

Planning for Influenza Pandemic

May 11, 2006

Operator: Good afternoon, ladies and gentlemen. Welcome to the Ontario Safety Association for Community & Healthcare Teleconference on Planning for Influenza Pandemic. At this time all participants are in a listen-only mode. Following the presentation we will conduct a question and answer session. To register for a question, please press *, one on your touchtone phone. Should you require any assistance during the call, please press *, then zero. I would now like to turn the presentation over to your moderator. Please go ahead.

Fiona Macpate: Thank you. Good afternoon and welcome to Ontario Safety Association for Community & Healthcare's Teleconference, Be Pandemic Prepared. My name is Fiona Macpate and I'm the OSACH consultant for the Halton and Peel Region. It's my pleasure to be the moderator for today's call. Our session will focus on the occupational health and safety aspects of pandemic planning. If you would like to follow along with today's presentation and have access to a computer, please log on to our website, www.osach.ca and look for the presentation link.

Over 300 health and community care organizations across the province are on the line with us today making this one of our most successful teleconferences and I think it's also an indication of the concern in our sector to be pandemic prepared. Please remember to stay with us after the presentation for a question and answer session. We will also be announcing a new OSACH publication that will be available for free download after the call.

Our special guest speaker this afternoon is Allison Stuart. Allison created and is now the Director of the Emergency Management Unit within the Ministry of Health and Long-Term Care. She was the Ministry's executive lead during SARS both at the Provincial Operations Centre and, later, at the SARS Operations Centre. Allison's responsibilities with the Ministry of Health and Long-Term Care have included Director, Hospitals Branch; Director of Central Region, and Administrator, Queen Street Mental Health Centre. Prior to joining the Ministry, Allison held senior management positions in both community and academic acute care hospitals. She has also taught both clinical and management nursing. Allison's academic background includes an undergraduate degree in nursing and a graduate degree in health administration, both from the University of Toronto. Allison was recently honoured by the Toronto Star as one of the top ten people to watch in 2006, and she is an acknowledged expert on matters related to emergency management, personal preparedness and pandemic planning. I can't think of a more qualified person to be leading our call today. Please welcome our special guest, Allison Stuart.

Allison Stuart: Thanks very much and thanks for the great introduction. I always think I sound so much better when somebody else is talking about me. I'm really pleased to have an opportunity to talk with this group and to have such a breadth of individuals that are on the line is really terrific.

I hope that by the end of this session you'll have some common information about the pandemic and avian influenza, and that we're all working with the same premise, with the same information. We'll also all have a shared understanding of what is being done at the provincial level around strategies to manage (a pandemic). We'll also have some tools that we can use collectively to make sure that we're staying in the loop and know what's happening and what's being thought as we move forward.

It's going to be a bit of a roller coaster ride because we've got lots to cover in a relatively short time, but I hope you'll hang on and we'll take off now. The first area that I want to talk about is, what exactly is an influenza pandemic? And, do we have one? As many of you know, we need to have a new virus for there to be a pandemic. It has to be a virus that affects humans very easily and furthermore, that it can be spread easily from human to human. If everyone has to be in touch with a virus directly, then it takes far too long for that virus to spread. So it's more like it's, as some of you will remember a shampoo commercial where they talk about, and I told two friends and they told two friends, you can see how the spread is much faster that way.

Now the virus itself, as well as being really good at infecting us and spreading, has to be one that causes us a lot of grief. It has to make us really sick and there has to be death as part of that so we're not looking at something that's just going to have us out of commission for 24 hours and then we're up and running again. And because it's a new virus, one that we're not immune to, we won't have any sort of natural built-in protection. The other sorts of things that go on with a pandemic, they're around three a century and we know that by looking back in time to the 1600s and every century has had around three per century. It usually starts in Southeast Asia and we know that we have some of the characteristics of a pandemic now but not by any means all of them.

So if we think about the avian influenza that we're reading about that has affected many parts of the world, it certainly qualifies as being a new virus, although it has been around for several years now, it's still a new virus. It, however, has had very limited spread to humans. That doesn't sound right when I say that but it's true. If you think about this virus as being endemic in birds, in some wild birds, the fact is there are roughly, and I'm not suggesting that we have all the information on all the people that have been ill, but roughly 200 or so have been lab proven to have avian influenza. That's not really very much when you think of the number of sites that have been affected and the number of opportunities.

The other is that there has been very limited human-to-human transmission. In the cases where we've been able to identify the avian influenza virus, there have been, I think, 16 cases where they cannot prove, show direct contact between the individuals and a sick bird or a dead bird. And in those 16 cases, several of the people died before they could complete the investigation and ask all the right questions. But most of the others, the situation was that, while they may not have had that direct contact, they were caring for somebody in, like a child or their parent, a very intimate contact without any kind of protection. In some of those cases, we're not sure whether the information is entirely accurate because in some countries people were told to kill their domestic poultry so they're kind of reluctant to come forward and say, well actually I didn't kill my domestic poultry. So the information is a bit sketchy.

