**This plan template is intended to support the planning and response to Communicable Disease Emergencies, including COVID-19. If you don’t already have a plan, this document can be used to create one. Tools in the appendices can be found at OneHealth.ca. As new resources and tools become available, they will be emailed to Health Directors and DEMs.**

**COVER PAGE**

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**Please note: The writing that is highlighted in blue are suggestions and should be reviewed and completed as required.**

|  |
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|  |
| Communicable Disease Emergency Plan |
| **INSERT NAME OF COMMUNITY** |

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# **1.0 APPROVAL**

|  |  |
| --- | --- |
| **Developed by:**Health Director  | **Date:** |
| **Approved by:**Band Manager | **Date:**  |
| **Approved by:**Chief & Council | **Date:** |

# **2.0 RECORD OF AMENDMENTS**

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| --- | --- | --- | --- | --- |
| **Version #** | **Date****Approved** | **Summary of Changes** | **Revised by** | **Approved by** |
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# **3.0 RECORD OF PLAN DISTRIBUTION**

The “Plan Distribution” section shows to whom the plan has been circulated. It records the program area/department of each person that receives a copy of the plan as well as the date the plan was distributed to them. In addition, the plan is available electronically.

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|  | **Area/Department** | **Received by****(Name/Position)** | **Signature** | **Date** **mm/dd/yy** |
| 1 | Band Administration |  |  |  |
| 2 | Director of Emergency Management |  |  |  |
| 3 | Health |  |  |  |
| 4 | Education |  |  |  |
| 5 | Social Services |  |  |  |
| 6 | Other |  |  |  |
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# **4.0 ACRONYMS**

|  |  |
| --- | --- |
| AEMA | Alberta Emergency Management Agency |
| AH | Alberta Health |
| AHS | Alberta Health Services |
| BCP | Business Continuity Plan |
| CDE | Communicable Disease Emergency |
| CMOH | Chief Medical Officer of Health |
| CPIP | Canadian Pandemic Influenza Preparedness: *Planning Guidance for the Health Sector* |
| ERP | Emergency Response Plan |
| FNIHB | First Nations and Inuit Health Branch (National),Indigenous Services Canada |
| FNIHB-AB | First Nations and Inuit Health Branch – Alberta Region,Indigenous Services Canada |
| FPT | Federal/provincial/territorial |
| GoA | Government of Alberta |
| HCWs | Health care workers |
| ILI | Influenza-like illness |
| ISC-RO | Indigenous Services Canada, Regional Operations |
| IPC | Infection Prevention and Control |
| MOH | Medical Officer of Health |
| NAS | National Antiviral Stockpile |
| NNADAP | National Native Alcohol and Drug Abuse Program |
| OH | Occupational Health  |
| PHAC | Public Health Agency of Canada |
| PPE | Personal protective equipment |
| WHO | World Health Organization |

# **5.0 BACKGROUND**

A **communicable disease** means an illness in humans that is caused by an organism or micro-organism, or its toxic products, and is transmitted directly or indirectly from an infected person or animal or the environment[[1]](#footnote-1). Communicable Disease Control programs aim to reduce the occurrence, spread and human health effects of communicable diseases. Communicable Disease Control is a mandatory program for all communities in Alberta. In Alberta, First Nations and Inuit Health Branch – Alberta Region (FNIHB-AB) Medical Officers of Health (MOHs) are designated under the Alberta *Public Health Act* to ensure that follow-up, control and reporting of notifiable diseases and other related activities are carried out in accordance with the Alberta *Public Health Act* and the associated *Communicable Diseases Regulation* (AR 238/85).

A communicable disease emergency is a current or imminent event that falls outside the scope of normal communicable disease control operations and requires prompt co-ordination of resources in order to protect the health and safety of community members.

## **5.1 Aim**

The aim of the Communicable Disease Emergency (CDE) plan is to ensure that INSERT COMMUNITY NAME is prepared to detect, respond to, and minimize the impact of a communicable disease emergency.

The plan will help assist INSERT NAME OF HEALTH DEPARTMENT staff to:

* Provide a prompt response to a communicable disease emergency
* Protect the health and safety of community members
* Prevent and control the spread of communicable disease
* Prevent or reduce morbidity (illness) and mortality (death) associated with the communicable disease emergency
* Provide accurate information to officials, community members and the media
* Cooperate with other emergency response partners and stakeholders
* Continue delivery of essential public health services

The Plan includes:

* Roles and responsibilities of individuals and families, INSERT COMMUNITY NAME, and provincial/federal partners with respect to a communicable disease emergency
* The decision-making process to activate and deactivate the plan
* Key components of communicable disease emergency preparedness and response
* Appendices with preparedness checklists, tools and resources that can be utilized when responding to a communicable disease emergency

## **5.2 Relationship to Other Plans**

The response to a CDE should be based upon existing emergency response plans (ERPs), protocols, structures and processes. In order to ensure a coordinated community response, it is essential that the CDE plan aligns with the community all-hazards ERP. The CDE plan should be a hazard-specific annex of the community all-hazards ERP.

The INSERT NAME OF COMMUNITY CDE plan aligns with the following plans:

(Add/ remove as applicable).

