



H1N1 Western Roundtable

November 29, 2010
Fairmont Hotel Macdonald
Edmonton



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Founded under the Societies Act in 1981, the Alberta Continuing Care Association (ACCA) is a voluntary, non-profit organization representing owners and operators of continuing care (long term care and designated assisted living) facilities and home care and support organizations throughout the province of Alberta.

The Association's purpose is to advance and elevate the status of continuing care by promoting awareness of its needs and potential to government, labour and allied health services, and the community by recognizing the needs of its publics and by providing a strong voice forum for all members.

Our membership employ over 16,000 Albertans who deliver over 21 million hours of hands-on care annually to more than 46,000 seniors and younger disabled adults in Alberta's continuing care system. ACCA membership represents the only organization in Canada with an alliance of:

- Private, non-profit (voluntary) and public sector providers
- Owners/operators of long term care, supportive living and home care and support organizations

Mission Statement

Enhancing quality of life for individuals receiving continuing care by assisting members in networking, education and pursuit of best practices.

Values

- Support members in the pursuit of quality of care and service for Albertans
- Promote professionalism, sensitivity and empathy in all interactions
- Integrity in relationships and accountability in the use of public funds

The Association is a credible voice for the industry and acts as an advocate for high standards and quality performance by its members. ACCA's number one priority is to increase the quality of care for the Albertans in our members' care.

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BC CARE PROVIDERS ASSOCIATION

Established 30 years ago, the BC Care Providers Association (BCCPA) represents more than 130 members who are responsible for more than one-third of all residential seniors' care beds across the province (more than 10,000).

The BCCPA membership represents the full continuum of care, including:

- long term care
- home support
- licensed private pay
- congregate & assisted living

In addition to providing increasingly complex care to a rapidly aging population, our members employ more than 7,000 staff and care for an average of 4,000 home care clients each year. BCCPA members have made more than \$1.4 billion in capital investment in the province and many members have been in operation for over 20 years

The Association supports members by:

- advocating on industry issues such as appropriate legislation, policy & funding
- promoting quality care through the adoption of recognized standards
- recognizing members as providers of high quality, cost effective care & services
- serving as a credible voice on behalf of the care sector
- facilitating timely communications & networking opportunities
- responding effectively to important issues affecting our care sector

The Association's 2010 goals and objectives are:

- promote funding solutions & ensure sustainability of members
- advocate and encourage human resource & labour relations solutions
- strengthen relationships with government, health authorities & stakeholders
- foster and promote standards & quality of care

Guest Speakers



Ron Soreanu is an Account Director in the Toronto office of Hill & Knowlton, a leading international communications consultancy. He offers an unparalleled depth of understanding of the Canadian public policy process, especially as it relates to health.



Dr. Allan Holmes, President and founder of Global Medical Services and Global Consulting, is a fellowship trained Emergency Physician. Currently, Allan continues to develop innovative educational programs while overseeing a number of complex health services projects both within Canada and recently on an international basis.

Canadian Senate Overview

PANDEMIC PREPAREDNESS IN CANADA:

A STUDY BY THE STANDING COMMITTEE ON
SOCIAL AFFAIRS, SCIENCE & TECHNOLOGY

November 2010

HILL & KNOWLTON

OVERVIEW

- Background
- Committee Membership
- Summary of the Recommendations
- Provincial & Territorial Perspectives
- Looking Forward



BACKGROUND

- At the request of the Minister of Health, the committee was tasked with determining the important lessons learned and establishing best practices as developed by management, operations, logistics and communications.
- Ten hearings were held between September & November 2010
- Testimony was heard from 37 organizations and 67 individual witnesses
- Hearings included an overview of the H1N1 situation in Canada, including the federal government's response as well as an assessment of the socio-economic and health impacts of the pandemic

BACKGROUND continued

- Each meeting was organized around a theme:
 - Background & overview of the H1N1 situation in Canada
 - Federal emergency preparedness & response
 - Vaccines, antivirals & adverse reactions
 - Surveillance, laboratory preparedness & liaison with international public health networks
 - Federal-provincial coordination
 - On-reserve First Nations and Inuit communities
 - Third-party organization perspectives

