OTTAWA CHC
INTEGRATED PLAN FOR PANDEMIC INFLUENZA AND SEVERE ACUTE RESPIRATORY INFECTIONS

June 2014

Partners:

Somerset West Community Health Centre (lead)
Carlington Community Health Centre
Centretown Community Health Centre
Pinecrest Queensway Community Health Centre
Sandy Hill Community Health Centre
SouthEast Ottawa Community Health Centre

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ACRONYMS

AC	Assessment Centre
CHC	Community Health Centre
IC4	Influenza Clinical Care Command Centre
EOC	City of Ottawa Emergency Operations Centre
ILI	Influenza Like Illness
LHIN	Local Health Integration Network
MOHLTC	Ontario Ministry of Health and Long-Term Care
OCHCIP	Ottawa CHC Integrated Plan for Pandemic Influenza or Severe Acute Respiratory Inflections
OIIPP	Ottawa Interagency Influenza Pandemic Plan
OIIPPC	Ottawa Interagency Influenza Pandemic Planning Committee
OPH	Ottawa Public Health
PCPs	Primary Care Providers
PHAC	Public Health Agency of Canada
PIDAC	Provincial Infectious Diseases Advisory Committee
SARI	Severe acute respiratory inflections

ACKNOWLEDGEMENTS

Ottawa Community Health Centres (CHCs) gratefully acknowledge the key partners that will support centres in fulfilling their role to operate Assessment Centres when a coordinated community response is needed to a pandemic influenza or severe acute respiratory infection. The support of Ottawa Public Health, the City of Ottawa, the Champlain Community Care Access Centre and the Champlain Local Health Integration Network is crucial to enable CHCs to continue to provide essential services for our vulnerable clients.

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Jack McCarthy
Executive Director
Somerset West CHC (lead CHC)

1. INTRODUCTION

1.1 Coordinated Community Response

Ottawa Community Health Centres (CHCs) have a defined role to operate Assessment Centres (ACs) to assess, diagnose and treat clients with pandemic influenza when a coordinated community response is needed.

The role of CHCs is outlined in the Ottawa Interagency Influenza Pandemic Plan - Version 5.0 (OIIPP)[1], which describes the circumstances in which a coordinated community response is needed as well as the roles and responsibilities for planning, managing and implementing a comprehensive response.

The Ottawa Interagency Influenza Pandemic Planning Committee (OIIPPC) comprised of the organizations and groups that have a stake in pandemic preparedness and response have developed the OIIPP in a joint effort to curtail serious illness and death and minimize social disruption in the event of a pandemic.

1.2 Emergency Management Structure

Municipal governments and local public health authorities are responsible for coordinating the local response to an influenza pandemic (OIIPP).

The emergency management structure for an interagency pandemic response in Ottawa is outlined in the OIIPP. Three decision centres will function interdependently to manage the health and community emergency response strategies:

- Ottawa Public Health Service Command Centre
- City of Ottawa Emergency Operations Centre (EOC)
- Influenza Clinical Care Command Centre (IC4).

The IC4 has the mandate to jointly develop objectives for managing health strategies with Ottawa Public Health, link health sector partners, coordinate and guide clinical care and to support coordination of other aspects of health care response to a pandemic emergency, including surveillance, coordination with municipal services, and public communication. Many of the health care providers represented are accountable to the Champlain Local Health Integration Network (LHIN).

Ottawa CHCs are represented on both the OIIPPC and the IC4.

1.3 Intent of ACs

During an influenza pandemic, people who develop influenza symptoms must have access to assessment, treatment and if necessary, referral to other services. They need to be able to access assessment services quickly. Ideally, most increased demand for medical care can be handled in the community by primary care providers, allowing acute care hospitals to focus on the treatment of people who are critically ill with influenza or other life threatening illnesses or injuries.

[1] Ottawa Interagency Influenza Pandemic Plan (Version 5.0 April 2014)

ACs are established only when the primary care system is overwhelmed. The objectives are to:

- Ensure timely access to assessment, treatment and referral services for clients who are unaffiliated or affiliated with primary care providers but cannot access services in a timely way
- Treat people with pandemic influenza or outbreak of contagious severe acute respiratory illnesses (SARI) and prescribe antivirals or other treatment according to current public health recommendations
- Identify and refer people who need hospital or other community based health and social services
- Allow for the continuation of essential (i.e. non deferrable) primary care and acute care services during a pandemic
- Contribute to the control of pandemic influenza
- Instill public confidence in influenza services available to them.

1.4 Pandemic Influenza or Severe Acute Respiratory Illness

Ottawa's Interagency Influenza Pandemic Plan 2014 (OIIPP) outlines the community response to a pandemic influenza and refers to Flu Assessment Centres. In keeping with the national direction, the OIIPP is understood to be a foundation for a coordinated community response to other SARI.

Ottawa CHCs are committed to this broader understanding and are prepared to respond to a pandemic influenza or SARI if the same conditions apply. The use of the term Assessment Centres reflects this commitment.

1.5 Integrated CHC Response Plan

The OIIPP is a summary umbrella plan that identifies who does what. Each partner has a responsibility to detail and operationalize its part of the plan.

The Ottawa CHC Integrated Plan for Pandemic Influenza or Severe Acute Respiratory Inflections (OCHCIP) outlines how they will fulfil their mandate if a coordinated community response is needed to respond to a pandemic influenza or SARI.

The plan outlines:

- The role of CHCs and other primary care providers
- Guiding principles for planning and implementing ACs
- The CHC management structure for planning and implementing ACs
- Triggers for preparing for, activating and deactivating ACs
- How ACs will be operationalized – the model
- The responsibilities of individual CHCs
- The role of key partners in supporting ACs

The OCHCIP will be reviewed biannually to ensure it aligns with the OIIPP as well as current clinical best practices for the treatment of influenza and SARI. Ottawa CHC human resource capacity and the roles of partners will also be reviewed and confirmed.

