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PANDEMIC INFLUENZA PLAN

SEPTEMBER 2010
VERSION 2.0

simcoe muskoka
DISTRICT HEALTH UNIT

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

By Dr. Charles Gardner and Bill Mindell
September 2010

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

In 2006 Simcoe Muskoka District Health Unit posted on its website (www.simcoemuskokahealth.org) its original pandemic influenza plan which provides 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 was 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 did 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. Since the posting of the plan, it has been reviewed, revised and maintained on an ongoing basis by a smaller agency committee, the Pandemic Influenza Plan Review Group (PIPRG). The SMDHU PIP assumes that pandemic influenza will cause many people to seek health care and will greatly strain the capacity of our health care system. A pandemic may also impede the ability of society to provide for our basic needs.

We stated in our Message in the original Pandemic Influenza Plan in 2006 that:

"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."

Three years later we had a pandemic. A novel human swine influenza A strain pH1N1 (or simply H1N1) appeared suddenly in Mexico and spread rapidly around the world. Although pH1N1 never achieved the devastating societal and health services impact that the Simcoe Muskoka District Health Unit Pandemic Influenza Plan (SMDHU PIP), and indeed the PIPs of all levels of government, had been designed to address, the plan was nevertheless at least partially implemented to address this extraordinary disease situation. We learned much from this experience and have modified some sections of our plan in light of it. However, we also learned that the original plan, where tested, served us well and that little modification was actually necessary. The SMDHU PIP is still designed to address the devastating pandemic that has yet to occur.

This revision of the plan also reflects changes made to the provincial Ontario Health Pandemic Influenza Plan (OHPIP) in August 2008. It is our intention to continually revise this plan on an as needed basis to keep it consistent with the plans of other levels of government and with the relevant knowledge base as it changes.

In a parallel process, the Simcoe Muskoka District Health Unit 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. The PIPRG also provides leadership to the SMHSEPC in keeping the regional PIP up to date.

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. With growth in public awareness of the potential for an influenza pandemic; especially after the SARS outbreak of 2003; governments, public agencies and businesses around the world began planning and preparing for such a public health emergency.

The Simcoe Muskoka District Health Unit (SMDHU) has been engaged in pandemic influenza planning as an agency for a decade. In the fall of 2005, this work was accelerated through the creation of a Pandemic Influenza Planner position and 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. After the original plans were posted in 2006 they have been reviewed and maintained on an ongoing basis by the SMDHU Pandemic Influenza Plan Review Group (PIPRG).

In 2009, a novel human swine influenza A strain pH1N1 (or simply H1N1) appeared suddenly in Mexico and spread rapidly around the world. Although pH1N1 never achieved the devastating societal and health services impact that the SMDHU Pandemic Influenza Plan (PIP), and indeed the PIPs of all levels of government, had been designed to address, the plan was nevertheless at least partially implemented to address this extraordinary disease situation. We learned much from this experience and have modified some sections of our plan in light of it. However, we also learned that the original plan, where tested, served us well and that little modification was actually necessary. The SMDHU PIP is still designed to address the devastating pandemic that has yet to occur.

Although the September 2010 plan (version 2.0) is complete to date, it continues to be a work in progress. Pandemic planning does not end; rather it evolves. As circumstances and knowledge 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);
- internal and external pandemic and emergency response planning structures;
- ethical framework (e.g. decision-making principles, core ethical values);
- legislative authority.

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.

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 four to six months after the pandemic strain has been identified. Until such time, antivirals may be recommended, if directed by the Province and/or the Federal government, for use preventively for identified groups such as healthcare workers and other essential service workers, and for the early treatment of cases. In the August 2008 OHPIP there is no role identified for public health in the storage, handling and distribution of antivirals. Public health activities are focused on vaccine distribution and delivery, especially mass immunization clinics (MIC).

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 (e.g. caring for an ill relative). 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 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, good planning is what separates a successful response from an unsuccessful one. With growth in public awareness of the potential for an influenza pandemic; especially after the SARS outbreak of 2003; governments, public agencies and businesses around the world began planning and preparing for such a public health emergency. As directed by the Chief Medical Officer of Health (CMOH) of Ontario, the Simcoe Muskoka District Health Unit (SMDHU) completed its first pandemic influenza plan in 2000,

Since then, global events such as the SARS outbreak and the outbreak of human cases of H5N1 influenza (2006) have refocused public health efforts on planning an efficient response to an influenza pandemic. To that end, the health unit began the process of updating and revising its original pandemic plan; a major revision was publicly released in June 2006 (version 1.0).

The plan has now been revised again in light of the 2009 experience gained from addressing the pH1N1 pandemic; this included a mass immunization campaign and the opening of a local Influenza Assessment Centre. It is also being revised to respond to a number of recommendations contained in an internal health unit evaluation of the pH1N1 response and the updated Chapters contained in the August 2008 revision of the Ontario Health Pandemic Influenza Plan (OHPIP).

The result 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, i.e. Clinical Service, Health Protection Service, Healthy Living Service, Corporate Service, Family Health Service and the Office of the medical Officer of Health.

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 and revising their own pandemic influenza plans.

It must be stated at the outset that this document will continue to be a work in progress. 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 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** defines the assumptions, processes and background information on which the PIP is based.

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 nine specific pandemic planning components, including: (1) surveillance (2) vaccine and antivirals (3) public health measures (4) emergency response (5) communications (6) orientation and training (7) business continuity/ redeployment and recovery planning (8) occupational health and (9) First Nations Communities. 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 PLANNING ASSUMPTIONS

In order that the plan remain as realistic and practical as possible certain planning assumptions must be used as a basis. The SMDHU PIP has adopted the planning assumptions contained in the Ontario Health Pandemic Influenza Plan (OHPIP), 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 six 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.

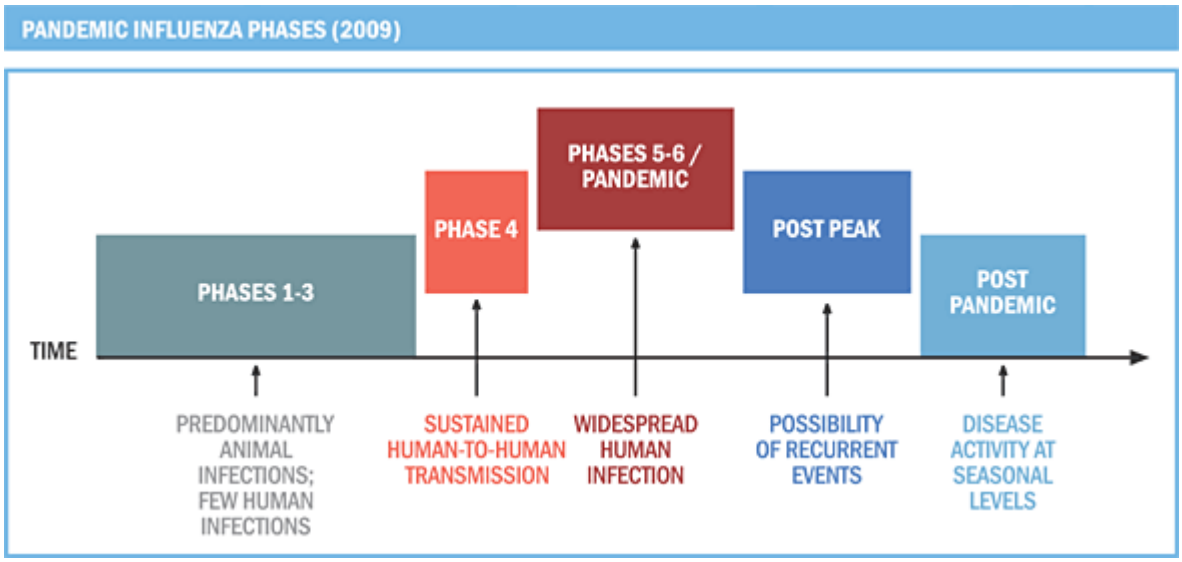
Communications

- 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 fiber 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 - 4 WORLD HEALTH ORGANIZATION PANDEMIC PHASES

WHO Pandemic Periods and Phases

The WHO pandemic phases were developed in 1999, revised in 2005 and again in 2009. The phases are applicable to the entire world and provide a global framework to aid countries in pandemic preparedness and response planning. In the 2009 revision, WHO has retained the use of a six-phased approach for easy incorporation of new recommendations and approaches into existing national preparedness and response plans. The grouping and description of pandemic phases have been revised to make them easier to understand, more precise, and based upon observable phenomena. Phases 1-3 correlate with preparedness, including capacity development and response planning activities, while Phases 4-6 clearly signal the need for response and mitigation efforts. Furthermore, periods after the first pandemic wave are elaborated to facilitate post pandemic recovery activities.



In nature, influenza viruses circulate continuously among animals, especially birds. Even though such viruses might theoretically develop into pandemic viruses, in **Phase 1** no viruses circulating among animals have been reported to cause infections in humans.

In **Phase 2** an animal influenza virus circulating among domesticated or wild animals is known to have caused infection in humans, and is therefore considered a potential pandemic threat.

In **Phase 3**, an animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks. Limited human-to-human transmission may occur under some circumstances, for example, when there is close contact between an infected person and an unprotected caregiver. However, limited transmission under such restricted circumstances does not indicate that the virus has gained the level of transmissibility among humans necessary to cause a pandemic.

Phase 4 is characterized by verified human-to-human transmission of an animal or human-animal influenza reassortant virus able to cause “community-level outbreaks.” The ability to cause sustained disease outbreaks in a community marks a significant upwards shift in the risk for a pandemic. Any country that suspects or has verified such an event should urgently consult with WHO so that the

situation can be jointly assessed and a decision made by the affected country if implementation of a rapid pandemic containment operation is warranted. Phase 4 indicates a significant increase in risk of a pandemic but does not necessarily mean that a pandemic is a forgone conclusion.

Phase 5 is characterized by human-to-human spread of the virus into at least two countries in one WHO region. While most countries will not be affected at this stage, the declaration of Phase 5 is a strong signal that a pandemic is imminent and that the time to finalize the organization, communication, and implementation of the planned mitigation measures is short.

Phase 6 indicates that a global pandemic is under way. In addition to the criteria defined in Phase 5, this phase is characterized by sustained community level spread of the new flu strain in several countries in at least two WHO regions. The declaration is based on the spread of the virus, not the severity.

During the **post-peak period**, pandemic disease levels in most countries with adequate surveillance will have dropped below peak observed levels. The post-peak period signifies that pandemic activity appears to be decreasing; however, it is uncertain if additional waves will occur and countries will need to be prepared for a second wave.

Previous pandemics have been characterized by waves of activity spread over months. Once the level of disease activity drops, a critical communications task will be to balance this information with the possibility of another wave. Pandemic waves can be separated by months and an immediate “at-ease” signal may be premature.

In the **post-pandemic period**, influenza disease activity will have returned to levels normally seen for seasonal influenza. It is expected that the pandemic virus will behave as a seasonal influenza A virus. At this stage, it is important to maintain surveillance and update pandemic preparedness and response plans accordingly. An intensive phase of recovery and evaluation may be required.

I - 5 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 PIP 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). Plan approvals are done by the Executive Committee. Other stakeholders and community partners were consulted during the evaluation of the plan following pH1N1 in 2009/10.
Reasonable - Decisions should be based on reasons (i.e. evidence, principles and values) and be made by people who are credible and accountable.	The 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: ▪ PIPRG members and other health unit staff, ▪ SMHSEPC Committee members, ▪ Current literature and best practice, ▪ Experience and lessons learned thru evaluation, ▪ 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.	▪ SMDHU 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 and considered. ▪ The evaluation of the plan as a basis for response to pH1N1 engaged stakeholders within the organization and community partners.
Responsive - Decisions should be revisited and revised as new	SMDHU PIP will continue to be developed, enhanced and revised as new information emerges from the federal

information emerges, and stakeholders should have opportunities to voice any concerns they have about the decisions (i.e. dispute and complaint mechanism).	and provincial plans, changing world experience (e.g. pH1N1 and knowledge. An agency PIP Review Group (PIPRG) has been established and 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 exist to ensure accountability throughout the pandemic. Decision making is concentrated in the Incident Management System (IMS) structure that the SMDHU uses to direct its actions in a pandemic or other emergency.

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 health 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 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.	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 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)
Family-Centered Care A family's right to make decisions on behalf of a child, consistent with the capacity of the child will be respected.	In order to respect a family's decision, decision makers will: • Respect families unique beliefs and values and acknowledge their choices
Respect for Emerging Autonomy When providing care for young people, their emerging autonomy will be respected.	In order to respect young people's emerging autonomy decision makers will: • Disclose age appropriate information

I - 6 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. Ontario Public Health Standards 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. New provisions to the Act, included in the May 2005 revisions, updated and expanded the existing legislation to also address 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 - 7 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 all local municipalities to develop emergency plans, and organize the deployment of all services or resources that may be required to manage the emergency.

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, be they man-made health related or environmental in nature (e.g. communicable disease, 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

Notification that pandemic influenza is in Simcoe County or the District of Muskoka will be made by the Medical Officer of Health (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 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 EOC 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.

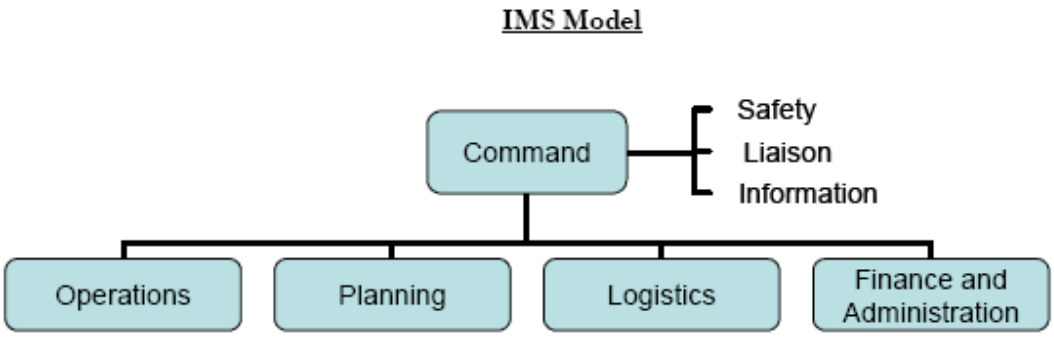
Emergency Management Systems

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, operations, 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;
- Declaring 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 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 the Incident Commander up to date with actions of other agencies and their responses.

Emergency Information/Public Information Officer

The Public Information Officer is responsible for the development and timely dissemination of approved emergency information messages and bulletins to the media and the public. This function is responsible for coordinating all media requests for interviews and conducting regular news briefings. Please note that the Incident Commander may be identified as the community spokesperson.
Each response agency is responsible for identifying a Public Information Officer for their organization. Individual agencies may already have an emergency information officer established within their organization functioning as a Public Information Officer, Media Relations or Communications Officer.

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

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 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 response plans up to 72 hours ahead
- Gathering information regarding incident specific impact
- Sharing information between all programs/teams
- Identifying alternate action to deal with emergency
- Developing the Emergency Management Team action plan
- Tracking individual/departmental services continuity plan and status
- Summarizing departmental plans for submission to senior management
- Advising Emergency Management Team of departmental service continuity plan conflicts, incongruities, overlap, etc.

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 at the direction of the Incident Commander
- 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
- Notifying team leaders that an emergency has been declared
- Communicating 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

Logistics

Logistics arranges 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:
- Arranging 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
- Arranging for transportation/accommodation
- Acquiring equipment and support services, office and medical supplies
- Arranging for food
- Maintaining operation of the Emergency Operations Centre (EOC)
- Acquiring outside services, arranging for services and/or equipment from other agencies, community
- Notifying, requesting assistance from and/or liaising with other levels of government

Finance and Administration

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

Finance & Administration responsibilities may include:
- Authorizing expenditures
- Monitoring the cost associated with emergency response (expenditure tracking) for staff services, municipal/agency resources (equipment/supplies)
- Identifying cost depleted
- Emergency procurement authorization
- Claims and compensation
- Administering 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 EOC Director 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

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

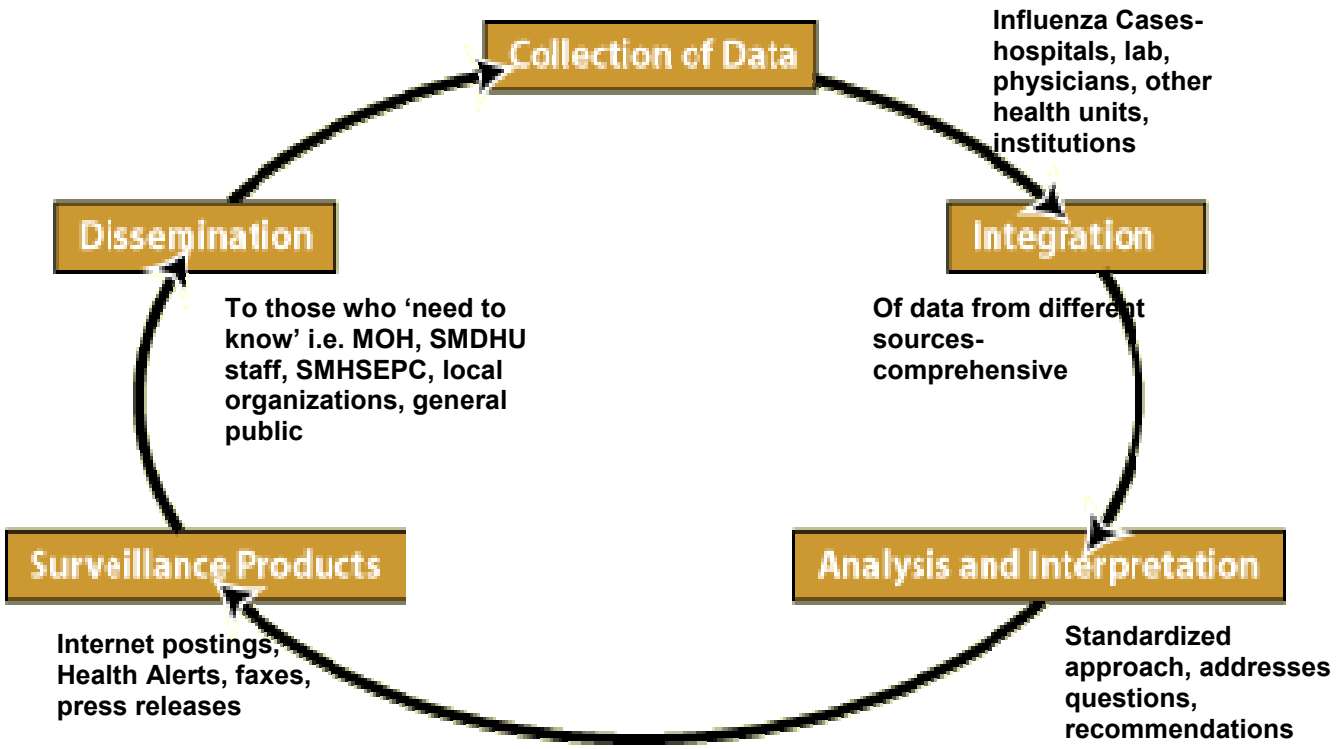


Diagram Source: Skills Enhancement for Public Health, Module 1– Basic Epidemiological Concepts

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 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
- A syndromic surveillance system used during the 2009 pH1N1 in other parts of the province. Currently four hospital corporations in Simcoe and Muskoka are participating in the new Queens University Emergency Syndromic Surveillance Team (QUESST) and are being monitored and assessed for future use. Work is being done to include all hospitals in the health unit
- School absenteeism surveillance.