MEMBERS

Standing Committee on Social Affairs, Science & Technology

- Art Eggleton, Chair, Lib. - (Ontario)
- Kelvin Kenneth Ogilvie, Deputy Chair, C - (Annapolis Valley - Hants - Nova Scotia)
- David Braley, C - (Ontario)
- Catherine Callbeck, Lib. - (Prince Edward Island)
- Andrée Champagne, C - (Grandville - Quebec)
- Jane Cordy, Lib. - (Nova Scotia)
- Jacques Demers, C - (Rigaud - Quebec)
- Lillian Eva Dyck, Lib. - (Saskatchewan)
- Nicole Eaton, C - (Ontario)
- Yonah Martin, C - (British Columbia)
- Pana Merchant, Lib. - (Saskatchewan)
- Judith Seidman, C - (De la Durantaye - Quebec)



SUMMARY OF RECOMMENDATIONS

- Communications & Messaging
- Vaccines & Antivirals
- Surveillance, Data Collection & Analysis
- Capacity
- Collaboration & Consultation
- Aboriginal Issues
- Roles & Responsibilities in Public Health



PROVINCIAL & TERRITORIAL PERSPECTIVES



LOOKING FORWARD

- The Senate study is expected to be released in December before the Senate breaks for the holidays.
- Should the Senate's report call for a response from the Government, it will then have 150 calendar days to respond to the Committee.





**CSA Standards
ROUNDTABLE ON HEALTHCARE &
EMERGENCY SERVICE SECTOR PANDEMIC
PREPAREDNESS**

VOICES FROM THE H1N1 INFLUENZA PANDEMIC FRONT LINES:

A White Paper About How Canada Could Do Better Next Time

June 8, 2010

Full copies of the report:

<http://www.csa.ca/cm?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1241708779869&ssbinary=true>

PREFACE

On December 15, 2009, CSA Standards (CSA) hosted a national *Roundtable on Healthcare and Emergency Service Sector Pandemic Preparedness* comprised of respected leaders across a variety of functions from Canada's leading healthcare and emergency service sectors – including infectious disease, family medicine, first responders (i.e., fire fighters), nursing and hospital / healthcare facility administration. The Roundtable was moderated by Dr. Allan Holmes, a Fellowship-trained Emergency Physician, President of Global Medical Services, expert on building pandemic plans and business toolkits, and pandemic advisor to federal and provincial governments and corporations across Canada. This one-day roundtable was possible thanks to arms-length support from Hoffmann-La Roche (Roche Canada). Roche did not participate in the discussion.

The H1N1 virus led to the first global influenza pandemic experienced in over 40 years. While the current *2006 Canadian Pandemic Influenza Plan* (with updates since) seemed to have been a step in the right direction for mitigating serious illness and overall deaths during this mild influenza pandemic outbreak, many believe that more can be done in the event of future, more moderate or severe influenza pandemics. Gaps exist in our pandemic planning for these types of scenarios. The CSA Roundtable discussion, therefore, focused on the challenges and opportunities faced by the healthcare and emergency service sectors about pandemic preparedness in Canada.

Why did CSA get involved? CSA is actively involved in the healthcare sector and wanted to contribute to the discussion of influenza pandemic preparedness in Canada, especially in light of the H1N1 pandemic. Additionally, CSA has been engaged in the emergency management field for many years, having introduced its first standard on the topic in the 1990s. In 2008, CSA introduced a comprehensive standard entitled *CSA-Z1600: Emergency Management & Business Continuity Programs*, and also has standards in related areas, including personal protective equipment.

A key discussion point at the Roundtable was lessons learned from the 2009 H1N1 influenza pandemic where participants shared their thoughts about successes and experiences, the actions taken by their respective organizations and by government, and their observations overall as to what worked and what didn't in the healthcare system. Roundtable discussion items included:

- Identification of the strengths and weaknesses of the current system in the event of a moderate or severe influenza pandemic
- The points of variance across jurisdictions
- Identification of what more needs to be done and the barriers that need to be addressed
- Healthcare continuity implications
- Suggested actions and timelines for potential improvements to existing plans

The following white paper is a summary of that informed Roundtable discussion and sets down the observations and recommendations in five key subject areas:

1. Pandemic Preparedness Planning
2. Personal Protective Equipment
3. Antiviral Medications
4. Vaccine Development and Delivery
5. Communications

The CSA Roundtable report, entitled *Voices From the H1N1 Pandemic Front Lines: A White Paper About How Canada Could Do Better Next Time*, highlights the informed opinions from the Roundtable participants about how Canada fared in each area, and lists constructive recommendations on how the leadership of Canada's healthcare and emergency service sectors can work in collaboration with governments and other decision-makers to improve on our pandemic preparedness plans going forward.