2. ROLE OF CHCS AND OTHER PRIMARY CARE PROVIDERS

2.1 Integrated Response of CHCs

Ottawa CHCs will be responsible for operating ACs to assess, diagnose and treat clients with pandemic influenza or other severe acute respiratory illness (SARI) in the event that a coordinated community response is needed.

This role has been mandated because Ottawa CHCs:

- Offer primary care services including a range of services, programs and supports to respond to people's individual health issues and issues that affect community health
- Have a well established foundation to respond collectively to specific issues, leveraging their resources for an efficient and effective response
- Have a wide range of partnerships with other health and community service organizations and groups to build on
- Effectively tailor services to respond to the diversity of the many different communities and vulnerable populations that they serve
- Have direct experience with responding to a previous pandemic as part of a coordinated community response
- Are accountable to the Champlain LHIN.

2.2 Role of Other Primary Care Providers

The OIIPP is built on an assumption that all primary care providers (PCPs) will be responsible for serving affiliated clients with pandemic influenza or a SARI in a timely way for as long as is possible. A key trigger for establishing ACs is when affiliated and unaffiliated clients cannot access assessment, diagnosis and treatment within 12 to 24 hours.

It is essential that each PCP develop a plan to serve its affiliated clients. Adjustments to services may be required.

Ottawa CHCs are prepared to establish a base of ACs across the City of Ottawa. Given the limit of CHC capacity, it is expected that other PCPs could assume a role in managing and staffing other ACs to allow for greater geographic access across the City and greater capacity if needs escalate.

The Champlain LHIN is prepared to leverage LHIN networks (e.g. Primary Care Networks) to ensure a responsive primary-care system during a pandemic or SARI and will do so to the extent that it is able. The LHIN currently has accountability agreements only with CHCs in terms of primary care, and not with family health teams, other family physicians, nurse-practitioner clinics, and urgent care centres.

The OCHCIP could be shared and form the foundation of plans for other PCPs.

3. PRINCIPLES AND LEADERSHIP STRUCTURE

3.1 Principles

Building on previous experience, the OCHCIP is guided by the following principles:

Defined leadership – work within a command structure that outlines roles and responsibilities for planning and managing the coordinated community response

Clear communications – establish processes that enable clear, efficient and effective communications to support appropriate action

Leverage resources – contribute collective CHC resources and leverage the resources from partners for an efficient and effective response

Scalable – offer a proportional response based on the level of severity and community need and aligned with capacity

Essential services – maintain a base of essential services, particularly for vulnerable clients

Accessible services – minimize barriers to accessing services, including geographic, language and cultural barriers

Responsive – work with partners to identify and respond to the needs of specific vulnerable populations

3.2 CHC Leadership

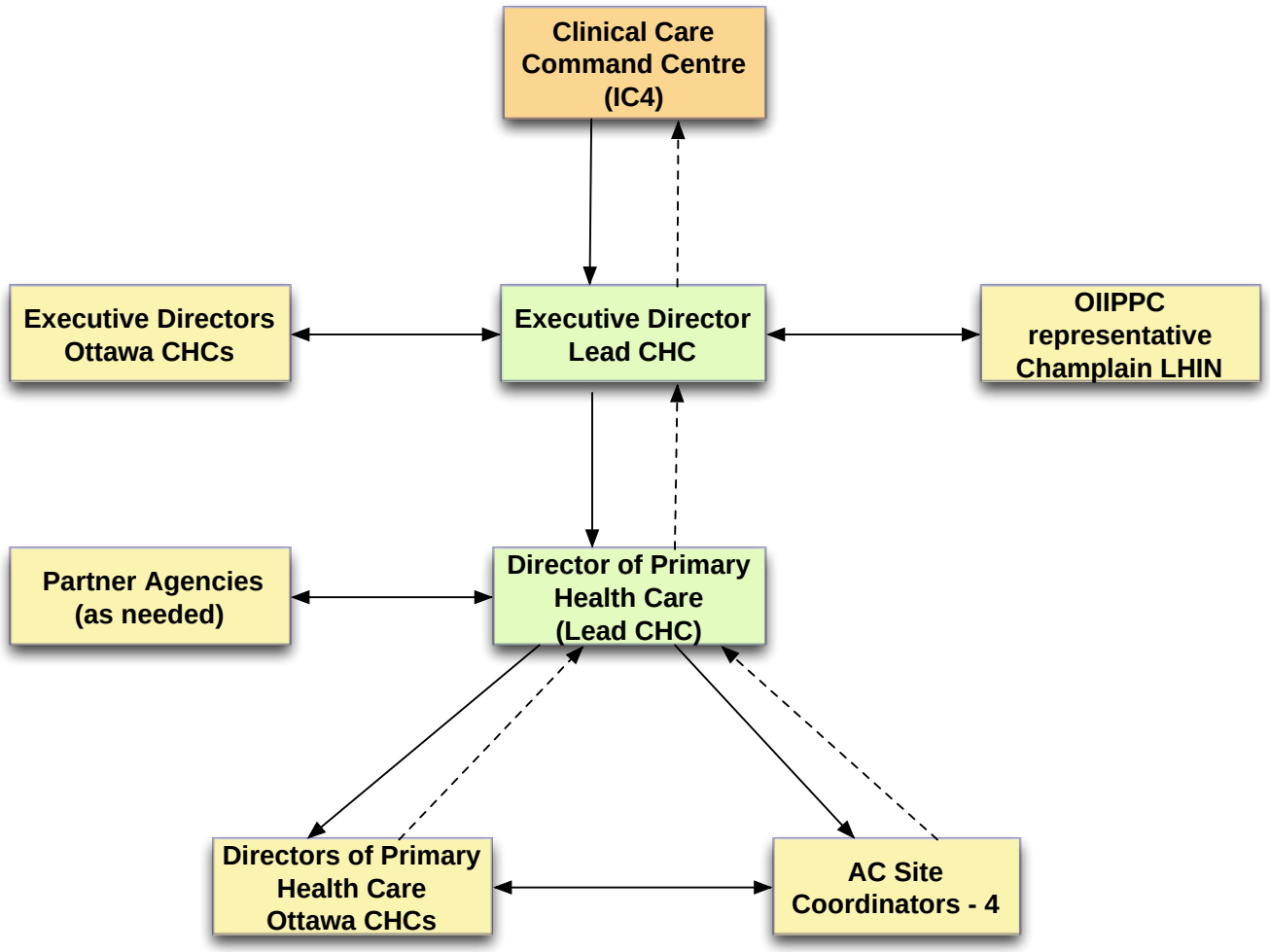
One Ottawa-based CHC will be the lead CHC responsible for coordinating and managing implementation of the OCHCIP. The lead CHC will:

