 6 *Regional and multi-regional epidemics*	Continue to work with MOHLTC to provide consistent messages	**External** 1. Liaise closely with MOHLTC for current developments and communications (MOH, Corporate Communication) 2. Provide daily SMHSEPC teleconference updates as required (based on Ontario updates, directives, etc.) (MOH or alternate) 3. Notify Telehealth of local pandemic activities and services - refer to health unit website (HLS)
Pandemic Period: Phase 6 *Regional and multi-regional epidemics*	Continue to provide information/updates to MOHLTC, health care workers, the media and the public Continue to provide information/updates to MOHLTC, health care workers, the media and the public (cont.)	**External** Provide feedback on effectiveness of public health interventions to the provincial level through MOH teleconferences, etc (MOH) Links/Partners & Public Continue activities from early Phase 6 and: 1. Communicate any changes in situation status/case definitions (CD, Corporate Communication) 2. Maintain the public version of regional surveillance/monitoring/tracking (CD) 3. Communicate any changes in national/provincial/local recommendations for containment strategies (CD, Corporate Communication) 4. Communicate any changes in vaccine priority groups/clinic locations/schedules (VPD, Corporate Communication) 5. Communicate burial site locations (EMP, Corporate Communication) via: Health Fax , extranet, Joint Media Centre (press releases and press conferences), website and Health Connection. 6. Communicate to all HCP who are administering vaccine importance of reporting adverse vaccine reactions via Health Fax (VPD) 7. Provide after care sheets to all person immunized by health unit staff and provide sheets to all who administer vaccine. Post aftercare and common side effect information to the web site (VPD, Corporate Communication) 8. Distribute weekly report of vaccine supplies, demand, distribution and uptake, and adverse events information to community health providers who are administering vaccine via Health Fax. (VPD) 9. Post Q&A re: vaccine, consent form, information on adverse events, and aftercare sheet on website (Corporate Communication, Corp S) 10. VPD

Pandemic Period: Phase 6 *Regional and multi-regional epidemics*	Gather information from the field and use that to inform/refine the communications plan	1. Daily briefings of EOC & Internal Communications Group to gather/share information and reflect updated/revised messages in communications. (PIMRC & IML)
	Monitor effectiveness of local communication strategy and modify as required	**External** 1. Monitor local media i.e., provincial press conferences, A-Channel and Rogers news and newspaper clippings, radio stations (Corporate Communication, IML) 2. Gather reports from Health Connection on caller response to public communication channels and messages. (Corporate Communication, IML)
Pandemic Period: Phase 6 **INTERNAL Communications**	Maintain internal structures to support pandemic planning and implementation	Continue early Phase 6 activities
	Develop and use information management systems to ensure all staff are kept informed of pandemic planning and implementation	Continue early Phase 6 activities and 1. Communicate any changes in case definitions (CD, IML) 2. Communicate any changes in national/provincial/local recommendations for containment strategies (CD, IML) 3. Communicate any changes in vaccine priority groups/clinic locations/schedules (VPD, IML) 4. Communicate burial site locations (EMP, IML) 5. Communicate immunization aftercare and common side effect information (VPD, IML) via teleconference and/or email updates to internal stakeholders and by posting to intranet/extranet
	Policies and Procedures	Continue to follow protocols and procedures for communication
	Training and Orientation	
Pandemic Period: Phase 6 *End of first wave; pandemic subsiding*	Identify lessons learned	**External** 1. Engage SMHSEPC Partners and stakeholders in debriefing exercises and communicate results (MOH) 2. Advise public of next pandemic wave, precautions, etc. to come via media, website, etc. (Corporate Communication)
	Evaluate local communications response	Internal/External 1. Review media logs/databases/tapes etc. and document findings (PIMRC & IML) 2. Engage in communications debrief health unit staff (PIMRC & IML) 3. Engage in communications debrief with SMHSEPC and with HSER Media Network (PIMRC & IML)

Pandemic Period: Phase 6 *End of first wave; pandemic subsiding*		**External** 1. Distribute press releases, letters to individuals appreciation of cooperation from other agencies, volunteers and health unit staff (MOH, Corporate Communication) 2. Step down and suspend joint media operations (MOH, Corporate Communication)
POSTPANDEMIC PERIOD		
Post pandemic Period: Return to Phase 1	Revise pandemic communications plan based on experience	**External** 1. Post epidemiology report to web site (CD) 2. SMDHU representatives participate in debriefing meetings with the MOHLTC and other external agencies (MOH) 3. Prepare simplified version of the report highlights for inclusion on web, follow-up MOH columns, annual reports, etc.(Corporate Communication) 4. Advise public & partners of current health unit program/service status (Corporate Communication) **Internal** 1. Post epidemiology report onto intranet. Share highlights of the report with all staff via intranet (CD) 2. Conduct debriefings, review and revise pandemic contingency plan and evaluate emergency response. (EMP, Corporate Service) 3. Final debriefing with ER communication team, EMP and management team. Teleconference/briefing note to all staff re: resuming all program activities with any exceptions. Develop and share report of pandemic experience, reassessment of pandemic plan based on assessment outcome. Report shared at teams and posted on intranet. Input final recommendations and make revisions to update pandemic plan. Archive information on intranet with links to WHO, CDC and HC for ongoing surveillance.(MOH, EMP, Corporate Communication)
	Return to Phase 1 activities	**Internal** 1. Restore normal communications system and activities. 2. Program teams to provide regular update to Health Connection via liaisons of their ability to respond to requests for service as we transition to post pandemic public health services. **External** 3. Ongoing promotion of the importance of flu immunization and personal infection control measures i.e., through press releases, PSAs, columns, publications and web. (CS, Corporate Communication) 4. Update pandemic plan on internet, share final report with HSER partners. Input their recommendations and make revisions on final report. (MOH, Corporate Communication)

APPENDICES

APPENDIX A - II - 5: CRISIS COMMUNICATION PLAN FOR PANDEMIC INFLUENZA

PANDEMIC INFLUENZA CRISIS COMMUNICATION TEAM:

- 2 FTE - Health Promotion Specialist
- 1 FTE - Media Coordinator

ISSUE/ACTION

This Crisis Communication Plan (CCP) sets out the Simcoe Muskoka District Health Unit's communications strategy for Phases 3-6 of the WHO Pandemic Influenza Alert.

BACKGROUND

Influenza is a serious respiratory illness caused by influenza A or B virus. When an outbreak of a new type of influenza virus affects a large number of people around the world, it is known as a pandemic.

There have been three flu pandemics in the last century, with the most severe being the 1918-19 Spanish Flu when 20 to 40 million deaths occurred worldwide. The other pandemics were less serious, but still caused significant illness and death.

With the recent spread of the avian influenza (H5N1) virus in south Asia and Eastern Europe, many experts believe the possibility for a pandemic to happen has increased. The avian flu is a concern because although it has currently only spread to a very few humans by direct contact with infected birds, some experts believe that the virus may mutate to cause person to person spread of the disease, thus causing a pandemic.

The World Health Organization and a large number of national health agencies, including the Public Health Agency of Canada, have recommended the development of pandemic plans to help reduce the impact of the next pandemic on the world's population.

The Simcoe Muskoka District Health Unit has created its own plan to combat a flu pandemic in this region. It is designed to meet the needs of the community and to be coordinated with the current plans that have been developed by the Public Health Agency of Canada, the Ontario Ministry of Health and Long-Term Care and other health care agencies in our communities. The Health Unit is also working with several community partners, through the Simcoe Muskoka Health Sector Emergency Planning Committee, on a region-wide plan including hospitals, municipal governments, ambulance and other health sector agencies.

Communications is an important and vital component of a comprehensive public health response to a pandemic. The creation of a general communications plan, as well as a crisis communication plan for the pandemic phase will help to inform and guide the public, media, staff and partners/stakeholders in implementing an appropriate response to a pandemic situation, as well as in the compliance of public health measures.

PUBLIC CONCERNS TO BE ADDRESSED

Person/family safety
Interruption of normal life activities

- What are the risks to me and my family?
- What is the best way to prevent me catching the flu?
- What should I do to prevent spreading the flu if I get it?
- At what point do I seek medical attention?
- Should I go to school/work?

- What is the province/region doing to protect me?
- How can I be reassured that everything that can be done to safeguard my health during a pandemic is being done?
- What is the health unit doing to protect us when a pandemic?
- Will I be able to access medications/antivirals?

STAKEHOLDER CONCERNS TO BE ADDRESSED

Adequate resources to respond (health, emergency, recovery)
Information to respond to patients/clients/publics served
Access to treatment supplies
Accurate information, situation updates and actions being taken
Business impacts
Quality of planning and implementation

- Are systems in place to receive/transmit communications with the health unit?
- How do we react to the crisis with a united front?
- What messages should we be giving to the public?

CONSTRAINTS

The following hurdles may potentially affect the smooth implementation of this crisis communications plan:

- Logistical challenges related to geography and location, both at health unit level and partner level (e.g. availability of spokesperson(s) at multiple, concurrent press conferences; location of joint media centre, etc.)
- Limited number of trained communications and technical personnel available
- Availability of necessary resources
- Personnel trained in crisis communications

GOALS AND OBJECTIVES

The goals of this crisis communication strategy are to:

- Provide the health unit with a comprehensive, well-planned communications strategy that can be quickly implemented in the event of an influenza pandemic that becomes localized to the Simcoe Muskoka.
- Provide a crisis communications strategy that will respond to the information needs of the public, media, health unit staff, workplaces, stakeholders and partners in a timely, efficient and effective manner.

These goals will be reached through the implementation of the following objectives:

- Develop a comprehensive timeline of key activities that will ensure the provision of factual, timely and accurate information to the public, media, staff, stakeholders and partners regarding all events, reports, surveillance, directives and information related to an influenza pandemic in Simcoe Muskoka..
- Develop key relevant messages that target specific audiences throughout the duration of the Stage 6 outbreak. Particular attention must be paid to the tone of the messages (e.g. public needs reassure that mechanisms and systems are in place - locally, provincially and nationally- to combat the pandemic).
- Create a collaborative process with partner agencies and services for the development and implementation of a joint crisis communications strategy for the region.

APPROACH

This CCP will incorporate the following approaches and concepts:

- Consistency in messaging across the region.
- Collaborative communications activities with regional partners.
- Emphasis on the dissemination of critical and timely information to the media, public, health unit staff and partners as required.
- Provide opportunities for dialogue and information sharing on the issues between the health unit and the public.
- Continuation of public education campaign for the public regarding influenza prevention and precautions.
- Communications activities are underpinned by the following principles:
    - 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.
    - Dissemination of information should be timely and transparent in order to build public trust and confidence.

TARGET AUDIENCES

1. Members of the public (residents of Simcoe Muskoka) – will require up-to-date information on pandemic status/statistics, signs and symptoms, prevention/self-protection measures, public health measures, systems and procedures in place to combat pandemic, antiviral and vaccine availability, etc. CHANNELS/VEHICLES: the media, distribution of resources (pamphlets, fact sheets, notices), internet, e-mail, Health Connection, health unit telephone system (pre-recorded messages), public information sessions, newspaper ads/inserts, PSA's, call-in shows.

2. Media (Simcoe Muskoka) – will require current, accurate and timely information on all issues listed above. CHANNELS/VEHICLES: regular press releases, PSA's, one-on-one interviews with health unit spokespeople, press conferences, taped television/radio shows, health unit internet site (News Room)

3. Health Unit staff – will require detailed, up-to-date information on pandemic status/statistics/surveillance, MOH/ MOHLTC public health directives, systems and procedures, antiviral and vaccine availability, information specifically for health unit staff. CHANNELS/VEHICLES: intranet, e-mail, taped telephone message (if urgent).

4. Partners/Stakeholders (Simcoe Muskoka) – will require up-to-date information on pandemic status/statistics/surveillance, MOH/ MOHLTC public health directives, systems and procedures, antiviral and vaccine availability, information specifically for health professionals and community partners. CHANNELS/VEHICLES: internet, e-mails, faxes, teleconferences, press releases, communiqués released by joint communication team.

5. Businesses/Workplaces (Simcoe Muskoka) – will require information on public health measures, public health directives, prevention/self-protection, essential service information. CHANNELS/VEHICLES: internet, faxes, e-mails, media, resources (fact sheets, etc.)

KEY PUBLIC MESSAGES

A) PANDEMIC ALERT PHASES 3-5

- Personal & family protection measures - Prevention is the key to avoiding the flu – annual universal flu shot, handwashing, covering mouth when sneezing/coughing, etc.
- During a pandemic, follow all public health measures and directives (reiterate what these are).

