TRANSCRIPT: MHSU TOWN HALL – APRIL 3, 2020

Nick Cherwinski (Moderator): Good afternoon, everyone. My name is Nick Cherwinski, I'm coming to you from Professional Practice, and I'm a friend of Portfolio M. It is my pleasure to serve as moderator today for this virtual Town Hall. I'll ask for our hosts, Drs. Hasselback and Crow, as well as Keva Glynn, to [begin].

Dr. Paul Hasselback (Medical Health Officer): Good afternoon. I'm privileged and honoured to work and live in the traditional territories of the Snaw'naw'as First Nation, and I'd also like to bring greetings to you from the whole of the Medical Health Officer group who have been working diligently to try to protect all residents in the Island area over this unique and unprecedented event associated with the COVID-19 virus. I also want to extend our thanks for the work that everyone has done, both in terms of supporting patients and clients through these very challenging times, many of whom are not receiving a level of service that they may have in the past, are struggling with the angst and the anxieties of the general population's concerns about COVID, as well.

I also want to extend my thanks for everyone on the island, and that includes health care workers and those that are attending this Town Hall, in practicing and in modeling those best activities of really good hygiene, handwashing, and social distancing. Our efforts are making a difference. I need to commend and almost celebrate how much of a difference it has made. Transmission of COVID-19 is at the moment fairly limited, and case counts are growing at a rate that is slower than our neighbours off the island, even here in British Columbia—and certainly, if we look as a province, we are doing better than many of our neighbours, particularly to the south of us.

Outbreaks are a dynamic, changing event. In the early phases, the approach is often to rapid identification, containment, identifying cases, tracing their contacts, managing aggressively. Then we move into this mid-outbreak, where the control mechanisms may focus on other aspects, which engage the whole of the potentially infected population, such as this social distancing and reinforcement of good hygiene. In the later phases, we may revert to some of those efforts to identify cases and to contain it as quickly as [possible] well.

So what we may recommend and do on one day, sometimes may appear very different a week later. It's the dynamic nature of managing the outbreak and minimizing the tragic outcomes that may occur. As a province and as an organization, Island Health, the response has been phenomenal. We were at the confluence of disease coming from Asia, Europe, and the United States. Our colleagues in the Lower Mainland are currently overwhelmed in having to respond

to the impact in the population in that area. Here on the island, our efforts of prevention and early control have been fortuitously beneficial.

It is way too early to celebrate, and we absolutely need to maintain our efforts—likely, at least through April, and potentially even longer. We also need to be asking the questions, as some of you have, about how do we sustain the services that are so needed by our clients … particularly those who have chronic illnesses?

From my heart, my sincere thanks to you and your teams. I know Keva Glynn will speak more specifically in response within MHSU, and our efforts to support those with less resources, including the underhoused. And Richard Crow will address some of the specific concerns being raised within MHSU teams. Maybe I can pass it to Keva to share her gratitude as well.

Keva Glynn (Executive Director, MHSU, PH, CYF): Thank you, Paul. So this is Keva Glynn speaking, I'm the executive director for Mental Health and Substance Use, Public Health, and Child and Youth Strategy. I'm really pleased to have the opportunity today [to] hear your questions. I've seen a lot of good questions coming in. Before we get into all of that, I want to also express my gratitude and my thanks to each of you for your resilience, for your willingness in this time of incredible uncertainty to step up and support our clients and each other, and for showing up to work each day. I've had a chance to speak to some of you who are providing direct care, and I just want to say how impressed I am and how proud I am to be part of a team that is continuing to provide care for some of our most vulnerable, in a very difficult time.

I'm going to ask Richard if he can also say a few words before we launch in.

Dr. Richard Crow (Executive Medical Director, MHSU, PH, CYF): Good afternoon. I'm Dr. Richard Crow, and I'm the executive medical director for the Portfolio that Keva and I co-lead, and that has Mental Health and Substance Use, Public Health, and Child Youth Strategy. And those are island-wide programs. I would like to just reiterate and thank everyone who is attending today, and more broadly, the staff and physicians who are providing services during this very challenging time. It's really quite an extraordinary team that we have, and many things have occurred in the last few weeks—extraordinary work that is being done in planning and also providing ongoing services during this pandemic. So my heartfelt thanks for all of your work.