- Represent the Ottawa CHCs on the OIIPPC through the Primary Care Director
- Represent the Ottawa CHCs on the C4 through the Executive Director and Primary Care Director
- Liaise with designated CHC representatives about developments, plans and the need for action
- Liaise and plan with key partners, particularly OPH, Champlain LHIN and the City of Ottawa, to establish the required supports
- Oversee the planning and implementation of ACs
- Coordinate CHC participation in debriefing and review of ACs managed by CHCs

Somerset West CHC is the lead CHC for the OCHCIP until 2016.

Figure 1 depicts the leadership structure for the OCHCIP. Given the need to operate within a command structure to ensure an efficient and effective response the flow of decision-making and management stems from the C4 through the lead CHC to others partner CHCs. Partners are committed to open communication, consultation and joint decision-making. The solid arrows depict the flow of communication and hyphenated arrows depict the flow of decision-making.

Figure 1: Leadership Structure for ACs



4. TRIGGERS FOR ACS

4.1 Preparing for, activating and deactivating ACs

The OIIPPC has defined the triggers for preparing for, activating and deactivating ACs, as outlined in the OIIPP.

TRIGGERS

Prepare to Open ACs when:

- Hospital emergency departments reporting approximately 20-40 patients with influenza like illness (ILI) per day

AND

- OPH surveillance data indicate significant volume of ILI activity

The LHIN decision to open ACs will be taken in collaboration with participating partners upon recommendation of the Medical Officer of Health, IC4 or the City Emergency Operations Centre (EOC) when:

- Existing PC system is no longer able to ensure clients are assessed, diagnosed and treated with antivirals within 12 to 24 hours of developing symptoms
- Hospital emergency departments reporting approximately >40 patients with ILI/day
- Clinic supplies and antivirals are available

Other Considerations

- # admitted patients waiting for beds
- Crowding and wait times in Emergency Departments
- Public distress (call volume)
- ILI cases within specific populations
- # of ILI cases in CHCs and primary care
- # of other patient visits to Emergency Departments
- # of ILI in critical care
- Anecdotal

The recommendation/ decision to close one or all ACs will take into consideration the same factors and other relevant information (e.g. need to change location for any reason).

4.2 CHC Role in Surveillance

Ottawa CHCs will be responsible for contributing information to support OPH surveillance activities. Partner CHCs will track and identify:

- The number of ILI or SARI cases amongst affiliated clients
- If specific populations appear to be more vulnerable
- The CHC's capacity to serve clients in a timely way.

5. AC OPERATIONS

5.1 Services Offered

The following services will be provided through ACs:

- Screen clients for ILI before they enter the AC and give people without symptoms information about where to get a vaccination and how to prevent infection
- Assess clients for ILI and offer self-care information for people who do not require additional care
- Triage clients to ensure that clients who are not well and require advanced care or who have complex health issues can be served on an urgent basis
- Provide treatment for those diagnosed with ILI, including the administration of antiviral drugs, as available, and within clinical guidelines at the time
- Refer individuals to additional community-based health and social supports if needed
- Provide urgent care as needed and arrange transport for clients who require acute care.

The anticipated hours of operation are 10:00 am to 6:00 pm seven days per week. Additional hours would require additional HR capacity, either from within CHCs or through partners.

Each AC will have the capacity to serve approximately 160 to 180 clients each day. Four sites will have a combined capacity to serve 640 to 720 people a day and approximately 4500 clients across a seven-day week.

5.2 Geographically Dispersed Locations

Working within their capacity to manage and staff ACs, CHCs will offer ACs in locations that are geographically dispersed across the City of Ottawa to facilitate access and minimize public travel. The locations of ACs reflect:

- CHC capacity to manage and staff ACs - currently at 4 sites
- Population distribution
- Champlain LHIN defined Health Link Areas (4,5,6 & 8) which correspond to client flow for health services and Primary Care Networks

Possible locations of ACs have been identified by area across the City of Ottawa. CHCs would offer ACs in:

- East end – St. Laurent area
- West end – Greenbank area
- Central – downtown area
- South - Heron/Walkley area

Additional sites for possible ACs have been identified to enhance access to suburban areas (east, west, south), and expanded capacity in the central area. This would require other PCPs to assume management and staffing of ACs or expanded CHC capacity.

5.3 Facilities

ACs may be offered through facilities owned by the City of Ottawa that meet the criteria outlined in Figure 2.

