TOWN HALL SUMMARY

April 28, 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, Geo 4, EOC Lead
- Dawn Nedzelski, Chief Nursing Officer & Chief Professional Practice
- Dr. Ben Williams, Interim VP, Medicine, Quality & Academic Affairs
- James Hanson, VP Operations & Support Services

INTRO/GENERAL UPDATES:

V. Schmid – Welcome.

Kathy MacNeil – *Territorial acknowledgement*. I want to give some high-level comments on where we are in our journey. What we at Island health have seen, is our ability to innovate and implement change very quickly when our patients and our communities need it. I think that is something we should be proud of and should hold up in this period of time. Sometimes, we've been seen to be difficult to change our systems and somewhat risk adverse around changing, and well, necessity has forced us to embrace some of this in a much more rapid way. Part of what's enabled some of that change has been the preparation that we've undertaken, the response activities across the lines of portfolios and structures. So the magic has happened when people have come together across the organization, not necessarily through chains of command or the stove pipes of the organizational structure, but when we actually reached out - that's when the real magic and innovation has taken place.

As we move forward in our new way we're going to have to continue that kind of work because that's how we know we can make changes happen. I know many of you have been watching how our hospitals have been functioning – our ED admissions and the utilization of our hospital services has quieted down even beyond the reduction of surgical volumes. I just want to call out that that wouldn't have been possible unless teams in the community had come together in new ways with primary care, with home and community care, using technology working with emergency department staff. That is a real nexus of a new way - the 'back door of our community - that becomes a new way of us moving forward. There you have patients who have paid the price in terms of their own suffering with pain and waiting for surgical care during this period of time. So, we are responsibly starting to do that work around planning or what a surgical volumes might look like in this COVID world - where we need to maintain physical distancing and universal precautions around PPE, and we need to maintain a new way of remote

working. Given our new parameters, what does surgery look like inside that context? There's active conversations happening about that with Michael Marchbank, the former CEO of Frasier health.

There are some things that we've learned about gaps that we've had in our system. Many of you probably already saw them, based on where you work and how you serve. But at the system level they've been highlighted. One of them has been in our vulnerable populations of homeless people. A virus like COVID-19 really has identified the risk that people live in who don't have secure housing. And we've often divided accountabilities. That's a housing problem or that's a social development problem, that's a health problem. The truth is it's all of our problem. That is how the work that's being undertaken by our MHSU team, working collaboratively with BC Housing and municipalities to find stable housing for people who are living at risk. It's new work for us. It's a new demand and it's not likely to go away when surgery ramps up or when we get back into more hospital-based services.

The other thing we've seen over this time has been the difference it makes when we have a robust public health service model and approaches. We've been so lucky here in BC to have a very robust team of public health advisors and owe it to them to ensure the resources to be able to run this long race of COVID-19. Many of you have seen the impact of virtual care and you're working with virtual care tools that you haven't necessarily used before. This time you have a patient portal system software, patients have now access to their own information. They can be full participants and architects of their care pathways. And we have the electronic health record, which has enabled information to be ready in real-time for patients who might've had to move sites or be relocated for care. That's such a huge advantage for us. Hard wiring these in these technological innovations into our care delivery model is the work for us to do now across all of the sectors.

The other thing the pandemic has highlighted is the vulnerability of frail elderly people, especially in long-term care. Again, knocking on wood, we've been so lucky at Island Health in the long-term care population that we serve. Unfortunately other jurisdiction haven't had that good fortune, and we know that the work going forward from here is to continue to support people to live safely and ensure we minimize the risks to them by bringing together primary care services so they can receive care in their homes. Some of this shouldn't be news to you. We've talked about this as we developed our strategic framework for 2025. Many of these innovations were conceived and they still ring true. So the good news is this warp speed incorporating these new ways of working actually puts us in a good place. In terms of achieving our strategies moving forward. And my hope is that we can use the work that's ahead of us over the next now weeks into months to continue that journey even further.

