national union

COVID-19 EMERGENCY MEDICAL SERVICES CONFERENCE CALL

April 17, 2020

The National Union of Public and General Employees (NUPGE) is a family of 11 Component and 3 affiliate unions. Taken together, we are one of the largest unions in Canada. Most of our 390,000 members work to deliver public services of every kind to the citizens of their home provinces. We also have a large and growing number of members who work for private businesses.

Larry Brown, President

Bert Blundon, Secretary-Treasurer

COVID-19 Emergency Medical Services Conference Call
April 17, 2020
1:00 p.m. EDT

PARTICIPANTS

HSAA/NUPGE	Mike Hennig Jordan Lenz Mike Parker Jason Soklofske
SGEU/NUPGE	Rob Buchanan
HSAS	Holly Bratt Natalie Horejda Karen Wasylenko Braden White
MGEU/NUPGE	Michelle Gawronsky
MAHCP	Cheryl Beal Lee Manning
OPSEU/NUPGE	Mirla Alvarado Jamie Ramage
NBU/NUPGE	Joyce Aucoin Michelle Burge Susie Proulx-Daigle
NSGEU/NUPGE	Lynette Johnson
NAPE/NUPGE	Chris Henley
NUPGE	Larry Brown, President Bert Blundon, Secretary-Treasurer Len Bush, Managing Director Anil Naidoo, National Representative Diane Fowles, Administrative Representative

Welcome and Introductions

Anil Naidoo welcomed participants to the call.

1. Opening Statement – Larry Brown, President

- Frontline healthcare workers are the ones putting themselves at risk to protect the rest of us—EMS workers are used to this but have not had the same attention as acute health care workers
- One of the reasons you are under the radar is that you do this all the time—in emergency situations there are always people leaving but you are going towards the problem
- Wanted to have the call because while you will have issues that are probably common throughout, e.g., PPE, but want to ensure we are aware of also specific issues that you may have as EMS workers
- Calls designed to share information with each other but also to identify small or big suggestions—share experiences—if something in one province, people across the country can learn from it
- Listen to see if there is a role we can play at the national level—whether it is more research that can be done on a specific area, whether the calls are useful enough to hold them again—take a read as we are going through
- In this particular call facing an issue that haven't faced as much in other calls and that is how complicated the jurisdiction is for EMS
- Trying to get a handle just in ON where there are 6 unions—multi-union situations occur in more than just ON—do we need to reach out to other national unions so we are not tripping over each other?
- At the national level proud to represent you—you play an important role and do it with such courage and commitment and compassion not just now but always—we are aware and very appreciative of the role you frontline workers play
- One thing that has distressed me to no end during this crisis is people working on the front line like you, putting yourselves at risk every day for the public are sometimes ostracized after work—people look at you as carrying the virus—those stories break my heart when I hear them

2. EMS Overview

Mike Parker – HSAA/NUPGE President

- Want to remain ahead of any issues coming out as seen in LTC in ON and BC
- Where are the hot spots now, and do we need to focus on anything we haven't been in recent past?
- Taking note on the conversation, notes produced from NUPGE, remember we don't want to be site specific
- Current COVID issues across the country
- Cross jurisdictional may be a bigger piece than this conversation, non-union work and two hat EMS workers—back to LTC where we see multiple employers—is it an issue with us?
- PPE—Is it an issue? What is the truth? What do we need? What do we want? Very different pieces and right now I don't agree with position of nurses in AB or nationally who say they want PPE never mind what the specific need for PPE may be. Becoming a very difficult piece because when we move to what we want, it could mean we can't all get what we need.

3. Cross Country Check-In

HSAA/NUPGE

Jason Soklofske - Advanced care paramedic - Medicine Hat:

- Calm before storm, call volume down—everyone at work, vacations cancelled so casuals are starving because fully staffed
- If you get sore throat, runny nose, etc. workers are pulled off right away and comes out of sick bank (so if casual then unpaid)
- Will be swabbed and back to work as soon as symptoms gone as long as you are negative
- Calls down but calls being done are more difficult
- Hot, a lot of work to do, stressful, high-risk taking on/off equipment—highest risk point is taking off masks, etc.
- A lot of stressed out crews but seeing people come together
- A lot of information coming from employer—if you read every email and policy document, it takes a few hours a day—some are doing that, some aren't

Jordan Lenz - Advanced care paramedic - Peace River:

- Facing similar issues to Medicine Hat
- Good to have one single point of information—if off for a few days there is quite a lot of reading and sometimes crews just aren't getting information before going out door
- At first saw patients cleared from hospitals fast but often too fast and we return to them when they are very sick—may skip step almost in haste to get them out, they become critically ill and the return calls are very long and involved
- PPEs an issue particularly in rural—80 km away from hospital so that is a long time to be doing critical/advanced medicine in full PPE
- Good amount of stress—crews are all in and together and out of the stress is coming a sense of team work