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 phases (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**
PHASE 1		
Phase 1 *No animal influenza virus circulating among animals has been reported to cause infection in humans.*	Maintain all interpandemic surveillance activities	1. Conduct passive surveillance of global statistics on novel 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. Statistics on these websites to be used in the development of SMDHU surveillance reports outlined in Phases 3 thru 6. 3. Receive and file weekly influenza reports from PHAC (FluWatch), MOHLTC (Influenza Bulletin). Compare to local situation. 4. Investigate all reported cases of influenza in community and institutions. 5. Submit weekly local influenza activity reports to MOHLTC and share with internal staff (CD, MOH etc.) on community and institutional flu activity (Appendix C). 6. Submit preliminary (Appendix D) and final (Appendix E) reports of all institutional respiratory outbreaks to MOHLTC within required time frames. 7. Communicate the location and status of institutional respiratory outbreaks to ICP's, EMS, other parties via password protected website ("CD Surv"). 8. Track staff influenza immunization rates (LTCH and hospitals) and submit to MOHLTC. 9. Disseminate information on influenza activity to CD team. 10. Continue to monitor the QUESST (Hospital Emergency Room Syndromic Surveillance)
	Maintain vigilance in FRI screening	1. Receive and investigate all positive FRI screens with a travel link and clusters of FRI from institutional settings in SM. Input into iPHIS as directed by the MOHLTC. 2. Educate SMDHU CD Team staff re: FRI best practice guidelines. 3. Review the effectiveness of FRI screening tool at acute care facilities in SMDHU jurisdiction. 4. Improve communication re: FRI surveillance with non-acute care facilities i.e. physicians, CCAC, walk-in clinics, EMS, LTCH.
	Liaise with hospitals and LTC homes on FRI surveillance	1. Establish liaisons with all LTC homes, acute care facilities and corrections in SMDHU jurisdiction. 2. Provide training/direction to LTC on FRI surveillance (e.g. LTCH annual workshop). 3. Assist with training/direction to hospitals on FRI surveillance. 4. Assist with review or development of policy and procedures for FRI surveillance in all health care settings.

Phase 1 *No animal influenza virus circulating among animals has been reported to cause infection in humans.*	Other Activities	1. Establish contacts at sentinel schools for surveillance of absenteeism during flu season and pre-pandemic period, develop and evaluate process and feedback mechanisms. Work with school liaisons, school PHNs and school CD representative 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 site data including schools as directed by the MOHLTC. 5. Determine minimum dataset; develop surveillance protocols, data collection and analysis methodology using MOHLTC tools. Explore the use of local and provincial 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 novel 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. 14. Link to community physicians, walk-in clinics, hospital emergency rooms and EMS to re-emphasize the surveillance protocols.
PHASE 2		
	Continues with all Phase 1 activities	
	Disseminate alerts	1. Review current information technology and information management support for tracking patients, contacts, antiviral distribution.

Phase 2 *An animal influenza virus circulating among domesticated or wild animals is known to have caused infection in humans and is therefore considered a potential pandemic threat.*		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 (e.g. links to Important Health Notices).
	Other	1. Establish baseline rates for deaths and hospitalizations due to seasonal influenza. 2. Establish incidence rates of seasonal influenza. 3. Health unit to investigate and track reports from clinicians re: suspect human case of infection with an animal strain of influenza or with any other novel human influenza strain - coordinate with CFIA/OMAFRA. 4. Create additional databases, as required.
PHASE 3		
Phase 3 *An animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks.*	Continue with all Phase 2 activities	
	Share surveillance information with stakeholders	1. Prioritize ongoing and activate additional surveillance activities (e.g. 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 via SMIPACN or HCP teleconference. 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 HealthFaxes and Situational Updates 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 internal 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. 2. Implement FRI with travel history screening, since human infection with novel influenza virus has occurred; FRI screening facilitates detection of novel influenza in Ontario.

	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, using MOHLTC and PHAC guidelines, as needed. 2. Investigate and report additional data elements (e.g. exposure information) should cases infected with novel influenza be identified in Ontario. 3. Identify surveillance/information needs for next phase.
	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.
PHASE 4		
Phase 4 *Human-to-human transmission of an animal or human-animal influenza reassortant virus able to cause "community-level outbreaks" has been verified.*	Continue with all Phase 3 activities	
	Identify surveillance/information needs should pandemic progress to next phase	1. Implement any new/updated FRI/SRI/ILI surveillance tools. 2. Implement active surveillance by contacting active surveillance stakeholders/partners (hospitals, infection control professionals (ICP), general practitioners, labs, schools, coroners, etc.) Further stakeholders may be added per Ministry guidelines. 3. May recruit additional local sentinel physicians. Ensure localities represent all areas of Simcoe Muskoka. 4. Enhance surveillance of worldwide situation. Assign CD staff member to alternate hours of work to accomplish real time web surveillance that is sent to the Director of Clinical Service for All staff intranet blog communiqué.
	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 and update SMDHU internet site. 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 or sporadic severe cases and admitted cases to MOH as needed. 2. Initiate automated, aggregate influenza situation reports and post to Intranet on weekly basis.
PHASE 5		
Phase 5	Continue with all Phase 4 activities	
	Increase current surveillance activities	1. CDSU hospital liaisons attend hospital infection control meetings to discuss surveillance requirements and outcomes. Set up health care providers teleconference with MOH and CDSU when local cases are identified. 2. Implement fluQandA@smdhu.org for health care providers.

Phase 5 *The same identified virus has caused sustained community level outbreaks in two or more countries in one WHO region.*		3. 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). 4. Disseminate influenza situation information/alerts to general public on daily basis (International/North American/Canadian stats) by the SMDHU internet website. 5. Begin holding regular surveillance meetings with surveillance/data management/reporting group. Membership, frequency of meetings to be determined – see Phase Three activities. 6. Ensure surveillance working group lead participates in decision making process led by MOH and involving designates from all service areas. 7. Increase frequency of monitoring the QUESST (Hospital Emergency Room Syndromic Surveillance). 8. If necessary based on QUESST and other data, communicate with partner agencies to alert them that surge capacity for health care provision may be appropriate.
	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 influenza strains are found in animals in Ontario.
	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. 2. Assign additional CD on-call staff as needed for 24 hour response; maintain business continuity plan.
PANDEMIC PERIOD PHASE 6		
Pandemic Period: Phase 6	Continue with 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	1 As outlined in Phase 1 to 3 activities. 2 Maintain FRI with travel history screening to detect entry of cases infected with

Pandemic Period: Phase 6 *In addition to the criteria defined in Phase 5, the same virus has caused sustained community level outbreaks in at least one other country in another WHO region.*	in Canada	pandemic strain.
	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. 2. 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 province.
	Participate in special studies and establish dedicated teams to activate the studies in collaboration with other public health authorities	1. Participate in special studies. i.e. OAHPP Agency Scientific Review Team.
	Implement laboratory testing protocol	1. Implement changes to revised lab protocols. Ensure changes are communicated to testing sites, i.e. physicians, hospitals, ambulatory care.
	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, LTCH) 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, as directed by Disease Control and Surveillance lead. 2. Ensure current surveillance requirements are communicated to health care providers.
	Disseminate pandemic alerts	1. Disseminate pandemic alerts via the SMDHU website; HealthFax and email.
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, databases, and reporting mechanisms. 2. Surveillance representative to attend regional/provincial teleconferences and report back to local surveillance group and IMS as needed.
	Disseminate epidemiological summaries to characterize outbreaks and impacts	1. Repeat data collection and analysis steps above and implement changes/improvements.

Pandemic Period: Phase 6 *Regional and mulit-regional epidemics*	Continue to provide timely data and analysis	1. Ensure only aggregate data entry into iPHIS at this time upon direction from the MOHLTC. 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. In conjunction with the MOHLTC and PHAC monitor vaccine efficacy, adverse reactions and coverage, once vaccine(s) available.
	Hospitals, long-term care homes and retirement homes with more than 10 beds report aggregate respiratory infection outbreak information using ministry's web-based surveillance system	1. Support partners as needed with reporting.
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. 2. Communicate changes to surveillance expectations to health care providers as needed.
	Review/adopt case definition, evaluate the current epidemiology and decreasing levels of activity in local jurisdiction	1. Communicate testing protocol changes to health care providers as needed.
	Continue to implement laboratory testing protocol	1. Communicate to health care providers.
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

II - 2 VACCINE AND ANTIVIRALS

INTRODUCTION

Influenza vaccination is a primary means of preventing disease and death from influenza.[13] In a pandemic influenza situation however, vaccine will not be available four to six months after the pandemic strain has been identified – this may not occur until Pandemic Phase 5 or 6.

Until a vaccine is available, antivirals will be useful 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 as described in the provincial plan 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.

During a pandemic, the MOHLTC will determine the distribution of vaccine to vaccine delivery agents. During the early stages of pH1N1 2010, the MOHLTC directed that only HUs would have access to vaccine. The limited capacity of local Hus to be the main keepers of vaccine as well as a 10 year history of successful UIIP programs, resulted in the MOHLTC broadening access to pH1N1 vaccine to all those HCPs who met pre-qualification criteria to store and handle vaccine

Ontario will use primarily a “Pull” strategy to ensure best use of available resources: influenza vaccine will be sent only to public health units, which will organize mass immunization clinics in various locations in their communities (Ontario Health Plan for an Influenza Pandemic, August 2008, p. 9 – 4).

In the early stages of a pandemic, while supply of vaccine is still limited, the Public Health Agency of Canada (PHAC), the MOHLTC, as well as the local MOH will determine and interpret sequencing groups for vaccine eligibility. 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.

Objectives

The vaccine and antiviral objectives are:

- To assist in the storage, allocation, distribution and dispensing of our jurisdictions’ supply of antiviral medications according to criteria set by PHAC and MOHLTC and MOH determination and interpretation of local needs.
- To ensure that safe, effective vaccine programs are available as quickly as possible.
- To ensure that vaccines are allocated, distributed and administered efficiently and appropriately.
- To monitor the safety and effectiveness of vaccination programs.

Phase 1 From WHO	Local Level Objectives From OHPIP	Public Health Unit Vaccine & Antiviral Activities
PHASE 1		
Phase 1 *No animal influenza virus circulating among animals has been reported to cause infection 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 approximately 45 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 (LTCH) 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 provides clinics for health unit staff. Health Unit policy B3.221 provides the parameters and expectations related to staff influenza immunizations. Supportive health unit policy encourages staff to be immunized. 3. 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). 4. Updating 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. 5. Medical directive for pandemic flu vaccine can be updated on an as needed basis. 6. Work with pharmacies and workplaces to promote UIIP and pandemic immunization. 7. Annual promotion with work places to promote annual UIIP (FP). 8. Participate in the Great Flu Challenge to promote influenza immunization amongst HCP.
	Increase annual influenza vaccine coverage rates among health care workers and emergency services workers	1. Statistics are collected and available from the CDSU team. 2. Promote influenza vaccine for HCP (Great Flu Challenge) and essential workers (work with paramedics to offer clinics where possible).
	Maintain up-to-date plans to acquire, store and distribute vaccine and antivirals	1. 3 large double door and 2 large three door vaccine 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 the capacity for 170 000 doses on any given day. This will serve about 1/3 the population of Simcoe Muskoka. Generators are in place in the Gravenhurst (GH) and Barrie offices. 2. Gravenhurst has a double door vaccine fridge with a capacity for 34, 000 doses of flu vaccine. All other outer office locations have single door Revco fridges: Cookstown, Collingwood, Midland, Orillia, and Huntsville: capacity of each of those fridges is 17,000 doses, leaving a small amount for routine childhood vaccines. These offices all have battery packs that will maintain the fridge's temp between 2 and 8 degrees C for 1.5 hours in the event of a power outage.

	Maintain up-to-date plans to acquire, store and distribute vaccine and antivirals	3. As of June 2009, the direction the MOHLTC is that antivirals are to be used for treatment only. Public health will not be involved in the storage, handling or distribution of antivirals. 4. 4. Ensure all office have generator backup for greater vaccine security.
Phase 1 *No animal influenza virus circulating among animals has been reported to cause infection in humans*	Work with stakeholders (e.g. professional organizations, labour associations) to develop plans to redeploy staff to administer vaccine and to provide training	1. Agreement in place with ONA re flexible work hours and change in assignment. Need to develop agency policy to clarify staff expectations re availability for clinics: day and evening. 2. Informal agreement in place with Georgian College for public clinic to be held in partnership with 2 HU staff, faculty and students on campus sites. 3. Paramedics do provide some immunization clinics to first responders and vulnerable populations. Annual review of a capacity to continue with this strategy. Agency has no plan to use of volunteers or to contract out to other volunteer agencies. 4. Need to explore access to staff for vaccination from community nursing agencies; dentists will be done on an as needed basis. 5. Annual review and updating of Orientation/Training Manual (from UIIP training manual). All agency nurses to maintain skills through participation in annual UIIP every third year.
	Maintain antiviral treatment and prophylaxis guidelines 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) 1. Develop key resources for antiviral e.g. types, who will have access (FP) Treatment focus. 2. Develop staff training tools for storing distribution and/ or administration of antivirals.
PHASE 2		
Phase 2 *An animal influenza virus circulating among domesticated or wild animals is known to have caused infection in humans and is therefore considered a potential pandemic threat.*	Continues with all Phase 1 activities	
	Distribute priority group enumeration tools to health care organizations to provide estimates of demand for antivirals	
	Submit estimates to MOHLTC	

PHASE 3		
Phase 3 *An animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks.*	Continue with all Phase 1 activities	1. Draft to as complete as possible all documents to support clinics e.g. Aftercare sheets, Vaccine and Antiviral information sheets. 2. Review and update educational materials.
	Confirm that security issues associated with storing and distributing vaccine has been addressed	1. Review the security requirements for the agency for: • storage at Health Unit offices • storage at Health Unit clinics. 2. Check with data team re: data needs for vaccine. 3. Confirm with MOHLTC re: AEFI and iPHIS.
PHASE 4		
Phase 4 *Human-to-human transmission of an animal or human-animal influenza reassortant virus able to cause "community-level outbreaks" has been verified.*	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. Update Memorandum of Understanding (MOU) with facilities operated by municipal county and city contacts and schools re having access to their facilities. 3. Update 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.
PHASE 4		
Phase 4	Ensure list of currently qualified vaccinators and potential vaccinators is up to date	1. Provide to Business Continuity Plan (BCP). Ensure all potential immunizers have current CPR. 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 2. Update list of currently qualified immunizers. 3. Review need to expand access to other HCP for immunization role.

