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# Alberta Pandemic Influenza Plan for the Health System

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April 2008
Executive Summary

As part of the Alberta Government’s commitment to protect the health of Albertans, Alberta Health and Wellness (AHW) is working to strengthen the health system capacity to prevent, be prepared for and respond to public health risks. This plan outlines Alberta’s health response to pandemic influenza. The goal is to implement an effective and timely response to this public health emergency to:

- reduce morbidity and mortality, and
- minimize societal disruption in Alberta by providing access to appropriate prevention measures, care and treatment.

This document will provide direction for the health response to AHW and key stakeholders within the health sector, namely the regional health authorities (RHAs) that are directly responsible for the delivery of health services. It will also serve to inform the Government of Alberta (GoA) and others to prepare Alberta for this or another similar public health emergency. This plan replaces all previous AHW pandemic influenza plans.

Pandemic influenza response is based on the appearance and epidemiology of a novel influenza virus in the world and evolves over time (“a disaster in slow motion”). This plan maps out key activities related to early detection, mitigation and consequence management in the health sector.

Pandemic influenza starts as a health emergency and may evolve into a general emergency. AHW, in partnership with the RHAs, will lead the health response and is the health subject matter expert. GoA ministries will provide support for the health response and municipalities are encouraged to assist the health regions to the best of their abilities and work to maintain their respective essential services.

Effective response relies upon effective working relationships and coordination with all jurisdictions, levels of government as well as private industry and individuals. The Alberta Pandemic Influenza Plan for the Health System (APIP) will work in tandem with the Alberta Pandemic Influenza Operations Plan (APIOP) coordinated by the Alberta Emergency Management Agency (AEMA) as well as all other jurisdiction/government plans, e.g. RHA and municipality response plans, GoA Business Continuity Plans. The APIP also links to the Canadian Pandemic Influenza Plan for the Health Sector (CPIP) and is synchronized with the World Health Organization (WHO) pandemic influenza response phases.

The emergency management structures and concept of operations during the event are based on the National Health Emergency Management System (NHEMS), a common response model that has been adopted by all RHAs provincially and the Public Health Agency of Canada (PHAC) nationally.

This plan will be updated as new information is made available.
Acknowledgements

The Alberta Pandemic Influenza Plan for the Health System builds from the Alberta Pandemic Influenza Contingency Plan 2002 and all previous AHW pandemic planning committee reports and documents and incorporates lessons learned from provincial pandemic influenza exercises and past infectious disease outbreaks, e.g. Severe Acute Respiratory Syndrome (SARS). It is informed by best practice recommendations for disasters and public health emergencies.

The support and assistance provided by stakeholders in Alberta’s pandemic influenza planning are gratefully acknowledged. Special thanks are given to the members of all provincial planning committees for their time, input and dedication.

This document was developed with input and direction from members of the Alberta Health and Wellness Pandemic Influenza Project Team:

Balderston, Dan Former Manager, Financial Reporting – Health Authority Funding and Financial Accountability
Balec, Angela Assistant Director – Communications
Berezanski, Joan Director – Office of the Provincial Medical Care Consultant
Berezowski, Krista Emergency Planning Coordinator – Emergency Health Services
Bouwsema, Darlene Acting Assistant Deputy Minister, Program Services – Emergency Health Services
Brick, Rick Executive Director – Human Resources
Brisson, Mark Executive Director – Information Management
Carmichael, Crista Organizational Effectiveness Manager – Human Resources
Chamberlain, Martin Barrister and Solicitor – Legal and Legislative Services
Christianson, Brenda Administrative Support – Provincial Program Development and Disease Control
Damer, Crystal Former Director – Cross Ministry Pandemic Influenza Preparedness
Elabdi, Micky Public Affairs Officer – Communications
Grimsrud, Dr. Karen Acting Chief Medical Officer of Health – Provincial Health Office
Hansen, Barb Executive Director – Provincial Program Development and Disease Control
Heinrichs, Bernice Project Manager – Provincial Program Development and Disease Control
Hnit, Erin Policy Analyst – Strategic Issues and Continuing Care

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Alberta Pandemic Influenza Plan for the Health System

Honish, Agnes  Former Senior Operational Policy Lead – Provincial Program Development and Disease Control

James, Eileen  Former Manager, Public Health Emergency Planning – Provincial Program Development and Disease Control

Janes, Kevin  Former Security Adviser – Information Management

Johner, Karlene  Former Project Manager – Provincial Program Development and Disease Control

Kessler, Sue  Senior Manager, Pandemic Preparedness – Provincial Program Development and Disease Control

Lai, Vivien  Senior Policy Advisor – Strategic Issues and Continuing Care

Lanman, Lydia  Former Senior Intergovernmental Policy Advisor – Federal/Provincial Relations

Lenuik, Greg  Public Health Information Officer – Provincial Program Development and Disease Control

Mattern, Linda  Director – Health Workforce Policy and Planning

Maslyk, Tina  Emergency Planning Coordinator – Emergency Health Services

Neuman, Arlynn  Former Research and Project Coordinator – Health Workforce Policy and Planning

Pasula, John  Former Risk Analyst – Risk Management

Pehowich, Meghan  Project Coordinator, Pandemic Planning – Provincial Program Development and Disease Control

Perry, Dr. Doug  Provincial Medical Care Consultant – Office of the Provincial Medical Care Consultant

Powell, Chris  Senior Financial Consultant – Health Authority Funding and Financial Accountability

Sandouga, Vicky  Director – Risk Management

Sartison, Elaine  Senior Manager, Immunization Program – Provincial Program Development and Disease Control

Sasaki, Janis  Barrister and Solicitor – Legal and Legislative Services

Simmonds, Kim  Epidemiologist – Surveillance and Environmental Health

Spillett, Diane  Consultant

Svenson, Larry  Manager, Epidemiologic Surveillance – Surveillance and Environmental Health

Tuckwell, John  Public Affairs Officer – Communications

Wakaruk, Marilyn  Former Assistant Director – Communications

April 2008
Zielinski, Michele  Former Project Manager, Pandemic Planning – Provincial
Program Development and Disease Control

Assistance from representatives of the Regional Health Authorities (RHAs) on the
Alberta Pandemic Influenza Working Group is also appreciated.
1 Introduction

The Alberta Pandemic Influenza Plan for the Health System (APIP) will primarily direct activities of Alberta Health and Wellness (AHW) and regional health authorities (RHAs) in response to pandemic influenza (refer to Appendix 1: Pandemic influenza – overview) within the context of the Canadian Pandemic Influenza Plan for the Health Sector 2006 (CPIP).

The APIP builds from the Alberta Pandemic Influenza Contingency Plan 2002 and previous AHW pandemic influenza planning committee reports and documents and incorporates lessons learned from provincial pandemic influenza exercises and past infectious disease outbreaks, e.g. Severe Acute Respiratory Syndrome (SARS). It is informed by best practices recommendations for disasters and public health emergencies. This plan replaces all previous AHW pandemic influenza plans.

AHW ROLES DURING EMERGENCY RESPONSE

In the event of pandemic influenza, the Minister of Health and Wellness and the department assume a leadership role under the provisions of the Emergency Management Act and the Public Health Act, including the related regulations (refer to Appendix 2: Legislative authority for Alberta’s health response for pandemic influenza). As such, AHW will provide overall direction to the provincial health-system response, by:

- monitoring the health of Albertans and health-care utilization/operational status of RHAs,
- coordinating the provision of information to and from RHAs and other service providers as appropriate,
- directing the overall provincial communication strategy and messages,
- communicating and obtaining support from the Government of Alberta (GoA) and federal, provincial, and territorial governments (F/P/T),
- coordinating and supporting the health responses of the nine RHAs and other health sector stakeholders, e.g. health professional regulatory colleges, Provincial Laboratory of Public Health and Health Link Alberta, including providing direction regarding:
  - surveillance,
  - public health measures,
  - self-care strategies,
  - vaccines and antivirals,
  - clinical care guidelines/triage, and
  - infection control.
RHA ROLES DURING EMERGENCY RESPONSE

RHAs will be responsible for supporting the local health response within their respective regions by:

- providing frontline service delivery of essential health and public health programs,
- reallocating/re-deploying resources when necessary to ensure reasonable equitable access to essential services and critical scarce resources to ensure an effective health response where possible,
- working directly with local jurisdiction stakeholders across all sectors,
- communicating to the public, staff and stakeholders in their regions, consistent with provincial direction (communication may be specific to the local situation),
- communicating their ongoing operational status to AHW, and
- requesting assistance from the province as necessary, recognizing that the ability to assist may be limited.

PURPOSE

The APIP is a coordinated and phased health response to pandemic influenza. The plan is based on a moderate scenario consistent with the last two pandemics and is scalable to address the more extreme response requirements should a severe scenario present itself.

The APIP describes key/critical activities needed to mitigate and/or respond to the projected scenarios expected during the pandemic influenza alert and pandemic influenza periods (refer to Table 1: Pandemic Influenza Phases, in Section 2, Plan Activation).

PLAN GOALS

The goal of the APIP is to facilitate the coordination of Alberta’s health system for an effective and timely response to a pandemic influenza emergency by:

- reducing morbidity and mortality, and
- minimizing societal disruption in Alberta by providing access to appropriate prevention measures, care and treatment.

OBJECTIVES

The objectives of the APIP are to:

- provide an emergency management framework to coordinate AHW and the RHAs response, and
- outline the roles and responsibilities primarily of AHW and the RHAs to facilitate timely and effective health response.
PLANNING ASSUMPTIONS

- Emergencies are managed locally first.
- AHW’s role is to provide overall leadership and coordination and to leverage support across jurisdictions.
- Routine business processes and communication pathways/networks will be maintained as much as possible.

KEY MITIGATION STRATEGIES

A health response to communicable disease emergencies commonly includes strategies related to surveillance, public health activities, health services/workforce, communications and emergency management.

While similar, each type of communicable disease emergency has specific containment/risk mitigation strategies. For a pandemic influenza these include vaccine, antivirals and self-care.

Vaccine
Immunization with the pandemic influenza vaccine (specific to the circulating virus) is the most effective strategy to prevent pandemic influenza. However, because production of the pandemic influenza vaccine can only be started once the pandemic influenza virus has been confirmed, Alberta will rely upon alternate control strategies in the early days of pandemic influenza. Pandemic influenza vaccine manufactured and approved in Canada will be released by the Public Health Agency of Canada (PHAC) in lots allocated to each province and territory according to population. As a result of this phased availability across the country, AHW, through all RHAs and the First Nations and Inuit Health Branch (FNIHB) of Health Canada (Alberta Region), will distribute/deliver pandemic influenza vaccine based on the nationally predetermined priority groups (refer to Section 6, Pandemic Influenza Vaccine for details).

Antivirals
During a pandemic influenza, antiviral medications (oseltamivir and zanamivir) will be used to:

- decrease the risk of transmission from the first cases and contacts identified in Alberta thereby delaying or slowing the transmission of the virus in the early phase, and
- treat ill persons who present within 48 hours of onset of illness (medication is not effective after 48 hours) to a designated health-care facility/provider in order to minimize morbidity and hospitalization rates.

AHW will distribute antiviral medications from a provincially-controlled stockpile (a component share of the national stockpile) on a per capita basis to the RHAs. Each
RHA will be responsible to deliver and distribute antivirals to eligible Albertans in their region for purposes of early treatment (refer to Section 7, Antivirals for details).

Directions/recommendations regarding the efficacy and effectiveness of an antiviral strategy for prophylaxis for target groups is pending national consensus at the time of print.

Influenza Self-Care

Influenza Self-Care was identified as a key strategy as part of Alberta’s contingency planning for a pandemic influenza. Unlike other communicable diseases, influenza affects the health of the population and places a strain on the health system each year. The Influenza Self-Care Strategy was initiated in the 2005-06 influenza season to support the overall delivery of health services, as well as to test and refine pandemic influenza strategies during the interpandemic period.

The goals of the Influenza Self-Care Strategy are to:

- increase the confidence and ability of the public in using self-care measures to prevent and treat influenza, and
- educate the general public about when to access the health system.

The Influenza Self-Care Strategy contains public education materials with information on how to prevent/prepare for influenza, care for self/family/others if ill and when to seek medical attention. A reference manual is available to guide health-care providers while working with their clients/patients (refer to Section 13, Provincial and Regional Communications for details).

2 Plan Activation

Given the nature of pandemic influenza, i.e. a disaster over the course of 12 to 18 months, implementation of the various components of the Alberta Pandemic Influenza Plan for the Health System (APIP) will be gradual, based on threat, severity and epidemiologic phase of the pandemic influenza and associated effects on scarce health care resources (refer to Table 1: Pandemic Influenza Phases in this section).

As the threat of pandemic influenza increases in the world, activation of and implementation of associated APIP components, would be based on:

- discussions held with the Public Health Agency of Canada (PHAC) and the Council of Chief Medical Officers of Health (CCMOH) across Canada,
- similar discussions held with Alberta’s Chief Medical Officer of Health (CMOH) or designate and regional Medical Officers of Health (MOHs),
- the CMOH or designate recommending activation of the APIP to AHW’s Deputy Minister,
AHW will determine which components of the APIP to activate to meet the situation requirements [e.g. the establishment of the Public Health Emergency Coordination Group (PHECG)]. For details of the structure and operation of the PHECG, refer to Appendix 4: Pandemic influenza health emergency management.

Upon decision to activate the APIP, the following communications will take place:

- The Minister of AHW will notify the GoA of the status of the pandemic influenza virus and the required response plan activities.
- The Deputy Minister of AHW will notify the RHA Chief Executive Officers.
- The CMOH or designate will advise the MOHs and the Managing Director of the Alberta Emergency Management Agency (AEMA) by way of phone, e-mail and/or fax of the activation of the APIP. AHW and AEMA will work closely together as the lead and the coordinating agencies respectively.
- RHAs will activate their plans in consideration of the provincial direction and their local situation, including contacting the municipalities who have the supporting role.

The communication mechanisms are currently under development.

Refer to Appendix 3: Communication - notification of activation of Alberta Pandemic Influenza Plan for the Health System for an outline of communication steps.

DECLARATION OF PUBLIC HEALTH EMERGENCIES (PROVINCIAL OR LOCAL):

- Pursuant to the Public Health Act, the CMOH or designate, after consultations with PHAC and MOHs, may recommend to the Lieutenant Governor in Council that the province declare a state of public health emergency. This would occur through communication with the Deputy Minister and Minister of AHW.

- If a RHA requires emergency powers, that RHA shall notify the PHECG if, pursuant to the Public Health Act, they:
  - intend to declare a local state of public health emergency,
  - intend to use any section 52.6 powers and/or
  - are seeking any court orders related to pandemic influenza.

This is very important as urgent access to the Courts can be facilitated by AHW and it is imperative that orders (court orders and orders under section 52.6) are coordinated, i.e. there are no conflicting orders (refer to Appendix 2: Legislative authority for Alberta’s health response for pandemic influenza).
USE OF EMERGENCY POWERS

The use of emergency powers during a pandemic needs to be carefully considered prior to actual utilization. There are issues of compensation, liability and enforcement which need to be considered. The power to take property and conscript people raises significant social and political issues. Use of these powers comes with legal, moral and social obligations. A RHA that intends to use the extraordinary 52.6 powers shall contact AHW through the PHECG.

Coordination of Emergency Powers

In the event of a major emergency such as a pandemic, both the Emergency Management Act and the Public Health Act may be invoked simultaneously. They should be treated as having equal authority. There may be times when two organizations need access to the same scarce resource. To ensure that public bodies are not competing for the same resource using competing powers, RHAs and local authorities need to keep each other informed of their plans and actions on a regular basis. Should a situation develop where conflicts cannot be resolved at the local level, then AHW shall be advised through the PHECG. The Ministers of AHW and Municipal Affairs will assist in resolving the matter and may direct a course of action.

Re-allocation of Scarce Resources

The Minister of Health and Wellness has the authority to coordinate the provision of health services and during a severe pandemic the Minister may re-direct scarce resources across RHAs should access to care become critical. However, this authority will only be used as a last resort. It is expected that RHAs will be responsible for assisting other RHAs and will re-allocate and deploy scarce resources as needed.

PANDEMIC INFLUENZA PHASES

The status of the pandemic influenza virus will be consistently reported using the six phases of the World Health Organization (WHO), and the expanded numbering system, to describe the virus within the context of Canada and Alberta (refer to Table 1: Pandemic Influenza Phases, at the end of this section).

NOTE: The phases for Canada and Alberta are not necessarily sequential; the probability is that some phases may be skipped as Alberta moves to coordinate with the Canadian and WHO phases.

In Alberta, there will be one phase assignment for the entire province, which will reflect the highest level of risk at any given time. The determined phase will trigger consistent and appropriate public health activities and associated communications across all RHAs (refer to Section 8, Public Health Measures).

This determination of the provincial phase will be made by the CMOH or designate, in consultation with the RHA MOHs, and in context with the global, or F/P/T situation. Geographic proximity of cases and influence/effect of cross-boundary transportation routes related to inter-provincial/territorial and U.S. boundaries will also be considered.
Beyond the provincial designation, RHAs may also individually assign regional phase terminology for purposes of triggering mobilization of internal health-care system resources, which based on the presence or absence of illness at that time, may vary region to region.
### Table 1: Pandemic Influenza Phases

**INTERPANDEMIC PERIOD – PHASE 1**

<table>
<thead>
<tr>
<th>WHO Phases</th>
<th>Canadian Phases</th>
<th>Alberta Provincial Phases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1</strong></td>
<td><strong>1.0</strong> <strong>Outside Canada</strong> no new virus subtypes detected in humans. Animals with an influenza virus subtype, with low risk for causing animal-to-human infection may be present outside Canada.</td>
<td></td>
</tr>
<tr>
<td><strong>In Canada</strong> – no new virus subtypes detected in humans. Animals with an influenza virus subtype with a low risk for causing animal-to-human infection present in animals in Canada. Risk of human infection and/or disease is low.</td>
<td>1.1.0 <strong>Global</strong> – in animals, low risk in humans; <strong>Canada</strong> – single case(s) in animals; <strong>Alberta</strong> – no activity. Animal case(s) with low risk influenza virus for humans noted in Canada but <strong>outside Alberta</strong>.</td>
<td></td>
</tr>
<tr>
<td><strong>Example:</strong> Highly pathogenic H7N3 detected in one poultry flock in Canada.</td>
<td>1.1.1 <strong>Global</strong> – in animals, low risk in humans; <strong>Canada</strong> – single case(s) in animals; <strong>Alberta</strong> – single case(s) in animals. Animal case(s) with low risk influenza virus for humans noted in Canada and corresponding, <strong>single case(s)</strong> in animals noted in Alberta.</td>
<td></td>
</tr>
</tbody>
</table>
### Table 1: Pandemic Influenza Phases…continued

<table>
<thead>
<tr>
<th>INTERPANDEMIC PERIOD – PHASE 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHO Phases</strong></td>
</tr>
<tr>
<td><strong>Phase 2</strong></td>
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<td></td>
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</tr>
</tbody>
</table>
### PANDEMIC ALERT PERIOD

#### Phase 3

<table>
<thead>
<tr>
<th>WHO Phases</th>
<th>Canadian Phases</th>
<th>Alberta Provincial Phases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 3</td>
<td>3.0 0</td>
<td>14</td>
</tr>
<tr>
<td>Outside Canada – human infection(s) with a new subtype occurring with no human-to-human spread, or at most, rare instances of spread to a close contact.</td>
<td>Outside Canada – human infection(s) with a new subtype occurring with no human-to-human spread, or at most, rare instances of spread to a close contact.</td>
<td>Outside Canada – human infection(s) with a new subtype occurring with no human-to-human spread, or at most, rare instances of spread to a close contact.</td>
</tr>
<tr>
<td>In Canada</td>
<td>3.1</td>
<td>3.1.0</td>
</tr>
<tr>
<td>Single human case(s) with a new subtype (animal to human), no or low human-to-human spread detected in Canada; no activity detected in Alberta.</td>
<td>Single human case(s), no or low human spread in Canada, no activity detected in Alberta.</td>
<td>Single human case(s), no or low human spread in Alberta.</td>
</tr>
<tr>
<td>Global</td>
<td>3.1.1</td>
<td>3.1.0</td>
</tr>
<tr>
<td>- new subtype no or low human-to-human spread; Single human case(s), no or low human spread in Canada; no activity detected in Alberta.</td>
<td>- new subtype no or low human-to-human spread; Single human case(s), no or low human spread in Canada; no activity detected in Alberta.</td>
<td>- new subtype no or low human-to-human spread; Single human case(s), no or low human spread in Alberta.</td>
</tr>
</tbody>
</table>