Mike Hennig:

- PPE—no one denied equipment—N95 mask no issue
- Restocking crews with PRUs at stations
- One issue in joint H&S committee is as soon as in aerosol generating procedure mode is addressing issue about full Tyvek suits or at least hair coverings
- Current gowns cover down to knees so people worry about exposure to hair, neck, bottom of uniforms—limited research on this—ON seems to have some podcasts from Dr. who went through SARS has different opinion than WHO and say hair covering and full suits for some procedures are needed
- Edmonton Fire walks in with full PPE
- Crews want dispatch to prescreen all calls with COVID questions as getting caught off guard on certain calls and walking in with surgical mask and they are showing definite COVID symptoms
- There is a pandemic screening card but dispatch system hasn't launched this
- Getting the run around as to why they aren't prescreening
- Alberta Health Services had an issue with casual labour—400 positions—members right now have no sick time, no short or long-term disability, and now employer has asked them to ramp up to full-time (90 days minus 1)—4 on, 4 off schedule

SGEU/NUPGE

Rob Buchanan:

- On front line one concern brought up related to WCB—would it fall under this if contaminated at work?
- Dispatch tried to do pre-screening but people not always honest—doing full PPE now with surgical masks (not N95)—put N95s on when needed
- Fully staffed but if things were to ramp up would not have the front line staff to deal with it
- If something happens—as a private service working for the health region, if something serious happens and assistance needed are we pushed to the back because private and not supported through the health region? Is it left up to private company to support us in that?
- What kind of support will we have through health region in this?

Anil re Compensation: Not same everywhere—some provinces have a code for COVID cases to allow full pay when asked to be off work for symptoms. Not settled in all provinces and issues regarding presumption.

Larry re Workers' Comp: Tested in several provinces—if established getting COVID was result of being at work, it is Workers' Compensation for sure—disadvantage is not full pay but advantage is do not have to burn up own sick leave

HSAS

Braden White:

- Haven't heard issues from frontline medics re: accessing PPE or having availability
- Dispatch doing some screening—difficult to have truthful or knowledgeable responses
- Most crews that respond to calls that sound as though there are respiratory involved starting off responding with procedure mask—doing quick doorway assessment—switching to N95 as they need it
- In Regina specifically got rid of all nebulized medication and using meter dose inhalers (not aerosol producing)
- However, still difficult to maintain PPE and cleanliness if more involved with advanced care—difficult to have that involvement while maintaining proper PPE

- No vacation cancelled unless workers' choice—most casual still getting hours
- WCB—no issues accessing—6 told to self-isolate after possible exposure (either poor PPE or poor information coming from calls)—all were negative and quarantine was as paid administrative leave
- Paramedics somewhat settling into this—call volume dropped by half when it first started for 1-2 weeks—volume just below norm now and just as busy as they were prior

Natalie Horejda:

- Rob re: concern about private not being heard—Karen & I sit on daily meeting with ministry and SHA - SGEU brought up concerns with long-term, personal care homes which are private & not under SHA—have been advocating for PPE and processes for them—have not heard anything about private EMS at those meetings—may want to rattle some cages for that
- N95 in SK—warehouse of 2009 H1N1 N95s cleared for use but SHA are having tested at Nelson labs in US - they are looking to put into circulation—without a surge there is 500+ day supply available
- Apparently federal warehouse of PPE from same pandemic and 2 million N95s were destroyed last year and not replenished
- Meetings with EMS leaders across province and conversation was re: N95s was being in the home, take off procedure mask and put on N95 and risks associated with that—from leader, can't just use the N95 randomly like that because 3 weeks down the road you might be looking for it and wishing you hadn't used it
- Heard varying stories in terms of supply and availability
- Screening - Same screening process re: EMS entering facilities as everyone else?—use screening tool—asymptomatic but something in screening tool is a trigger and deemed unfit for work you get pandemic pay—if deemed unfit because of a symptom you have, it is sick time—some confusion on triggers—not consistent, what are the criteria?—SHA will do a summary document on this

MAHCP

Lee Manning:

- Evolving on daily basis—shortage of N95 masks
- Some rural folks bought own masks and bought N200 masks—if they wore them they would be disciplined because there is no policy or protocol for use