* INSERT NAME OF COMMUNITY all-hazards Emergency Response Plan
* Alberta’s Pandemic Influenza Plan
* INSERT PLAN TITLE
* INSERT PLAN TITLE
* INSERT PLAN TITLE

## **5.3 Plan Development, Maintenance and Testing**

INSERT TITLE OF PERSON is responsible for developing the community CDE plan. The completed plan will be submitted to INSERT TITLE OF PERSON/S for approval, with approval documented in *Section 1.0-APPROVAL*. After the plan is approved it will be circulated to:

* INSERT NAME or TITLE OF POSITION or DEPARTMENT
* INSERT NAME or TITLE OF POSITION or DEPARTMENT
* INSERT NAME or TITLE OF POSITION or DEPARTMENT
* INSERT NAME or TITLE OF POSITION or DEPARTMENT
* Etc.

*Section 3.0-RECORD OF PLAN DISTRIBUTION* will be used to record which person, position, or department received a copy of this plan, as well as the date the plan was provided to them.

The CDE plan is a living document. Over time, gaps emerge, information changes, and roles of other agencies may alter. It is therefore critical that the plan is periodically reviewed and the applicable changes made to ensure the plan remains useful and up-to-date.

The plan will be reviewed at least annually by COMMUNITY HEALTH COMMITTEE/ COMMUNITY EMERGENCY COMMITTEE/ INSERT TITLE OF PERSON. Changes to the plan will be made as required. Revisions made will be recorded in *Section 2.0-RECORD OF AMENDMENTS* and submitted to INSERT TITLE OF PERSON for administrative approval. After the plan is revised and approved it will be recirculated to applicable Departments and community partners.

Training and exercises are essential to emergency preparedness because they help individuals understand their role in the event of an emergency/disaster event. Exercises can also help identify gaps in the plan, thereby building upon and strengthening the plan over time.

INSERT COMMUNITY NAME supports employee training that includes but is not limited to the following: (Add/delete/adjust as applicable)

* Basic Emergency Management
* Incident Command System
* Emergency Operations Centre
* Crisis Communications
* Stress management
* First Aid/CPR
* Promoting community resiliency

The CDE plan, or component(s) of the plan, will be tested at least annually (e.g. tabletop exercises, functional exercises, etc.). INSERT NAME OF POSITION is responsible for ensuring the plan is tested annually and that any necessary revisions are made to the plan.

## **5.4 Mutual Aid Agreements**

Mutual aid agreements are written agreements with nearby communities to assist during an emergency. These agreements could include the type of support needed (for example, supplies, staff, or knowledge). It could also indicate how the community requests support, and who the request should come from.

NOTE: Ensure this section aligns with your community all-hazard ERP. You may wish to include health specific Mutual aid agreements in this section, or may choose to remove this section if the information is already contained within the community ERP.

INSERT COMMUNITY NAME has mutual aid agreements with the following communities/organizations. The agreements are attached to this Plan. INSERT TITLE OF PERSON updates the agreements every INSERT NUMBER OF YEARS.

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| **Community Name** | **Last Update (Year)** | **Next Update Due (Year)** |
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# **6.0 ROLES AND RESPONSIBILITIES**

Preparing for, responding to and recovering from a communicable disease emergency can be complex. Individuals, organizations and jurisdictions at all levels have a role to play. The following are some of the high-level roles and responsibilities for preparing for, responding to, and recovering from a communicable disease emergency.

## **6.1 Individual and Family Level Responsibilities**

Emergency preparedness begins at the individual level. All individuals should make efforts to protect themselves, their family and their personal property from the effects of emergencies. Further, individuals should be aware of the risks in their community and should be prepared to look after themselves and their family for a minimum of 72-hours during an emergency. In the event of a communicable disease emergency individuals should:

* Follow guidance and/or “self-care” guidelines provided by health officials.
* Follow public health recommendations that are intended to reduce the spread of disease and to reduce the strain on the health care system.
* In the case of a pandemic, plan to be self-sufficient and implement or follow family emergency plans.

## **6.2 Community Level Responsibilities**

Effective emergency management starts at the local level. Communities are responsible for developing and implementing emergency management plans. Within the context of a CDE, First Nations communities in Alberta are responsible for:

* Developing and maintaining a community CDE plan. The plan should be an annex of the community’s all-hazards Emergency Response Plan (ERP).
* Developing and maintaining business continuity plans (BCPs) for addressing the impact of a CDE on local services.
* Collaborating with FNIHB-AB, Indigenous Services Canada-Regional Operations (ISC-RO), neighbouring communities, local Alberta Health Services (AHS), and the Alberta Emergency Management Agency (AEMA) so that community CDE planning and response activities are aligned with the provincial response.
* Maintaining relationships and partnerships with federal, provincial, regional, and local authorities responsible for all-hazards emergency preparedness and response.
* Implementing BCPs to ensure the continuation of local critical services during a CDE.
* Supporting the public health response to a CDE.

## **6.3 Provincial Level Responsibilities**

### **6.3.1 *Alberta Health (AH)***

The role of Alberta Health is to lead and coordinate the provincial pandemic health planning, response, and recovery, including:

* Participating in the development and maintenance of a Pandemic Influenza Plan for the province of Alberta.
* Coordinating surveillance activities for the province.
* Assessing and communicating pandemic severity and impact in Alberta to stakeholders.
* Exercising legislative authority under the *Public Health Act* and the *Communicable Diseases Regulation* to protect the health of Albertans, including the declaration of a provincial public health emergency, if required.
* Developing provincial policies, legislation, guidelines and standards for responding to a pandemic, as necessary.
* Maintaining Alberta’s portion of the National Antiviral Stockpile (NAS).
* Managing Alberta’s pandemic vaccine.
* Connecting with federal/provincial/territorial (FPT) counterparts, including FNIHB-AB, on health impacts, resources and communications.