Nick Cherwinski: For those that are dialed in and are looking at slides from a PDF slide deck, we have an agenda set—to the best of our ability—of what we will be covering today. A couple things for logistics that you all need to know: while you're listening in, you won't be able to unmute, so please remember to use Slido as the way by which to add 'likes' to a question that you agree with, or questions you would like to pose.

As moderator, I've given the panelists the option to respond in a couple of ways: one, to the best of their ability, with the known information that they currently have; and two, to be able to take a question away for further investigation and respond at a later time. What that means is we are recording, and we will be providing a transcript that will be posted on the main COVID Island Health page for folks to be able to look at that transcript later.

One other thing I want you to be aware of is that we will not be able to answer every single question in Slido. What we will do is we will be guided and influenced by those questions, because they're excellent questions, and we want to be able to learn from everyone that's participating in this. You will have an influential voice. All of our panelists are watching the questions and are being guided by your concerns, so thank you.

I'm going to pass back to Keva to give a brief update on each of the workstreams, and then we're going to get into the rest of the questions and answers.

Keva Glynn: Thanks, Nick. Okay, so if you look on your slide deck, Slide 5 gives an overview—a diagram—of how our workstream is set up. And just to position our workstream relative to all the other workstreams that are happening under the Incident Management Structure (IMS), this is but one of about ten workstreams. Our area of focus includes mental health and substance use (MHSU), acute and community; and the underserved, which we are mostly defining as unhoused, but it also includes other vulnerable populations like immigrants and refugees.

So within this piece of work, there are a number of envelopes or packets of work, which you'll see are described in that diagram on Slide 5. I [won't] go into a lot of detail here, because I've seen through Slido that you have particular questions, and we want to make sure that we have time to get into those. But this is more to orient you to the overall scope of work that's happening. So under local community initiatives, which we're also calling the unhoused or unstably housed, there's quite a bit of work around identifying shelters and housing opportunities to support social distancing, as well as facilities or sites in the event that we do have COVID-positive individuals, and they could be supported and cared for there, as well as contained, in terms of isolating the transmission of disease.

We're also looking at how we provide health assessments and screening, what that looks like in different communities; harm reduction services; quite a bit of work with our contracted agencies, addressing their particular challenges and issues; as well as work with our municipal partners and BC Housing. So that is a substantial piece of work, and fairly complicated, with many different partners—and going well, in general. Jacqueline Mackinnon is leading that overall workstream, and then we have local leads within each of the communities, who are

doing that partnering work and really sorting out the challenging operational questions on the ground.

Another stream I wanted to reference—and we have Dr. Crow and Dr. Hasselback here, who can answer more questions around this—but in terms of our work with physicians and physician engagement, we have physician leads engaged in all of our workstreams, and they've been contributing to the site plans and contingency planning for the sites. I wanted to particularly name Dr. Chris Blashko and Dr. Wei Song, who have been very active, as well as regionally, Dr. Natasha Frolic and Dr. Joris Wiggers, who are really taking a lead in our communities as well.

In terms of the community planning for the underserved, our addictions medicine colleagues, Dr. Ramm Hering, Dr. Anne Nguyen, and Dr. Roger Walmsley have all been stepping up. And everyone else, too, but I know that it's been an additional amount of work, particularly for them.

So this morning, we sent out information about how we can expedite contracts for new and expanded clinical services related to COVID. And Janine Gowans is your contact person in the event that you want to follow up with her on that. We also sent a link to a tracking tool, which is one place to go and one place to enter information—and that's where you would put your time that you're spending on COVID planning. And that is also connected with Janine; there's a checkbox survey that she has sent out. Finally, virtual care within acute care, that's been worked on, and I think I saw a few questions about that within Slido.