I'll just close with acknowledging that today is the National Day of Mourning - a day across the country where we recognize those who have been injured or lost their lives at work. Those tragic losses at work impact us and they stay with us much like when we lose members of our family or members in our community. I'll just share a personal story. I worked with a former leader in another jurisdiction and I can remember the day that he got the phone call that his brother had been killed at work. It sent a ripple throughout our whole team. His brother was a foreman in a highway construction site and a car was going too fast in a construction zone and hit him and he and another person on the team were

killed. Thankfully those things don't happen often, but when they do, they stay with us. Safety is the ultimate must-have in our workplace. Whether it's in healthcare or construction, we have to remember that if we don't have safe work environments for ourselves, we can't give safe care to patients.

R. Stanwick – Before I commence, I just wanted to say that planning is going on with Dr. Henry in terms of how we work our way out of this COVID crisis. The way in which the measures were put in was very, very quick. Unfortunately, teasing our way out of it, so that we don't bring the virus back, is going to take time. When Dr. Henry keeps telling us to remain calm and be patient, those are very powerful words. That's what we're going to be asking of you as we slowly move forward and reduce some of the restrictions and look at what we can open up safely and do it in a fashion that has the least unintended consequences on the population.

In terms of recurrence status, we do have a number of clusters on the Island. One in particular involving a population on Cormorant Island, and the community has been notified first that 26 cases in total have tested positive. The good news is that 12 of these individuals have recovered - very much the typical picture in BC where the vast majority of people do well. But, it also reminds us that we are always susceptible to the introduction of this particular virus. Travel within Canada is not prohibited but some people do travel for work and the circumstances are such that we have imported an outbreak from another province. It speaks to what happens when you confine people, whether it's in correction facilities, work camps, immigrant workers. When you gather people close together, there's always the risk of the spread of the virus. We have to continue to behave like it is with us all of the time, you don't let your guard down. That is one of the lessons of moving forward from the second outbreak that when we're closer to the people we are familiar with, that's when we tend to let our guard down.

I referenced serology in the past and there was a question about this in the material today. It is going to be critical for us to understand how the virus has been circulating within our community and serology will help us be way more definitive. Doing a mass screening is a much more effective way of understanding how the virus has spread.

There's another question about relapse. It seems that some people may get the condition a second time, that there's a lapse of time between people having the disease and then seemingly they are found to have the virus again. We don't know if those people truly are re-infected and whether they basically can communicate the disease. We continue to learn about this particular virus and every time one opens up medical journals or list-serves we find something new (i.e. its impacts on kidney disease or large vessel thrombosis in young people, neurological issues). So, we need to be patient.

E. Bjarnason – We have a lot of response occurring. Our underserved population portfolio is working tirelessly across the Island in relation to housing the underserved, protecting them from COVID, protecting the populations they live in from an outbreak. In long-term care, we've moved along with how staff were coming in/out and there's a lot of work happening there. I'm really thankful for the work that Mark Blandford and Dr. Fyfe have been leading, and how we've had such an excellent track record.

We have five cases in our hospitals right now, one in critical care - so we're trending down in critical care numbers. We may have more cases in the future, but overall our hospital cases and our number of deaths shows us that we have some stability on Vancouver Island.

Our hospital capacity is there, so we need to be doing the right thing for the population and ensuring that people are getting the access that they need to health services. We also need to be a COVID-aware health system. We've got to work towards a new normal where we keep the virus at bay, but we care for those who need care. As we move forward. We are going to need to really identify what the new normal standards are for acute care. We also want to support what we've learned over the last few months, which is that we can provide a lot of care in the community as well. So really what we're doing right now is working towards that identifying what that new normal should needs to be for our hospitals. We will restart an increased volume of surgeries and diagnostics when the time is right and when the medical health officer and the minister of health indicate that. But we are working behind the scenes getting ready for that. We live in a COVID-aware health system and we need to really look at how we work with some of the inefficiencies that we may have in place in order to respond - whether that's around O.R. protocols or long-term care access protocols.