Sincerely,



Doug Morton
Director, Health and Safety
CSA Standards

PARTICIPANTS

The CSA Standards (CSA) *Roundtable on Healthcare and Emergency Service Sector Pandemic Preparedness* was comprised of senior representatives across a variety of functions from Canada's leading healthcare and emergency service sectors – including infectious disease, family medicine, first response (i.e., fire fighters), nursing and hospital / healthcare facility administration.

The Roundtable was moderated by Dr. Allan Holmes, a Fellowship-trained Emergency Physician, President of Global Medical Services, expert on building pandemic plans and business toolkits, and pandemic advisor to federal and provincial governments and corporations across Canada.

CSA would like to thank the following organizations for their time and input:

Association of Medical Microbiology and Infectious Disease Canada
Canadian Association of Emergency Physicians
Canadian Healthcare Association
Canadian Nurses Association
Centre for Excellence in Emergency Preparedness
College of Family Physicians of Canada
Hamilton Health Sciences
National Emergency Nurses Affiliation
Ontario Hospital Association
Ottawa Hospital
Prince George Fire Fighters Union

EXECUTIVE SUMMARY

The objective of the CSA Roundtable on Healthcare and Emergency Service Sector Pandemic Preparedness White Paper – entitled *Voices From the H1N1 Influenza Pandemic Front Lines: A White Paper About How Canada Could Do Better Next Time* – is to help those entrusted with making healthcare decisions, as well as those who deliver care and services to the public, as they continue to prepare for future influenza pandemics.

At the time that the CSA Roundtable was held in December 2009, the H1N1 virus remained a threat, Canadians were still in the process of being immunized, and the very real possibility of a third wave, mutation or a new viral strain (such as the threat of the H1N1 combining with the H5N1 virus) remained ever present.

What was clear from the Roundtable discussion was that many things went right during the recent H1N1 influenza pandemic: government decision-makers and healthcare and emergency service workers had made best efforts to plan appropriately, and when the pandemic hit, they worked extremely hard to implement those plans – often placing themselves and their families at risk. Among the successes were the early recognition of a new strain of influenza virus, governments and organizations moved quickly to put plans into action, and a new vaccine was developed, tested and delivered to Canadians approximately six months from identification of the virus.

But although there were successes – many of which were not apparent to the public – there were also failures and perceived failures.

The 2009 influenza pandemic was less lethal than it might have been and while there clearly were lives lost, a fact the Roundtable participants do not wish in any way to minimize, Canadians were fortunate in that it could have been much, much worse.

A mild pandemic, like what was seen with the H1N1, provides Canada with an opportunity to review existing pandemic preparedness plans, to determine how they could be readjusted to address gaps and failures, and to identify what could be done even better in the delivery of front-line care next time. And there will be a next time.

To that end, the CSA Roundtable took the opportunity to consult with respected leaders across a variety of functions from Canada's leading healthcare and emergency service sectors – infectious disease, family medicine, first response (i.e., fire fighters), nursing and hospital / healthcare facility administration – to collect immediate feedback regarding their experiences during the 2009 H1N1 influenza pandemic. The goal was not only to look back to evaluate how Canada fared, but also to look ahead to identify ways we could do better next time – when an influenza pandemic might be more moderate or severe than the 2009 H1N1 pandemic.

While it was impossible for Roundtable participants to fully explore and respond to every part of Canada's complex and comprehensive pandemic preparedness system in a single day-long session, participants were able to talk first-hand about their experiences and to describe how well our system did and did not function “on the ground” during the 2009 H1N1 influenza pandemic.

A number of themes emerged from the Roundtable discussions and are summarized below.