Offering ACs through city-owned facilities will:

- Ensure ACs are dispersed across the City to expand access and minimize public travel
- Allow CHCs to maintain essential services, particularly for vulnerable clients
- Leverage partner infrastructure, resources and expertise.

The City of Ottawa will make a best effort to assign facilities that meet the established criteria within 5 business days of the LHIN decision to open ACs, based on the triggers defined.

Figure 2: Site Criteria

AC Site Criteria	
Geographic distribution	• Locations in east, west, central and south Ottawa
External Space	• Accessible for disabled • Adequate parking for at least 50 vehicles including parking spaces for people with disabilities • Separate entrances and exits and the ability to restrict access
Internal space	• Large room(s) on the ground floor to establish designated areas that enable adequate client flow for screening and triage, registration and waiting, assessment (minimum 4 stations; maximum 8 stations), urgent care (space for up to 4 stretchers) and discharge (to home or hospital) • Storage space for client records • Storage space for supplies • Space for garbage disposal and used dirty supplies • Adequate washroom facilities for males and females • Adequate washroom facilities for the disabled • Space for staff breaks
Communication	• Wired for internet • Cellular phone capabilities • Intercom system (preferred)
Other Requirements	• Ability to convert space into an AC within three business days • Tables, chairs and dividers (preferred) • Equipped with a power generator (preferred)

5.4 Staffing – Roles and Responsibilities

The roles and responsibilities for operating an AC are defined in Figure 3. Figure 4 outlines the reporting relationships within an AC.

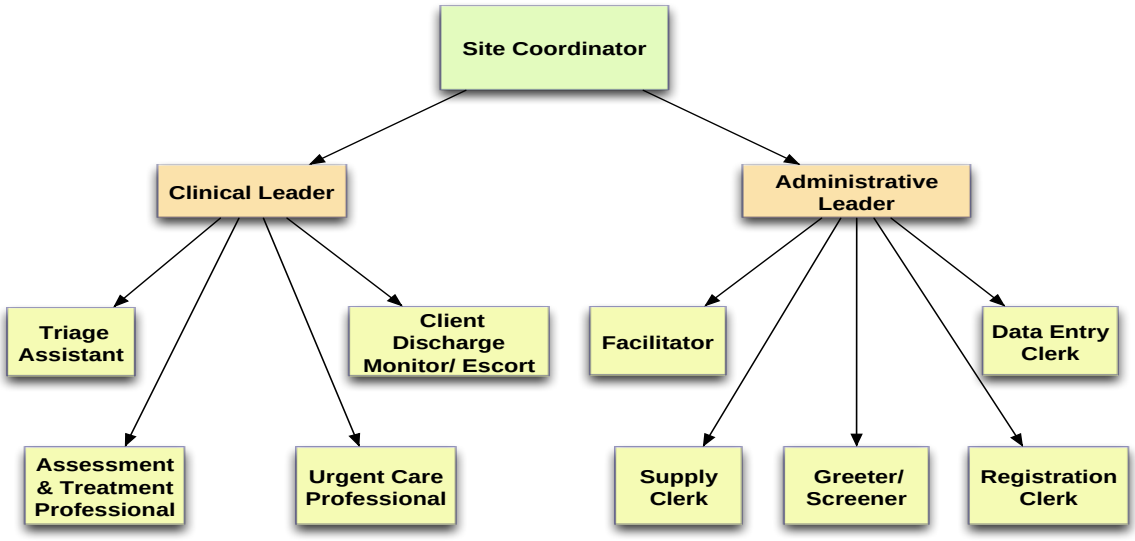
Appendix A outlines the assumptions used to assess HR capacity and Appendix B outlines the associated CHC staffing positions that could assume the AC role and associated responsibilities.

Figure 3: AC Roles and Responsibilities

AC Role	Responsibilities
Site Coordinator	• Overall responsibility for providing safe, effective & efficient operation of the AC • Oversee operational details of planning • Regular reporting to CHC AC lead, OPH, other key stakeholders • Coordinate staffing & services with other ACs • Ensure identification & resolution of health & safety issues • Oversee financial operations including documentation & maintenance of staff hours • Oversee data collection and management • Oversee physical & psychosocial well-being of staff and clients
Clinical Leader	• Ensure quality care & counseling • Monitor adherence to clinical policies • Oversee scheduling & assignment of clinical staff • Monitor and identify need for staffing recruitment & deployment • Ensure adequate infection control & cleaning • Oversee acquisition of resources to support operations (e.g. medical supplies, equipment)
Administrative Leader	• Manage reception and registration • Oversee storage, inventory & restocking of supplies • Ensure surveillance data is collected & records managed according to established protocols • Develop reports to be shared amongst ACs, OPH & other key stakeholders • Arrange scheduling & assignment of staff • Monitor need for staffing recruitment & deployment in areas of logistical support • Track and document staffing hours • Track expenses
Supply Clerk	• Procure supplies • Manage storage, inventory & restocking of supplies • Assist with cleaning & infection control, if needed
Greeter/ Screener	• Greet clients at the entrance & screen according to ILI screening tool • Provide self-care information to those without symptoms & ask them to leave the building or redirect to vaccination clinic • Identify & report clients who cannot wait in line to the quick entry area • Direct clients who can wait in line to the registration & waiting area
Registration Clerk	• Register clients and provide Client Assessment Tool (CAT) with a number • Direct clients with questions to the Triage Assistant • Monitor fax & phone lines
Facilitator	• Assist clients to complete demographic & history information on CAT • Provide support to clients who do not speak English/French or have literacy issues • Arrange translation as needed • Direct clients to waiting area where they will take a number & wait for an assessment
Triage	• Monitor clients for presenting symptoms

