Influenza A (H1N1) Pandemic Plan

Canadian Dental Association

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FOREWORD

Although it is difficult to estimate the impact of a pandemic event, it is recognized there may be significant social and economic disruption, and health care services may be stressed beyond capacity. The magnitude of the disruption and the strain on the health care system will depend on the virulence of the virus, the rate of transmission and the effectiveness of public health measures in prevention and response.[1] Although the focus in this document is the 2009-10 Influenza A (H1N1) pandemic, there are a number of possible "surge" events that have the potential to strain the resources and overwhelm the infrastructure of the healthcare system, ranging from local natural disasters to more widespread terrorism. Planning for pandemics or other catastrophes is vital, so that our disaster response capacity, both as healthcare providers and as small business owners, is maximized.

Between the extremes of panic and complacency
lies the solid ground of vigilance
– Dr. Margaret Chan
Director-General, WHO,
July 2, 2009

This Pandemic Plan provides an overview of pandemic influenza and strategies for dental offices in caring for patients and maintaining business continuity of dental practices. The document also addresses the coordination of communication between the CDA, its provincial/territorial partners, members and other audiences. This guidance should be read in conjunction with relevant provincial and territorial guidance documents.

PANDEMIC PLANNING IN CANADA

Pandemic preparedness has been underway in Canada for at least a decade, with the knowledge that a severe influenza pandemic is a not a matter of if, but when. The Public Health Agency of Canada (PHAC), working with the federal, provincial and territorial governments,

[1] Canadian Pandemic Influenza Plan for the Health Sector (available at http://www.phac-aspc.gc.ca/cpip-pclcpi/)

published the Canadian Pandemic Influenza Plan for the Health Sector in 2004[1], and continues to update it as scientific information evolves.

The impact on health by pandemic influenza has been estimated by PHAC[1]:

- Up to 70 % of the population could become infected, but only between 15 and 35 % of the population will become "clinically ill" – which means ill enough to miss work for at least half a day.
- For a pandemic of mild to moderate severity, if a vaccine and antivirals are not available, up to 50 % of the clinically ill will seek outpatient care, 1 % of the clinically ill will be hospitalized and recover, and 0.4 % of the clinically ill will die.
- Individuals who recover from illness caused by the pandemic strain will no longer be at risk of infection by that strain.
- If the pandemic causes illness in 35 % of the population, businesses should expect up to 25 % of their staff to be away from work in the peak two weeks. Some will be ill, and others will be caring for relatives and friends or afraid to go to work. There may also be school closures and other pandemic-related public health measures that affect the work force.

Modeling available data has yielded Canadian estimates of the use of health care resources by affected patients with various outcomes, as shown in the table below. Further modeling estimates the economic impact (direct and indirect) on Canada's health system alone to be between 10 and 24 billion dollars.

Estimated number of cases by outcome[2]

Outcome	Attack Rate 15%			Attack Rate 35%		
	Mean Number	5th Percentile	95th Percentile	Mean Number	5th Percentile	95th Percentile
Death	17,768	10,544	24,954	41,459	24,603	58,227
Hospitalization	46,639	34,042	59,166	108,824	79,431	138,053
Outpatient Care	2,086,327	2,027,496	2,145,282	4,868,097	4,730,825	5,005,657
Ill, no formal care	2,394,443	2,335,458	2,455,967	5,587,035	5,449,401	5,730,591
TOTAL	4,545,177	4,407,545	4,685,464	10,605,415	10,284,265	10,932,623

Phases of a pandemic

[2] Canadian Pandemic Influenza Plan for the Health Sector (available at http://www.phac-aspc.gc.ca/cpip-pclcpi/)

The World Health Organization (WHO)[3] pandemic influenza plan uses a six-phase approach to describe a pandemic. Phases 1–3 correlate with preparedness, including capacity development and response planning activities, while Phases 4–6 clearly signal the need for response and mitigation efforts. The designation of a phase reflects the spread of the virus, not the severity. In June 2009, WHO declared Phase 6, the Pandemic Phase, for the H1N1-09 influenza virus (also referred to as novel influenza (or nH1N1), indicating that a global pandemic was underway. This is the first declaration of a global influenza pandemic in 41 years: the 1968 "Hong Kong" influenza (H3N2) with one million deaths worlwide, was relatively mild compared to the H1N1 influenza pandemic of 1918, where one third of the world's population was infected and clinically ill, with the number of deaths estimated at 50 to 100 million deaths.[4]