On the residential side, there are lots of questions about PPE (personal protective equipment), and particularly how our contracted providers can access [PPE]. We're doing a fair bit of work on that, and Matt Herman and Lauren Fox are leading that work. [There are] also questions about food security and grocery delivery, how that's panning out. I think there's more we need to dig into there. As well, I wanted to just acknowledge—and in the community, especially—the staff who have put their hands up to be reassigned, to do different duties, and how incredibly helpful that is. I know it's an additional challenge within your everyday work to take on something new, and [I] really appreciate those who have put up their hands and volunteered. It's incredibly helpful for us and for our clients.

Child, Youth, and Family is also a component of this. Tanis Evans and Dr. Carol-Ann Saari and others have done work around identifying Jack Ledger House as a contingency plan within COVID. We've been working on that idea within different contexts for many years, and so it's incredible work, I think. A great demonstration of flexibility for that to come about in this time.

And then finally, I'll just touch on Communication and Engagement. We want to ensure that you as our teams are getting the information that you need, and that we're also hearing from you what the issues are, so this is one way that we can do it, and [we're] certainly open to other ways, other ideas that you might have.

Nick Cherwinski: Thank you, Keva. So, before the Town Hall started, we had two main themes that we wanted to ensure we communicated about and provided responses to. You may hear some answers to your questions on Slido, as some of the responses are going to be [comprehensive] enough to respond to that.

To start, though, one of our first main themes we wanted to ensure that we had commentary and response on was an overview of the PPE dialogue and key messages [related to it]. For that, I'm going to ask Dr. Richard Crow, as well as Julie Marriott, to start us off. Another piece of information for everyone on the call to be aware of is that while Keva, Richard, and Paul are the hosts, we actually have panelists from all of the directors for Child and Youth, we have Lisa Murphy and Kelly Reid, and of course Tanis Evans, and Tara Fitzgerald all dialed in. And so they're also going to be able to respond to questions as we move through the remaining 45 minutes or so.

Dr. Richard Crow: Thank you, Nick. And just before I start, specifically about PPE, I wanted to just comment on how positive it's been to collaboratively work with my co-leads, both Keva and Paul, and throughout our response to this pandemic, we are seeing such collaboration between our administrative leads and staff and physicians. We're all in this together, and it's fantastic to see this. So I just wanted to add that as a general comment on the work that's been occurring.

In terms of PPE, it is one of the areas that is actively discussed on a daily basis. And certainly the executive EOC dealing with the pandemic is fielding many questions about this and responding to them. And there will be updates, because this is an area that is also constantly changing. So I will mention our source of truth is to go to our COVID Response Intranet page, and then also, there's a Medical Staff site. Because of the changes that are occurring, it's really key to keep up to date by looking at both, because we can't just communicate out every day or two, other than through that mechanism. So please do look at that.

So PPE is a very high priority for Island Health. And it's actually essential for a pandemic response plan. You've likely heard lots in the media about the supply, and currently we have it, but the question is how [long] will that supply last? Just as important as the supply is our utilization of PPE. It is incredibly important that we follow best practice. And that will enable a much better supply, if we're using it appropriately. So really looking at both of those factors will be key. It is intended that we follow best practice in all of our sites—so hospitals, long-term

care facilities, and community settings—and that we conserve the [supply we have], again, use it appropriately in all of those settings.

I do want to acknowledge that within MHSU, we do have high-risk populations. And we do need that protection for our providers and staff as support people—in terms of people who have direct care responsibilities. So that is escalated in comments when we report out to the executive. We do emphasize that: the needs of MHSU is a key priority.

So in the process of using PPE, an absolutely key and essential concept is that you need point-of-care risk assessments in order to determine whether you need PPE. And that really is key. And there are outliers in terms of how to do that. Perhaps we will comment on it briefly, as well. But you need that assessment. And that will determine your PPE. And then if yes, if your exposure is such that you need it, then you would do droplet precautions by donning the PPE. There's a specific area, and that's if you're doing aerosol-generating medical procedures, that you actually need that N-95 mask. And I've seen a lot about N-95 masks and what is appropriate. But that is needed for aerosol-generating medical procedures where a surgical mask is usual with your droplet precautions.