- Reassure the public that systems and processes are in place to safeguard public health during a pandemic.
- Agencies/services throughout the region are working together to deal with pandemic flu issues – identify pertinent issues and how they will be dealt with.
- Dispel rumours and address false reports

B) PANDEMIC PHASE 6

FIRST CASE REPORTED IN SIMCOE MUSKOKA

- Flu is confirmed in Simcoe Muskoka – details as appropriate
- Personal & family protection/prevention measures – explain mode of transmission, etc.
- Watch for symptoms of flu & instructions of how to deal with the symptoms, including when to seek medical attention
- Surveillance is taking place to monitor and track the path of the disease
- Address rumours and dispel false reports

SPREAD OF FLU IN Simcoe Muskoka

- Spread of flu has occurred – report on details
- Public health measures – if implemented
- Protective and prevention measures
- "we are in control" message
- Address rumours and dispel false reports

ACTIVITIES

Activities for Phase 3, 4, 5 and 6 appear in the Pandemic Communication Activities pages of this document. Additional detail for Phase 6 Crisis Communications activities appear in Appendix B

EVALUATION OF CCP

It is imperative that proper evaluation is conducted on this plan, including formative, process, impact and outcome components. Keeping in mind that time constraints and urgent emerging priorities may hinder some of this process, the evaluation ideally will include:

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

- Tracking of all public enquiries:
    - # calls to Health Connection
    - # website hits
    - # email enquiries

- Tracking of staff-related communications
    - # staff enquiries

- Testing of messages and materials
    - Public feedback
    - Surveys

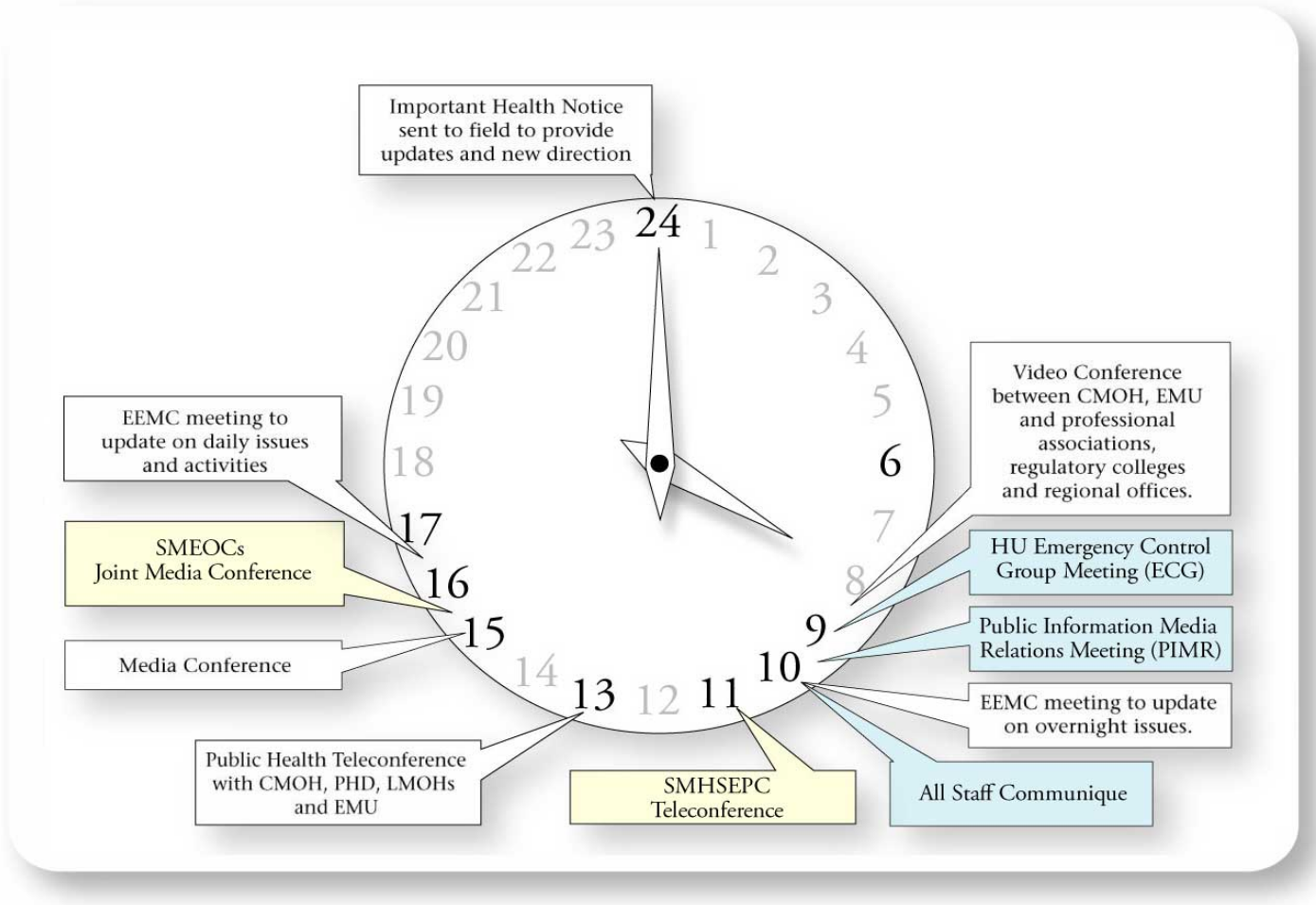
- Impact indicators

- Outcome indicators

APPENDIX B - II - 5: CRISIS COMMUNICATION PLAN - PHASE 6 ACTIVITIES

PANDEMIC PHASE	AUDIENCE	ACTIVITY
PHASE 6 Increased and sustained transmission in general population	**PUBLIC**	1. Hold regular press conferences (frequency to be based on situational assessment) throughout the pandemic, as required, and for the following events: o Flu reaches Canada/Ontario KEY MESSAGES • allay public fears, offer reassurance that plans, systems, processes, etc are in place to deal with the crisis • self-protection/prevention • be vigilant – signs & symptoms, when to seek medical attention o First flu case reported in Simcoe Muskoka (SM) KEY MESSAGES • supply details of case as appropriate, • reinforce "we are prepared" message • reinforce protection/prevention message o Spread of flu in SM population KEY MESSAGES • As above • "we are managing the crisis" message
		2. Issue regular press releases (frequency to be based on situational assessment), and as required - see activity above
		3. Distribution of prevention materials as determined • Fact sheets, brochures • Determine location and mode of distribution
		4. Internet • launch public version of regional disease surveillance/monitoring/tracking • daily updates from and links to MOHLTC, PHAC, etc. as needed • launch section for public health measures/directives
	STAFF	5. Activate and implement Crisis Communications Plan (CCP)
		6. Intranet/email updates, including: • Daily surveillance reports • Regular situation and information updates (from all necessary sources) • Public health measures & directives • Human resources plan
		7. Regular liaison with Health Connection to meet their information needs
	PARTNERS/ STAKE-HOLDERS	8. Work closely with SMHSEP Communications Committee (CC) to implement joint crisis communications plan components including, teleconferences, email list serve, newsletter, extranet, etc.
		9. Joint press conferences – deliver joint key messages

		10. Disseminate required information to SMHSEP extranet site
	AUDIENCE	**ACTIVITY**
	COMMUNICA-TIONS TEAM	• Activate CCP
		• Liaise closely with MOHLTC for current developments and communications
		• Activate process evaluation of CCP


Important Health Notice sent to field to provide updates and new direction
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Video Conference between CMOH, EMU and professional associations, regulatory colleges and regional offices.
HU Emergency Control Group Meeting (ECG)
Public Information Media Relations Meeting (PIMR)
EEMC meeting to update on overnight issues.
All Staff Communique
SMHSEPC Teleconference
Public Health Teleconference with CMOH, PHD, LMOHs and EMU
Media Conference
SMEOCs Joint Media Conference
EEMC meeting to update on daily issues and activities

II - 6 ORIENTATION AND TRAINING

INTRODUCTION

Knowledgeable and well trained staff are essential for an effective and coordinated response to a pandemic influenza emergency. The goal of the SMDHU Orientation and Training plan is to enhance and support the development of public health staff in their skill and capacity to respond competently in the event of a pandemic influenza emergency. This plan identifies pandemic influenza orientation and training activities specific to SMDHU staff.

The objectives of the Orientation and Training plan are:

- To ensure that SMDHU staff have the necessary knowledge and training to competently respond to a pandemic influenza emergency.
- To address orientation and training needs as identified in the SMDHU PIP and outline the training and resources needed.
- To identify orientation and training gaps within the SMDHU PIP and to propose recommendations on how these can be addressed.

The SMDHU Training and Orientation plan uses the WHO pandemic phases to organize orientation and training activities according to the OHPIP phase specific local objectives.

Phase 1 From WHO	Local Level Orientation & Training Objectives for SMDHU	Public Health Unit Orientation & Training Activities
INTERPANDEMIC PERIOD PHASE 1		
Interpandemic Period: Phase 1 *No new influenza virus subtypes have been detected in humans*	All SMDHU staff will have general knowledge of SMDHU PIP. P = Responsible for Planning I = Responsible for Implementation * It is the recommendation of the Orientation and Training Sub-Committee that the plans in this document would be best served by the identification/assignment of health unit staff (Corp S/Human Resources) to the role of Orientation and Training Co-ordinator to oversee and document the activities that are described in this chapter of the SMDHU Pandemic Plan, 2006	1. Core PIP PowerPoint slides which can be used to develop presentations. 2. Core group of trained staff able to do PIP presentations. 3. PIP presentation has been delivered to CS, Corporate Services, FHS & HLS during in-service day. HPS outstanding HPS in-service planning committee (P) Pandemic Influenza Presenters Group (P & I). 4. PIP Intranet site with FAQ section – further development of site still needed to reflect PIP process, plan, etc. Pandemic Influenza Planner (P), Health Communication Group (P & I), Webmaster (P & I). 5. Multimedia PIP presentation to be used for new staff, staff unable to attend an in-service and as a general refresher- Corporate Services (P & I), Orientation and Training Co-ordinator (P&I) 6. Agency pandemic influenza plan document – Pandemic Influenza Planner (P & I), PIPAC (P & I), PIP subcommittees (P & I). Have a working draft. 7. Process for communicating updates to PIP plan out to staff. Corporate Communication. (P&I) 8. List of staff who has recently received PIP session through in-service meeting – O_T subcommittee (P), Coordinating Secretaries (I), In-service Planning Committees (P & I). Orientation and Training Coordinator (I). Have a list of HLS staff that were present for the HLS PIP presentation. 9. PIP to be a component of new staff orientation which includes orientation to SMDHU PIP, intranet & internet sites as well as WHO, PHAC & OH plans. All new staff to receive a PIP orientation –HR (I). Link to HR needs to be established –O_T (P)?
Interpandemic Period: Phase 1 *No new influenza virus subtypes have been detected in humans*	Core group of SMDHU staff capable of delivering PI presentations and acting as a resource for community partners.	1. Core PIP PowerPoint slides which can be used to develop presentations. 2. Core group of trained staff able to do PIP presentations. Training of Presenters/developing the process of responding to RFS, Orientation and Training Coordinator Orientation and Training Coordinator (P&I) 3. PIP resources including articles, WHO, PHAC and OH plans, FAQs on intranet PIP. 4. Train the presenter session. Orientation and Training Coordinator (P&I) 5. AV/tech training.
	All SMDHU staff will have general knowledge of agency emergency response plan and be familiar with agency	1. Emergency management framework 2. Emergency management plan (hardcopy & intranet) 3. Emergency Response PowerPoint presentation

Interpandemic Period: Phase 1 *No new influenza virus subtypes have been detected in humans*	emergency management framework. All SMDHU staff will have general knowledge of agency emergency response plan and be familiar with agency emergency management framework. (cont.)	4. ER presentation has been delivered to Corporate Services, FHS & HLS during in-service day. HPS & CS outstanding. HPS & CS in-service planning committees (P) ERC (P & I). 5. Emergency Response multi-media presentation to be used for new staff, staff unable to attend an in-service and as a general refresher - Corporate Services (P & I) ERC (P& I). 6. Internal FAQ on Emergency Response Management- EMT (P&I) 7. List of staff who have received ERM orientation session through in-service meeting– O_T subcommittee (P), Coordinating Secretaries (I), In-service Planning Committees (P & I). Have a list of HLS staff present for ERM presentation. Orientation and Training Co-ordinator (P&I) 8. ERM to be a component of new staff orientation which includes orientation to SMDHU emergency response plan and framework, which includes ERM intranet section – EMT (P&I). ER is briefly covered in new staff orientation check list which is part of the agency orientation covered by HR in the first week.
	All SMDHU staff will have general understanding of which emergency control group/coordinators they fall under and what their reassigned duties will be in the event of PI	1. Emergency management framework 2. Emergency management plan (hardcopy & intranet) 3. Emergency Response PowerPoint presentation 4. List of redeployments and outline of reassigned duties specific to PI – (EMT, BC, Executive Committee, Orientation and Training Coordinator)
	All staff will have general understanding of SMDHU business continuity plan and essential service activities	1. Draft Business Continuity Plan. 2. Orientation sessions to Business Continuity Plan- HR (P&I) 3. Learning module – HR (P&I)
Interpandemic Period: Phase 1 *No new influenza virus subtypes have been detected in humans*	All appropriate staff will have working knowledge of access to, storage and administering of universal flu vaccine and antivirals.	1. FAQ for flu vaccine 2. National Annual Influenza Statement 3. Provincial Universal Influenza Program 4. Annual Medical Directive for Administering of Influenza Vaccine 5. Orientation and training workshop for Universal Vaccine Program. 6. Current VPD staff, casual VPD staff and cross trained SMDHU PHNs who participated in universal flu clinics. 7. List which identifies who currently has the appropriate training to administer universal flu _VPD (P&I) 8. Orientation and training package/workshop and related material posted to the internet – VPD program (P & I), Webmaster (I). 9. FAQ on antiviral Tamiflu posted to the intranet – VPD (P&I), Webmaster (I)
	All appropriate staff will be knowledgeable in the use of iPHIS, COGNOS and outbreak template.	1. iPHIS/Cognos ReportNet trainers on staff 2. iPHIS/Cognos ReportNet training manual 3. Surveillance (Durham Region) database – training 4. Outbreak CD Manual 5. Trained CD staff