Phase 4 *Human-to-human transmission of an animal or human-animal influenza reassortant virus able to cause "community-level outbreaks" has been verified.*	Review mass vaccination program	See Appendix A – Mass Immunization Plan
	Address any issues that may impede rollout of a mass immunization program	1. Redeploy manager and/or supervisor and ad hoc staff to initiate supply inventory and ordering process 2. Stat Sheet/Replenish List to be created for clinics.
	Review/update (if necessary) educational materials on administering vaccines	1. Annual update of UIIP training manual and medical directive training. 2. Annual update of VPD guidebook. 3. List of emergency contact numbers relevant to each clinic location will be available. Included will be information on closest door for ambulance and any other relevant information. 4. Review and update policies and forms for use in clinics: incident reports, medication error, health and safety reports needle stick injury report.
	Confirm plans for distributing antivirals	1. As of the August 2008 revision to the OHPIP Health Units are not involved in the distribution of antivirals.
PHASE 5		
Phase 5 *The same identified virus has caused sustained community level outbreaks in two or more countries in one WHO region.*	Review and, if necessary, modify plans for storing, allocating, distributing and administering vaccine	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	1. Annual training for staff on documentation tools. 2. Ongoing use of data base for all immunizations clinics to maintain skill in data base use. 3. Continue to explore options of staff working from home with access to resources/training/schedules and clinic sites.

	antivirals for treatment or prophylaxis	
	Work with health organizations to train non-traditional vaccinators	1. Explore on an as needed basis the need to use of EMS, Veterinarians, and Dentists. Medical directive would need to be updated to include these other non traditional vaccinators.
PANDEMIC PERIOD PHASE 6		
Pandemic Period: Phase 6 *In addition to the criteria defined in Phase 5, the same virus has caused sustained community level outbreaks in at least one other country in another WHO region.*	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. 2. Notify all VDA of vaccine availability, qualification requirements and distribution procedures. See list of current locations for UIIP clinics Clinic Schedules Flu Clinic Bin Contents
	Apply national target groups and guidelines as directed by the province	1. Implement as directed. Link with communication re target groups.
	Epidemiology	1. Update priority groups as per direction from the MOHLTC. 2. Review and revise resources as necessary re: Antiviral Fact Sheet FAQ.
	If antivirals are being used, implement adverse drug reaction reporting system	1. Entered on iPHIS.
	When vaccine is available: • Activate mass vaccination clinics • Activate plans to supply vaccine to participating VDA • Implement distribution and security plans • Implement streamlined VAAE surveillance, in collaboration with PHAC	1. Vaccinate all SMDHU staff. 2. Confirm mass immunization sites. 3. Obtain individual building/area maps for clinic design Implement Clinic/Client Operational Flow Chart. See Appendix A - Mass Immunization Plan.
	Communicate with bordering jurisdictions about vaccine distribution plans and coordinate efforts as much as possible	1. Communicate through VPD network via HealthFax, web, teleconference – refer to Communication Framework.

Period: Phase 6		
	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 CEMS 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 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. Need an agency policy to provide parameters and clarification regarding staff expectations of shifts to be worked including evening availability. An effective computer scheduling program and several administrative support persons are needed to support the scheduling of staff. Access to scheduling from home would be an asset.
	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 Vaccine Associated	1. Continue to implement the Mass Immunization Plan and vaccination by Vaccine Delivery Agent (VDA).

Pandemic Period: Phase 6 *End of first wave; pandemic subsiding*	Adverse Event (VAAE) data • continue ongoing VAAE surveillance • restock supplies and resume routine programs	
	Review/revise guidelines and/or protocols used during the mass vaccination campaigns	1. As needed.
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	

APPENDICES

APPENDIX A - II - 2: MASS IMMUNIZATION PLAN

APPENDIX B - II - 2: MASS INFLUENZA IMMUNIZATION CLINICS LINE MANAGMENT PROTOCOL

APPENDIX C - II - 2: ASSESSMENT CRITERIA FOR MASS IMMUNIZATION CLINICS

APPENDIX D - II - 2: POTENTIAL MASS IMMUNIZATION CLINICS

II - 3 PUBLIC HEALTH MEASURES

INTRODUCTION

The August 2008 OHPIP contains the following information from Public Health Measures and Factors to Consider when Choosing Public Health Measures.[14]

1. 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
- social distancing measures which may include, restricting public gatherings and closing schools.

2. 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

3. Authority to Use Public Health Measures:

- The Health Protection and Promotion Act provides the local Medical Officer of Health (MOH) the authority to implement public health measures within his or her jurisdiction
- Under the Immunization of School Pupils Act, the local MOH has the authority to issues orders respecting students in a school
- With a pandemic, the threat will not be limited to Simcoe Muskoka and the decisions to implement certain public health measures will be made by the Chief Medical Officer of Health in consultation with local MOH's.

4. Effectiveness of Public Health Measures:

The US Centers for Disease Control in its 2007 report, *Interim Pre-pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States – Early, Targeted, Layered Use of Nonpharmaceutical Interventions*, has analyzed the effectiveness of different public health measures in reducing the spread of an illness like pandemic influenza. According to that analysis, case and contact management are only partially effective because people are infectious before they develop symptoms and not all contacts will be identified before they develop symptoms.

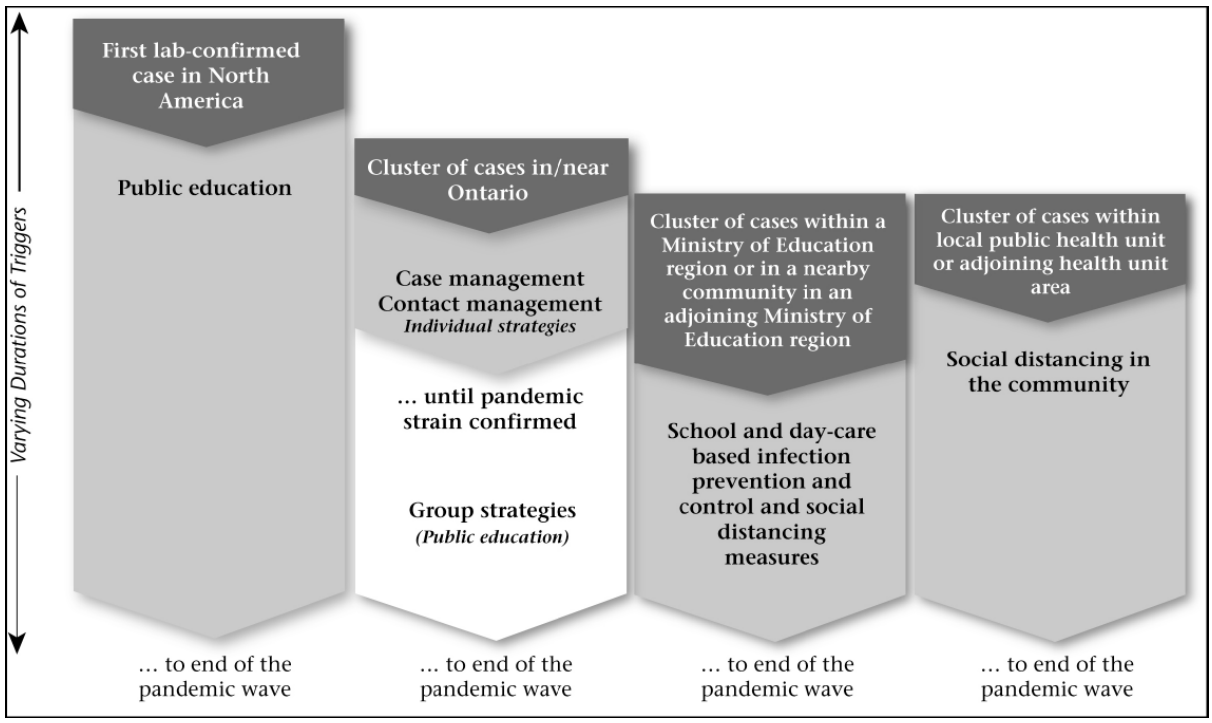
The most effective measures are:

- hand hygiene
- social distancing strategies in daycare. A recent study found that children (ages 25 to 36 months) in group care with six or more children were 2.2 times as likely to have an upper respiratory tract illness as children reared at home or in small group care (< six children).
- school closures – particularly when combined with additional measures that disrupt young people's other social networks, such as meeting at the mall. (For example, a nation-wide school closure in Israel during an influenza pandemic resulted in significant decreases – 42% – in diagnoses of respiratory infections.)
- low cost, sustainable social distancing strategies that disrupt adult networks and suppress the spread of the virus i.e. travel restrictions that close large hub airports (as opposed to smaller airports). (from OHPIP August 2008, pages 6-5 – 6-6)

The type of public health measures used during an influenza pandemic and their timing will depend on:

- the epidemiology of the strain (e.g. pathogenicity, models of transmission, incubation period, attack rate in different age groups, period of communicability, susceptibility to antivirals).
- timing of the measure, i.e. for case and contact management to be most effective, aggressive follow-up in the alert phases is more effective.
- public compliance of the measure, past experience indicate the public generally comply with personal protective measures at the beginning. Keeping the public interest as the pandemic spreads with time will be an important consideration.

5. The following Pandemic Phases and Public Health Measures Activities have been developed from the OHPIP Chapter 6, August 2008.



PUBLIC HEALTH MEASURES DEFINITIONS, ACTIVITIES AND TIMEFRAMES

The OHPIP 2008, Chapter #6 defines six public health measures that may be used to slow the spread of pandemic influenza. It also describes the types of activities that can be used to implement each measure.

1. Public Education – defined as:
Clear, consistent, accurate information given to the public to help them be prepared for a pandemic and reduce their risk.

Public education should begin as early as possible in the pandemic (i.e. in Phase 4) and continue throughout a pandemic.

Recommended Strategies
Public education includes providing information about influenza and how it spreads, as well as information about:

i. Individual infection prevention and control measures, including education about:
- hand hygiene, respiratory/cough etiquette, including covering one's mouth when coughing or sneezing and proper tissue disposal, and other personal protective measures to avoid droplet/contact spread
- the importance of fresh air and how to increase air circulation in buildings
- the wearing of masks by the public or people who do not have influenza. This practice is not recommended at this time because it has not been proven effective in stopping or slowing the spread of influenza; however if individuals choose to wear masks, they should:
  - wear a surgical mask
  - learn the proper procedures for putting masks on and taking them off (to avoid contact with droplets)
  - know how to dispose of the mask properly (i.e. without increasing the risk of infection)
  - know that a mask or any other personal protective equipment is not a substitute for hand hygiene
- how to clean and disinfect environmental surfaces to avoid droplet/contact spread.

ii. Social distancing, including messages advising people:
- to stay home from day-care, school, work and public events if they have influenza-like-illness (ILI) symptoms or have had contact with someone with ILI
- to avoid large gatherings or crowds
- to reduce non-essential travel
- when and how to get information on any closures, cancellations or changes to community services/events
- about emergency preparedness supplies they should have in their homes (e.g. food, water)

iii. Influenza care, including information about:
- how to access health care advice/triage services (e.g. Telehealth, internet sites)
- where and how to seek medical care in a way that minimizes exposure to influenza (e.g. go to your family physician for other health services, go to flu centres if you have influenza symptoms)
- SMDHU fact sheets on self care and how to care for others who are ill at home were updated in 2009.
  SMDHU development during 2009 has included:
- updated tools regarding hand hygiene and respiratory etiquette such as posters, FAQ's, fact sheets, other promotional materials are available on the SMDHU web site
- postings to the website may include:
  - handwashing and tips for staying healthy
  - managing HINI in the home

- linkages to other sites with messaging regarding these topics.

2. Travel Restrictions

Restricting people from traveling between countries in order to slow the spread of influenza.

Note: Travel restrictions are the responsibility of the Public Health Agency of Canada (PHAC), and Ontario will comply with federal directions.

i. Foreign travel advisories

The PHAC website (http://www.phac-aspc.gc.ca) provides Travel Health Advisories about the occurrence of communicable diseases around the world and recommends measures to reduce risk. For example, on June 1, 2007, the website advised travelers going to any of 13 countries that have had confirmed cases of H5N1 (avian influenza) to avoid contact with domestic poultry and wild birds, to ensure all poultry dishes are thoroughly cooked and to practice proper hand hygiene.

ii. Voluntary foreign travel restrictions

In the event of a pandemic, PHAC could either ask people to consider deferring unnecessary travel or recommend that people defer unnecessary travel (depending on the severity of pandemic).

iii. Closing borders

During a pandemic, PHAC could close the borders, restricting people who have symptoms of ILI, have had contact with someone who has ILI or who is from an area where there is pandemic activity from entering the country.

iv. Reducing transit use

During a severe pandemic, public health officials could recommend strategies to reduce the number of people traveling by transit at one time (i.e. staggering work hours, controlling the number of individuals permitted on streetcars and subway cars).

3. Case Management

Case management involves public health nurses and inspectors OR public health staff following up with individuals ill with influenza (i.e. cases) to provide information and strategies to reduce transmission to other people.

i. Voluntary isolation

Cases (i.e. people with ILI) are asked to isolate themselves and avoid contact with others, usually for up to 5 days after symptoms develop (7 days for children, who are infectious longer) – although the time will be determined by the epidemiology of the pandemic strain. While isolated, the person should practice good hand hygiene and cough etiquette (i.e. frequent, thorough hand hygiene; cover their mouth when coughing or sneezing); stay two metres* away from others (i.e. social distancing); and wear a surgical mask when out in public.

People with influenza could be isolated at home or in a hospital, depending on the severity of their illness and hospital capacity.

ii. Self Care

Cases (people with ILI) and their families are given clear, concise information about:

- how to care for someone with influenza at home
- when and where to seek medical attention.

iii. Antivirals

Health care providers have access to the provincial stockpile of antivirals to provide their patients with pandemic influenza or influenza symptoms receive antivirals, know how to take them, and adhere to treatment. Antivirals are accessible from both acute care and private pharmacies.

iv. Public health follow-up

Case management could also include:

- ***Individual*** monitoring of people with ILI (e.g. daily phone calls, visits) to ensure they are complying with voluntary isolation, care and treatment, gathering information on their contacts, and notifying the contacts
- ***Group*** education by providing ongoing public information and messages for people in voluntary isolation
- **Failure to comply with isolation recommendations, particularly in the instance of a severe pandemic may result in the medical officer of health exercising his/her legislative authority to order an individual to take certain actions to protect and limit the spread of illness.**

Timeframes

Because case management is highly labour intensive, public health units will likely only be able to use the traditional individual or one-to-one approach **in the pandemic alert period and early in the pandemic period**, when there are a relatively small number of cases and there is an opportunity to contain the virus. The main purpose will be to confirm the presence of the pandemic strain. After that time, public health units may use a group/public education approach to reinforce the importance of isolation, self-care, and compliance with treatment. Individual case reports at this time may not be practical or possible. Individual investigations may be focused to severe cases, requiring hospitalizing.

4. Contact Management

Contact management is a highly labour intensive process of individually contacting anyone who has had close contact (i.e. within two metres) with someone with influenza during the time the person was infectious. Contacts are notified and advised to take steps to protect their health and the health of others.

i. Education

Public health nurses and inspectors OR public health staff advise contacts about symptoms to watch for and what to do if they become ill.

ii. Voluntary and modified quarantine

Depending on the severity of the virus, usually only in severe pandemics, close contacts of cases (people with ILI) who are otherwise healthy may be asked to quarantine themselves at home and avoid contact with other people until the incubation period is over (usually three days but time will be determined based on the pandemic strain). People who are symptom-free may be asked to maintain a modified quarantine, that is: they can leave the home to obtain essential supplies (e.g. food for the family) but not to go to work or engage in social activities. This type of modified quarantine allows families to continue to function, while reducing the risk of exposing others.

iii. Public health follow-up

Follow-up with contacts can occur in two ways:

- ***Individual*** monitoring of contacts to ensure they are complying with voluntary quarantine, noting if they develop symptoms (i.e. become cases), directing them to care if they develop symptoms and notifying their contacts
- ***Group*** education by providing ongoing public information and messages to people in voluntary modified quarantine.
- **Failure to comply with isolation recommendations, particularly in the instance of a severe pandemic may result in the medical officer of health exercising his legislative authority to order an individual to take certain actions to protect and limit the spread of illness.** See Appendx B – II – 3: Preparing and Serving a HPPA Section 22 Order and Appendix C – II – 3: Sample Orders – Individual and Class.

Because contact management is highly labour intensive, public health units will likely only be able to provide individual contact management **in the pandemic alert period and early in the pandemic period**, when there are a relatively small number of cases and there is an opportunity to contain the virus. The main purpose will be to confirm the spread of the pandemic strain. After that time, public health units will rely more on public education messages to reinforce the importance of being aware of symptoms, seeking care, and voluntary or modified quarantine for people who have been exposed to someone with influenza. However, it is imperative that CD staff remain exclusively available to investigate unique cases and assist in outbreak control throughout the pandemic.

5. School and day-care based infection prevention and control and social distancing measures

School and day-care-based measures are steps designed to reduce the number of contacts that children have in schools and day care centres. They are important because schools are dense social environments and children without preexisting immunity to influenza viruses are more susceptible than adults to infection. Children also shed more virus for a longer period of time, which makes them more infectious, and they are less likely to practice hand hygiene. Compared to adults, children are responsible for more secondary household transmission (CDC, 2007).

Local plans to be updated in consultation with local boards and posted to website as required. See Appendix D – II – 3: pHINI School Board Recommendations as an example.

i. Infection prevention and control measures

Everyone in school and daycare settings is encouraged to adopt infection prevention and control measures including:

- washing hands frequently and meticulously
- practicing respiratory hygiene/cough etiquette, including covering one's mouth when coughing or sneezing and proper tissue disposal
- cleaning and disinfecting environmental surfaces (e.g. door handles, lunchroom tables, desks, etc.)
- increasing fresh air in buildings (i.e. open windows)
- asking parents to keep children who are sick at home.

ii. Social distancing

Public health can request changes in the school environment or school practices that reduce contacts between children by limiting the number of children in a given area and keeping children further apart, such as:

- space students 2 metres (6 ft) apart
- suspending interschool sports activities
- avoiding social mixing of different groups of children (e.g. school dances)
- reducing large gatherings within the school setting (e.g. cancelling assemblies, having students eat lunch in class rooms, staggering recesses or lunches if possible, cancelling school trips)
- reducing the number of children allowed in a given area at a given time
- suspending non-essential after school activities (e.g. clubs, sports).

iii. School/day care closures

The public health unit can issue orders to temporarily close day cares, elementary schools and high schools. Any decision to close schools would be discussed with the affected school boards.