However, the virus as it presents in humans is showing up as being around a 50% mortality rate. Now that sounds horrible, and it is, but we need to put that in perspective as well. In the countries where we've seen human outbreaks of avian influenza, they've been relatively poor countries, ones that don't enjoy the same kind of health care system that we do. So people aren't as likely to get into the health care system unless they're really ill. If you think you can get over it at home, then you'll stay home. Similarly, the mortality rate looks now as if more young people and children are being impacted and, while that may be true strictly on an epidemiological point of view, I think we also have to take into account who's feeding domestic birds. Quite often it's the kids' job to go and feed the four chickens behind the house and play with the chickens, chase the chickens and so on, so not surprising that they may have had more contact with potentially ill birds. I'm not downplaying any of this but it's about statistics, and they can tell pretty well any story you want to hear.

We know that the population does not have immunity to this virus and we all know, because they keep telling us, that we're overdue for a pandemic. So it looks like it has many of the features of a pandemic but it's missing out on probably of the two most important (characteristics), its spread to humans and its spread among humans. It just hasn't got to that point. Whether it will at some future stage, I don't know, but at this stage it's certainly not there.

As many of you know, the World Health Organization has divided us into six phases, and we're always in one phase or another. So the first phase would be, there's no action anywhere of anything and phase six means that we're in a pandemic. We're in phase three now which says that there is a new virus but there has been very limited human-to-human spread and that's been through close contact. But we have to remember that we aren't guaranteed that we'll go to phase four next. We might skip a phase; we might go to phase five, for example. And we have been at phase three for a couple of years now so hopefully we'll stay there for at least a couple more years.

A couple of reminders that an influenza pandemic is not the same as seasonal flu. While I know that this audience understands this, it is a message that you will need to reinforce when you're talking to other people, because they get a bit confused. Flu is flu is flu and we know it's not quite like that. We know that the pandemic is not the same as SARS. For many of us, we still recall our SARS experience, where we really had a virus that affected people, mostly vulnerable people in institutional settings and the people around them, be they family or health care workers. In an influenza pandemic we're talking about a virus that will be community based and will be everywhere; it'll be pervasive. And, as we discussed, avian influenza and pandemic are not one of these, although an avian influenza could become a pandemic, but that's not where we are at this point in time.

So now that we're all experts on pandemics and avian influenza, let's talk about what's happening here in Ontario as to what kinds of steps are being taken to prepare for whenever a pandemic occurs. We have, as many of you will know, developed the Ontario Health Plan for an Influenza Pandemic which we call OHPIP just because we can't keep saying that long phrase every time. And we're not in any way suggesting that somehow if Ontario pulls its socks up and really works hard, that we will be able to avoid a pandemic. If there's a pandemic, it will come to Ontario. What we do hope to be able to do is to soften the impacts, soften the impacts on people in terms of their health, soften the impacts on society in terms of what it does to the infrastructure of society, the economics, everything, every aspect of our lives. Our goals aren't terribly lofty. What we just want to do is round off the edges of the pandemic.

We've decided that we have to focus in four areas. One is being ready and that's what you're doing now, what we're doing in terms of all the planning that is underway. We're being watchful. Many of you are participants in programs that contribute to that watchfulness in terms of doing screening of individuals, also keeping track of people that have influenza-like illnesses and so on. And that contributes to a, not only a provincial bank, but a national and international bank that starts looking at whether there are any unusual blips of activity. I think that's the technical term, blips of activity, so that we're aware of anything that might be a little bit different than what the experts would be expecting.

We need to be decisive. There are two kinds of emergencies. There are those emergencies that really hit us in the face and that's when there's a traffic accident or a building falls down or a bridge gives out. Those are emergencies, when it's really clear from the get-go that you've got an emergency. And then there's a whole other set of emergencies and they're more insidious. They're the ones that creep up on us. We start off with, say, one person being ill and then a second and it may take us a bit of time to say, huh, we've moved from just having a bad day; we're now really in an emergency situation. And people that do reviews of emergencies after the fact often say, well why didn't you declare an

emergency earlier? Well, oftentimes you don't know that you're in an emergency right from the get-go.

What we've said is that we think it's important that Ontario be bold in terms of assuming that we're in an emergency, so once there's a pandemic declared by the World Health Organization, that's not when we'll say, okay, well we've got an emergency here in Ontario because we'll be exhausted before we actually have the virus here in Ontario. But we will certainly go on heightened alert and I would suggest that probably when we see the virus in Canada that, even if it's not in our province, we'll be, if not an emergency status, we'll be pretty darn close because it's a way of rallying everybody and keeping people focused on that which we need to do.

Finally, it's important to be transparent in terms of our communications with the public, with the health care sector so that we're being very clear about what we know, what we don't know and making sure that we have loops in place so that we can get information back. We need to hear if that was our second best idea. We need to know that so that we can improve and make sure that we're responding in a way that's meeting the needs, bearing in mind that sometimes at the provincial level we see, because we're looking at all parts of the province and from a little bit of a higher angle, we see things that aren't necessarily obvious when you're right in the trenches. So it is a bit of a balancing act.