- There was considerable variability in the H1N1 virus' impact globally and across Canada which made consistency in planning and response more difficult.
- Canada's pandemic plans need a common baseline of preparedness at the grassroots level (e.g., among public health units, front-line healthcare workers and first responders) for training, readiness, processes and inter-operability – to ensure a nation-wide standard of care and an ability to provide mutual support to each other.
- Canada's pandemic preparedness plans lacked a severity index (sometimes referred to as a risk matrix) which could have helped guide decision-making by provincial and local authorities. A severity index tool would have helped local planners determine the extent of mitigation measures to put in place to slow down the progression of the pandemic.
- For any index to be effective, there is a need to review infectious disease and pandemic research to identify “triggers” – events or milestones in the epidemic or pandemic process that signal a qualitative change in the situation – and the need to recognize triggers and then apply relevant mitigation strategies against those triggers in order to reduce the risk of further infection spread.
- Concern that the 2009 H1N1 influenza pandemic – which was milder than anticipated – will now be used as the yardstick for future pandemic preparedness planning and concern that the public and the media will tune out public health messages the next time around.
- The need to remain vigilant in Canada's pandemic preparedness planning: infectious disease preparedness must always be on our radar screens, not just every 40 years.
- Recognition that as a pandemic unfolds, Canadians must be flexible in learning as we go, recognizing that despite the best-laid plans, mistakes will happen (or responses may be slower than the public expects) when dealing with the unknown.
- The need for consistency in messaging – from healthcare providers, government spokespersons, and the media – while recognizing the fluidity of a pandemic situation. Spokespersons shouldn't be afraid to say “we don't know that right now” or “we aren't sure”.
- The need for better acceptance of the “precautionary principle” in ensuring that the front-line healthcare system remains intact by ensuring optimal protection of front-line healthcare providers and first responders.
- The need for broader risk management frameworks with more mitigation efforts such as personal protective equipment and antivirals to prevent the spread of the disease between: 1) hand-washing, social distancing, sneezing into sleeves not hands, and staying home if one feels ill; and 2) vaccination against the virus once a vaccine is ready. A continuum of responses is needed to address the gap between hand-washing and the use of a vaccine.

RECOMMENDATION SUMMARY

The CSA *Roundtable on Healthcare and Emergency Service Sector Pandemic Preparedness* has a number of points of advice for those entrusted with making healthcare decisions, as well as those who deliver care and services to the public, as they continue to prepare for future pandemics.

Roundtable participants took on the task of identifying ways to improve Canada's pandemic preparedness system very seriously, and in the process, they were not shy about identifying deeply-rooted structural problems that affect many aspects of healthcare delivery in Canada – including our response to serious events such as a national influenza pandemic. As a result, there are a range of Roundtable recommendations: some that can be addressed immediately, some that will require longer-term discussion and planning, and yet others that may even seem idealistic. But the over-arching goal in developing these recommendations is that addressing identified gaps will allow Canada to build on the successes of the 2009 influenza pandemic and will make the pandemic planning and implementation process more responsive and fluid in the future. This is vital.

The recommendations fall into six key areas:

I. PANDEMIC PREPAREDNESS PLANNING

Harmonization

- Develop one harmonized federal and provincial framework to create a pan-Canadian benchmark standard approach for pandemic preparedness planning, while preserving the flexibility for local level implementation.
- Ensure appropriate training and testing on the front lines, and review local planning preparedness readiness – including through standard accreditation processes.
- Create a feedback mechanism from the “bottom-up” to ensure that the implementation realities that are unfolding on the ground (in public health, hospital, non-hospital and first response settings) either through training and testing or in an actual influenza pandemic are fully considered – and to ensure that federal, provincial, local and institutional plans are fully integrated and work in the real world.
- Implement a mandatory bi-annual review of the new harmonized plan to ensure that the plan is sustainable and a mandatory post-pandemic review.

Scalability

- Incorporate a severity index into the harmonized plan to help guide front-line decisions about prevention and treatment.
- Incorporate implementation triggers (events or milestones in the epidemic or pandemic process that signal a qualitative change in the situation) into the harmonized plan.

2. PERSONAL PROTECTIVE EQUIPMENT

Fear of contagion

- Government and organizational leaders must be sensitive to the anxieties caused by a new and/or potentially dangerous viral disease such as influenza and work to proactively counteract this fear with clear and consistent messaging about the safe, rational use of protective equipment.
- Recognize that while national guidelines on the use of personal protective equipment may be helpful organizations will naturally adopt a “precautionary principle” and do everything they can to protect their people. They should not be chastised for this.

