TOWN HALL SUMMARY

May 19, 2020

This is a summary of today's Town Hall. Full dialogue via audio links are throughout the document.

SPEAKERS (in order of speaking):

- Victoria Schmid, ED Quality, Safety & Improvement
- Kathy MacNeil, President & CEO
- Dr. Richard Stanwick, Chief Medical Health Officer
- Marko Peljhan, ED, Portfolio 4, Sooke Region, West Shore and Urban Greater Victoria
- Dr. Ben Williams, Interim VP Medicine, Quality & Academic Affairs
- Kent Flint, Director, HR Client Services and Organizational Development

INTRO/GENERAL UPDATES:

V. Schmid – Welcome and introductions.

Kathy MacNeil – Lead in: Traditional acknowledgement and recognition of Speech Pathology Month and Physiotherapy Month.

Here at Island Health, we are busy implementing our restart plan, and in our context that means we're restarting clinical services with the parameters in place for safe hospitals, clinics and care environments as specified in the WorksafeBC guidelines. In those guidelines, there is a pyramid of protection and the most impactful measure of protection we can take is physical distancing. It goes from physical distancing to administrative controls (i.e. policies, work-at-home, etc.) and moves into physical engineering (i.e. plexiglass, space design), and the final protective step is the use of PPE. So, just to remind us all there are multiple steps that we can put in place to protect ourselves from the COVID-19 virus.

Marko's going to talk a little about our specifics around our plans this week around surgery, diagnostics and ambulatory care. But I'll just mention it takes almost nothing for us to come back to volumes. And I noticed today as I walked through the hallways past the lab, we have people lining up along the hallway. So we're going to have to work on that because that's not what WorksafeBC has in mind when they talk about a safe work environment. Today our occupancy rate is at 86%, and I know that our minister and the ministry have been very deliberate in watching hospital occupancy as we start to ramp up these services and they will be setting some targets for us as health authorities around hospital occupancy to ensure that we maintain safety.

Initiatives like hospital at home are really important for us to be able to have alternative locations to provide acute care for medicine patients – you'll hear more about that in coming weeks. Just to say there are some initiatives that will be really important for us to take to almost advanced quickly. So that we can get out ahead of that occupancy stress.

Last week we talked about the plans for the Summit and so it's exciting to say that the residents from Oak Bay Lodge and Mt. Tolmie Hospital are actively planning for the move into their new home on July 10-12. I know the residents, families and staff have been very much looking forward to that and we are as well. As many of you know, when the public health emergency was called, we put some blunt instruments in place around changes to our visitor policy and parking policy, and we are now working through what bringing those back to a new normal might look like in the context of COVID-19. We're doing that in concert with our other provincial partners. You may have heard Dr. Henry speak to the plans to look at long-term care visitor policy into next month. We're also looking at and engaging our patient advisory council around what a visitor policy resumption might look like. And so those are two big pieces of work that it's important for us around the patient and staff experience.

Just a reminder on parking - now that our services are coming back to a new normal we have more patients coming on site. Please leave space for them in our parking lots because it's important that we don't contribute to the anxiety of having to come into an environment at this time.

Richard Stanwick – From a public health perspective, as we've heard from Dr. Henry, there are some things that are definitely going to be happening this week and some they're going to be held off to the future - and one of them being in terms of long-term care visitors. To answer a question in advance, it likely won't be until June before we adjust the pattern we have now of allowing visitors back into our long-term care facilities. This is an area where the greatest risk still exists, and an area that the province still wants to go slowly. We want to see how the rest of society copes as we move forward first.

WorksafeBC has produced guidelines for how we can more safely move forward. We have to assess the risks and then work with staff and others find ways to mitigate it, put policies in place and then of course, importantly communicate exactly what those are. One of the things that has come up and, and gotten asked a number of times at the weekend, how is this process going to work? Well, these policies and guidelines will be operationalized within businesses - following the checklists. Businesses will be responsible for monitoring and fine tuning them, but it'll be WorksafeBC and to a lesser extent environmental health. We'll be out in the field checking on those policies to see that not only did the businesses live up to the spirit of it, but also whether they achieved what they were trying to accomplish in terms of creating that physical distancing. So there will be an opportunity for people, if they spot something that they feel is not in the best interest of the public or that their workers are being put at risk, they will be able to complain to both WorkSafeBC and to our environmental health office in Island Health. The good news though is that these guidelines exist. There were many businesses that voluntarily closed and they're opening up now. Construction continued, forestry continued, there were a variety of takeout services within restaurants, there were opportunities where businesses could have stayed open and some voluntarily closed. In phase 2 you are going to see personal service establishments, K-12, a whole raft of businesses which will be in fact slowly ramping up. A lot of people were really hopeful that this would happen within the first couple of days, but people are looking at what these guidelines are and consulting with their employees. That this is a collaborative effort because WorkSafeBC's primary responsibility is for the employee. We want to keep the gains that we