### **6.3.2 *Alberta Health Services (AHS)***

The role of AHS is to provide continuity of health services to Albertans. AHS responsibilities specific to pandemic response and recovery include:

* Reviewing and implementing pandemic operational health service response and recovery plans.
* Prioritizing delivery of critical health services and programs during a pandemic.
* Carrying out the legislated roles of the MOH under the *Public Health Act* and the *Communicable Diseases Regulation*, including advising (in consultation with the CMOH) on the declaration of a local state of public health emergency, if necessary.

### **6.3.3 *Alberta Emergency Management Agency (AEMA)***

AEMA is responsible for acting as the coordinating and supporting agency for the Government of Alberta (GoA) and its emergency management partners. AEMA roles include:

* Supporting First Nations communities in the development and exercising of their all-hazards ERP.
* Coordinating the cross-governmental response to a pandemic.
* Coordinating and supporting requests for assistance from local authorities as necessary.
* Maintaining critical emergency management services to First Nations communities in Alberta during a pandemic, to the greatest extent possible.

## **6.4 Federal Level Responsibilities**

### **6.4.1 *Indigenous Services Canada***

Indigenous Services Canada-Regional Operations (ISC-RO) has a formal agreement with the Government of Alberta (GoA) to mutually support First Nations communities in emergency management activities. Under this agreement, the AEMA provides emergency management services to First Nations communities. AEMA First Nations Field Officers provide a range of emergency planning, preparedness and response services to First Nations communities in Alberta[[2]](#footnote-2).

Indigenous Services Canada’s responsibilities for the management of communicable disease emergencies in First Nations communities are carried out by the First Nations and Inuit Health Branch – Alberta Region (FNIHB-AB). FNIHB-AB has Medical Officers of Health (MOHs) who, like provincial MOHs, have been delegated authority, powers and responsibilities under the Alberta *Public Health Act* with respect to communicable disease control and public health emergencies. FNIHB-AB is responsible for:

* Supporting First Nations communities in Alberta in the development, maintenance and exercising of community CDE plans.
* Collaborating and liaising with AH, AHS, AEMA, and other federal departments to ensure comprehensive and coordinated preparedness and response activities in First Nations communities during a communicable disease emergency.
* Leading and coordinating the public health response to communicable disease emergencies in First Nations communities in Alberta[[3]](#footnote-3).
* Coordinating surveillance activities in First Nations communities in Alberta and adjusting surveillance activities and processes, as required.
* Coordinating and supporting the provision and administration of vaccine in First Nations communities.
* Coordinating the distribution of personal protective equipment (PPE) for health care workers (HCWs) and support staff providing health services in First Nations communities in Alberta.
* Providing information and guidance to health care workers and support staff providing health services in First Nations communities in Alberta.
* Providing infection prevention and control (IPC) guidance and self-care information to First Nations communities in Alberta.
* Working collaboratively with AH and AHS to:
	+ Ensure that First Nations on-reserve have equitable access to antiviral medications, vaccines and/or appropriate antimicrobial prophylaxis.
	+ Ensure that First Nations communities have access to health services similar to those for other residents of Alberta during a CDE.
* Deploying, allocating, consolidating resources to support First Nations communities (to the greatest extent possible) in maintaining critical health services.
* Prioritizing the delivery of ISC services and programs during a CDE.
* Ensuring the continuity of critical services provided by ISC, to the greatest extent possible.
* Liaising with and providing health advice and counsel to First Nations community leadership.

# **7.0 CONCEPT OF OPERATIONS**

## **7.1 Activation of the Communicable Disease Emergency Plan**

INSERT TITLE OF PERSON may activate the CDE plan based on situational requirements. In the absence of the INSERT TITLE OF PERSON, the INSERT TITLE OF PERSON can activate the plan.

**A FNIHB MOH can be contacted at** **sac.cdemergenciesab-urgencesmtab.isc@canada.ca** **for consultation, prior to activating the plan**

Examples of triggers for partially/fully activating the CDE plan are:

1. The FNIHB-AB MOH’s declaration of a communicable disease outbreak in the community.
2. The declaration of a Public Health Emergency by the provincial Chief Medical Officer of Health
3. The incidence of a pandemic-related infectious disease case in the community or area adjacent to the community or province.

When the plan or any of its components are activated, the INSERT TITLE OF PERSON will assume the lead role in notifying

* INSERT
* INSERT
* INSERT

## **7.2 Deactivation of the Communicable Disease Emergency Plan**

INSERT TITLE OF PERSON will deactivate the Communicable Disease Emergency plan when:

* Local impact of the CDE has diminished to a level where routine operations may be resumed.
* The public health emergency is declared over by the provincial Chief Medical Officer of Health/FNIHB-AB MOH, and local impact has diminished to a level where routine operations may be resumed.
* The FNIHB-AB MOH declares an outbreak is over and indicates that First Nations communities should deactivate their CDE plan. Routine operations may be resumed.

## **7.3 Emergency Operations Centre Location**

An emergency operations centre is a central command centre, where the emergency is managed from.

The location of the Emergency Operations Centre is INSERT LOCATION OF THE EOC IN THE COMMUNITY.

## **7.4 Key Components of the Communicable Disease Emergency Plan**

The following provides an overview of the key components of CDE preparedness and response.

### **7.4.1 *Communications***

Communication of information and advice is often the first public health intervention during an emergency. Providing clear and consistent information about the disease, who it affects, how it spreads and ways to reduce risk is an effective way to help reduce the spread of infection before other interventions like vaccines are available. Communications should follow the principles of honesty, openness, and cultural sensitivity to build and maintain public trust. Communication should be accurate and consistent so that appropriate actions are taken to help minimize deaths, illness and social/economic disruption.