Pandemic influenza, in contrast to seasonal influenza, is characterized by a shift in the virus subtype, shifts of the highest death rates to younger populations, successive pandemic waves which may occur over an 18-month period, higher transmissibility than that of seasonal influenza, and differences in impact in different geographic regions. Historically, successive pandemic waves have been considerably more virulent than the initial wave. In the early summer of 2009, the first wave of H1N1 caused disease of mild severity, in the majority of those affected. Canada is currently preparing for the second wave, expected to hit in the fall of 2009 –as early as September. All provinces continue to monitor the number and severity of cases and remain at high alert for changes.

DENTAL OFFICE STRATEGIES

Strategies for the dental office include those measures to be taken to provide safe and effective care for patients and a safe work environment for staff, as well as processes which can be implemented to minimize, to the extent possible, the impact on the business aspects of the practice.

[3] World Health Organization: Global Alert and Response (available at: http://www.who.int/csr/disease/avian_influenza/phase/en/)

[4] Taubenberger JK, Morens DM. 1918 influenza: the mother of all pandemics. Emerg Infect Dis [serial on the Internet]. 2006 Jan (available at http://www.cdc.gov/ncidod/EID/vol12no01/05-0979.htm)

1. CARING FOR PATIENTS

Influenza is generally a respiratory illness characterized by rapid onset of a range of symptoms, including fever, headache, cough, sore throat and aching muscles and joints. The incubation period for influenza usually ranges from 1 to 3 days. Person-to-person transmission of influenza virus occurs through droplets from the respiratory tract that are spread by direct contact, through coughing or sneezing, or by hands (or other surfaces) contaminated with respiratory secretions. The importance of the airborne route in transmission is unknown. Influenza is highly contagious and can spread quickly in settings where groups of people are gathered together. Although information is evolving, the period of communicability for influenza is believed to be during the 24 hours before the onset of symptoms and during the most symptomatic period, usually 7 days from clinical onset.[5] While viral shedding occurs in the 24 hours prior to symptom onset, transmission of the virus to another person is much more efficient once symptoms are present. In adults, the amount of viral particles shed (e.g. while sneezing or coughing) is related to the severity of illness and temperature elevation. For those receiving antiviral therapy, the duration of viral shedding is likely to be shorter.

Survival of the influenza virus outside the body varies with temperature and humidity. It generally survives 24 to 48 hours on hard, non-porous surfaces; 8 to 12 hours on cloth, paper and tissue; and 5 minutes on hands. Survival of the virus is enhanced under conditions of low humidity and in cold temperatures.

Prevention of influenza spread

During an influenza pandemic, vigilance regarding influenza-like illness (ILI) must be enhanced. Staff and patients should be educated about the symptoms, transmission and prevention of influenza. It should be emphasized that the actions of individuals are the key to spreading the transmission of influenza. Hand sanitizers should be readily available at the entrance to the practice, in the waiting room and at the front desk. Informative brochures should be readily available and signage posted. Downloadable Information Kit and Sheets for Health Professionals are available from the Public Health Agency of Canada and province-specific information is available from provincial and territorial dental associations and colleges.