J. Hanson – In response to the question about opening up surgeries when there's a shortage of N95's – I can say the ministry is well aware that we are considering N95's in our modeling when it comes to ramping up surgery. There are two streams to that discussion – clinical and logistical/supply chain.

PHSA has done a really good job recently of securing more 3m masks than we've seen in the past. So they are working on solidifying our supply chain in an environment that is globally strained right now. They've done a really good job recently securing more product and bringing down the noise. The other thing I'd say is that our clinicians are really stepping into the space of reusable PPE, and as we ramp up our surgeries and considering bringing more services on board, I think this is really important. We're seeing utilization of half shield respirators and products that we've not utilized before. That will absolutely decrease a requirement for the single use N95 masks.

E. Barnason – There were a couple of the other questions around access to services. When will fertility services start again – or screening mammography? We are looking at core emergent services right now. We'll wait and see what comes up in the next week or so. Those other services are all being considered, but I haven't heard any specific plans on either of those yet. Some other jurisdictions have come out with a levels of response. I think we can expect something similar to come out.

B. Williams – I want to touch on our state in our acute care facilities in particular, although in some ways it applies to primary care too and the incredible access that we have. We do not have to go back to the days where our hospitals were overcrowded, where nurses and other members of the team had to work overtime all the time, where we didn't have enough colleagues to provide the support our patients needed, where there were patients in our hallways. We do not have to go back to those days, but it's going to have to be very intentional on our part not to go there. Over the summer, as our burden of

disease with COVID gets lighter, we'll probably slip back into the kind of practice patterns that we used to have. Right now we have this amazing opportunity where our community has come together to avoid being in hospital and our staff and medical staff are supporting patients to be treated at home. If we can keep that mindset of 'where is the best place to treat our patients,' then we don't have to go back to those days. We don't have to go back to days where patients had to wait two or three hours to get seen in our EDs. That system is up to us and it's up to our community – it's what we provide outside of our EDs in patient homes, in our partnership with primary care so that patients can get the care they need without having to come in.

It's also up to us how we want to continue being with one another. So this regular pattern of communication where we come together weekly like this, or where we get updates regularly from our CEO, where our medical staff and our medical leaders come together a couple of times a week from across our health authority to talk about issues that are important to us. We might not need to keep up that cadence, but we're the bosses of how we choose to stay connected. I hope that we maintain this, not just through COVID, but as our new way of being in this healthcare system.

Dr. Stanwick mentioned the cluster of Cormorant Island cases. It's really important for all of us to know that we're not the leaders in this. We are really proud of how that community is coming together and we are supporting it, but it's the Namgis First Nation and the village of Alert Bay who have come together to provide an exceptional community response. We are incredibly proud to participate and we've really done our best to help out with extra staff, extra positions, whatever resources that we can bring to help out, but we take the lead from the community in terms of what's needed.

And lastly, today I want to talk about what the next 12 to 18 months is going to be. And I really want to say is it's not going back to normal. Thankfully, the number of COVID outbreaks on Vancouver Island have not been significant. And so as there's pressure to open up, to go back to the way things used to be. If we don't physically distance and if we don't hand-wash and we don't model those activities for our communities, then any one of those clusters can lead to what we've seen in New York or Italy. It's up to us occupying this place of privilege and healthcare to model those behaviors. And as society understandably, bangs that drum to go back to normal, it's up to us to say it can't be the new normal and we need to continue to do what Dr Stanwick and Dr. Henry call us to do, especially physical distancing, washing our hands and never going out when we're sick.

QUESTIONS & ANSWERS:

When all of this begins to ease, are we still going to be working remotely until there's a vaccination made readily available for all workers?

S. Torgerson – At the beginning of this, to keep people safe, we kind of did a blunt instrument and said everybody go home, work remotely and we backfilled the technology to support that. Now that we're in this place to bring people back, we are going to have a much more thoughtful process. HR right now is in

the process of setting up a framework in which to have leader/staff conversations about who remains remote, who comes back and how we can bring people back and still follow the principles of physical distancing. It will be a very local response - so there might be a combination of that. Stay tuned.