AC Role	Responsibilities
Assistant	• Assess suitability of clients to wait using standard screening tool • Direct clients with more severe symptoms or risk factors to next available clinician or Urgent Health Care Professional
Assessment & Treatment Professional	• See clients in order presented • Review client history & perform assessment using established criteria • Provide/dispense antiviral (per medical directive) • Consult with physicians in complex cases as appropriate • Provide clients with take home information sheet • Indicate need for 24-48 hour follow-up
Urgent Care Professional	• Perform assessment based on established criteria • Assess need for hospitalization • Provide medical support & monitoring of clients awaiting transport to hospital • Consult on complex cases
Client Discharge Monitor/ Escort	• Book clients for 24-48 hour follow-up as directed by health care providers • Monitor clients awaiting transport & provide direction to paramedics • Direct clients to exit after assessment process has been completed • May be asked to monitor clients until family is available to collect them • Ensure that clients exit in an orderly manner
Data Entry Clerk	• Enter data from Client Assessment form • Print/provide copies of assessment Note – this role may not be required

Figure 4: AC Reporting Relationships



5.5 Staffing Level

A point in time estimate of capacity indicates that CHCs have the collective capacity to operate 4 ACs. The required positions and FTEs to operate an AC are outlined in Figure 5.

Figure 5: AC Positions and FTEs

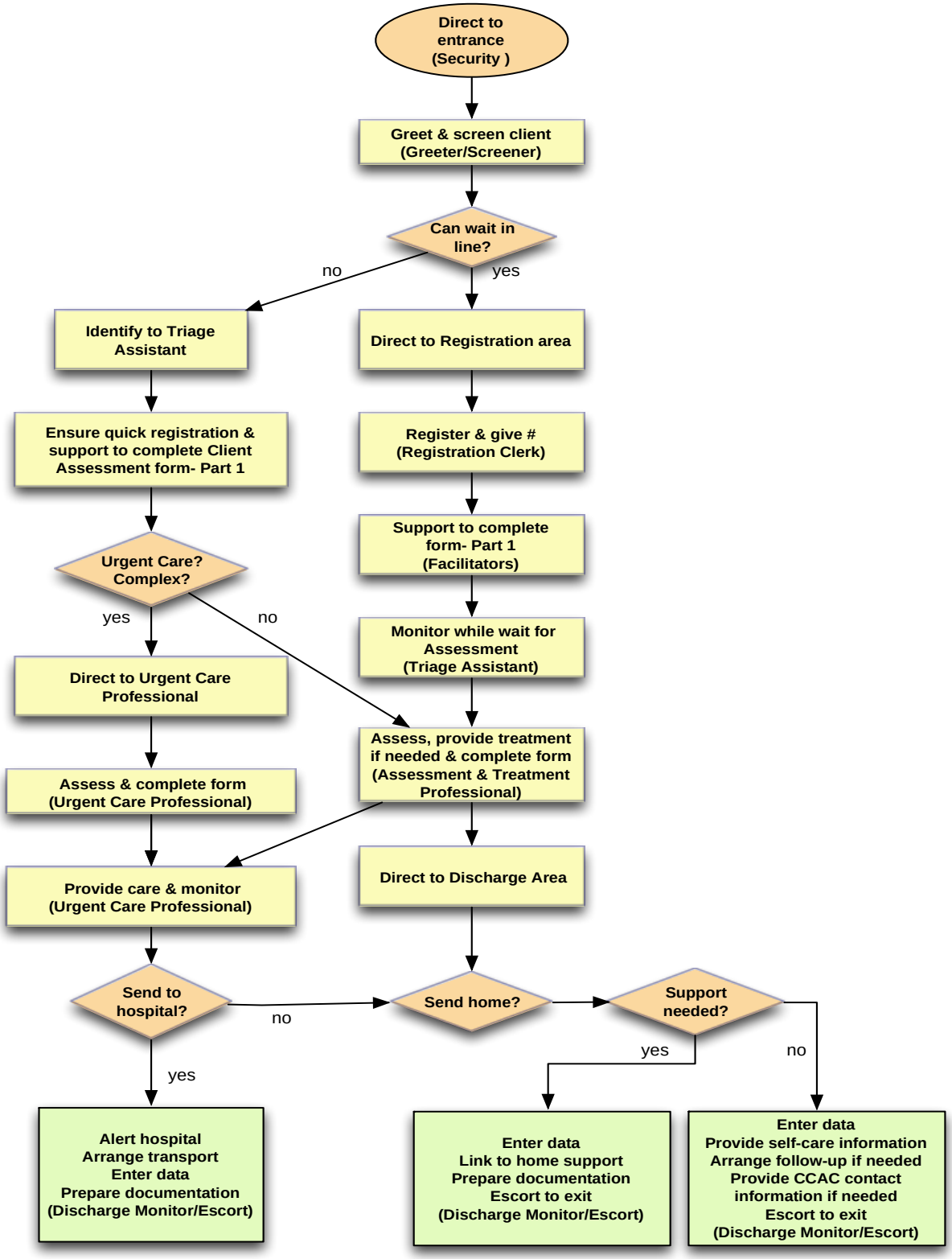
Position	Capacity - FTEs
Site Coordinator	1
Clinical Leader	1
Administrative Leader	1
Supply Clerk	1
Greeter/Screener	2
Registration Clerk	2
Facilitator	3
Triage Assistant	1
Assessment & Treatment Professional	5
Urgent Care Professional	1
Client Discharge Monitor/Escort	2
Data Entry Clerk	2
Total	22

5.6 Client Flow

Each AC will be organized to optimize client flow from entrance to discharge. The intent is to have clients move in one direction from initial screening to triage to ensure that clients with more urgent needs or complex health issues receive timely assessment and care.

Figure 6 outlines the key activities, client flow and roles.