Educational information provided for staff should include:

- What a pandemic is and that pandemic influenza is a novel strain of influenza
- The difference between an upper respiratory infection and influenza

[5] Public Health Agency of Canada H1N1 Virus (available at: http://www.phac-aspc.gc.ca/alert-alerte/h1n1/faq_rg_h1n1-eng.php#tphp)

- The mode of influenza transmission and the importance of
    - routine practices[6] for all patients,
    - respiratory etiquette
    - strict adherence to hand washing/hand antisepsis
    - frequent disinfection of common surfaces, such as computer keyboards, telephones etc.
- The practice-specific influenza plan, including:
    - Front desk procedures
    - Infection control for infected and non-infected/asymptomatic patients
    - Policies regarding absence from work and the importance of staying home when ill
    - The communication protocol for the office should practice interruption occur *(see Section 2. Business Impact and Continuity)*

Pre-appointment screening

The front office staff is the first vital link in preventing transmission of influenza in the dental office. When calling to book or confirm appointments, patients must be asked about ILI symptoms. If symptoms are reported, the appointment should be rebooked at a later date, when the patient is asymptomatic and has recovered completely.

Initial triage

By the office staff

Upon arrival, patients and accompanying persons should be asked about symptoms of acute respiratory illness. Individuals who report any symptoms should immediately be instructed to:

- use 60-90% alcohol-based hand gel sanitizer
- don a surgical mask, ensuring that the nose and mouth are covered
- be seated at least 2 metres (6 feet) away from others
    - patient should be taken into an operatory, with door kept closed, as soon as possible, for evaluation of influenza symptoms by the dentist

By the dentist

An assessment of the ILI symptoms should be made by the dentist.

- evaluation of patient symptoms that meet the definition for ILI include acute onset of respiratory illness with fever and cough and **one or more of the**

[6] "Routine practices" is the term used by Health Canada to describe basic standards of infection prevention and control. It combines the principles of "universal precautions" and "body substance precautions".

following: sore throat, arthralgia, myalgia, or prostration (with the caveat that young children and elderly may not present with fever)

- patients with ILI should be asked to delay all routine/non urgent dental procedures until their illness is resolved and they are symptom free

Infection control during patient care

Strict adherence to hand hygiene – washing with soap and water or use of a 60-90% alcohol-based gel hand sanitizer – is the cornerstone of infection protection.

Routine practices must be used for all patients, with additional precautions including full personal protection (eye protection, mask, single use gown, gloves) for symptomatic patients.

Non infected/asymptomatic patients

- Routine dental treatment on asymptomatic patients can proceed
- Although viral shedding may occur in the 24 hours prior to symptom onset, transmission of the virus to another person is much more efficient once symptoms are present
- Routine practices should be used as usual for non infected/asymptomatic patients

Patients with ILI or confirmed H1N1

- It is anticipated that relatively few people will need urgent dental treatment within a practice
- Whenever possible, these patients should be scheduled at the end of the day
- Limit the treatment provided to the minimum necessary to address the patient's pain or oral infection
- Minimal staff, essential to the provision of care, should be present in the operatory
- Routine practices, including the use of personal protective equipment (PPE), should be used to carry out a specific examination to determine whether the dental condition can be palliated with measures such as analgesia and/or antibiotics if indicated by the clinical problem; or whether emergency dental care is necessary
- Personal protective equipment should consist of a mask, eye protection, single use gown and non sterile gloves

- Single use gowns should cover unprotected skin and protect soiling of clothing/regular clinic wear. They may be may be disposable or non disposable, but only used within the treatment room and for a single patient
- Special handling of linen or waste contaminated with secretions from patients suspected or confirmed to have influenza is not required
- Standard infection control procedures for disinfection of counter tops and other operatory surfaces and for instrument reprocessing should be followed
- Patient should wear a surgical or procedure mask at all times in the dental office when not actively receiving treatment

Are N-95 masks (respirators) required when treating patients with H1N1 influenza?

- **Recommendations vary among different health authorities**
  - ♦ **WHO and the Public Health Agency of Canada advise that health care workers wear N-95 masks for aerosol generating procedures in patients with suspected (ILI) or confirmed H1N1 influenza**
  - ♦ **The US Centres for Disease Control (CDC) recommends that all health care workers in all settings who are in close contact with individuals with ILI or H1N1 influenza wear an N-95 mask**
- **Recommendations vary among different provincial/territorial health authorities in Canada**
- **National and provincial/territorial occupational health standards require that <u>if N-95 masks are worn, they must be fit tested</u>[7]**