I know for some of you, working remotely has worked out really well and been very productive and enjoyable. For others it has come with some distress or stress. I would like to remind you that we have supports for employees and I encourage you to use them if you need them. Stay well.

Provinces are giving employees danger pay, why aren't we?

S. Torgerson – I would say that the key word here is province. And so this is a provincial decision and a conversation at a provincial table. But what I can say, I will bring that forward in the provincial forums that I am part of.

How can we counter false narratives like the virus is a hoax? I'm seeing many people saying this.

R. Stanwick – When you have a crisis like this, there's always the thinking that it's a conspiracy to ruin our economy or that these are just evil forces out to vaccinate everyone. What people have to do is find their sources of truth and stick with them. Unfortunately, in some instances, prominent people in leadership positions advocating bogus solutions, but this is not a time for frivolity around the management of treatment. In BC, we've been very fortunate having Dr. Henry and Minister Dix conveying messages that people need to follow to keep themselves well. I know in one of the MLA town halls there were questions about alternative therapies. We're still learning, but to-date we have not found an effective medical therapy. Unfortunately, there are instances where people are spending hard earned dollars to go after certain therapies. The other thing to consider is that individuals are identifying themselves as healthcare professionals and there are scams going on. In these cases, if you are contacted by Island health or any other group, and you're not certain that they are real, hang up and give us a call. Please be not only a voice of truth, but also a voice of reason in terms of therapy, and a voice of caution in terms of people trying to take advantage of the vulnerable at this time.

Can you reiterate the science around immunity and relapse?

R. Stanwick – We are still learning about immunity and COVID-19. We have seen instances in China, South Korea and Singapore where people seemingly re-acquire the disease months after having a confirmed case. There again, we're not sure whether these individuals are seeing a recurrence or reinfection. We have lots of learning to do. If you want to keep current with this, go to BCCDC to find good information in quality journals like JAMA and others.

Is parking is going back into effect on May 1st?

J. Hanson - We will be taking our direction on parking from the Ministry of Health, as it was their decision to stop parking fees across the province. We don't have any notice right now about when they will reboot parking fees, but when we do, we will share that with all staff. In the interim, I just have to

thank everybody for parking in appropriate spots. As we begin to see more clients and visitors to our sites, it will be very important that we leave those visitor spots open.

How many tests does Island Health do a day? What is our testing strategy?

E. Bjarnason – Last week, our testing criteria was updated provincially. This happens about every couple of weeks and that's because our strategies around 'why' we test changes. The first reason we test is because we want to support people to know if they're positive, but we're widening that testing strategy to get a broader range of symptomology and really get a better sense of the greater population. So we've doubled our testing last week when that new criteria came into place. So we're typically in the 450 to 500 range per day – and it can range on weekends to anywhere from 300 to 500 tests a day.

The testing criteria was quite specific and for a fever over 38 degrees Celsius – and cough and shortness of breath. It's now much broader for milder or symptoms both respiratory and gastrointestinal. So even with that broader criteria and our testing going up, our positive rate is still a low number, so that's a positive sign for Vancouver Island.

Should visitors who are unable to self distance from staff and, or patients be wearing masks to protect staff and patients from themselves?

E. Bjarnason – Good question. I think an example would be in perinatal or labor delivery, but there's a number of areas where that could be true. The answer is, if anyone is unable to self distance because of the physical environment and the nature of their visit, then they should wear a mask.

PPE communications have been a bumpy road – and sometimes conflicting. How do we know where the real communication on PPE is?

V. Schmid – Thanks to everyone for their patience. PPE is a very important part of how we stay safe and how we keep our patients safe in this type of environment. The approach that we've been taking is to align to a provincial approach, so that as health authorities, we are thinking and acting as one. As we've moved in that direction, we weren't always in lock step with each other here, and there were corrections that needed to happen. Part of that is the disease burden that we're working in is not always the same as our health authority counterparts. So, there has been some correcting along the way, resulting in lots of different messages around PPE.