Figure 6: AC Client Flow



5.7 Supplies

A range of supplies is required to support the clinical and administrative functions of an AC. The provincial government will procure some supplies and some will be procured locally. The lead CHC will partner with Ottawa Public Health to determine what partner is best positioned to procure what supplies. Both partners have access to emergency supplies that could be used to support ACs. During a pandemic, there may be a shortage of supplies and pre planning is required.

The supplies required to support an AC are outlined in Appendix C.

5.8 Infection Prevention and Control

It is assumed that the facility being used will have a regular standard of maintenance provided by the owner.

To minimize transmission for clients and staff, ACs will adhere to current occupational health and safety and infection control policies and procedures recommended by the Provincial Infectious Diseases Advisory Committee (PIDAC)[2] and the Public Health Agency of Canada (PHAC)[3] for healthcare settings.

At a minimum infection prevention and control measures will include:

- Providing training to staff about infection control practices and use of appropriate personal protective equipment
- Requesting symptomatic clients to use hand sanitizer and don surgical masks
- Providing education to clients
- Ensuring hand hygiene supplies are readily available and used
- Posting signs about routine infection prevention and control measures (i.e. hand hygiene, cough etiquette)
- Provision and use of appropriate and fit tested protective equipment for staff
- Establishing and maintaining cleaning and disposal procedures
- Ensuring workspaces and equipment are cleaned between clients
- Establishing a regular screening schedule for disinfecting areas frequented by clients (e.g. door handles, sinks and toilets, reception counters).

A purchase of service arrangement will be established through the CHCs responsible for AC site coordination to ensure appropriate cleaning occurs that ensures adequate infection control in the areas where clients are being served.

[2] http://www.publichealthontario.ca/en/eRepository/RPAP_All_HealthCare_Settings_Eng2012.pdf

[3] http://www.phac-aspc.gc.ca/cpip-pclcpi/annf/v4-eng.php#V-6-2-6

5.9 Use of Technology

The OIIPP indicates that all agencies should optimize the use of technology to support their pandemic response. MOHLTC's reporting requirements place demands on health care providers to ensure that computer systems have the capacity for a large volume of data and for confidentiality of client information.

Ottawa CHCs would like to explore the feasibility of registering and inputting client data on-line with partners to:

- Facilitate sharing of information including recommendations with clients and with other health care providers; and
- Minimize the need for data entry from paper forms to enable reporting to OPH and through them to the Champlain LHIN and the MOHLTC.

6. INDIVIDUAL CHC RESPONSIBILITY

6.1 Individual CHC Plans

Partner CHCs are required to have a plan in place to enable them to fulfil their role as defined in the OCHCIP. While centres offer common services there are differences in terms of how they operate depending on the communities they serve, their staffing levels, the city-region-wide services they operate and other factors.

The requirements outlined in Figure 7 align with standard emergency planning of CHCs.

Figure 7: Individual CHC Responsibility

Area	Responsibility
Essential services	• Identify the essential services that the CHC will need to continue and develop a plan to do that (may involve delivering services in different ways) • Have a plan to contact and support affiliated clients or community members who are vulnerable and may be challenged to access ACs
Human Resource Mobilization	• Develop a plan to communicate effectively with staff (e.g. up-to-date "fan-out" strategy to contact management and staff, call in systems) • Identify the competencies of staff that could be redeployed and the roles they could assume • Maintain a current list of temporary/relief workers that could be mobilized • Understand how city-region-wide service partnership agreements would need to be adjusted and how staffing resources could be utilized in a pandemic/SARI situation • Have a plan to manage staffing deployment when there are high levels of staffing illness or family care requirements
Supplies	• Stock four weeks of personal protective supplies (the MOHLTC has stocked an additional 4 weeks of supplies for all CHCs) • Organize Biennial Fit Testing for an influenza respirator for all staff that may work in an

Area	Responsibility
	AC
Affiliated clients	• Have a plan to assess, diagnose and treat affiliated clients that may present with influenza or SARI on a priority basis prior to activation of ACs • Establish a communications plan to inform affiliated clients with ILI how to access ACs • Establish telephone screening and triage response to identify clients with ILI and advise them to go to an AC (OPH will provide a city-wide screening) • Establish a communications plan to inform clients of service restrictions in a pandemic situation

6.2 Essential Services

Centres have established a common understanding of essential services that each centre adapts to enable the centre to serve clients who are most vulnerable. Ottawa CHCs provide leadership in offering a range of city and region-wide services for vulnerable populations requiring centres to clarify what services are essential and will be maintained if ACs are activated.

CHC essential services are understood to include:

- Acute episodic primary care and chronic disease management
- Obstetrics and newborn care
- Acute mental health care
- Telephone triage and prescription renewals
- Information and referral services
- Community support services (where available)
- Outreach to vulnerable clients

Vulnerable clients are identified as:

- Having diminished ability to perform activities for daily living due to physical/emotional illness or disability
- Limited in their capacity to prepare for an emergency
- Limited in their role as caregivers for dependents
- Any other person that staff determine to be at risk in an emergency

Specific vulnerable population groups include, but are not limited to:

- Clients who are isolated or have limited social supports
- Clients with physical disabilities
- Clients with mental health issues or substance abuse issues
- Clients who are homeless
- Clients with language barriers

See Appendix D for more details.

7. PARTNER ROLES

7.1 Partner Roles to Support ACs

To fulfil the mandate to operate ACs, Ottawa CHCs require the support of key partners. Table 5 indicates the roles of partners to support ACs as outlined in the OIIPP[4].

