



Pandemic Influenza Plan

June 2006

FOREWORD

The Durham Region Health Department Pandemic Influenza Plan outlines the actions to be carried out by the Durham Region Health Department as the lead in managing the response to a pandemic, in coordination with the Regional Emergency Management Office and other Regional Departments. The plan also sets out the linkages with local area municipalities, health care facilities and agencies in the Region for coordination of response.

For other Regional departments and local municipalities, procedures and checklists involving a response to an influenza pandemic should be based upon the Durham Region Pandemic Influenza Plan, which is part of the Region's emergency plans and is a supporting document to the Health Department plan. The regional plan is administered by the Durham Emergency Management Office (DEMO)

Holders of the plan are responsible for keeping it current by incorporating any amendments that may be issued in the future.

This plan was written by the Durham Region Health Department's Influenza Pandemic Planning Committee under the authority of the Medical Officer of Health. Comments or suggestions relating to this plan should be directed to:

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DURHAM REGION HEALTH DEPARTMENT PANDEMIC INFLUENZA PLAN

1.0 GENERAL

1.1 Background

- 1.1.1 Influenza is caused by two groups of viruses, namely Influenza A and B. The incubation period is usually one to three days and the disease is communicable from one day prior to onset of symptoms to five days after (seven days in children). Transmission is generally via droplet from respiratory secretions at a short distance (<1m). The other possible mechanism of transmission is by direct contact with contaminated surfaces. Influenza viruses are unique in their ability to cause sudden illness in all age groups on a global scale. Influenza is usually limited to the winter months in temperate climates (October – April) but does circulate year-round in tropical climates. Epidemic influenza occurs approximately every one to three years and is confined to a region or country. An outbreak on a world-wide scale of a new strain of influenza that is capable of causing serious illness is called a pandemic. There have been three pandemics in the last century, with the worst being the 1918-19 “Spanish flu” that caused over 20 million deaths worldwide and 549,000 deaths in the USA. The most recent pandemic was in 1968-69 (“Hong Kong flu”).

With the recent development in Asia of human illness with avian flu (H5N1) the likelihood of a future pandemic has increased. It is unknown when the next influenza pandemic will occur. The vulnerability of the world to pandemic illnesses has been highlighted by the recent outbreak of a novel virus (SARS-CoV) causing severe respiratory illness on a world-wide scale. The potential for this or other novel illnesses in the future is ever present. The timing and pattern of the next influenza pandemic is unpredictable but a short lead time is likely. It has been estimated that the first peak in illness will occur two to four months after the virus arrives in Canada and the peak in mortality would occur one month later. Outbreaks will occur simultaneously and millions of people in Canada could become ill with the disease. Estimates of deaths range from 4,000 to 180,000 in Canada and therefore the social impact could be devastating. During an outbreak, both material and human resources can become scarce. In Britain during the 1957-58 (“Asian flu”) pandemic peak there was a 20% absenteeism in the general population; one third of the health care staff for a hospital was absent. In contrast to the usual influenza

season, historically in pandemic influenza the highest attack rates occur in those <65 years representing the majority of health care workers and the general workforce.¹ Therefore, there will likely be difficulties with human as well as material resources. Preparedness plans now exist at multiple levels including Health Canada, World Health Organization (WHO), the Ontario Ministry of Health and Long-Term Care (MOHLTC) and the Center for Disease Control (CDC) to help coordinate the response.

1.2 Goals

1.2.1 The aim of this plan is to ensure that Durham Region Health Department is prepared to effectively respond to an influenza pandemic in the Region.

1.3 Objectives

1.3.1 The objectives of the pandemic influenza plan are to:

- minimize sickness and death from influenza illness.
- minimize the social and economic impact of pandemic in the Durham Region.
- implement an effective surveillance program at all phases of the pandemic.
- implement public health measures as required by the MOHLTC.
- implement vaccination dissemination and administration as soon as possible in compliance with the MOHLTC.
- assist with the coordination of antiviral distribution to designated priority groups as per the MOHLTC.
- ensure security of vaccine and anti-virals when in possession of the Health Department.
- provide timely, credible information to health care professionals, the public and the media.
- ensure maintenance of essential Health Department programs and services.
- effectively manage anticipated reductions in Health Department staff.