Interpandemic Period: Phase 1 *No new influenza virus subtypes have been detected in humans*	Number of internal iPHIS trainers will be increased	1. iPHIS trainers on staff 2. iPHIS user manuals 3. iPHIS train the trainer workshop – iPHIS trainers (P&I) 4. Designated training facility needed.
	All appropriate staff will have working knowledge of surveillance principles and procedures	1. Skills Enhancement courses through PHAC. 2. Agency support for some staff to take course 3. Group of staff who have completed and/or are in process of completing course 4. FAQs on surveillance posted to the intranet – CD (P & I), Agency epidemiologists (P & I), Webmaster (I) 5. Surveillance 101 workshop – CD (P & I), Agency epidemiologist (P&I)
	To have current outbreak, influenza and FRI policy and procedures.	1. Process for annual review and updating of CD outbreak, influenza and FRI protocols. 2. Provide staff education re: use of FRI Surveillance Protocols – CDSU (P&I)
	All appropriate staff will have a working knowledge of GIS and its application to outbreak investigation and data analysis	1. Limited GIS mapping capabilities within HU. 2. Specific GIS data collection requirements related to pandemic influenza – CD (P & I), VPD (P & I), agency epidemiologists (P & I). 3. GIS 101 orientation and training workshop - agency epidemiologists (P & I). 4. List identifying which staff need GIS training.
Interpandemic Period: Phase 1 *No new influenza virus subtypes have been detected in humans*	Designated back up staff will be able to operate and troubleshoot any issues related to communication equipment.	1. Operating manuals for fax, photocopier and MIKE phones 2. Staff trained on communication equipment operation 3. On call kit 4. Tips on intranet 5. Learning module on equipment operation Coordinating Secretaries (P&I) 6. Training session – Tech Team (P&I) 7. Additional tips on intranet site – Tech Team (P &I)
	To have an ongoing SMDHU orientation and training schedule for pandemic influenza.	1. Orientation and training coordinator (P&I) 2. Orientation & training database – Information & technology team (P &I)Orientation and Training Coordinator (P&I)
INTERPANDEMIC PERIOD PHASE 2		
Interpandemic Phase 2 *A circulating animal influenza virus subtype poses a substantial risk of human disease*	All mangers and supervisors will have working knowledge of SMDHU PIP and IMS	1. SMDHU emergency response plan and framework. 2. Individual manager's emergency manual. 3. Pandemic Influenza plans (SMDHU,PHAC,OHPIP,WHO) 4. Orientation session for SMDHU PIP- Pandemic Influenza Planner (P&I), Emergency Response Coordinator (P&I). 5. Managers and Supervisors to receive stress management training which will include how to manage/supervise staff that are under exceptional stress HR and EAP components – HR (P&I)

Interpandemic Phase 2 *A circulating animal influenza virus subtype poses a substantial risk of human disease*	All staff will have working knowledge of reassigned duties in the event of redeployment	1. Post SARS training session & debriefing 2. Public Health Professional competencies –CDC 3. Program Guidebooks 4. Emergency Response Plan/Framework 5. PIP & ER presentations. 6. Health Connection multimedia learning module. 7. Universal Influenza Vaccine program manual 8. iPHIS training manual/workshop. 9. Orientation session and packages related to reassigned duties under ER plan such as: • VPD (P&I)- access, storage and administering of flu vaccine and antivirals, medical & ministry directives, mass immunization clinic plan • CD (P&I) – iPHIS, COGNOS, outbreak template, case investigation, contact tracing, surveillance, lab specimen collection, infection control - measures, Ministry directives. • Investigate: Do redeployed staff need to be registered in advance with the province in order to access iPHIS? Will there be a need for tech support in house related to this issues and do we have the capacity to provide this support? • EMT (P&I) - shelter/assessment/triage training, CISS database, HPPA (closure orders), EMR P&P • HC (P&I) – call center, PIP intranet, key messaging, CAPS, Ministry Directives. (Staff to be assigned agent ID ahead of time) • Health Information group (P&I) – automated data analysis and dissemination 10. Hands on training related to reassigned duties under ER plan. 11. Stress management training for staff HR (P&I)
	Designated spokespersons will be able to respond to media inquires appropriately.	1. Half-day Media Workshop. 2. Media consultants on staff. 3. Trained staff (directors, managers, supervisors, HC team) 4. PI media training workshop- Media Consultants (P&I) 5. FAQ/Key Messages directed to media questions posted to the intranet – Corporate Communication (P&I), Webmaster (I) 6. Media Training multimedia module – Corporate Communication (P&I)

PANDEMIC PERIOD PHASE 3		
Pandemic Alert Periods Phase 3 *Human infection(s) with a new subtype, but no human-to-human spread or spread to a close contact only*	PI simulation exercise will be conducted to test and evaluate SMDHU PIP.	1. ERM plan and framework. 2. SMDHU draft PI plan 3. Simulation exercise to be designed and conducted – Simulation exercise planning group (P&I). Have a planning group responsible for this. 4. Evaluation Tool for simulation exercise -Simulation exercise planning group (P & I), Health Information Group (P & I). See Emergency Response Framework.
	To implement orientation & training recommendations based on evaluation findings of simulation exercise.	1. Evaluation report with recommendations – Health Information Group (P&I), Simulation Exercise Planning Group/SMHSEPC (P&I). 2. Revised SMDHU PIP & ERP. 3. Communicate revision to all staff. 4. To re-train all staff as needed and based on evaluation findings
PANDEMIC ALERT PERIOD PHASE 4		
Phase 4 *Small cluster(s) with limited human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet by fully transmissible*	To provide ongoing notification of updates and current practices for all appropriate staff.	1. Process for keeping staff informed of current practices related to reassigned duties. 2. Current and updated redeployment list.
PANDEMIC PERIOD PHASE 6		
Pandemic Period: Phase 6 *Increased and sustained transmission in general population*	All appropriate staff will have working knowledge of security measures related to access to pandemic influenza vaccine and antivirals.	1. Provincial document outlining priority groups 2. Security protocols/guidelines related to vaccine/ antiviral access & priority groups– VPD (P & I) 3. Agreements/ Service contact with security/police agency – VPD (P & I), Corporate Services (P & I), MOH (P &I). See Vaccine - Antiviral and Emergency Response Frameworks.
	All new surge capacity staff (external and/or internal) will have a working knowledge of assigned duties related to the pandemic.	1. Orientation session and packages related to reassigned duties under ER plan such as: • VPD (P&I) - access, storage and administering of flu vaccine and antivirals, medical & ministry directives, mass immunization plan.

Pandemic Period: Phase 6 *Increased and sustained transmission in general population*	All new surge capacity staff (external and/or internal) will have a working knowledge of assigned duties related to the pandemic. (cont.)	• CD (P&I) – iPHIS, COGNOS, outbreak template, case investigation, contact tracing, surveillance, lab specimen collection, infection control - measures, Ministry directives. • EMT (P&I) - shelter assessment training, CISS database, HPPA (closure orders), EMR P&P • HC (P&I) – call center, PIP intranet, key messaging, CAPS, Ministry Directives. • Health Information group (P&I) – automated data analysis and dissemination
	All returning staff will have an understanding of how to reduce the risk of transmission	1. Disease process understanding for communicability and transmission risks 2. Protocols and recommendations for staff returning to work after a FRI illness – CD (P&I) 3. FAQ on personal hygiene and respiratory illness etiquette – CD (P&I)
POSTPANDEMIC PERIOD		

HC Redeployment Training Module

Goal: To provide phone response training to SMDHU staff who have been redeployed to HC in the event of a declared emergency.

Learning Objectives:

Staff redeployed to HC will be able:

1. To provide the public with accurate and current information related to the declared emergency.
2. To utilize HC communication and information technologies effectively.
3. To document client interactions using the HC electronic database as per documentation guidelines.

Sample HC Training outline: -

HC Pandemic Influenza Phone Response Training

Agenda

Welcome & Introductions

Outline of HC Role r/t declared emergency

HC Operation (HC procedures, access modes, scheduling)

Communication and Information management (key messages, ministry directive, intranet)

HC Communication and Information Technologies (call center training)

Documentation

Wrap up

II - 7 BUSINESS CONTINUITY/RE-DEPLOYMENT AND RECOVERY

INTRODUCTION

In the event of an influenza pandemic it is anticipated that all businesses – private and public - will experience high employee absenteeism due to illness and/or other personal employee situations that arise as the result of an emergency. Businesses and agencies alike must plan for the negative effects a pandemic will have on the workforce, and prepare business continuity plans accordingly.

Business continuity is the process by which a business or agency plans to maintain essential services during a time of emergency. The process involves both the redeployment of staff and the return to normal business operations (recovery).

The objectives of the Business Continuity section of this plan include:

- To provide a Business Continuity Plan (BCP) template to support the BCP process for SMDHU.
- To develop a process to facilitate the business recovery following the pandemic.
- To ensure that the BCP is inclusive of all SMDHU stakeholders.

The development of a BCP will help to minimize the disruption of service and programming. The SMDHU PIP BCP will address the following issues:

- Staff redeployment – identification of skill sets of all staff
- Identification and inventory of essential services
- Availability of supplies and materials required to maintain essential services during a pandemic
- Identification of relevant human resources, and health and safety issues
- Plans for surge capacity
- Recovery strategies for the post-pandemic period

Phase 1 **From WHO**	**Local Level Objectives** **for SMDHU**	**Public Health Unit** **Business Continuity Planning Activities**
INTERPANDEMIC PERIOD PHASE 2-5		
Interpandemic Period: Phase 2-5 *No new influenza virus subtypes have been detected in humans*	The development of SMDHU-Business Continuity Planning strategy. • It is the recommendation of the Business Continuity Planning Sub-Committee that the plans in this document would be best served by the identification/assignment of a health unit staff to the role of Business Continuity Coordinator to oversee and document the completion of the BCP activities that are described in this chapter of the SMDHU Pandemic Plan, 2006	BCP Coordinator is responsible for the following activities 1. Conduct a business process review throughout the agency to identify • multiple uses and variations for agency services terminology • create consensus for the terminology and use consistent language for the definitions of service area activities and functions • identify the key individuals • define agency needs for ongoing BC Planning (combined with the annual operational planning cycle) 2. BCP Coordinator involve union/association representatives if relevant 3. BCP Coordinator to develop a process to ensure the ongoing review and revision of the agency SMDHU BC/Redeployment and Recovery Plan
	Identify required skill sets and opportunities for staff reallocation	1. BCP Coordinator to ensure operational plans (software) will be configured to capture the BCP requirements 2. Program teams will ensure Annual Operational Plans include minimum requirements to support BCP, i.e. FTEs, activity priority levels, skills/roles (skill sets based on job description) 3. Program Teams, the ER Plan and SMDHU PIP need to identify the number of staff and skills/special requirements necessary to perform essential activities. 4. HR will develop a process to ensure InfoHR can and will maintain an inventory on each employee (personal information and professional skills). 5. HR and professional leadership designates to develop a process to support advanced or accelerated approvals for use of staff that may not possess the necessary certifications, license, etc.
	Business Continuity Planning Redeployment and Recovery subcommittee to develop the Essential Services/Functions Inventory tool	1. BCP subcommittee reviewed examples of BC Plans from other health units to determine their appropriateness for SMDHU BCP. 2. Selected the Halton Region Essential Services/ Functions Inventory tool for use in SMDHU 3. BCP subcommittee chair reviewed the Essential Services/ Functions Inventory Tool (Appendix B) with the PIPAC subcommittee to ensure appropriateness 4. BCP subcommittee developed preliminary instruction to support the identification of