Infection prevention and control and social distancing measures in schools and daycares would be implemented **early in the pandemic and be maintained throughout a pandemic**. School closures, if required, would also have to be implemented **early in a pandemic** to be effective (see below), and would be maintained for between four and 12 weeks, depending on the severity of the pandemic. See Appendix E – II – 3: Child Care Settings Guidance for example of guidance to Day Care Providers.

6. Social distancing in the community

Social distancing measures are designed to reduce the number of close contact encounters that adults have in the community – including the workplace and the post secondary education system.

i. **Workplace infection prevention and control for non health care settings**
Public health provides information and education that helps non-health care workplaces implement infection prevention and control measures including:
- installing hand sanitizer stations in all workplaces and post secondary institutions
- encouraging employees to wash their hands frequently and meticulously and practice respiratory hygiene/cough etiquette, including covering their mouth when coughing or sneezing and proper tissue disposal
- cleaning and disinfecting environmental surfaces
- increasing fresh air in buildings (i.e. open windows)
- asking employees to stay home from work and social engagements when sick.

ii. **Social distancing**
Public health can ask workplaces and post secondary institutions to make changes to their environments and practices that reduce contacts between adults, such as:
- spacing employees/students two metres (6 ft.) apart
- allowing employees/students to use computer technology to work/study from home
- limiting the number of people in a work/study setting at any given time
- conducting meetings/academic lecturers via television, radio, mail, Internet, teleconference or videoconference instead of face-to-face
- staggering employee working hours and academic lectures to reduce the number of people on the transit system at the same time
- establishing liberal absence/sick leave policies so workers who are ill or have ill family members can remain away from work until symptoms in the household have resolved
- cohorting students in dormitories, in order to keep student with influenza separate from other students.

iii. **Restricting public gatherings**
- Public health can issue orders restricting or discouraging social and other large gatherings – particularly those held indoors, including:
  - sporting events
  - faith based ceremonies
  - dances and other social activities.

Depending on the severity of the pandemic, social distancing measures are implemented **early in the pandemic and maintained through the pandemic**.

Public Health Measures implementation will be based on severity of the pandemic strain based on surveillance data collected at all levels. In the 2008 OHPIP the following chart was inserted to assist in planning:

PUBLIC HEALTH MEASURES BY PANDEMIC SEVERITY

Public Health Measure	Severity of the Pandemic		
	Mild	**Moderate**	**Severe**
Public Education	1. Reinforce general infection prevention and control practices 2. Where to get information on self-care	PLUS 3. Provide messages re: social distancing	PLUS 4. Provide message re: masks for people who do not have flu – not recommended, but if individuals choose to use them, they should use surgical masks
Travel Restrictions	Business as usual: 1. Refer travelers to PHAC website for Travel Health Notices and International Reports	1. Consider deferring unnecessary travel 2. Consider measures to reduce the number of people on transit vehicles at any one time in the affected area	1. Recommend deferring unnecessary travel 2. Recommend measures to reduce the number of people on transit vehicles at any one time in the affected area
Case Management	1. Voluntary isolation 2. Self-care 3. Antivirals 4. Public Health Follow-up – individual (one-to-one) as long as necessary to confirm the pandemic strain, then switching to group management strategies		
Contact Management	1. Reinforce public education messages and provide information on where to go for care	1. Consider voluntary modified quarantine 2. Public health follow-up – using group strategies	1. Recommend voluntary modified quarantine – if indicated by severity of the pandemic
School and Day Care Measures	Business as usual 1. Reinforce infection prevention and control measures within the affected Ministry of Education region	2. Consider social distancing (e.g., limit sizes of groups and activities in schools) within the affected Ministry of Education region 3. Consider closing day cares, elementary schools and secondary schools within the affected Ministry of Education region for < 4 weeks*	2. Recommend closing day cares, elementary schools and secondary schools within the affected Ministry of Education region for < 12 weeks*
Social Distancing in the Community	Business as usual 1. Reinforce public education/infection prevention and control measures within affected areas	2. Consider implementing social distancing measures in post-secondary institutions, workplaces and community in affected areas (e.g., distance between desks, flex hours, meeting via video or teleconferencing, working at home) 3. Recommend that people avoid indoor public gatherings	2. Recommend implementing social distancing measures in post-secondary institutions, workplaces and community in affected areas (e.g., distance between desks, flex hours, meeting via video or teleconferencing, working at home) 3. Restrict all public gatherings

As the province further develops resources and guidance documents, this portion will be updated and modified to reflect the current recommendations and best practice.

Other supportive documents for businesses, faith groups, employers, first responders, etc, may be found at: http://www.health.gov.on.ca/en/public/programs/emu/pan_flu/

APPENDICES

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. To ensure 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**
PHASE 1		
Phase 1 *No animal influenza virus circulating among animals has been reported to cause infection in humans*	Develop pandemic emergency response plan & Business Continuity plan	**Internal** 1. Establish internal pandemic planning committee to develop and maintain Agency Influenza Pandemic Response Plan: Pandemic Influenza Plan Review Group (PIPRG), chair: Clinical Services Director. 2. Appoint a Pandemic Influenza Planner (PIP) to oversee and coordinate pandemic planning and write overall plan. 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. 8. Link with key stakeholders to ensure responsibilities outlined within plan are coordinated with other response agencies (PIPRG). 9. Develop pandemic specific support plans, as required (PIPRG). **External** 1. Establish Health Sector Emergency Planning Committee (SMHSEPC) as per recommendation by Ministry of Health & Long Term Care to assist in the development of the plan (County/District/MOH). 2. Develop and maintain a coordinated, inter-agency pandemic influenza plan for the health sector of Simcoe County and the District of Muskoka (PIPRG/County /District/Health Sector Planners). 3. Establish working group to assist with planning and identify opportunities to coordinate response. 4. Ensure key stakeholders within the plan understand their identified roles (PIPRG /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. 8. Develop support plans, as required (Death Surge Plan, Assessment Centre Plan, Vulnerable Population Plan, Crisis Communication Plan).
Phase 1 *No animal influenza virus circulating among animals has been reported to cause infection in humans*	Conduct simulation exercises to test pandemic plans	**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 participant 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. Conduct exercise. 13. Conduct “hot wash”. 14. Site selection. 15. Conduct formal debriefings and evaluate exercise and plans. 16. Evaluate exercise/existing plans. 17. Communicate findings. 18. Modify plans. SMHSEPC Pandemic Simulation exercise was held in November, 2006 **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). 3. Consider involvement of Key Response Partners. 4. Review previously conducted simulation exercises and findings. 5. Determine exercise format and develop Exercise.

Phase 1 *No animal influenza virus circulating among animals has been reported to cause infection in humans*	Conduct simulation exercises to test emergency response plans during a pandemic	6. Communicate invitation to participate to staff and identified key responders. 7. Conduct Exercise. 8. Conduct debriefing. 9. Evaluate exercise and plan. 10. Modify Plan. SMDHU Pandemic Simulation exercise was held in September 2006
Phase 1 *No animal influenza virus circulating among animals has been reported to cause infection 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). 2. Provide Orientation to PIPRG 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. Adopt 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). 6. Determine if IMS system is being adopted by the province and the Ministry of Health (HPS, EMP). 7. Contact other health units to determine if this model is being used (HPS–EMP). 8. Develop a proposed IMS Response Framework (HPS, EMP). 9. Review IMS with Executive to determine if agency wants to adopt similar model (HPS – ER Manager/EMP). 10. Develop an orientation and implementation plan (HPS -EMP) – See Orientation and Training Framework. 11. Integrate the IMS structure into the general agency's emergency response plan/framework (HPS, EMP). 12. Receive Plan Approval from Executive (HPS, EMP). 13. Train staff on IMS structure (completed 2009 - 2010). 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). 2. Ensure that Health Unit response restructure and emergency notification systems are compatible with other health sector agency plans (HPS). 3. Ensure that emergency response structure and notification systems are compatible with the Ministry of Health and provincial reporting protocols (HPS, EMP).

Phase 1 *No animal influenza virus circulating among animals has been reported to cause infection in humans*	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.
Phase 1 *No animal influenza virus circulating among animals has been reported to cause infection 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, CS VPD Team). (Information obtained from enumeration tools is for emergency service providers only Police, Fire, LTCHs, 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). 2. Calculate more specific impacts using CDC's FluAid 2.0 and FluSurge 2.0 software program (HPS, EMP) 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).
Phase 1 *No animal influenza virus circulating among animals has been reported to cause infection 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). 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). 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. 12. Develop strategies for support (support and referral services, how to communicate to vulnerable population, public educations and awareness campaigns to educate). 13. Coordinate 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).

PHASE 2		
Phase 2 *An animal influenza virus circulating among domesticated or wild animals is known to have caused infection in humans and is therefore considered a potential pandemic threat.*	Distribute priority group enumeration tools to organizations responsible for essential community services	1. Obtain relevant mail-out information from Outlook contact directory (CS PIP Planner) 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).
	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). 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).
PHASE 3		
	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) • HealthFaxes/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.

Phase 3 *An animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks.*	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 B 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) (CS, 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/HealthFax 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 HU's (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).
PHASE 4		
	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 (the results of the pH1N1 outbreak evaluation were not a simulation, but are applicable). 3. Make recommendations for plan revision based on exercise findings (HPS, EMP, CS, PIP).
	Update all staff about an influenza pandemic	1. Orient 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. PIPRG to provide staff orientation on Pandemic Planning.

Phase 4 *Human-to-human transmission of an animal or human-animal influenza reassortant virus able to cause "community-level outbreaks" has been verified.*	Update all staff about an influenza pandemic	4. CS to assist with transfer of information related to disease/infection control, directives from the Ministry, Ministry Fact sheet/resources. 5. PIPRG 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 orient all staff to public education materials/resources (Corp S). 7. Provide staff briefing by email and teleconference with update and actions required of staff (MOH, CS). 8. Update staff on current protocols/directives/PPE measures. 9. Provide staff training for staff redeployment or potential redeployment (Program Directors). 10. 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). 11. 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 • Establish systemic approach to receiving, storing and disseminating information • Establish 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 CEMC's to receive and disseminate current/critical emergency information) (Existing ER Plan).

PHASE 5		
Phase 5 *The same identified virus has caused sustained community level outbreaks in two or more countries in one WHO region.*	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. Update contact lists for all essential community services. 2. Assign staff to be responsible for list development and maintenance (Corp S, HPS, EMP). 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 mass faxing (CS). 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 (HealthFax, 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, CS, VPD Team) Information obtained from enumeration tool is for emergency service providers only Police, Fire, LTCH'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 and the local municipal CEMC's determine if conditions warrant activation of local plans (See Phase 6 for plan activation activities).
PANDEMIC PERIOD PHASE 6		
Pandemic Period: Phase 6 *In addition to the criteria defined in Phase 5, the same virus has caused sustained community*	Activate local emergency response plans	**Internal** 1. Confirm 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

level outbreaks in at least one other country in another WHO region.		coordinated efforts by all of most of the health unit's staff and resources (MOH). 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 PIP 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. Communicate 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 *In addition to the criteria defined in Phase 5, the same virus has caused sustained community level outbreaks in at least one other country in another WHO region*	Confirm plans to provide food, medical and emergency social services for persons confined to their homes as directed by public health	1. Confirm 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). 2. Approach lead agency to get agreements in place (FH, HPS ,EMP, County/District CEMC's). 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

Pandemic Period: Phase 6 *In addition to the criteria defined in Phase 5, the same virus has caused sustained community level outbreaks in at least one other country in another WHO region.*	Confirm plans to provide food, medical and emergency social services for persons confined to their homes as directed by public health	conjunction with District/County, May-September, 2006). 5. Maintain list of Community Service Providers (HL, FH, HPS, EMP). 6. Implement a process for identifying persons requiring assistance (FH, Lead Social Service Agency, CCAC). 7. Implement 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. Coordinate 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). 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 *In addition to the criteria defined in Phase 5, the same virus has caused sustained community level outbreaks in at least one other country in another WHO region.*	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. Activate Business Continuity/Staff Redeployment Plan. 2. Manage equipment/ Implement the agency's Business Continuity Plan (MOH). 3. Modify/cut public health services (Program Directors). 4. Establish a contact person for staff inquiries and ensure a listing of the availability of staff and contact information is maintained (supplies resources (Corp S). 5. Receive requisitions for additional supplies and ensure that identified resources are provided (Corp S). 6. Manage staff resources. Receive requests for additional staff resources. 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. Work with Simcoe Muskoka Health Sector Emergency Planning committee (SMHSEPC) to assist member agencies with essential services planning.
	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.
	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

Pandemic Period: Phase 6 *In addition to the criteria defined in Phase 5, the same virus has caused sustained community level outbreaks in at least one other country in another WHO region.*		• 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. 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*	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. Make recommendations 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. Arrange 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).
	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 of staff and key stakeholders, and evaluate information (EOC Chair, ECG). 4. Evaluate and develop lessons learned to help prepare for the next emerging disease

		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).
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).
	Return 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, and Disaster Plan Survey). 3. Consult with funeral home directors/hospitals on morgue capacity (Funeral Home Survey Results, Funeral Services Association of Canada). 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, and HPS). 7. Propose communication strategies to lead agency to clarify expected roles (A/MOH). 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

II - 5 COMMUNICATION

INTRODUCTION

Effective and timely internal and external communications provide the backbone for a coordinated response to an influenza pandemic.[15] 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 minimize the impacts
- 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 to protect health and respond to challenges during each phase of the pandemic

The information needs of internal, external and 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. It describes specific actions required during each of the pandemic phases.

A complimentary crisis communications plan has also been developed to articulate the risk communication goals, objectives, approaches, audiences, key messages, activities and evaluation plan.

This communication plan has been developed with consideration of our partners in the community, health and emergency sectors and governments at all levels to ensure the common goal of improved readiness to protect the health of the population.

COMMUNICATION ACTIVITIES

Phase 1 **From WHO**	**Local Level Objectives** **From OHPIP**	**Public Health Unit** **Communication Activities**
PHASE 1		
Phase 1 *No animal influenza virus circulating among animals has been reported to cause infection 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, HealthFax (VPD/Corporate Communication) • one-to-one contacts with health care partners (VPD) • promotion of pneumococcal vaccine for high risk through physicians, LTCH, 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). 3. Support access to information for multi language via health unit website (post what is available in French/other languages), MOHLTC/PHAC websites and Vulnerable Populations Section Leads. (Corporate Communications, SMHSEPC). 4. Support access to information for low-literacy via television and radio media, telephone (Health Connection) and Vulnerable Populations contacts. (Corporate Communications, Health Connection, SMHSEPC). 5. Periodic review of existing educational materials for currency, accuracy and relevance.

Phase 1 *No animal influenza virus circulating among animals has been reported to cause infection in humans*	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) • standing item on agendas of SCICN, CDSN, Hospital IC & PAC LTCH (CD) • enhanced CD Surveillance website to include pandemic educational resources (CD Team) • HealthFax to Physicians, acute care facilities, LTCH and Rest & Retirement Homes, NPs, walk-in clinics, ambulance, emergency departments, midwives (CD). • Education Strategy for Essential and Emergency Service Workers (EMP) 2. Education/Awareness – reporting requirements • routine confirmation of reporting requirements (case definitions) and outbreak reporting for LTC and acute care via LTC education workshop and SMIPACN (Infection Prevention and Control Network) (CD). **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 i.e. Public Health Measures, MOHs (CD Mgr/MOH). 2. Participate on pandemic-related regional planning networks i.e. GTA Communicators, GTA VPD Managers (Corporate Communications TL/VPD Mgr). 3. Establish/maintain links with the MOHLTC Communications Branch (Corporate Communications). Links/partners 1. Maintain databases of health sector contacts including • Acute care (CS)

Phase 1 *No animal influenza virus circulating among animals has been reported to cause infection in humans*	Continue to work to improve the communication/information infrastructure (MOHLTC and Community Partners)	• LTC (CS) • Rest and Retirement (CS) • Daycares (CS) • Physicians (CS) • Pharmacists (HLS) • Occupational Health (CS) • NPs (CS) • Midwives (FHS) • Hospitals (CS) • LHINs (Corp S) • Allied Health Professionals (e.g. respiratory tech, personal support workers: SMHSEPC) • Neighbouring Health Unit communication personnel (Corp S) • Upper-tier municipality communication links (Corp S). 2. Maintain databases of emergency response sector contacts including: • EMC (HPS) • Police & Fire (HPS) • SC & MD Emergency Management (HPS) • Ambulance/Paramedics (HPS). 3. Develop and maintain key contacts list for Essential Service Workers (ESW) including: • funeral directors/embalmers (HPS) • public works, water works & gas (HPS) • managers of COMSOC, education, government managers (health & social program admin) (Corp S) • food suppliers/operators (process to collect/post & maintain. 4. Develop and maintain key contact list of Emergency Service Workers (EMS) including: • correctional service officers (CS) • RCMP (HPS) • Red Cross (employees & volunteers) (Corp S) • St. John's (First Aid, respiratory volunteers & youth members) • CFB (HPS). 5. Re-establish linkages with Health Sector Emergency Planning partners (SMHSEPC)via • Committee meetings (DCS, MOH) • Email distribution list (SC Chair) • SMHSEPC Extranet (SC). 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 through upper tier EOC's (EMP). 8. Develop and utilize electronic communication methods for ongoing