<u>Dentists should follow the advice of their provincial/territorial dental association/college regarding the use of fit tested N-95 masks when treating patients with suspected or confirmed H1N1 influenza</u>

[7] Fit testing procedures and frequency should be in accordance with provincial/territorial occupational health standards or where not specifically designed, at minimum, should follow CSA Z94.4-02:Selection, Use and Care of Respirators. Section 7. Fit Testing. CSA:2002 (Standard is available for purchase from CSA; excerpt available at: http://www.safemanitoba.com/uploads/bulletins/standardcsa_respirator_z94_4_02.pdf)

Need for local collaboration

Arrangements should be in place to ensure that asymptomatic individuals with an urgent dental problem can access appropriate care if their usual dental practice is not able to provide care owing to circumstances, such as illness of the dentist or support staff absences, related to the pandemic.

Individuals with influenza must be able to access emergency dental treatment.

Dentists and support staff who have had H1N1 influenza will be immune to the virus. Those who have had H1N1 vaccine will also have immunity, but this will not be as great as that conferred by a previous H1N1 infection.

In considering whether to treat symptomatic patients with urgent dental needs, it is expected that members of the dental team will put patients' interests first and act to protect them.

Hospital dental departments, where available, will face the same challenges with respect to dental staff illness and absence, as well as the need for their patients of record to access emergency dental care. Furthermore, as happened during the 2003 SARS crisis, all ambulatory care areas within a hospital may be required to close, to improve the overall surge capacity response of the organization.

Dentists have an ethical obligation to ensure that their patients are cared for during a pandemic and should work collaboratively in their local area to ensure access to care for patients and to support their colleagues during this stressful time.

Referral to a hospital dental department may not be feasible in most regions.

2. BUSINESS IMPACT AND CONTINUITY

The primary impact on business, including small businesses such as dental practices, will be on staffing and human resources. The association of Canadian Manufacturers and Exporters (CME) has projected that 15-35% of the workforce may be ill at any one time, with the number increasing to 50% absenteeism during the peak two week period in each pandemic wave.[8] All

[8] Influenza Pandemic: Continuity Planning Guide for Canadian Business (available at http://www.cme-mec.ca/pdf/CME_Pandemic_Guide.pdf)

businesses will be affected, and unlike natural disasters or other surge events, a pandemic will affect all sectors across the country and around the world, restricting the ability to move operations to another area or seek outside assistance. Furthermore, a pandemic will not be a short, solitary episode, but will present in waves, limiting the ability for a recovery phase to begin for some time. The provision of key infrastructure services such as telecommunications, energy supplies, financial services and transportation may be disrupted. The U.S. Congregational Budget Office has estimated that, during a severe pandemic, transportation by air, rail and transit may decline by 67%.[9] Goods, including dental equipment and supplies, usually imported across the Canadian-U.S. border, may be unavailable. Staff absences, patient cancellations, disruption of the supply chain and interruption of banking services will occur if the pandemic is widespread.

Staff absences

It is anticipated that 25-50% of the dental and support staff could be absent from work for up to 2 weeks at the height of a severe pandemic wave, with lower levels of absence for a few weeks either side of the peak. Reasons for staff absence may include:

- Personal illness
- Caring for dependants who are sick
- Child care related to school and daycare closures
- Bereavement
- Transportation disruptions

Employees must be educated about influenza, including signs and symptoms, how it is spread and should be encouraged to receive the influenza vaccine as soon as it is available.

People with influenza are likely to be away from work for up to 2 weeks. To minimize the spread of disease, there should be no pressure or incentive for ill staff to return to work prematurely. Similarly, staff must not be allowed to return to work too early even in the face of personal financial need. The duty of care as an employer includes consideration of risk and safety for employees, as well as patients.

Dentists in each province/territory should consult their provincial/territorial employment standards and legislation, when making decisions related to support staff absences.

[9] The Congress of the United States, Congressional Budget Office, 'A Potential Influenza Pandemic: Possible Macroeconomic Effects and Policy Issues' (available at http://www.cbo.gov/ftpdocs/69xx/doc6946/12-08-BirdFlu.pdf)

Many staff will experience anxiety and fear, and some may experience bereavement and grief. Increased fatigue, conflict with coworkers, worry about the well being of their families and personal financial concerns may be sources of stress and may affect work performance. Staff who are ill may feel abandoned and isolated, and be worried about future employment.