The FNIHB-AB communications goals during a communicable disease emergency are

* To provide First Nations communities in Alberta with accurate, clear and timely information about the communicable disease emergency, including actions community members can take to protect their health.
* To minimize stress, anxiety, confusion by providing timely messaging that is consistent with provincial messaging.
* To communicate and share information with internal and external stakeholders, in order to facilitate consistent timely messaging and the coordination of activities and resources.
* To incorporate psychosocial considerations into messaging.

In the event of a CDE, all provincial messaging will be through AH and AHS. FNIHB-AB will work closely with AH and AHS to ensure that First Nations communities receive timely, accurate and consistent messaging. FNIHB-AB will also work closely with other federal departments (e.g. Public Health Agency of Canada) to ensure that information being provided to First Nations communities is accurate and consistent. FNIHB-AB will provide regular information and updates to First Nations community leadership, administration and health services/organizations. The information provided will be aligned with AH/AHS messaging, however, as appropriate, it may also include information specific to First Nations on-reserve. The FNIHB-AB MOH will serve as the FNIHB-AB spokesperson for the communicable disease emergency public health response in First Nations communities in Alberta. FNIHB-AB will also provide timely and relevant health related information to workers providing health services in First Nations communities.

INSERT TITLE OF COMMUNITY will share communications in INSERT LANGUAGES.

INSERT TITLE OF PERSON or their delegate is the key spokesperson to communicate on health related matters with community members, health facility staff, and other local/ provincial/ federal partners and stakeholders.

INSERT TITLE OF PERSON or their delegate is the key spokesperson to communicate on non-health related matters related to the emergency with community members, health facility staff, and other local/ provincial/ federal partners and stakeholders.

INSERT TITLE OF PERSON will receive all media inquiries during the communicable disease emergency and will ensure that those responsible for communication are designated speakers.

**GO TO APPENDIX B for Communications planning checklists, tools and resources**

### **7.4.2 *Surveillance***

Public health surveillance is the continuous, systematic collection, analysis, and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice.[[4]](#footnote-4) In the event of a CDE, surveillance activities will be critical for informing the public health response. For example, CDE surveillance will use data from existing routine influenza surveillance practices along with enhanced surveillance and special studies in order to determine important information such as:

* the identification and geographic spread of a novel virus in Canada and Alberta;
* the intensity, severity, and impact of the CDE (e.g. clinical cases, hospitalizations and deaths; severe clinical syndromes and associated risk groups; demands on the health system);
* the identification of any changes in the characteristics of the virus.

FNIHB-AB will work in collaboration with AH and AHS to ensure that surveillance practices in First Nations communities are aligned with provincial surveillance activities. CDE surveillance will be built upon existing surveillances practices, however, during a CDE information needs can change rapidly and surveillance activities may need to be quickly modified or new surveillance practices implemented. FNIHB-AB will inform public health staff in First Nations communities in Alberta of any changes to surveillance practices on-reserve and will work with health staff in First Nation communities to ensure that any new or modified surveillance practices are implemented.

**GO TO APPENDIX C for Surveillance planning checklists, tools and resources**

### **7.4.3 *Public Health Measures***

Public health measures are non-pharmaceutical interventions that are intended to slow down the spread of a communicable disease[[5]](#footnote-5). By slowing down the spread of the communicable disease, public health measures can help to reduce the overall number of people infected, the number of severely ill cases, and the number of deaths. Public education, infection prevention and control practices, the management of cases and their contacts, and social distancing (e.g. school or workplace closures) are all examples of public health measures.

Public health measures can be actions that are taken by individuals or by communities. Examples of **individual actions** that can slow the spread of respiratory illnesses (e.g. influenza) include:

* Effective hand hygiene,
* Voluntary self-isolation (i.e. staying home while sick),
* Practicing “cough etiquette”,
* Avoiding large crowds/gatherings.

Examples of **community-based actions** that can slow the spread of respiratory illnesses (e.g. influenza) include:

* Increased cleaning and disinfection of surfaces in public settings,
* Cancellation of large/mass public gatherings, during a novel virus pandemic,
* Closure of schools and/or workplaces, during a novel virus pandemic (or as discussed with a FNIHB-AB MOH).

Some public health measures, such as hand hygiene and “cough etiquette”, are applicable to any CDE. However, other public health measures (e.g. school closures) might only be used in a moderate to severe CDE since they could have significant social and economic impacts.

Not all public health measures are used at all times. The types of public health measures that are used, and their timing, will be based on the available evidence, including the current information known about the characteristics of the pandemic virus. As additional information is obtained, public health measures may be modified or new public health measures may be put into place.

First Nations communities that are considering restrictive measures that go beyond what has been recommended (e.g. school/business closures) are encouraged to contact a FNIHB-AB MOH to review the current evidence of effectiveness of these measures and any potential negative social consequences (e.g. social disruption).

FNIHB-AB will:

* Promote public health measures that reduce the transmission of influenza and other respiratory illnesses.
* Report on-reserve cases to AH.
* Provide community health staff with current provincial case and contact management guidelines.
* Coordinate case and contact management in First Nations communities in Alberta.
* Develop, implement, and discontinue, as required, public health measures that reflect provincial guidance.
* Inform First Nations communities of current public health measures, and of any changes to public health measures.