#### Example:

- Case imported into Canada from area outside Canada experiencing an avian outbreak. Case arising in Canada "de novo" or in association with an avian outbreak in Canada.
### Table 1: Pandemic Influenza Phases…continued

#### PANDEMIC ALERT PERIOD – PHASE 4

<table>
<thead>
<tr>
<th>WHO Phases</th>
<th>Canadian Phases</th>
<th>Alberta Provincial Phases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 4</strong>&lt;br&gt;Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.</td>
<td>4.0&lt;br&gt;<strong>Outside Canada</strong> – small clusters(s) with limited human-to-human transmission are occurring but spread is highly localized, suggesting that the virus is not well adapted to humans. No cases identified with these clusters have been detected in Canada.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.1&lt;br&gt;<strong>In Canada</strong> – single human case(s) with the virus that has demonstrated limited human-to-human transmission detected in Canada; no cluster(s) in Canada.&lt;br&gt;&lt;br&gt;<em>Example:</em> Detection of an imported case in Canada that is infected with the novel virus known to be causing small clusters of human cases outside Canada.</td>
<td>4.1.0&lt;br&gt;<strong>Global</strong> – small clusters;&lt;br&gt;<strong>Canada</strong> – single human case(s);&lt;br&gt;<strong>Alberta</strong> – no activity. Single human case(s) with the virus demonstrating limited human-to-human transmission detected in Canada (no clusters); <strong>no activity detected in Alberta</strong>.</td>
</tr>
<tr>
<td></td>
<td>4.1.1&lt;br&gt;<strong>Global</strong> – small clusters;&lt;br&gt;<strong>Canada</strong> – single human case(s);&lt;br&gt;<strong>Alberta</strong> – single human case(s).&lt;br&gt;&lt;br&gt;Single human case(s) with the virus demonstrating limited human-to-human transmission detected in Canada (no clusters); corresponding, <strong>single case(s) limited human-human transmission in Alberta</strong> (no clusters).</td>
<td></td>
</tr>
</tbody>
</table>
### PANDEMIC ALERT PERIOD – PHASE 4

<table>
<thead>
<tr>
<th>WHO Phases</th>
<th>Canadian Phases</th>
<th>Alberta Provincial Phases</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>In Canada</strong> – small localized clusters with limited human-to-human transmission are occurring in Canada but spread is highly localized, suggesting that the virus is not well adapted to humans.</td>
<td><strong>Global</strong> – small clusters; <strong>Canada</strong> – localized; <strong>Alberta</strong> – no activity. Small localized clusters, limited human-to-human transmission, noted in Canada; no activity detected in Alberta.</td>
<td></td>
</tr>
<tr>
<td><strong>Example:</strong> Detection of a localized cluster of cases in Canada linked to an imported case or from cases arising in Canada.</td>
<td>4.2.0 Global – small clusters; Canada – localized; Alberta – no activity. Small localized clusters, limited human-to-human transmission, noted in Canada; no activity detected in Alberta.</td>
<td></td>
</tr>
<tr>
<td>4.2.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Global</strong> – small clusters; <strong>Canada</strong> – localized; <strong>Alberta</strong> – single case(s). Small localized clusters, limited transmission, noted in Canada; corresponding subtype, single case(s) limited human-to-human transmission cases of infection(s) in Alberta (no clusters in Alberta).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.2.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Global</strong> – small clusters; <strong>Canada</strong> – localized; <strong>Alberta</strong> – localized. Small localized clusters, limited transmission, noted in Canada; corresponding, small localized, limited human-to-human transmission, clusters of infection(s) in Alberta.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 1: Pandemic Influenza Phases...continued

**PANDEMIC ALERT PERIOD – PHASE 5**

<table>
<thead>
<tr>
<th>WHO Phases</th>
<th>Canadian Phases</th>
<th>Alberta Provincial Phases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Larger 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 (Substantial pandemic risk).</strong></td>
<td><strong>5.0 Outside Canada</strong> – larger clusters are occurring 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 (substantial pandemic risk). No cases identified with these clusters have been detected in Canada.</td>
<td></td>
</tr>
<tr>
<td><strong>5.1 In Canada</strong> – single human case(s) with the virus that is better adapted to humans detected in Canada. No cluster(s) identified in Canada. Detection of an imported case in Canada that is infected with the virus known to be causing larger clusters of human cases outside Canada.</td>
<td><strong>5.1.0 Global</strong> – larger clusters; <strong>Canada</strong> – single case(s); <strong>Alberta</strong> – no activity. Though globally larger clusters noted; in Canada, only single case(s) with the virus that is better adapted to human transmission; no clusters; no activity detected in Alberta.</td>
<td></td>
</tr>
<tr>
<td><strong>5.1.1 Global</strong> – larger clusters; <strong>Canada</strong> – single case(s); <strong>Alberta</strong> – single case(s). Though globally larger clusters noted, in Canada, only single case(s) with the virus that is better adapted to human transmission; no clusters; corresponding, single case(s) with the virus better adapted to human transmission in Alberta.</td>
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</tbody>
</table>
Table 1: Pandemic Influenza Phases…continued

<table>
<thead>
<tr>
<th>PANDEMIC ALERT PERIOD – PHASE 5</th>
<th>WHO Phases</th>
<th>Canadian Phases</th>
<th>Alberta Provincial Phases</th>
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</thead>
<tbody>
<tr>
<td><strong>5.2</strong></td>
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<tr>
<td><strong>In Canada</strong></td>
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<tr>
<td>– larger localized cluster(s)</td>
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<tr>
<td>with limited human-to-human</td>
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<tr>
<td>transmission occurring in</td>
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<tr>
<td>Canada but human-to-human</td>
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<tr>
<td>spread still localized,</td>
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<tr>
<td>suggesting that virus is</td>
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<tr>
<td>becoming increasingly better</td>
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<tr>
<td>adapted to humans but may not</td>
<td></td>
<td></td>
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<tr>
<td>yet be fully transmissible.</td>
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<tr>
<td><em>(Substantial Pandemic Risk)</em></td>
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<tr>
<td><strong>Example:</strong></td>
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<tr>
<td>Detection of a large but</td>
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<tr>
<td>localized cluster of cases in</td>
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<td>Canada linked to an</td>
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<td>imported case or from cases</td>
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<tr>
<td>arising in Canada.</td>
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</tbody>
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| **5.2.0**                       |            |                 |                          |
| **Global**                      |            |                 |                          |
| – larger clusters;              |            |                 |                          |
| **Canada**                      |            |                 |                          |
| – localized;                    |            |                 |                          |
| **Alberta**                     |            |                 |                          |
| – no activity.                  |            |                 |                          |
| Larger localized clusters of    |            |                 |                          |
| infection(s), with better       |            |                 |                          |
| human-to-human transmission     |            |                 |                          |
| (not fully adapted to human     |            |                 |                          |
| transmission) noted in Canada;  |            |                 |                          |
| **no activity detected in       |            |                 |                          |
| Alberta.                        |            |                 |                          |

| **5.2.1**                       |            |                 |                          |
| **Global**                      |            |                 |                          |
| – larger clusters;              |            |                 |                          |
| **Canada**                      |            |                 |                          |
| – localized;                    |            |                 |                          |
| **Alberta**                     |            |                 |                          |
| – single case(s).               |            |                 |                          |
| Larger localized clusters with   |            |                 |                          |
| limited human-to-human          |            |                 |                          |
| transmission in Canada (not     |            |                 |                          |
| fully adapted to human          |            |                 |                          |
| transmission); **only single    |            |                 |                          |
| case(s) noted in Alberta.       |            |                 |                          |

| **5.2.2**                       |            |                 |                          |
| **Global**                      |            |                 |                          |
| – larger clusters;              |            |                 |                          |
| **Canada**                      |            |                 |                          |
| – localized;                    |            |                 |                          |
| **Alberta**                     |            |                 |                          |
| – localized.                    |            |                 |                          |
| Larger localized clusters with   |            |                 |                          |
| better human-to-human           |            |                 |                          |
| transmission (not fully adapted |            |                 |                          |
| to human transmission) in       |            |                 |                          |
| Canada; corresponding, **larger**|            |                 |                          |
| clusters of localized            |            |                 |                          |
| better adapted human            |            |                 |                          |
| transmission infections in       |            |                 |                          |
| Alberta.                        |            |                 |                          |
## Table 1: Pandemic Influenza Phases…continued

### PANDEMIC PERIOD – PHASE 6

<table>
<thead>
<tr>
<th>WHO Phases</th>
<th>Canadian Phases</th>
<th>Alberta Provincial Phases</th>
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</thead>
<tbody>
<tr>
<td><strong>Phase 6</strong>&lt;br&gt;Pandemic: increased and sustained transmission in general populations.</td>
<td>6.0&lt;br&gt;<em>Outside Canada</em> – increased and sustained transmission in general population has been observed. No cases detected in Canada.</td>
<td>6.1.0&lt;br&gt;<em>Global</em> – Increased and sustained transmission;&lt;br&gt;<em>Canada</em> – single case(s);&lt;br&gt;<em>Alberta</em> – no activity. Single case(s) with pandemic influenza virus noted in Canada (no clusters); <strong>no activity detected in Alberta</strong>.</td>
</tr>
<tr>
<td>6.1&lt;br&gt;<em>In Canada</em> – single human case(s) with the pandemic virus detected in Canada. No cluster(s) identified in Canada. <em>Example:</em> Detection of an imported case of the pandemic influenza virus in Canada.</td>
<td>6.1.1&lt;br&gt;<em>Global</em> – increased and sustained transmission;&lt;br&gt;<em>Canada</em> – single case(s);&lt;br&gt;<em>Alberta</em> – single case(s). Single case(s) with pandemic influenza virus detected in Canada and corresponding, <strong>single case(s) with pandemic influenza virus noted in Alberta</strong>.</td>
<td></td>
</tr>
<tr>
<td>6.2&lt;br&gt;<em>In Canada</em> – localized or widespread activity observed in the Canadian population. <em>Example:</em> Large numbers of clinical cases being rapidly identified with no history of travel to an affected area.</td>
<td>6.2.0&lt;br&gt;<em>Global</em> – increased and sustained transmission;&lt;br&gt;<em>Canada</em> – localized or widespread;&lt;br&gt;<em>Alberta</em> – no activity. Localized or widespread infection(s) with pandemic influenza virus noted in Canada; <strong>no activity detected in Alberta</strong>.</td>
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Table 1: Pandemic Influenza Phases...continued

### PANDEMIC PERIOD – PHASE 6

<table>
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<tr>
<td></td>
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<td>6.2.1</td>
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<tr>
<td></td>
<td></td>
<td>Global – increased and sustained transmission;</td>
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<tr>
<td></td>
<td></td>
<td>Canada – localized or widespread;</td>
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<tr>
<td></td>
<td></td>
<td>Alberta – single case(s)</td>
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<tr>
<td></td>
<td></td>
<td>Localized or widespread cases with pandemic influenza virus noted in Canada; single case(s) with pandemic influenza virus noted in Alberta.</td>
</tr>
<tr>
<td></td>
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<td>6.2.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Global – increased and sustained transmission;</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Localized or widespread cases with pandemic influenza virus noted in Canada; corresponding, localized or widespread cases with pandemic influenza virus noted in Alberta.</td>
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Post-Pandemic Period will entail recovery and a gradual return to the Interpandemic Period

## 3 Coordination of Emergency Response

### ROLES AND RESPONSIBILITIES OF THE KEY JURISDICTIONS INVOLVED IN A PANDEMIC INFLUENZA RESPONSE

Emergency response for pandemic influenza requires a collaborative approach to ensure coordination among governments and jurisdictions. Each level of government will have a different role in responding to pandemic influenza depending on their jurisdictional authority. Clear communications and decision-making pathways will be established to ensure coordination at all levels. The following organizations will be involved or impact the emergency response to pandemic influenza in Alberta. High-level roles and responsibilities are outlined in this section.
INTERNATIONAL

World Health Organization (WHO)
WHO will assist members to accomplish public health goals for pandemic influenza. WHO will set specific objectives and actions to be taken by WHO and make recommendations for national authorities for:

- planning and coordination,
- situation monitoring and assessment,
- prevention and containment,
- health-system response, and
- communications.

Given that pandemic influenza is a global concern, international laws, as well as F/P/T legislation, may be needed for an effective response. The International Health Regulations (IHRs) provide a legal framework under WHO to protect against and control the international spread of disease while avoiding unnecessary interference with international traffic and trade. Provisions in the IHRs include obligations for states to:

- notify WHO of all potential public health emergencies of international concern,
- develop core capacity for surveillance and response, and
- establish a national focal point as the contact point for WHO on all IHR matters.

The Public Health Agency of Canada will be Canada’s IHR focal point.

FEDERAL

The Government of Canada is responsible for:

- management of international aspects of pandemic influenza response, and in particular the relationship between Canada and the WHO as described in WHO’s IHR,
- coordination of pan-Canadian issues, processes and activities related to pandemic influenza response, and
- development, maintenance, renewal, exercising and evaluation of the Canadian Pandemic Influenza Plan for the Health Sector (CPIP), through the Public Health Agency of Canada.

Health Canada
Health Canada has authority to negotiate agreements and provide funding for technical and operational activities related to health.

Health Canada is the regulatory authority in the country that is responsible for ensuring the safety, efficacy, effectiveness and quality of all drugs, including vaccines, marketed
in Canada for human use. Vaccine regulation in Canada is subject to the provisions of the *Food and Drugs Act* and regulations.

**First Nations and Inuit Health Branch - Alberta Region (FNIHB) of Health Canada**

FNIHB will be responsible for individuals living on reserves. They will provide community and public health services for individuals living on First Nation reserves, which includes the administration of vaccine, dispensing of antiviral medications for early treatment, infection control and self-care education. All reserves do not have primary/acute care services. Persons from these communities will have access to necessary health services from RHAs through existing referral patterns.

**Public Health Agency of Canada (PHAC)**

PHAC will coordinate the national emergency health response, working with the provinces and territories. This will include:

- liaison with WHO, the U.S. Centers for Provincial Program Development and Disease Control and other national/international organizations,
- collection, compilation and reporting of epidemiological data,
- ensuring availability of vaccine and antiviral drugs and allocating them equitably to the provinces and territories, and
- implementing national communication strategies, plans and frameworks.

**Pan-Canadian Public Health Network Council**

This Council has been established by the F/P/T Conference of Deputy Ministers with a mandate and terms of reference as the senior and central governance body of the Pan-Canadian Public Health Network. The Council is the senior forum for F/P/T collaboration on public health issues. It provides both scientific advice and policy advice to the F/P/T Conference of Deputy Ministers. The Council will be the focal point for coordination of F/P/T action in a pandemic influenza response.

The Pan-Canadian Public Health Network Council, with the support of the PHAC as well as the provincial and territorial jurisdictions, has developed a pan-Canadian plan, entitled the *Canadian Pandemic Influenza Plan for the Health Sector (CPIP)*, to help enable Canada to prepare for and respond to pandemic influenza. The CPIP, its annexes, and related documents address roles and responsibilities in a pandemic influenza response between F/P/T jurisdictions. Jurisdictions will work through the Council to ensure that the jurisdiction-specific plans, programs and delivery mechanisms for a pandemic influenza response are shared, complementary and integrated.

**Public Safety Canada**

This organization is a consolidation of federal programs related to security and emergency preparedness and is responsible for the nationwide coordination of the pandemic influenza response, including surveillance, international liaison, and coordination of the vaccine response.

April 2008
Federal employees working/living within Alberta
The federal government is responsible for providing health care for some of its employees who reside in Alberta, e.g. members of the RCMP, the Canadian or foreign military, staff and inmates in federal correctional facilities (Correctional Service of Canada). However, families of these individuals are the responsibility of the RHAs in which they reside.

PROVINCIAL OR TERRITORIAL

The provincial or territorial jurisdictions have the responsibility of planning, developing, organizing, directing and delivering the provision of public health surveillance, preparedness, and response services to their populations.

Each province and territory is responsible for its individual jurisdiction’s pandemic influenza plan, and is responsible for ensuring that its pandemic influenza plans are prepared, including at the RHA level.

The provincial or territorial jurisdictions are expected to participate actively in pan-Canadian pandemic influenza planning and response activities and are expected to identify appropriate individuals to act as its lead for these activities. Recognizing the national and international nature of pandemics, each provincial or territorial jurisdiction must ensure that its pandemic influenza response planning and delivery occurs in a manner which is coordinated and consistent with the CPIP and with the planning and delivery of other provincial or territorial jurisdictions.

Alberta Health and Wellness (AHW)
As stated in the Public Health Act and Emergency Management Act, AHW is the legislated authority to respond to public health emergencies such as a pandemic influenza and will lead and coordinate the provincial health response by:

- directing provincial disease surveillance activities and participating in national surveillance,
- coordinating the provision of information to and from RHAs and other service providers as appropriate,
- directing the overall provincial communication strategy and messages,
- communicating and obtaining support from the Government of Alberta (GoA) and federal/provincial and territorial governments (F/P/T),
- coordinating and supporting the health responses of nine RHAs and other health sector stakeholders [e.g. health professional regulatory bodies, Provincial Laboratory of Public Health (PLPH), Health Link Alberta] including providing direction regarding:
  - public health measures,
  - self-care,
Alberta Pandemic Influenza Plan for the Health System

- vaccines and antivirals,
- clinical care guidelines/triage, and
- infection control.

**Alberta Emergency Management Agency (AEMA)**
AEMA is the legislated authority to support a municipal response to emergencies that exceed the capabilities of the local authorities (as per the *Emergency Management Act*). It provides coordination and communication for operational management of non-health sectors.

The *Alberta Pandemic Influenza Operations Plan* (APIOP) is a cross-government plan that addresses pandemic influenza planning issues outside of the health sector and focuses on maintaining essential services and assisting in the maintenance of basic human needs during pandemic influenza.

AEMA will be responsible to assist municipalities during the response to pandemic influenza by:

- communicating with municipalities,
- monitoring the effect of pandemic influenza on essential services,
- coordinating federal assistance programs, and
- monitoring the need for social/societal support to community residents.

AEMA will also assist ministries to address business continuity disruptions.

**Other Provincial Government Ministries**
Each GoA ministry will be responsible to manage their activities in accordance with broader government priorities. This may involve activation of a ministry business continuity plan to deal with the impact of pandemic influenza. These plans include strategies to address the ministry-specific essential services and support the health response and key stakeholders as listed in the *Government Emergency Planning Regulation*.

**LOCAL AUTHORITIES**
A timely and comprehensive emergency response to pandemic influenza requires effective coordination and communication between the health and municipal authorities within the local area.

**Regional Health Authorities (RHAs)**
The RHAs are responsible for developing a pandemic influenza emergency response plan. RHAs will:

- take the lead in providing advice and counsel to the local governments' emergency services,
• deliver all required critical health and public health services/programs within their respective jurisdictions including mass immunization and distribution of antiviral medications,
• maintain a regional surveillance system and report information to AHW,
• liaise with local partners, (e.g. first responders, community services, mortuary services, schools, workplaces),
• collaborate with AHW in the delivery of public information and education programs,
• assess capacity of health services and work with AHW to identify additional/alternate resources,
• reallocate/re-deploy resources when necessary to ensure reasonable equitable access to essential services and critical scarce resources to ensure an effective health response where possible, and
• declare local public health emergency and utilize powers if necessary.

Municipalities
Under the Municipal Government Act the role of a municipality is to:
• provide good government,
• provide services, facilities or other things that, in the opinion of council, are necessary or desirable for all or a part of the municipality, and
• develop and maintain safe and viable communities.

Municipalities will be responsible for developing consequence management guidelines and procedures for health emergencies. The procedures will enable local governments, working in conjunction with health authorities, to maintain continuity of essential services and support residents.

Building on “all-hazard” emergency response plans already in place, municipalities will be responsible for:
• supporting RHAs in responding to the health emergency as requested and as appropriate (e.g. providing information to the public, and establishing alternate care sites),
• continuing local government,
• maintaining public safety services (e.g. fire and police),
• maintaining essential public works and municipal services (e.g. water treatment/delivery, waste management, garbage disposal and utilities), and
• co-operating with RHAs in provision of the social service needs of citizens.
BUSINESS AND INDUSTRY

Businesses and industry will be responsible for developing their own “all-hazards” business continuity plan, which will incorporate pandemic influenza.