realize. Businesses also want to make sure that people feel comfortable coming back to their businesses. But I think everybody's excited about the fact that there will be some degree of return to normality. Restaurants will certainly look different than pre pandemic period. In terms of supporting our businesses, please, if you can, start engaging in and fostering our local business.

Marko Peljhan – I'm going to be focusing the report out today on our resuming of elective procedures, in particular diagnostics and endoscopic surgery and ambulatory procedures. Our focus continues to be on those individuals who have a wait time significantly over benchmark and we're continuing to prioritize urgent and emergent cases as we bring on electives. While we work towards a 100% ramp up, where we're not quite there yet and don't anticipate we will be over the next couple of two weeks due to safety measures, such as reduced slates and the precautions that we're taking both pre, peri and postoperative care to ensure physical distancing and enhance cleaning protocols. I mentioned last week, that we canceled just over 4,000 surgical procedures and we are calling every one of those individuals to ensure that they want to proceed with their surgery at their earliest opportunity or if they wish to postpone or if they wish to be removed from the waitlist. As of this morning, we've completed 1700 of those 4,000 calls and we anticipate completion through this week, those calls are also occurring seven days a week. Regarding postponed ambulatory procedures - we are not calling every one of those patients due to the sheer volume, but we are working with our physicians in outpatient and clinic areas to reschedule those patients as soon as possible.

In many of our areas, we can see much of a slowdown. We just saw a physical slowdown while we had a virtual ramp up. In many of our areas, we're looking at how to maintain that mix of physical and virtual visits, and working with our outpatient areas and physician leads within each of those departments. For surgical, ambulatory and diagnostic patients, we have enhanced screening protocols in place, so as we're checking in with them we're booking appointments the asking screening questions to expedite the testing that's required for those individuals. We want to continue to maintain physical distancing and for patients and for our families, we are looking at some virtual options items like talk to texts. We are hoping in the coming days and weeks, to initiate some technology that supports families and caregivers and loved ones to stay connected to the family while they're in having elective procedure and ability to connect and contact them. So hopefully by next week we'll have more information on how we're rolling that out for you. We've seen an increase in our ambassador volumes this morning. So I want to thank each one of our ambassadors – and know that some changes to our visitor restrictions maybe forthcoming in the coming days and weeks. That's a space that we're going to be watching very closely ensuring that our ambassadors have all that they require and need to practice in a safe and respectful work environment.

Our testing and assessment centers are still testing around 200 or so per day. We're really not seeing any new cases in the community and our hospital hospitalization of COVID is very stable with really no change in the last couple of weeks. In the coming weeks we'll be looking at just how we continue with assessment centers and what that means for that is continue to look at those Geo by Geo basis.

Ben Williams – This week we're going to start welcoming many more patients and some of our staff back to our site. It's really important that we all recognize when we do that, our first priority is safety. And as we implement safety protocols, calling patients and screening them before they come in, and having the ambassadors continue with their role, we'll probably get some lineups in that process, extra cleaning between patients. We will have bumps along that road and it will make us slower than we normally are. And some of the work that we're doing is really effective and some that's not effective and we need to change. I think it's important as we enter these next few weeks to expect that it's not always going to be perfect and that our patients sometimes are going to tell us – or our staff are going to tell us – that we don't have it right, and that's okay. We're going to move slowly and diligently and we'll change our attack as we need to, to provide the services our patients rely on but in a very safe way.

We also have partners in the community – primary care, community physio, chiropractics, etc. WorkSafeBC will ensure consistency in how that's done, but it's also all going to be a little bit different and it's going to make it a little bit messy for the patient journey. I think we're all used to how it worked: people would leave the ED and follow up with primary care or their PT, etc. That world's going to look different now and it's going to be a little bit confusing for all of us. And I don't really think there's anyone in our team that hasn't been affected. It's the moment in healthcare leadership and the moment and providing care, whether you're in a hospital or in your community or you're in a physical therapy office, right now we're all changing how we work.