- Was sent a picture of poor quality mask, straws on piece of plastic—apparently they will give to people. Number of ongoing issues with PPE
- WCB - Up in the air—government announced making some changes and may compensate for use of sick time in hospital—question still about whether they will be able to access WCB, paid straight up (doubtful) for being sent home or contracting the virus
- Washing down stations - Clean rigs but no protocol on how to do—just told to sterilize
- Boils down to with poor management, comes poor protocols, comes confusion, so not driving towards positive solution in many cases

Cheryl Beal:

- When paramedics off work because of possible exposure—problem as there is further delay getting them back to work because they have to be cleared by Occupational Health—OH has a lag of 5-7 days right now—so people off for prolonged period when they don't have to be—creating concern re shortage of staff, etc.
- PPE problem in rural areas—medics told by supervisors to make do without proper fitting PPE—told to save PPE and enter home by themselves and working alone—major concerns
- Re: masks purchased by them—masks are not foreign to the system as urban are issued and using these masks—exact same equipment

Jason Soklofske's comment/question:

- Screening fail rate is 100% at doorway—personally masking
- Single medic on scene—if taking position on this should discuss—need to have a balance to limit exposure—understanding if it is a questionable scene don't want to be by yourself—we do work alone with paramedic response units entering by themselves a lot—if going to take a position would like more discussion

OPSEU/NUPGE

Jamie Ramage:

- 22 different bargaining units
- Fortunate in ON—do have trials and tribulations and stressors re PPE but no shortage on PPE

- In ON have 5 unions representing paramedics so comments are solely OPSEU perspective
- Hot spots—long-term and community care. Massive decrease on travelling transmission so now community transmission and long-term care
- Driving call volume up but other calls down by 30%—people scared to go to hospitals—social media question regarding last time called to a motor vehicle accident or someone falling—everything changed and everyone scared to go to the hospital
- Dispatch prescreens calls and we are alerted when call has failed COVID testing or passed and proceed accordingly
- Most services have moved to minimal PPE—eye protection, surgical mask, gloves regardless of whether call has screened positive or negative
- On arrival mandated to do point of care risk assessment—6 ft away, assess with questions and from there based on assessment can digress to go to full PPE
- If dispatch screens call as positive not only send paramedics but also send PRU
- PRU is to solely be the driver—PRU stays outside and remains clean—does all the communications—2 crew members enter the house in full PPE to pick up patient, bring to vehicle, stay in back with patient—PRU remains clean and drives vehicle to hospital—PRU goes into hospital, makes report, makes hospital aware while crew waits in vehicle with patient—system works well
- If crew screens patient as COVID negative on screen—PRU cleared up and moves on
- Equipment—some service has multiple layers of protection
- COVID response crew—outfitted with a PAPR—positive air pressure respirator (hood with tube)—self-contained unit
- They are given that type of equipment initially going to be used for inter facility transfers of COVID positive patients—haven't needed this a lot yet so expanded role that if closest to COVID positive screened call they will be first to respond - if determined COVID negative another vehicle sent
- Also used if ACP on board or if call for high risk procedure that may generate aerosol and they will treat patient as they have the protection
- Medical directives have eliminated any type of aerosol-generating procedure including intubation. TLT, resuscitation, CPAP, nebulized Ventolin, admin of medication nasally—everything really cut back to absolute minimum and when

those things implemented expectation maximum protection, take your time, no rushing, stop CPR while doing procedures, stop CPR going through hospital

- Fire response—down by 75%—only respond to unconscious patients, VSA, or collisions—role is limited
- Payment - If COVID or isolation can be traced back to work related—covered by WSIB—a lot of discussion re: reduction in pay—hard to push because if they had required another occupational injury, this is all they would receive
- If community acquired, paid as sick time—many places have separated that from regular sick time
- Part timers - Any scheduled work during isolation, they will be paid for shifts they are off, either through WSIB or sick time—most part time agreements don't specify no. of hours so most are averaging a few weeks back to pay through period of isolation
- N95 masks - Resources limited—limit usage—all calls minimum protection is eye protection/surgical face mask/gloves
- E.g., If someone called in cut finger and short of breath they would be tagged by dispatch as COVID positive—when they do point of care assessment and determine shortness of breath is because they are upset because they cut their finger—crew will then mark them as COVID negative and continue patient care with eye protection/surgical mask/gloves
- If we assess as COVID positive, back out and put on appropriate protection and takes as long as it takes
- Have seen drastic increase on time on calls—does take a lot of time as don't want people putting equipment on ahead of time because if unnecessary it is a waste and don't want to tax limited supplies—but if we do get there and there is an issue, back out
- Larger services moved to N7700 by Honeywell—covers half face with interchangeable cartridges
- Properly fitted N95 still get fogging on glasses—with N7700 there is nothing
- Has been used in the field when someone failed N95 testing—has been used for a period of time
- A lot of services have started using—personal issue so responsible for cleaning and upkeep—employer replaces canisters—testing shows between 14 - 30 days of usage for canisters