Figure 8: Partner Roles

Partner	Role	Activities
Local Health Integration Network (LHIN)	**R**	The LHIN will: • Work with community health centres to implement the OCHCIP as required • Engage other primary care providers through LHIN networks to identify their roles in the provision of additional ACs as required • Involve Champlain LHIN Physician Leads (Primary Care, Critical Care, Emergency Department) to act in an advisory role and promote coordination among providers • Liaise with the lead CHC and other primary care providers responsible for managing and staffing ACs to ensure appropriate supports are in place as required • Coordinate the AC cost reimbursement • Facilitate communication and sharing of information to partners and the MOHLTC
OPH	**P**	OPH will: • Liaise with the lead CHC and other primary care providers responsible for managing and staffing ACs to support planning and implementation as needed • Assist with securing supplies, including accessing antivirals from the MOHLTC stockpile • Coordinate communication structures such as regular meetings and teleconferences • Conduct a public education campaign to promote the ACs • Provide the client assessment form to be used by ACs
Clinical Care Command Centre (IC4)	**P**	The IC4 will: • Provide guidance around clinical services provided by ACs • Address operational issues and challenges related to ACs • Interpret clinical guidelines • Provide a forum for discussion with clinical care providers around common issues such as logistics • Establish standardization of care between clinical care providers • Liaise with the lead CHC
Champlain Community	**P**	CCAC will: • Provide care coordination for clients requiring home support

[4] Roles are defined in the OIIPP as:
R- the organization being responsible for the coordination needed to implement the overall emergency function
P- Partner: partners are critical stakeholders in implementing the task
S: Support: Supporters are stakeholders that can provide support when required, a partner or having a support role

Partner	Role	Activities
Care Access Centre		• Support transition planning to hospital or home as needed (including transition to Community Support Services) through on-site support as capacity allows – otherwise by telephone or at home as need indicates • Provide phone call follow-up for clients going home if recommended (primarily clients who have received an antiviral) as capacity allows Note – CHCs will follow-up with affiliated clients if capacity allows
City of Ottawa	**P**	The City of Ottawa may provide City facilities and logistical/human services to support dedicated ACs or designated primary care sites.
Ottawa Paramedic Service	**P**	Once ACs are activated, the Paramedic Service will transport patients who meet the Ambulance Act criteria to hospitals with designated ACs (where designated as per the Hospitals Act). The transportation is direct from any non-hospital facility to the AC. The Paramedic Service will also transport patients who meet the Ambulance Act criteria from a designated AC to a hospital.
OPH	**P**	OPH, with the assistance of the Paramedic Service, will develop plans for alternate means of transport to and from ACs, such as taxis, for patients who do not meet the criteria for an ambulance.
Academy of Medicine	**S**	The Academy of Medicine will assist in eliciting cooperation of members for providing AC/pandemic clinical care services.
MOHLTC	**S**	Stock and provide some supplies to be used by ACs

7.2 Partners Serving Vulnerable Populations

CHCs and their partners serve different vulnerable populations in Ottawa.

CHCs are committed to ensuring that affiliated clients or community members who are vulnerable and may be challenged to access ACs have access to these services.

Inner City Health Inc. is understood to have a leadership role for the pandemic response for the adult homeless population.[5]

Wabano Centre for Aboriginal Health has a mandate to serve the First Nations, Inuit and Métis population and has a pandemic plan to guide their work.

[5] Ottawa Adult Homeless Sector Pandemic Plan (2013)

8. NEXT STEPS

The OCHCIP is the first iteration of an integrated CHC plan for ACs. Further work can be done to enhance the efficiency and effectiveness of Ottawa CHCs and their partners when a coordinated community response is needed.

a. Establish a mock schedule outlining how CHC staff will be deployed across the four ACs
b. Partner with OPH to explore the feasibility of developing an on-line version of the Client Assessment Form
c. Share the plan with the Champlain LHIN who can engage Primary Care Networks in discussions about the PCP role in pandemic situations and explore the potential for other PCPs to manage and staff ACs to enhance access and expand capacity if required
d. Share the plan with partner CHCs across the Champlain region to inform their pandemic planning

APPENDIX A - CHC HR CAPACITY - ASSUMPTIONS

Ottawa CHCs have a "***point in time"*** understanding of their collective HR capacity to manage and staff ACs. In 2014, the Ottawa CHCs can be responsible for 4 ACs. This estimate will be reviewed and revised if needed every two years.

The following assumptions guide the determination of capacity:

Essential Services - CHCs have defined essential services that they need to maintain as outlined in Appendix D. It is estimated that a skeleton staff of up to one third of CHC staff from across each CHC will need to be dedicated to offering essential services including maintaining contact with vulnerable clients by phone or through outreach.

Illness/caregiving responsibilities - In a worse case scenario, it is estimated that up to one third of CHC staff will be unable to work as a result of personal illness or the need to care for family members.

Competency-based – CHC staff can fulfil roles and responsibilities that align with their skills and expertise regardless of their current role and job description. CHC Executive Directors and Directors/Managers will designate staff in line with their inventory of staff competencies and/or their knowledge of individual staff.

Orientation and Training – Orientation and training can be provided to ensure all staff assuming AC roles will be comfortable with their designated role and responsibilities.

Minimizing Spread of ILI - To minimize the spread of ILI and to reallocate staff resources, it is assumed that CHC group programs/services will be postponed or cancelled. Staff not providing essential services can support ACs.

Expanding capacity - CHC staff that work part-time or as relief will be asked to increase their hours to expand capacity.

Capacity of City/Region Wide Programs - Some CHCs offer city-wide/regional programs, which are a mix of essential/non essential services. Staff not providing essential services can be available to support ACs across the city/region.

Scheduling - Scheduling will be centralized by the lead CHC in collaboration with Site Coordinators of each AC to enable redeployment of staff where necessary. CHC staff teams working directly with clients will work on a three or four day rotation with some exceptions possible. CHC teams would be rotated across the AC sites. Staff involved in managing the AC will work five of seven days.