1.4 Scope

- 1.4.1 This plan outlines the coordinated public health actions to be taken for the protection of the life and health of the residents of Durham Region in the event of an influenza pandemic outbreak.
- 1.4.2 This plan applies to the Durham Region Health Department.
- 1.4.3 Local area municipalities, school boards, health care institutions, and other organizations and agencies are encouraged to utilize this document in the preparation and coordination of their contingency plans with the Region. These plans should be reviewed and revised as required to complement this plan.
- 1.4.4 This plan is intended to coordinate with the Provincial and Federal plans. Hence, where these plans are still in progress (e.g., antiviral strategy) assumptions for the Durham Region Health Department plan have been developed wherever feasible.

1.5 Legal Powers

- 1.5.1 The Medical Officer of Health (and Associate Medical Officer of Health), under the Health Protection and Promotion Act (HPPA), R.S.O. 1990, have the authority to control communicable diseases including influenza and respiratory outbreaks in institutions and the power to identify, reduce or eliminate health hazards. Under the HPPA, public health inspectors also have the authority to identify, reduce or eliminate health hazards.
- 1.5.2 The Regional Chair, as Head of Council, under the Emergency Plans Act, R.S.O.1990, may declare that an emergency exists in the Region or any part thereof and may take action and make orders as he considers necessary to protect the property and the health, safety and welfare of the citizens.

2.0 REGIONAL PLANNING BASIS

2.1 Regional Risk Assessment

- 2.1.1 To understand the magnitude of the problem and to develop contingency plans, estimates on the potential impact of an influenza pandemic are required. No one can accurately predict when the next pandemic will occur, nor can they accurately forecast who will become ill and suffer adverse health outcomes. However, the

Centre for Disease Control (CDC) in Atlanta has developed a programme to estimate impacts.

- 2.1.2 The CDC programme has been used to provide estimates of the low to high impact of an influenza pandemic on Durham Region. The estimates are for total impact and cannot predict how a pandemic may spread through the Region over time. In addition, recent mortality rates with Highly Pathogenic Avian Influenza (HPAI) have been much higher than with previous human influenza strains and, therefore, unexpectedly high mortality rates may occur. The figures in the table below are for a Regional population of 563,220 for the year 2004.²

Estimates for Ontario and Durham Region³

	Ontario	Durham Region
People Infected*	9,294,541	422,415
Clinically Ill**	1,858,908 – 4,337,452	84,483 – 197,127
Require Outpatient Care	769,879 – 3,316,237	35,043 – 150,024
Hospitalization Required	7,474 – 65,498	293 – 2,816
Deaths	2,892 – 19,773	107 – 832

- *Assumptions:*
 - *population estimate for 2004: Durham 563,220, Ontario 12,392,721 (based on 2001 census).*
 - **75% infected.*
 - ***15-35% clinically ill (ill enough to be off work for $\geq \frac{1}{2}$ day).*
- *See Annex A for low, mid and high estimates for Canada, Ontario and Durham Region.*
- *Estimates based on Meltzer MI, Cox NJ, Fukuda K, 1999a; 1999b.*

2.2 Regional Planning Basis

- 2.2.1 An influenza pandemic will affect all of Durham Region and Ontario. For planning purposes, the worst case must be used.
- 2.2.2 Little or no direct assistance will be able to be provided by neighbouring jurisdictions, or higher levels of government.
- 2.2.3 Durham Region Health Department must plan to respond to an influenza pandemic using its own resources, supplemented by material resources that may be made available as per the MOHLTC's pandemic plan (e.g., clinic supplies).
- 2.2.4 The Durham Region Health Department Pandemic Influenza Plan outlines the Health Department's response to and coordinates with the Durham Region's Influenza Pandemic Plan.