Phase 1 *No animal influenza virus circulating among animals has been reported to cause infection in humans*	Continue to work to improve the communication/information infrastructure (MOHLTC and Community Partners)	communication & updates with Health Sector including: • HealthFax to Physicians and LTCH, Emergency Room, Infection Control Practitioners, NPs, Midwives, walk-in clinics, Ambulance, Rest and Retirement, Hospitals (CD (CD) • SMHSEPC email distribution list (SC Chair) • SMHSEPC extranet (SC) • HU website. 9. Develop electronic communications methods to exchange information with Emergency Service Workers (EMSW). • fax, listserve & web based (EMP/HPS/Corp S). 10. Develop electronic communications methods to exchange information with Essential Service Workers (ESW) • 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. Maintain 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).
Phase 1 **INTERNAL Communications**	Establish internal structures to support pandemic planning and implementation	**Internal** 1. PIPRG – Structure, meetings/minutes (PIP, MOH). 2. PIP Committees – structure, meetings/minutes & plans (PIPRG 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 • Communications (internal, including staff updates and briefings) • Communications (external, including partner updates, situation reports, media releases) • Surveillance (local, provincial, federal and world; surveillance tools) • Vaccines and antivirals (including priority groups, mass vaccination plan & implementation, medical directives) • Public Education measures (including public education materials) • Orientation and training (including training materials) • Health and Safety

		• Business Continuity (including redeployment plans).
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 system i.e. web based (DCS, CD, Corporate Communications). 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).
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 Training and Orientation Lead). 2. Training & Orientation • prepare staff "team" to provide on-site presentations to respond to RFS. (CD). 3. Ensure staff is informed of SMDHU ER plan and ER structure (EMP).
PHASE 2		
Phase 2 *An animal influenza virus circulating*	Work with professional organizations and labour associations to actively promote UIIP to the public and health care workers	Continue activities from phase one.

among domesticated or wild animals is known to have caused infection in humans and is therefore considered a potential pandemic threat.	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.
Phase 2 *An animal influenza virus circulating among domesticated or wild animals is known to have caused infection in humans and is therefore considered a potential pandemic threat.*	Continue to reinforce the importance of prevention/mitigation activities	**External** Links/partners 1. 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 materials (SMHSEPC, EMC Network). **External** Public 1. Education & Awareness • introduction to PIP (local action) in collaboration with SC & DofM upper tier 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 (HC) • Newsletter/Health Matters (PIP/Corporate Communications).
Phase 2 *An animal influenza virus circulating among domesticated or wild animals is known to have caused infection in humans and is therefore considered*	Continue to work to improve the communication/information infrastructure (MOHLTC and community partners)	**External** 1. Links/partners • establish operational guidelines for communicating world developments & local actions to Health Sector & ER partners • establish communications system i.e. email/listserve, extranet, fax, rounds/professional groups meetings • communicate updates and directives as per operational guidelines • establish operational guidelines for communicating world developments & local actions to non SMHSEPC partners i.e. including Emergency Service

a potential pandemic threat.	Continue to work to improve the communication/information infrastructure (MOHLTC and community partners)	Workers, Essential Service Workers • establish communications system i.e. email/listserve, fax • establish partners, functions, locations, protocols/processes for joint media centre (SMHSEPC – Communications Committee). 2. Develop a SM Emergency website in partnership with Simcoe County and the District of Muskoka to include (or include links to): • World Developments/ Alert status • FAQ • Pandemic Plans (local, provincial & federal) • Definitions • Legislation – roles & responsibilities • Local Status/surveillance • Infection Control/Public Health measures • Directives (including IHN from MOHLTC, HPPA closures_ • Vaccine & Antiviral priority groups • Tracking tools/checklists • Educations materials – including personal protection measures (e.g. handwashing, cough etiquette) • Media communications. 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) • determine the most feasible means for broadcast media monitoring. 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).
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. PIPRG maintain communication through meetings, emails, intranet. 2. PIP Committees continue to maintain communication through meetings, emails, and 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 PIPRG, 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 • Vaccines – storage and handling etc. • Antivirals access • 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 /Corporate Communication/Corp S/HPS). 3. Extranet Site Development – develop site to keep staff informed from locations outside the agency (Corporate Communication/Corp S). 4. Staff updates through presentations. 5. Build systems for use: Cell phones, Blackberries & Adobe Connects – 2-way communication for key off-site/on-site staff. (Corp S/ EMP) • Include training to support the use of systems for tele/video conferencing as required. 6. Establish emergency response media partners (Corporate Communications).

	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/Corp Communications TL/Corp Services) to include: • Outlook access from home • Plan for those without home internet access • Plan for urgent communication re: staff deployment.
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/managers).
PHASE 3		
Phase 3 *An animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks.*	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 (Ministry materials & Health Canada) to all partners for distribution to patients/clients/families and the public (Mgt .Team & Corporate Communications) or post to the health unit website. Public 1. Staff to share key messages about public health measures with the public whenever health teaching opportunities arise (all staff). 2. Distribute resources (Ministry & Health Canada) about public health measures to community agencies where the public can access, including HU office reception areas (HLS, Corporate Communications). 3. Post public health measures information to health unit website (Corporate

		Communications, Corp S). 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 PHM Framework.
Phase 3 *An animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks.*	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 to SC to post links to the SM Emergency website: • mass vaccination program • vaccine and antiviral priority groups (& numbers) when available/known • vaccine clinic supply locations (VPD, Corporate Communications).
	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 neighbouring 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	**External** Links/partners 1. Communicate change in alert status as per protocols, plus required public health measures, access to antiviral & vaccine, surveillance requirements

Phase 3 *An animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks.*	audiences, focusing on existing influenza prevention messages and WHO/PHAC updates	(case definitions) and REMINDER of communication channels/protocols via email, list serve and HU/SM emergency website & extranet (CS, EPM, Corporate Communications). 2. Post info to HU website and forward to SC to create links from SM Emergency site to include: • 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 (CD, VPD, HPS, Corporate Communication) • Communicate with identified Health, Emergency, Social/Family Service, Education, Vulnerable Population, Essential Service partners, and neighbouring health units, Ministry of Health, Emergency Service Workers and Essential Service Workers via list serves and web posting to include: • World Developments/ Alert Status • Surveillance protocols/procedures and tools (where appropriate) • Local surveillance data • Public health measures • Antiviral & vaccines access (priorities based on viral activity and supply) • Clinic schedules • Flu Assessment Centres • Emergency supports i.e. alternate care, housing, food. See Appendix D – Audience Grid & Appendix E - Situation Update template 3. Work with SMHSEPC to develop appropriate communication tools to share information with partners and community agencies and service providers. (Corporate Communications). **External** Public 1. 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). 2. Vulnerable populations • Communicate as per SMHSEPC Vulnerable Population plan – Vulnerable

		Population Sector leads responsible for information dissemination. SMDHU as one sector lead carries responsibility to communicate with: o Daycares o LTC o Rest & Retirement Homes o Group Homes o Correctional Services (EMP, Corporate Communications).
	Review and, if necessary, update pandemic contact list	Continue from phases 1 and 2 activities
Phase 3	Establish and maintain internal structures to support pandemic planning and implementation	Review structure used previously for PIPRG for the ongoing requirements identified that fit with SMDHU ER structure (Executive Committee)
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) • Initial bulletin to all staff re: change in alert status includes known information and steps being taken by MOH and others to develop further understanding of the situation, and as appropriate • Recommend general statements for public if approached with questions on the street. 2. Update information for SMDHU staff on the intranet regularly i.e. • Current SMDHU PIP • WHO Levels • Surveillance • FAQs • Communications (including staff, media, partner and public information tools) • Public Health Measures • 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, antiviral access) • Flu assessment centres • Orientation and Training • Business Continuity • Health & Safety (CD/VPD Mgrs, Corp Service, Corp Communications & CS). 3. Communicate with all staff the vaccine and antiviral priority groups via management team/team meetings, intranet, email (MOH, DCS, VPD manager, managers, Corporate Communications) Review and finalize PIP Crisis Communications Plan with emphasis on:

		• Key message development • Communications Plan • Development of new prevention/information resources if necessary. (Corporate Communications).
Phase 3 **INTERNAL Communications**	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 IMS communications processes to include MOH office, (Incident Commander), Operations Chiefs, Information Officer & Communications System Director, Planning, Logistics and Corporate Communications (CSD, Corp Communications) • 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. Training and Orientation • Vaccination (including mass vaccination plan) • CD investigation • CD follow up • Phone response (including key messages) • Media and media monitoring • Voice messaging (VPD, CD, IT, HC, Corp Services & Communications).
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 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.
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*	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 Communications). Links/Partners - continue all Phase 1, 2 & 3 activities 1. 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 Communications Committee (Corporate Communications in collaboration with Simcoe County and District of Muskoka).
	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).
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. (Corp Communications). 2. Support access to information for multi language via health unit website (post what available in French/other languages), MOHLTC/PHAC websites and Vulnerable Populations Section Leads. (Corporate Communications, SMHSEPC).
	Establish and maintain internal structures to support pandemic planning and implementation	**Internal** 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 Communications) Pandemic situation updates posted regularly to the intranet (CD). 2. Post Mass Immunization Plan on the Intranet.
	Establish policy & protocols to support pandemic planning and implementation	1. Review, finalize and implement agency pandemic policies and operational guidelines (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 (Corp Communications).
PHASE 5		
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 Communications).
	Participate in Crisis Communication network	1. Confirm who participates locally in the following meetings/teleconferences: • SMHSEPC, School Board, Media Briefings planning, Flu Assessment Centre planning (MOH, Directors, CS/Healthy Schools/EMP Managers, Corporate Communications). 2. Report crisis communications planning to Executive Committee, SMHSEPC and Communications Committee, and to internal stakeholders (Corporate Communications). 3. Update health unit Crisis Communications Plan accordingly (Corporate Communications). 4. Update JMC Crisis Communications Plan, review training needs and provide training as needed (Corporate Communications in collaboration with Simcoe County and District of Muskoka).
	Implement plans to communicate with all relevant audiences, including the media, key opinion leaders, stakeholders, and employees	**External** Links/Partners 1. Advise partners of pandemic situation updates (regularly), health/travel alerts, public health measures, access to vaccine and antivirals, flu assessment, public immunization clinics, via email, Listserve extranet and HealthFax (MOH, DCS, CS Managers, Corporate Communications). 2. Stakeholder meetings/forums (if appropriate given transmission status, etc.) (Corporate Communications). Public 1. Activate automated VOIP messages (Corporate Communication). 2. Advise public of pandemic situation updates, health/travel alerts via press

Phase 5 *The same identified virus has caused sustained community level outbreaks in two or more countries in one WHO region.*	Implement plans to communicate with all relevant audiences, including the media, key opinion leaders, external stakeholders, and employees	release/PSAs, media interviews and post daily to the web site (Corporate Communication). See Appendix I-11-5 – Media Briefings Plan Sample Review needs and acquire resources for media briefings (see Press Conference Checklist form i.e. C1.020 (F3) Staff 1. Activate emergency response media contacts – situation status, requirements, roles, processes (Corporate Communications). 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 Communications). 3. Share provincial, national, other relevant external agency key messages with SMDHU media spokespersons and Health Connection. (Corp Communications).
Phase 5 **INTERNAL Communications**	Establish and maintain internal structures to support pandemic planning and implementation	1. Establish processes that reflect the ER planning structure.
	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: • Pandemic Alert Status • Current surveillance – including data/forms, protocols and case definitions • Communications • Public Health Measures, including health and travel alerts • Vaccine and Antiviral access, clinics • Flu Assessment Centre • Business Continuity Plan and redeployment expectations including staff reporting mechanisms • Health and Safety • Directives (MOHLTC & EMO) • Policies – e.g. staff vaccination, mandatory isolation order • Out-of-office information access (Outlook, web & radio) (MOH, Corporate Communications). 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 Communications).
	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	Continue Phase 3 & 4 activities as required.
PANDEMIC PERIOD PHASE 6		
Pandemic Period: Phase 6 *In addition to the criteria defined in Phase 5, the same virus has caused sustained community level outbreaks in at least one other country in another WHO region.*	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 Communications). 3. Activate process evaluation of crisis communications plan (Corporate Communications).
	Distribute fact sheets	**External** 1. Distribution of education materials (prevention, mitigation, personal protective measures, personal protective equipment, etc) i.e. • fact sheets, brochures via website, 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 Communications, all programs) • advertising via newspaper (clinics) and digital screens at community centres and Georgian Mall (Corporate Communications).
	Continue regular communication with communication partners	**External** Links/Partners 1. If emergency situation declared and/or deemed appropriate, work with Joint Media Centre to implement joint crises communications components • Joint press conferences – postings to the SM Emergency website • Joint press releases – postings to the SM Emergency website • Ongoing media contacts (MOH and Corporate Communications in collaboration with SC & DofM). 2. Maintain regular contact with SMHSEPC Communications Committee via teleconference (Corporate Communications). 3. Engage School Board key contacts and communications personnel in regular meetings via teleconferences (as situation dictates).
	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 partners of health unit redeployment, essential services and alternate care sites via email/listserve, teleconference or videoconference, HU & SM Emergency websites (MOH, Corporate Communications).

Pandemic Period: Phase 6 *In addition to the criteria defined in Phase 5, the same virus has caused sustained community level outbreaks in at least one other country in another WHO region.*	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	Public 2. Notify the public of health unit redeployment, essential services and alternate care services via media i.e. press release, press conference (MOH, Corporate Communications). 3. Activate expanded Health Connection services (as required) to include: • Enhanced staffing • Expanded hours. **IF State of Emergency declared** Links/Partners 1. Notify SMHSEPC partners of need/rationale to "stand-by" and be ready to activate their emergency response plan via email/listserve (MOH or alternate, EMP). 2. Notify SMHSEPC partners via email/listserve that the health unit has activated its emergency response plan.(MOH or alternate, EMP). 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/listserve (CD, DHL, Corporate Communications). 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 Communications) • Include explanation of relative risk to public due to emergency conditions (key anxiety abatement process). • respond to media inquiries via interview/press conference (MOH and Corporate Communications). 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 Communications, Health Connection). 2. Advise public that trained volunteers/helpers are in place to support pandemic activities via joint media centre. (press release, press conference & interviews) (Corporate Communications in collaboration with SMHSEPC communications). 3. Advise partners and public of alternate health services and care sites via email/Listserve, HealthFax, Joint Media Centre (press releases and press conferences), website and Health Connection. (Corporate Communications, and in partnership with SMHSEPC communications).

Pandemic Period: Phase 6 *In addition to the criteria defined in Phase 5, the same virus has caused sustained community level outbreaks in at least one other country in another WHO region.*	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	4. Advise partners and public of vaccine security measures, mass immunization clinic plans, including priority groups and sites via email/Listserve, HealthFax, Joint Media Centre (press releases and press conferences), website and Health Connection. (VPD, Corporate Communications, and in partnership with SMHSEPC communications). 5. Inform partners and public of food, emergency and medical services available for people confined to home via email/Listserve, HealthFax, Joint Media Centre (press releases and press conferences), website and Health Connection.(EMP, Corporate Communications, and in partnership with SMHSEPC communications). 6. Advise partners and public of infection control measures, isolation and quarantines, travel restrictions, community facility/school closures, event cancellations, etc. via email/Listserve, HealthFax, Joint Media Centre (press releases and press conferences), website and Health Connection. (CD, Corporate Communications, and in partnership with SMHSEPC communications). 7. Advise partners and public of pandemic situation updates daily (or as required) via email/Listserve, HealthFax, Joint Media Centre (press releases and press conferences), website and Health Connection. (CD, Corporate Communications, and in partnership with SMHSEPC communications).
	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 Communications).

Pandemic Period: Phase 6
 	
INTERNAL Communications
	Establish and maintain internal structures to support pandemic planning and implementation	1. IMS daily briefing (teleconferences) meetings to include (Emergency Control Group)
		• Command
		• Operations
		  • investigation and surveillance
		  • public health measures
		  • mass vaccination plan
		  • flu assessment
		  • health protection
		  • community health nursing and support
		  • public inquiry and community awareness
		• EOC Operations and Communications Systems
		  • information technology
		  • public/partner communications
		  • media

Pandemic Period: Phase 6
 	
INTERNAL Communications
	Establish and maintain internal structures to support pandemic planning and implementation	• documentation
		• Planning
		  • forecasting
		  • long-range and contingency planning
		  • data synthesis and reporting
		• Logistics
		  • staff deployment/ staffing issues
		  • volunteer deployment
		  • health and safety
		  • facilities and supplies
		• Finance and Administration.
		2. Implement daily communications briefings via media monitoring, meeting, email, situation updates, intranet, MOHLTC (update/directives, press conference, web/public materials), clinic-site binders and meetings. Communication tools include: IHNs, media Q &As, SMDHU Situation Update, SMDHU Clinic Lead Updates, SMDHU Q & A log, email/intranet blog. (MOH, DCS, CD/VPD/HLS Management, Clinic coordinators, Corp Communications Team Leader, Media coordinators).
		3. Post all communications tools to the intranet.(CD Research Analyst).