Interpandemic Period: Phase 2-5 *No new influenza virus subtypes have been detected in humans*		priority services using the Ethical Decision Making Framework (refer to this document Part I), Factors to Consider when Prioritizing Activities (Appendix C - II - 7) and a projected absenteeism rate of 20% at the peak of the pandemic. 5. Tested the prioritization of services in Family Health Services and identified areas that needed further clarification i.e. inclusion of and communication with external committees and task groups and the inclusion of administrative time related to each activity. 6. BCP Subcommittee collected preliminary services lists from Clinical Services and Family Health. 7. BCP Coordinator to develop comprehensive instructions for Essential Services/ a. Functions Inventory tool use 8. BCP Subcommittee adopted the definition of Essential services as follows (from Halton Health Unit): a. A service and/or function that when not delivered creates an impact on the health and safety of individuals. b. A service and/or function that may lead to the failure of a business unit if activities are not performed in a specified time period. c. Identify essential services and/or functions that must be performed to satisfy regulatory requirements. 9. BCP Coordinator to ensure inventory tool is completed by each service area (including ER and PIP) as per tool instructions to determine the priority of the services and redeployment strategy.
	Prepare a Business Continuity Plan for each essential service/function	1. BCP Coordinator in conjunction with program teams to develop essential service action plan template and process for completion (Appendix A). Plan to include details of how each of the essential service/function is maintained, reduced, modified and/or eliminated, who has decision making authority, what solutions will be put in place, any necessary actions to follow. 2. See communication plan for internal communication related to BCP. 3. Service areas and program teams to complete essential service action plan template as per instructions.
	Review your Business Continuity Plan with the Corporate Steering Committee	1. BCP Coordinator to present draft BCP to executive to ensure that all critical elements in the plan are addressed 2. BCP Coordinator to customize the “Preparedness Checklist” (Appendix D) in order to review SMDHU BCP. 3. BCP Coordinator to ensure communication and problem solving between program teams and executive related to the outcome of the review process
	Annual completion and review of Essential Services Inventory	1. BCP Coordinator to develop a process to ensure Essential Services Inventory is informed by the updated Annual Operational Plans. 2. BCP Coordinator in conjunction with executive will review the completed Essential Services Inventory for agency feasibility, usability and risk assessment.

Interpandemic Period: Phase 2-5 *No new influenza virus subtypes have been detected in humans*	Revise, test the plan and update as required	1. BCP Coordinator and EMCs to develop a process to communicate the BCP for information and training purposes 2. BCP Coordinator and EMCs to plan and conduct emergency response simulation exercise to test BCP Plan 3. BCP Coordinator and EMCs to develop a process to incorporate feedback from simulation exercise into agency BCP or relevant policies and procedures
	Ensure availability of supplies and materials required to maintain essential services during a pandemic	BCP Coordinator to link with facilities to achieve the following: 1. To develop an inventory tracking system to ensure access to a current inventory of materials and supplies, suppliers and backup sources 2. To work with suppliers and determine which items may be safely stockpiled to meet the defined need. For items that are unable to be stockpiled, alternative agreements will need to be negotiated to secure access 3. To secure priority access to supplies and materials from current suppliers and/or back up sources 4. Program teams, ER plan and PIP will determine the amount of materials and supplies needed to carry out essential service activities taking into account surge potential for a two month period. 5. To ensure secure storage and transportation of supplies and materials. 6. To ensure current cleaning contracts are revised to include access to additional cleaning support during SMDHU pandemic response 7. To ensure appropriate signing authority procedures can be achieved for expenditures during an emergency 8. To explore alternative policies and procedures that cover signing authority and acquisitions during pandemic response 9. See Public Health Measures framework to identify staff needs for PPE and cleaning equipment
	Identify any relevant HR and Health and Safety issues/implications for implementation	1. BCP Coordinator and HR to compile a list of relevant HR and Health and Safety issues/implications to be used for decision making during identification of priority A activities 2. Upon completion of the identification of these issues, BCP Coordinator and HR to work with agency management to document a planned response for each essential service/function to mitigate these identified risks and this planned response is reflected back in the essential services inventory 3. HR list see page 8 of Ottawa 4. BCP Coordinator or ONA negotiations representatives to communicate with ONA and non-union labour relations committee re: relevant HR and health and safety issues/implications and incorporate feedback into planning 5. Communication plan will continue to be informed by any plan developed to address HR and/or health and safety issues 6. HR to work with the surveillance sub-committee to determine staff absenteeism monitoring and reporting requirements and ensure these requirement are reflected in agency policies and communicated to key internal contacts

		7. HR will ensure that all pandemic incidences are recorded and investigated in compliance with the occupational health and safety act 8. HR will develop policies and procedures to address issues related to occupational health and safety issues i.e. staff refusing to work, potential dangerous work assignments.
Interpandemic Period: Phase 2-5 *No new influenza virus subtypes have been detected in humans*	Identify any relevant redeployment and surge capacity issues/implications for implementation Identify any relevant redeployment and surge capacity issues/implications for implementation (cont.)	1. see Orientation and Training for staff training schedule for surge activities and redeployment patterns are determined. 2. see Communications Plan for details of the process internal communication with staff related to re-deployment expectations prior to initiation of BCP and during the pandemic response 3. During annual operational planning process, program teams will identify essential services activities and surge activities for staff to reinforce understanding of agency redeployment needs during the pandemic 4. HR to develop a confidential process to determine and document any personal staff circumstances for consideration during redeployment. 5. see Communications Plan for details of the process external communication with community partners related to impact of public health during the pandemic. 6. HR and Program Teams to develop a plan to address alternative work arrangements (i.e. teleconferences, conference calls, working from home). 7. BCP Coordinator to ensure elements of the BCP to ensure transparency in decision making and include criteria for work that can be conducted from home, maintaining client confidentiality, communication between staff in alternative work settings and the health unit office and other relevant redeployment and surge capacity issues. 8. Maintain communications with SMDHU Health Sector Emergency Planning Group and community partners to support ongoing problem solving related to Business Continuity Planning needs 9. see Public Health Measures for pending requirements that will need to be considered during redeployment decision making during Phase 6 of the Pandemic 10. BCP Coordinator to work with service area director and HR to ensure all BCP Redeployment and Recovery Strategies will be examined within the existing Agency P and Ps and the ONA Collective Agreement .Where P and Ps are identified to be in contrast with Redeployment and Recovery needs, these will be highlighted and a priority problem solving process identified. 11. HR to review policies and procedures pertaining to planned absence (vacation, LOA, comp) to include language that will address cancellation of time off to support agency BCP. 12. Service area directors to identify essential services that are at high risk for being unable to operate due to lack of access to expertise or skilled individuals to maintain the service and develop a priority problem solving process to address this need. 13. Once volunteer needs have been determined, HR will develop a Volunteer Registration process (compliance with WSIB)

INTERPANDEMIC PERIOD PHASE 4		
Interpandemic Period: **Phase 6**	Initiate the BCP as per the ER Plan	1. Refer to the ER Framework for Business Continuity Plan activation 2. Refer to the Communications Framework for details related to internal and external communication 3. Anticipated reduction in services due to pandemic response may extend over an 8 week period.
PANDEMIC ALERT PERIOD		
PANDEMIC PERIOD		
POSTPANDEMIC PERIOD PHASE 6		
Post-pandemic Phase	Termination of the BCP and transition to post -pandemic public health services	1. Refer to the ER Plan for Business Continuity Plan termination 2. MOH (in collaboration with CMOH) to establish criteria and process for agreeing to return to non-pandemic operations 3. Refer to the Communications Plan for details related to internal and external communication of the plan termination 4. Refer to recovery strategy activities for next steps 5. BCP Coordinator to work with program teams to develop recommendations to inform the order in which services that have been impacted during a pandemic become re-initiated 6. Once the Pandemic emergency has been declared over, the process of resuming public health services that have been impacted will be informed by the number of staff released by reduction in surge activities and priority program needs 7. SMDHU in conjunction with Health Sector Emergency Planning (HSEP) to develop a process for determining the impact of the pandemic on the community and subsequent public health service needs
	Recovery strategies (need to move some of these based on planning vs. Implementation activities)	1. HR to determine access to EAP critical incidence stress management debrief services for all SMDHU staff (small group vs. entire agency)

	Recovery strategies (need to move some of these based on planning vs. Implementation activities) (cont.)	2. Following the debrief HR will work with EAP and executive to institute appropriate recovery strategies to support staff (individuals or groups) in resuming public health services 3. see Communications Framework for the details of the process for ongoing communication between Health Connection and program teams ability to respond to RFS 4. see Orientation and Training Framework for inclusion of Stress Management Training 5. HR to work with EAP and agency management to develop a process to support staff who identify or present with signs and symptoms of stress during or after the pandemic response
Post-pandemic Phase	Evaluation of the Business Continuity Recovery and Redeployment Activities	1. BCP Coordinator and SMDHU evaluation specialist, in conjunction with the Province and local partners, will participate in the evaluation of local business continuity activities 2. BCP Coordinator to update internal SMDHU Business Continuity Plan, pandemic plan and ER plan as appropriate

APPENDIX A - II - 7: ACTION PLAN TEMPLATE FOR MAINTAINING ESSENTIAL SERVICE

Action Plan Template for Maintaining Essential Service/Activity

Business Group:			
Essential Service: (identify and provide brief description)			
Individual/Position Responsible for implementing specific action plan	(Name)	(Phone Numbers)	(Email Address)
Activation Procedure: (describe)			
Corporate and Community impact issues (list any)			
Action Plan (list action plan including, notifications plans, communications strategy, staffing reallocations plans, use of other sector services, any change in scope of service delivery, monitoring and reporting needs, etc)			
Resource Needs: (list needs and contact information for resource needs – staffing, equipment, contracting out services)	(Name and Business Address)	(Phone Numbers)	(Email Address)
Training Needs (outline training plan as required)			

Essential Service Response Priority Listing

Introduction to Program Pandemic Planning

In the event of a pandemic, many public health resources will have to be redefined and reallocated. The impact of a pandemic will be greatest at the community level, and the health unit will be expected to play a major role in coordinating the local response. To meet these increased needs while maintaining various levels of mandatory programs, the health unit will have to increase surveillance, vaccination, monitoring, and communication activities and "scale back" some other programs and services. This package includes information and worksheets to help you prioritize program activities. Please keep in mind that this package is a 'working document' meaning that it will be revised and adjusted to suit program specific needs. The information included within this package has been modify from the 2005 Ontario Health Pandemic Influenza Plan* (OHPIP).

Process:

1. Identify all services/activities within a program/division/business unit area and list them in the column identified as Service/Activity.

Levels of Public Health Program Activities

To ensure some consistency across the province in the availability of public health services during a pandemic, OHPIP has identified four levels of program components/activities in public health units:

Priority Level A – Must Do – critical services, cannot be deferred or delegated

Priority Level B – High Priority – do not defer if possible or bring back as soon as possible

Priority Level C – Medium Priority – can wait if Pandemic is not too long

Priority Level D – Low Priority – can be brought back when the Pandemic is over

* Ontario Health Pandemic Influenza Plan (2005). Section 7.4 Public Health Services, pp. 58-60. Available at http://www.health.gov.on.ca/english/providers/program/emu/pan_flu/ohpip_mn.html

Emergency Planning
Essential Service and Redeployment Availability Worksheet

Service:

1	2	3	4	5	6	7	8
Team	**Program Service/Activity**	**Prof Designate**	**Priority A/B/C/D**	**Current FTE**	**100% FTE**	**Min FTE Required**	**FTE Available**

Legend:

Col. 1: Service Area Team or Unit (e.g. CDSU)
Col. 2: Specific service or activity (e.g. reportable disease surveillance)
Col. 3: Professional Designation (e.g. PHN, RN, PHI, etc.). If more than one designation carries out this function, repeat the function on the next line(s) with the other designation(s)
Col. 4: Priority A/B/C/D (see page 153, 154 and 156 of the draft SMDHU PIP for decision criteria)
Col. 5: Current FTE (the number of full time equivalent staff of that professional designation currently carrying out this service or activity)
Col. 6: Same as #5 if every approved position was filled today
Col. 7: The absolute minimum number of FTE (as described in #5) who are *required* to carry out this function (for up to a 10 week period) during a public health emergency
Col. 8: Subtract Col. 7 from Col. 5 to get the number of people available for redeployment in an emergency

When deciding how to prioritize programs the SMDHU will use the Ethical Framework for Decision Making described earlier in this plan. In addition the following factors will be considered:

As per the OHPIP (2005) public health programs that have **one or more of the following factors** must continue to be provided during a pandemic:

- The activity is **mandated by legislation** to be directly provided by public health **within a specified time frame** AND **addresses a high health risk**

For example:
- Does the activity involve a health hazard, or is it likely to be a health hazard, requiring same day assessment and initiation of action within 24 hours?
- Does the activity involve an assessment of a reported suspect/confirmed infectious disease case/outbreak?
- Does the activity involve an assessment of a high risk mother requiring a first response within 24 hours?
- Does the activity involve a potential for "rabies transmission"?
- Does the activity involve a response to an adverse drinking water test result that requires immediate action in accordance with Ontario Drinking Water Standards?