2.3 Regional Planning Assumptions

2.3.1 The following are the planning assumptions that will apply to all pandemic influenza planning in the Region:

- Ontario will have a lead time of at most three months, possibly less, from the time a pandemic is first declared by the World Health Organization (WHO) to when it spreads to the province.
- Pandemic influenza usually spreads in two or more waves. A second wave could occur within three to nine months of the initial outbreak wave and may cause more serious illnesses and deaths than the first. The length of each wave is approximately six to eight weeks.
- Attack rate (significantly clinically ill – i.e., off work for $\geq \frac{1}{2}$ day) is approximately 35%.
- A vaccine will not be available for at least four months after the virus is identified and will likely not be available for the first wave.
- Once available, the vaccine will be in short supply and high demand.
- Because Ontario will not have a large enough initial supply of vaccine to immunize everyone, the province will set priorities for who receives limited vaccine and antiviral drugs.
- The availability of health care workers during the pandemic could be reduced by up to one-third and the health care system will have to supplement existing resources through a variety of mechanisms.
- Non-life threatening health services will be significantly curtailed, consolidated or suspended completely.
- The pandemic will impact the provision of priority services by the Durham Region.

2.4 Concept of Operations

2.4.1 Refer to the Durham Region Pandemic Influenza Plan for the current structure.

- 2.4.2 In Durham Region, the Medical Officer of Health (MOH) has the overall responsibility for directing the Health Department's response to an influenza pandemic from the onset. The MOH will direct health operations from the Health Operations Centre (HOC).
- 2.4.3 Based on the projected effect on the Region, the Chair, on the advice of the Medical Officer of Health or as directed by the Province, will declare a Regional emergency under the *Emergency Management Act* and fully activate the Regional Emergency Operations Centre (REOC).
- 2.4.4 The Medical Officer of Health will implement public health measures and manage the health response to the outbreak. The role of the other Regional departments will be to support the Health Department efforts and to maintain essential services in the Region. Coordination for support to the Health Department and the maintenance of essential services will take place in the REOC.
- 2.4.5 All Municipal Emergency Operations Centres (MEOC) as well as operations centres in Regional departments will be activated.
- 2.4.6 A provincial emergency will likely be declared before the strain of influenza appears in Ontario. In Ontario, the overall response will be managed from the Provincial Emergency Operations Centre (PEOC) with the Ministry of Health and Long Term Care (MOHLTC) providing command and control services for the health care sector.
- 2.4.7 See Annex B for a schematic diagram showing the emergency management and health sector response structure.

2.5 Priority Programs and Services

- 2.5.1 The Durham Region Health Department has developed lists of priority programs and services (excluding Emergency Medical Services) that required continuation during several recent emergencies (e.g., Y2K, SARS 2003, and Blackout 2003). These documents have been used by the Durham Region Health Department to define the scaling up and down of Health Department programs and services and will be used for pandemic planning (see Health Department Operations Annex H). In addition, the MOHLTC is also working with public health units to develop recommendations regarding the provision of priority public health services to assist local health units and ensure consistency across the province. Once completed, the Health Department Operations annex will be revised with final recommendations.

2.5.2 Emergency Medical Services (EMS) is an essential service.

2.5.3 Within the Regional organizational structure, outside the Health Department, priority services include:

- Durham Regional Police Services – crime prevention, crime investigation, traffic operations, 911 system.
- Works Department – water, sewer, traffic signal control, road maintenance (depending on the situation), facilities (HVAC systems, life safety systems), fleet maintenance (EMS, Works).
- Social Services – homes for the aged, financial assistance to persons in need, assistance to developmentally handicapped adults, cheque processing and distribution, reception centre (nuclear emergency), evacuee centres (nuclear or non-nuclear).
- Regional Emergency Management Structure – staff of the Regional Control Group and for the Regional Emergency Operations Centre, staff for the Social Services and Works operations centres.

2.5.4 Outside the Regional organizational structure:

- It is recognized that the Health Department will need to partner with organizations outside of the Health Departments organizational structure. These would include for example acute care hospitals, long-term care facilities and other community health care providers.