	Develop and use information management systems to ensure all staff are kept informed of pandemic planning and implementation	1. Provide situation update to staff via teleconference, email and intranet posting, to include (teleconference updates - frequency to be determined as situation unfolds): (MOH, DCS, ADCS, Corporate Communications): • Global/Provincial/local situation update, including surveillance reports. • Standby for activation of the emergency response plan. • Activation of the emergency response plan. • Public Health Measures in place. • Access to antivirals/vaccine. • Implementation of the business continuity plan - current stage. • Process to access information off site i.e. outlook, clinic binders, clinic facilitators, clinic laptop, clinic postings, clinic cell phone/blackberry. • Process to access password protected extranet for situation updates, staff schedules/assignments, etc. • Process for staff to report to work/report absence on a daily basis. • Emergency information media stations for urgent staff PSAs. • Hours of expanded Health Connection service. • Role of trained volunteers. • Health and Safety. 2. Keep staff informed of local emergency response/resources via email, intranet, clinic coordinators, extranet (MOH, DCS, ADCS, Corporate Communications) • Current Mass clinic plans, including priority groups, sites and staff

Pandemic Period: Phase 6 **INTERNAL Communications**		schedules, Vaccine Adverse Event Reports (VAER) results (as required). • Current priority groups for antivirals, access points. • Current vaccine supply/access for non-priority groups. • Infection control procedures including mandatory isolation orders, stay at home if ill, restrictions (including travel), cancellations, closures. • Assessment and alternate care sites (activation and deactivation). • Food, medical and emergency social services for those confined to their homes. • Social and support services for the public. • Burial locations. • 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, staff vaccination. (MOH). 5. Activate Daily Communications Briefings including MOH, IMS, Corporate Communications Team Leader, CD/VPD/HLS Management, clinic coordinators, media coordinators.
	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 clinics (clinic coordinators, vaccinators, registrars & after care) via manual, PowerPoint and workshop (CS) 4. Training for vaccination clinics (IT runners, clinic facilitators) via manual and workshop (Corporate Service). 5. Continue to orient all staff to new public education materials and community resources. (refer to intranet for information). 6. 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-*		**External** Provide feedback on local effectiveness of public health interventions to the provincial level through MOH teleconferences, etc (MOH).

regional epidemics **Pandemic Period: Phase 6**	Continue to provide information/updates to MOHLTC, health care workers, the media and the public	Links/Partners & Public Continue activities from early Phase 6 and: 1. Communicate any changes in situation status/case definitions (CD, Corporate Communications). 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 Communications). 4. Communicate any changes in vaccine priority groups/clinic locations/schedules (VPD, Corporate Communications). 5. Communicate burial site locations (EMP, Corporate Communications) **via**: email/listserve HealthFax, 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 HealthFax, listserve (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 Communications). 8. Distribute regular reports of vaccine supplies, demand, distribution and uptake, and adverse events information to community health providers who are administering vaccine via HealthFax. (VPD). 9. Post Q&A re: vaccine, consent form, information on adverse events, and aftercare sheet on website (Corporate Communications). 10. Introduce empathy messages where appropriate e.g. personal impacts. 11. Monitor the media and messaging going to the public from media sources.
Regional and multi-regional epidemics	Gather information from the field and use to inform/refine the communications plan	1. Daily briefings of IMS & Communications Group to gather/share information and reflect updated/revised messages in communications. (MOH, DCS, DCS, DHLS, Corporate Communications Team Leader).
	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 Communications). 2. Gather reports from Health Connection on caller response to public communication channels and messages. (Corporate Communications Team Leader).
Pandemic Period: Phase 6	Maintain internal structures to support pandemic planning and implementation	Continue early Phase 6 activities.
INTERNAL Communications	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, Corporate Communications TL). 2. Communicate any changes in national/provincial/local recommendations for

		containment strategies (CD, Corporate Communications TL). 3. Communicate any changes in vaccine priority groups/clinic locations/schedules (VPD, Corporate Communications TL). 4. Communicate burial site locations (EMP, Corporate Communications TL). 5. Communicate immunization aftercare and common side effect information (VPD, Corporate Communications TL). via teleconference and /or email update and 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 Communications).
	Evaluate local communications response	**Internal/External** 1. Review media logs/databases/tapes, Health Connection stats, web stats, etc. and document findings (PICAC, & Corporate Communications). 2. Engage in communications debrief health unit staff (Evaluation Specialist) 3. Engage in communications debrief with SMHSEPC and with SM Communications. (MOH, DCS, Corporate Communications)
		External 1. Distribute press releases, letters to individuals appreciation of cooperation from other agencies, volunteers and health unit staff (MOH, Corporate Communications). 2. Step down and suspend joint media operations (MOH, Corporate Communications).
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 Communications). 4. Advise public & partners of current health unit program/service status (Corporate Communications). 5. Prepare response to potential post-pandemic criticism fro media e.g. vaccine

Post pandemic Period: **Return to Phase 1**		efficacy, waste, expense, focus on vulnerable. (Corporate Communications). **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, Corp S). 3. Teleconference/email to all staff re resuming all program activities with any exceptions. 4. Develop and share report of pandemic experience, reassessment of pandemic plan based on assessment outcome. Report shared at teams and posted on intranet. 5. Input final recommendations and make revisions to update pandemic plan. (PIPRG, Exec). 6. Archive information on intranet with links to WHO, CDC and HC for ongoing surveillance (CS, Corporate Communications).
	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** 1. 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 Communications). 2. Update pandemic plan on internet, share final report with HSER partners. Input their recommendations and make revisions on final report. (MOH, Corporate Communications).

APPENDICES

II - 6 ORIENTATION AND TRAINING

INTRODUCTION

Knowledgeable and well trained staff members 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 Subcommittee 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 by the other PIPAC subcommittees and outline the training and resources needed.
- To identify orientation and training gaps within the health unit's pandemic influenza plan 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.	1. PIP orientation will be provided to staff through service area meetings. New staff members will receive PIP orientation upon hire as part of SMDHU orientation. Includes but not limited to orientation to SMDHU PIP, SMHSEPC PIP, intranet & internet sites as well as WHO, PHAC & OHPIP plans. 2. PIP resources are posted to the intranet/internet including general information and sector specific information. http://www.simcoemuskokahealth.org/Promos/HumanSwineFlu.aspx 3. A Core group of PIP PowerPoint slides are available to use to develop presentations. S:\Incident & Emergency Response\pH1N1\4.Communications\8.Presentations 4. PIP presentation to be used for new staff, staff unable to attend an in-service and as a general refresher. 5. Updates made to the PIPs and resources need to be communicated out to staff. 6. List of staff members who have received PIP orientation needs to be maintained.
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. A Core group of PIP PowerPoint slides are available to use to develop presentations. S:\Incident & Emergency Response\pH1N1\4.Communications\8.Presentations 2. A core group of staff are trained and able to provide PIP presentations. Depending on demand more staff could be trained to provide this education. 3. As new information becomes available core group of PIP slides and presenters will be updated with the most current information. If necessary, AV/tech training will be provided to the presenters (i.e. DPM and laptop setup).

Interpandemic Period: Phase 1 *No new influenza virus subtypes have been detected in humans*	All SMDHU staff will have general knowledge of agency emergency response plan and be familiar with agency emergency management framework.	1. Emergency response orientation will be provided to staff through service area meetings. New staff members will receive emergency response orientation upon hire as part of SMDHU orientation. Includes but not limited to IMS, emergency management framework, SMDHU emergency management plan. 2. Emergency management resources are posted to the intranet/internet. Intranet: http://intranet.smdhu.net/Portals/Services/HealthProtection/Programs/emergencymanagement.aspx Internet: http://www.simcoemuskokahealth.org/Topics/Emergency.aspx 3. Emergency Response presentation to be used for new staff, staff unable to attend an in-service and as a general refresher. 4. List of staff members who have received PIP orientation needs to be maintained.
	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. List of redeployments and outline of reassigned duties specific to PI.
	All staff will have general understanding of SMDHU business continuity plan and essential service activities	1. Business continuity plan orientation will be provided to staff through service area meetings. New staff members will receive business continuity orientation upon hire as part of SMDHU orientation. Includes but not limited to IMS, emergency management framework, SMDHU emergency management plan, designated essential services, redeployment and the impact on programs pH1N1 as an example. 2. Business continuity presentation to be used for new staff, staff unable to attend an in-service and as a general refresher.
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	1. Annual Universal Influenza Immunization Program orientation including vaccination and medical directive training for staff identified. 2. Current statement on Influenza Immunization from the National Advisory Committee on Immunization (Canadian Communicable Disease Report). 3. Maintain current lists of VPD staff, casual VPD staff and cross trained SMDHU PHNs who participate/participated in universal flu clinics: all agency nurses to participate in UIIP every third year. 4. Orientation and training package/workshop and related material posted to the internet.
	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 manuals are available. 3. Outbreak CD Manual. 4. iPHIS trained staff include members of the following teams CD, SH, select staff from HPS.
	An appropriate number of internal iPHIS trainers will be available	1. iPHIS trainers on staff. 2. iPHIS user manuals available.

		3. iPHIS train the trainer workshop.
Interpandemic Period: Phase 1 *No new influenza virus subtypes have been detected in humans*	All appropriate staff will have working knowledge of surveillance principles and procedures	1. Skills Enhancement for Public Health modules available through the Public Health Agency of Canada. 2. Maintain list of staff who have completed and/or are in process of completing course(s). 3. FAQs on surveillance posted to the intranet. 4. Surveillance 101 workshop.
	To have current outbreak, influenza and FRI policy and procedures.	1. Process for annual review and updating of CD outbreak, influenza and FRI documents. 2. Provide staff education re: use of FRI Surveillance Protocols
	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. Outline specific GIS data collection requirements related to pandemic influenza. 3. GIS 101 orientation and training workshop. 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 SMDHU equipment (e.g. fax, photocopier and other communication devices, etc.) are made available. 2. Staff trained on communication equipment operation will train backup staff. 3. Instructions and FAQs will be made available.
	To have an ongoing SMDHU orientation and training schedule for pandemic influenza.	1. Orientation & training database.
Interpandemic Period: Phase 1 *No new influenza virus subtypes have been detected in humans*	All mangers and supervisors will have working knowledge of SMDHU PIP and IMS	1. Emergency response orientation will be provided to all managers and supervisors through management meetings. Includes but not limited to IMS, emergency management framework, SMDHU emergency management plan, and individual emergency response manuals. 2. Emergency management resources are posted to the intranet/internet. Intranet: http://intranet.smdhu.net/Portals/Services/HealthProtection/Programs/emergencymanagement.aspx Internet: http://www.simcoemuskokahealth.org/Topics/Emergency.aspx 3. 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.
Interpandemic Period: Phase 1	All staff will have working knowledge of reassigned duties in the event of redeployment	1. Program Guidebooks and applicable P&Ps to the area of redeployment. 2. PIP, emergency response, and business continuity plan orientation. 3. Orientation and training related to reassigned duties under ER plan such as:

No new influenza virus subtypes have been detected in humans		• VPD - access, storage and administering of flu vaccine, medical & ministry directives, mass immunization clinic plan • CD – iPHIS, COGNOS, outbreak template, case investigation, contact tracing, surveillance, lab specimen collection, infection prevention and control measures, ministry directives. • ER - shelter/assessment/triage training, CISS database, HPPA (closure orders), • HC – call center, PIP intranet, key messaging, CAPS, Ministry Directives. • Health Information group – automated data analysis and dissemination. 4. Hands on training related to reassigned duties under ER plan. 5. Stress management training for staff.
Interpandemic Period: Phase 1 *No new influenza virus subtypes have been detected in humans*	Designated spokespersons will be able to respond to media inquires appropriately.	1. Half-day Media Workshop available and provided by staff media consultants. 2. Media consultants on staff. 3. Trained staff (directors, managers, supervisors, HC team). 4. PI media training workshop. 5. FAQ/Key Messages directed to media questions posted to the intranet. 6. Media Training multimedia module.
INTERPANDEMIC PERIOD PHASE 2		
	Continue with all Phase 1 activities	
PANDEMIC PERIOD PHASE 3		
	Continue will all Phase 2 activities	
Pandemic Alert Periods Phase 3 *Human infection(s) with a new subtype, but no human-to-human*	PI simulation exercise will be conducted to test and evaluate SMDHU PIP.	1. ER plan and framework. 2. SMDHU PIP. 3. Work group to develop and deliver simulation exercise to be designed and conducted. 4. Evaluation tool for simulation exercise developed and deliver to staff.

spread or spread to a close contact only	To implement orientation & training recommendations based on evaluation findings of simulation exercise.	1. Prepare an evaluation report with recommendations. 2. Revise SMDHU PIP & ERP as necessary. 3. Communicate revisions to all staff.
PANDEMIC ALERT PERIOD PHASE 4		
	Continue with all phase 3 activities	
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 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 with all phase 4 activities	

PANDEMIC PERIOD PHASE 6		
	Continue with all phase 5 activities	
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.	1. Provincial document outlining priority groups. 2. Security protocols/guidelines related to vaccine access & priority groups. 3. Agreements/ Service contact with security/police agency.
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.	1. Orientation and training related to reassigned duties under ER plan such as: • VPD - access, storage and administering of flu vaccine, medical & ministry directives, mass immunization clinic plan • CD – iPHIS, COGNOS, outbreak template, case investigation, contact tracing, surveillance, lab specimen collection, infection prevention and control measures, ministry directives. • ER - shelter/assessment/triage training, CISS database, HPPA (closure orders), • HC – call center, PIP intranet, key messaging, CAPS, Ministry Directives. • Health Information group – 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. 3. FAQ on personal hygiene and respiratory illness etiquette.
POSTPANDEMIC PERIOD		

APPENDICES

APPENDIX A - II - 6: HEALTH CONNECTION REDEPLOYMENT TRAINING MODULE

APPENDIX B - II - 6: H1N1 PROGRAM OVERVIEW PRESENTATION

APPENDIX C - II - 6: ROLE OF H1N1 CLINIC COORDINATOR

APPENDIX D - II - 6: CLINIC FACILITATOR ROLE

APPENDIX E - II - 6: VACCINE STORAGE AND HANDLING

APPENDIX F - II - 6: CLINIC COMMUNICATION PROTOCOL

APPENDIX G - II - 6: AFTER CARE ORIENTATION SLIDES

APPENDIX H - II - 6: STORAGE AND HANDLING OF VACCINE

APPENDIX I - II - 6: VACCINE ADMINISTRATION

APPENDIX J - II - 6: MEDICAL DIRECTIVE AND INFORMED CONSENT

APPENDIX K - II - 6: ANAPHYLAXIS MEDICAL DIRECTIVE TRAINING

APPENDIX L - II - 6: H1N1 MEDICAL DIRECTIVE TRAINING

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
- Internal communication strategy developed to communicate schedules and critical information to 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**
PANDEMIC PERIOD PHASE 2-5		
Phase 2-5	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 Lead involve union/association representatives if relevant. 3. Clinical Director 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. Executive 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. Management, 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 continue to 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.

Phase 2-5	Executive Committee approved Essential Services	1. Clinical Director will continue to review the Essential Services/ Functions Inventory Tool (Appendix B) with the PIPRG subcommittee to ensure appropriateness. 2. Clinical Director will continue to review instructions to support the identification of 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. 3. 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. 4. BC Coordinator collected preliminary services lists from each service area which will be reviewed annually by PIPRG. 5. BCP Coordinator to develop comprehensive instructions for Essential Services/ a. Functions Inventory tool use. 6. Executive adopted the definition of Essential services as follows A service and/or function that when not delivered creates an impact on the health and safety of individuals. a. 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. b. Identify essential services and/or functions that must be performed to satisfy regulatory requirements. 7. 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. Executive approved Essential Service October 2009 should be reviewed in light of the pH1N1 and G8 experiences.
	Prepare a Business Continuity Plan for each essential service/function Executive identified staffing needs to ensure continuation of Priority A Essential Services	1. BCP Coordinator in conjunction with Executive 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. 4. Evaluation Specialist to develop evaluation tools.
	Review your Business Continuity Plan with Executive	1. Clinical Director to present draft BCP to executive to ensure that all critical elements in the plan are addressed.

Phase 2-5		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. 4. Clinical Director, BCL and Emergency Response Manager to review and update annually the Essential Services Listing.
	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.
	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. Management, 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. SMDHU to evaluate the feasibility of maintaining a 4 week supply with the MOHLTC providing a 4 week supply. 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 and to ensure SMDHU has 4 week supply.
Phase 2-5	Identify any relevant HR and Health and Safety issues/implications for implementation	1. BCP Lead 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 Lead 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. 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. 4. Communication plan will continue to be informed by any plan developed to address HR and/or health and safety issues. 5. Implement as required Staff absence tool developed Oct 2009 (Appendix D-11-8: Staff Absence Tracking Tool) to monitor absences to ensure surge capacity is met. 6. HR to work with the surveillance sub-committee to determine staff absenteeism monitoring and reporting requirements and ensure these requirements are reflected in agency policies and communicated to key internal contacts. 7. HR will ensure that all pandemic H & S 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. 9. HR to develop H & S procedures to ensure best practices regarding technology and ergonomic requirements i.e.) Pelican cases, moving equipment, (Appendix H & S issues).
	Identify any relevant redeployment and surge capacity issues/implications for implementation	1. See Orientation and Training section 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 (see communication plan for expectation and disseminating of scheduling and critical information to internal staff). 3. During annual operational planning process, management will identify essential services activities and surge activities for staff to reinforce understanding of agency redeployment needs during the pandemic. 4. Clinical Service & HR to develop policy clearly outlining agency expectation for

	Identify any relevant redeployment and surge capacity issues/implications for implementation (cont.)	redeployment availability. 5. HR to develop a confidential process to determine and document any personal staff circumstances for consideration during redeployment. 6. See Communications Plan for details of the process external communication with community partners related to impact of public health during the pandemic. 7. HR and Executive to develop a plan to address alternative work arrangements • (i.e. teleconferences, conference calls, working from home). 8. BCP Lead 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. 9. Maintain communications with SMDHU Health Sector Emergency Planning Group and community partners to support ongoing problem solving related to Business Continuity Planning needs. 10. See Public Health Measures, Occupational Health & Safety for pending requirements that will need to be considered during redeployment decision making during Phase 6 of the Pandemic. 11. BCP Lead 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. 12. 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. 13. 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. 14. Once volunteer needs have been determined, HR will develop a Volunteer Registration process (compliance with WSIB).
PHASE 6		
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. 4. In the event of partner surge plans being implemented, staff may be redeployed to

		influenza assessment centres as per MOA.
POST PANDEMIC PERIOD		
Post-pandemic Period	Termination of the Redeployment Strategy and return to normal operations 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. Executive to work with managers and 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 Incident 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). 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. 6. Acknowledgement of staff's contribution and the end of the incident.