**GO TO APPENDIX D for Public Health Measures planning checklists, tools and resources**

### **7.4.4 *Infection Prevention and Control***

Infection prevention and control (IPC) programs in health care settings are essential to prevent the transmission of communicable diseases. IPC programs aim to prevent, limit or control the acquisition of health care associated infections for everyone in the health care setting (e.g. patients, workers, visitors, contractors, etc.).[[6]](#footnote-6) The main objective of IPC during a CDE is to ensure that the risk of transmitting the illness within a health care setting is as low as possible.

### **7.4.5 *Occupational Health***

Occupational health (OH) considerations are also very important during a CDE since it will be critical to keep health care workers healthy. OH programs identify workplace hazards and provide appropriate processes and training to ensure employees can perform their duties in an environment that minimizes exposure to environmental hazards, including infectious diseases. Important OH issues during a CDE include the vaccination of health care workers (if applicable), the use of PPE, criteria for work exclusion and/or fitness-to-work, work reassignments, and psychosocial support.[[7]](#footnote-7)

The application of appropriate IPC and OH practices is important in all health care settings along the continuum of care, including but not limited to medical first response, ambulatory care (including practitioners’ offices), community clinic settings, acute care, long-term care and home care settings. Important elements of IPC and OH for CDE preparedness and response in health care settings include the following4:

* adequate staffing of trained IPC and OH professionals;
* point-of-care risk assessments that are carried out by individual HCWs before they enter a patient’s environment or initiate patient care;
* education and training for HCWs on IPC and OH issues;
* provision of vaccine to persons working for or being cared for by the health organization;
* ongoing surveillance for health care associated infections, including respiratory infections;
* respiratory protection programs to ensure that HCWs who may need N95 respirators are trained, fit-tested and prepared; and
* systematic administrative practices (based on policies, guidelines, protocols) to enable rapid identification and segregation of patients, HCWs and visitors with symptoms of ILI.

In the event of a CDE, FNIHB-AB will communicate specific IPC and OH guidance to HCWs in First Nations communities in Alberta as well as FNIHB-AB regional staff. In the absence of specific guidance for a novel virus, Routine Practices should be applied to all health care settings and client care circumstances at all times. FNIHB-AB will ensure that any changes to Routine IPC/OH Practices, based on current knowledge of a novel virus, are promptly communicated to HCWs in First Nations communities in Alberta. FNIHB-AB will also ensure that HCWs in First Nations communities are provided with appropriate IPC training and resource materials and access to the PPE necessary to implement recommended IPC/OH practices.

**GO TO APPENDIX E for Infection Prevention and Control planning checklists, tools and resources**

### **7.4.6 *Antiviral Medications***

**NOTE: AS OF MARCH 12, 2020, there are no antiviral medications clinically proven to be effective for COVID-19**

In the case of an influenza pandemic, antiviral medications (e.g. anti-influenza drugs) are the only influenza-specific medical intervention that will be available at the start of a pandemic. In 2004, a National Antiviral Stockpile (NAS) was established to ensure that there is equitable access, across Canada, to a secure supply of antivirals to be used for pandemic influenza. Without stockpiling there may not be enough antiviral medications available at the time of a pandemic due to an anticipated high global demand for such medications. The NAS can only be accessed in response to a pandemic and the use of antiviral medications from this stockpile must be in accordance with established national and provincial guidelines. Antiviral medications from the NAS have been distributed to each of the provinces and territories, based on population numbers, and each province and territory is responsible for maintaining their portion of the NAS.

In the event of an influenza pandemic, AH will allocate and distribute antiviral medications from the provincial stockpile. FNIHB-AB will be responsible for the delivery and administration of antivirals in First Nations communities in Alberta, in accordance with the guidelines for antiviral release. Provincial clinical guidelines for administration and reporting will be followed by community health staff including side effects, adverse events, and unused medication, as per the direction provided by FNIHB-AB.

**GO TO APPENDIX F for Antiviral Medications planning checklists, tools and resources**

### **7.4.7 *Vaccines***

**NOTE: AS OF MARCH 12, 2020 there is no vaccine for COVID-19**

Vaccination is an essential public health intervention during a pandemic. The federal government has made a commitment to secure enough pandemic vaccine for every person in Canada in order to help prevent illness and death due to a pandemic virus. As stated in CPIP, the objectives of a pandemic vaccine program are to[[8]](#footnote-8):

* provide a safe and effective vaccine for all Canadians as quickly as possible;
* allocate, distribute and administer vaccine as efficiently as possible; and
* monitor the safety and effectiveness of pandemic vaccine.

The development and production of a pandemic vaccine will take up to 8-9 months from the time the pandemic virus has been identified. Therefore, it is unlikely that a vaccine will be available during the first wave of the pandemic. When the vaccine does become available it will be received in batches, not all at once.

The initial batches of the vaccine may need to be allocated to specific subgroups of the population (i.e. priority groups) with the goal of minimizing serious illness, deaths and societal disruption. If it is necessary to prioritize certain subgroups of the population ahead of others, decisions on the order of priority will have to take into account multiple factors (e.g. disease characteristics, timing of vaccine availability, vaccine characteristics, ethical considerations, operational considerations, etc.), many of which will not be known until a pandemic occurs. Annex D of CPIC – Preparing for the Pandemic Vaccine Response identifies different subgroups of the population and provides examples of who might be included in each group but, for reasons described above, it does not indicate the order of priority.

The subgroups of the population that are found in Annex D of CPIP are useful for planning and preparing for a priority-based vaccine program. Community planners can determine how the different subgroups would be identified and accessed in their community so that if it was determined that a priority-based vaccine program was necessary during a pandemic, it could be quickly implemented. Whether or not a priority-based vaccine program is implemented there will eventually be enough pandemic vaccine produced to immunize all Canadians that wish to be immunized.