Businesses will be responsible for ensuring safe working environments for employees in accordance with the existing Occupational Health and Safety Act and Employment Standards and Guidelines.

Critical infrastructure industries will be responsible for developing an industry response plan, to ensure continuity of services to the citizens of Alberta and for identifying essential workers.

PUBLIC

Albertans will be encouraged to make general family emergency preparedness plans and to become familiar with the Influenza Self-Care Strategy educational materials. Influenza self-care messages will be adjusted to reflect the epidemiology of the pandemic influenza virus and availability of resources (e.g. vaccine and antiviral medications).

Diagram 1 summarizes the flow of information between the various jurisdictions during pandemic influenza.
DIAGRAM 1: Information flow between jurisdictions during pandemic influenza

PROVINCIAL COORDINATION

Critical liaison between AHW and RHAs will be established and maintained throughout the pandemic influenza. The current strong public health network will carry through the initial phases to implement surveillance and public health activities, then will be enhanced with the addition of emergency management structures/key functions, as necessary.

Pandemic influenza will start as a health emergency but depending on the severity may evolve into a general provincial emergency. AHW will be responsible for coordinating the
delivery of the APIP, which supports the health response to the public health emergency. AEMA will be responsible for coordinating the delivery of the Alberta Pandemic Influenza Operations Plan (APIOP), which supports the municipal, societal and essential GoA services responses.

Where possible, routine business processes and communication pathways/networks will be maintained. However, as the emergency evolves and command/control structures are put in place across jurisdictions, these will need to be modified/adjusted to accommodate the necessary vertical pathways/streamlined decision-making required during an emergency.

Provincially, the health system’s key stakeholders, including AHW, nine RHAs, provincial health authorities (e.g. Alberta Cancer Board, Alberta Mental Health Board), FNIHB, and the Provincial Laboratory of Public Health will implement a common emergency management model based on the National Health Emergency Management System (NHEMS), a nationally adopted system based on the Incident Management System. The use of a common model allows for unity of command, clear communication, and consistent terminology. The system is flexible and can be escalated and de-escalated during an incident.

A Pandemic Task Force including the CMOH or designate and the ministers and the deputy ministers from the lead ministries with significant roles in pandemic influenza response, will oversee and direct Alberta’s health and non-health response to pandemic influenza (refer to Diagram 2: Provincial coordination of emergency response). The Pandemic Task Force reports directly to Cabinet.

The AHW Public Health Emergency Coordination Group (PHECG) has the responsibility to guide and coordinate the provincial health response to pandemic influenza. The PHECG will assist the RHAs by providing a forum for provincial communication and coordination of regional response activities.

The PHECG is based on the Incident Management System. The RHA’s emergency operations centres and other key stakeholders will have direct communication channels to the PHECG. For details of the structure and operation of the PHECG, refer to Appendix 4: Pandemic influenza health emergency management.

The Government Emergency Operations Centre, led by AEMA, provides direction to the non-health sector during pandemic influenza. It will have direct links to municipalities and is responsible for coordinating the GoA operational response to pandemic influenza.

The emergency operations centres of RHAs and local municipal governments will communicate with each other at the local level.
DIAGRAM 2: Provincial coordination of emergency response

Pandemic Task Force
Government of Alberta Health/Non-Health Response
Comprised of Ministers and Deputy Ministers*
Provides direction to overall provincial response

Deputy Minister
Alberta Health and Wellness

Public Health Emergency Coordination Group
Alberta Health and Wellness
Emergency Operations Centre
Provides direction and coordination for management of health sector response during pandemic.

Non-Health Response

Managing Director
Alberta Emergency Management Agency

Government Emergency Operations Centre
Alberta Emergency Management Agency Operations Centre
Provides coordination to non-health sector response during a pandemic.

9 RHAs
FNHB Alberta
Provincial Health Authorities
Professional Regulatory Bodies
Provincial Laboratory of Public Health

Local Municipality
Government of Alberta Ministries
Industry Stakeholders

*This Pandemic Task Force includes Ministers and Deputy Ministers of:
Alberta Health and Wellness
Alberta Municipal Affairs
Service Alberta
Alberta Agriculture and Rural Development
Alberta Employment and Immigration
Alberta Solicitor General and Public Security
Alberta Finance and Enterprise
Alberta Justice and Attorney General
Treasury Board
Corporate Human Resources
4 Planning Assumptions

These assumptions should not be interpreted as predictions for the next pandemic influenza, but instead be considered as a reflection of current expert opinion regarding a reasonable scenario to guide pandemic influenza planning activities.

EXPECTED COURSE OF A PANDEMIC INFLUENZA

- Pandemic influenza is inevitable. Global experts suggest that pandemic influenza will occur in the next one to three years.
- Based on the last two pandemic influenza events, it is estimated that the next pandemic influenza virus will first emerge outside of Canada and then arrive in Canada within three months. This time could be much shorter due to increases in the volume and speed of global air travel.
- The pandemic influenza virus may arrive in Canada at any time of year (i.e. potentially outside of the usual influenza season in Canada or at the same time).
- The first peak in illness in Canada could occur within two to four months after the arrival of the virus in Canada. The first peak in mortality is expected to be approximately one month after the peak in illness.
- Pandemic influenza may last between 12 to 18 months.
- Pandemic influenza will occur in two or more waves. The space between waves may vary. More than one wave can occur within a 12 month period but there could be up to 12 months between the start of the first wave and the start of the second wave.
- In a local community, a pandemic influenza wave of illness will generally last six to eight weeks but this time period may vary.
- A pandemic influenza wave will sweep across Canada in one to two months. Outbreaks will occur simultaneously in multiple locations although different areas of the country may experience peak activity at different times. This will limit the ability of one community/jurisdiction in helping others.

CHARACTERISTICS OF THE PANDEMIC INFLUENZA VIRUS

- The incubation period (the time between infection and symptoms) for the pandemic influenza virus is one to three days, with a range of one to seven days.
- More efficient transmission occurs when symptoms such as coughing are present and viral shedding is high (i.e. early in symptomatic period).
- Risk of airborne transmission is being reviewed.
- People can spread the virus 24 hours before and up to five days after the start of symptoms (seven days for young children).
• Since there will be no specific immunity to the new virus on a population basis the novel virus will be transmitted efficiently from person to person resulting in large numbers of people being infected.

• The course of illness (without complications) is five to seven days. Assume that people who are ill will be unable to work or go to school for this time period.

EXTENT AND SEVERITY OF ILLNESS

• The impact of pandemic influenza is unpredictable in timing, severity of illness and age groups primarily affected.

• Because the population will have had limited, if any, prior exposure, most people (regardless of age) will be susceptible.

• More severe illness and death than the usual annual influenza is likely in all population groups.

• The initial clinical presentation will be consistent with known human influenza strains (e.g. H3N2). Sub-clinical infections can occur.

• Individuals who recover from illness caused from the pandemic influenza strain will be immune to further infection by that strain.

• The groups that are at high risk for complications or poor outcomes due to annual influenza will likely be at increased risk during the pandemic influenza.

EFFECT ON THE HEALTH SYSTEM IN A MODERATE SCENARIO - ADAPTED FROM U.S. MELTZER MODEL (Meltzer, 1999)

• The majority of the Alberta population (over 70%) will be infected over the course of the pandemic influenza; 15% to 35% of the population will become clinically ill. (i.e. asymptomatic and sub-clinical infection can occur.)

• The second wave of illness could be more severe than the first. For planning purposes assume the majority of the cases will occur in the first wave e.g. with a 35% attack rate overall, assume 25% clinically ill in the first wave.

• Using FluAid* in the absence of any intervention (e.g. vaccine and antivirals), and an attack rate of 25% in the first wave:
  - Number clinically ill (25%) = 825,000 people
  - Outpatient visits = 338,000 – 622,000 or four times a normal influenza year
  - Hospitalizations = 3,000 - 12,000 or four times a normal influenza year
  - Deaths due to influenza = 1,000 - 3,000 or eight times a normal influenza year

*based on 2005 mid-year population projections for Alberta (3.3 million), including demographic and at-risk population data.

• For a pandemic influenza of mild to moderate severity and in the absence of any intervention (e.g. vaccine and antivirals) of those who are clinically ill:
- 50% will seek outpatient care,
- 1% will be hospitalized and recover, and
- 0.4% will die. Of this number, the majority will have required hospitalization.

- For a severe pandemic influenza and in the absence of any intervention (e.g. vaccine and antivirals) of those who are clinically ill up to:
  - 10% may be hospitalized, and
  - 2% may die.

- Existing health care services will be stressed and referral for services will be affected; alternate models of care may be implemented to provide best possible care for the most people e.g. influenza assessment centres for triage.

**ABSENTEEISM**

- Pandemic influenza will lead to increased absenteeism from school, the workplace, etc. as a result of personal illness, care-giving requirements and possibly the fear of exposure. Public health measures and use of antivirals may reduce absenteeism.

- During the peak two weeks of illness in the community, an absenteeism rate of 20% to 25% can be expected for many reasons, for example, illness, caring for others, pandemic influenza related public health measures (e.g. school closures), and normal baseline absenteeism (an 8% average in a normal winter). For business continuity planning purposes it would be prudent for organizations to assume up to a third of the workforce absenteeism (for all reasons) in this peak period.

- The effect will vary depending on setting, i.e. high versus low population density in the workplace. The health-care system could expect to experience peak absenteeism at the top of this range – the highest of all industries.

**ACCESS TO VACCINE**

- Vaccine will be the primary means of pandemic influenza prevention.

- The supply will not be available until four to six months after the pandemic influenza virus strain is confirmed, therefore plans for the first wave should assume lack of vaccine. The vaccine may be available in time to mitigate the impact of the second wave.

- Once available, regional public health authorities will manage vaccine administration based on predetermined provincial priority groups.

- Pandemic vaccine will be made available from the Public Health Agency of Canada in lots; each person will likely need two doses.
ACCESS TO ANTIVIRAL DRUGS

- Use of antiviral drugs is one of several tools aimed at reducing the effect of pandemic influenza. Other tools include vaccines and non-medical interventions (e.g. self-care).

- Antiviral drugs will be in short supply and high demand; it is highly likely that there will not be any suitable antiviral drugs available for purchase during pandemic influenza.

- Regional public health authorities will manage antiviral drug administration based on the nationally and provincially agreed upon strategy for the pandemic period (i.e. focus on early treatment). National consensus regarding use of antivirals for prophylaxis for health-care workers and essential service workers is pending.

GOVERNMENT OF ALBERTA’S RESPONSE

- The Government of Alberta (GoA) will implement a coordinated cross-ministry response.

- Alberta Health and Wellness will serve as the lead agency/health subject matter experts, with Alberta Municipal Affairs/Alberta Emergency Management Agency as the coordinating agency in support of all other ministries.

- The GoA will coordinate with federal/regional levels of authority and other key stakeholders.

- This plan has been developed to address the expected moderate scenario for the next pandemic influenza. However, prudence dictates that the GoA must consider the consequences of a severe pandemic. Therefore, the governance components of the plan are structured to enable the GoA to respond to a severe pandemic with minimal reorganization.

NON-MEDICAL INTERVENTIONS AND INFECTION CONTROL

- Influenza Self-Care will be a key health services strategy during pandemic influenza (refer to [http://www.health.gov.ab.ca/influenza/Self_Care.html](http://www.health.gov.ab.ca/influenza/Self_Care.html)).

- The most effective infection prevention and control practices include frequent hand washing and respiratory etiquette (cover your cough). Refer to Section 12, Infection Control Measures.

- From a community perspective masks are not likely to be effective to reduce the spread of disease in the general population.

- Planned non-medical interventions (public health measures) include the isolation of those who are ill (in hospital or self/home isolation) and quarantine of those in contact with ill persons (prior to widespread illness).
• Non-medical interventions that will not likely be effective are the restriction of indoor public gatherings, use of masks by the public and early screening at international borders.
• School and day care closures may or may not be effective.

5 Surveillance

Globally, detection of the pandemic influenza virus will emerge from a coordinated system of international, national, provincial and local authorities who provide laboratory, disease and epidemiological surveillance information. It is expected that a novel strain capable of initiating pandemic influenza will not begin in Canada.

The WHO will report the detection of a novel virus, capable of initiating pandemic influenza, to the Public Health Agency of Canada (PHAC) providing the pandemic influenza phase level. Canadian/Alberta pandemic influenza phases will be correspondingly reported by PHAC and AHW respectively (refer to Table 1: Pandemic influenza phases in Section 2, Plan Activation).

The goal of collecting pandemic influenza surveillance indicators is to monitor the impact of pandemic influenza and provide accurate surveillance information from multiple sources of data and information resources.

Provincial surveillance data required will come from multiple sources. The primary sources of data will be the Provincial Laboratory of Public Health (PLPH), RHAs, Service Alberta Vital Statistics, Alberta Agriculture and Rural Development, and Alberta Health and Wellness.

Surveillance activity will expand/collapse corresponding to the phase of pandemic influenza (refer to Table 1: Surveillance activities, sources, reporting, in this section). Surveillance information will be used to support and guide decision-making as well as provide an indication of the status of the pandemic influenza and the capacity of the health system to respond. The expansion/collapse of certain surveillance activity is a reflection on the human resource capacity to maintain this activity at the source and to limit data capture to those most meaningful for response decisions across pandemic phases. Not all data will be required and/or available during all phases of the pandemic influenza. It is anticipated that during phases 1 to 3 surveillance activities will not change. At phase 4 there will be modifications to surveillance data, both collected and provided. With progression to phases 5 and 6 there are activities that will need to be discontinued, modified and introduced.

Various data sources are required to produce an accurate assessment of the effect of pandemic influenza in Alberta. The majority of data will be supplied to AHW via internal resources or by RHAs. To ensure quality data, consistent forms and timelines will be used throughout the province. AHW will provide daily/weekly reports to various
stakeholders depending on the phase. While RHAs will be responsible for collecting, collating and reporting regional data to AHW, AHW will be responsible for collating regional data, statistical analysis, interpretation, and reporting on the provincial status to the GoA and the PHAC (refer to Appendix 5: Pandemic influenza surveillance report).

The last pages of this section contain tables to summarize roles and responsibilities (refer to Table 2: Surveillance roles and responsibilities.)
### Table 1: Surveillance activities, sources, reporting

<table>
<thead>
<tr>
<th>Surveillance Activities &amp; Core Data Elements</th>
<th>Definition &amp; Rationale For Collecting</th>
<th>Data Source</th>
<th>Transmission Method</th>
<th>Reporting Pathway And Frequency</th>
<th>Phase Of Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Laboratory Surveillance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Isolate submission                          | • Submission of specimens (nasopharyngeal or throat swabs) by physicians, especially sentinel physicians and public health practitioners for examination/analysis by the PLPH.  
  • Provides confirmation of influenza cases and strain type, basic demographics of cases. | • PLPH information system. | • Electronic via e-mail. | • Weekly to Provincial Program Development and Disease Control (PPDDC).  
  • Daily to Surveillance and Environmental Health (SEH).  
  • Routine submission of isolates from sentinel physicians will continue throughout pandemic influenza.  
  • Submissions from non-sentinel physicians and public health practitioners will stop at Phase 5.2.2 (Pandemic alert period).  
  • Provision of line list occurs once a public health emergency is declared Phases 5 (Pandemic alert period) and 6 (Pandemic period). |                          |
| Antiviral resistance                         | • Systematic testing for antiviral resistance.  
  • Data on resistance patterns informs action regarding antiviral use and distribution. | • PLPH information system. | • Electronic via e-mail. | • Phone call to Provincial Health Officer (PHO) on first evidence.  
  • Daily reporting to SEH (dependent on isolates submitted).  
  • Testing begins in Phase 5 (Pandemic alert period) |                          |

Continued…
### Epidemiologic Surveillance

<table>
<thead>
<tr>
<th>Surveillance Activities &amp; Core Data Elements</th>
<th>Definition &amp; Rationale For Collecting</th>
<th>Data Source</th>
<th>Transmission Method</th>
<th>Reporting Pathway And Frequency</th>
<th>Phase Of Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outbreak reporting</strong></td>
<td>• Timely detection and reporting of outbreaks in long-term care (LTC), schools and acute care facilities by RHAs. • Determines where influenza-like illness (ILI) is occurring in the province and infectivity of the pandemic influenza virus.</td>
<td>• Respiratory Outbreak Form.</td>
<td>• Secure fax/e-mail.</td>
<td>• Weekly to PPDDC. • Discontinued at Phase 5.2.2.</td>
<td>• Routine reporting of outbreaks in schools, LTC and acute care will stop at Phase 5.2.2 (Pandemic alert period).</td>
</tr>
<tr>
<td><strong>Initial Alberta pandemic influenza cases</strong></td>
<td>• Determines the exposure dynamics, risk to the population and the natural history of the disease.</td>
<td>• Fastest Means Possible (FMP) – phone call to on call Deputy/Chief Medical Officer of Health and pandemic influenza case report.</td>
<td>• Phone call and secure fax/e-mail.</td>
<td>PPDDC</td>
<td></td>
</tr>
<tr>
<td><strong>Health services utilization</strong></td>
<td>• Number of individuals diagnosed with ILI presenting at emergency departments, admitted to an acute care setting, admitted to an intensive care unit (ICU) or seen at a RHA sentinel site. • Used to determine the pathogenicity of the pandemic influenza strain and determine the effect on the health-care system.</td>
<td>• Supplemental enhanced service event (SESE). • RHA sentinel sites.</td>
<td>• AHW data warehouse. • Secure fax or e-mail.</td>
<td>• SEH on a weekly basis. • Daily from sentinel sites.</td>
<td>• Routine emergency visits, and hospital and ICU admissions reporting will increase at Phase 4.2.1 (Pandemic alert period). • RHA sentinel sites reporting will start at Phase 6.1.1 (Pandemic period).</td>
</tr>
</tbody>
</table>

Continued…
<table>
<thead>
<tr>
<th>Surveillance Activities &amp; Core Data Elements</th>
<th>Definition &amp; Rationale For Collecting</th>
<th>Data Source</th>
<th>Transmission Method</th>
<th>Reporting Pathway And Frequency</th>
<th>Phase Of Data Collection</th>
</tr>
</thead>
</table>
| Physician visits                            | • Physician ILI consultation rate reported by RHA and age group.  
• A sensitive measure of influenza activity used to determine where infections are occurring in the province. | • Supplemental enhanced service event (SESE).  
• Sentinel physician network (TARRANT) System | • AHW data warehouse.  
• E-mail to AHW. | • SEH  
• From TARRANT | • Routine reporting will continue throughout pandemic influenza. |
| Adverse reactions                           | • Number and rate of adverse reactions from either the pandemic influenza vaccine and to antivirals. | • Vaccine: Based on current practice (ARI reporting form). | • Vaccine: Fax or e-mail to AHW  
Antivirals  
The current surveillance system of reporting serious and unexpected adverse drug reactions will be used: Alberta Regional Adverse Reaction Centre. To report an adverse reaction, call: | • Vaccine: Daily by 4 p.m. | • Reporting will begin at Phase 6.1.1 (Pandemic period). |


School closures  
*This information is difficult to obtain because of the number of school districts and will be a low priority.  
• Number of schools closed in the province and location.  
• Used to determine effect of the pandemic influenza in the province. | • Fax or e-mail | • SEH | • Reporting will begin at Phase 4.2.1 (Pandemic alert period). |

Continued…
<table>
<thead>
<tr>
<th>Surveillance Activities &amp; Core Data Elements</th>
<th>Definition &amp; Rationale For Collecting</th>
<th>Data Source</th>
<th>Transmission Method</th>
<th>Reporting Pathway And Frequency</th>
<th>Phase Of Data Collection</th>
</tr>
</thead>
</table>
| Workplace absenteeism                       | • Proportion of staff at AHW that are not at work.  
• Used to estimate the effect of pandemic influenza on the workforce in AHW. | AHW         | • To be determined  | • To be determined               | • Routine reporting will continue throughout pandemic influenza. |
| Mortality                                   | • Number of deaths from all causes and cause specific death data for pneumonia and ILI related deaths. | Service Alberta Vital Statistics. | • Electronic from secure F/T/P server. | • Weekly                      | • Routine reporting will continue throughout pandemic influenza. |
|                                            | • Used to determine the virulence of the pandemic influenza strain and mortality rate. Age specific death rates are used to detect unusual patterns in mortality. | Manual data collection at Service Alberta Vital Statistics. | • Daily by SEH                  |                                | • Cause-specific mortality reporting will begin at Phase 5.2.2 (Pandemic alert period). |

**Other**

| Animal surveillance                        | • Surveillance of livestock and wild animals that test positive for a possible pandemic strain of influenza.  
• Used to identify the potential risk for animal to human transmission in Alberta. | Alberta Veterinary Surveillance Network (AVSN). | • Phone call from Provincial Veterinarian to CMOH (significant events); routine e-mail. |                                | • Routine reporting will stop at Phase 4.2.2 (Pandemic alert period). |

| Health Link Alberta                        | • Sentinel surveillance regarding early clusters of symptoms based on calls received. | Health Link Alberta | • To be determined | SEH                        | To be determined |

| National surveillance                      | • National human surveillance. | PPDDC and SEH | Reporting of any human case of the possible pandemic influenza strain reported to PHAC stops at Phase 6 (Pandemic period). |
Table 2 summarizes the roles and responsibilities of the primary partners providing health surveillance during pandemic influenza.