Post-pandemic Period	Evaluation of the Business Continuity Recovery and Redeployment Activities	1. BCP Coordinator to update internal SMDHU Business Continuity Plan, pandemic plan and ER plan as appropriate. 2. Debrief's will be held with all staff as required by the Evaluation Specialist. 3. Recommendations from these debriefs will be forwarded to the PIPRG via the Clinical Director for consideration in updating the plan.

APPENDICES

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

APPENDIX B - II - 7: ESSENTIAL SERVICES ASSESSMENT TOOL

APPENDIX C - II - 7: FACTORS TO CONSIDER WHEN PRIORITIZING PROGRAM ACTIVITIES

APPENDIX D - II - 7: BUSINESS CONTINUITY PREPAREDNESS CHECKLIST

APPENDIX E - II - 7: STAFF ABSENCE TRACKING TOOL

APPENDIX F - II - 7: INCIDENT RECOVERY AND RETURN TO BUSINESS PLAN

II - 8 OCCUPATIONAL HEALTH

Occupational Health and Safety Measures and Infection Prevention and Control for an Influenza Pandemic

Occupational health and safety measures and infection prevention and control measures can help protect SMDHU staff and clients from exposure to the influenza virus.

This section describes the regulatory framework and legislated requirements, roles and responsibilities for workplace health and safety; the risks of influenza transmission in the workplace; the importance of education; the hierarchy of control measures that can reduce the spread of influenza in different settings; and recommended infection prevention and control measures. Recommendations are based on the precautionary principle as set out by Justice Campbell in the final report of the SARS Commission (Spring of Fear, December 2006) which stated: "We cannot wait for scientific certainty before we take reasonable steps to reduce risk."

Objectives

- To ensure SMDHU staff have access to appropriate training, infection prevention and control practices, personal protective equipment, and other supports to reduce exposure to influenza in the workplace.

The Regulatory Framework for Occupational Health and Safety

Occupational Health and Safety Act

SMDHU is required to comply with applicable provisions of the Occupational Health and Safety Act (OHSA) and its Regulations. Employers, supervisors and workers have rights, duties and obligations under the OHSA. In addition, the OHSA section 25(2) (h) requires an employer to take every precaution reasonable in the circumstances for the protection of a worker.

There is a general duty for an employer to establish written measures and procedures for the health and safety of workers, in consultation with the Joint Health and Safety Committee. Such measures and procedures may include, but are not limited to, the following:

- safe work practices
- safe working conditions
- proper hygiene practices and the use of hygiene facilities
- the control of infections.

A worker who is required by his or her employer to wear or use any protective clothing, equipment or device shall be instructed and trained in its care, use and limitations before wearing or using it for the first time and at regular intervals thereafter and the worker shall participate in such instruction and training. SMDHU will be able to demonstrate training, and will document the workers trained, the dates training was conducted, and materials covered during training. Human Resources will track this.

Under the Occupational Health and Safety Act, a worker must work in compliance with the Act and its regulations, and use or wear any equipment, protective devices or clothing required by the employer.

Health care associated infections in workers, acquired as a result of workplace exposures, are occupational illnesses that must be reported to the Ministry of Labour, to the workplace Joint Health and Safety Committee, and to the trade union, if any, in accordance with the Occupational Health and Safety Act s.52 (2). Refer to SMDHU policy and procedure for instruction.
Role of the Workplace Safety and Insurance Board (WSIB)

The Workplace Safety and Insurance Act sets out requirements designed to prevent work related injury or disease and to respond to injured/ill workers. Employers must notify WSIB about a workplace injury or illness within three days. The notice must include such details as steps taken to prevent a recurrence.

Emergency Management and Civil Protection Act

The Emergency Management and Civil Protection Act gives the Lieutenant Governor in Council and the Premier special powers to deal with declared emergencies in Ontario. Under this Act, orders can be issued authorizing persons to provide services during an emergency.

Note: Although the Emergency Management and Civil Protection Act provides special powers, the Occupational Health & Safety Act cannot be overruled in any emergency because worker safety is paramount. All roles, responsibilities, duties, and authority outlined in the OHSA remain intact during an emergency. In the event of any conflict with the Emergency Management and Civil Protection Act, the OHSA prevails.

Health Protection and Promotion Act

Under the Health Protection and Promotion Act, when the Chief Medical Officer of Health is issuing a directive to health care practitioners, he or she must consider the precautionary principle in determining whether there exists or may exist an immediate risk to the health of persons anywhere in Ontario as a result of an outbreak of an infectious or communicable disease and, in the limited situation where the proposed directive relates to worker health and safety, determining the use of any protective clothing, equipment or device.

The Transmission of the Influenza Virus

Influenza is primarily **droplet spread**: it can be directly transmitted from person-to person when people infected with influenza cough or sneeze, and droplets of their respiratory secretions come into contact with the mucous membranes of the mouth, nose and possibly eyes of another person. Particles expelled by a coughing or sneezing person can travel some distance and may be inhaled by someone who is within two metres of a coughing or sneezing person (short-range transmission).

Because the virus in droplets can survive for extended periods of time on surfaces or hands, the virus can also be **contact spread**: people can acquire influenza indirectly by touching contaminated hands, surfaces and objects, and then touching their mouth, nose or eyes.

The issue of whether influenza can also be spread by airborne transmission in other situations (i.e. other than during procedures that generate aerosols) is controversial. Current scientific literature and experience with other influenza viruses does not conclusively confirm or rule out airborne transmission. In Ontario, employers should take all reasonable steps to protect health workers from exposure to the pandemic strain of influenza in their workplace.

Education and Training

To ensure that staff members have the knowledge and skills to reduce influenza transmission, SMDHU will provide appropriate education and training. Ongoing education and support are key to workplace health and safety. All education programs will be developed in consultation with and reviewed by the Joint Health and Safety Committee.

SMDHU will:

- assess the education and training needs of staff related to infection prevention and control and occupational health and safety related to pandemic influenza

- provide initial and ongoing education and training for all staff in:
    - the principles and procedures of infection prevention and control
    - the hierarchy of controls used to reduce the spread of influenza
    - the correct use of personal protective equipment.

The following are learning objectives for Pandemic Influenza Training for Health Workers as defined by the Ontario Health Plan for an Influenza Pandemic:

Influenza Pandemic Background:

1. Describe the potential impact of an influenza pandemic and how it might affect individuals, society and the health care system
2. Define the terms outbreak, epidemic and pandemic
3. Identify criteria for an influenza pandemic and how a pandemic is declared in Ontario
4. Identify the roles of Public Health and Emergency Management Ontario in the management of a pandemic
5. Distinguish between seasonal and pandemic influenza
6. Distinguish between avian and human influenza
7. Describe how avian influenza or another stain might theoretically evolve into human influenza
8. Discuss how an influenza pandemic may begin and spread
9. List the World Health Organization (WHO) stages of pandemic influenza and the level of influenza activity related to each

Infection Control (Basic):

1. Define routine practices in infection control
2. Discuss hand hygiene and its importance in infection control
3. Describe appropriate respiratory hygiene
4. Define influenza-like-illness (ILI)
5. Describe how and over what period of time the virus is transmitted from person to person
6. Describe droplet and contact precautions, including environmental measures
7. Define airborne transmission
8. Describe the role of vaccination in the prevention of influenza
9. Identify types of personal protective equipment (PPE) that will protect users from the virus
10. Describe how to safety don and doff PPE
11. Describe infection control practices at home and in the workplace; e.g. cleaning surfaces, keyboards, desks, and practicing coughing etiquette

Personal and Family Care:

1. Summarize characteristics of influenza pandemic and their impacts
2. Discuss personal hygiene and infection control in the home and community (basic and during an outbreak/pandemic), including cleaning surfaces, utensils and doing laundry
3. Describe the role of seasonal influenza vaccine and issues related to pandemic influenza vaccine
4. Identify the role and uses of antiviral medications
5. Identify personal readiness strategies people can use to prepare themselves and their families for a pandemic
6. Identity potential strategies that people working in health care can undertake to address personal and family issues if they are not present due to illness or working
7. List supplies that you should have on hand in case an emergency occurs
8. Identify ways in which people in the community can assist each other during a pandemic
9. List circumstances and describe rationale for “staying home when sick”

10. Discuss the impact of caring for dependent children, adults and pets during a pandemic on health care workers
11. List reliable sources of information that people can access before and during a pandemic

System Planning and Business Continuity in an Influenza Pandemic
1. Describe the role and implications of the Emergency Management Act
2. Identify municipal and provincial pandemic influenza planning responsibilities and where Ontario health care organizations fit
3. Identify key national, provincial and local lead organizations and their roles
4. Identify key local organization that health care organizations must interact with during pandemic influenza planning and response
5. Describe the basic organization, structure and role of the Incident Management System in responding to an influenza pandemic
6. Identify public health measures in the control of a pandemic
7. Describe strategies to optimize staffing during a pandemic
8. Discuss screening and surveillance of staff with respect to ensuring a sage workplace and business continuity
9. Engage joint health and safety committees and conduct risk assessments

Infection Control (Advanced):
1. Describe modes of transmission of infectious agents
2. Discuss routine practices
3. Discuss the differences between respirators and surgical or procedure masks
4. Discuss droplet transmission precautions
5. Discuss contact transmission precautions
6. Discuss airborne transmission precautions
7. List examples of organisms requiring each of type of precautions
8. Discuss the effect of environmental and equipment cleaning, disinfection and disposal
10. Discuss the benefits and limitations of seasonal and pandemic influenza vaccine
11. Discuss the benefits and limitations of antiviral prophylaxis in virus spread

Occupational Health and Safety:
1. Discuss the importance of appropriate attendance management in relation to a pandemic and any modifications to agency Policy & Procedure.
2. Identify relevant worker health and safety legislation
3. Describe workers' rights and obligations with respect to infectious disease under the Occupational Health and Safety Act (OHSA)
4. Describe employers' obligation with respect to infectious diseases and infection control under the OHSA and the Regulation for Health Care and Residential Facilities
5. Identity the reporting requirements for occupationally-acquired illnesses
6. Identify the Joint Health and Safety Committee's role and responsibilities under the OHSA
7. Identify psychosocial needs of health care workers and recovery strategies
8. List the roles and responsibilities of employers and workers under the emergency Management Act, influencing risk assessments and the "precautionary" principle
9. Identify ways that employers/association/unions can help staff manage personal issues and work responsibilities at home or in alternate locations
10. Discuss ethical issues facing health care workers
11. Discuss financial compensation for health care workers who cannot work due to illness or caring for dependents
12. List sources of influenza occupational health and safety information

Communication Strategies
1. Identify reliable sources of information about pandemic influenza
2. Identify ways for health care workers to communicate with employers, access information and updates, and receive guidance from supervisors and occupational health personnel

3. List the types of information required by an employer to contact and employee (contract worker, or others such as physicians) during an emergency
4. Discuss the importance and means of keeping contact information current
5. Discuss appropriate means of communicating with patients/families/clients/public
6. List sources of influenza occupational health and safety information
7. Describe the information cycle and how it applies to communicating with the public and health care workers

Risk Assessment

To identify and implement measures to protect workers from the risk of acquiring pandemic influenza, SMDHU will conduct a risk assessment in consultation with the Joint Health and Safety Committee.

The Hierarchy of Controls

Protection of workers from infectious diseases may be best achieved using a hierarchy of controls (i.e. at the source, along the path and with the worker).

Reducing the risk of influenza transmission in the workplace requires a comprehensive strategy that includes:

- engineering controls that make the work environment or setting safer
- administrative and work practices that reduce the risk of infection
- personal protective equipment used by health workers
- other infection prevention and control measures that protect patients and visitors as well as health workers.

Engineering controls

The first and most effective line of defense against short-range inhalation transmission because they involve permanent changes in the work setting that reduce exposure to influenza, and they eliminate the risk of “human error” or non-compliance with recommended practices or use of personal protective equipment.

- physical barriers, including acrylic partitions (or sneeze guards) in waiting areas or other high risk zones
- space/design plans for waiting areas that keep sneezing and coughing clients at least two metres away from other clients if possible, or have separate areas for people with ILI
- equipment such as sinks, tissues and disposable towels in every clinic room as well as alcohol-based hand rub (ABHR) and no-touch trash cans in key locations throughout the setting
- surfaces in patient care areas that are easy to clean – combined with appropriate cleaning procedures (administrative and work practice)
- ventilation systems that are designed and maintained in accordance with CSA Standards and Special Requirements for Heating, Ventilation and Air Conditioning (HVAC) Systems in Health

Administrative and Work Practices

Administrative and work practices include ways of organizing and providing services – at the system level and the individual organization level – that reduce the risk of exposure to influenza. Including:

- managing client flow. SMDHU will assess client/traffic flow patterns and make changes, directing people with symptoms of ILI to certain entrances and exits, and limiting access to certain parts of the facility.

- screening policies and procedures for influenza-like illness (ILI) for clients, staff and visitors that would direct them to take appropriate steps to reduce risk (e.g. instruct clients with ILI to put on a surgical mask, perform hand hygiene, and keep at least 2 metres away from others, ask ill visitors not to enter patient care areas).

- work practices such as having staff members wear N95 respirators when entering a room/area with persons with ILI.

- staffing plans that:
    - identify staff who may be at high risk of complications from influenza so they can be offered work assignments that do not knowingly expose them to the influenza virus (Note: during a pandemic, personnel at high risk should be accommodated. Appropriate alternative work should be provided where available.)
    - set out how staff will be deployed and managed during a pandemic.

- HR policies that encourage ill employees to stay home. SMDHU will establish a clear expectation that staff do not come into work when they have ILI symptoms and support this expectation with appropriate attendance management policies. Actively exclude workers who are ill (i.e. send workers home who arrive at work ill).

- social distancing procedures that minimize face-to-face contact between staff members in situations where they are not wearing PPE, such as arranging to meet by e-mail and teleconference instead of in person

- processes for handling and cleaning equipment and clothing that reduce possible exposure

Personal Protective Equipment (PPE)

Table 7.3 from the Ontario Health Plan for an Influenza Pandemic August 2008 lists the personal protective equipment suggested in different situations. SMDHU will:

- stockpile a four-week supply of appropriate personal protective equipment required
- maintain a written respiratory protection program, and provide fit testing and training for staff using N95 respirators
- ensure that workers have quick easy access to the personal protective equipment required.
- develop procedures and provide training to help ensure staff put on, use, take off and dispose of personal protective equipment.
- instruct clients with ILI symptoms (i.e. coughing, sneezing) to perform hand hygiene and wear surgical/procedure masks (if their condition allows) when in common areas, such as waiting rooms

Coping with Equipment Shortages

- during a pandemic, SMDHU may experience PPE shortages. In those cases, employers will assess services and reprioritize to ensure staff involved in high risk activities are protected at all times

Table 7.3: Personal Protective Equipment Suggested for Patient Care During an Influenza Pandemic

NOTE: PPE is only one component of the hierarchy of infection prevention and control measures required to protect health workers. Gloves, gowns and/or masks (during seasonal influenza) should be used where indicated by routine practices and additional transmission-based precautions based on a workplace specific risk assessment conducted in consultation with the Joint Health and Safety Committee.

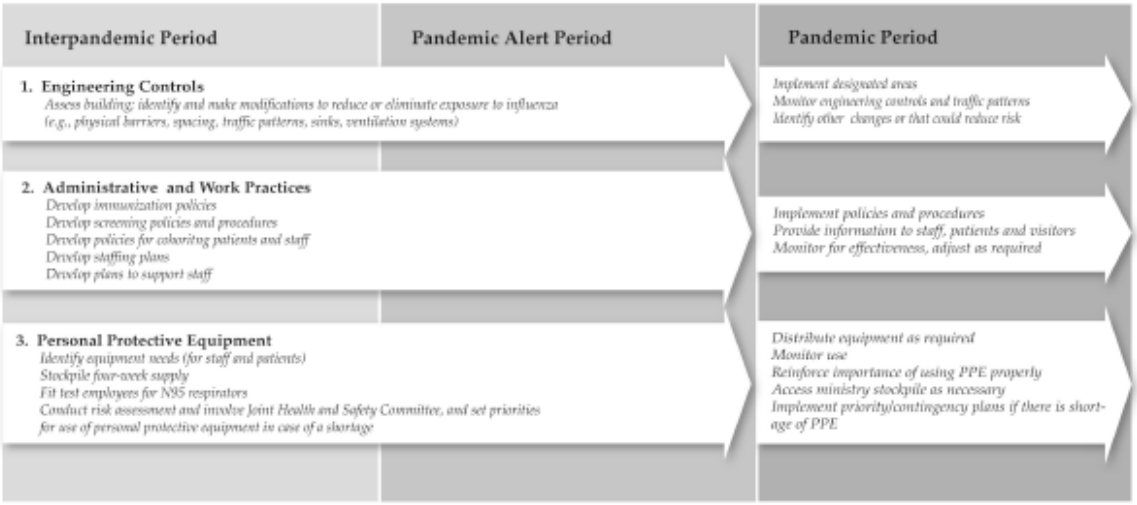
	Seasonal Influenza (including ILI[1]) no risk factors for airborne diseases	**Pandemic Influenza** (including ILI[1])	**Aerosol Generating Procedures on Patients with Pandemic Influenza*** (including ILI[1])
Patient accommodation	Single patient room AIIR[2] not required	Single patient room or cohort AIIR[2] not required	In AIIR[2] if available
Precautions	Routine/Droplet/Contact	Routine/Droplet/ Contact	Routine/Droplet/ Contact/ Airborne
Hand hygiene	Yes	Yes	Yes
Gloves	If indicated by Routine Practices[3]	If indicated by Routine Practices[3]	If indicated by Routine Practices[3]
Gown	If indicated by Routine Practices[3]	If indicated by Routine Practices[3]	If indicated by Routine Practices[3]
Surgical mask for HCW	Yes	No	No
N95 respirator for HCW	Not routinely	Yes[4]	Yes[4]
Eye Protection	If indicated by Routine Practices[3]	If indicated by Routine Practices [3]	Yes
Surgical Mask on Patient	At triage and if outside of room	At triage and if outside of room	Not applicable

[1]ILI: Influenza-like illness
[2]AIIR: Airborne infection isolation room
[3]See Provincial Infectious Diseases Advisory Committee (PIDAC) resources on routine practices.
[4]*The use of N95 respirators are being recommended to protect health workers from the possibility of short-distance fine droplet aerosol transmission. See Council of Canadian Academies Report.*
*Detailed information on the types of aerosol-generating procedures and personal protective equipment requirements are provided in World Health Organization interim guidelines for infection prevention and control of epidemic and pandemic-prone acute respiratory diseases in health care – June 2007, pp 43-44. Available at: *http://www.who.int/csr/resources/publications/WHO_CD_EPR_2007_6/en/index.html*

Applying the Hierarchy of Controls in Different Health Settings

The principles of the hierarchy of controls apply to all health settings but each setting will face unique issues. Figure 7.2 from the Ontario Health Plan for an Influenza Pandemic August 2008 illustrates the planning and implementation of the hierarchy of controls by pandemic phase.