Now one of the things that we all learned, I think, in SARS was there was lots of information and communication but it wasn't necessarily efficient. It didn't necessarily get the right information to the right people at the right time and sometimes it simply interfered with any of our ability to get our job done. So we established what we're calling our information cycle and that information cycle is designed to ensure that we all have information that's timely, that there isn't somebody who's got way more information than you do and that sort of thing. So the way it will work is as follows, and we'll be using these for other emergencies as well but we're focusing here on pandemic. Each morning we will be having a teleconference with representatives of associations that have members across the province and it'll be a pretty eclectic teleconference involving all sorts of different health care-related groups. And what we are going to be asking is, what's different from yesterday? What's different from when we talked yesterday? What are the issues that you are contending with that we can help solve? If everything's going splendidly then don't talk. We don't need just to hear your voice. Really keeping it very focused so that we have a sense of what we need to focus our energies on that day.

We'll then take this forward, start working it up, working both with our Executive Emergency Management Committee which is chaired by the Deputy Minister of Health and has both the Chief Medical Officer of Health and myself sitting on that committee. Just, that will give us sort of the lay of the land for our work. We will then have a teleconference mid-day with our public health units because that

gets down, once again, to get a bit of an update on what's happened in the morning. And then we will be going to a media conference. Now one of the things that we were, two of the things that we're doing, one, the reason that we've built in a media conference is that it's extremely useful to use the media to get information out to lots of different people so we want to make sure that they have the right information because we know they're going to publish, we know they're going to do their broadcasts, let's make sure they have information that's accurate, timely and meets their needs.

Now the other thing we're going to do is, we will be slipping in, in our spare time, a teleconference with other sectors, so that will be like the correctional services, it'll be banking, all sorts of different sectors. Now it won't be much of a two-way conversation; it will be simply us giving them an information dump so that they can then work through their issues. But we think that will be helpful so that they stay focused and know what sorts of vulnerabilities from a health care perspective they have to contend with. We will then use the balance of the day to continue working on the various issues that have been raised and then every midnight we will send out an important health notice.

Many of you will be familiar with the important health notices; we send them out when there's something happening where we think health care providers may need to alter what they're doing as a result of whatever the event is. By sending these important health notices out at midnight, the idea is that everybody will start their day, now we recognize it's a 24-hour day and so on, but they start their day with common information and we think that that will be helpful for everyone. And for people who find that it takes a while for such things to trickle down to wherever they happen to be working, these important health notices will also be on our website. In fact, they'll probably be on our website before they get through the 34,000 email addresses that we send this to. And anybody that would like to be on the, on our very exclusive club of 34,000, just send us an email at the address at the back of the slide deck and we'd be glad to add you to the list.

Now on the next page we just show you an important health notice so you know what you're looking for and this is actually a real, live important health notice that was used. But it's just to give you a sense of what it looks like so we don't send them out frivolously, that they are approved by both the Chief Medical Officer of Health and myself before they go out and we hope to be able to provide the information in a way that everybody can get very quickly, even when you're rushed off your feet.

Now, there are certain assumptions that we're working with as we do our planning and it's important that we keep reminding ourselves of the assumptions because, as we get more information, some of these assumptions may be proven wrong. Some may be proven right but we need to be reminding ourselves that they were, our plans were based on assumptions because we

don't have the real life experience of having the pandemic right now, thank goodness. We're assuming that everybody will be at risk and that communities will be affected at different times. It's not going to just fall like a blanket on Ontario; it'll, some communities will get it before others and so on and so forth. We're also, we know that the modellers tell us that it will take, or can take, a virus three months to get around the world and we hope that we will have that three months, that we're the last stop along the way but we can't count on it. So we're assuming little lead time before the first wave of a pandemic hits. And we're also working with the assumption of a multi-waved pandemic; at least two waves and the waves are roughly eight weeks long.

Now there's a space in between the waves and that space allows us to do a couple of things. We can do a bit of regroup, lessons learned, those sorts of things, get a little bit of R&R because everybody will be tired, to be ready for a second wave. Now, I'm anticipating that the second wave, and some waves will be, well will be just as challenging, I'll say, because I think the public in general will have forgotten that we said there was going to be a second wave and will think somebody has done something wrong and that's why we have a second wave. So that's going to be challenging to manage. Also, people will have been affected by that first wave; they will know people that have been sick, they may have been sick themselves, their financial situation may be impacted, so they're not in any mood for this to come back again. And we need to be thinking about what we need to have in place to make sure that we can manage that changing personality, if you will, of Ontarians.

We're also assuming that the attack rate will be 35%. And what that means is that when the pandemic is all over and people are starting to write studies and journal articles and all that sort of thing, and looking back at the pandemic, they'll say, huh, around a third of the people got sick. So that doesn't mean that a third of the people are sick all the time; it means when you add everybody up over the life of the pandemic, as around 35% got sick and we, and that means that they were sick enough to be off work or school for at least half a day. They're suggesting that at any one time the peak absenteeism would be around 20% and that would include those people who are sick, those people who are staying home to give care to other people and those people who are too afraid to come to work. We can't do much about those who are sick. We can, through training, education, communication, great planning, we can affect those other two numbers, not perfectly. It's not as if all of a sudden everybody's going to feel great about having a pandemic but we can influence those other two numbers and we can all be part of that influencing of the other two numbers.