QUESTIONS & ANSWERS

We are unable to socially distance in our office due to the set up (close desks, charts, narrow halls) and are not wearing masks. Will this be reviewed?

Ben Williams – So our job right now is to keep each other safe. The first way we keep each other safe is through physical distance. The second way we keep each other safe is through administrative practices. So we put practices in place to try to make it easier to physically distance and then we just slightly less effective things that we can do. We also have physical barriers for work areas where that works. If we can't do any of those things, if we have to be at work and we be 2M apart, and we can't have a barrier between us, then wearing a mask is the way we protect each other. So it's not the most important thing, but it is an important tool in our arsenal.

VCH partners with local bike shops for price reduction on E-bikes & payroll deductions schemes. Safer travel for transit users, will Island Health do the same?

James Hanson – This is a great idea, so we'll look into it. We don't currently have plans to do this, and I don't think anybody on the team was looking specifically at e-bikes, but it's something that we'll explore.

Will there be consideration to continue to allow remote working arrangements for those who have lost childcare and full time school? *AND* **The school districts have announced "rotating school days" June1 what are full time employees supposed to do for childcare, since the SD is full time presently?**

Kent Flint – Several non-clinical individuals who were in traditional office environments were sent home or sent to remote work locations, and there have been questions about how long that will continue. I just want to reassure people that our goal is to keep each other safe. And for those of you that have been working from home or working remotely we're not in a rush to bring people back to their traditional office environments. In offices, we're looking at implementing factors tied to physical distancing and other best practice approaches to safety. We formed a task force that is comprised of people from different corporate support departments that are really looking at putting in place proper supports for leaders and departments so that we can come up with the best solutions for people coming back to the office when that's appropriate. But for the time being, continue working in the same workspace that we have been for the last few months.

Re: childcare – daycares and childcare environments are endeavoring to stay open, re-open, or expand their availability. I encourage people to reach out to their childcare provider in their community. With just over a month remaining in the school year, employees need to be looking at continuing with arrangements for childcare as they typically would have put in place over the summer break. There are some great links in the HR FAQ, siblings to childcare referral centers and ministry supports resources.

How could Island health get the message out to the public that frequent hand washing is better than wearing gloves?

Richard Stanwick – It's cheaper, from a very practical perspective. In fact gloves give you the same vulnerability as they can easily become contaminated. And probably one of the worst things that people have observed is that once people have gloves on, they forget and touch their face. So in some ways gloves are almost an impediment to the type of hygiene that we want to see practiced. There are certain circumstances where people (general public) should wear gloves, but those are few and far between. The best thing is to have their bottle of sanitizer and a bar of soap. And we'll also pass that to our communications team to make sure we're actively sharing that message with the broader public.

We would have laughed a year ago at people wearing handmade fabric masks in public and now that is what we're asking people to do in certain circumstances. What's the research that supports the messaging?

Richard Stanwick – The issue with these cloth and handmade masks is that they're not medical grade. What they can do is provide some protection, not for you but from you. And so, by and large, people wearing masks are actually doing their civic duty by keeping the secretion to themselves. Those masks need to be cleaned regularly and make sure they're dry. Once that mask is wet or soiled, it's time for a change. Only a dry cloth mask is keeping secretions in.

We keep hearing information about secondary side effects like strokes, inflammatory disease, et cetera. Can you speak to that?

Richard Stanwick – This virus is really running the gamut in terms of the consequences that it can cause the general population. At first we saw it largely as a virus that was respiratory in nature and it could affect the GI tract. It shouldn't surprise us that we're also finding out it can trigger certain aspects of the clotting system and creating a situation where people are at increased risk of conditions like stroke. There's also the phenomena that kids are seeing in terms of that inflammatory disease of the blood vessels. As a pediatrician, I remember treating kids with Kawasaki disease, which is very similar in terms of presentation. So given that this virus is exposed to the entire world, there's going to be people with genetic or different complications that are well outside the mainstream because of the mass exposure. We're actually getting to see all of the mischief this virus can cause. And it's not a surprise, it's a bit of a

We hear that you are learning more about the virus, as time passes, what current research are you using to base your plan on going forward?