There's also quite a bit of information on how to conserve PPE and make it more appropriate. And at our link that I keep mentioning, our COVID Response webpage, there is a link that will give you the details. I'm not going to run through them right now. But the key, I think, is to look at that. There are details on how to put on and off your PPE, et cetera. So please look at that, and it is a constantly changing situation. Currently, again, we have the PPE for clinically-appropriate use, and we will continue to distribute it. But let's preserve it and make sure we're using it appropriately.

Julie, if you have a few comments.

Julie Marriott (Infection Control): Hi everyone, my name is Julie Marriott. I'm one of the infection control practitioners across the island. I would just like to say that, addressing the question of a point-of-care risk assessment, this is likely something you're doing without even thinking about it. Every practitioner does it with every single encounter you have with a client, resident, patient. It's really thinking, 'what am I going to do with this person, how close am I going to get to this person, and what is the risk that they have something that they can transmit that I need to protect myself [from]?' So those are the questions you should ask yourself.

I'd recommend asking those questions when you're able to continue to have your social distance—more than six feet, or two metres. And if you need to go into that closer distance, and there is a concern that they are symptomatic, or you're unable to tell if they're

symptomatic, there is a high risk that you will be in close contact with that person, resident, client, then that is the time to decide whether you need to don your PPE.

When we're talking about conserving PPE, you may have seen some messages around continuing to wear your mask in between different client or patient interactions. That is one way that we can conserve PPE. It's important to know that does not translate to a gown or gloves. The best thing that you can do to prevent spread of any respiratory droplet type of infection is good hand hygiene. So wash your hands often with soap and water, or if you have access to alcohol-based hand rubs, or what we call hand sanitizer, that is going to be one of the most important protections for yourself and for everyone else.

There are infection control practitioners across the island who are willing and ready to help you if you have specific questions. We've tried to put as many resources up on our COVID page as we can. But if you know of one in your area, reach out, if you have specific questions around an area that you're working in. And we'll be here to help guide you.

Nick Cherwinski: Thank you both. I have some Slido questions as follow-up for folks to have their voices heard. A question in particular, a very specific question: what are the criteria/precautions for face-to-face assessments of MHSU patients who have urgent mental health needs but can't use video? Is a phone call adequate?

Dr. Richard Crow: It is a challenge to determine those exact criteria. I haven't seen them, but we will certainly try to address it as clearly as possible. There are certainly patients, and Dr. Song has made this very clear, that virtual care will not always work. In-person, face-to-face [care] is needed with some patients, particularly if they're dysregulated, psychosis, et cetera. There may be a clear need, that it isn't always virtual care. Not all of that has been worked out in detail, and I know that they are looking at it, particularly within our emergency psychiatric services. And so we'll get back to you in terms of if they're establishing the more specific [criteria]. It is sometimes a clinical judgment, but again, there are not going to be sort of blanket, 'everything is virtual'—although we're shifting to [virtual] when possible.

Nick Cherwinski: Dr. Crow, I have a follow-up question from Slido which says, can health care workers use masks at work at their discretion, even if they are not providing direct care? Are reusable or autoclaved masks something we can use?

Dr. Richard Crow: This also has been a bit of a controversial area. We're seeing different comments in terms of… what we want to know is that the use of the mask is actually protective to the individuals. And so again, we would use the [point-of-care] assessment in terms of whether you need appropriate PPE. The issue of wearing masks other than for that purpose is controversial. There has been the view that you may be carrying [the virus], and you'd

contaminate yourself if you've got a mask on. Masks do help for symptomatic patients, in that it will decrease the exposure [unintelligible] … but I think this probably relates more to that staff. Actually, I'll ask Julie as well to comment on the utilization of those masks. But it is something being updated and reviewed constantly. But in terms of the formal assessment, please follow what we were just saying, in terms of the risk assessment [for] whether you need PPE.

Julie Marriott: I know that for some people, it feels like you're keeping yourself safe if you're just wearing a mask around all the time. It is really important that it doesn't give you a false sense of security, for a couple of reasons: you still want to really get ingrained into your practice that you're doing that point-of-care risk assessment every time. So while it may be that you're going around, thinking, 'okay, I've got this mask on, I'm protected,' and you're not really paying attention to the assessment of the client that you're going to interact with. That should be the first thing on your mind before you put your PPE on: what is my risk assessment?