In the event of a pandemic, AH will receive the pandemic vaccine for those living in Alberta, including First Nations on-reserve. First Nationscommunity health staff will deliver the pandemic vaccine program unless the community has existing agreements with Alberta Health Services regarding the provision of immunization services[[9]](#footnote-9). All community health nurses will obtain and maintain their immunization competency. Provincial vaccination procedures, as per direction provided by FNIHB-AB, will be followed including reporting, administration, side effects, adverse events, and unused vaccine. Site-specific vaccine storage protocols exist and will be followed. All cold chain breaks are to be reported to FNIHB-AB as per standard protocols.

INSERT COMMUNITY NAME will develop, maintain and periodically test its pandemic vaccine/mass immunization plan (intended to maximize vaccine administration rates). A copy of the pandemic vaccine plan can be found INSERT LOCATION.

Potential clinic locations are: LIST POTENTIAL CLINIC LOCATIONS

**GO TO APPENDIX G for Vaccine planning checklists, tools and resources**

### **7.4.8 *Health Services***

In the event of a pandemic, the health care system will be challenged. The demand for health services will significantly increase, while at the same time the number of available HCWs will decrease because of illness-related absenteeism and personal and/or family responsibilities. It is possible that health services could become overwhelmed due to a surge in people seeking medical care. Depending upon the impact of a pandemic, it is also possible that care will be provided in settings that are not usually used for health care (i.e. alternate care sites).

The goal of health care service delivery in Alberta during a pandemic is to:

* provide the best possible care for the most people,
* to minimize the spread of the pandemic virus, and
* to maximize the efficiency and effectiveness of the delivery of care with the available resources.[[10]](#footnote-10)

The promotion of self-care will be a key strategy during a pandemic. If individuals are able to care for themselves and their family members it will reduce the demand on health care services. FNIHB-AB will provide HCWs on-reserve with information, resources and tools to promote self-care in the community. Since Community Health Nurses will have significant demands placed on them during a pandemic, the use of alternative health workers to promote self-care could also be considered. For example, Community Health Representatives, elders and/or traditional healers could help with educating the community about at-home self-assessment, provide information on self-care and support the community as a whole. In addition, Health Link Alberta (811) will help avoid unnecessary visits to physicians and emergency departments by providing advice on self-care at home**. Health Link Alberta is a 24 hours a day, 7 days a week toll-free telephone service (Dial 811) that is available to all Albertans. During a pandemic, this service will assist people with self-care, identify those who need to seek medical care and provide advice on the most appropriate transportation and location to seek care.**

Resource management and surge capacity planning are essential components of pandemic preparedness. Resource management and surge capacity planning involves developing strategies to ensure that facilities, supplies and human resources are enhanced during a pandemic so that appropriate health services are provided, to the greatest extent possible.

Although primary care is often the focus with respect to health services during a pandemic, it is very important that health care programs and services such as mental health, home care, long-term care (e.g. Elder’s lodges), Treatment Centres, and other community health and social services are also included in pandemic preparedness and planning. Their functioning is critical for providing early and appropriate management to those who do not need acute hospital care. These groups/programs should be involved in pandemic planning and should have BCPs in place so that, in the event of a pandemic, they can continue to provide their services to some of the most vulnerable patients in the community with minimal interruption.

Given the health service demands during a pandemic, and the impact of a reduced workforce, it will likely be necessary to reduce or suspend routine health programs and services in order to support response activities (e.g. pandemic vaccine campaigns) and to maintain critical health services to the greatest extent possible.

In the event of a pandemic, FNIHB-AB will provide surge capacity nursing support to First Nations communities in Alberta, however, in a prolonged or high-impact pandemic FNIHB-AB may not be able to maintain the level of support needed. FNIHB-AB will collaborate with AH, AHS and PHAC to provide health care service assistance, if required and available, to First Nations communities.

**GO TO APPENDIX H for Health Services planning checklists, tools and resources**

### **7.4.9 *Psychosocial Supports***

In addition to posing a physical health threat, the secondary consequences of a CDE may be substantial. During a CDE, illness, death, caregiving responsibilities and the fear of infection may place high to extreme demands on the health care system and could also contribute to sudden and significant shortages of personnel and resources in all sectors.

High rates of absenteeism and fear of infection could disrupt normal business activities. There may be periods of time when community members will not be able to, or will refuse to, participate in the normal routines of school, work and leisure activities. In addition, individuals could be dealing with the grief of losing friends, family members or co-workers.

The multiple secondary consequences of a CDE, along with the primary (medical) consequences, can have significant implications for the psychological, emotional, behavioural and psychosocial well-being of individuals and communities. Some of the psychosocial implications for individuals and families include:

* emotional and financial strain associated with economic downturns and employment issues (e.g. job loss, worker shortages);
* increased occurrence of mental health problems (e.g. stress, fear, anxiety, depression);
* increased family violence, substance abuse, and other antisocial behaviours as a result of increased stress and decreased supports;
* occupational issues, such as high to extreme work demands or stress associated with non-routine roles and responsibilities at work;
* increased stress, fear and anxiety associated with stigma and social exclusion;
* breakdown of social support networks, social customs and community support mechanisms; and
* increased stress and distress resulting from real or perceived differences in access to and availability of psychosocial support and other health resources.

Planning to address the psychosocial impacts of a CDE is a very important component of planning since insufficient psychosocial support could negatively impact the ability to effectively respond to a CDE. HCWs in First Nations communities are expected to experience high to extreme levels of stress during a CDE and particular attention to their psychosocial needs will be critical in order to ensure the continuity of the public health response and the continuity of essential health services.