### Table 2: Surveillance roles and responsibilities

<table>
<thead>
<tr>
<th>Alberta Health and Wellness</th>
<th>Regional Health Authorities</th>
<th>Alberta Veterinary Surveillance Network</th>
<th>Provincial Laboratory of Public Health</th>
<th>Sentinel Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Coordinate surveillance activities for the province: expand/collapse surveillance activity as required.</td>
<td>• Collect, collate and report regional surveillance data as requested by AHW, including data from sentinel health service utilization sites if established.</td>
<td>• Report animal surveillance of livestock (poultry) to AHW on a case-by-case basis until Phase 4.2.2 (Pandemic alert period).</td>
<td>• Continue to provide routine aggregate data on a weekly basis until a provincial pandemic influenza is declared.</td>
<td>• Sentinel physicians will collect influenza isolates and submit them to the PLPH.</td>
</tr>
<tr>
<td>• Confirm RHA reporting requirements.</td>
<td>• Collect data related to pandemic influenza virus, morbidity/mortality, health services utilization, absenteeism, vaccine/antiviral coverage and adverse effects.</td>
<td>• Once pandemic influenza is declared, provide a line list of all positive influenza isolates in the province of Alberta to AHW, including basic demographics, if available, and antiviral resistance data on a case-by-case basis to AHW.</td>
<td></td>
<td>• TARRANT will report the ILI consultation rate to AHW.</td>
</tr>
<tr>
<td>• Collate regional data, analyze and report daily and/or weekly on provincial status to GoA and PHAC.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### 6 Pandemic Influenza Vaccine

Immunization of susceptible individuals is the primary means to decrease morbidity and mortality from influenza during an epidemic or pandemic. Therefore, the primary control strategy for pandemic influenza in Alberta is immunization with pandemic influenza-specific vaccine. However, because production of the vaccine can only be started once the pandemic influenza virus has been confirmed, Alberta will rely upon alternate control strategies in the early days of pandemic influenza. Supporting strategies include antivirals for early treatment of those ill with influenza, infection control and prevention and public health measures to decrease transmission opportunities (refer to corresponding topics in this section for more information).
It is estimated that it could take four to six months until vaccine is available in Canada once a strain is identified. Therefore, the distribution and delivery of vaccine within Canada and Alberta will most likely occur after the first wave.

The objectives of the national pandemic influenza vaccine program are to:

- provide a safe and effective vaccine program to all Canadians as quickly as possible,
- allocate, distribute and administer vaccine as rapidly as possible to the appropriate groups of people, and
- monitor the safety and effectiveness of the immunization program.

(CPIP, 2006)

The pandemic strain of the influenza vaccine will become available in lots from the Public Health Agency of Canada, to the provinces and territories, and supply will likely be limited in the early stages of pandemic influenza. As a result, AHW will distribute/deliver pandemic influenza vaccine based on priority groups, through all RHAs and FNIHB.

**ROLES AND RESPONSIBILITIES**

A summary of roles and responsibilities for each of the primary partners is located at the end of this section (refer to Table 2: Roles and responsibilities for pandemic vaccine).

During pandemic influenza, the national Pandemic Influenza Committee (PIC), which includes representation from the National Advisory Committee on Immunization (NACI), will reassess pre-existing priority groups to ensure that they are consistent with the overall goal of the pandemic influenza response, as soon as epidemiological data on the pandemic influenza virus becomes available. Based on this review, vaccine recommendations will be distributed as national guidelines, as soon as possible, to facilitate a consistent and equitable approach.

It is anticipated that two doses of vaccine per person will be required to achieve a protective response during the entire pandemic period. Alberta will target immunizing the entire population of the province within six months of receiving the vaccine. In establishing this target, it is assumed that over 90% of Albertans will want to be immunized with the pandemic influenza vaccine and that the health system will have the capacity to deliver the vaccine. The rate-limiting factor in the ability of the health system to achieve this target will be vaccine availability.

AHW will allocate pandemic influenza vaccine in lots to each RHA on a per capita basis by priority group as the pandemic influenza vaccine is received within Alberta. RHAs will be responsible for delivery of this vaccine based on the criteria established for each of the nationally-determined priority groups. Refer to Appendix 7.1: Priority group definitions for definitions of the sectors included in each recommended priority group.
Group 1 will receive their first dose followed by a second dose four weeks from the first; subsequent groups will follow.

**VACCINE FOR FEDERAL POPULATIONS LIVING IN ALBERTA**

Refer to Appendix 6: Health services in distinct communities/populations.

**VACCINE PRIORITY GROUPS**

[Refer to Appendix 7.1: Priority group definitions for pandemic immunization program implementation (CPIP 2006)]

Current national vaccine priority groups and rationale are:

**Group 1** – *Health-care workers, public health responders and key health decision makers.*

The health-care and public health sectors will be the first line of defence in pandemic influenza. Maintaining the health-service response and the vaccine program is central to the implementation of the response plan in order to reduce morbidity and mortality.

**Group 2** – *Pandemic influenza societal responders and key societal decision makers.*

The ability to mount an effective pandemic influenza response may be highly dependent on persons being in place to maintain key community services. Those individuals that are essential to the response or to maintaining key community services may vary among jurisdictions.

**Group 3** – *Persons at high risk of severe or fatal outcomes following influenza infection.*

To meet the goal of reducing morbidity and mortality, persons most likely to experience severe outcomes should be immunized. For planning purposes, this priority group has been based on the high-risk groups identified by the NACI for annual vaccine recommendations. If necessary, prioritization of the following subgroups within Group 3 would depend on the epidemiology of influenza disease at the time of pandemic:

- persons living in nursing homes, long-term care facilities, homes for the elderly (e.g. lodges),
- persons with high-risk medical conditions living independently in the community,
- persons 65 years of age and over living independently and not included in groups 3a and 3b,
• children six months to 23 months of age (current vaccines are not recommended for children under six months of age), and
• pregnant women.

**Group 4** – *Healthy adults (all individuals, 18 to 64 years of age, who are not at high risk and who do not fall into one of the other occupation-based priority groups).*

This group is at lower risk of developing severe outcomes from influenza during the annual influenza season, but it comprises the major work force and represents the most significant segment of the population from an economic impact perspective. Immunization of healthy adults would reduce the demand for medical services and allow individuals to continue normal daily activities. Simultaneous absence of large numbers of individuals from their places of employment, even for non-essential personnel, could produce major societal disruption. Medical facilities could also be overwhelmed by health-care system demands, even for outpatient services. This might compromise the care of those with complications.

**Group 5** – *Children, 24 months to 17 years of age.*

This group is at the lowest risk of developing severe outcomes from influenza during annual epidemics, but it plays a major role in the spread of the disease. While children’s absence from school or day care might not have the direct economic and disruptive impact of illness in adults, it could have an indirect effect because of adults having to care for sick children.

*(CPIP, 2006)*

**Note:** The CPIP Annex D related to vaccine priorities is currently under review. This section of APIP will be revised upon completion.

**VACCINE DISTRIBUTION**

The vaccine manufacturer will transport vaccine with the appropriate cold chain management (e.g. proper temperature controls) to AHW. AHW will assume responsibility for transporting the vaccine with appropriate cold chain management from to predetermined points of delivery within each region as identified by the RHAs and FNIHB.

RHAs and FNIHB will be responsible for appropriate cold chain management until the vaccine is administered.

RHAs and FNIHB will be expected to have a quick and effective delivery system for providing this vaccine to the public.
VACCINE DELIVERY

Once the pandemic influenza vaccine is available, AHW will direct and deliver vaccine to each region on a per capita basis by priority group and based on the amount of each lot received. It is anticipated that the vaccine will be in a multi-dose vial from which at least eight doses can be withdrawn, depending on the type of syringe being used.

RHAs are responsible for the delivery of pandemic influenza vaccine to the people living or working within each RHA’s regional boundaries, including:

- The administration of vaccine to each individual in Alberta by provincially determined priority groups.
- The delivery of two doses of vaccine (at least four weeks apart) for each person identified within the priority groups with a target of immunizing the eligible population of Alberta within six months. The vaccine supply will determine how many priority groups can be immunized with the first dose, before administration of the second dose can occur four weeks later. It may be necessary to hold back enough vaccine to ensure delivery of the second dose of vaccine to the first three priority groups.
- The reporting to AHW on all vaccine received from AHW and administered to a priority group (refer to Appendix 7.2: Mass immunization clinic guidelines).

VACCINE ADMINISTRATION

AHW will provide program guidelines related to the administration of the vaccine that include: a vaccine chart, a list of target groups based on order of priority, a vaccine schedule, a cold chain management guideline, and an adverse reaction monitoring process.

Monitoring
AHW will be responsible for monitoring the uptake of vaccine in Alberta. RHAs will monitor vaccine distribution within their region and report utilization following AHW reporting guidelines. A tracking system will be developed using a daily and weekly reporting system to be completed by each RHA. A final report on vaccine distribution will be completed in the post-pandemic phase (refer to Appendix 7.3: RHA immunization report forms). AHW will then report on provincial vaccine supply and delivery to the federal government through PHAC as directed.

Recording
All regions are required to maintain records of all doses of vaccine administered.

Mandatory minimum requirements include:

- Client's name
- Date of birth
- Provincial health-care number (PHN) or proof of Alberta residency
- Priority group (if applicable)
• Code name of vaccine
• Lot number
• Date of immunization
• Dosage
• Immunizer’s signature

Electronic data entry will not be a requirement during pandemic influenza. Individual paper records in the form of flow sheets should meet minimal reporting requirements and remain at the RHA for a minimum of seven years. This data is required for monitoring and adverse event surveillance purposes. Maintenance of individual hardcopy records of immunization is not required.

A system to identify each dose administered should be developed and include the provision of a personal record to the client.

Reporting
• RHAs are responsible for reporting to AHW on vaccine administered to individuals in their regions and any reported adverse events.
• The surveillance of adverse events related to pandemic influenza vaccine will be based on current practice and reporting requirements. AHW will communicate to RHAs any change to reporting requirements that may be necessary for pandemic influenza immunization including, what is a reportable vaccine adverse event, what information needs to be captured, and the process for reporting adverse events. The RHAs will communicate with physicians, emergency rooms, etc. on the type of reactions and the most appropriate means of reporting the adverse events during the pandemic influenza period, as per provincial guidelines.

Note: Anaphylaxis to the pandemic vaccine must be reported to the CMOH or designate within 24 hrs of its occurrence, as per AHW protocol.

• AHW and the RHAs will establish adequate resources to deal with adverse reaction reporting in a timely manner, i.e. fax or e-mail to AHW by 4:00 p.m. daily.
• Weekly summary and final reporting forms are included in Appendix 7.4: RHA immunization report forms.

DEFERRAL SCHEDULE FOR ROUTINE IMMUNIZATION SERIES DURING PANDEMIC INFLUENZA

RHAs will re-deploy staff and resources as required in efforts to maintain essential services and meet demands for health services throughout pandemic influenza. Once pandemic influenza vaccine is available, health-system resources may need to be further readjusted in order to support rapid immunization of the Alberta population. As a result, there may be a provincial adaptation of the routine immunization programs based on the epidemiology of the circulating novel virus, the availability of the pandemic
influenza vaccine, the phase of the pandemic influenza in Alberta, and the need to maximize public health resources. The order for deferral of routine immunization programs is outlined in Table 1: Immunization program deferral plan.

A seasonal influenza vaccine or the pneumococcal polysaccharide vaccine will not be administered during pandemic influenza as the primary circulating influenza virus will be the novel virus causing the pandemic.

When the delivery of the pandemic influenza vaccine occurs at maximum capacity (i.e., public health resources are required for mass immunization clinics) childhood immunization programs will be deferred, as necessary, at the discretion of the RHA.
Table 1: Immunization program deferral plan

<table>
<thead>
<tr>
<th>Immunization Program Priorities (Program deferral begins with #1 and proceeds to #5)</th>
<th>Estimated Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1  • First priority for deferral. Routine adult immunization  • Pneumococcal  • Td</td>
<td>• Deferral implemented when public health resources required for alternate duties, i.e. public health measures, antiviral distribution, etc. • Earliest estimated program deferral likely at: 4.1.1 Global - Small Clusters, Canada - Sporadic, Alberta - Sporadic: Sporadic limited human-human transmission infection(s) noted in Canada (no clusters); corresponding, sporadic limited human-human transmission infection(s) in Alberta (no clusters).</td>
</tr>
<tr>
<td>#2  • Second level deferral of program. Non-routine biological programs for non-emergent use, i.e. contact of typhoid carriers</td>
<td></td>
</tr>
<tr>
<td>#3  • Third level deferral of program.  • Pentacel® – 18 months  • Quadracel®/MMR – preschool  • Hepatitis B/Varicella – Grade 5  • dTap/Td – 14 to 16 years</td>
<td>• Deferral when increased public health resources required for public health measures and for immunization clinics (as initial lots of vaccine become available). It is estimated vaccine will be available in Canada 4 to 6 months after novel virus with human-human transmission emerges in the world.</td>
</tr>
<tr>
<td>#4  • Fourth level deferral of program (2nd priority for reinstitution between waves, if possible). Adverse events associated with routine immunization with the exception of anaphylaxis and other severe events deemed significant by clinicians – including IMPACT</td>
<td></td>
</tr>
<tr>
<td>#5  • Final level of deferral (first priority for reinstitution between waves and as possible).  • Pentacel®/Meningococcal Conjugate/Pneumococcal Conjugate – 2, 4, 6 months;  • Measles/Mumps/Rubella/Varicella (MMR/VZ) – 12 months</td>
<td>• Continue this program as long as possible: deferral only when pandemic influenza vaccine available for mass immunization clinics throughout the province.</td>
</tr>
</tbody>
</table>
Table 2: Roles and responsibilities for pandemic vaccine

<table>
<thead>
<tr>
<th>Canadian Phase</th>
<th>Alberta Health and Wellness</th>
<th>Regional Health Authorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>• Review pandemic influenza educational materials/communication strategy, in conjunction with annual Influenza Self-Care Strategy.</td>
<td>• Conduct initial availability assessment of supplies, equipment and locations potentially required for a vaccine-based response (i.e. mass clinics).</td>
</tr>
<tr>
<td></td>
<td>• Conduct initial availability assessment of supplies, equipment and locations potentially required for a vaccine-based response (i.e. mass clinics).</td>
<td>• Develop list of currently qualified immunization providers and sources of potential immunization providers.</td>
</tr>
<tr>
<td></td>
<td>• Develop list of currently qualified immunization providers and sources of potential immunization providers.</td>
<td>• Review educational materials regarding administration of vaccines.</td>
</tr>
<tr>
<td>4.0 and 5.0</td>
<td>• Review and modify, if necessary, contingency plans for storage, distribution and administration of pandemic influenza vaccine to nationally defined priority groups.</td>
<td>• Review and modify if necessary, contingency plans for storage, distribution and administration of pandemic influenza vaccine to nationally defined priority groups.</td>
</tr>
<tr>
<td></td>
<td>• Ensure staff members are trained and infrastructure is in place to record immunizations, including requirements for a two-dose immunization program (i.e. recall and record-keeping procedures).</td>
<td>• Ensure staff members are trained and infrastructure is in place to record immunizations, including requirements for a two-dose immunization program (i.e. recall and record-keeping procedures).</td>
</tr>
<tr>
<td></td>
<td>• Review estimates of the number of people in the RHA who fall within each of the priority groups and access strategies.</td>
<td>• Review estimates of the number of people in the RHA who fall within each of the priority groups and access strategies.</td>
</tr>
<tr>
<td>4.1 and 5.1</td>
<td>• Review and modify if necessary, plans for vaccine security (i.e. during transport, storage and clinic administration).</td>
<td>• Review and modify if necessary, plans for vaccine security (i.e. during transport, storage and clinic administration).</td>
</tr>
<tr>
<td>4.2 and 5.2</td>
<td>If a pandemic influenza vaccine is available:</td>
<td>If a pandemic influenza vaccine is available:</td>
</tr>
<tr>
<td></td>
<td>• Follow national recommendations for use of the available vaccine.</td>
<td>• Follow national recommendations for use of the available vaccine.</td>
</tr>
<tr>
<td></td>
<td>• Provide information on vaccine to RHAs/physicians.</td>
<td>• Provide information on vaccine to physicians and other stakeholders.</td>
</tr>
<tr>
<td></td>
<td>• Receive vaccine and arrange for shipping of vaccine to RHAs/FNIHB.</td>
<td>• Activate immunization clinic capability.</td>
</tr>
</tbody>
</table>

Continued…
Alberta Pandemic Influenza Plan for the Health System

<table>
<thead>
<tr>
<th>Pandemic Alert Period</th>
<th>Canadian Phase</th>
<th>Alberta Health and Wellness</th>
<th>Regional Health Authorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.0 6.1 and 6.2</td>
<td></td>
<td>• Implement surveillance, in collaboration with PHAC (supply, distribution, utilization, adverse events).</td>
<td>• Implement surveillance (supply, distribution, utilization, effectiveness, adverse events).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Activate communication plan regarding vaccine strategy.</td>
<td>• Activate communication plan regarding vaccine strategy.</td>
</tr>
</tbody>
</table>

When pandemic influenza vaccine is available:

- Receive vaccine at AHW and arrange for shipping of vaccine to RHAs/FNIHB.
- Implement surveillance, in cooperation with PHAC.
- Activate communication plan regarding vaccine strategy.
- Communicate with bordering jurisdictions to facilitate awareness of the vaccine distribution plan and coordination and collaboration on efforts as much as possible.

Adapted from CPIP, 2006.
7 Antivirals

BACKGROUND

Antivirals will be the first medical intervention during an emerging pandemic influenza, since it is unlikely that an effective vaccine will be available at the start of the pandemic influenza. Early antiviral treatment of sick persons who go to a designated health-care provider/facility within 48 hours of symptom onset is the most efficient and cost-beneficial strategy towards decreasing morbidity and hospitalization rates during pandemic influenza (CPIP, 2006).

The antiviral strategy focuses on the use of neuraminidase inhibitors oseltamivir (Tamiflu®) and zanamivir (Relenza®) as the drugs of choice for the treatment and prophylaxis of novel influenza viruses with pandemic potential and for the pandemic influenza virus. Since replication of influenza virus in the respiratory tract peaks between 24 and 72 hours after the onset of illness, neuraminidase inhibitors (which act at the stage of viral replication) must be administered as early as possible. Due to the lack of evidence for benefit when antiviral drugs are started more than 48 hours from onset of illness, treatment should generally be restricted to those presenting within 48 hours of symptom onset unless experience with the pandemic influenza virus suggests otherwise (CPIP, 2006).

Alberta’s antiviral stockpile (as part of the national stockpile) includes enough antivirals to cover approximately 17.5% of the population, i.e. enough to provide treatment to those who become ill and need medical attention in a moderate pandemic.

The national antiviral stockpile is composed of approximately 90% oseltamivir with a portion of oral suspension for the treatment of children and adults or intubated patients who cannot swallow capsules, and 10% zanamivir. As zanamivir is inhaled, little is systemically absorbed; thus, it may be preferred for pregnant and nursing mothers in order to minimize exposure of the fetus or young infant. Zanamivir may also remain effective should resistance develop to oseltamivir. One limitation, however, is that not all persons will be able to use the inhalation device successfully. Another limitation is that inhaled zanamivir would not be expected to be effective for treatment if the pandemic influenza virus replicates systemically instead of just in the respiratory tract. Utilizing antivirals from two drug manufacturers enhances security against supply disruptions (CPIP, 2006) (refer to Appendix 8: Pandemic antiviral medications).