The other thing about wearing a mask around all the time is, it's really important to remember that piece of PPE is contaminated. And so many people touch their face without realizing—I'm a face-toucher myself; I'll rub my eyes, touch my face—if you have that mask on, and you're touching that mask, you're adjusting it, pulling it down under your chin to get a drink of water, putting it back up, you've just contaminated your hands now. And your hands are what you go around and touch the environment with. So it gives you this false sense of security. Those are the two things that I would say about wearing a mask around all the time.

Nick Cherwinski: Thank you, both. So, to get into other questions, I'm going to move this along to virtual care. And so on virtual care, there are several key messages. Both our speakers, both of our respondents, Dr. Crow, and of course, Monica Flexhaug, do have information, and they will do their best to respond to as many of the Slido questions regarding remote care as they possibly can. We're bucketing virtual care into also some of the questions around working from home. So we're hoping that our respondents will be able to respond to dozens of similar questions within their responses to, and comments on, the topic of virtual care.

Dr. Richard Crow: Thank you. So virtual care, again, is a very hot topic that is discussed at the executive level, as we will continue to have further directions regarding this. But there is absolutely this shift to using virtual care for care delivery whenever possible. This is a new type of service, and so it's being deployed currently, but as you can imagine, there's a huge ask for many, many different areas to deploy resources to enable virtual care.

Island Health has a particular platform that they are using and they've been planning to have this roll out over time, but now, everything has accelerated. It's called MyVirtualVisit, and it's a new toolset that enables e-visits from any location and device. Island Health is wanting to see

this used, and ambulatory services, community services, primary care, and urgent care are just some of the examples of where we're rolling this out.

Requests will be prioritized, and the IM/IT team is going through that prioritization. I did want this group to know that MHSU is one of the priority areas in terms of this deployment of virtual care. And that will include things like webcams, mics, and the platform that is needed. However, the full deployment isn't there yet, and many of you are wanting to see this happen as fast as possible. Hopefully, [there's] at least an understanding that it can't be deployed everywhere as quickly as we would like. So pending the ability and the whole deployment of MyVirtualVisit, there are alternatives and existing tools that can be used. The IM/IT team is working—actually, even meeting today with Monica Flexhaug and Dr. Song—in terms of looking at, again, some of the enablement of other devices. These tools include, of course, the traditional telephone. A great deal of our services can actually occur by phone as well. Skype and FaceTime [as well]. Zoom is one that we're trying to answer questions on, and it is able to be used. WhatsApp and Facebook are not recommended for security reasons.

I'll ask Monica, if she wants to detail [more]. We have sent out already information on virtual care. Again, I keep mentioning our source of truth, we'll still need to go back to the COVID webpage and the Medical Staff webpage. The Medical Staff webpage has quite a bit on virtual care, as well. So please, do look at those sources, and we'll be sending out updated information specific to our workstream.

Monica Flexhaug (Director, Special Projects, MHSU): Hello everyone, I'm working with a great project team to try and move this work forward for Portfolio M. I absolutely want to acknowledge all of the eagerness to continue providing care during this time, and your desire to find alternative mechanisms. I also want to further Dr. Crow's comments about the prioritization. We've been working with our virtual care team for over a year now, and that partnership has allowed us to move this work forward with MyVirtualVisit from a fast-tracked perpective. We recognize that for you providing care, it may not feel fast-tracked. But we are making some significant progress, which I'll tell you about in a moment.

I do also want to acknowledge that some of you are trying to use very public technology, some of which will work, some of which will not. Even some of the challenges that we're having with Zoom, for example—within Island Health, given that we're focused on MyVirtualVisit, there is not technical support to go toward trying to use [Zoom]. So we've heard you, we've heard your experiences around that and your frustration, but that is one of the challenges of using public systems when we're trying to focus into a platform that can be used throughout the organization and throughout our sites.