Other high-risk groups include those providing essential services in First Nations communities, first-responders, and those individuals that are providing psychosocial support services. The primary objective of a psychosocial response to any disaster or public health emergency is to restore and increase individuals’ capacity to go on with their lives by addressing their social, emotional, psychological and physical needs. It includes supporting and strengthening social systems (e.g. social support networks) and helping individuals to regain a sense of control and to effectively manage stress.

The ability of individuals to meet their basic needs is essential to maintaining a sense of personal control and well-being. A CDE may impact people’s ability to meet their basic needs both directly (e.g. illness) or indirectly (e.g. disruption in services or supply chains). Helping people continue to meet their basic living needs can be supported by:

* Finding ways to help people to communicate their basic needs and concerns (e.g. for medical care, emergency shelter, food, clothing, etc.) and developing plans for meeting those needs; and
* Providing support with problem-solving and practical assistance to allow people to meet their needs (e.g. in accessing food, medical care, child and elder care, other emergency assistance programs).

Providing access to accurate and timely information during a CDE is also very important to the psychosocial well-being of people. Lack of information fuels rumours, uncertainty and misinformation which, if left unaddressed, can quickly lead to fear, distress and social panic. Providing people with timely and accurate information is key to helping them to help themselves and to maintaining or regaining control over their lives.

Psychosocial support does not end once a CDE is over. Rather, psychosocial support during the recovery phase is as essential as that offered during the response. Recovery from any disaster is a long-term process, and many affected individuals find that recovering from an event is more stressful than the disaster or emergency event itself. Thus, psychosocial recovery plans are important to ensure that the long-term psychosocial needs of individuals and communities are identified and supported.

**GO TO APPENDIX I for Psychosocial Supports planning checklists, tools and resources**

# **8.0 RECOVERY AND EVALUATION**

## **8.1 Debriefs**

Processes, activities, and decisions made during the CDE response should be documented for future reference. The response should be evaluated to see what went well, what could be done differently, and what the outcome was. This evaluation helps ensure that lessons learned from the real-life event are captured and remain available to inform CDE plan revisions.

Debriefs are recommended following any CDE. All of the following types of debriefs are recommended:

* Quick tactical debriefing with CDE RESPONSE TEAM (what went well, what didn’t, how to improve);
* Operational debriefing, including community partners/stakeholders;
* Questionnaire (to volunteers, community partners/stakeholders, owners of building sites used, etc.) in order to identify gaps and future considerations for improvement.

After a CDE, an After-Action Report will be completed and submitted to INSERT TITLES OF PEOPLE WHO SHOULD RECEIVE REPORT. A summary of the report should also be shared with community members.

**GO TO APPENDIX J for Communicable Disease Emergency Community After-Action Review Template**

TITLE OF PERSON or their delegate is responsible to organize the debriefings. TITLE OF PERSON or their delegate is responsible to complete an After-Action Report. TITLE OF PERSON or their delegate is responsible to ensure the lessons learned are incorporated into the CDE plan.

## **8.2 Recovery**

After the emergency is over, INSERT COMMUNITY NAME will recognize the losses, celebrate the community’s resilience, and begin the healing process. The following events will be considered after the emergency has been declared over.

1. INSERT LIST OF IDEAS TO PROMOTE COMMUNITY RECOVERY AND BUILD RESILIENCE

Recovering from an emergency is a critical component of emergency management. After a CDE is over, systematic actions will be taken to return to a “normal” or “pre-CDE” state. Also, during the recovery phase the response to the CDE will be evaluated, debrief sessions will be held and pandemic plans will be reviewed and updated based on lessons learned.

**GO TO APPENDIX K for Emergency Management - Checklists, Tools, Resources**

# **9.0 APPENDICES**

## **9.1 Appendix A: Definitions**

| **Term** | **Definition** |
| --- | --- |
| **All-hazards** | The all-hazards approach is an approach that recognizes that the actions required to mitigate the effects of emergencies are essentially the same, irrespective of the nature of the event, thereby permitting an optimization of scarce planning, response and support resources. The intention of all-hazards generic emergency planning is to employ generic methodologies, modified as necessary by particular circumstances.[[11]](#footnote-11) |
| **Business Continuity Plan** | A plan for ensuring that an organization’s critical services and/or business functions will continue in the event of an emergency. |
| **Case** | A person who is infected with a specific communicable disease, such as influenza. |
| **Communicable Disease** | An illness in humans that is caused by an organism or micro-organism or its toxic products and is transmitted directly or indirectly from an infected person or animal or the environment[[12]](#footnote-12). |
| **Communicable Disease Emergency** | A current or imminent event that falls outside the scope of normal communicable disease control operations and requires prompt co-ordination of resources in order to protect the health and safety of community members. |
| **Contact** | A person who has been in close contact with a person who is infected with a communicable disease. |
| **Essential Services** | Services that must be provided immediately or will definitely result in the loss of life, infrastructure destruction, or loss of confidence in the government. These services normally require resumption within 24 hours of interruption.[[13]](#footnote-13) |
| **Hazard** | A potentially damaging physical event, phenomenon or human activity that may cause the loss of life or injury, property damage, social and economic disruption or environmental degradation.[[14]](#footnote-14) |
| **Impact** | Within the context of a pandemic, impact refers to the effects of a pandemic on the population.[[15]](#footnote-15) |
| **Morbidity** | Illness. A departure from a state of well-being, either physically or mentally. |
| **Mortality** | The death of a person. |
| **Novel** | New and different from what has been known before. |
| **Pandemic Influenza** | Influenza caused by a new and very different version of influenza virus that causes widespread illness around the world because most people have no natural immunity to it. |
| **Pandemic Vaccine** | A vaccine developed to provide protection against infection with the pandemic virus. Production of this vaccine requires specific knowledge about the pandemic virus, which will not be available until after the virus is already causing illness in humans. |
| **Personal Protective Equipment** | Equipment such as masks, gowns, goggles, gloves used by health care workers to protect themselves and their patients against infectious disease. |
| **Preparedness** | To be ready to respond to an emergency or disaster and manage its consequences through measures taken prior to an event, for example emergency response plans, mutual assistance agreements, resource inventories and training, equipment and exercise programs.[[16]](#footnote-16) |
| **Recovery** | To repair or restore conditions to an acceptable level through measures taken after a disaster, for example return of evacuees, trauma counselling, reconstruction, economic impact studies and financial assistance.[[17]](#footnote-17)  |
| **Response** | To act during or immediately before or after a disaster to manage its consequences through, for example, emergency public communication, medical assistance to minimize suffering and losses associated with disasters.[[18]](#footnote-18) |
| **Severity** | The clinical severity of disease in individuals.[[19]](#footnote-19)  |