3.0 HEALTH PLAN IMPLEMENTATION

3.1 Pandemic Phases

3.1.1 The Health Department has organized its pandemic influenza plan to be consistent with the WHO 2005 pandemic phases (Annex C, Table 1):

- Phase 1: Interpandemic Period – No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human infection or disease is considered to be low.
- Phase 2: Interpandemic Period – No new influenza subtypes have been detected in humans. However, a circulating animal

influenza virus subtype poses as substantial risk of human disease.

- Phase 3: Pandemic Alert Period – Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.
- Phase 4: Pandemic Alert Period – Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.
- Phase 5: Pandemic Alert Period – 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).
- Phase 6: Pandemic Period – Increased and sustained transmission in general population.
- Postpandemic Period – Return to Interpandemic Period.

3.2 Notification Procedures

3.2.1 The MOH or designate will be responsible for determining the pandemic phase of Durham Region and will notify internal and external stakeholders as per the Communication Annex (Annex F).

3.2.2 Sources of information to be used in deciding the pandemic phase include:

- MOHLTC surveillance data
- Health Canada/Public Health Agency of Canada surveillance data (i.e., FluWatch)
- WHO surveillance data
- Local surveillance data

3.3 Response Actions

3.3.1 Detailed action plans have been developed for each WHO Phase and are described in the following Annexes:

- Surveillance (Annex D)
- Antivirals and Vaccine (Annex E)
- Communications (Annex F)
- Public Health Measures (Annex G)
- Health Department Operations (Annex H)

- Assessment Centre Operations (Annex I)

Briefly, the response actions are outlined below for each phase:

Interpandemic Period – Phase 1-2

- The Health Department will participate in routine influenza programs and services as mandated by the MOHLTC including:
 - Universal influenza immunization program.
 - Influenza surveillance using:
 - Respiratory disease outbreaks in institutions investigations.
 - Community outbreak investigations, including school absenteeism / work absenteeism (i.e., > 500 employees).
 - Sporadic case investigations.
 - Febrile respiratory illness/severe respiratory illness (FRI/SRI) investigations.
 - Public and health care professional communications/ education about the influenza season and infection control (e.g., handwashing).
- Health Department staff will monitor the epidemiology of influenza from their normal workplaces.
- The pandemic influenza plan will be reviewed and updated at least annually.
- All staff will be trained on the Health Department Pandemic Influenza Plan.
- Key stakeholders will be made aware of the plan.
- Health Department will maintain an Influenza web page with the current Pandemic Influenza Plan, influenza information and resource links.

Pandemic Alert – Phase 3-4

- Same as above, plus:
 - Meeting of the Pandemic Influenza Planning Committee to update plans and procedures at each increase in Phase and/or at least quarterly (e.g., staffing numbers, contact numbers, etc.).
 - Enhanced surveillance of worldwide situation.
 - Enumeration of priority groups for allocating antivirals and/or vaccines.
 - Enhanced communications.
 - Review of vaccine and antiviral status.

Pandemic Alert – Phase 5

- Same as above, plus:
 - Review plans for vaccine and antiviral storage, distribution, and administration.

- Review priority groups and estimates of number.
- Update staff on pandemic plans and procedures.

Pandemic Period – Phase 6 (not in North America): Partial Activation

- Same as above, plus:
 - Enhance local surveillance.
 - Enhance local communications.
 - Review public health measures with health care stakeholders as appropriate.
 - Monitor vaccine progress (earlier if appropriate).
 - Monitor provincial and federal antiviral dissemination plans.
 - Review vaccine/antiviral distribution plans.
 - Update medical directives (earlier, if appropriate).
 - Confirm locations for vaccine/antiviral administration.
 - Coordinate with Police for vaccine/antiviral security.
 - Partial activation of the Health Operations Centre.
 - Partial activation of the Regional Emergency Operations Centre (as per DEMO).

Pandemic Period – Phase 6 (in North America): Full Activation

- Same as above, plus:
 - Full activation of annexes for appropriate phase.
 - Full activation of the Health Operations Centre.
 - Full activation of the Regional Emergency Operations Centre (as per DEMO).
 - Enhanced surveillance implemented (as per MOHLTC requirements).
 - Medical Officer of Health (MOH) will advise Chair of the Board of Health/Regional Chair regarding the status of an emergency in the Region in accordance with the Emergency Management Act.