We're assuming that the vaccine won't be available on the first wave but it, and it'll be, initially, it'll be hard to get in the second wave but eventually we'll all be able to get the vaccine and we're lucky in Canada in that we're, we have a domestic supplier of the vaccine which means that we're not having to negotiate with some other country. Antivirals, we're all familiar with the discussions that

have been ongoing about Tamiflu and when it should be used, how it should be used, should it be stockpiled, etc. I'll talk a little bit more about that later, but we know the antivirals will be in short supply and high demand. And we know that the community infrastructure may be affected in other ways; we're really focused on the pandemic and this disease outbreak but if some parts of the community haven't had, if their plans are not all perfect, it may be that we find that we have a shortage of food in such and so town because the trucks, the transports didn't get there or there might be intermittent power outages or whatever it might be. It's not forever but simply until, there's been a glitch in the system so we have to be aware that that could happen.

So those are our assumptions and now I'd like to talk, just for a minute, about what we don't know, which is probably not the most comforting of topics but I think it's important that we're very open about that. We don't know the characteristics of the, the specific characteristics of the virus. We know the characteristics of flu viruses but this particular virus and how it's going to play out is not known and it's important for us to know because that gives us further advice on which group's are most vulnerable, is it the aged, the young, people in their middle years, who knows? It also tells us about what personal protective equipment would be most effective in the circumstances. If it's something that is spread only by contact then that's important to know versus something that is like a TB that spreads through the air. So not having that information really does compromise our ability to do our planning so we need to all recognize that. Obviously, we don't know when the pandemic will occur; we don't know which public health measures will be used, when they might be used and, in some cases, there's some question as to whether they would be used at all. That the pervasiveness of this virus is such that it really won't make a lot of difference whether we use some of the public health measures.

And we don't know, and I say this cautiously given that I work for the government, that we don't know the level of support for financial, legal and other impacts that the government or governments will provide. I think that the Government of Ontario and it doesn't matter which, the government of the day, it doesn't matter which one, I think they've all been pretty good in terms of responding after an emergency in terms of helping people get whole again and being able to get on with their lives. We're hoping that they'll be able to fund a bit of information ahead of time because that'll simply help us all with the planning that we do.

So let's talk about something we do know about. Let's talk about those things we know and then what we can do as a result. I mentioned antivirals. We know there's two ways of using antivirals. You can use them as treatment where you get, take two pills a day for five days, or you can use them as prophylaxis, where you take a pill a day for as long as you want protection which would presumably be for the whole wave which would be 56 pills. Now, I've already mentioned that they're in short supply and high demand and when you see that emphasis on

how much of a low prophylaxis takes, 56 pills per person, versus treatment of 10 pills per person, you can see some of the dilemma that people are having to deal with.

Something that will not be used during a pandemic is quarantine because we know that it won't be effective. The virus will run through a community and we know that the virus will make, or the assumption is that the virus can be in your body and you may be shedding it for 48 hours before you even know you're sick. So very difficult to assume that quarantine would be of assistance. Having said that, right at the outset, we may try quarantine for the first few clusters more with the idea of buying us 24 hours, 48 hours so we can get our act together. So it's not something that we see using throughout the pandemic at all. But what we will be saying is, stay home if you're sick; you're not helping if you're at work when you're ill. And we're also knowing that because we're going to have shortages, that we will need to be augmenting who is at work by some innovative ways and our planning talks about using skills as the basis for trying to figure out who else could help when some of us will be home ill and not being able to contribute.

What else do we know? We know that the virus for sure is spread through contact closer than a meter and that includes coughing and sneezing. What we're able to do about it very much depends on the work environment so it's really important that every work environment do its own work audit, what goes on in your workplace and really walking through that to see where the areas of vulnerability are. It's easier in an office to do things like screenings and how you can manage social distancing which is staying at least a meter away from somebody else. That's easier in the office than it is in a community setting or at the bedside but, once again, you can use the audit of the activities that you're doing and looking at what can we do differently.

One basic little thing in terms of interviewing a patient or a client instead of doing it across, face-to-face, come up, meet with them from the side, simple little things. Or if you're meeting across the table, make sure the table is a meter wide, those sorts of things. It's not perfect but it's just some additional measures we can all take. And, of course, cough and sneeze etiquette. I know that your mother and my mother told me that we should cover our mouths and our nose with our hands when we sneeze or cough. I'm telling you your mom was wrong. I know it's hard to believe but what we should be doing is coughing or sneezing into our arms, not into our hands because our hands get into our face far too much and we also touch so many other objects and people with our hands.

We can also look at where there are situations where we can't avoid that close contact, that less than a meter contact so we need to look at what barriers do we need. And they can be physical barriers such as how you set up your office, the cough etiquette thing where you're sneezing into your arm, plexiglass screens, those are all things that we can do in office situations, pretty hard to carry around

your own plexiglass screen when you're providing patient care, though. And so that's when we start talking about personal protective equipment and the use of masks. And as many of you will know, that there's been a lot of discussion about masks and respirators and what's the appropriate mask for this situation. The science that's available on this topic overwhelmingly suggests that a surgical mask is sufficient for pretty well all situations.