- There is a high risk that staff will **lose their professional qualifications** and/or put themselves in a position of **negligence** if the intervention is not provided in a timely way (i.e. duty of care).

For example:
- Will not providing the service endanger citizens' health and safety (i.e. communicable disease case and contact follow-up)?

- The activity is **required at certain times** of year or at a **certain point in the disease/illness cycle**.

For example:
- Will not providing the services at a certain time endanger citizens' health and safety (i.e. post exposure prophylaxis for blood borne exposure, providing emergency contraceptive medication)?

- The activity is **necessary to eliminate an imminent threat** to public health or the health of an individual exposed to the threat.

- There is a high risk of **legal liability** from not providing the intervention.

For example:
- If the service were not provided, would it constitute negligence?
- Will not providing the services endanger citizens' health and safety?

Roles and Responsibilities for a Pandemic Influenza Business Continuity Plan	Check whether the action is addressed in the Plan	Document who is responsible for each action/decision making process
Who has responsibility for activating the Business Continuity Plan for your organization and who is that person's back up?		
Has your organization identified a process through which the decision will be made to activate and terminate the Plan?		
Do you have a communication strategy for reaching employees and business partners as a result of having to implement any section of the Business Continuity Plan?		
PLANNING		
Who do you need input from both internally and externally to prepare and review a Business Continuity Plan for your agency/business? • Elected officials • Legal counsel • Community partners • Labour Unions and bargaining agents		
Who is in charge in the event of a pandemic episode and are the roles of the various stakeholders clearly defined? Who makes what decisions? Who notifies the various stakeholders?		
Is the Pandemic Influenza Business Continuity Plan integrated with your emergency preparedness plan(s)?		
Who has responsibility for procurement matters, e.g., ordering resources and/or equipment during an emergency episode?		
Who needs to approve the Business Continuity Plan?		
TESTING OF THE PLAN		
How will you test and/or evaluate your Business Continuity Response Plan?		
How will you test your communication systems, e.g., fan-out?		
DECISION-MAKING AND REPORTING		
Who will be in charge and make decisions within your agency/business concerning services during a pandemic/emergency episode?		
What will be the mechanism for regular reporting to your management staff/Boards/Government (whichever are appropriate for your organization) councils during a pandemic episode?		
Is there a contact list of all internal and external client and partner agencies and stakeholders?		
Is there a contact list of all senior staff within your agency/business?		
If public transportation became a problem, can employees arrange alternate forms of transportation to work?		
If necessary, could staff live at the work location or alternative work location for some period of time?		
Have you prepared site-specific notification for office closures and contacts for the public/clients?		
SURVEILLANCE/ATTENDANCE		
Who in your organization has responsibility for collecting/managing information about staff absenteeism?		

Roles and Responsibilities for a Pandemic Influenza Business Continuity Plan	Check whether the action is addressed in the Plan	Document who is responsible for each action/decision making process
Who is that person's back up?		
Do you have data on the average number of staff absences due to illness and vacation at different times of the year (monthly rates)?		
Is there a mechanism within your agency/business to monitor and report increasing staff absenteeism due to illness to health authorities (e.g., Health and Safety Coordinator, Health Department)? (An increase in staff absenteeism due to illness might be attributed to the spread of infections among co-workers suggesting an outbreak of disease.)		
DELIVERY OF ESSENTIAL SERVICES TO THE COMMUNITY		
Does your agency/business have a responsibility for the provision of services to the community during an emergency? • Provision of food • Mass housing • Care for special needs people • Home care and child care		
Have these services been planned for should there be a staff reduction due to absence?		
Who has signing authority for expenditures during an emergency and who is that person's back up?		
Are there clearly stated policies and procedures that cover signing authority and acquisitions?		
What is the staff capacity of your agency/business and are there provisions to bring in additional staff and/or volunteers?		
Have alternative service providers been identified to assist with maintaining your essential services? What duties will they have and what additional training will they require? Have insurance coverage and union issues been addressed?		
What is the surge capacity of services delivered by your agency/business?		
Has an inventory been prepared for specialized equipment/facilities that may be needed during a pandemic episode?		
Is there a mechanism that will ensure that additional equipment, e.g., pagers, cell phones, refrigerators etc. can be obtained with minimum delay?		
Who has authority for ordering repair/replacement equipment and who is that person's back up?		
MATERIALS AND SUPPLIES		
Are you currently stocked with all necessary supplies for regular day-to-day functions?		
Does your agency/business have contact lists for all your suppliers and alternate suppliers?		
Does your agency/business have access to inventory (including serial numbers) of all computer equipment, printers, fax machines, photocopy machines in case repairs are needed?		
Does your agency/business have contact lists for all equipment repair persons?		

Roles and Responsibilities for a Pandemic Influenza Business Continuity Plan	Check whether the action is addressed in the Plan	Document who is responsible for each action/decision making process
Who authorizes repairs and supply/equipment orders? Are there other employees who can take over this responsibility in the event of an emergency?		
TRAINING/ORIENTATION		
What are the training needs pertaining to emergency and pandemic flu contingency plans for internal and external business partners/agencies? What additional training will be required?		
What orientation/education should be arranged for your employees to raise awareness about a pandemic flu emergency?		
Has staff been made aware of basic infection control guidelines to prevent the transmission of influenza? (e.g., handwashing procedures etc.)		
DELIVERY OF SERVICES		
Have services in your agency/business been prioritized to take into account minor to major staff absences due to illness?		
What is the role of your agency/business with respect to assisting with service demands in health care facilities (e.g., Hospitals, Long-term care facilities, Homes for the aged, Homes for special care) and has this plan been communicated to these facilities?		
Who will make decisions about reducing levels of service and/or canceling services temporarily?		
Is there a pre-approval process in place for purchasing additional supplies? If not, how long does it take for approval to be granted?		
How will reduction/temporary cancellation of regular services be communicated to local stakeholders, the public and business partners?		
Does your plan identify the need to consult with the Medical Officer of Health prior to any major communication strategy about reducing service delivery due to staff absences relating to influenza?		
Could any of the agency's/business's services be provided from another work location?		
Have sites providing vulnerable services (such as nursing homes, homes for the aged, homes for special care) been identified and has the inventory of such services been shared with appropriate service providers? • Patient transportation • Patient assessment services • Food services • Equipment supply services (i.e. oxygen equipment)		
Has your agency developed a list of skills and professional competencies of staff that are transferable to other business units, agency functions or for support to health care institutions in the community?		
Have support services been planned for workers, such as transportation, day-care, meals and grief counseling?		
Do you have a plan to replenish depleted supplies?		

Roles and Responsibilities for a Pandemic Influenza Business Continuity Plan	Check whether the action is addressed in the Plan	Document who is responsible for each action/decision making process
HUMAN RESOURCES		
Has your agency prepared an inventory of skills in the event that people from your agency/business are required to perform duties/functions in other business units/agencies to maintain essential services?		
Have liability issues been addressed for volunteers and re-assigned staff members?		
Do you have a current list of staff complete with telephone numbers? Has someone been assigned responsibility to ensure that it remains current?		
Do you have a current list of recently retired staff (complete with telephone numbers) who may be contacted in the event of extreme staff shortages?		
Do relevant employees have access to a list of all employees and relevant stakeholders?		
Is there a copy of the Health and Safety manual on site in your agency/business?		
Who will be in charge of communicating to the employees in your agency? Do you have a backup person(s) to take on this responsibility?		
Who will represent your agency/business on community emergency response team(s), if requested to participate, and are there back-ups to those persons?		
Who will be responsible for payment issues related to overtime and/or additional salary issues? Are there staff designated as backup for these positions?		
In the event of a staff shortage, what roles/responsibilities could external contract workers and volunteers fill? What roles/responsibilities could co-workers fill?		
Who has the authority to hire contract/temporary workers and to take on volunteers? Is there a backup person for this job?		
Does your agency/business have a system staff use to report absence due to illness and other reasons? Is this information accessible on a daily basis?		
RECORDS AND RECORD KEEPING		
Has your agency/business developed appropriate records keeping procedures for items such as: • Staff absences • Vacation • Complaints and issues		
Do you have a plan to record significant decisions that were made during a pandemic flu/emergency?		
Is regular reporting to Boards/government required?		
COMMUNICATION		
In your organization, who has primary responsibility for communicating with the public/business partners/staff?		

Roles and Responsibilities for a Pandemic Influenza Business Continuity Plan	Check whether the action is addressed in the Plan	Document who is responsible for each action/decision making process
Who is that person's back up in the event that this person is sick with the flu?		
Are there people in your organization who have sole access to incoming information, e.g., business information, incidence reports, complaints etc., if so, have you arranged for designates to receive this information?		
Does your organization maintain a central inventory of passwords to office equipment and electronic files? Is there a designate for the person who has responsibility for the inventory?		
If your information technology person is ill, whom can you turn if you experience computer problems?		
How does your staff communicate with each other during office hours and after-office hours? Is there an alternate form of communication they can rely on, e.g., cell phones, pagers etc?		
Who are your security contacts should there be a problem with physical access to your work location and is there a back up to your security contacts?		
If mail service is interrupted, are there critical items you need to receive or deliver that you will need alternative arrangements for?		
Does your organization send out time-sensitive letters or documents and is there a back-up system for these?		
How are courier packages generally received and sent out?		
How will you send out public service announcements and news releases? Do you have a process for consulting with the Health Department prior to any releases?		
Will employees and the public be able to access a website or telephone number to get updates on service delivery news?		
RECOVERY		
What are the immediate lessons learned?		
Who will have the authority to notify the various employees, clients, and stakeholders regarding reinstating services and finally return to full service?		
Who will be responsible for evaluating your local response?		
What factors should be examined as part of the evaluation?		
Have any counseling needs for staff been provided for?		

Adopted from the Ontario Ministry of Health and Long-Term Care

PART III

III - 1 PANDEMIC HEALTH SERVICES

The provision of health services during an influenza pandemic will undoubtedly be the most challenging aspect of pandemic influenza response. Our health care system is currently functioning at close to maximum capacity at all times, and will face significant challenges in responding to the increased demands that are projected to occur during an influenza pandemic.

Table 9.1 Distribution by Week of Hospital Resource Utilization for Ontario Based on 35% Attack rate
Ontario Health Pandemic Influenza Plan, June 2005, page 69.

Impact of Influenza with 35% Attack Rate on Hospital Capacity									
35%^ Attack Rate 6 Weeks		*Week 1*	*Week 2*	*Week 3*	*Week 4*	*Week 5*	*Week 6*	*Week 7*	*Week 8*
Hospitals	Weekly Admissions	7,320	10,370	12,811	12,811	10,370	7,320		
	Peak Admission/day			1,996	1,996				
Hospitals	Hospitalizations	7,320	10,370	12,811	13,549	12,430	9,895		
	hospital capacity	47%	66%	82%	86%	80%	63%		
ICU	ICU admissions	1,098	2,054	2,628	2,825	2,754	2,236		
	% ICU capacity	73%	136%	174%	187%	182%	148%		
Ventilators	# on ventilators	549	1,027	1,314	1,413	1,377	1,118		
	% ventilator capacity	29%	54%	69%	74%	72%	59%		
Deaths	# of influenza deaths			1,442	2,043	2,523	2,523	2,043	1,442
	70% deaths in hospital			1,009	1,430	1,766	1,766	1,430	1,009

Note: The above numbers were calculated using FluSurge software developed by the U.S. Centers for Disease Control and Prevention (a version of the software can be found online at http://www.cdc.gov/flu/flusurge.htm). It utilizes population estimates for 2004 based on 2001 census data. FluSurge is designed to provide a sense of the impact of a pandemic on hospital capacity over a selected duration of weeks. The program differs slightly from the CDC's FluAidprogram (http://www2a.cdc.gov/od/fluaid/), which provides a range of estimates for the total impact of an influenza pandemic for a given area at a macro level.

As noted earlier, FluSurge and FluAid require the user to enter population data for a particular community or area, both programs may yield different results in terms of the estimated number of deaths and hospitalizations for a given population. Please note that these programs are intended to provide planners with an idea of the potential effect that an influenza pandemic will have on health services within the area so that communities and healthcare facilities can plan appropriately. Local planners are encouraged to utilize either program to suit their particular requirements, however, should not rely on these programs to provide an accurate prediction of a pandemic impact.