Postpandemic Period

- Return to appropriate Interpandemic Period phases.

3.4 Declaration of a Regional Emergency

- 3.4.1 As the virus spreads and essential services are threatened, it is the responsibility of the Regional Chair to consider the declaration of an emergency for Durham Region. The timing is flexible and will depend on the effects to essential services. Advice on the timing of the declaration of a Regional Emergency will be provided to the Chair by the Medical Officer of Health.

3.4.2 The provincial government may also consider declaring a provincial emergency. Currently, a health emergency will likely fall under the jurisdiction of the Chief Medical Officer of Health, although legislation to clarify activities and responsibilities is pending.

3.5 Surveillance (see Annex D)

3.5.1 A regional influenza surveillance and monitoring system will:

- Review and update case definitions as per Public Health Agency of Canada and the MOHLTC.
- Detect the entry and escalation of an influenza pandemic in Durham Region community.
- Continue to track the spread of the influenza virus through the community, after initial detection.
- Confirm resolution of activity and monitor for recurrence of activity in the Durham Region.

3.5.2 The Health Department will focus on clinical surveillance of influenza-like illness in order to detect the arrival of influenza promptly and to provide timely information on influenza activity locally. The surveillance system will include:

- Sentinel Physician Reporting
- School and Daycare Reporting
- Workplace Absenteeism Reporting
- Hospital and Urgent Care Facility Reporting
- Emergency Room visits
- Febrile respiratory illness admissions
- All cause mortality in hospitals
- Long Term Care Facility Statistics and Reporting
- Community Case Reports
- Social/economic impact assessment
- Encourage stakeholders to develop and maintain a database for healthy recovered and skill set/occupation (potential human resource)
- Encourage other information gathering systems (Federal and Provincial) such as vaccine efficacy
- Other data collection systems will be investigated (i.e., TeleHealth)

- 3.5.3 The surveillance program will be flexible and scalable so that routine surveillance can be expanded quickly with the arrival of the virus in the Region. The surveillance plan has three phases: Interpandemic Period, Pandemic Response Phase and the Post-Pandemic Period. Details of the surveillance plan are set out at Annex D.
- 3.5.4 The Provincial and Federal Pandemic Influenza Plans will be coordinating laboratory services which potentially will include:
- Viral culture, PCR testing, antigen testing and serology results.
 - Antiviral resistance and antimicrobial resistance trends (i.e., risk of secondary infections).

3.6 Antivirals and Vaccines (see Annex E)

3.6.1 Antivirals:

- The Federal and Provincial Governments are securing a stockpile of antiviral medications which will be available for defined priority groups. (See Annex E Table 3 and Tables 4, a-d). Because of large volume of medication that would be required for prevention and the anticipated short supply, antiviral medications may not play a significant role in reducing the mass effects of a pandemic. At the direction of provincial and federal authorities, the Health Department will be responsible for participating in the use and distribution of available antiviral medications.
- There are currently two classes of antiviral medications for the treatment of influenza: (1) M2 channel inhibitor (M2CI) - amantidine and rimantidine (2) Neuraminidase inhibitor (NI) - oseltamivir and zanamivir. The M2 channel inhibitors are active only against Influenza A but the NI are active against both Influenza A and B. Studies have shown these medications to be 70-90% effective in preventing illness. Similar levels of efficacy can likely be achieved with novel (pandemic) strains, at least until antiviral resistance occurs.
- Recommended dosage for antiviral drugs to prevent influenza (prophylaxis) would require approximately 30 doses per month for each medication for the non-ill population for as long as the exposure continues. Treatment doses would be approximately twice daily for five days, totaling 10 doses per ill person.

- Currently, there is much debate at the Provincial and Federal levels regarding the use and stockpiling of antivirals for prophylaxis. The Health Department will monitor these policy discussions and revise the plan accordingly.