Deployment strategy

- Any overarching federal or provincial plan for the use of personal protective equipment must be based on a blend of the science with the practicality of real-world use.
- Guidelines should be reviewed for reasonableness – that is, they must be useful and applicable in most real-world settings, including primary care settings.
- To ensure that existing supplies of vital items like protective masks will not run out, more attention must be paid to the stockpiling of these items, and when to deploy them, plus attention should be paid to other forms of protection such as antivirals to compensate for the real-world limitations of protective equipment.

3. ANTIVIRAL MEDICATIONS

Antiviral medications for prophylaxis

- The federal government should acknowledge that some provincial government antiviral stockpile were utilized for pre-exposure prophylaxis use during the 2009 H1N1 influenza pandemic and should clarify the protective usage of federal/provincial/territorial antiviral stockpiles for first responders and all healthcare workers, (not just those in “closed facilities”), to ensure consistency across the nation depending on the severity of the circulating pandemic strain.
- There is currently no compelling evidence that if correctly implemented, the pre- or post-exposure prophylactic use of antivirals leads to drug resistance. Until and unless this changes, approved antivirals should be seen as an effective protective intervention during an influenza pandemic.

Guidelines for antiviral use

- Recognize that healthcare workers and first responders will be sensitive to the anxieties caused by a new and/or potentially dangerous pandemic strain and require clear guidelines for pre- and post exposure prophylaxis use of antivirals – including the identification of “triggers” which would activate the deployment of antiviral stockpiles for protective use in both circumstances.
- Develop and fund mock exercises to clarify best practices to deploy and replenish antiviral drugs.
- Currently in Canada antiviral drugs are prescribed mostly by a physician. During an influenza pandemic, there should be a mechanism that allows non-MD health practitioners to prescribe them according to practice guidelines.

4. VACCINE DEVELOPMENT AND DELIVERY

Priority groups for vaccination

- Decisions about who should be on the priority list for vaccination against a potentially dangerous new strain of influenza must be established as soon as possible.
- The nature of their jobs places healthcare workers and first responders in a unique position. If they are not immediately protected via vaccination, they are at high risk for catching and spreading influenza to others. High rates of absenteeism will make it difficult to provide service and care to the public. For this reason, both of these types of front-line workers must be routinely included on priority lists for vaccination.

Multi-faceted approach for protection

- A vaccine should play a key role in pandemic preparedness, but it should be promoted realistically and not as a “magic bullet.” Decision-makers must understand the risks of over-promising when they are not fully in control of delivering on those promises.
- A useful plan should incorporate “triggers” which activate those parts of the plan related to vaccination (i.e., when to start vaccinating) and which groups should be given priority.
- Better vaccine distribution systems must be designed and implemented for future outbreaks of viral illness. We should seek advice from experts in managing crowd control, including those outside the healthcare system.

5. COMMUNICATIONS

Coordinated communications strategy

- Create a federal/provincial/territorial body of medical officers and disaster management experts to spearhead a coordinated communications effort.
- Develop some over-arching principles for effective communication with the healthcare and first responder communities, key government and professional stakeholders, the public and the media.
- Let the public and the media know that during the course of a rapidly-changing situation, stories may change and inconsistency should be expected.

Reaching all healthcare workers

- Develop and establish a communications network that addresses the information needs of hospital and non-hospital workers.
- First responders also should be a key target audience for communications.
- Establish one recognized source / body for information.
- Incorporate a “bottom-up” feedback loop in communications plans so those working on the ground have quick and consistent access to decision-makers and spokespersons, enabling those below to “feel listened to” and giving those higher up a reality check about how things are really working.
- Enlist the media and social media as valuable allies. Educate key producers, editors, reporters and bloggers about the need for informed and responsible reporting during a potentially serious pandemic. Find out what they need to carry out their duties and loop this back into the communications plan.