Based on the above parameters, the Ontario plan estimates that for the province, pandemic influenza alone will use 86% of all acute care beds, 187% of ICU beds, and 74% of ventilator supported beds during the peak of influenza activity. The use of these resources will not be evenly distributed throughout the eight weeks of a pandemic wave. Table 9.1 indicates the distribution of hospital resource utilization for the province based on a 35% attack rate.

In order to respond to these daunting figures, a coordinated approach from all sectors of the health care system will be required. As well, a change in public expectations will also be needed.
As a community, we will be forced to "triage" who gets care and who gets it first. The concept of triage is outlined in the Ontario Health Pandemic Influenza Plan as requiring consideration of the populations'

needs as a whole, and not necessarily each individual's needs. This is a very different way of addressing our usual health care expectations and will force us to ask and answer complex and burdensome questions.

Overview of Health Care Planning

Planning the health care response will require looking at all aspects of the health care system including:
• Telehealth Ontario
• Primary health care providers - family physicians, pediatricians, walk-in clinic
• Emergency departments/urgent care centre
• Hospital care, including intensive care
• Long term care facilities
• Home care including the Community Care Access Centre (CCAC) and nursing agencies
• Emergency medical services and medical transportation services

Pandemic influenza planning may also require the implementation of alternate methods of health care delivery including:
• Self care
• Triage sites
• Alternate health care sites or non-traditional health care sites
It is expected that all health care organizations will develop pandemic influenza plans including Business/service continuity plans. A mechanism will also be required to coordinate these various plans, since one organization's plan will invariably have implications on other organizations.

Self Care

The ability to care for oneself and one's family without requiring medical care will be essential to minimize the use of health care services during an influenza pandemic. Telehealth Ontario (1-866-797-0000) provides 24-hour access to telephone consultation with a registered nurse. Telehealth will need to be prepared to respond to a substantial increase in call volume during a pandemic. Their advice will be critical in assisting people with self-care and avoiding unnecessary health care visits. It will be essential to ensure that Telehealth has the required information regarding triage sites, immunization clinics and antiviral distribution locations as these are established in Simcoe County and the District of Muskoka.

Triage Sites and Primary Care

Substantial planning is required to determine how primary health care will be delivered in Simcoe County and the District of Muskoka. It is quite likely that triage centres will need to be established in several locations. These centres will assess people with influenza-like illness to determine if they can be sent home with self-care instructions or whether they should be referred to a hospital emergency department for further assessment and possible hospital admission. These triage centres may also determine eligibility for treatment with antiviral drugs that will be available at the centres. The locations, staffing and services provided by these triage centres is currently being investigated. Stringent infection control practices will be required in these centres to prevent transmission of influenza to health care staff and among clients.

The role of primary care providers during influenza pandemic remains to be determined.
It is likely that some primary care providers will be asked to provide care at triage centres.
Provisions will therefore need to be made for the patients in their practice who require non-influenza related care. As well, it will need to be determined if all patients with suspected influenza will be sent to the triage centres, or whether these individuals will also be seen in primary care provider's offices. In either situation, stringent client screening for possible influenza and infection control practices will be required in primary care providers' offices. It will need to be determined if equipment such as masks and eye protection will be provided provincially or whether the primary care provider will be required to purchase these items.
A prioritization process is being considered to assist in determining which routine primary care interventions can be deferred during an influenza pandemic in order to free up capacity among primary health care providers.

Hospital Planning

Refer to SMHSEPC Health Services Template for Plan

Alternate Care Sites (Non-Traditional Care Sites)

The Canadian Pandemic Influenza Plan outlines the possible roles of non-traditional care sites as follows:
• Care of patients who are not critically ill when hospitals are overloaded
• As residences for individuals unable to care for themselves
• As "step-down" units to care for stable patients who have been transferred from acute care hospitals the Canadian plan recommends "satellite sites" with linkages to existing health care facilities as opposed to "free standing sites". Satellite sites can more readily take advantage of the health care facility's infrastructures, policies and procedures, equipment etc. An idea to be further explored within Simcoe Muskoka is the use of long-term care facilities. Further exploration of this option would require planning regarding moving existing patients from long-term care facilities to other long-term care facilities or back into the community during a pandemic. Discussions will need to take place at the Health Sector Emergency Planning Committee regarding the extent to which these sites are inventoried and plans regarding what would be required to equipment, staff and operate sites that do not routinely provide health care.

Long-Term Care Facilities

In preparing their pandemic plans, long-term care facilities should consider mechanisms to provide as much care on site as possible in order to minimize transfers to acute care facilities. Discussions between long term care and acute care facilities can help delineate the type of support the hospitals can provide to long-term care facilities during a pandemic in order to prevent the need for hospital admissions. Criteria for transferring residents to acute care should be developed. Additional support from community physicians and nurse practitioners for long-term care facilities may also help minimize transfers to acute care facilities.
Residents and their family members will need to be asked about the possibility of taking residents home for care. This will free up spaces in the long-term care facility for people who can be discharged from hospital to the facility, and for members of the community who need urgent admissions to the facility. Residents and their family members will also need to review the level of care that will be available for residents in the long-term care facility, specifically as it relates to the possible unavailability of acute care transfers.

Community Care Access Centre (CCAC)

Community Care Access Centre will need to determine how to expand their capacity during
a pandemic, as early discharge from acute care will be a strategy used to increase acute care bed capacity. Planning for business/service continuity will be critical to cope with this early discharge process.

Emergency Medical Services and Medical Transportation Services

Business continuity planning, alternate sources of health care providers and alternate mechanisms to transport patients in non-urgent situations are elements of planning for emergency medical services.

Laboratories

As with other health care organizations, business continuity planning will be crucial for laboratories. The Ontario Health Plan for Pandemic Influenza provides a model to assist in prioritizing services in public health and community laboratories dependant on the severity of the influenza pandemic. Local plans to coordinate laboratory services, including specimen collection, transportation of specimens, testing, and reporting to local health units, are being developed.

Next steps

Considerable work is still required to address the provision of heath care services in a pandemic. This work will be conducted under the leadership of the Simcoe Muskoka Health Sector Emergency Planning Committee. Discussions also need to occur at the provincial level regarding rationalizing the use of health care services during a pandemic, and information on what to expect from the health care system needs to be communicated to the public. Self-care materials require development or adaptation. The locations, staffing and functions of triage centres require careful consideration. The role of primary care providers in the triage sites and management of influenza patients in their offices also requires considerable discussion. The availability of additional clinical space within the hospitals and in long-term care facilities affiliated with the hospitals requires exploration. The development of an inventory of possible alternate care sites outside of health care settings should be discussed as well. All organizations involved in the delivery of health care should ensure that they conduct comprehensive business/service continuity planning.

(Adopted from the Pandemic Influenza Plan for Middlesex-London, January 2006 and the Ontario Health Pandemic Influenza Plan, May 2005)

III - 2 SIMCOE MUSKOKA HEALTH SECTOR EMERGENCY PLANNING COMMITTEE

INTRODUCTION

This is the introduction to the Simcoe Muskoka Health Sector Emergency Planning Committee (SMHSEPC) Pandemic Influenza Plan.

In October 2005, Simcoe County, in conjunction with the Simcoe Muskoka District Health Unit, reconvened the Health Sector Emergency Planning Committee. This committee was originally established in 2003 for the purpose of advising and assisting in the development of health sector emergency plans.

Since 2003 however, changes have occurred in the area that have broadened the geographic boundaries of this committee. These changes include the merging of the Simcoe County Health Unit and the Muskoka-Parry Sound Health Unit as well as the establishment of the Local Integrated Health Network # 12, which includes most of Simcoe County and the District of Muskoka. With these changes in mind, members agreed that this committee would include the District of Muskoka and that its leadership would be a collaborative effort involving Simcoe County, the District of Muskoka and the Simcoe Muskoka District Health Unit. Membership of this committee, as outlined in the Terms of Reference, includes over 45 members representing approximately 35 healthcare agencies.

As its first order of business, the re-named Simcoe Muskoka Health Sector Emergency Planning Committee (SMHSEPC) unanimously agreed that there was a need for a coordinated, inter-agency approach to pandemic planning and ongoing support for the planning in progress among its healthcare partners. It was determined then that the focus of the SMHSEPC over 2005-2006 would be on pandemic planning.

The objectives established for pandemic planning by the SMHSEPC included:

- The development of an Inter-Agency Pandemic Plan for Simcoe County and the District of Muskoka by July 2006.
- The provision of education and support for members of the SMHSEPC that were beginning to develop pandemic plans as well as those agencies that were well into the process of planning.
- To provide an opportunity for networking, identification of planning needs and sharing of pandemic planning strategies and resources.

In December 2005, the SMHSEPC approved the use of a planning template for the Inter-Agency plan. This template is closely aligned with the WHO pandemic phases and the local public health requirements outlined in the Ontario Health Pandemic Influenza Plan. The template consists of six pandemic planning components: surveillance, vaccine and antivirals, public health measures, emergency response, communications and health services. Further, each component is divided into eight columns that list the roles and responsibilities for: SMHSEPC, Public Health Unit, Hospitals, LTC, Primary Care - Family/Community Physicians, Community Care and Mental Health Agencies, Federal Agencies and other supporting health sector representatives.

This plan was developed by the committee members between January 2006 and June 2006, and approved by the SMHSEPC on September 19, 2006.

TERMS OF REFERENCE

County of Simcoe and District of Muskoka
Health Sector Emergency Planning Committee

Purpose: This committee is established to prepare for planned and coordinated response to health related emergencies.

This committee will advise on and to assist in the development of health sector plans and procedures.

Scope: For planning purposes, this project will be inclusive of the geographic boundaries of the County of Simcoe and the District of Muskoka.

Objectives:

1. To improve the capability and capacity of the health sector to respond to emergencies.
2. To coordinate emergency management programs within the health sector.
3. To facilitate the coordination of existing health sector plans and procedures.
4. To facilitate the coordination, cooperation and communication between health care organizations and agencies within the identified communities and with the Province and other organizations as required.
5. To provide a forum for health sector information sharing.
6. To address local planning issues that may include:
   - ✓ Clarification of responsibilities and capabilities of health sector organizations which may have a response and recovery role
   - ✓ Identification of gaps within existing emergency management program plans
   - ✓ Mass immunizations and/or pharmacological administration
   - ✓ Mass causality events
   - ✓ Hospital evacuation and sheltering plans
   - ✓ Other health and long term care facility evacuation and sheltering plans
   - ✓ Staffing, medical supplies and essential medications for emergency facilities such as reception and evacuee centers
   - ✓ Decontamination requirements
   - ✓ Recommendation for joint training
   - ✓ Best practice recommendations for Infection Prevention & Control

Co-Chairs:

Review the position of Co- Chair on an annual basis.
(Recommend that Co-Chairs be one member of the Simcoe-Muskoka District Health Unit and one planner member of the County of Simcoe.)

Membership:

- representative(s) of:
  - Collingwood General and Marine Hospital
  - North Simcoe Hospital Alliance
  - Orillia Soldiers' Memorial Hospital
  - Royal Victoria Hospital
  - Stevenson Memorial Hospital
  - Penetanguishene Mental Health Centre
  - Muskoka Hospital
- representative(s) of Simcoe Muskoka District Health Unit
- representative(s) of County of Simcoe & District of Muskoka CCAC's
- representative(s) of County of Simcoe & District of Muskoka Long Term Care sectors

- representative(s) of County of Simcoe & District of Muskoka EMS / Paramedic Services
- representative(s) of North Simcoe Muskoka LHIN #12 and Central LHIN #8
- representative of Georgian Sector Community Emergency Management Coordinating(CEMC) Committee (Simcoe/Muskoka)

- County of Simcoe Emergency Planning Manager
- representative of Regional Infection Control Network
- representative(s) of First Nations Reserves in area

Other Resources:

- representative of Emergency Management Ontario
- representative of MOHLTC Regional office & Provincial office
- adhoc representation of any organization considered by the Committee to be able to provide input as needed

Reporting Relationships:
Individuals have the responsibility to report to their respective organizations and their respective mandates.

Each organization/agency is responsible for the development and maintenance of its emergency management program plan and preparedness to implement those plans.

County of Simcoe has offered to provide administrative support to the Steering Committee.

Version: December 2, 2005

III - 3 PANDEMIC INFLUENZA PLANNING ADVISORY COMMITTEE

TERMS OF REFERENCE

Purpose:

- The purpose of the Simcoe Muskoka District Health Unit Pandemic Influenza Planning Advisory Committee (PIPAC) is to provide direction for planning, provide a venue for information sharing and discussion, and provide a forum for resolving local planning and implementation issues, and setting timelines for project completion.