We have organized the work on the MyVirtualVisit platform into two streams: one for acute, and we have a small working group and project manager for the virtual team helping us to identify what will make best sense within our acute sites, including our psychiatric emergency services, acknowledging that we cannot go completely virtual. Interactive care is still likely going to be needed. So that process of determining from a clinical perspective when it's appropriate to use virtual technology or not, as Dr. Crow has mentioned, will come down to some focal decision-making.

The second stream is our community services. And we are doing this work from a program perspective, not an individual perspective. So I know many of you have reached out to IM/IT, to Dr. Song, to myself, asking to be put on the list, and we've captured that information. The most effective way to roll this out is by program, where we can create virtual waiting rooms that, then, you are assigned to.

So we do have a number of program areas that are already underway. A couple will be operational, I understand, early next week—including Victoria USTAT, VMHC, Brooks Landing, and we are uploading individuals in Campbell River MHSU and Port Alberni. This is not the fulsome list. And if your team has not been contacted yet by Judy Gerrand, or someone from IM/IT, please do talk to your coordinator and/or manager. We would like to coordinate the receipt of interest to be on the list and activated through some central resources, rather than ping-ponging around the organization.

And I do want to mention that we have had one physician already online doing her care through MyVirtualVisit. So we're getting there quickly. Finally on this, I do want to acknowledge that Child, Youth, Family is also part of that process, and Acute. We've had a few different questions there.

To support this changed practice, there is also guidance on the Island Health website around how to conduct care from home. We really encourage you to keep in mind some of the security [considerations] of providing home-based care, including your own privacy, as well as the client that you're working with. We've had some development of a virtual care module to support clinicians in understanding how to change their practice over virtual platforms, and we will be updating that earlier notice we sent around March 20th early next week, with more up-to-date links and information about the various strategies that are underway. Thank you.

Nick Cherwinski: Thank you, Monica, and thank you, Richard. I understand that one of our other panelists is likely to jump in now as well to add to the response.

Lisa Murphy (Director of Operations, MHSU, Central/North Island): I think it's me, Nick. Can I just add a quick comment? Just really appreciate all the work on the virtual strategies, of

course. Just want to add that the other kind of balancing conversation in all of this is how we support teams and team-based care, so that becomes an element in the conversations, too.

Nick Cherwinski: Thank you, Lisa. I would like to pose a question regarding some conflicting messaging coming from a variety of different channels with regards to working from home versus working from the actual location. Some units are being asked to still come in, and some units are being permitted to work from home. I'd like to open it up to any of the panelists that feel they're able to respond to that question.

Dr. Richard Crow: Yes, I think what's important is [that] although we're wanting to shift to virtual care whenever possible, our patient/client population needs access to our services still. So we're generally, in each community, having at least one location that is open, that is staffed—but that there would be a navigator at the front to screen them. But that if there are individuals who do need that face-to-face contact, that there are services available, or that they get a way of connecting. And our services, they may be phone calls, or there may be an enablement of some of the virtual care with video.

But what we want to ensure is that at least in each community, there is an access point, so that those who truly need more urgent service provision [can get it], or those that don't know at least what the other options are, so that they can go to a site and learn that. So staff will be asked to be manning some of our services to enable that access. I don't know if our directors want to comment beyond that, but that's sort of a higher-level understanding that some services will still be needed. It can't all be virtual. Face-to-face is still needed.

Nick Cherwinski: Thanks, Dr. Crow. I have Jennifer Nadiger, who's a manager from our HR client services who'd like to add just a little bit more on that.

Jennifer Nadiger (Human Resources): Thanks, Nick. So just to add from our perspective, of course, the determination of how much work from home can happen, or whether a work-from-home arrangement is even applicable, does truly rely [on] the operations to determine what the care needs are, and what the business needs are. I just wanted to put that in there. And what was just described is very accurate, because there's a lot of factors that come into play when assessing that need.

Nick Cherwinski: Thank you, Jennifer. Do we have any other comments from any of our other panelists? Lisa Murphy, do you have any comments with regards to some of the ethical implications of working in this scenario? I know you've been doing some reflecting on a recent publication that was posted in the CEO/CMHO daily memo.