Richard Stanwick – The best sources of research is with the BC Centre for disease control and the Public Health Agency of Canada. The CDC does provide good information – it's their president's interpretation that the problem. What people have to realize is that there is a deluge of research. Some of it is good quality, some of it hasn't even been peer reviewed. What one should do is count on the people who are experts at synthesizing these, like Cochrane reviews. There's always the hope that that one paper out of some obscure location has come up with something that should make us do things totally different.

One of the things that was a conscious decision on the part of BCCDC is we do not follow one offs. So if you get a report in on a great cure that somebody has found, we would not follow it without a rigorous scientific approach. A lot of these papers bring forward exciting ideas, but as we know in medicine, a lot of exciting ideas never pan out when subjected to the scientific approach.

Are Island Health COVID survivors still being monitored in case of reinfection? Of 86 NYC residents infected with COVID, 12 tested positive for same bug again.

Richard Stanwick – The criteria Vancouver Coastal were going to use to clear these leads were ones that involved travel – they wanted 2 negative swabs. They gave up after a number of months with a couple of individuals because they still were able to detect the virus. And so the real question is, if you follow these people serially, is it that they never stopped shedding the virus - and that this is not a reinfection but merely a continuation of shedding the virus? The impression is that those individuals are not producing enough virus or that the virus is viable to cause infection in others. Some people argue that there may be the opportunity that people have been infected and then get re-exposed, that the virus has the ability to actually propagate a little bit in this person. But again, it appears that they are not able to transmit the virus to others. So, once you have beaten the virus off for the first time, now how long that immunity lasts because it's such a recent infection? We don't know. Here's some new evidence to

throw out there - somebody has finally been doing some serology in the United States on a population that would be best described to street involvement. We talk about herd immunity and of the people that were tested, less than 5% actually showed evidence of having the antibody. So the real question is, was this population just not infected? The obligation we have in terms of communicating with our staff and the public is what our current state of knowledge is. And it involves every day when you go into your listservs, if you go to BCCDC website, there's something new there for you.

What is being done to test community to see quickly that numbers are increasing? AND **How quickly will we be able to ramp down if our numbers start to increase? Our most at risk HCW's are being left with very little protection.**

Richard Stanwick – This will be driven by serology over several months to learn what our population is about, what proportion of our population has acquired the virus. And the other critical piece is what sort of surveillance and testing we are going to have to ramp up so that we can have that early detection of the virus. And then using it to identify individuals and their contacts and put them into isolation. So these will be our primary tools in keeping those numbers down. In terms of what the tipping point is – I think a lot of that will be determined by BCCDC. My hope is we don't find out the way we traditionally know when the flu has arrived, which is by our first long-term care outbreak. We do not want to see that with this particular virus knowing how deadly it is.

I am 65 & must work & use local transit. Buses do not ensure physical distancing/restrict # of riders. Why is transit not ensuring essential worker safety?

Richard Stanwick – Transit continued to operate throughout, but on a reduced schedule and with significantly fewer riders. This is going to be a challenge that transit is facing, including the increased cleaning of the buses (meaning some buses out of circulation), and how they're going to set up the seating on the buses. The frustration that you've likely heard is of people left standing at the bus stop. The question is how they are going to handle increased ridership as we have more and more people using that means of getting them to work. People may have to look at this idea of staggered work hours – especially if school hours are going to be staggered. This is going to be a very significant component as we promote something other than the automobile.

I heard the outbreak in Abbotsford was amongst staff congregating at shift change, will our HA be looking at these factors?

Marko Peljhan – The key principle that we're employing here is physical distancing. And while it's imperative that we have that exchange of information during a shift change, and morning reports and huddles, we need to be doing that in an area that maintains confidentiality and has enough space for physical distancing. So we need to look on a unit by unit level to ensure that we have enough space to congregate. In smaller areas where it's not possible to get that distance, staff need to wear masks. It's

imperative that staff have the information and equipment you need to work in your clinical areas, and most importantly, that you feel safe. If any one of those are challenged, we want to hear about that.

HR FAQ says children with flu-like illness should be insolating at home for 10 days. How will staff/parents be compensated? What type of leave is this?

Kent Flint – In keeping with our organizational direction, outside of COVID, parents can access available leave banks such as vacation or banked overtime.

The full list of questions and answers will be available here at the end of each week.