During the pandemic, more lenient office policies in terms of sick time and personal leave should be implemented.

Frequent and open communication with all staff (especially those who are away from work) to impart information and to hear their concerns, is one of the most important things an employer can do.

Maintain a current list of staff contact numbers and home email addresses.

Delegate a staff member and one backup person to take home the next day's patient schedule with contact numbers each evening, in case of multiple cancellations or closure of the practice the following day.

Disruption of the supply chain

The demand for medical/surgical supplies and medications will increase substantially around the world. Local suppliers of dental products and equipment, dental labs and repair personnel may experience difficulties due to their own staff absences and transportation difficulties. Most dental supplies and medications are produced outside of Canada, and there may be barriers which include medication embargoes, cross border issues and transportation disruption.

Critical clinical and office supplies, including those needed for infection control and emergency dental procedures, should be stocked and rotated, according to best estimates of need and shelf life/expiry dates.

Equipment should be well maintained and undergo preventive maintenance procedures.

Financial implications

There will be significant reduction in gross revenues of the practice, due to staff absences and patient cancellations. Accounts receivable may grow significantly during and immediately after the pandemic, as patients struggle with personal and financial issues and discretionary spending may be lower for some time. Fixed costs, including staff salaries and wages, rent, leasing, payments to suppliers, loan repayments and taxes will remain static. Supply shortages may lead to short term price increases. Credit may be in short supply as all business sectors are affected. Employee absenteeism will affect all sectors including banks, and it may be difficult for employees to readily access bank accounts. Payment in cash during the emergency, if feasible, may be very helpful for your staff.

Pandemic Outbreak insurance, to offset income loss during a pandemic, is offered as part of the TripleGuard™ insurance package by the Canadian Dentists' Insurance Program,[10] administered by CDSPI. The plan automatically provides up to $1,000 per day after the first 24 hours up to a $20,000 aggregate annual limit. Increased dollar coverage is available for additional premiums.

Pandemic outbreak insurance provides coverage if "you are prohibited from entering your office by an order from a civil authority or public health official." – TripleGuard™ Insurance Plan brochure

PROFESSIONAL RESPONSIBILITY TO THE PUBLIC

As healthcare professionals, dentists must act ethically in this difficult situation. It is the professional duty of all dentists to put patients' interest first, while taking into account your own personal health and safety and that of your staff.

The healthcare system may be overwhelmed with a shortage of trained medical staff due to illness. There will be a need for people with health care training to deal with increased demand in the health system. In addition, volunteers will be needed to assist in many roles. Dentists may be called upon to provide care and assistance in a number of domains.

[10] CDSPI TripleGuard™ (available at http://www.cdspi.com/html_eng/ins_plan_triple_2b8.html)

If you are asked to do something outside your normal area of practice, be sure that you are competent for the task , working within current regulations with respect to regulated scope of practice. Also, be sure to check that you are covered by indemnity.

Remember that scope of practice alone does not qualify a dentist to perform certain care activities. Equally important is demonstrated competency. Competencies are defined as the skill, knowledge and judgment required to deliver a particular health service. A competency-based approach in pandemic planning identifies the competencies necessary and the competencies available to deliver the services that people need during an influenza pandemic. Taking guidance from the Canadian Pandemic Influenza Plan for the Health Sector, many provincial/territorial pandemic plans have determined the competencies needed to provide care and support during a pandemic.

Dentists who are asked to work outside their usual area of practice, should seek guidance from their regulatory body to :

- **ensure that the activities are within the regulated scope of practice in the jurisdiction in which they are licensed and practicing; AND**
- **that they are competent to perform those activities by virtue of appropriate training and recent experience.**

Even when influenza care competencies are not controlled acts, they may require a certain level of education, training and judgment to be done effectively.