APPENDIX B - AC ROLES THAT CORRESPOND TO CHC POSITIONS

Role	CHC Position – Primary	CHC Position – Back up
Site Coordinator	Director of Health Services Primary Care Coordinator/Manager	Director/Manager of Community Health Services Director/Manager of Mental Health & Addictions Services Executive Director Director of Child & Family Services
Clinical Leader	Director of Health Services Primary Care Coordinator/Manager Nursing Team Leader	Registered Nurse Physician Nurse Practitioner
Administrative Leader	Administrative Coordinator Executive Coordinator	Corporate Services Director Director of Planning & Evaluation Human Resources Coordinator
Supply Clerk	Clinical Aide Bookkeeper	
Greeter Screener Facilitator Client Discharge Monitor/ Escort	Health Promoter Community Developer Community Health Worker Outreach Worker Counsellor Volunteer Coordinator Registered Practical Nurse Chiropodist Dietitian	
Registration Clerk Data Entry Clerk	Medical Secretary Medical Reception Administrative Assistant Social Services Intake – Practical Assistant	Health Promoter Community Developer Community Health Worker Outreach Worker Counsellor Volunteer Coordinator Registered Practical Nurse Chiropodist Dietitian
Triage Assistant	Registered Nurse Respiratory Therapist	Physician Assistant Nurse Practitioner
Assessment & Treatment Professional	Nurse Practitioner Registered Nurse Respiratory Therapist Physician Assistant	Physician
Urgent Care Professional	Physician Nurse Practitioner	Physician Assistant Nurse Practitioner

APPENDIX C - SUPPLIES TO OPERATE AN AC

Supplies that are required to operate ACs have been identified. The province is responsible for procuring some supplies and other supplies need to be procured locally. Responsibility for procurement and storage of required supplies has been identified. During a pandemic, there may be a shortage of supplies and pre planning is required.

Requirement	Responsibility
Hand Hygiene • Liquid soap • Alcohol rub • Paper towels • Dispensers	Province
Personal protective equipment • Surgical/procedure masks (adult and pediatric) • N95 respirators • Paper gowns • Non latex exam gloves • Eye protection	Province
Vital signs assessment • Thermometers (disposable or disposable covers) • Stethoscopes • Blood pressure cuffs (adult and pediatric) • Oximeter and probes (adult and pediatric • Tongue depressors • Flashlights (medical)	Province
Disinfectants • Disinfecting wipes (CAVT) • Surface cleaner and disinfectant (hospital grade)	Province
Antiviral clinic supplies • Medication information sheets/inventory • Paper bags (small)	Province
Pharmaceuticals • Antivirals • Antibiotics (to be confirmed) • Anti-diarrheal medication (to be confirmed) • Anti-nausea medication (to be confirmed)	Province
Assessment/information • Assessment forms – common tool • Adverse reaction forms (PHAC) • Self-care education information (multiple languages)	OPH
Medical supplies • Cots (20) • First aid kit • Disposable blankets • Crash cart (CPR valve, bag valve mask resuscitator, AED Defibrillator, extra medications) • Stretchers (4 in urgent care) • Wheel chairs • Facial tissues • Paper square absorbent examination table covers	CHCs City of Ottawa

Requirement	Responsibility
• Paper cups	
General cleaning supplies • Garbage bags • Garbage cans • One-use paper towels • Mops • Buckets	City of Ottawa
Infection Control • Specialized disposal bags for vomit/diarrhea	CHCs
Administrative supplies • Ticket number machine • Clipboards • Flipcharts and paper • File boxes • Envelopes • Notes pads • Pens, pencils, markers • Post-it notes • Stapler and staples • Scissors • Elastic bands • Tape	CHCs
Space • Portable partitions or other option to provide privacy • Rope/stands/mechanism to cordon off areas • Collapsible chairs • Tables for registration • Fire extinguishers • Toilet paper • Paper towels • Flashlights	City of Ottawa
IT and Supplies • Telephones – fixed and mobile • Computers • Printers and toner • Public announcement system /bullhorns • 2 way hand held radios/messaging devices for key personnel/security staff • DVD/TV for orientation/training and waiting room • Fax machine • Photocopier/scanner • Computer paper	CHCs City of Ottawa

APPENDIX D - CHC ESSENTIAL SERVICES

A. Acute episodic primary care and chronic disease management
- Acute/new onset pain (e.g. eye pain, abdominal pain, headache, etc)
- Shortness of breath
- Vomiting and diarrhea
- Diabetic with very high or very low blood sugars
- Bleeding
- Infants less than 3 months old with fever
- Recent onset rash

B. Obstetrics and Newborn Care
- Last few weeks of pregnancy
- Newborns

C. Acute mental health care
- Crisis intervention/counseling

D. Telephone Triage and Prescription Renewals
- Direct patient to call pharmacy where possible

E. Information and Referral Services
- Inquiries about ILI/SARI
- Support for clients with language barriers

F. Community Support Services (where available)
- Transport to medical appointments
- Access to food bank or meals-on-wheels

G. Outreach to Vulnerable Clients
- Telephone outreach
- Home visits where needed

Vulnerable clients are defined as:
- Having diminished ability to perform activities for daily living due to physical/emotional illness or disability
- Limited in their capacity to prepare for an emergency
- Limited in their role as caregivers for dependents
- Any other person that staff determine to be at risk in an emergency

Specific vulnerable population groups include, but are not limited to:
- Clients who are isolated or have limited social supports
- Clients with physical disabilities
- Clients with mental health issues or substance abuse issues
- Clients who are homeless
- Clients with language barriers