PURPOSE

Antivirals will be used during pandemic influenza for three purposes:

Containment

Antivirals will be used as a public health measure for containment of early cases and contacts, i.e. treatment of cases and prophylaxis of close contacts when human-to-human transmission is occurring. This will decrease the risk of transmission from the first cases and contacts identified in Alberta to delay or slow the evolution of pandemic...
influenza. Containment with this strategy will not be effective once pandemic influenza virus is widespread, therefore this strategy will be limited to the early phases of pandemic alert and initial pandemic phases in Alberta (refer to Appendix 9: Public health measures – summary by pandemic phase). A portion of the provincial antiviral stockpile will be reserved for the purpose of outbreak control.

Early treatment
The best option to minimize morbidity and hospitalization is early treatment of all ill individuals who present within 48 hours of onset of illness to a designated health-care facility (i.e. those individuals who are ill enough to require care). The greatest effect from the broad treatment of ill individuals is in reducing complications and hospitalizations.

Early treatment during second wave
A portion of the Alberta stockpile will be allocated for treatment during the second wave. Regardless of the availability of vaccine, there will be a need for a supply of antivirals for treatment of seriously ill patients.

ROLES AND RESPONSIBILITIES

The roles and responsibilities for the management of antivirals are outlined at the end of this section in Table 1: Roles and responsibilities for antivirals.

ANTIVIRALS FOR FEDERAL POPULATIONS LIVING IN ALBERTA

Refer to Appendix 6: Health services in distinct communities/populations.

ANTIVIRAL DISTRIBUTION

AHW will distribute antiviral medications from the provincial stockpile on a per capita basis to the RHAs and FNIHB for early treatment. Each RHA and FNIHB will be responsible for the delivery and administration of antivirals to Albertans requiring antiviral treatment in agreement with the guidelines for antiviral release. It is expected that the RHAs and FNIHB will monitor the release of antivirals and adhere to the guidelines to ensure only those who are eligible receive treatment. A group of the antiviral leads from across the province will be meeting to discuss the implementation of antivirals for early treatment.

- The trigger for mass distribution of the national antiviral stockpile held in Alberta from AHW to RHAs will be on the direction of the CMOH or designate at the initiation of pandemic influenza in Canada (most probably phase 6.1.0 or higher).
- AHW will distribute antivirals from the national stockpile to RHAs and FNIHB on a per capita basis under appropriate transportation and storage conditions (refer to Appendix 8.1: Antiviral shipment monitoring report form and Appendix 8.2: Antiviral temperature excursion report form).
Antiviral dispensing

- RHAs may deliver antivirals to individuals in the community, in long-term care facilities in hospitals and in other facilities. National clinical guidelines for the dispensing of antivirals are under development.

- As part of pandemic influenza planning, RHAs should complete an inventory of dispensing supplies, identify suppliers of dispensing materials and undertake discussions regarding the availability of supplies on short notice (refer to Appendix 8.4: Mass antiviral clinic guidelines).

Recording

All regions are required to maintain records of dispensing and receipt of antivirals.

- Mandatory minimum requirements include:
  - Client's name
  - Date of birth
  - Provincial health care number (PHN)
  - Name of antiviral
  - Lot number
  - Date antivirals dispensed
  - Dosage dispensed, and
  - Dispenser’s signature

- Electronic data entry will not be a requirement during pandemic influenza. Individual paper records in the form of flow sheets should meet minimal reporting requirements and must remain at the RHA for a minimum of seven years.

- A system should be established to determine receipt of antivirals, (e.g. coloured wristbands). A personal record should also be provided to the client.

Monitoring and reporting

- AHW will be responsible for monitoring antiviral use in Alberta.

- A tracking system has been developed using a weekly utilization of antiviral drugs form (refer to Appendix 8.5: Tracking form for distribution of antivirals in Alberta and Appendix 8.6: RHA antiviral usage weekly report form). These forms are to be completed by each RHA with a final report on antiviral distribution completed in the post-pandemic phase (refer to Appendix 8.7: RHA antiviral usage final report form).

- The current surveillance system of reporting serious and unexpected adverse drug reactions will be used via the Alberta Regional Adverse Reaction Centre. To report an adverse reaction, call 1-866-234-2345 or go online at:
  http://www.hc-sc.gc.ca/dhp-mps/medeff/report-declaration/centres/index_e.html
• Each RHA should ensure that staff members are trained and available to respond to questions and circumstances related to adverse reactions appropriately, including severe reactions.

COMMUNICATIONS

Communication strategies are necessary to address different target groups (e.g. health professionals and the general public) regarding the distribution of antivirals during pandemic influenza including:

• fact sheets,
• key messages, and
• self-care messaging.

If required, interpreters should be available to translate.

Refer to:
• Appendix 8.8: Antiviral key messages for the public
• Appendix 8.9: Fact Sheet – oseltamivir for treatment or prevention of influenza (for public),
• Appendix 8.10: Fact Sheet – zanamivir for treatment or prevention of influenza (for public),
• Appendix 8.11: Comparison of antiviral medications (for health-care professionals)
• Pandemic Influenza Provincial Antiviral Distribution Plan (June 2006) for more information.

Table 1 summarizes the roles and responsibilities of AHW and the RHAs related to providing antivirals during pandemic influenza.

Additional information related to Communications can be found in Section 13.
### Table 1: Roles and responsibilities for antivirals

<table>
<thead>
<tr>
<th>Canadian Phase</th>
<th>Alberta Health and Wellness</th>
<th>Regional Health Authorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>• Review and modify if necessary, contingency plans for storage, distribution and administration of antivirals.</td>
<td>• Review and modify if necessary, contingency plans for storage, distribution and administration of antivirals.</td>
</tr>
<tr>
<td></td>
<td>• Review and modify if necessary, plans for antiviral security (i.e. during transport, storage).</td>
<td>• Review and modify if necessary, plans for antiviral security (i.e. during transport, storage).</td>
</tr>
<tr>
<td></td>
<td>• Review antiviral educational materials/communication strategy.</td>
<td>• Conduct initial availability assessment of supplies, equipment and locations potentially required for an antiviral-based response (i.e. mass clinics).</td>
</tr>
<tr>
<td></td>
<td>• Use neuraminidase inhibitors for treatment of cases if new virus subtype occurring in Alberta.</td>
<td>• Review educational materials regarding administration of antivirals.</td>
</tr>
<tr>
<td></td>
<td>• Provide information on antivirals to RHAs/physicians. Ensure stakeholders are aware of how to report adverse drug reactions if antivirals are being used.</td>
<td>• Ensure staff members are trained and infrastructure is in place to record antiviral dispensing.</td>
</tr>
<tr>
<td></td>
<td>• Implement surveillance, in collaboration with PHAC (supply, distribution, utilization, effectiveness, adverse events).</td>
<td>• Use neuraminidase inhibitors for treatment of cases if new virus subtype occurring in Alberta.</td>
</tr>
<tr>
<td></td>
<td>• Activate communication plan regarding antiviral strategy.</td>
<td>• Provide information on antivirals to physicians. Ensure stakeholders are aware of how to report adverse drug reactions if antivirals are being used.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pandemic Alert Period</th>
<th>Alberta Health and Wellness</th>
<th>Regional Health Authorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 and 5.1 4.2 and 5.2</td>
<td>• Ensure prompt mobilization of antivirals allocated for early containment.</td>
<td>• Ensure prompt mobilization of antivirals allocated for early containment.</td>
</tr>
<tr>
<td></td>
<td>• Provide antivirals for treatment of cases and for prophylaxis for contacts of cases, based on local epidemiology and available supplies, if new virus subtype occurring in Alberta (see related activities in Phase 3.1).</td>
<td>• Treat cases and provide prophylaxis for contacts of cases, based on local epidemiology and available supplies, if new virus subtype occurring in Alberta (see related activities in Phase 3.1).</td>
</tr>
</tbody>
</table>
Alberta Pandemic Influenza Plan for the Health System

<table>
<thead>
<tr>
<th>Pandemic Period</th>
<th>Canadian Phase</th>
<th>Alberta Health and Wellness</th>
<th>Regional Health Authorities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6.0</td>
<td>• Review and if necessary revise national recommendations on antiviral use, based on available epidemiological data.</td>
<td>• Activate antiviral distribution plan. Based on local epidemiology and available supplies, administer antiviral treatment according to guidelines (see related activities in Phase 3.1).</td>
</tr>
<tr>
<td></td>
<td>6.1 and 6.2</td>
<td>• Arrange for mass shipping of antivirals to RHAs/FNIHB.</td>
<td>• Communicate with bordering jurisdictions to facilitate awareness of antiviral distribution plans.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Based on local epidemiology and available supplies, support RHAs in operationalizing early treatment (see related activities in Phase 3.1).</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Communicate with bordering jurisdictions to facilitate awareness of antiviral distribution plans.</td>
<td></td>
</tr>
</tbody>
</table>

8 Public Health Measures

Public health measures are population-based interventions that are intended to limit and/or slow the spread of pandemic influenza in the general population. Enactment of these measures across all RHAs will be directed by public health authorities. These measures will be reviewed and updated as information becomes available during pandemic influenza and will be consistently applied province-wide at each phase. Geographic proximity of cases and prominence of cross-boundary transportation routes will be an important consideration for the CMOH/MOH in determining the appropriate and uniform response phase for public health measures in the province of Alberta (refer to Appendix 9: Public health measures - summary by pandemic phase).

PUBLIC HEALTH MANAGEMENT OF INDIVIDUALS WITH INFLUENZA-LIKE ILLNESS (ILI)

In addition to local clinicians, public health officials in Alberta will be actively involved in the management of suspected/confirmed cases infected with a novel influenza virus during the pandemic alert period.

The goals of public health case management are to:

- increase case knowledge of how to reduce disease transmission;
- reduce transmission opportunities;
• document and report ill individuals meeting case definitions; and
• ensure case management is well integrated and appropriate for the pandemic phase.

A summary of the provincial approach that will be implemented to ensure appropriate and consistent public health case management in the pandemic alert and pandemic period can be found in Appendix 9.1: Public health management of individuals with ILI – pandemic alert period, and Appendix 9.2: Public health management of individuals with ILI – pandemic period. Individual case management by public health authorities will not be sustainable once the virus is widespread.

Should a clinician/regional MOH have a high level of suspicion that an individual may be infected with the novel virus (e.g. traveler with an epidemiological link to a risk area/situation), the MOH will inform AHW through the CMOH and proceed with actions outlined in Appendix 9.1: Public health management of individuals with ILI – pandemic alert period.

Case management and contact follow up of the initial cases in Alberta/Canada will provide an opportunity to monitor both cases and close contacts, ensure compliance with public health and infection control measures and provide opportunity for the assessment of interventions, i.e. antivirals and client education and communication. The information gathered by public health once a novel strain is detected in Alberta/Canada will be important to evaluate the effectiveness of interventions such as antivirals and to track pandemic influenza across Canada.

ISOLATION

Under the Public Health Act “isolation” means the separation of a person infected with a communicable disease from other persons in a place and under conditions that will prevent the direct or indirect conveyance of the infectious agent from the infected person to a susceptible person. Simply stated, isolation is social distancing or removal of a person who is ill with a communicable disease from others to prevent transmission.

• Isolation can occur in the home, hospital or alternate care site. It can be voluntary or involuntary, i.e. social distancing if ill, or using the powers of the Public Health Act.

• The regional MOHs will decide on implementation and discontinuation of mandatory isolation under the direction provided by the CMOH or designate (to ensure a uniform provincial approach). In the pandemic alert period it should be implemented prior to case confirmation for precautionary purposes.

• Compliance with isolation by ill persons can potentially reduce secondary cases and slow the spread of illness in the population in the pandemic alert/early pandemic phases. This could reduce societal and health system disruption and allow more time for vaccine development and distribution.

• The recommended duration of isolation is five days after symptom onset in adults (seven days in children) or until symptom resolution whichever is longer. During the
pandemic period, epidemiologic data will guide the duration of isolation. In the absence of data on the period of communicability for the novel virus, isolation will extend to 24 hours following resolution of symptoms.

- Treatment of individuals who present within 48 hours of symptom onset is expected to reduce the duration of symptoms, rate of complications and potentially decrease the period of communicability.

- Throughout all pandemic phases, individuals should be encouraged to practice good hand and respiratory hygiene and to frequently disinfect potentially contaminated surfaces in the home. Individuals should be provided with information on how to appropriately access medical attention while minimizing potential exposures (refer to Section 12, Infection Control Measures, Section 13, Provincial and Regional Communications, and Appendix 9: Public Health Measures – summary by pandemic phase).

PUBLIC HEALTH CONTACT MANAGEMENT

The goals of public health contact management are to:

- identify contacts prior to their becoming ill and infectious,
- provide early detection of additional cases decreasing time between communicability and isolation,
- limit or slow disease spread,
- reduce further exposure to the virus of individuals in close contact with cases, and
- gain knowledge about the effect of the implemented strategies.

A contact is someone who has had a face-to-face exposure within one metre of a person who is ill/presumed ill (a case) (CPIP, 2006). At present there is no information on the duration of exposure necessary to allow for transmission of the pandemic influenza virus. Contact definition will be reviewed and updated by health experts provincially/nationally throughout pandemic influenza.

Illness monitoring may be passive (self-monitoring) with reporting of any illness, or active with or without activity restrictions depending on situation, resources and recommendations of the CMOH or designate and the MOH. Monitoring is recommended for three days after last exposure or duration of incubation period, whichever is longer.

All contacts require basic information on personal protective measures, symptoms of ILI, what to do if symptoms develop, how to seek medical attention and details on activity restrictions. Information can be provided to contacts on an individual basis by distributing printed fact sheets or via telephone.

In the pandemic alert period, aggressive and comprehensive contact tracing and monitoring by public health officials as well as quarantine of contacts may decrease...
transmission rates. However, once the virus is widespread, individual based public health monitoring and contact tracing will not be feasible for the duration of pandemic influenza due to resource limitations. At this point, contact follow-up/tracing will shift from individual management to population management, e.g. identification of exposure sites, such as the workplace or public gatherings. Self-monitoring and voluntary quarantine are important measures at all times but become more important at this stage, when public health resources may be overwhelmed.

Communications and information on self-care will be distributed to the public by clinicians/RHAs. Information topics include:

- Personal protective measures (e.g. hand washing, respiratory etiquette).
- Household infection control – if a family member is ill (refer to Section 12, Infection Control Measures).
- Symptoms of ILI.
- What to do if symptoms develop.
- How, when and where to seek medical attention.
- Information regarding activity restrictions.

QUARANTINE

Quarantine is defined in the Public Health Act as "the limitation of freedom of movement and contact of persons with other persons, and in respect of premises, the prohibition against or the limitation on entering or leaving the premises, during the incubation period of the communicable disease in respect of which the quarantine is imposed;" i.e. individuals who have been in contact with a person with influenza may not leave their residence, nor may anyone enter the residence until the incubation period for influenza has passed. The Public Health Act also states that quarantine is "an action necessary to protect the public health," where the purpose is to "suppress the disease in those who may already have been infected with it, protect those who have not already been exposed to the disease, break the chain of transmission and prevent spread of disease, and remove the source of infection."

The use of quarantine is not anticipated to be as effective with pandemic influenza as with other diseases with a longer incubation period, as a short incubation period allows for a more rapid spread of disease.

If cases/clusters occur in Canada/Alberta before declaration of pandemic influenza, public health interventions such as fast and efficient activity restrictions/instructions for contacts will be most effective especially if the novel strain is not yet demonstrating ease in human-to-human transmission.

A summary of the provincially recommended approach that will be implemented for public health management of contacts in the pandemic alert and pandemic periods can be found in Appendix 9.3: Public health management of contacts of cases – pandemic
COMMUNITY-BASED DISEASE CONTROL STRATEGIES

Traditional public health control measures such as sustained isolation, quarantine (beyond the initial cases/phases) and public closures are not effective for pandemic influenza once pandemic influenza is in the community, given the characteristics of the influenza virus: e.g. short incubation period, high infectiousness through direct/indirect contact, extended survival on environmental surfaces, non-specific clinical symptoms (may not realize they are ill), asymptomatic infection and spread from asymptomatic individuals.

There is limited scientific evidence relating to the effectiveness of community-based disease control strategies such as restricting indoor public gatherings as they have never been evaluated on a large scale. These measures have the potential to reduce the spread of disease, but they also have the potential to significantly disrupt the social and economic functioning of the province. These measures will be reviewed in the early stages of pandemic influenza when information becomes available from other areas. The recommendations are generally a consensus of national and international experts. At the local level, the decision on implementation of these measures will be made by the MOH in consultation with the CMOH or designate.

Any potential benefit of these measures is most likely to occur early on as the first cases of pandemic influenza appear in Alberta. Aggressive intervention at this time may temporarily contain the pandemic influenza strain and/or delay widespread community transmission.

During pandemic influenza MOHs/CMOH will direct the most effective community measures based on the current situation and epidemiology of the pandemic influenza strain.

It is anticipated that individuals and groups may take measures in excess of those recommended in Table 1: Community-based disease control strategies recommended during pandemic influenza (e.g. school closures by school boards, outside of the recommendations by public health).

The information in Table 1 is meant to focus community resources on interventions that have the highest likelihood of being effective in decreasing pandemic influenza transmission.
Table 1: Community-based disease control strategies RECOMMENDED during pandemic influenza

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Public Health Recommendation</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recommend symptomatic individuals stay home from public events (self isolate).</td>
<td>• Potentially decrease or delay disease spread. • Feasible. • Acceptable.</td>
<td>• Unclear effectiveness. • Increased absenteeism. • Not enforceable.</td>
<td>• STRONGLY RECOMMENDED.</td>
<td>• Intervention may spread out the demand for health care services by delaying the spread of disease in the community.</td>
</tr>
<tr>
<td>• Closing schools and daycares.</td>
<td>• Potentially decrease or delay disease spread. • Feasible. • Acceptable in short term.</td>
<td>• Gatherings outside of schools may facilitate transmission. • Absenteeism.</td>
<td>• RECOMMENDED for consideration.</td>
<td>• Potentially effective if high attack rates in pre-school or school age children.</td>
</tr>
</tbody>
</table>

Refer to Appendix 9.5: Community based disease control strategies NOT recommended by WHO.

Management of geographically isolated communities
The recommendations for community-based disease control strategies outlined in the previous section are intended to apply to all communities in Alberta. Regional MOH or FNIHB MOH will direct the most effective community measures based on the current situation and epidemiology of the pandemic influenza strain.

Geographically isolated communities that consider restrictive measures outside of those recommended by provincial/regional public health experts should be aware of the limited evidence of their effectiveness and potentially negative societal consequences.

Travel and border related measures
International travel for personal and commercial reasons has increased significantly since previous pandemic influenzas. Unlike other communicable disease emergencies, travel within Canada will not be restricted and borders will not be closed by public health officials during pandemic influenza.

However, public health advisories will be issued by the Chief MOH or regional MOHs based on the information in Appendix 9.6: Recommended travel and border-related measures.
Temperature screening is not a recommended intervention at this time. The SARS experience reinforced this as an ineffective public health intervention on a mass level during the height of illness. Border measures implemented by federal authorities such as screening for ILI will require local public health follow up.

_Table 2_ summarizes the roles and responsibilities of AHW and the RHAs related to public health measures during pandemic influenza.
# Table 2: Roles and responsibilities for public health measures

<table>
<thead>
<tr>
<th>Pandemic Alert Period</th>
<th>Canadian Phase</th>
<th>Alberta Health and Wellness</th>
<th>Regional Health Authorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td></td>
<td>• Review national recommendations for public health management of cases and other control measures and modify if necessary.</td>
<td>• Review staffing requirements for implementation of pandemic influenza response including control measures and public education.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ensure adequate resources are available to implement recommended public health measures.</td>
<td>• Consider delaying introduction of public health programs that may not be adequately resourced if situation evolves into pandemic influenza or other alternatives such as contracting out.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Prepare and revise (if necessary) educational and guidance materials for public health partners and public.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.1 and 4.2</td>
<td>• Establish current level of risk to guide public health actions (e.g. transmission characteristics associated with secondary cases).</td>
<td>Manage cases and contacts of cases in Alberta:</td>
</tr>
<tr>
<td></td>
<td>5.1 and 5.1.2</td>
<td>• Evaluate interventions and revise recommendations as necessary.</td>
<td>• Isolate cases.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Review and if necessary, update and disseminate national recommendations regarding containment strategies, i.e. cancellation of public gatherings, school closures.</td>
<td>• Quarantine or activity restriction of contacts.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Track and monitor compliance with containment strategies.</td>
<td>• Administer antivirals as per guidelines.</td>
</tr>
<tr>
<td></td>
<td>6.0</td>
<td>• Review and if necessary, update and disseminate national recommendations regarding containment strategies, i.e. cancellation of public gatherings, school closures.</td>
<td>• Case and contact management for Phase 6.1 and 6.2.</td>
</tr>
<tr>
<td></td>
<td>6.1 and 6.2</td>
<td>• Increase public messaging.</td>
<td>• Discontinue quarantine strategy if previously implemented.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Shift focus to self-care and self-monitoring as case numbers increase, with concurrent increase in public education messaging.</td>
</tr>
</tbody>
</table>

*Adapted from CPIP, 2006.*
9 Health Services

ROLES AND RESPONSIBILITIES

A summary of roles and responsibilities for which an organization delivers health services, e.g. AHW or the regional health authority, is located in Table 1: Roles and responsibilities for health services, at the end of this section.