Lisa Murphy: Yeah. We meet every morning at 8:30 – coordinators and managers and physician partners join. This has been a common theme we've been working through. Some communities didn't have broad walk-in access, so it really does vary from community to community. We wanted to be very clear, and I think everyone shares this with leadership, is how would clients [and] families who need immediate service know where to get that, and how would they get it quickly? And usually an exceptional circumstance, ow, how would it be face-to-face for a new person if required? So it's quite individual. And I know managers have been working with teams on those plans.

[We're] also wanting to support people [for whom] the only choice for doing the work is face-to-face. So then it becomes PPE and all those other conversations about how do we all stay in this together?

Nick Cherwinski: Thank you, Lisa. Still on a similar topic, but now moving to deployment and redeployment, if Shauna Potter or Kelly Reid or Lisa Murphy, any of the panelists would like to discuss current state on the topic of redeployment or reassignment. That's a number-one question on Slido as well.

Kelly Reid (Director of Operations, MHSU, South Island): Dr. Crow mentioned something, or maybe it was Keva, and it was quite inspiring. Many of our staff have already put up their hands and said, 'I want to be a part of the good work that's occurring now,' and so that's redeployment as we would all love to see it, and I think it's happening. Our staff are moving to the places where we need them right now in a voluntary and very positive way. We do know that this crisis has created pockets of intense need in our system. And strangely, it's also created areas where there's capacity. And as a health-providing organization, we have to make sure all of our assets, our staff, our resources, are focused on the areas of most need. And that's our responsibility. So staff reassignment is something that we have to consider, we are considering, and just recently, in fact, this week, we're finishing a staff reassignment strategy that has come up and is being discussed in the HR working group, so it will be validated and approved by leadership.

Basically, our first line of reassignment is to do more of exactly what's going on now: engaging with staff, maybe casuals, who are interested in working in other areas to participate in the important high-needs work. If things progress to a point where we need to just move our staff, we have the ability to do that as well—but I want to be really clear that we will not ask staff or direct staff to work in areas where they do not have skills to work safely. In some cases, even when you have the skills, we'll have to make sure that staff have the support and extra training to ensure that they can be successful and safe when doing that work.

Lisa Murphy: I could just add that the team working with Kristine Douthwright, the Practice Support Team, has reassigned themselves, essentially, to provide peer support to the larger organization, and that's been incredibly well-received. So that's kind of an early example of reassignment that might not even be seen as reassignment. It's been very, very positively received.

Nick Cherwinski: Thank you, both, and thank you for continuing to 'like' some of the questions on Slido. As we're rounding into the last ten minutes, I'm noticing there's particular interest in one question regarding something that, to some extent, has been touched already, but I think it's a slightly nuanced question. Here's the question for panelists: could a public phone or intercom be placed two metres from the mail slot for pamphlets and harm reduction supplies so we could talk through a window? There's a lot of interest on that particular question; lots of people are curious about knowing about it. I'm wondering if any of the panelists could speak broadly about this idea of social distancing being maintained wherever possible and innovative approaches such as the one being suggested.

Lisa Murphy: Is there any information about which sites we're talking about, or if we're talking about harm reduction more broadly across our sites? I would be happy to take that one on. I work closely with Norma Winsper, who's working with OPS services, for example. If people were willing to maybe send me a little bit more detail, we could see what we can do around that one.

Tara Fitzgerald (Director, Public Health): That's something our harm reduction coordinators can also contribute to.

Lisa Murphy: Okay. So we can take that one on, and if people have a bit more detail, that would probably be really helpful.

UPDATE (APRIL 6, 2020): The harm reduction coordinators are working to create a temporary solution for this issue.

Nick Cherwinski: So send a little more detail, whoever posed that question, to Lisa Murphy. Thank you. I'm going to do another live question, unless any of the other panelists would like to comment on that. Tara, did you have more to say?

Tara Fitzgerald: Just the emphasis that it's incredibly important to try to maintain the distribution of harm reduction supplies, recognizing that we have the unfathomable situation of having two concurrent public health emergencies. So there is definitely a situation of increased risk for people using substances alone, with reference to overdose. So access to harm reduction supplies is definitely essential, and doing that in safe ways is incredibly important. Our harm

reduction coordinators are vital in providing coaching and information about how to adapt practices in these stressful times. So [I'm] super happy to contribute to a working group where we're sharing best practices on that topic.