Dr. David Stiff PhD

David is the senior manager of applied research at RiskAnalytica, a multidisciplinary systems analysis firm specializing in risk measurement and management modelling, having conducted over 60 population health and economic studies that have been highly influential in motivating and informing policy change. David has over 10 years of experience in research and numerical modelling. After completing his PhD in computational physics at Queen's University in Kingston, he held a post-doctoral research fellowship at the Max Planck Institute for Nuclear Physics in Germany before returning to Canada to take up his current position at RiskAnalytica.

2009 H1N1 PANDEMIC

Impact of Antivirals and Vaccines

RiskAnalytica's research shows that without the reported use of antivirals and vaccines in 2009, the pandemic could have resulted in nearly:

- 200%** ↑ HOSPITALIZATIONS, EMPLOYEE ABSENTEEISM, AND GDP IMPACTS
- 300%** ↑ HEALTHCARE COSTS, AND DISEASE BURDEN
- 400%** ↑ NUMBER OF DEATHS

Cost Effectiveness of Interventions

Generally, antiviral and vaccine interventions in 2009 were cost-effective when Quality Adjusted Life Years saved (QALYs) are considered in accordance with World Health Organization guidelines.

We estimate that together, antiviral and vaccine use resulted in over:

- **\$100 million saved** in direct health care costs
- **\$1.6 billion saved** in terms of indirect economic production impacts (through avoidance of 6.5 million sick days)
- **27,000 QALYs saved**

*Quality Adjusted Life Years: measure of health outcome that combines effect of intervention on length of life and quality of life.

Recommendations

1. Avoid basing future pandemic plans solely on the 2009 pH1N1 experience

Our concern is that people will normalize their assessments of future pandemic threats against the most recent experience. Our analysis shows that if the severity of pandemic is increased (to resemble the mortality rate seen during the 1957/58 Asian Flu pandemic), and the pandemic response remained the same as last year, a best case scenario estimates that there would have been a >20% increase in absenteeism, at least four times the hospitalization and thirteen times the number of deaths compared to what was experienced last year.

2. Timing is crucial, and practical details to deploy alternate interventions should be thoroughly tested

Our analysis shows that had the pandemic in Canada been a full single wave, possibly due to its arrival in the fall instead of in the spring, a vaccine would not have arrived in time. Current vaccine manufacturing processes and the resultant distribution timelines appear to be insufficient to protect Canadians against the hospitalizations, mortalities and economic disturbances that could accrue from a pandemic with a significant first wave.

3. Any post-pandemic debates should further investigate the role of antivirals and the size of the Canadian stockpile

Our research indicates that Canada could be at risk of running out of its federal and provincial antiviral stockpiles before the end of a significant first pandemic wave, prior to vaccines becoming available. Furthermore, the benefits of widespread antiviral use* are significant in the absence of a vaccine.

*Widespread antiviral-use assumes 50% of those ill seek treatment, and 5% of the population seeks antivirals for post-exposure prophylaxis.

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British Columbia

pH1N1: British Columbia Summary

H1N1 2009 Mild	Attack Rate	Confirmed Hospitalizations	Confirmed Mortalities	QALYs Lost
H1N1 2009: No antivirals or vaccination	24%	1,832	159	3,833
H1N1 2009: Observed antiviral use only	23%	1,714	91	2,541
H1N1 2009: Observed vaccine use only	19%	1,321	112	2,772
Base Fit: H1N1 2009: observed antivirals and vaccine use	16%	1,062 <small>(Actually reported: 1,058)</small>	54 <small>(Actually reported: 55)</small>	1,575

What had happened and what was the significance of pH1N1 intervention for BC?

- Vaccine had some affect on the pandemic process in BC (accelerated fall off from the peak), however, not to the extent shown in other provinces. In terms of saving deaths, antiviral intervention was the more significant intervention.
- Without the reported use of antivirals and vaccine, potential impact could have been:
 - 1.7 times the hospitalization and GDP impacts
 - 2.4 times the healthcare costs and QALYs
 - Almost three times in terms of deaths

Alberta

pH1N1: Alberta Summary

H1N1 2009 Mild	Attack Rate	Confirmed Hospitalizations	Confirmed Mortalities	QALYs Lost
H1N1 2009: No antivirals or vaccination	26%	2,420	220	5,491
H1N1 2009: Observed antiviral use only	25%	2,312	129	3,684
H1N1 2009: Observed vaccine use only	17%	1,526	136	3,488
Base Fit: H1N1 2009: observed antivirals and vaccine use	15%	1,290 <small>(Actually reported: 1,276)</small>	70 <small>(Actually reported: 71)</small>	2,066

What had happened and what was the significance of pH1N1 intervention for Alberta?