HEALTH SERVICES

The goal for all health service delivery during pandemic influenza is to provide the best possible care for the most people with pandemic influenza, to minimize the risk of influenza for those with other conditions and to maximize the efficiency of the delivery of care as provided through regional health authorities.

ESSENTIAL SERVICES

It is anticipated that during pandemic influenza the demand for health services may exceed the current capacity of the regions (e.g. facilities, supplies, human resources). The health system may not be able to maintain interpandemic period service delivery levels during pandemic influenza. As such, each RHA will review the capacity of their health-care facilities and will identify their essential health services and the health workforce requirements to support them. Health services may be suspended or deferred, consolidated or ramped up to support pandemic influenza-specific health care system requirements and routine services for all other conditions e.g. tertiary services, emergency care, obstetrics etc. Care may need to be provided by persons doing work that is not normally part of their daily activities, both health-care workers (HCW) and volunteers, and possibly in settings not usually used for health care (CPIP, 2006).

If, after working through pre-established processes with other RHAs, a RHA is unable to secure enough workers to maintain essential health services, it will submit an action request to the Public Health Emergency Coordination Group (PHECG) (refer to Appendix 4: Pandemic influenza health emergency management). AHW will then communicate through the media, province-wide, requesting the support/mobilization of HCWs. If no support continues to be available, the RHA will need to work with other RHAs to address mobility of clients to other regions. A policy and process for the redirection of human resources across RHAs during an influenza pandemic is under development.

INFLUENZA ASSESSMENT CLINICS (TRIAGE)

RHAs will develop detailed triage plans including the locations and types of care to be delivered. If it is necessary to transfer patients, the RHA will establish a transfer and transportation agreement with the affiliated acute care hospital. In more sparsely settled areas with lower numbers of health professionals, it may be more feasible to
enhance staffing at usual sites (i.e. physician offices, walk-in clinics, hospitals) rather than to set up triage sites.

There may be two levels of triage in pandemic influenza:

1. Basic triage based on clinical evaluation by health-care workers, utilizing oximetry but not laboratory or radiology technology, in medical offices/clinics, and at influenza assessment clinics. Decisions would be made to discharge patients to self-care or “low tech” follow up or to send the patient immediately to an advanced triage facility.

2. Advanced triage facilities will include clinical evaluation by registered nurses or physicians using laboratory/radiology investigations, in hospitals or influenza assessment clinics, with disposition to self-care, “low tech” follow up, or admission to a hospital (AHW Clinical Subcommittee Report, September 24, 2003).

(Refer to Appendix 10.1: Triage of patients in large urban centres and Appendix 10.2: Triage of patients in small communities.)

Because outbreaks will be occurring simultaneously across the province, all RHAs should be as self-sufficient as possible and be prepared to deal with influenza co-morbidity with reasonable expectations of successful outcome.

RHAs will inform AHW regarding enactment of their triage plans and the status of their health services throughout the pandemic alert and pandemic period through a predefined surveillance process (refer to Section 5, Surveillance).

Difficult decisions may need to be made about who gets available care and who does not, in the face of absolute shortages of equipment/medication (e.g. ventilators, antiviral medications) or personnel. Processes of ethical decision-making, both anticipatory and reactive, during a pandemic influenza, are being developed by the Alberta Pandemic Preparedness Ethics Working Group at time of print.

ALTERNATE CARE SITES

Alternate influenza care sites may be required for supportive or palliative care in addition to influenza assessment clinics for triage.

Where alternate care sites are used, RHAs will develop detailed plans including the locations and types of care to be delivered and will establish a transfer and transportation agreement with the affiliated acute care hospital.

MEDICAL SUPPLIES

The increased demand for health services will also require significant medical supply resources during pandemic influenza.
RHAs are responsible for completing an assessment of the medications, medical supplies and equipment expected to be needed by their health region during a pandemic and developing a plan for accessing any outstanding resources.

To support preparedness, AHW has provided one-time funding ($30 million) to RHAs in 2007 to purchase medical supplies for a pandemic influenza. RHAs are expected to maintain a four to six week stockpile of supplies for treatment of their regional population.

RHAs are encouraged to collaborate with other regions on stockpile purchasing.

The Public Health Agency of Canada’s National Emergency Stockpile System (NESS), operating under the Centre for Emergency Preparedness and Response, supports the provinces and territories in any human or natural disasters by delivering medical supplies when these jurisdictions run out of their own supplies (refer to Appendix 11: National Emergency Stockpile System). To access these supplies, the Director of AHW’s Emergency Health Services would submit a request to the Alberta Emergency Management Agency. Please note that the National Emergency Stockpile System resources are not to be relied upon and are only to be used when all other options have been exhausted.

HEALTH LINK ALBERTA

Health Link Alberta, a telephone advice line sponsored by AHW, is a health information service which will be an essential service throughout pandemic influenza. The Health Link Alberta phone lines (Toll Free 1-866-408-5465, Calgary Health Region 403-943-5465, Capital Health Region 780-408-5465) will be staffed appropriately during the pandemic influenza by both the Calgary and Capital Health regions.

During the pandemic alert period, Health Link Alberta will provide “sentinel surveillance” to AHW regarding early clusters of symptoms based on calls received and will serve as a primary communication source for the public.

During a pandemic period, Health Link Alberta will provide an important first-line triage function. Persons with influenza-like illness may be advised (i.e. voluntary isolation) to remain at home and call Health Link Alberta for assistance in assessing their symptoms and receiving self-care advice as well as information on health service locations as necessary.

Health Link Alberta has developed both adult and pediatric pandemic influenza community telephone triage protocols.

RHAs should coordinate telephone triage protocols with emergency rooms and ambulance services. Health Link Alberta will continue to function as a primary communication tool for informing the public.
AHW will directly provide timely provincial updates to Health Link Alberta through all pandemic influenza phases regarding epidemiology of presenting virus; status report of health system provincially; recommended clinical, self-care and public health guidelines; and key communication messages (refer to Section 13, Provincial and Regional Communications).

The RHAs will directly provide timely region-specific updates to Health Link Alberta, e.g. status of health services, and directions to people in each region regarding how and where to access services etc.

ACUTE CARE SERVICES

To the fullest extent possible, RHAs will provide medically appropriate health services; distribute guidelines prioritizing health-care needs, service delivery and accessing resources; coordinate clinical care services with bordering jurisdictions; and maintain existing referral patterns and use common/standardized approaches for:

- hospital admission and discharge of influenza patients;
- clinical care guidelines, including long-term care guidelines (refer to Section 11, Clinical Care Guidelines and Tools);
- infection control guidelines (refer to Section 12, Infection Control Measures);
- access to tertiary and specialized care; and

OUT-OF-REGION/OUT-OF-PROVINCE REFERRALS

Inter-pandemic period referral patterns for out-of-region and out-of-province patients will be maintained such that RHAs that currently provide tertiary care and province-wide services would continue to do so to the extent possible given resources, changes in capacity and patient outcomes.

Referring regions and provinces will repatriate patients when the level of care provided by the receiving region is no longer required. It is understood that the capacity of RHAs to receive or repatriate patients will fluctuate greatly throughout the course of pandemic influenza response. The ability of a region to accept (or repatriate) transferred patients will be evaluated on a continual basis, e.g. daily and case-by-case. This process will be coordinated through the RHAs via the Critical Care Line (for trauma, cardiac, neurosurgery, pediatric, or ICU, etc. cases), Urgent Care Line (for plastics, acute abdominal, etc. cases which are not appropriate for the Critical Care Line) and admission/discharge processes (e.g. patient transport offices with the Provincial Flight Coordination Centre). AHW will monitor the situation and redirect based on provincial requirements.
Modified processes may be implemented based on the RHA’s ability to maintain operations as previously described and the stage of emergency response in keeping with experience in other emergency/high-demand situations, i.e. job action, screening teams, regional co-ordination centres, and rural coordination.

**LONG-TERM CARE**

During pandemic influenza the management and reporting of ILI/influenza cases will follow the processes used to address annual influenza outbreaks in long-term care (LTC) facilities. This process includes notification, viral confirmation, infection control, cohorting (the separation of individuals with influenza from those who do not have the illness) and clinical management of influenza in residents.

These facilities will, wherever possible, enhance care levels within their facilities and programs to meet the medical needs of their residents, rather than send residents to hospitals, acute-care centres or specialty units. Appropriate staffing and resources to support these care levels include daily medical coverage at the facility with on-site medical leaders as well as access and use of pulse oximeters and therapeutic equipment (e.g. intravenous, or oxygen).

Alternate influenza care centres, if established by a RHA, will support managing the care of acutely ill LTC residents in the same manner as all Albertans.

In the event that a referral to an acute or alternate influenza care centre is clinically indicated, LTC facilities will follow regional guidelines to determine transfer of residents from LTC facilities to acute-care facilities or an alternate influenza care centre (refer to Appendix 10.3: Triage of residents in long-term care facilities).

**HOME CARE**

While Influenza Self-Care will be the major strategy to support the health system during pandemic influenza, regional home care programs across the province will be supported by the RHAs as an essential service to the greatest extent possible.

**MENTAL HEALTH SERVICES**

Mental health services may experience higher volumes during a pandemic. Refer to Appendix 12: Mental health during pandemic influenza for a summary of a literature review conducted by the Influenza Self-Care Strategy Stakeholders Committee and Appendix 12.1: Fact sheet: dealing with stress or feelings of fear because of pandemic influenza (for public).

Each RHA will determine which mental health services it will be able to maintain, discontinue or enhance over the phases and waves based on given resources, demand and risk to individuals or the community. Services to current mental health patients will also need to be addressed.
SPECIALIZED SERVICES

RHAs will continue to coordinate and access specialized care such as cancer therapies, kidney dialysis, blood services, etc. through their regular processes.

HEALTH SERVICES IN DISTINCT COMMUNITIES/POPULATIONS

Refer to Appendix 6: Health services in distinct communities/populations.

Table 1 summarizes the roles and responsibilities of AHW and the RHAs related to health service delivery during pandemic influenza.

Table 1: Roles and responsibilities for health services

<table>
<thead>
<tr>
<th>Canadian Phase</th>
<th>Alberta Health and Wellness</th>
<th>Regional Health Authorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 4.1 and 4.2 5.1 and 5.2</td>
<td>• Fund laboratory testing for rapid case confirmation. • Review, modify and distribute F/P/T guidelines to RHAs on clinical management of cases, infection control measures, use of antiviral medications etc. • Disseminate strategy to RHAs for collecting and monitoring data on health-care service use and demands.</td>
<td>• Review, adapt and distribute F/P/T guidelines from AHW on clinical management of cases, infection control measures, use of antiviral medications etc. • Review, adapt and distribute guidelines prioritizing health-care needs and service delivery, accessing resources. • Review capacity of health-care facilities; conduct availability assessment of medications, supplies and equipment. • Review, adapt and distribute detailed regional and facility level plans, including the locations/type of care to be delivered at influenza assessment sites and alternate sites if applicable. • Coordinate plans for patient repatriation, referrals and services across jurisdictions.</td>
</tr>
</tbody>
</table>
### Alberta Pandemic Influenza Plan for the Health System

<table>
<thead>
<tr>
<th>Pandemic Alert Period</th>
<th>Alberta Health and Wellness</th>
<th>Regional Health Authorities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Canadian Phase</strong></td>
<td>• Plan to mobilize financial resources.</td>
<td>• Develop plans to mobilize human and financial resources.</td>
</tr>
<tr>
<td></td>
<td>• Implement pandemic influenza alert communication strategy.</td>
<td>• Collaborate with other regions on stockpile purchases.</td>
</tr>
<tr>
<td></td>
<td>• Enhance care levels in LTC facilities.</td>
<td>• Develop delivery plans for antiviral medications and pandemic vaccine.</td>
</tr>
<tr>
<td></td>
<td>• Support home care as an essential service.</td>
<td>• Manage cases and contacts of cases in Alberta: isolation, surveillance of contacts and self-care education.</td>
</tr>
<tr>
<td></td>
<td>• Initiate Health Link Alberta pandemic influenza alert response.</td>
<td>• Implement pandemic influenza alert communication strategy.</td>
</tr>
<tr>
<td></td>
<td>• Have a plan to maintain specialized services.</td>
<td>• Determine which mental health services will be maintained and plan for providing services to current mental health clients.</td>
</tr>
</tbody>
</table>
### Canadian Phase

<table>
<thead>
<tr>
<th>Pandemic Period</th>
<th>Alberta Health and Wellness</th>
<th>Regional Health Authorities</th>
</tr>
</thead>
</table>
| 6.0 6.1 and 6.2 | • Activate the AHW Public Health Emergency Coordination Group (PHECG) to guide and coordinate the provincial health response by:  
  • Direct RHA disease/health system capacity surveillance activities and participate in national surveillance.  
  • Coordinate the provision of information to and from RHAs and other service providers as appropriate.  
  • Coordinate and support the health responses of nine RHAs and other health sector stakeholders, e.g. health professional colleges, Provincial Laboratory of Public Health, Health Link Alberta; including providing direction regarding:  
    - public health measures.  
    - self-care strategy.  
    - vaccines and antivirals.  
    - triage.  
    - clinical care guidelines.  
    - infection control.  
  • Direct the overall provincial communication strategy and messages, for consistency.  
  • Communicate and obtain support from the government of Alberta (GoA) and federal/provincial and territorial governments (F/P/T).  
  • Evaluate health service response after each wave. | • Continue to deliver health services and programs within their respective jurisdictions to the greatest extent possible.  
• Distribute antiviral medications and pandemic vaccine when available.  
• Maintain a regional surveillance system and report information to AHW.  
• Assess capacity of health services and work with AHW to identify additional/alternate resources.  
• Suspend or defer, consolidate or ramp up health services to support pandemic influenza specific health-care requirements and routine services for all other conditions.  
• Access sources of additional health-care workers as necessary.  
• Acquire extra supplies needed to provide health-care in alternate influenza care sites and open these sites as needed.  
• Track stocks of necessary medical equipment and supplies.  
• Reallocate/re-deploy resources when necessary to ensure reasonable equitable access to essential services and critical scarce resources to ensure an effective health response where possible.  
• Collaborate with AHW in the delivery of public information/education programs.  
• Liaise with local partners (e.g. first responders, community services, mortuary services, schools, workplaces).  
• Coordinate clinical care and health services with bordering jurisdictions.  
• Monitor capacity of mortuary and burial services.  
• Monitor need for social and psychological services.  
• Inform AHW of triage site activation. |
10 Health Workforce

Health-care workers (HCWs) will be in critical demand throughout pandemic influenza. Their ability to provide services will be significantly affected by absenteeism caused by illness, the need to care for family members, or fear. Their ability to be re-deployed or re-assigned to support essential services will also be significantly affected by the knowledge and skills required to work in alternate work settings.

ROLES AND RESPONSIBILITIES

Alberta Health and Wellness’ Health Workforce Division
The Health Workforce Division at AHW has encouraged regulatory colleges to develop appropriate business continuity plans that address issues specific to pandemic influenza (refer to Appendix 13: Alberta health professions regulatory bodies pandemic influenza planning).

The Division will serve as the primary communication point for information to the regulatory bodies during pandemic influenza (e.g. notification of activation of the Alberta Pandemic Influenza Plan for the Health System, request activation of their plans and confirm the activation, confirm the number of expedited licensures and the notification of the end of a pandemic influenza).

Alberta Health and Wellness’ Public Health Emergency Coordination Group (PHECG)
The PHECG, at AHW, will monitor the health workforce capacity across the province. Although HCWs are employees or contractors of RHAs or other health-care organizations, there is an expectation that all RHAs will be as self-sufficient as possible and also collaborate with other regions as needed. During a severe pandemic based on authorities provided to the Minister of Health and Wellness under the Public Health Act, AHW may require RHAs to redirect human resources across RHAs.

Alberta Advanced Education and Technology
Alberta Advanced Education and Technology will:

- collaborate with the post-secondary sector to monitor the use of students once pandemic influenza is declared,
- continue to work with post-secondary institutions and AHW to develop and/or share existing curriculum to facilitate the use of health program students during pandemic influenza, and
- work with AHW, RHAs and educational institutions to ensure a consistent approach to the use of health program students.
Professional Regulatory Bodies
It will continue to be the responsibility of the professional regulatory bodies to register and govern members of the regulatory health professional workforce.

After activation of the Alberta Pandemic Influenza Plan for the Health System, the Minister of Health and Wellness will advise the professional regulatory bodies to activate their respective pandemic influenza plans and confirm their activation.

There may need to be a regional/provincial news release, through the media, requesting health professionals to return to work (e.g. retirees) and for those professionals to go to their regulatory college to register as appropriate.

Regional Health Authorities
During a pandemic influenza, it will continue to be the responsibility of the RHAs to assess the health needs of the region, determine priorities in the provision of health services and to allocate the available human resources accordingly.

As the employer or contractor, RHAs will assign HCWs based on their pandemic influenza plan for health service delivery (e.g. regional essential services will be staffed as priority).

The regions will access appropriately skilled HCWs employed within their respective regions based on pre-existing plans, partnerships, volunteerism and/or utilization of the emergency powers contained in the Public Health Act when a declaration of public health emergency is made.

The RHAs will report the status of their workforce to AHW (refer to Section 5, Surveillance).

LEGISLATION RELATED TO HEALTH WORKFORCE ISSUES
In terms of workforce planning the specifics of any situation must be considered, along with the legislation involved, to determine if the emergency powers in Section 52.6 of the Public Health Act would be required.

Employers who engage health care professionals to provide services during a pandemic influenza will need to add the health care professionals to their payroll to ensure these professionals are eligible for workers’ compensation benefits and liability coverage.

MOBILIZATION OF THE HEALTH WORKFORCE
RHAs will communicate with their employees regarding requests for HCWs and will include information regarding skill sets required and points of contact.

Health provider organizations should note in their planning that during a pandemic individual HCWs will continue to make personal decisions regarding their competence to provide safe and ethical care and requests for redeployment until mandated.
otherwise through a RHA or a government directive. As HCWs may be employed by more than one public and/or private employer, conflicts may develop as to which employer they will provide additional support to and to which employer they will provide reduced support.

If after working through pre-established processes with other RHAs, a RHA is unable to secure enough workers to maintain essential health services, it will submit an action request to the Public Health Emergency Coordination Group (PHECG) (refer to Appendix 4: Pandemic influenza health emergency management). AHW will then communicate through the media, province-wide, requesting the support/mobilization of HCWs. If no support continues to be available, the RHA will need to work with other RHAs to address mobility of clients to other regions.

Regulated colleges will support the distribution of a media release to their members through existing newsletters, web sites, etc. and will provide a critical, rapid-registration function (as required) to facilitate the licensure of HCWs. They will not act as an employment agency or make decisions for the re-deployment of staff.

PHYSICIAN ISSUES

The Council of Medical Directors (CMD) has identified the following physician-specific workforce issues, which are being addressed by subcommittees of the Physicians Issues in Disaster Planning Working Group:

- **Funding:** there is a need to consider physician-payment models during a pandemic influenza.

- **International Medical Graduates, Medical Students, Residents and Retired Physicians:** there is a need to establish potential suitable roles, licensing, medical liability coverage, privileging, scheduling and deployment and training and orientation as well as methods of contacting individuals.

- **Liability:** there is a need to examine liability issues, in responding to a pandemic influenza, and also as it relates to working outside normal areas of practice (e.g. a surgeon performing primary care work during a pandemic influenza).

- **Licensing:** there is a need to examine issues surrounding licensing, including trans-jurisdictional and emergency licensure.

- **Ethics:** there is a need to develop a process for ethical decision-making on a system, organization and individual level for issues likely to arise in a pandemic. This work is being completed by a working group lead by the Provincial Health Ethics Network and AHW.