3.6.2 Vaccines:

- Inactivated influenza vaccine has long been considered the cornerstone of influenza control. It is assumed that vaccination will also serve as the central preventative strategy during the next pandemic. The Health Department will be responsible for making arrangements for the acquisition, transport, storage, security and delivery of vaccines.
- Routine Influenza Vaccine. Every year the Health Department encourages people to be vaccinated with routinely available influenza vaccine. In addition the Health Department recommends that all eligible persons receive pneumococcal vaccination in part to reduce secondary complications of influenza.
- Prioritization for Immunization. The influenza strain in a pandemic will be novel and there will be a delay in the production and distribution of any new vaccine. While the goal will be to immunize the entire population of Durham Region, the availability of vaccine may necessitate the immunization of priority groups, as established by the Federal and Provincial governments. (See Annex E Table 2).
- Mass Immunization Clinics. The Health Department will be responsible for the organization and staffing of a mass immunization program for the general public in the Region. Locations for public immunization clinics will be large enough and accessible to the general population. Clinics will be established at designated locations in municipalities or regional areas, as availability of vaccine and staffing permits. Locations of clinics will be guided by population requirements.
- Priority Group Clinics. Locations will also be identified for non-public clinics to facilitate administration to designated priority groups.
- Immunization Teams. The operation of clinics will involve a team of people to administer the vaccine and to operate the clinic. The proposed team composition and potential scenarios will be pre-determined (See Annex E Table 5a and b). As

vaccine becomes available, team lists will be drawn up and clinic locations confirmed.

Note:

All clinics must be easily securable, and modifiable for crowd control.

3.7 Communications (see Annex F)

3.7.1 The Medical Officer of Health will provide up to date health information and advice to the health care stakeholders, the media and the public in a timely manner.

3.7.2 Components. Communications planning and operations for a pandemic comprise the following components:

- public information/public directives
- media plan
- public inquiry
- rumour control
- staff information
- health/medical information to the health care community
- web page links to fact sheets
- coordination with other Health Department Regions

3.8 Public Health Measures (see Annex G)

3.8.1 In addition to the use of antivirals and vaccines to combat the spread of the pandemic virus, other infection control measures must be implemented.

3.8.2 At the onset of a pandemic, procedures or guidelines will be reviewed and circulated to groups who will have a key role in the prevention of the spread of the virus.

3.8.3 Procedures must be in place for the following:

- guidelines for hospitals and long term care facilities with respect to infection control during a pandemic.
- procedures for other health care workers (i.e., doctors, clinics, laboratories).
- procedures for schools, workplaces, day care centres, places of public assembly.

3.8.4 The Medical Officer of Health or designate will distribute the above procedures when available from the MOHLTC.

3.8.5 As the effects of the pandemic progress in the Region, the Medical Officer of Health may consider the imposition of precautionary or protective measures including:

- closing schools and daycares
- banning public events such as sports/cultural gatherings
- closing public centres such as recreation complexes
- closing cinemas, theatres, and bars
- reducing personnel at workplaces to critical process staff
- closing work places
- use of masks
- where appropriate, consultation with the Regional Emergency Operation Center (REOC) will occur

3.9 Health Department Operations (see Annex H)

3.9.1 The Health Department Operations is under development and will include the following areas:

- plans for Health Department service continuity
- identification of core critical services
- prioritization of core critical services
- plans for re-allocation of staff to support pandemic response
- identify areas of surge capacity potential during a pandemic
- identify support for areas dealing with surge capacity
- identify impact on service delivery based upon varying levels of staff absenteeism (0%-50%)

3.10 Emergency Mortuary Arrangements

3.10.1 The Health Department will maintain a list of all funeral homes in the Region. When directed, a reporting system will be established with the funeral homes. This reporting system will ensure that the Region can track the effectiveness of the funeral homes in meeting any increased requirements.

3.10.2 The Health Department is working with area mortuary services to assist with development and establishment of emergency temporary mortuary services such as cold storage units.

3.11 Assessment Centre Operations (see Annex I)

3.11.1 The Health Department will be working in collaboration with local acute care facilities on the development of a plan for the operation of assessment centers in the Region during a pandemic. The Assessment Centre Operations annex is under development at this time.