- Vaccine had some affect on the pandemic process in Alberta (some reduction of the peak and accelerated fall off from the peak), however, not to the extent shown in other provinces. In terms of saving deaths, antiviral intervention was the more significant intervention.
- Without the reported use of antivirals and vaccine, potential impact could have been:
 - 1.9 times the hospitalization and GDP impacts
 - 2.6 times the healthcare costs and QALYs
 - Three times in terms of deaths

Participating Organizations

Alberta Continuing Care Association
Alberta Health and Wellness
Alberta Health Services
Alberta Union of Provincial Employees
Allen Gray Continuing Care
BC Care Providers Association
BC Professional Fire Fighters Association
CapitalCare
Care Givers Group
CBI Home Health
College & Association of Registered Nurses of Alberta
College of Licensed Practical Nurses of Alberta
Continuing Care Safety Association
Edmonton Police Association
Edmonton Police Services
Excel Society
Extendicare (Canada) Inc.
Global Medical Services and Global Medical Consultants
Health Quality Council of Alberta
Hill & Knowlton
Park Place Seniors – Alberta & British Columbia
Revera Continuing Care
RiskAnalytica
Roche
St. Michael's Health Group
The Good Samaritan Society – Alberta & British Columbia
United Nurses of Alberta
Worksafe BC

H1N1 Roundtable Summary

Planning

There was consensus that in light of 2009 experience, Canada is not very well prepared for a large pandemic - particularly if it started in the fall instead of the spring.

Significant consensus that a more relevant, accurate and adjustable scale to measure the severity of a pandemic in real time is greatly needed.

Front line workers expect their employers to be responsible for their protection during pandemic crisis. Existing collective agreements appeared to be flexible enough to respond to 2009 crisis situation.

Uncertainty remains for some about the actual risk frontline health care workers and emergency responders and what their place in antiviral and vaccine distribution chain they should take. This must be sorted out in-between pandemics instead of during them. - This was a big problem in 2009.

Recognition that stringent rules/guidelines would need to become more adoptable during a crisis. Most agreed allowances for extreme circumstances should be written into regulations in-between pandemics instead of during one.

Vaccine, Antivirals & Medical Equipment

Access to antivirals was important part of reducing 2009 impact – however operational challenges to distribution need to be addressed. Access more difficult in health/home care sector due to exhaustive checklist of requirements and time to get family approval.

Suggestion that government's primary focus should be on early access to antivirals instead of relying on distribution of vaccine to limit impact of future pandemics.

Supply of fitted masks was a significant challenge in 2009. In addition to shortages, there was confusion about how to properly fit masks – which created fear for care staff. Supply companies ran out of stock, organizations were required to re-fit test their employees as there are no standards in mask sizes. Each supplier's masks were slightly different in size. During a large pandemic, there would be no way to provide number of masks required.

Equipment should be stockpiled between pandemics and consideration needs to be given for financial impact on small care providers and organizations regarding the purchasing of this important equipment. Some organizations indicated that they have not the physical capability to stockpile masks in their buildings.

Communication & Role of Government

Concern shared by participants that public may have lost a significant amount of confidence in government and ability of public health officials to respond effectively to pandemic after 2009 experience.

Consensus among participants that communication from health and government agencies was often mixed. Many reported 2009 experiences where health care professionals, doctors and supervisors discouraged immunization and use of antivirals.

Peer pressure was reported as one of the most common reasons why people got vaccinated in 2009. Some seniors care providers gathered staff, patients and families to review information and make collective decision about vaccine and use of antivirals.

Overcoming language barriers was a significant 2009 challenge. Little appears to have been done since around health promotion outreach to multi-cultural communities.

Next Steps

- Meeting summary distributed to participants
- BCCPA and ACCA will review roundtable trends/suggestions and include them in ongoing advocacy with respective provincial governments
- Summary will be forwarded to federal Minister of Health for review/response
- Release of reports on pandemic response from Public Health Agency of Canada and Senate of Canada expected in coming weeks and early in New Year



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