The exception that some will acknowledge is that if a healthcare worker is doing something that may induce aerosolization of the virus, that they should be wearing an N95 respirator so somebody that's doing a bronchoscopy or suctioning where you may be poking the person into spraying that virus, that in those situations an N95 would be appropriate. That's what the science is telling us. However, many individuals are telling us that they're looking for something more; that that doesn't give them a sense of confidence and comfort that they will be safe enough in the workplace and we're acknowledging that there is more to this than simply the science. We all have to have that emotional connection as well and so currently we're looking at what other steps make sense in terms of personal protective equipment. We talk about extending it to include certainly all aerosolizing procedures. Do we also include those situations where we don't know what the person is sick with and until we do know what the person is sick with, we wear an N95 as being that added protection. So that's the way the discussion is going now and it's by no means finalized but I wanted to let you know and I think you're probably the first group to formally be told this, that we are looking at how to most appropriately use something beyond a surgical mask for health care workers.

Now some of you may wonder whether you should be, and your families and others should be wearing masks, just walking along the street. Public Health is saying they don't think that that will be very useful, however, I think a lot of people will, of their own choosing, decide that they want to use a mask because of the pervasiveness of the outbreak. But that won't be something that we're saying, everybody put on a mask.

One of the other things we know about this virus or viruses like this is that they can live on hard surfaces for up to 48 hours and, so that means that we all have to be really vigilant in terms of our infection control practices in the workplace. Lots of cleaning needs to happen. We need to have hand sanitizers everywhere. I wish I had thought of this earlier because I think that hand sanitizers are what water bottles were, like around 15 years ago. Nobody ever thought people would pay to buy water. Similarly, I don't think people would have thought a few years ago that people would be wandering around with their own hand sanitizers but I think it's increasingly seen as being the norm, and I think it's something we should all be encouraging.

Also need to look at equipment that is used by multiple individuals, things like stethoscopes, telephones, those sorts of things and seeing what steps need to

be taken in the environment that you're in in terms of those multi-use pieces of equipment. And that's something that every environment will have to look at for their own purposes. And, of course, if we're doing all this hand washing and cleaning we need to make sure that somebody's picking up the garbage much more frequently than previously. We also know that if you're healthy it's easier to fend off other illnesses so we're all being encouraged to stay healthy or get healthy, including getting your annual flu vaccine, not because it's going to protect you against the pandemic, but because it'll make you, overall, in better health than if you've just, are in the recovering stages of a flu. Similarly, something that we tend to forget as adults and that is to make sure that we keep our immunization up-to-date on all range of diseases and I think this is a good reminder for us to make sure that our healthcare providers have discussed with us what it is we should have in place and making sure that we do have it.

And, of course, as individuals we know that we can take steps that will help our own health and we also know that our employers could do things to help keep us safe. And these, some of the things we can do, they're pretty easy to understand and to incorporate into our lives. We can self-screen at home. We know what the standard questions are for influenza-like illnesses so we can do that self-screening if we're not feeling well. We don't need to have to come to work and then do screening and then go home. We can do that at home. We should all be staying home when we're sick; come to work when we're well but stay home when we're sick. Hand hygiene, that's coughing and sneezing etiquette, flu vaccine, something that I need lots of help with because I talk with my hands and that is to avoid touching my face so that I'm not passing virus on to mucous membranes. And, of course, keeping informed is something that we all can do. We all have a responsibility. We expect our employers to provide us with information but that, I think, does not obviate our need to get information.

As employers, there's a huge role here for the Joint Health and Safety Committee. There's still, this is something where we all need to be working together to come up with the best strategy. Lots of training will be required and there's work being done through my unit to develop some training modules that people can use and we'll have more material on that later. We need to look at the absenteeism policies. Some of them are punitive in terms of, if this is your X absents then you don't get paid, that sort of thing, for the first couple of days, something like that. So we need to be looking at those. We need to also look at, what do we do if we have a staff member who is not ill but is staying home because they have to look after somebody who is ill? How are we going to handle those sorts of things? We can anticipate that we're all going to be under stress and our employee assistant programs are going to be stressed as well so we're going to need to talk about how do we get those kinds of services? And as individuals, what do we know? What are our triggers? How do we know when we're at a point where we're about to lose it? And what steps can we take?

We also know that nature abhors a vacuum, that rumours will be used to fill in every little space so let's make sure that everybody is communicating and we need to be communicating now and starting to provide base line information and then continue, continually adding to it and I suggest to individuals that they find a couple of websites that they like, ones that work for them. And that they continue to monitor those so that they're getting information that is being provided in a way that works. What I don't suggest is people go to the bloggers to get information because a lot of that is not based on science; it's very lacking in credibility.

We need to be really conscious of what a diverse community we live in and so when we're communicating we need to be respectful of the diversity of language that people are used to. There's a booklet that is just being released now that's being put out by the Ministry of Health that's called, What You Should Know About a Flu Pandemic, and this booklet is going to be in hospitals, doctors offices, pharmacies and so on. It is also available on the website in 24 languages which I think is fantastic. There's really a great opportunity for all of us to be able to share that with members of the public and members of our staff who may be more comfortable in another language and who also may have family members that are more comfortable in another language.

Something that we should remind ourselves of when we're getting kind of stressed thinking about pandemics and that is, now I know it probably doesn't apply to anybody that's on the telephone line today, but if you happen to know anybody that's over the age of 40, I want you to go, next time you see them, shake their hands, congratulate them because they've already lived through two pandemics. There was one in the '60s and one in the '50s and it helps to put things in perspective that most of us will get through a pandemic, that we will all survive this. And that's part of the message that we have to send out as well as the message that says we've got to keep planning, we've got to keep doing things to help us be as prepared as possible.