The point of truth is always our Intranet site, which has the latest PPE information up on it. And that is current as to this minute, but may change in an hour, so please check there with your questions. If you do have questions and you're not getting clarity, reach out to your leader and seek that clarity.

What stage are we at in the PPE framework?

V. Schmid – Provincially there's a five-stage PPE framework: stage one is where we have a plethora of PPE and stage five is where we've run out of various items on that inventory list. We're currently in stage

four. We've been working through conservation methods and that's really helped to shape what we're doing around PPE usage. Island Health's supply chain is still a little bit lumpy in places, and it'll take a while to re-establish a really consistent supply chain, but there is much innovation in that space and I anticipate a lot of Canadian producers will step in for us in the future. So thank you for your continuing patients with PPE.

How are we putting public donations of PPE to use?

J. Hanson – There is much innovation and donations occurring by community members. We have received tens of thousands of surgical masks, thousands N95s and industrial-grade masks from suppliers like Home Depot. We've had individuals reach out and collaborations with schools like UVIC and Camosun College and some industrial partners in the plastic industry. There is a process provincially where all of our equipment is managed and assessed to determine whether or not it's a medical grade and whether or not can be distributed in our supply chain for our clinical teams.

Last week we moved the products we received from UVIC, Camosun and others right into the system, so clinical folks across the Island will start seeing that product in their supply chain. Surgical masks and other donations – if they fail our clinical trials it doesn't mean that they can't be utilized in community settings as protective masks to solve transmission and other settings (i.e. grocery stores). So it's been an incredible local and provincial response. We've seen unprecedented donations in this regard and we are working to get what's appropriate into the system. Just to be clear, we will not supply a product into our regular clinical domain until we have utilized our regular supply and approved the product. We will be in a position where we're utilizing different equipment, such as: laser cut shields, eye protection, N95 masks or the Cera industrial mask. You'll see these on units and that shouldn't alarm anybody. That is a reality of the supply chain that we're all working within as a province and all of those products will have been approved by Health Canada and the provincial OHS teams working behind the scenes to make sure you're safe. So if you see something different, it means it's been through a rigorous process to get to the shelf that you're utilizing your problem.

Will the restrictions on visitors to LTC facilities be lifted with precautions such as masks put in place anytime soon before a vaccine is available?

R. Stanwick – This is the very question we were pondering last night with Dr. Henry. Long-term care is one of the most vulnerable of all populations and the measures that we put in place on the Island have kept the virus out of our facilities. That certainly comes with a price and we recognize that restricting visitors is having unintended consequences for families. The lack of stimulation on cognitive decline is real and is being considered at the provincial level so that we are consistent.

One of the things we hope to do is look at creative ways of doing things like allowing a single individual from a family to be named and provided with PPE that they would have to bring with them each time they visited and made sure they wore it while they were visiting with those individuals. We are trying to be flexible and figure out how we can accomplish the continued visitation of people with loved ones, but

at the same time not end up having to deal with an outbreak where we could end up locking the place down and losing residents to that virus. It's a high priority and we recognize it's a population that benefit significantly from visitors.

When we come up with a vaccine for this, will it be an annual vaccine and will we require people to have the vaccine to come to work?

R. Stanwick - We need to have a vaccine to gauge the current strain and frequency with which you need to be immunized. We may need one or two vaccinations to get the proper levels of immunity. And in terms of having this vaccine at work? Well, if you're serologically immune to it, then it doesn't really make sense to get a vaccine against a disease that you're not going to spread. So this is going to create some very interesting challenges to intelligently use the vaccine on the populations that are still susceptible. And the frequency will be yet to be determined. It's another 'stay tuned' answer as we need to get a vaccine that works first.

Note: remaining questions will be answered in an FAQ – and shared at the end of the week.