Nick Cherwinski: Thank you. Moving down the list, to be able to touch on another one that's a very hot topic with regards to cleaning. A number of people have asked questions about their local cleaning, and whether or not the cleaning is sufficient. I'm wondering if any of our panelists are able to comment about local cleaning efforts.

Lisa Murphy: I can jump in. That's one of the reasons we decided to move staff and move some staff to working at home, was to not just create that social distance, but to maybe reduce the number of sites that required cleaning. I hadn't heard specific concerns about that until probably late last week. If it was particular sites, we often have different contractors, so [I] would be happy to follow up on that in the areas that I work in.

Nick Cherwinski: It seems on Slido that Queen Alexandra is one of the sites being named, and Kelly, you've got further comment.

Kelly Reid: I just want to mention, I think that's one of the great things about these question and answer processes: sometimes issues come up, and we don't always know what the questions are that are most important to staff. This is one that I'm happy to take on and connect with our Island Health cleaning leaders. I'm sure they're probably called something different than that. But make sure that we get the staff what their strategy is, given the importance of having a clean work environment. I can take that back to our 8:30 meeting and ensure the coordinators are aware and can take it back to their staff.

UPDATE (APRIL 6, 2020): The Queen Alexandra Acting Site Director will be working with Environmental Support Services to address this concern.

Nick Cherwinski: Thank you, Kelly. There are two directors for environmental services, and I'll get you their names shortly. Another question that seems to be quite popular is a question around ensuring that all areas at Queen Alexandra get Wi-Fi. I'm wondering if any of our panelists are able to comment on that particular topic.

Keva Glynn: It's been a longstanding issue for many years. And certainly one that has been looked into a number of times and continues to be. I will take it back, because now would be a promising time to take this forward. It involves some substantial infrastructure pieces, but [I] absolutely recognize the challenges that are there. No question. And in particular with the approach we're taking with virtual care, I'll take it back. I can't make any guarantees, given the investments required.

Nick Cherwinski: Another well-liked question with regards to contracted service providers, if there's any comments you'd like to share, excitement around some of the services and conversations that you're involved in with the city? Anything comment-wise you'd like to provide for [everyone] to learn about?

Keva Glynn: To support our local planning in particular, we're working with Emergency Management BC and Health Emergency Management BC, and with our municipalities and BC Housing, and then very closely with our contracted providers to figure out our local plans. And the local plans look different depending on the community—[different] populations' needs, and what the partners are bringing to the table. So the planning is quite focused, depending on the populations' needs. There are lots of people involved locally, especially our Public Health managers and leads, and our MHSU managers and needs. And the work is unfolding. It has many dimensions: political, contractual, obviously in public health and housing. So lots of complexities there, and also with the introduction of safe supply, another added dimension that is really significant, and is going to make a huge difference for our clients and for the way we deliver services. Lots of opportunity there. Also lots of complexity.

Nick Cherwinski: Thanks, Keva. Just rounding up in the last couple of minutes, I'm going to open it up for all panelists to provide updates that you know have not been covered in this Town Hall that critically need to be stated.

Keva Glynn: I'll say one: just that having the chance to go through the Slido questions as I was sitting there, I see that there are many questions that people have. Very good questions—pertinent, relevant, timely—that we haven't had a chance to answer right now. What I'd like to commit to is that we'll have a look through those questions and ensure that we're tracking, and that people get the answers that they need, because that guidance and support is really crucial.

Dr. Richard Crow: What I wanted to reiterate, and I've already mentioned it, but it is our source of truth. Because things are changing so frequently, [please] go to our COVID Response webpage, because the latest is there, or the Medical Staff webpage. You'll get the updates from what is happening at the provincial level as well—they're all up there. Anything that our CEO or Chief Medical Officer are communicating [is there]. Watch your emails. Things change so much. But if you miss [those updates], go to the source of truth. It's a really vital resource to answer many of your questions.