Now many of you will want to or may want some further information about personal protection and I've mentioned that we're looking at our mask use and where N95s might be appropriately used and you can expect more information to come out on that and it will, we will have that information in our next version of our pandemic plan which is out in June, although it might be very late in June. We're also having an occupational health and safety annex in the next version which will be directed to anybody who's working in a pandemic so, volunteers, staff, contract workers, whatever and we'll look at the special needs in different types of work settings, so community, long-term care, chronic care, acute, etc. and based on sort of three stages, the planning stage, the response stage and the recovery stage. And we will be using a hierarchy of controls in terms of what are the full range of measures that we should be considering, not relying on only one measure but on a variety of measures. So that's something that I'm looking forward to and we will have that as part of the plan.

Now if you were all in a room in front of me, at this point I'd ask you all to stand if you thought that you would be playing a role in a pandemic and usually 95% of the people in the room stand up and everybody's standing, looking around and wondering what this is about. And then I ask the next question. I say, have you prepared your families for a pandemic? Have you talked with them about the sorts of things that collectively you need to have in place that will allow you to feel comfortable enough to come to work and them to feel comfortable enough to send you to work? And most of the room sits down. So I want you to do that in your head for yourself, but to identify whether you've had those kinds of discussions at home. And you will need to have those discussions more than once but they're very important so that you can share information in making sure that you're all at a point of comfort as you go into the potential of a pandemic. So we talked about things like being prepared, stay healthy, keeping informed, develop your own contingency plan. If the daycare is closed or the school is closed, who will be looking after the children? If you have a parent or a grandparent who is able to stay independent in the community because they get Meals on Wheels and someone comes in and bathes them a couple of times a week, what happens if those services aren't available? Who's going to look after that person that's so important to you? These are things that you can think of now and sort of plan for now. And in addition, I encourage you to look at our website and others where they have checklists of things you can do around being prepared for any kind of emergency but certainly for a pandemic because once you've got a sense of ease that you've done what you can, it's easier for you to reach out and help other people and I encourage you to take those steps.

Now in your package you'll see a couple of resources by no means exclusive. There are lots of others than you can add to that list and I'd encourage you to let us know of resources that you have found particularly helpful and we'll add them to our website. But I think, on our website you'll find that it's got quite a bit of information; it's growing all the time. Increasingly we provide information in multiple languages which I think is helpful and we're also providing different websites for different groups, be they first responders or healthcare providers, the public, that sort of thing. And we also have a hotline, well it's not terribly hot but it's a hotline that you can call or an email address that you can send your questions to and we will answer them and if we don't have an answer then we will attempt to find an answer. So we'd be happy to hear from you as you reflect and do your own planning.

Thank you very much for the opportunity of speaking with you and I'm going to turn it back to, over to you, Fiona.

Fiona Macpate: Thank you very much, Allison. I think everyone would agree that Allison has provided us with some very important and very timely information and I think we'll all go away being better prepared as individuals and organizations to deal with a pandemic.

At this time I'd like to turn the call over to our teleconference operator who will explain how to signal your intent to ask a question. Please go ahead.

Operator: Certainly. Thank you. Ladies and gentlemen, if you would like to ask a question, please press * one on your touchtone phone. To withdraw your question, please press the pound sign. If you use a speakerphone lift your handsets before entering your request. Please stand by for the first question. Our first question comes from Nancy Johnson calling from the Ontario Nurses Association. Please go ahead.

Nancy Johnson: Hi, Allison. It's a lot of great information there. I just had a couple of quick comments that I thought I'd make, picking up on your suggestion to engage joint health and safety committees. Earlier in the teleconference you talked about a workplace audit. I think you'd agree it's a particularly important in the planning phase to use the joint health and safety committees and I would suggest that perhaps we could emphasize the need to engage them in conducting these audits or risk assessments in the planning phase. So I just wanted to move to the thought of a risk assessment situation in the planning phase.

And then the second comment is about the overwhelming science that supports surgical masks. As you know, we have to take issue with that particularly with the notion that it's only in, for emotional reasons, that we're looking to seek properly approved respiratory protection. In particular, Dr. Tellier of the Hospital for Sick Children has publicly presented evidence of the airborne transmissibility of influenza and have others and most recently the American Institute of Medicine has posted a draft report acknowledging the need to do research to produce reliable data that determine the roots of transmission. Having said that, we, thanks for letting us know that the province is now extending its consideration of respiratory protection to N95 for health care workers and, as you know, they already are providing that kind of respiratory protection for emergency services workers so happy to hear this new development.

Allison Stuart: Nancy, I'm not sure if I got a smack or a congratulations but I'll, I'm sure we'll be talking further.

Operator: Thank you. And our next question, just a moment, comes from Thomas Hayes calling from the Ottawa Hospital. Please go ahead.

Dale Levesque: Hi, Allison. It's Dale Levesque from the Ottawa Hospital. Thank you very much for your talk today. The one question we have here is in regards to supplies. We've been meeting with some of our vendors and looking at supply chain management issues and they touched on some elements that happened in, during the SARS crisis in which products were either embargoed from other countries or there was recalls for medical equipment, specifically respirators, PB and other things to repatriate products to other countries. Has

the province given any thought to supply chain management issues and ensuring that there are supplies on-site for the hospitals and for healthcare workers as well as the safety supply within the province and ensuring the supply to the hospitals?