- **Role of community physician offices:** there is a need to examine the role of community offices, business continuity plans, infection prevention and control practices, knowledge and skills, patient education and information, effective relationships with RHAs, access to tools, documents, guidelines, recommendations, web sites, policies, procedures etc.
• **Communication:** There is a need to develop a plan for communicating to physicians in a current, authoritative, and consistent method during a pandemic. A communications sub-committee of the Physician Disaster Planning Working Group has been formed and is meeting regularly.

*Table 1* summarizes the roles and responsibilities of AHW and the RHAs in relation to the roles of the health workforce during a pandemic influenza.

**Table 1: Roles and responsibilities regarding the health workforce**

<table>
<thead>
<tr>
<th>Alberta Health and Wellness – PHECG</th>
<th>AHW Health Workforce</th>
<th>Advanced Education &amp; Technology</th>
<th>Regional Health Authorities</th>
<th>Regulatory Colleges</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Minister will advise the professional regulatory bodies to activate their respective pandemic influenza plans and confirm their activation as necessary.</td>
<td>• Primary communication point for information to colleges.</td>
<td>• Collaborate with the post-secondary sector to monitor the use of students once pandemic influenza is declared.</td>
<td>• Assess the health needs of the RHA, determine priorities in the provision of health service and allocate available human resources accordingly.</td>
<td>• Activate their respective pandemic plans and confirm their activation on the direction of the Minister.</td>
</tr>
<tr>
<td>• Monitor health workforce capacity.</td>
<td>• Receive guidelines from federal government and communicate to RHAs as necessary e.g. Workers’ compensation.</td>
<td>• Continue to work with post-secondary institutions and AHW to develop and/or share existing curriculum to facilitate the use of health program students during pandemic influenza.</td>
<td>• Apply recommended human resources guidelines.</td>
<td>• Support fan out of media information on websites etc.</td>
</tr>
<tr>
<td>• At the request of RHA(s) work with the media etc. provincially to request HCWs to return to work (e.g. retirees) and to go to their regulatory college to register as appropriate.</td>
<td></td>
<td>• Work with AHW, RHAs and educational institutions to ensure a consistent approach to the use of students (i.e. it is assumed that students will be approached as members of the public who may volunteer to work during a pandemic influenza).</td>
<td>• Report status of health workforce AHW PHECG.</td>
<td>• Provide critical rapid registration.</td>
</tr>
</tbody>
</table>
11 Clinical Care Guidelines and Tools

The spectrum of illness associated with influenza virus infections is wide and ranges from asymptomatic (no symptoms) infection to fatal disease, with the latter associated with viral pneumonia. Previous experience of a population with an “antigenically-related” virus variant (a virus that is new in the population e.g. SARS) is a determinant of the severity of the disease. Therefore, with a pandemic influenza strain, which would be new in the population, the anticipated clinical spectrum will be more severe.

The information in this section is based on characteristics of an interpandemic influenza and may need modification once a pandemic influenza occurs. As soon as the pandemic influenza strain is identified and more is known about the virus-specific clinical presentation, relevant information will be communicated through the WHO/PHAC/provincial and regional health networks to frontline clinicians. A pandemic influenza case definition will provide the criteria for reporting cases of suspected or confirmed pandemic influenza in the early stages of disease surveillance.

DIAGNOSTIC ALGORITHMS

There will be a large number of cases and limited resources during pandemic influenza, therefore assessment guidelines are expected to be used by regional health-care staff and those with minimal triage experience to appropriately evaluate the needs of each individual. Staff will ensure equitable access to the scarce health services and the triage of influenza patients will occur efficiently in a crisis situation. Triage personnel within each RHA will decide when patients can be managed:

- in an ambulatory setting [a patient who is able to walk and does not have to be kept in bed (e.g. health clinics, doctor’s offices)],
- redirected home,
- sent to an alternate influenza care site, or
- sent to emergency services, or
- admitted to an acute care hospital.

Refer to Appendix 14.1: Triage of adults and Appendix 14.2: Triage of children.

MEDICAL MANAGEMENT

The most common complication will be pneumonia (primary viral pneumonia or secondary bacterial pneumonia). Non-respiratory complications will also be seen (e.g. cardiovascular or neurological) but the magnitude of these complications cannot be predicted until the pandemic influenza strain appears.

Protocols will be used to assist in the appropriate management of patients with pneumonia. For examples refer to:
Alberta Pandemic Influenza Plan for the Health System

- **Appendix 14.3**: Patient care orders: community acquired pneumonia – adult admission,

- **Appendix 14.4**: Pneumonia care – instructions for adult patients, or

- The Alberta Medical Association's "Community Acquired Pneumonia" Toward Optimized Practice (TOP) program guidelines, located online: [http://www.topalbertadoctors.org/TOP/CPG/](http://www.topalbertadoctors.org/TOP/CPG/)

Relevant information from the Canadian Pandemic Influenza Plan for the Health Sector 2006 can be found in **Appendix 14.5**: Clinical guidelines for influenza management. This document is an excerpt from the Calgary Health Region's Physician Response: Pandemic Influenza Operational Guide.

**Appendix 14.6**: Clinical presentation and management of influenza is a document intended for use with the algorithm found in **Appendix 14.7**: Pandemic influenza illness assessment algorithm. This document is designed to provide a quick reference for community physicians during a pandemic influenza.

There will be a need for RHAs to work with physicians who do not fall under the authority of the RHAs. Work is progressing through the Physicians Issues in Disaster Planning Group to address the role of community offices in emergency preparedness and disease response and communication with physicians.

**CRITICAL OR INTENSIVE CARE FACILITIES/UNITS**

Critical or intensive care facilities/units already operate very near to capacity. They have a limited ability to increase size due to limitations in location (e.g. need for wall pressure systems such as oxygen), staff and equipment (e.g. ventilators). Increased capacity will be achieved mostly through postponement of elective procedures, particularly those requiring Intensive Care Units (ICUs). Capacity might also be increased by using beds in recovery rooms, coronary care areas, and pulmonary wards; expanding ICU physically (ideally close to ICU); establishing a ward to care for patients less critically ill; and/or establishing a “weaning” unit, (e.g. use extubation protocols to hasten discharge from ICUs). Dental surgical facilities could also provide staff and equipment.

**CRITICAL CARE EQUIPMENT**

Bottled oxygen is used to supply portable ventilators. Using bottled oxygen could become problematic during a pandemic influenza, due to of lack of supply and portability of care. The lack of oxygen wall-outlets in alternate-care sites may increase the need for bottled oxygen. In addition, the number of people who know how to use bottled oxygen is limited.

Oxygen concentrators are currently used in homes by individuals with chronic obstructive pulmonary disease (COPD), and may be a better option for rural areas and
institutions. These units can produce up to 80% oxygen at six litres of flow. This would not run a ventilator, but could supply nasal oxygen.

In the event of acute respiratory failure without other organ system involvement, bilevel positive airway pressure (BiPAP) will be administered through a face or nasal mask. This is as effective as or more effective than intubation and mechanical ventilation. At the University of Alberta Hospital BiPAP therapy is routinely used in the treatment of COPD. As well, patients with BiPAP machines used for treating sleep apnea (a small number), often have underlying respiratory disease, and are an easy group to treat and keep out of the ICU.

12 Infection Control Measures

Implementation of comprehensive infection prevention and control (IPC) strategies will help prevent the transmission of pandemic influenza and other infectious diseases with or without the availability of immunization or chemoprophylaxis.

Infection control precautions and associated procedures will be communicated to the public (e.g. Influenza Self-Care Strategy) and health-care professionals through AHW and RHAs. RHAs will ensure that all regional staff/HCWs are familiar with the recommended precautions (refer to Appendix 15.1: Summary of the Alberta pandemic influenza infection control guidelines). This document is a quick reference for health-care providers.

PRINCIPLES ON THE TRANSMISSION OF INFLUENZA

Efficient transmission of pandemic influenza occurs when symptoms such as coughing are present and viral shedding is high (i.e. early in symptomatic period). The role of airborne transmission over short distances remains controversial. Influenza is highly contagious; it can spread quickly in settings where large groups of people gather together.

People can spread the virus 24 hours before and up to five days after the start of symptoms [usually up to three to five days for “immunocompetent” (healthy) adults and seven days for young children].

Influenza viruses have been shown to survive on hard, non-porous surfaces for 24 to 48 hours, on cloth paper and tissue for eight to 12 hours and on hands for five minutes. Survival of the virus is enhanced under dry conditions (low humidity) and cold temperatures.

The influenza virus is readily inactivated (destroyed) by soap and water, waterless antiseptic agents (>60% alcohol), hospital germicides, and routine household cleaning products. Thorough, adequate cleaning is an important method to kill the influenza virus on surfaces. Antibacterial cleaning products, in place of routine cleaning products, are not required in the home during an outbreak of influenza.
GENERAL INFECTION PREVENTION AND CONTROL PRACTICES

Key preventative measures, such as respiratory etiquette and hand hygiene, reduce the likelihood of contamination of the environment and transmission of respiratory infections [refer to Appendix 14.5: Clinical guidelines for influenza management and the influenza self-care strategy section found in Section 13, Provincial and Regional Communications].

Hand hygiene
Frequent, thorough, hand hygiene (washing) is the cornerstone of infection prevention and control (refer to Appendix 15.2: Hand hygiene procedures).

Respiratory hygiene/cough etiquette
Respiratory hygiene measures include:

- using disposable, one-use tissues for wiping noses and dispose of tissues promptly after use into a regular waste container,
- covering nose and mouth when sneezing and coughing,
- washing hands after coughing, sneezing or using tissues, and
- keeping fingers away from the mucus membranes of the eyes and nose.

Use of masks by the public during a pandemic influenza
There is no evidence that the use of masks in general public settings will be protective/effective (refer to Section 8, Public Health Measures). An individual may wish to use a mask if ill with influenza or caring for someone who has the illness (refer to Appendix 15.3: Use of masks by the public during pandemic influenza)

INFECTION PREVENTION AND CONTROL PRACTICES FOR HEALTH-CARE WORKERS

Influenza transmission-based precautions include “routine practices” plus additional precautions. Routine practices (e.g. infection prevention and control practices which are applied to all patients at all times in all settings) include:

- meticulous hand-washing,
- the use of gloves, masks, eye protection, face shields and gowns when splashes or contamination with blood or body fluids are anticipated,
- the cleaning of patient-care equipment, the patient’s physical environment and soiled linen, and
- the use of precautions to reduce the possibility of HCW exposure to blood-borne pathogens.

The Alberta position regarding the use of personal protective equipment (PPE) during a pandemic influenza is under discussion between infection prevention control, occupational health and safety, and public health experts. A document entitled Best
Practice Guideline for Workplace Health and Safety During Pandemic Influenza is being developed by the GoA and will be made available for use in all Alberta workplaces once a decision on PPE is made.

To prevent the spread of infection between infected and non-infected persons in settings where patients confirmed or suspected of having a pandemic influenza might receive health-care services, routine and additional precautions, such as those in Table 1: Infection control practices during pandemic influenza in healthcare settings should be in place. Some routine and additional precaution recommendations may be achievable only in the early phases of the pandemic and other recommendations may not be achievable as the pandemic influenza spreads and resources (equipment, supplies and workers) become scarce.

Table 1: Infection control practices during pandemic influenza in health care settings

<table>
<thead>
<tr>
<th>Isolation/Precautions</th>
<th>Routine Practice/Standard Precautions</th>
<th>Routine Practice/Standard Precautions and Additional Precautions for Patients with Suspected or Confirmed Pandemic Influenza</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hand Hygiene</strong></td>
<td>• Yes: Contact with patient, patient items or equipment.</td>
<td>• Yes: Contact with patient, patient items or equipment.</td>
</tr>
<tr>
<td><strong>Wear Gloves</strong></td>
<td>• If contact with infectious materials (blood and body fluids) is anticipated.</td>
<td>• When entering room and contact is anticipated with patient and patient items.</td>
</tr>
<tr>
<td><strong>Wear Gown</strong></td>
<td>• If contact with infectious materials (blood and body fluids) is anticipated.</td>
<td>• When entering room and contact is anticipated with patient and patient items.</td>
</tr>
</tbody>
</table>
| **Wear Mask**          | • Wear surgical mask if within one metre of patient with respiratory infection. | • A national/provincial recommendation is being developed.  
• Patients should wear a surgical mask during transfers if possible. |
| **Eye Protection**     | • If potential splattering or spraying of infectious materials (blood and body fluids). | • During aerosol generating procedures,  
• If potential splattering or spraying of infectious materials (blood and body fluids) and  
• When providing direct care to a coughing patient (within one metre) unless the patient is wearing a mask. |

Continued…
### Alberta Pandemic Influenza Plan for the Health System

<table>
<thead>
<tr>
<th>Isolation/Precautions</th>
<th>Routine Practice/Standard Precautions</th>
<th>Routine Practice/Standard Precautions and Additional Precautions for Patients with Suspected or Confirmed Pandemic Influenza</th>
</tr>
</thead>
</table>
| **Patient Accommodation** | - Single room preferred.  
- Perform risk assessment. | - Isolation can occur in the home, hospital or alternate care site. It can be voluntary or involuntary, i.e. social distancing if ill or using the powers of the Public Health Act.  
- Minimize crowding between patients, visitors and workers (keep one metre spatial separation).  
- When Pandemic Phase 6.2 declared open pre-planned cohort areas/units.  
- Restrict patient movement and transport to medically necessary activities only. |
| **Patient Care Equipment** | - Non-critical equipment is to be cleaned between patients.  
- Discard single use items.  
- Toys and personal effects should not be shared between patients.  
- (Refer to Appendix 15.4: Cleaning procedures for common items). | - Dedicate use of non-critical equipment to a single patient (e.g. stethoscope, BP cuff).  
- Minimize supplies kept in room. |
| **General Environment** | - Clean high touch areas (e.g. taps, light switches, doorknobs) at least daily and when soiled.  
- Deposit laundry into hamper- avoid touching outside areas.  
- Garbage contained and not leaking.  
- Regular dishes and utensils may be used- wash dishes in hot soapy water or correctly functioning dishwasher. | - After discharge clean room thoroughly including bed, cubicle curtains and high touch surfaces.  
- Deposit laundry into hamper- avoid shaking linens and touching outside areas of hamper.  
- Double bagging not required.  
- Disposable dishes not necessary. |

Continued…
### Alberta Pandemic Influenza Plan for the Health System

**Isolation/Precautions**

<table>
<thead>
<tr>
<th>Patient Transport</th>
<th>Routine Practice/Standard Precautions</th>
<th>Routine Practice/Standard Precautions and Additional Precautions for Patients with Suspected or Confirmed Pandemic Influenza</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Use a clean blanket to cover a patient on a stretcher.</td>
<td>• Limit movement/activities of patients including transfers, unless the patient has recovered from pandemic influenza.</td>
<td>• Limit movement/activities of patients including transfers, unless the patient has recovered from pandemic influenza.</td>
</tr>
<tr>
<td>• Patient MUST wash their hands.</td>
<td>• Notify area receiving patient.</td>
<td>• Notify area receiving patient.</td>
</tr>
<tr>
<td>• Patient MUST wash their hands.</td>
<td>• Patients MUST wash their hands, wear a clean gown and not touch other people or objects outside room</td>
<td>• Patients MUST wash their hands, wear a clean gown and not touch other people or objects outside room</td>
</tr>
</tbody>
</table>

**Visitors**

<table>
<thead>
<tr>
<th>Visitors</th>
<th>Routine Practice/Standard Precautions</th>
<th>Routine Practice/Standard Precautions and Additional Precautions for Patients with Suspected or Confirmed Pandemic Influenza</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Check with nurses: visitors must wear a surgical mask if within one metre of patient who has an acute respiratory illness.</td>
<td>• Restrict visitors to those that are essential to patient care or those made by close relatives of terminally ill patients. Visitors should be immune-immune refers to those who have recovered from pandemic influenza or have been immunized against the pandemic influenza strain.</td>
<td>• Restrict visitors to those that are essential to patient care or those made by close relatives of terminally ill patients. Visitors should be immune-immune refers to those who have recovered from pandemic influenza or have been immunized against the pandemic influenza strain.</td>
</tr>
</tbody>
</table>

**Work restriction**

<table>
<thead>
<tr>
<th>Work restriction</th>
<th>Routine Practice/Standard Precautions</th>
<th>Routine Practice/Standard Precautions and Additional Precautions for Patients with Suspected or Confirmed Pandemic Influenza</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health care workers should be fit for work.</td>
<td>• Health care workers are fit to work in any clinical area and with all patients if the health care worker:</td>
<td>• Health care workers are fit to work in any clinical area and with all patients if the health care worker:</td>
</tr>
<tr>
<td></td>
<td>- Has not been exposed to pandemic influenza or</td>
<td>- Has not been exposed to pandemic influenza or</td>
</tr>
<tr>
<td></td>
<td>- Has been immunized against pandemic influenza or</td>
<td>- Has been immunized against pandemic influenza or</td>
</tr>
<tr>
<td></td>
<td>- Has recovered from pandemic influenza illness and is past the period of communicability (five days)</td>
<td>- Has recovered from pandemic influenza illness and is past the period of communicability (five days)</td>
</tr>
<tr>
<td></td>
<td>• Health care workers who have been exposed to pandemic influenza and are in the incubation period may work with pandemic influenza patients as long as the health care worker remains asymptomatic.</td>
<td>• Health care workers who have been exposed to pandemic influenza and are in the incubation period may work with pandemic influenza patients as long as the health care worker remains asymptomatic.</td>
</tr>
<tr>
<td></td>
<td>• It is preferred that staff members with influenza symptoms not work. Where necessary, symptomatic staff may work with pandemic influenza patients as long as the health care worker is well enough to perform their duties.</td>
<td>• It is preferred that staff members with influenza symptoms not work. Where necessary, symptomatic staff may work with pandemic influenza patients as long as the health care worker is well enough to perform their duties.</td>
</tr>
</tbody>
</table>
### Alberta Pandemic Influenza Plan for the Health System

<table>
<thead>
<tr>
<th>Isolation/Precautions</th>
<th>Routine Practice/Standard Precautions</th>
<th>Routine Practice/Standard Precautions and Additional Precautions for Patients with Suspected or Confirmed Pandemic Influenza</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• Symptomatic health care workers may work with all patients if the worker is past the period of communicability and is well enough to perform their duties.</td>
</tr>
</tbody>
</table>

| Care of the Deceased | Routine practice.                        | Routine practice. |

Alternate influenza care sites are those settings that are designated for operation prior to pandemic influenza and become operational only when pandemic influenza is declared by the World Health Organization. Alternate influenza care sites include triage settings, self-care settings and temporary influenza hospitals (refer to Appendix 15.5: *Features of infection control in specific traditional and alternate influenza care settings*). It is important to note that the use of personal protective equipment is only one component of a hierarchy of controls that are in place to prevent disease transmission. Engineering control such as ventilation and administrative controls such as antivirals and vaccinations provide a framework in which disease transmission risk is reduced.

Isolation, a component of routine practice and additional precautions, is described as the separation of a person infected with a communicable disease from other persons in a place and under conditions that will prevent the direct or indirect conveyance of the infectious agent from the infected person to the susceptible person. Simply put, isolation is social distancing or removal of a person who is sick with a communicable disease from others to prevent transmission. The recommended duration of isolation is five days after the onset of symptoms in adults (seven days in children) or until symptom resolution (the person gets well) whichever is longer.

Individuals should be encouraged to practice good hygiene and to frequently clean potentially contaminated surfaces in the home. The public should be provided with specific information on how to appropriately access medical attention while minimizing potential exposures.
13 Provincial and Regional Communications

The implementation of an effective communications strategy is essential in ensuring messages during all phases of a pandemic are accurate, timely, continuous and consistent in nature.

The information in this section is based on communications activities that will be delivered by Alberta Health and Wellness (AHW) and the regional health authorities (RHAs) as well as other key stakeholders. Tools and tactics to be used in the event of a pandemic are also identified in this section.

ROLES AND RESPONSIBILITIES

Alberta Health and Wellness

As identified in Section 3, Coordination of Emergency Response, Alberta Health and Wellness (AHW) is the lead agency for pandemic influenza planning with the Alberta Emergency Management Agency (AEMA) providing coordination and all other ministries providing support. AHW will provide regular communications to RHAs, FNIHB and the public.

Regional Health Authorities

RHAs will be responsible for communicating information to physicians and other health-care professionals and health-service personnel within their system. Each RHA will have its own communications plan for communicating region specific information to its employees, and partners (e.g. municipalities) and the public.