Objectives:

- To provide clarification of responsibilities and capabilities of Pandemic Influenza Planning
- To monitor the status and identify completion of working group tasks
- To coordinate and support efforts of all working groups
- To identify any gaps or overlaps
- To identify resources necessary to facilitate planning, implementation and communication
- To complete and disseminate the Health Unit Pandemic Influenza Plan

Composition:

- Medical Officer of Health and AMOH
- Director, Clinical Service
- Pandemic Influenza Planner
- Chair of each planning group

Term of Service:

- December 2005 to June 2006

Role of Members:

- To participate in meeting the PIPAC objectives

Role of Chair – Medical Officer of Health

- Set Agenda
- Facilitate the meeting
- Call Ad-Hoc meetings as necessary

Role of Secretary:

- Record minutes, attendance
- Book the meeting room and equipment as needed
- Distribute minutes in a timely manner – via e-mail
- Maintain Committee electronic files/resources

Meeting Frequency and Duration:

- Twice a month at the Barrie or GH office locations
- Second and Fourth Tuesday morning of each month
- From 9:30 to 12:00

Reporting Relationships:

- Each Planning Group Chairperson communicates the activities of the PIPAC to their respective group members
- Each Planning Group Chairperson communicates the activities of the planning group to PIPAC
- PIPAC reports to Executive through the Committee Chair and Pandemic Planner.
- PIPAC Chair reports to the Board of Health

PIPAC SUB-COMMITTEE MEMBERSHIP

MEMBER	DEPARTMENT	OFFICE
SURVEILLANCE		
BRENDA GUARDA, Chair	Corporate Services	Barrie
Stephanie Wolfe	Clinical Services	Barrie
Brenda Armstrong	Health Protection Services	Barrie
Leigh Fairbrother	Clinical Services	Barrie
COMMUNICATIONS		
SHAWN FENDLEY, Chair	Corporate Services	Barrie
Megan Williams	Corporate Services	Barrie
John Challis	Corporate Services	Barrie
Mackenzie Doris	Healthy Living Service	Barrie
EMERGENCY RESPONSE		
KELLY MAGNUSSON, Chair	Health Protection Services	Barrie
Ed Quinn	Health Protection Services	Gravenhurst
Jennifer Simpson	Family Health	Gravenhurst
Shernette Campbell	Health Protection Services	Barrie
Ellen Hartwick	Healthy Living Service	Midland
PUBLIC HEALTH MEASURES		
ANN CORNER, Chair	Clinical Services	Barrie
John Barbaro	Corporate Services	Barrie
Mary Ann Holmes	Family Health	Cookstown
Sara Syvanen	Healthy Living Service	Gravenhurst
VACCINE & ANTIVIRALS		
LAURIE STANFORD, Chair	Clinical Services	Barrie
Cathy Thompson	Clinical Services	Barrie
Jennifer Kowal	Family Health	Gravenhurst
Nicole Ritchie	Health Protection Services	Gravenhurst
BUSINESS CONTINUITY		
LORI WEBEL-EDGAR, Chair	Family Health	Barrie
Carrie Innes	Healthy Living Service	Collingwood
Donna Milne	Clinical Services	Midland
Brenda Hadley	Corporate Services	Barrie
ORIENTATION & TRAINING		
REINA BARKER, Chair	Healthy Living Services	Barrie
LeAnne Hochevar	Health Protection Services	Barrie
Shelley Duncan	Health Protection Services	Gravenhurst
Lucy Bray	Family Health Services	Barrie

PIPAC SUB-COMMITTEE OBJECTIVES

Surveillance

Purpose:

- The purpose of the PIPAC Surveillance Subcommittee is to develop a simple, well-documented, and flexible surveillance system that provides automated data analysis and dissemination in a timely fashion

Objectives:

- To identify data collection, integration, analysis/interpretation, reporting methodology and dissemination needs that require action
- To identify resources necessary to facilitate the collection, integration, analysis, interpretation, reporting methodology and dissemination of surveillance data
- To identify any gaps related to surveillance
- To identify and recommend to PIPAC and external agencies/stakeholders that need to participate in the pandemic influenza surveillance system
- To identify issues relevant to the other subcommittees/working groups i.e., dissemination of surveillance information (communications), training related to data collection and data entry (orientation and training)
- To complete revisions as agreed in PIPAC timelines and submit documents accordingly to PIPAC Coordinator
- To support efforts of all working groups
- To test and evaluate the surveillance plan to identify gaps, measure effectiveness, make recommendations for revisions and to retest
- To liaise with the Health Sector Emergency Planning (HSEP) group when necessary

Vaccine & Antiviral

Purpose:

- The purpose of PIPAC Vaccines and Anti Viral Planning Group is to develop the plan for how the SMDHU is going to store, handle and distribute vaccine and antivirals.

Objectives:

- To identify data collection tools and tracking tools needed for inventory management of vaccine and antivirals and submit required action to PIPAC for delegation and action
- To identify the resources necessary for maintaining the database and tracking tools
- To complete the plan for mass immunization clinics and antivirals distribution centres.
- To identify resources necessary for staffing mass immunization clinics and antiviral distribution centres including immunizers, volunteers ands security personnel, clinic/center locations. Identify formal agreements that need to be developed.
- To complete our plans for storage, handling and administration of antivirals
- To review the current SMDHU plan/provincial plan and national plan and ensure they are compatible.
- To seek clarification from provincial working group on vaccine and ant-virals re: expectations at local level
- To link with other working groups re: enumeration tool outcomes and their relevance to our planning for priority groups
- To support efforts of other working groups
- To identify action items in the work plan
- To submit required action items to PIPAC Coordinator

Public Health Measures

Purpose:

- The purpose of the PIPAC Public Health Measures Subcommittee is to develop the public health measures planning component of the agency plan by incorporating non-medical measures to reduce the burden and spread of illness within Simcoe County and the District of Muskoka.

Objectives:

- Review and integrate recommendations for public health measures which will impact on the spread of pandemic influenza utilizing local, provincial, federal and where appropriate international documents and
  i. Plan for completion of those tasks
  ii. Submit required action to PIPAC for delegation
- To complete the Public Health Measures subsection of the Health Unit Pandemic Influenza Plan
- To identify issues, education and resources necessary to facilitate planning, implementation and communication
- To identify and recommend to PIPAC external agencies/stakeholders that need to participate in the PHMS
- To identify issues relevant to the other subcommittees/working groups
- To complete revisions as agreed in PIPAC timeline and submit documents accordingly to PIPAC Coordinator
- To support efforts of all working groups
- To liaise with the Health Sector Emergency Planning (HSEP) group when necessary
- To support PIPAC Committee requests for service as required

Emergency Response

Purpose:

The purpose of the PIPAC Emergency Response Subcommittee is to develop the emergency response component of the plan that incorporates communication and coordination between community/emergency service providers and public health.

Objectives:

- To develop a comprehensive plan that incorporates internal, external partners
- To ensure that the pandemic plan synchronizes with the health unit's emergency response plan.
- To identify resources necessary to facilitate planning, coordination, implementation and communication of the plan
- To identify any planning gaps or overlaps i.e. as it relates to internal and external communications needs/processes.
- To complete revisions as agreed in PIPAC Timeline and submit documents accordingly to PIPAC Chair
- To link with and support other workgroups
- To identify issues relevant to the other subcommittees/working groups
- To ensure that the plan includes strategies that will promote business continuity planning for necessary services
- To identify priority actions items and develop timelines for implementation
- To collaborate with external partners in the planning process
- Liaison with Health Sector Emergency Planning Committee
- Provide presentations to the HSEPC related to the emergency Response component of the plan.
- Submit draft products to the Pandemic PIPAC Coordinator

Business Continuity

Purpose:

- The purpose of the Simcoe Muskoka District Health Unit PIPAC Business Continuity Planning Redeployment and Recovery Subcommittee to develop a Business Continuity Plan (BCP) for SMDHU specific to Pandemic Influenza that is congruent with the Agency Emergency Response Plan.

Objectives:

- To assist in the development of a BCP template that will support the BCP process for SMDHU
- Implement and monitor the status of the BCP and identify completion of sub committee tasks
- To identify any gaps or overlaps with other PIPAC subcommittees
- To identify subcommittee resources necessary to facilitate planning, implementation and communication via PIPAC
- To develop a process to facilitate the business recovery following the Pandemic
- To ensure that the BCP is inclusive of all SMDHU stakeholders

Orientation & Training

Purpose:

- The purpose of the PIPAC Orientation and Training subcommittee is to develop a plan that outlines the orientation and training needs that have been identified within the SMDHU Pandemic Influenza Plan and to make recommendations on how these can be met.

Objectives:

- To identify orientation and training needs that require action and
  a) propose recommendations for completion of those tasks
  b) submit required action and recommendation to PIPAC for delegation
- To identify resources necessary to facilitate planning, development and implementation of orientation and training activities
- To identify any orientation and training gaps or overlaps
- To identify and recommend to PIPAC external agencies/stakeholders who need to participate in broader pandemic influenza orientation and training activities.
- Identify new resources/information as pertinent to orientation and training and share within the subcommittee and at PIPAC as indicated
- Inform other subcommittees and program areas of action steps needed related to orientation and training e.g. development of orientation and training activities related to surveillance
- To complete revisions as agreed in PIPAC Timeline and submit documents accordingly to Pandemic Influenza Planner
- To support efforts of all working groups
- To test and evaluate the training and orientation plan to identify gaps, measure effectiveness, make recommendations for revisions and to retest

III - 4 GLOSSARY

TERMS

The following glossary of terms refers to terms used throughout the Plan, including the annexes.

A

Acute - Short term, intense symptomatology or pathology, as distinct from chronic. Many diseases have an acute phase and a chronic phase. This distinction is sometimes used in treatments.
Acute Care -Acute care refers to services provided by physicians and other health professionals and staff in the community and in hospitals. These include emergency, general medical and surgical, psychiatric, obstetric and diagnostic services.
Alternate Level of Care *See also Acute Care, InterQual Criteria*
This term refers to alternative care that, had it been available, would have been more appropriate for a person in an acute care hospital who does not meet the criteria for acute care.
Amantadine An antiviral agent indicated in adults and children >1 year for the treatment of illness due to influenza and for prophylaxis following exposure to influenza type A viruses. It has no effect against the influenza type B virus.
Antigen Any molecule that is recognized by the immune system and that triggers an immune response, such as release of antibodies.
Antigenic drift - A gradual change of the hemagglutinin or neuraminidase proteins on the surface of a particular strain of influenza virus occurring in response to host antibodies in humans who have been exposed to it. It occurs on an ongoing basis in both type A and type B influenza strains and necessitates ongoing changes in influenza vaccines.
Antigenic shift The movement of a type A influenza virus strain from other species into humans. The novel strain emerges by reassortment with circulating human influenza strains or by infecting humans directly. Because they flourish in the face of global susceptibility, viruses that have undergone antigenic shift usually create pandemics.
Antibody Protein molecules that are produced and secreted by certain types of white cells in response to stimulation by an antigen.
Antigen Any substance that provokes an immune response when introduced into the body.

B

Bed *(Institutional Bed)* In any institution a “bed” includes infrastructure support, including staffing, which is required to care for the patient in that “bed”. Therefore the requirements for a “bed” in an intensive care unit, for example, include all the support required for a patient to be cared for at that level.

C

CDC Centers for Disease Control and Prevention – an American federal agency of the HHS
CEPR Centre for Emergency Preparedness and Response
CIDPC Centre for Infectious Disease Prevention and Control
CMOH Chief Medical Officer of Health
CPIP Canadian Pandemic Influenza Plan
Cross-resistance The development of strains of a pathogen that not only withstands the effects of a given antimicrobial agent, but other chemically related agents as well.

D

E

Epidemic - An outbreak of infection that spreads rapidly and affects many individuals in a given area or population at the same time.
Epidemiology The study of epidemics and epidemic diseases

EOC Emergency Operations Centre
ERP Emergency Response Plan

F

Flu Another name for influenza infection, although it is often mistakenly used in reference to gastrointestinal and other types of clinical illness.
F/P/T Federal/Provincial/Territorial

G

Goblet cell A mucous gland in the epithelial lining of specific mucus-secreting passages of the respiratory tract. Mucigen droplets swell the upper portion of the cell, giving it a goblet-like shape.

H

H5N1 A strain of influenza type A virus that moved in 1997 from poultry to humans. While the outbreak of this virus was rapidly contained, it produced significant morbidity and mortality in persons who became infected, probably from direct contact with infected poultry.

Health Care Workers *(Pandemic)*
Health Care Workers are professionals, including trainees and retirees, non-professionals and volunteers, involved in direct patient care; and/or those working/volunteering in designated health care facilities or services. For the purposes of this definition, Health Care Workers are those whose functions are essential to the provision of patient care, and who may have the potential for acquiring or transmitting infectious agents during the course of their work. This group would also include public health professionals during the pandemic.
Health Status - The state of health of an individual or a population, as in community health status.
High-Risk Groups Those groups in which epidemiologic evidence indicates there is an increased risk of contracting a disease.