Allison Stuart: Thanks very much for the question. In terms of where we're at with that, as you'll know from OHPIP 2005, the expectation is that every organization will be stockpiling four weeks supply of those items that are most relevant for their workplace and we've suggested what they might be in the annex to the plan. And, similarly, we said that the government will also stockpile a four week supply so that we collectively will cover that first wave of activity and the government has supported this position by the, taken in the plan and the resources are in place to do that. We have some of that supply now but certainly not enough for the entire province for four weeks.

Operator: Does that answer your question sir?

Dale Levesque: Yes, it does. Thank you.

Operator: Thank you. And our next question comes from Sean Weylie calling from Idlewyld Manor. Please go ahead.

Sean Weylie: Hi, Allison. Sean Weylie here in Hamilton. One of the issues that I know a lot of organizations are dealing with right now is the issue of communication and dealing with the whole issue around email communications. With the increased sensitivity to spamming and different things like that, what is the plan as far as IT goes to ensure that some of these emails that are going out to 34,000 people aren't caught up in spam filters and making sure that that information does actually get to the organizations? We've had issues in the past where bulk mail-outs from the Ministry and stuff like that end up caught in our spam filters and it's two weeks or three weeks before somebody is able to release those from the spam filters. So I was just wondering what kind of contingencies are in place there?

Allison Stuart: That's a great question and it's actually one I can answer. As soon as anybody says anything that starts with IT I'm usually beyond my capabilities. But what we do do is we test the system and we send out sort of a test mailing. I believe it's every quarter.

Sean Weylie: Okay.

Allison Stuart: To make sure, and it's, there's some magic attached to it so that they know where it got to and so on.

Sean Weylie: Okay.

Allison Stuart: To test it.

Sean Weylie: Perfect.

Allison Stuart: Now if, the other failsafe, of course, is that we always put our important health notices on our website.

Sean Weylie: Okay. So that's the alternate place?

Allison Stuart: Yes.

Sean Weylie: To look for it?

Allison Stuart: Yes.

Sean Weylie: Great. Thank you.

Operator: Thank you. And our next question comes from Jessie Bielski calling from the Brain Injury Services of Northern Ontario. Please go ahead.

Jessie Bielski: Yes. Hello. I'm sort of commenting on something that's already been mentioned that the government announced that they were going to supply pandemic kits to front-line health care workers. And it's looking like it's going to go to family doctors, community care centres and midwives. I just wanted to know if you know anything more about other community agencies that are providing care, for instance, us at Brain Injury Services, we provide care in a residential setting for ten individuals. Are we too small to be considered on that list? And should we be putting together our own kits?

Allison Stuart: The emergency infections, not sure what we ended up calling them, profession control kits, I think, they were sent out, well, they haven't been sent out, I apologize. They will be sent out to roughly 15,000 recipients, mostly people that are in solo-type practices so physicians' offices in the communities, nurse practitioners in the community, community health centres, midwives, that's the focus. And the reason for that was that it's just plain too hard to get supplies to that many individual offices, etc. in an emergency so we wanted to give them a little bit of a head start because there will, as we indicated in the earlier question, we will have stockpiles available for others that will be used to augment what's made available, or what the organization has on their own. In terms of your own situation, I would suggest that you follow through and do as is expected of others in terms of the four week/four week split.

Jessie Bielski: Okay. Thank you very much.

Operator: Thank you. And our next question comes from Mike Ward calling from North York Hospital. Please go ahead.

Roseanne Clark: Hi. Yes. My name is Roseanne Clark. I'm on the Health and Safety Committee. I wanted to know if there will be any restrictions on healthcare workers who work at different organizations, for example, different hospitals maybe, in the doctor's office and that, and out of hospitals?

Allison Stuart: At this point, that's an excellent question, and particularly coming from North York General makes a lot of sense because you were certainly part of that discussion during SARS. At this point we're not anticipating that there would be that kind of limitation, partly because if we did that, an already scarce resource would become even more scarce but also there's no magic. It's not something where, because you work, it's, you could get exposed to the virus going out to get a litre of milk. So really having those kind of artificial rules don't work for this kind of outbreak.

Roseanne Clark: Okay. Thank you very much.

Operator: Thank you. And our next question comes from David Wong calling from the Toronto Rehab Institute. Please go ahead.

Madeline Ashcroft: Hello. It's actually Madeline Ashcroft, Manager of the Section Control here, and hello, Allison. I'm bothering you about masks again. I've been bothering you since SARS about masks, I think.

Allison Stuart: Well we've talking about masks since SARS.

Madeline Ashcroft: Yes, okay. How about that? I've just come freshly from the CHICA Conference and we had speakers from the Public Health Agency of Canada and Sheila Basrur spoke also and this is the first I've actually heard mention of N95, there might be some change going on and I was wondering, first of all, is there something different that's going out to occ. health vs. infectious control people? And is this for certain high risk procedures? Is this when you're unsure of the diagnosis and you may have a patient with TB? And is this going to be clarified in the update for the Fry Tieback Best Practice document that we're anticipating?