AHW Communications/Public Affairs Bureau will use the established RHA Communications Council network for two-way communications with health region communications staff until the activation of the Public Health Emergency Coordination Group (PHECG).

Refer to Table 1: Roles and responsibilities for communications at the end of this section.

Health Workforce

- AHW Health Workforce Division will provide general information to professional regulatory bodies/associations to be shared with their members. Regular communication will be established with all regulated health professions pandemic influenza planners prior to the event.
- The Council of Medical Directors (CMD) has formed a Physicians’ Issues in Disaster Planning Working Group, a sub-working group which is addressing the issue of communication to physicians who are not employed by RHAs.
National physician organizations (e.g. Canadian Medical Association) will coordinate with their provincial counterparts regarding pandemic influenza communications to their members.

**Public Affairs Bureau**
As in any public emergency, the Public Affairs Bureau (PAB) will coordinate all government public communications during a pandemic influenza. The role of the PAB in crisis communications is to oversee public communications for the GoA response in conjunction with the lead ministry, in this case AHW.

**Other levels of government**
AHW Communications participates in the Pandemic Influenza Committee (PIC) Communications Subcommittee, which includes federal/provincial/territorial representatives, and will continue to liaise with this group during all phases of pandemic influenza. AEMA and Alberta Municipal Affairs will communicate with municipalities, as will the RHAs. As part of the ongoing cross-government work, Alberta Municipal Affairs Communications branch, along with AEMA, will develop a plan for two-way communications with municipalities.

**KEY AUDIENCES**

**Albertans**
Communicate to the public directly and through the media, to inform on healthy habits and emergency preparedness prior to pandemic influenza and give clear instruction and up-to-date information as soon as the pandemic progresses.

**Government**
Assist elected officials and provincial government staff, particularly AHW staff, to understand the roles and processes involved in pandemic influenza response. Information exchange with the federal/provincial/territorial governments is key.

**Industry and community groups**
Assist key industry and community groups to understand what the response plan is, how they fit within it and what they can do to be prepared. Examples of groups are businesses, industry, school boards, and child-care agencies.

**GoA staff**
Alberta Health and Wellness’ staff need to be informed about their role in pandemic influenza so they can effectively support the response, limit illness in their household and workplace, and be able to communicate appropriately to the public. The Ministry’s internal communications plan should be transferable to other government departments as each Ministry needs to prepare its staff for pandemic influenza, and messaging should be consistent across government. The Pandemic Project Management Office, along with Corporate Human Resources, is addressing policy direction for government employees.
PROVINCIAL SPOKESPERSON

The Chief Medical Officer of Health (CMOH) or a designate will be the spokesperson for issues related to the response plan specifics and medical information. Depending on local circumstances, Medical Officers of Health from RHAs may be called upon to be spokespersons.

Technical experts may be identified through the Chief Medical Officer of Health to provide media briefings and background information.

The Premier, the Minister of Health and Wellness, or other ministers will participate in public announcements that involve government policy, declarations of states of emergency, or a broad provincial response initiative.

COMMUNICATIONS TOOLS

Web Site

A public web site for responding to or preparing for a pandemic will be a primary source of information for the general public, media, RHAs, health professionals, businesses, schools and other organizations.

Prior to pandemic influenza, the web site will feature basic information on pandemic influenza, instructions for various audiences on how to prepare for such an event, self-care information, and updates on how the government and the regions are preparing.

During pandemic influenza, the public website will be updated to highlight the latest news on pandemic developments, information on the evidence of a pandemic influenza in Alberta, government news/information bulletins as they are issued, and easy access to RHA-specific information such as health-service provider locations, vaccination schedules, and outbreak instructions.

The web site upon completion will have an easy to remember address that will be widely publicized (www.pandemic.alberta.ca).

Health Link Alberta

Health Link Alberta, is an AHW sponsored telephone advice line and health information service. This tool will be an essential service throughout a pandemic influenza and will be staffed appropriately during the pandemic influenza by the Calgary Health Region and Capital Health.

AHW will provide timely provincial updates (via e-mail) to Health Link Alberta through all pandemic influenza phases on issues regarding: epidemiology of presenting virus; a status report on the provincial health system; the recommended clinical, self-care and public health guidelines; and key communication messages for the public.
Alberta Pandemic Influenza Plan for the Health System

The RHAs will directly provide timely region-specific updates to Health Link Alberta, e.g. the status of health services in the region, directions for the public to regional health services, etc.

Media
AHW Communications/Public Affairs Bureau will use existing tools, techniques and processes to communicate to the public through the media. The communication tools employed will include:

- news releases,
- backgrounders,
- postings to the public web site,
- regular media availabilities,
- technical briefings, and
- distribution of fact sheets.

Content and timing of these tools will be coordinated through AHW Communications, PAB and AHW Public Health Emergency Coordination Group (PHECG).

During a pandemic influenza, a regular schedule of daily new bulletins, media availabilities and web postings will be used to efficiently deliver updates to the public.

Public awareness campaign
A broad public awareness campaign will be implemented in alignment with the appropriate pandemic phases. A wide variety of communications channels will be employed. These could include direct mail, print, radio and television advertising, including outdoor and transit advertising.

- Print ad templates have been produced for quick assembly and distribution to newspapers as the need arises for public information.
- Radio ads can be quickly produced through the PAB.
- A direct-mail brochure is available for the public.

Certain groups will be hard to reach and will be targeted differently, working with organizations that serve and support them. Groups include:

- non-English speaking residents/visitors,
- the homeless and marginalized populations,
- persons who are hearing/visually impaired, and
- Aboriginal communities.
The Influenza Self-Care Strategy
The provincial Influenza Self-Care Strategy will be used as a resource for public education during the inter-pandemic and pandemic periods. Existing self-care messages on how to prevent/prepare for influenza, the care for self/family/others if ill and when to seek medical attention will be adjusted to reflect the epidemiology of the pandemic influenza virus and availability of resources, e.g. pandemic influenza vaccine and antiviral medications during the pandemic phase. Materials will be made available on the public web site or from RHAs (printed materials).


The web pages include public and professional resources such as:

- a pocket-sized public information booklet,
- six, topic-specific fact sheets for the public (to supplement the information booklet)
  - Pandemic influenza
  - Hand washing to prevent influenza
  - How to take a temperature – children and adults
  - Over-the-counter (non-prescription) medications for influenza
  - Influenza antiviral medications
  - Dealing with stress or feelings of fear because of influenza,
- professional/detailed version (full and abbreviated text),
- “English Express”, a low-literacy publication version of the Influenza Self-Care Strategy for those Albertans who speak/read English as a second language, and
- a version of the self-care booklet entitled The Flu and You! Don't let the Flu get you down! prepared specifically for marginalized populations. The booklet and a training manual for professionals are under development.

KEY MESSAGES

The coordination of communication messages with local, regional, F/P/T, and international bodies will establish a process for consistent messaging for responding to a pandemic influenza. While research shows that Albertans distinguish between roles and responsibilities of different levels of government, in the event of a health emergency, Albertans have a strong desire to see that communications among all levels are coordinated and consistent. Regional, national and international communication links will be coordinated through AHW.
Messengers, up to and including Phase 3.0, will focus on:

- distinguishing between concerns of seasonal influenza and the much more heightened concerns around pandemic influenza,
- the limited availability of antivirals,
- the limited to no availability of a vaccine during the first wave, and
- limited availability of health services during the height of the pandemic influenza.

AHW and the RHA Communications Council have developed a set of key messages for the pandemic alert and pandemic periods, e.g. preparedness, avian influenza, vaccine distribution, and public health measures. These documents will be updated regularly as new developments occur. AHW Communications will work with AHW Human Resources to develop a plan to educate and inform department staff using existing methods of communications.
Table 1 summarizes the roles and responsibilities of AHW and the RHAs related to communications during pandemic influenza.

### Table 1: Roles and responsibilities for communications

<table>
<thead>
<tr>
<th>Canadian Phase</th>
<th>Alberta Health and Wellness</th>
<th>Regional Health Authorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.0</td>
<td>• Communicate the elevation of pandemic influenza risk to RHAs, key stakeholders, municipalities and the public and provide updates.</td>
<td>• Communicate to the public, staff and stakeholders in their regions consistent with provincial direction (communication may be specific to the local situation).</td>
</tr>
<tr>
<td></td>
<td>• Update and review communications plans and networks.</td>
<td>• Identify media spokespersons/experts.</td>
</tr>
<tr>
<td>4.0</td>
<td>• Coordinate with other departments on the provincial communications response to pandemic influenza.</td>
<td>• Identify resources for translation.</td>
</tr>
<tr>
<td>5.0</td>
<td>• Identify government spokespersons and their areas of expertise.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Identify media spokespersons/experts. Coach key spokespersons to effectively communicate technical messages to the public.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Monitor and analyze media coverage.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide regular briefing updates for Premier’s Office, Ministers and MLAs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide MLAs with information for their constituents.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide key provincial stakeholders with information for their audiences/media.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide technical and scientific information to RHAs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Support coordination of RHA/key stakeholder plan activation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Design and test public education campaign.</td>
<td></td>
</tr>
</tbody>
</table>

Continued…
### Pandemic Period

<table>
<thead>
<tr>
<th>Canadian Phase</th>
<th>Alberta Health and Wellness</th>
<th>Regional Health Authorities</th>
</tr>
</thead>
</table>
| 6.0            | • Implement Communications component of pandemic influenza plan.  
                 • Mobilize provincial spokespersons.  
                 • Ensure timely health related communications to all stakeholder groups.  
                 • Inform ministers of health response/provide updates.  
                 • Keep stakeholders/partners up-to-date with the latest information and aware of their roles and responsibilities.  
                 • Implement public education awareness campaign.  
                 • Inform public and stakeholders of self-care, progress of pandemic influenza situation (antivirals, vaccine etc.), steps taken to provide necessary services to maintain population health/social stability.  
                 • Explain, clarify and demystify the crisis.  
                 • Ensure media has up to date information.  | • Communicate to the public, staff and stakeholders in their regions information consistent with provincial direction (communication may be specific to the local situation).  
                 • Provide local information to regional public on access to health services for influenza and non-influenza illness, details of local response efforts.  
                 • Communicate local situation to province in a timely manner. |

Adapted from CPIP, 2006.

### 14 Caring for the Dead

The estimated increase in deaths for Alberta during pandemic influenza varies dependent on the projections for gross attack rate and yearly population. For example, should pandemic influenza occur in Alberta in 2008, the most likely projections for the total number of deaths due to pandemic influenza based on a midyear population are: 1,209 (15% attack rate), 2,015 (25% attack rate), 2,822 (35% attack rate). This would be in addition to the approximately 17,000 deaths throughout Alberta in any given year.

There is no provincial requirement for autopsies of those who have died of pandemic influenza. Autopsies will be done, with permission of the next-of-kin, in those cases where a physician requests one, as per non-pandemic influenza protocols.

The Office of the Chief Medical Examiner will participate in disease surveillance by identifying unexpected deaths due to influenza outside of the hospital. In those deaths...
investigated by a Medical Examiner, the decision as to whether or not an autopsy will be done lies solely with the Medical Examiner.

RHAs will accommodate the increased number of deaths, given that the majority of deaths caused by pandemic influenza will not occur under circumstances that involve the Medical Examiner’s Office.

During pandemic influenza, the same system and resources that manages yearly deaths will be used; however accommodations will be required for the increased number of deaths, including:

- **Death Certificates** - RHAs need to ensure timely completion of the death certificates prior to releasing a body to a funeral home.
  - The Funeral Service Association of Canada (FSAC) has identified the timely completion of the death certificate as the major block leading to delays in the body’s final disposition. AHW is currently addressing this issue.

- **Body Storage** – if needed, each RHA and their Director of Disaster Services are responsible for the creation of a temporary morgue. This facility will be limited to a body storage facility, refrigerated to a temperature of 4°C. A practical alternative is temporary rental of refrigerated tractor/trailer units, placed at a hospital where there are procedures in place for the admission and release of bodies.
  - AEMA is leading discussions with other GoA Ministries to identify potential centralized morgue facilities. There is little stigma attached to using government facilities for these purposes rather than municipal or privately-owned buildings. The buildings would have to be equipped with existing refrigeration capabilities and security systems. Installation of refrigeration capabilities into existing warehouses could be completed in as little as five days.

- **Handling Precautions** - the bodies of those who have died from pandemic influenza will be handled using routine practice precautions. Health-care facilities currently do not wrap bodies at time of death. Anticipating that delays may occur before the bodies are delivered to the funeral service, the FSAC recommends that either shrouding, in a heavy weight wrap, or securing in a zippered body bag be instituted at Pandemic Phase 6.2.

- **Funeral Services** – services might be delayed for several weeks following death; however, currently there are no plans to resort to mass burials or mass cremation.

- **Public Restrictions** – in the event that a restriction on public gatherings is ordered, the FSAC will be included in planning any communications with the public when issues surrounding death/caring for the dead are to be discussed. It is anticipated there will be limited resistance to restricting public gatherings. There are some ethnic and cultural groups which may require individual consultation and direction.

AEMA and/or AHW are continuing discussions with the Public Trustee Office and other social service agencies to facilitate payment to the funeral services for final disposition for those individuals/families without the resources to pay for these services.
FSAC members are reviewing their inventory level in light of potential increases in demand. Access to necessary supplies may become a significant issue, as major suppliers are located in Eastern Canada. Failure to maintain supply chains could delay final dispositions.

For information on how to handle deaths that occur in a medical facility or nursing home, (refer to Appendix 16.1: Flow chart – process when a death occurs in a medical facility). If a death is anticipated in an individual’s home (including seniors’ residences), a physician will provide direction to the family on the process to follow, i.e. the physician will confirm the death and sign the death certificate and the family will contact the funeral home (refer to Appendix 16.2: Flow chart - process when a death occurs outside of a medical facility).

15 References and Resources


Multi-Agency Pandemic Planning – Death Management meeting minutes (October 25, 2006).


# 16 Glossary of Terms

## A

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AEMA</td>
<td>Alberta Emergency Management Agency</td>
</tr>
<tr>
<td>AHW</td>
<td>Alberta Health and Wellness</td>
</tr>
<tr>
<td>AMA</td>
<td>Alberta Medical Association</td>
</tr>
<tr>
<td>APIP</td>
<td>Alberta Pandemic Influenza Plan for the Health System</td>
</tr>
<tr>
<td>APIOP</td>
<td>Alberta Pandemic Influenza Operations Plan</td>
</tr>
<tr>
<td>ARI</td>
<td>Acute Respiratory Illness</td>
</tr>
<tr>
<td>AVSN</td>
<td>Alberta Veterinary Surveillance Network</td>
</tr>
</tbody>
</table>

## B

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BiPAP</td>
<td>Bilevel Positive Airway Pressure</td>
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</table>

## C

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CCMOH</td>
<td>Council of Chief Medical Officers of Health</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Provincial Program Development and Disease Control (United States)</td>
</tr>
<tr>
<td>CEPR</td>
<td>Centre for Emergency Preparedness and Response</td>
</tr>
<tr>
<td>CHA</td>
<td>Capital Health</td>
</tr>
<tr>
<td>CHR</td>
<td>Calgary Health Region</td>
</tr>
<tr>
<td>CMD</td>
<td>Council of Medical Directors</td>
</tr>
<tr>
<td>CMOH</td>
<td>Chief Medical Officer of Health</td>
</tr>
<tr>
<td>CMOSH</td>
<td>Council of Medical Officers of Health (Alberta)</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>CPIP</td>
<td>Canadian Pandemic Influenza Plan for the Health Sector (CPIP, 2006)</td>
</tr>
</tbody>
</table>
Alberta Pandemic Influenza Plan for the Health System

D

D/CMOH Deputy/Chief Medical Officer of Health
DI Diagnostic Imaging

E

EMT Emergency Management Technician
EOC Emergency Operations Centre
ER Emergency Room

F

FMP Fastest Means Possible (reporting of notifiable diseases)
FNIHB First Nations and Inuit Health Branch Health Canada
F/P/T Federal, Provincial and Territorial
FSAC Funeral Service Association of Canada

G

GoA Government of Alberta

H

HCW Health-Care Worker
H3N2 Hemagglutinin and neuraminidase virus – a subtype of the influenza A virus
H5N1 Hemagglutinin and neuraminidase virus – a subtype of the influenza A virus that is highly pathogenic and occurs mainly in birds. Contact with poultry infected with this subtype has resulted in human cases of avian influenza, primarily in South East Asia.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>IHR</td>
<td>International Health Regulations</td>
</tr>
<tr>
<td>ILI</td>
<td>Influenza-like Illness</td>
</tr>
<tr>
<td>IMS</td>
<td>Incident Management System</td>
</tr>
<tr>
<td>IPC</td>
<td>Infection Prevention and Control</td>
</tr>
<tr>
<td>LPN</td>
<td>Licensed Practical Nurse</td>
</tr>
<tr>
<td>LRTI</td>
<td>Lower Respiratory Tract Infection</td>
</tr>
<tr>
<td>LTC</td>
<td>Long-Term Care</td>
</tr>
<tr>
<td>MD</td>
<td>Medical Doctor</td>
</tr>
<tr>
<td>MMR</td>
<td>Measles/ Mumps/Rubella</td>
</tr>
<tr>
<td>MOH</td>
<td>Medical Officer of Health</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>NACI</td>
<td>National Advisory Committee on Immunization</td>
</tr>
<tr>
<td>NESS</td>
<td>National Emergency Stockpile System</td>
</tr>
<tr>
<td>NHEMS</td>
<td>National Health Emergency Management System</td>
</tr>
<tr>
<td>OH&amp;S</td>
<td>Occupational Health and Safety</td>
</tr>
</tbody>
</table>
Alberta Pandemic Influenza Plan for the Health System

P

PAB    Public Affairs Bureau
PHAC   Public Health Agency of Canada
PHECG  Public Health Emergency Coordination Group
PHN    Provincial Health Care Number or Public Health Nurse
PHO    Provincial Health Office (AHW)
PIC    Pandemic Influenza Committee
PLPH   Provincial Laboratory of Public Health
PPDDC  Provincial Program Development and Disease Control Branch (AHW)
PPE    Personal Protective Equipment

R

RCMP   Royal Canadian Mounted Police
RHAs   Regional Health Authorities
RN     Registered Nurse

S

SARS   Severe Acute Respiratory Syndrome
SESE   Supplemental Enhanced Service Event
SEH    Surveillance and Environmental Health Branch (AHW)

T

Td      Tetanus/diphtheria

V

VZ     Varicella
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>WCB</td>
<td>Workers’ Compensation Board</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
17 Appendices

Appendix 1: Pandemic influenza – overview
Appendix 2: Legislative authority for Alberta’s health response for pandemic influenza
Appendix 3: Communication – notification of activation of Alberta Pandemic Influenza Plan for the Health System
Appendix 4: Pandemic influenza health emergency management
Appendix 5: Pandemic influenza surveillance report
Appendix 6: Health services in distinct communities/populations
Appendix 7: Pandemic immunization program
   7.1: Priority group definitions
   7.2: Mass immunization clinic guidelines
   7.3: RHA immunization report forms – daily, weekly, final
Appendix 8: Pandemic antiviral medications
   8.1: Antiviral shipment monitoring report form
   8.2: Antiviral temperature excursion report form
   8.3: RHA antiviral request form
   8.4: Mass antiviral clinic guidelines
   8.5: Tracking form for distribution of antivirals in Alberta
   8.6: RHA antiviral usage weekly report form
   8.7: RHA antiviral usage final report form
   8.8: Antiviral key messages for the public
   8.9: Fact sheet – oseltamivir for treatment or prevention of influenza (for public)
   8.10: Fact sheet – zanamivir for treatment or prevention of influenza (for public)
   8.11: Comparison of antiviral medications (for health-care professionals)
Appendix 9: Public health measures – summary by pandemic phase

9.1: Public health management of individuals with influenza-like illness – pandemic alert period
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Appendix 10: Triage of patients

10.1: Triage of patients in large urban centres
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10.3: Triage of residents in long-term care facilities

Appendix 11: National Emergency Stockpile System

Appendix 12: Mental health during pandemic influenza

12.1: Fact sheet – dealing with stress or feelings of fear because of pandemic influenza (for public)

Appendix 13: Alberta health professions regulatory bodies pandemic influenza planning

Appendix 14: Clinical care guidelines

14.1: Triage of adults
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Appendix 15: Alberta pandemic influenza infection control guidelines

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Appendix 16: Care of the dead

16.1: Flow chart – process when a death occurs in a medical facility
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