COORDINATION OF COMMUNICATION

Communication planning is an essential part of any emergency preparedness plan. In accordance with the Canadian and provincial/territorial pandemic plans, the CDA recognizes the importance of a unified approach, with distinct roles and responsibilities specified for different authorities. In the event of a pandemic, the World Health Organization establishes and disseminates the phase of global pandemic alert level; the Government of Canada coordinates nationwide implementation of the Canadian Pandemic Influenza Plan, while provincial/territorial governments respond by initiating their own plans and mobilizing local resources. Regional health authorities also play an integral role in ensuring that national and provincial/territorial plans are followed at the local level. Following a similar logical progression, the CDA will respond to governmental authorities and act in coordination with corporate members to gather and disseminate pertinent information and resources.

The overall objectives of communication planning during a pandemic are to[11]:

- **Create a strong communications network**
- **Define clear roles and responsibilities**
- **Define a variety of communications options, strategies, methods and tools**
- **Develop consistent, coordinated messages**

Purpose of the CDA communication plan

The purpose of the Communications Plan is to establish a transparent and inclusive framework, through collaboration with CDA corporate members, and:

- To provide coordinated, reliable, consistent, and effective messaging to the dental profession and the public;
- To respond to new information and emerging issues rapidly; and,
- To demonstrate accountability during and after the pandemic, by reviewing, evaluating and improving communications and responsiveness of CDA during a crisis and communicate these "lessons learned" to corporate members and others

CDA will also share information contained in the CDA Pandemic Influenza Plan with interested audiences via the CDA website.

Key communication activities

This CDA pandemic communication plan provides procedures for the co-ordination of communication within the CDA, with corporate and individual members, and between the CDA and other agencies. This plan addresses internal (not public), and external (public) communication and is aligned with the pandemic response plan. Relevant stakeholders and resources include, but are not limited to other national and international dental organizations such as FDI and the American Dental Association (ADA); Health Canada (HC) and the Public Health Agency of Canada (PHAC); the CDRAF; Canadian faculties of dentistry; Canadian specialty organizations; the Dental Industry Association of Canada (DIAC); and other professional health care associations.

[11] Canadian Pandemic Influenza Plan for the Health Sector (available at http://www.phac-aspc.gc.ca/cpip-pclcpi/)

The following **key communications activities** are outlined below:

1. Gathering information
2. Assessing and synthesizing information
3. Disseminating information
4. Evaluating communication and responsiveness

Gathering, assessing and disseminating information will be an ongoing and dynamic process, with information flowing to, from and among multiple stakeholders. As a priority, the role of the CDA communications staff is to gather all of the available facts from **reliable** sources including the Public Health Agency of Canada, Health Canada, corporate members, and CDA's network of contacts in other dental organizations, the dental industry, and scientific/clinical/academic experts. News media will also be scanned for relevant information.

CDA will assess and synthesize information from all sources and disseminate it in collaboration with corporate members.

Coordination of activities

The **CDA Emergency Response Team (CDA ERT)**, in addition to the meetings of the leadership through the **Dental Issues Group (DIG),** will be mobilized to carry out the mandate of the CDA during a pandemic and will be responsible for coordination of CDA's response in providing support to members and the Canadian health care system. The **ERT** will be formed by the Director of Public Affairs or by the designated person carrying out their responsibilities if the Director is not available. In order to provide meaningful communication, the **CDA ERT** will:

- Determine a schedule of internal meetings
- Receive daily or more frequent briefings from communications staff with respect to important updates. These updates may include:
    - new items posted on the PHAC, FluWatch and Health Canada websites
    - enquiries received from corporate and individual members, and others
    - traffic on the pandemic site of the CDA website
    - relevant media reports
    - media requests and identified potential spokespersons
- Participate in daily teleconferences with the PHAC
- Liaise with Health Canada through the Office of the Chief Dental Officer
- Liaise with other dental organizations (FDI, ADA and others) on an ad hoc basis
- Coordinate daily conference calls with corporate members (CM to specify who will take part in the conference calls)
- Seek input from clinical and scientific experts as needed
- Determine, in conjunction with corporate members, the daily messaging to the profession, who will deliver it, and the mechanisms to be used

Communications tactics

A pandemic section on the website will be the primary method of disseminating information about the pandemic. It will contain the Pandemic Plan, useful resources such as checklists and downloadable signage, as well as daily updates on new information from WHO, PHAC and other relevant and reliable sources.