Allison Stuart: Well the Fry is, remember our respiratory illness document, I believe the full title says in for non-outbreak situations. When we talked about a pandemic we're, obviously, in a different set of conditions. It will be, you will find more detail about masking, etc. in our OHPIP 2006 and it will address issues such as high risk procedures, the, if you will, unknown patients, those sorts of things for sure.

Madeline Ashcroft: Okay. So it's not that there's something absolutely outrageously new? It's just what we already.

Allison Stuart: I think it's just moving the yardstick some.

Madeline Ashcroft: Okay.

Allison Stuart: In recognition that there are situations where there's more of an exposure factor, if you will, that's probably not a scientific term, than in others.

Madeline Ashcroft: I guess, recognizing that post-SARS it's very hard to make some staff members feel safe and comfortable unless they do have an N95 mask on and the downside of that, one of the downside things, if they are going to be wearing it for long periods of time is the effect it has on the individual. And so, I mean we've been told over and over again in infection control by all the experts, local experts particularly, and people in tieback that there's no evidence to support N95 for influenza or pandemic influenza so we're hungrily reading everything we can get our hands on when anything else comes up in the media.

Allison Stuart: And I'd like to reinforce that certainly the, and I don't want to get into a debate with Nancy because Nancy and I have way too many debates, but the, there is a large body of evidence, including WHO and others that are saying, surgical masks are the appropriate mask in a pandemic. We know that in Ontario particularly, because of our experience with SARS where we were using N95s, it just seems counter-intuitive for a lot of people to say, well wait a minute, we had a relatively contained outbreak and we had to use an N95. Now we're talking about this huge pervasive outbreak and you're saying we can use a surgical mask. So there's sort of a disconnect and I may have not stated it correctly in saying emotional, but it's sort of an intuitive disconnect between those two pieces. And what we're trying to do is come up with an approach that is, certainly acknowledges the science because we've, we must do that but also acknowledges that as individuals we need to go that next step and be comfortable enough that we are going to be able to come to work because we think we've got the right kinds of protections in place.

Madeline Ashcroft: Thank you very much.

Allison Stuart: And bother me any time.

Fiona Macpate: I think we have time for one more question.

Operator: Great. Thank you. Our next question comes from Leslie Browen calling from the Lake of the Woods District Hospital. Please go ahead.

Dr. Carey MacDonald: This is actually Dr. Carey MacDonald calling from Kenora, Ontario. Well we raised the issue of supply chain problems and food, for example, was mentioned and we're an area of isolated communities. If food actually became in short supply, given the size of the population that might actually have a beneficial effect on health care overall? However, if the liquor stores shut down and we have 5% of our population go into withdrawal all at the

same time, that's a huge problem. Is there any plan for community-based Librium depots?

Allison Stuart: Not to my knowledge but I'm sure that if you feel that's appropriate for your community you should get right on to it.

Dr. Carey MacDonald: I think we'll have to work on this, thank you.

Fiona Macpate: We'll take one more question.

Operator: Great. Thank you. Our next question comes from Lina Di Carlo calling from Credit Valley Hospital. Please go ahead.

Lina Di Carlo: Hi, Allison. It's always a pleasure listening to you. I just wondered has any thought been given to the aspect of how we're going to deal with ill health care workers? Are we going to fast track them through the system? Are we expecting hospitals to dedicate a unit for them or see them through Emerge? Are we going to set up clinics in the community whereby people and health care workers can go and be assessed?

Allison Stuart: You've raised a good point that I really don't have an answer for one part of it but I do for the other. What we are contemplating and we haven't got it fully worked out yet but we will by the end of June and that is that we will have assessment treatment centres in the community that will, people will be encouraged to go there instead of the places they might normally go and it will be strictly an assessment and basic treatment to try and keep people out of the, as out of the health care as we can. In terms of, are we going to do something special and I don't mean it in a, as if we want, never mind. I'll start again. Are we going to do something special for health care workers recognizing that we need to get our health care workers healthy and back to work? We hadn't really thought of that, at least there hasn't been discussion of that at the provincial level but it may be something that we ought to be considering and if folks have thoughts about that, I'd really appreciate it if you'd share them with me and send them in or leave a message for us. That would be great.

Lina Di Carlo: Sure. Thank you.

Fiona Macpate: Okay. Thank you. I'd like to thank Allison at this time again for her presentation and I'd also like to thank all of you who have taken the time out of your busy schedules to listen in across the province. Just in closing, please remember to check the OSACH website for your free download of our newest publication, Health and Safety in Emergency Management, A Guide for the Protection of Community and Healthcare Staff. This guide focuses on the occupational health and safety components of an emergency management plan. It was developed to assist management and staff of community and health care organizations as well as joint health and safety committees and health and safety

representatives to identify strengths and enhancement opportunities in the plans. While on your website, don't miss our important links to resources on influenza and pandemic planning which will also include links to the Ministry of Health and Health Canada, WSIB and to our infection control education session. All of these will help you to be pandemic prepared. And don't forget to check back with us in a few days when the transcript of this call will be available on the web. Again, thank you very much for participating in our teleconference and have a good day.

Allison Stuart: Thanks. Bye-bye.

Operator: Thank you ladies and gentlemen. This concludes the conference call for today. You may now disconnect your line and have a great day.