Figure 7.2: Hierarchy of Controls by Pandemic Period



Note: The hierarchy of controls used in any setting should be based on a risk assessment conducted in consultation with the Joint Health and Safety Committee, infection prevention and control and occupational health services.

Infection Prevention and Control Measures

SMDHU will implement appropriate infection prevention and control measures.
These measures are designed to protect workers, clients and visitors from exposure to the pandemic strain of the virus.

They include:

- access to infection prevention and control expertise
- ongoing surveillance programs for febrile respiratory illnesses
- immunization policies that encourage staff providing care and/or services to patients/residents/clients to be immunized against seasonal influenza
- consistent use of routine practices and additional precautions

Infection Prevention and Control for the Client with Influenza/ILI

Clients who have influenza symptoms (i.e. fever, cough) who present at SMDHU should be asked to:

- practice hand hygiene: clean their hands using alcohol-based hand rub
- wear a surgical or procedure mask and either wait in a separate area or keep at least two metres away from other clients and staff. If the patient cannot tolerate a mask (e.g. children, people with chronic breathing problems, people with dementia), s/he should wait in a separate area or keep at least two metres distance from other patients and be provided with tissues to contain coughs.
- If masks are not available, patients should be encouraged to use another method to cover their mouth and nose when coughing or sneezing (e.g. tissue, coughing into sleeve).
- Patients who have symptoms of influenza like illness and a travel history to an area with a health alert should be moved immediately out of the waiting room and put in a separate room.

Infection Prevention and Control for SMDHU Staff

To protect workers from risk of occupational exposure to the pandemic influenza strain, OHPIP recommends the precautions usually used with influenza, including hand hygiene, routine practices, droplet and contact precautions for routine care, and airborne precautions when performing aerosol-generating procedures. In addition to droplet precautions, OHPIP recommends the use of N95

respirators (instead of surgical masks) when in a room/area with influenza patients. This recommendation is based on the precautionary principle and is designed to protect workers from the risk of fine droplet spread.

Hand Hygiene

SMDHU staff members should follow rigorous hand hygiene measures, as follows:

- Perform hand hygiene before seeing clients; after seeing clients and before touching one's face; and after removing and disposing of personal protective equipment.
- When hands are visibly dirty or contaminated with respiratory secretions, wash with soap and water.
- If gloves are worn, perform hand hygiene immediately after removing gloves.
- If hands are not visibly soiled, use an alcohol-based hand rub containing between 70 and 90% alcohol to routinely decontaminate hands in all clinical situations including contact with a client with ILI.
- When cleaning hands with soap and water, wet hands first with water, apply the amount of product recommended by the manufacturer to hands, and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and pat dry thoroughly with a disposable towel. Use a disposable towel to turn off the faucet.
- When decontaminating hands with an alcohol-based hand rub, apply product to the palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. Note: Sinks that patients use may be heavily contaminated and should not be used by health workers for hand hygiene unless no other alternative is available.

Routine Practices

When interacting with clients, including clients with influenza or symptoms of ILI, health workers should use routine practices:

- wear a mask and protective eye wear when working in the clinic room or near a coughing patient
- wear appropriate gloves when likely to have contact with body fluids or to touch contaminated surfaces
- use standard operating procedures to handle, clean and then disinfect equipment, clean clinic rooms, and handle soiled linen; prevent needlestick/sharp injuries; and address environmental cleaning, spills management, and handling of waste. See SMDHU IPAC P&P.

Commercial, pre-packaged, cleaning or disinfectant wipes that are easily accessible to all workers allow efficient cleaning of equipment and surfaces between patients.

How to Remove Personal Protective Equipment (PPE)

After the staff member has completed the client interaction and is away from the area:

- Remove gloves and discard using a glove-to-glove/skin to skin technique.
- Remove gown (discard in linen hamper in a manner that minimizes air disturbance).
- Perform hand hygiene.
- Remove eye protection and discard or place in clear plastic bag and send for decontamination as appropriate.
- Remove respirator and discard.
- Perform hand hygiene.
- This is a minimum procedure. If health workers believe their hands have become contaminated during any stage of PPE removal, they should perform hand hygiene before proceeding further.

Droplet and Contact Precautions

During a pandemic staff providing services for clients with influenza or ILI should use droplet and contact precautions:

- use procedures that minimize contact with droplets (e.g. sitting next to rather than in front of a coughing patient when taking a history or conducting an examination)
- take only the equipment required to provide service into the clinic room
- whenever possible, use disposable equipment and discard it with regular garbage
- clean and disinfect any reusable communal or shared equipment after use
- wear an N95 respirator (this is a modification to droplet/contact precautions based on risk in accordance with infection prevention and control principles).
- remove Personal Protective Equipment (PPE) properly
- wipe down any areas touched by a patient with influenza during a visit (e.g. arms of the chair in the waiting room, the examination table, the edge of the desk,).

Infection Prevention and Control Practices for the Public/Visitors

SMDHU should advise the public/visitors about the steps they can take to reduce the risk of being exposed to influenza, including:

- having the annual influenza immunization
- practicing hand hygiene: washing their hands frequently with soap and water or using alcohol-based hand rub – particularly after coughing or sneezing and when entering and leaving a health setting
- keeping at least two metres away from someone who is coughing or sneezing avoiding activities where large number of people gather in enclosed spaces (e.g. sporting events, concerts)
- thoroughly cleaning surfaces in the home in areas occupied by someone with ILI, focusing on "high touch" items such as taps, doorknobs, light switches, the telephone and bed table, that the ill person has touched that others may also touch
- complying with any public health measures recommended by the medical officer of health
- staying home from work or school when ill
- covering their mouth when coughing using a tissue or sleeve rather than their hands
- not visiting people in hospital or a long-term care home when ill with influenza.

The wearing of masks or respirators by the public/people caring for someone who has influenza has not been proven to be an effective means of limiting the spread of influenza during a pandemic. However, if individuals who do not have ILI choose to wear masks, they should:

- wear a surgical/procedure mask
- learn the proper procedures to put masks on and off
- dispose of the mask immediately after removing it and then immediately perform hand hygiene
- know how to properly dispose of used masks without contaminating themselves and increasing the risk of infection
- understand that masks or any protective equipment is not a substitute for hand hygiene.

Psychological Support for Workers

During an influenza pandemic, staff members are likely to be working extended or extra shifts in an environment with high levels of stress – caused by the demand for care and fear of the emerging pandemic. As part of pandemic preparedness, employers should develop psychosocial support services that will help health workers and their families cope with fatigue, the discomfort of wearing personal protective equipment for long periods of time, and stress and anxiety. In addition to the services provided by employee assistance programs, employers may consider providing:

- counseling

- assistance with child care, pet care, meals and other home responsibilities.

Managing Workers with ILI

The SMDHU will determine an appropriate length of time an employee needs to be absent from work during a declared pandemic based on the epidemiology of the illness. In general a physician's note will not be needed for return to work.

Communications

During a pandemic, it is critical that frontline staff receive the information they need to work safely. In addition to Important Health Notices, MOHLTC will use a number of different mechanisms to communicate with health workers and stakeholders (e.g. telephone, email, fax, website, videoconferencing, public education, advertising, stakeholder communications, and media relations).

References: MOHLTC, Ontario Health Plan for an Influenza Pandemic, Ch. 7, 2008.

II - 9 FIRST NATIONS COMMUNITIES

The OHPIP, Chapter 20. Guidelines for First Nations communities, describes the responsibilities of different levels of government for first nations communities with respect to PIP. The Province of Ontario, the Government of Canada through First Nations and Inuit Health (FNIH) and the First Nations communities share responsibility for First Nations health services in Ontario. The responsibilities and relationships for the provision of services of local public health units with respect to First Nations communities are variable across the province.

In Ontario there are 134 First Nations communities of which 106 are non-isolated (i.e. road access less than 90 km to physician services) and 28 are isolated (i.e. regular flights, no year round road access, good telephone and radio services).

In Simcoe Muskoka there are four non-isolated First Nations communities (locations): Wahta Mohawks of Gibson (Bala), Moose Deer Point (Mactier), Chippewas of Beausoleil (Christian Island) and Chippewas of Rama (Rama). In the summer of 2009 the health unit consulted with the FNIH on planning for local First Nations communities in light of H1N1 and assesses the status of their PIP. In the fall of 2009 the Medical Officer of Health and the Director of the Clinical Service visited each of the bands and discussed the impending H1N1 pandemic and their preparations in each community with each of the Band Chiefs and Band Council members, administrators and/or health service workers.

The province is still working on exactly how things will operate with FNIH and the Chiefs of Ontario, but some responsibilities have been defined. FNIH is responsible for surveillance activities, Ontario will provide antivirals to FNIH for distribution through First Nations community health centres and nursing stations, and provincially supplied vaccine will be distributed to First Nations by local public health units.

First Nations people living outside First Nations communities have equitable access to influenza programs and services in the communities in which they do live.

The populations of the SMDHU First Nations communities in 2009 were reported as follows:

- Wahta Mohawks of Gibson (Bala): 168
- Moose Deer Point (Mactier): 152
- Chippewas of Beausoleil (Christian Island): 598
- Chippewas of Rama (Rama): 654

Total: 1572

All four communities had either completed their PIP or had one under development. Their plans for vaccination and antiviral distribution, if required, were clear in all cases. Because the Wahta Mohawks of Gibson and the Moose Deer Point communities had historically received many of their public health services from the Parry Sound area they continued to be supplied with vaccines from the North Bay Parry Sound District Health Unit even though they were technically now in the SMDHU catchment area. We opted not to change this service relationship. They also both received their vaccines, and other health care services, from nurse practitioners in a group based in Parry Sound.

The Chippewas of Beasoleil (Christian Island) and of Rama communities both receive their vaccines and supplies from the SMDHU. While Rama had a health clinic and staff to provide immunizations, the Chippewas of Beausoleil have their influenza vaccines administered by SMDHU staff each year; this was continued for pH1N1. Both communities depended on antiviral prescriptions from community physicians or nurse practitioners that were not part of the First Nations communities.

There were two elementary schools among the four communities: one each on Christian Island and at Rama. Both these schools were included in the school absenteeism surveillance program established for pH1N1.

PART III

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 17.1: Impact of 35% Influenza Attack Rate on Hospital Capacity

35% Attack Rate - 8 Weeks		Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10
Hospital Admission	Weekly admissions	3,691	6,152	9,228	11,689	11,689	9,228	6,152	3,691		
	Peak admissions/day				1,821	1,821					
Hospital Capacity	# of patients in hospital	2,713	4,522	6,783	8,592	8,897	7,820	5,997	3,934		
	% capacity needed	16%	26%	40%	50%	52%	46%	35%	23%		
ICU Capacity	# of patients in ICU	554	1,174	1,803	2,382	2,578	2,507	1,992	1,376		
	% ICU capacity needed	37%	78%	119%	158%	171%	166%	132%	91%		
Ventilator Capacity	# patients on ventilators	277	587	902	1,191	1,289	1,254	996	688		
	% usage of ventilators	25%	54%	82%	109%	118%	114%	91%	63%		
Deaths	# of influenza deaths			731	1,218	1,828	2,315	2,315	1,828	1,218	731
	# of deaths in hospital			512	853	1,279	1,621	1,621	1,279	853	512

Notes:
1. All results showed in this table are based on most likely scenario.
2. Number of influenza patients in hospital, in ICU, and number of influenza patients on ventilator are based on maximum daily number in a relevant week.
3. Hospital capacity used, ICU capacity used, and % usage of ventilator are calculated as a percentage of total capacity available (see manual for details).
4. The maximum number of influenza patients in the hospital each week is lower than the number of weekly admissions because we assume a 5-day stay in general wards (see manual for details).
5. The CDC's FluSurge program (http://www.cdc.gov/flu/flusurge.htm) provides more specific detail with respect to hospital capacity during a pandemic and can display the impact on capacity over time depending on the duration of the pandemic (in weeks), which differs slightly form the FluAid program. While both FluAid and FluSurge 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. This may be because both programs use a slightly different age distribution for entry of population data.

Source: Ontario Health Pandemic Influenza Plan, August 2008

Based on the above parameters, the Ontario plan estimates that for the province, pandemic influenza alone will use 52% of all acute care beds, 170% of ICU beds, and 117% 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 17.1 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.

Assessment Centres and Primary Care

Substantial planning has been ongoing to determine how primary health care will be delivered in Simcoe County and the District of Muskoka. It is quite likely that Influenza Assessment 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 assessment 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 assessment centres is currently being planned through SMHSEPC.

One such Centre was opened in Barrie by several partners during the pH1N1 outbreak. The memorandum of agreement (MOA) created by the partners following pH1N1 is located in Appendix 111-1. The SMDHU is one partner to this agreement and committed staff to be redeployed during pH1N1; as per agreement staff would be redeployed again in a similar situation. Although the SMDHU does not have sufficient resources to contribute staff to all such assessment centres in its jurisdiction, the staffing agreement can, nevertheless, serve as a model for other surge capacity planning in the localities of the County of Simcoe and the District of Muskoka.

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 assessment 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 assessment 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 the SMHSEPC Health Services Template for these plans

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 equip 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.

A model surge capacity arrangement was established during pH1N1 for the opening of an Assessment Centre. The MOA describing this arrangement can be found in Appendix 111-1. Other Simcoe Muskoka population centres need to develop similar local agreements, possibly working through the SMHSEPC, to prepare for the next pandemic surge.

APPENDICES

APPENDIX 111-1: MEMORANDUM OF AGREEMENT

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 planning 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 Algonquin Healthcare
- representative(s) of Simcoe Muskoka District Health Unit
- representative(s) of North Simcoe Muskoka CCAC and Central CCAC
- 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 PLAN REVIEW GROUP (PIPRG)

Purpose:
The purpose of the Pandemic Influenza Plan Review Group (PIPRG) is to review and maintain the SMDHU PIP on an ongoing basis.

Objectives:
1. Review the June 2006 draft of the PIP and any comments that come forward from the Directors prior to approval of the PIP by the Executive Committee
2. Recommend any changes necessary to the plan
3. Following approval of the PIP, review the entire plan annually
4. Maintain the PIP to keep it current and consistent with other provincial, national and international PIPs
5. Develop and monitor work plans for the completion of outstanding items from the PIP; report on progress toward completion
6. Lead in the implementation of pre-pandemic aspects of the PIP

Chair:
- Bill Mindell, Director, CS

Members:
- Kelly Magnusson, Manager, HPS – Emergency Response Lead
- Ann Corner, Manager, CS – Public Health Measures Lead
- Laurie Stanford, Manager, CS – Vaccine & Antiviral Lead
- Shawn Fendley, Team Lead, Corp S – Communications Lead
- Leigh Fairbrother, Supervisor, CDSU, CS – Surveillance Lead
- Brenda Hadley, HR Advisor, Corp S – Business Continuity Lead
- Ryan MacDougall, CDSU, CS - Orientation & Training Lead
- Cindy Francis - Secretarial Support

Adhoc Members:
- Dr. Colin Lee, AMOH
- Dr. Chuck Gardner, MOH
- Reina Barker, Manager, Health Connection

Term of Service:
- ongoing

Role of Members:
- Participate in meeting the objectives of the review group
- Report on the progress of outstanding items
- Lead, assist in and/or facilitate the completion of outstanding items
- Ensure that the PIP is up-to-date at least annually

Role of Chair
- Set Agenda
- Facilitate the meeting
- Schedule meetings as necessary
- Communicate to the Executive Committee
- Maintain overall responsibility for the PIP

Role of the Secretary:

- Record the minutes and update previous minutes based on the group's feedback
- Book the meeting room and equipment as need
- Distribute minutes in a timely manner
- Maintain Committee electronic files/resources

Meeting Frequency and Duration:

- Twice between July 25th and September 13th, 2006 and quarterly thereafter
- Meeting schedule to be based upon mutually agreed upon times
- Duration: ½ day sessions

Reporting Relationships:

The Chair communicates the activities of the review group to Executive Committee

Approved by Executive Committee: July 26, 2006

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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