1. Alberta *Public Health Act Communicable Diseases Regulation* (AR 238/85).Retrieved from: http://www.qp.alberta.ca/documents/Regs/1985\_238.pdf [↑](#footnote-ref-1)
2. “First Nations Office – Regional Contacts”. Available from: https://www.alberta.ca/first-nations-office.aspx [↑](#footnote-ref-2)
3. FNIHB-AB Medical Officers of Health (MOHs) are responsible for carrying out the legislated roles of the MOH under the Alberta *Public Health Act* and the associated *Communicable Diseases Regulation* (AR 238/85). [↑](#footnote-ref-3)
4. World Health Organization. “Public Health Surveillance”. Available from: http://www.who.int/topics/public\_health\_surveillance/en/ [↑](#footnote-ref-4)
5. Public Health Agency of Canada.2015.Canadian Pandemic Influenza Preparedness: *Planning Guidance for the Health Sector.* Available from: http://www.phac-aspc.gc.ca/cpip-pclcpi/  [↑](#footnote-ref-5)
6. Public Health Agency of Canada.2018. Canadian Pandemic Influenza Preparedness: *Planning Guidance for the Health Sector.* Available from: http://www.phac-aspc.gc.ca/cpip-pclcpi/index-eng.php [↑](#footnote-ref-6)
7. Public Health Agency of Canada. 2011. Canadian Pandemic Influenza Preparedness: *Planning Guidance for the Health Sector -* Annex F: Prevention and Control of Influenza during a Pandemic for All Healthcare Settings.

Available from: http://www.phac-aspc.gc.ca/cpip-pclcpi/annf/index-eng.php [↑](#footnote-ref-7)
8. Public Health Agency of Canada.2018.Canadian Pandemic Influenza Preparedness: *Planning Guidance for the Health Sector.* Available from: http://www.phac-aspc.gc.ca/cpip-pclcpi/  [↑](#footnote-ref-8)
9. Current immunization practices in First Nations communities in Alberta will continue unless they are superseded by a federal/provincial agreement. [↑](#footnote-ref-9)
10. Government of Alberta. 2014. Alberta’s Pandemic Influenza Plan 2014. Available from: https://open.alberta.ca/publications/alberta-s-pandemic-influenza-plan [↑](#footnote-ref-10)
11. Public Safety Canada. 2009 Federal Policy for Emergency Management. Available from: https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/plc-mrgnc-mngmnt/index-en.aspx [↑](#footnote-ref-11)
12. Alberta *Public Health Act Communicable Diseases Regulation* (AR 238/85).Retrieved from: http://www.qp.alberta.ca/documents/Regs/1985\_238.pdf [↑](#footnote-ref-12)
13. Alberta Health. 2014. Alberta’s Pandemic Influenza Plan 2014.

Available from: https://open.alberta.ca/publications/alberta-s-pandemic-influenza-plan [↑](#footnote-ref-13)
14. Public Safety Canada. 2011. An Emergency Management Framework for Canada - Second Edition. Available from: https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/mrgnc-mngmnt-frmwrk/index-eng.aspx [↑](#footnote-ref-14)
15. Public Health Agency of Canada.2018. Canadian Pandemic Influenza Preparedness: *Planning Guidance for the Health Sector.* Available from: http://www.phac-aspc.gc.ca/cpip-pclcpi/index-eng.php [↑](#footnote-ref-15)
16. Public Safety Canada. 2011. An Emergency Management Framework for Canada - Second Edition. Available from: https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/mrgnc-mngmnt-frmwrk/index-eng.aspx [↑](#footnote-ref-16)
17. Public Safety Canada. 2011. An Emergency Management Framework for Canada - Second Edition. Available from: https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/mrgnc-mngmnt-frmwrk/index-eng.aspx [↑](#footnote-ref-17)
18. Public Safety Canada. 2011. An Emergency Management Framework for Canada - Second Edition. Available from: https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/mrgnc-mngmnt-frmwrk/index-eng.aspx [↑](#footnote-ref-18)
19. Public Health Agency of Canada.2018. Canadian Pandemic Influenza Preparedness: *Planning Guidance for the Health Sector.* Available from: http://www.phac-aspc.gc.ca/cpip-pclcpi/index-eng.php [↑](#footnote-ref-19)