CDA Alerts (or another mechanism agreed to by individual corporate members) will be used for rapid broadcast of critical information.

JCDA will be used to convey information of a less urgent nature, where a broad audience is the intended target.

Upon careful consideration and planning, media may be used to inform the public about CDA's pandemic plan and how dentists will ensure patient safety throughout the pandemic. Key media spokespeople, including backup, and their availability need to be identified (CDA President is the primary media spokesperson for the CDA). Key media messaging will be shared with corporate members for use locally if desired.

Given that

- **the provision of health care is a provincial/territorial responsibility and**
- **the prevalence/severity of the pandemic will vary across the country**

dentists should consult their provincial/territorial dental associations, colleges and other provincial/territorial authorities frequently for updates, and follow their guidance and advice.

Serving accountability

Following the Severe Acute Respiratory Syndrome (SARS) outbreak in 2003, Health Canada established the National Advisory Committee on SARS and Public Health[12] to assess the lessons learned from that crisis. Key findings of the review were that responses to the crisis were seriously confounded and limited by the lack of jurisdictional clarity about roles and responsibilities and there was a need for organizations to be seen to be active in supporting their constituencies.

[12] Health Canada. Learning from SARS – Renewal of Public Health in Canada. 2003 (available at http://www.phac-aspc.gc.ca/publicat/sars-sras/naylor/)

Communication lessons that were learned from the SARS crisis highlight the importance of continued monitoring and evaluation of communication strategies.[13] Throughout the pandemic phases, coordinated communication is required between the CDA, corporate members, dentists and the public at large, and ongoing evaluation should be carried out so that potential communication gaps can be addressed and improved upon in a timely manner.

Following the pandemic, evaluation of communication efficiency and effectiveness should be undertaken with specific stakeholder groups, including both corporate and individual members, using a variety of mechanisms. Information should be specifically solicited regarding the strengths and weaknesses associated with the response to the pandemic and steps needed to improve future communication.

Input from corporate members should be obtained in a debriefing teleconference, structured written or online surveys and individual interviews. These evaluations should be designed to assess:

- the perceived clarity of roles and responsibilities
- the clarity, consistency and timeliness of communication
- responsiveness by CDA to information requests
- the availability of CDA staff and knowledge of the designation of appropriate backup person(s) should the most responsible CDA staff member(s) be absent due to personal or family illness
- mechanism for communication with corporate members – for example, usefulness, length and frequency of teleconferences
- gaps in the overall pandemic plan

Input from individual members, via a CDA web-based survey, should evaluate the accessibility, clarity, consistency, timeliness and general adequacy of communication from CDA and corporate members; usefulness of information on the CDA website; responsiveness by CDA for assistance; and gaps in the overall pandemic plan.

Data analysis should be undertaken to assess the volume of pandemic related calls to CDA from dentists and the public, as well as the number of hits to the pandemic section of the CDA website.

[13] Health Canada. Learning from SARS – Renewal of Public Health in Canada. Chapter 8B.5: Communications Structures and Processes (available at: http://www.phac-aspc.gc.ca/publicat/sars-sras/naylor/8-eng.php#fn1)

"The [National Advisory] Committee [on SARS and Public Health] emphasizes that in drawing lessons from the SARS outbreak, our intent has been not to 'name, shame, and blame' individuals, but rather to move and improve systems that were suboptimal."[14]

It is in this spirit that open and transparent evaluation of the performance of communications to, from and between CDA and its partners, will be done. Information from the evaluations of current strategies and their effectiveness will be shared with corporate members. The CDA will use a collaborative approach to update and modify the communications plan, and the overall pandemic plan, as required.

[14] Health Canada. Learning from SARS – Renewal of Public Health in Canada. 2003 (available at http://www.phac-aspc.gc.ca/publicat/sars-sras/naylor/)