I

Inactivated vaccine A vaccine prepared from killed viruses, which no longer retain their infective properties.
Infection - Condition in which virulent organisms are able to multiply within the body and cause a response from the host's immune defenses. Infection may or may not lead to clinical disease.
Infectious - Capable of being transmitted by infection, with or without actual contact.
Influenza A highly contagious, febrile, acute respiratory infection of the nose, throat, bronchial tubes, and lungs caused by the influenza virus. It is responsible for severe and potentially fatal clinical illness of epidemic and pandemic proportions.
Influenza type A - category of influenza virus characterized by specific internal proteins
and further sub grouped according to variations in their two surface proteins (hemagglutinin and neuraminidase). It infects animals as well as humans and has caused the pandemic influenza infections occurring in this century.
Influenza type B A category of influenza virus characterized by specific internal proteins.
It infects only humans, causes less severe clinical illness than type A, and spreads in regional rather than pandemic outbreaks.
Influenza type C A category of influenza virus characterized by specific internal proteins. It does not cause significant clinical illness.
Inpatient An individual who receives health care services while admitted in a health care facility overnight or longer.
Isolate A pure specimen obtained by culture.

J

K
L
M

MD *(Doctor of Medicine)* An individual holding a doctoral degree in medicine.
Mean *(statistical)* commonly referred to as the "average", the mean of a set of quantities is the sum of the quantities, divided by the number of quantities summed.
Median *(statistical)* The value such that for a series of ranked quantities, one half are above the median, and one half are below.
MOH Medical Officer of Health
Morbidity Departure from a state of well-being, either physiologic or psychological illness.
Morbidity Rate The number of cases of an illness (morbidity) in a population divided by the total population considered at risk for that illness.
Mortality Death, as in expected mortality (the predicted occurrence of death in a defined population during a specific time interval).
Mortality Rate The number of people who die during a specific time period divided by the total population.
MOU Memorandum of Understanding
Mutation A permanent, transmissible change in the genetic material of a cell.

N

NACI National Advisory Committee on Immunization
NESS National Emergency Stockpile System
Neuraminidase A hydrolytic protein antigen spiking from the surface of the influenza virus. It dissolves the protective viscosity of cellular mucous lining, allowing release of new viruses into the respiratory tract.
Neuraminidase inhibitors, A new class of antiviral agents that selectively inhibit neuraminidase activity in both influenza type A and type B viruses, while having no effect on human neuraminidase.
NML National Microbial Laboratory
Non-traditional Site The following is a definition of a Non-traditional Site for the purposes of Pandemic Influenza planning: A Non-traditional Site is a site offering care for influenza patients. These sites are currently not an established health care site, or are established sites which usually offer a different type or level of care. The Functions of an Non-Traditional Site will vary depending on the needs of the community but will focus on monitoring, care and support of influenza patients.

O

OCIPEP Office of Critical Infrastructure and Protection and Emergency Preparedness

Opportunistic Infections
An infection in an immune compromised person caused by an organism that does not usually cause disease in healthy people. Many of these organisms are carried in a latent state by virtually everyone, and only cause disease when given the opportunity of a damaged immune system.
Outpatient An individual who receives health care services without being admitted to a health care facility.

P

PAHO Pan American Health Organization
Palliative A treatment which provides symptomatic relief, but not a cure.
Pandemic Referring to an epidemic disease of widespread prevalence around the globe.
Pathogen Any disease-producing microorganism or material.

PCR *(Polymerase Chain Reaction)*
A highly sensitive test that can detect and/or DNA fragments of viruses or other organisms in blood or tissue. PCR works by repeatedly copying genetic material using heat cycling, and enzymes similar to those used by cells.
Preventive Care A comprehensive type of care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examinations, immunization, and well-person care.
Preventive Medicine Taking measures for anticipation, prevention, detection, and early

treatment of disease.
Primary Care Primary care is the first level of care, and usually the first point of contact, that people have with the health care system. Primary care involves the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. It includes advice on health promotion and disease prevention, assessments of one's health, diagnosis and treatment of episodic and chronic conditions, and supportive and rehabilitative care.
P/T Provincial/Territorial
Public Health The art and science of protecting and improving community health by means of preventive medicine, health education, communicable disease control, and the application of social and sanitary sciences.

Q

QTMH Quarantine, Travel and Migration Health
Qualitative Of, relating to, or expressed in relative or subjective terms‹impossible to precisely quantify.
Quantitative Of, relating to, or expressed in terms of quantity.

R

Record A paper or electronic document that contains or is designed to contain a set of facts related to some occurrence, transaction, or the like.
Registered Nurse (RN) One who has graduated from a college or university program of nursing education and has been licensed by the state.
Resistance The development of strains of a pathogen that is able to withstand the effects of an antimicrobial agent.
Respiratory tract Structures contained in the respiratory system, including the nasopharynx, oropharynx, laryngopharynx, larynx, trachea, bronchi, bronchioles, and lungs.
Rimantadine - An antiviral agent indicated in adults for the treatment of illness due to influenza and for prophylaxis following exposure to influenza type A viruses. It has no effect against the influenza type B virus.

S

SARS Severe Acute Respiratory Syndrome
Secondary Care - Services given by a specialist, normally after a referral from a primary care physician, and often in an acute care hospital. It does not include the services of specialists whose services are only available in major urban centres; this level of service would normally be considered Tertiary Care.
Significance *(statistical)*- Infers that an observation was unlikely to have occurred by chance alone. Statistical significance is often based on a p value < 0.05. Below this level, the smaller the p value, the greater the statistical significance.
Strain A group of organisms within a species or type that share a common quality. For example, currently circulating strains of influenza include type A (H1N1), type A (H3N2), and type B (H3N2).

Subacute Care Comprehensive, cost-effective inpatient level of care for patients who: a) have had an acute event resulting from injury, illness or exacerbation of a disease process, b) have a determined course of treatment and, c) though stable, require diagnostics or invasive procedures but not intensive procedures requiring an acute level of care. Typically short term, sub acute care is designed to return patients to the community or transition them to a lower level of care. Subacute care is offered in a variety of physical settings. The philosophy of subacute care is to ensure that patients are receiving the most appropriate services at the most appropriate phase of their illness while ensuring quality, cost-effective outcomes.
Subtype A classification of the influenza type A viruses based on the surface antigens hemagglutinin (H) and neuraminidase (N).
Symptoms Any perceptible, subjective change in the body or its functions that indicates disease or phases of disease, as reported by the patient.

T

Toxicity The extent, quality, or degree of being poisonous or harmful to the body.
Toxin A harmful or poisonous agent.
Triage A system whereby a group of casualties or patients is sorted according to the seriousness of their illness or injuries, so that treatment priorities can be allocated between them. In emergency situations it is designed to maximize the number of survivors.
Type A classification of influenza viruses based on characteristic internal proteins.

V

Vaccination - The act of administering a vaccine.
Vaccine A substance that contains antigenic components from an infectious organism. By stimulating an immune response (but not disease), it protects against subsequent infection by that organism.
VAER Vaccine Adverse Events Reporting
Virology The study of viruses and viral disease.
Virus A group of infectious agents characterized by their inability to reproduce outside of a living host cell. Viruses may subvert the host cells' normal functions, causing the cell to behave in a manner determined by the virus.
Volunteers *(Pandemic)* A volunteer is a person registered with a government agency or
Government designated agency, which carries out unpaid activities, occasionally or regularly, to help support Canada prepare for and respond to a Pandemic Influenza outbreak. A volunteer is one who offers their service of their own free will, without promise of financial gain, and without economic or political pressure or coercion.

W

WHMIS The Workplace Hazardous Materials Information System (WHMIS) is Canadian legislation covering the use of hazardous materials in the workplace. This includes assessment, signage, labelling, material safety data sheets and worker training. WHMIS closely parallels the U.S. OSHA Hazcom Standard. Most of the content of WHMIS is incorporated into Canada's Hazardous Products Act and the Hazardous Materials Information Review Act which are administered by Health Canada. Certain provincial laws may also apply. Enforcement of
WHMIS is performed by the Labour Branch of Human Resources Development Canada or the provincial/territorial OHS agencies.
Wild type A naturally occurring strain of virus that exists in the population.
World Health Organization (WHO)
A specialized agency of the United Nations generally concerned with health and health care.

ACRONYMS

AEFI	Adverse Events Following Immunization
BC	Business Continuity
BCP	Business Continuity Plan
CAPS	Community Action Profile System
CBC	Canadian Broadcasting Corporation
CCAC	Community Care Access Centres
CD	Communicable Disease (including CDSU and CDIU)
CDC	Centers for Disease Control and Prevention – an American federal agency of the HHS
CDIU	Communicable Disease Investigation Unit
CDP - HL	Chronic Disease Prevention – Healthy Lifestyle
CDP - T	Chronic Disease Prevention - Tobacco
CDSU	Communicable Disease Surveillance Unit
CD Surv	CD Surveillance Secure Website
CEPR	Centre for Emergency Preparedness and Response
CEMC	Chief Emergency Management Coordinator
CFIA	Canadian Food Inspection Agency
CH	Child Health
CIDPR	Centre for Infectious Disease Prevention and Control
CIOSC	Canadian Integrated Outbreak Surveillance Centre
CISS	Computerized Inspection Services System
CMHS	Community Mental Health Services
CMOH	Chief Medical Officer of Health
C-GNOS ReportNet	Web based business intelligence solution used in conjunction with iPHIS to provide surveillance reports
Corporate Communication	Corporate Communications
Corp S	Corporate Service
CPIP	Canadian Pandemic Influenza Plan
CS	Clinical Service
D	Director (e.g. DCS)
DM	District of Muskoka
EAP	Employee Assistance Program
ECG	Emergency Control Group
EMP	Emergency Management Program
EMS	Emergency Medical Services
EPI	Epidemiologist
EOC	Emergency Operations Centre
ER	Emergency Response
ERP	Emergency Response Plan
FAD	Foreign Animal Disease
FAQ	Frequently Asked Questions
FHS	Family Health Service
FRI	Febrile Respiratory Illness
GH	Gravenhurst Office
HBHC	Healthy Babies/Healthy Children Program
HC	Health Connection
HLS	Healthy Living Service
HPPA	Health Promotion and Protection Act

HR	Human Resources
HU	Health Unit
ICP	Infection Control Practitioner
ILI	Influenza Like Illness
IML	Information Management Lead (a position relating to our emergency response plan)
iPHIS	Integrated Public Health Information System - is a web-based, integrated reporting and case management information system for communicable diseases. In April 2005, iPHIS replaced RDIS (Reportable Disease Information System) as the communicable disease database used in Ontario public health units to report diseases mandated under the Health Promotion and Protection Act (HPPA) R.S.O 1990, Chapter H.7. as reportable to the MOHLTC.
IRIS	Immunization Records Information System
LTC	Long Term Care
MD	(Doctor of Medicine) An individual holding a doctoral degree in medicine
MOH/AMOH	Medical Officer of Health/Associate Medical Officer of Health
MOHLTC	Ministry of Health and Long-Term Care
MOU	Memorandum of Understanding
MT	Management Team
NACI	National Advisory Committee on Immunization
NESS	National Emergency Stockpile System
NML	National Microbial Laboratory
OCIPEP	Office of Critical Infrastructure and Protection and Emergency Preparedness
OH	Oral Health
OH&S	Occupational Health and Safety
OMAFRA	Ontario Ministry of Food, Agriculture and Rural Affairs
P/T	Provincial/Territorial
PAHO	Pan American Health Organization
PCR	(Polymerase Chain Reaction) A highly sensitive test that can detect and/or DNA fragments of viruses or other organisms in blood or tissue. PCR works by repeatedly copying genetic material using heat cycling, and enzymes similar to those used by cells.
PHAC	Public Health Agency of Canada
PHI	Public Health Inspector
PHL	Public Health Laboratory
PIMRC	Public Information and Media Relations Coordinator (a position relating to our emergency response plan)
PIP	Pandemic Influenza Planner
PIPAC	Pandemic Influenza Plan Advisory Committee
PSA	Public Service Announcement
QTMH	Quarantine, Travel and Migration Health
R&R	Rest and Retirement Home
RH	Reproductive Health
RN	Registered Nurse
RRFSS	Rapid Risk Factor Surveillance System
SARS	Severe Acute Respiratory Syndrome
SC	Simcoe County
SH	Sexual Health

SL	School Liaison
SMDHU	Simcoe Muskoka District Health Unit
SMHSEPC	Simcoe Muskoka Health Sector Emergency Planning Committee
TBD	To Be Determined
UIIP	Universal Influenza Immunization Program
URL	Uniform Resource Locators
VAER	Vaccine Adverse Events Reporting
VIP	Violence and Injury Prevention
VPD	Vaccine Preventable Disease
WHO	A specialized agency of the United Nations generally concerned with health and health care.

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