- 400 medics—all been personally issued—if filters changed every 14 days have 6 weeks of service
- Canister filters made in Mexico so concern when Trump put embargo stoppages on about them getting to them—supplies limited

Mirla Alvarado:

- Labour Relations - Have multiple agreements and trying to keep up relationships with Employers
- Not been aware of any time vacation has been rescinded but locals have engaged in conversations with some employers were it may be entertained and possibly voluntary basis
- Issues with dedication to one employer—have workers who work multiple locations especially with part-timers—not enforced in any location
- Extended lieu and overtime bans that were to expire in March but have been extended for application of collective agreement
- One case in communication centre with positive test
- 10-12 others self-isolated due to travel

Jamie Ramage:

- Tried to work cooperatively with employers and results have been positive
- Trying to get employer to allow to cancel vacation voluntarily up to September and they are resistant as they don't want us to, not pushing us to cancel—resisting option to cancel

Jordan Lenz's question - Students not quite finished? Ford wants to put them in? What is the thoughts putting brand new medics who haven't finished training into one of most challenging time? Alberta College of Paramedics would have a meltdown if put through

Jamie Ramage - had discussions with employers:

- Not as bad as it seems—has to have finished 80% of program so means they have finished all of theoretical and all of their mandatory placements—last 20% is 500 hours riding with paramedic—still have to write their certification
- 100% finished schooling but haven't finished final ride out but they are granted 120 to get their certification and can be employed during that period of time
- Not too concerned as will have ability to guide where the new workers would go
- As COVID goes forward and looking at different types of teams: 3 man teams, designated drivers—opportunity to use less experienced for that type of thing—if

we get into mandatory screening could bring them up to the level required with training & they could do swabbing—not necessarily front line—lots of opportunity to use new people without worrying about the level of care they will give to the public—should be able to use a lot of them to stop depletion of our resources

- Can put them to good use but will not say that to the employer
- My perspective only—5 unions and they don't always agree on issues

Anil - Students being moved forward into the frontlines especially in healthcare is a topic—everyone is being fast tracked and something to consider as we may be putting people at risk without full training and frontline health care has high rates of COVID infections made worse by ongoing PPE issues

NBU/NUPGE

Joyce Aucoin:

- NBU doesn't currently represent paramedics but may change once challenge at the labour board—do have members working in ambulance under Medavie
- Government did make decision if exposed and put on leave pending testing you will be paid for leave, permanent or casual—if positive continue on paid leave—if negative, return to work or if still sick you go to your sick leave
- Prescreening by dispatch and then at the door screening as well
- 2 people on crew—One person in first to prescreen so both don't get compromised
- PPE - Had a devoted supply—appears to be plenty for those who need it—definite concern though with usage rate
- Some PPE was locked up but have since signed PPE agreement with all unions—available but in centralized location—professional point of care assessment standards so not to be denied unless good reason
- Everyone going into a facility now being given 2 surgical masks minimum per day—more intensive areas get more
- 2 RHAs—One mainly Fr, on EN , Medavie looks after ambulance basically hospital on wheels, long-term care—a lot of players—difficult to get consistency on standards so they created Pandemic Task Force—Chief medical officer, RHAs, etc., screen so all partners including long-term care have—all get consistent messaging

- Issues re: cleaning ambulances—largely rural no luxury of multiple crews—have to put ambulance out of service for cleaning causes problems for coverage—rolling deployments for coverage
- Had a shortage of FR/bilingual paramedics—already a problem this hasn't made it easier
- Flattened curve so far—longer time to make calls but regular calls are way down (accidents down, etc.) but if acute situation, it would cause a problem
- PPEs—enough for now and assured more coming in but could change quickly

NSGEU/NUPGE

Lynette Johnson:

- NSGEU has hospital based paramedics—ground ambulance represented by IUOE
- Emergency Dept. are eerily quiet which they find disturbing
- Given procedure masks for everyday usage, N95 for aerosol generating procedures
- Busiest ED in Halifax. Some bought P100s from 3M with replaceable cartridges—forbidden by health authority to use because they aren't approved by health authority even though that is the respirator used by entire ground ambulance (1600 members)
- Spoke to ground ambulance (IUOE)—very early on moved to P100s with replaceable cartridges which is part of their everyday kit just like stethoscopes—no issues, abundance of filters, confident that will last for long time—would like to move to Tyvek suits instead of gowns for water permeable aspect of calls—risks of exposure and returning home to family members and exposing them—would like to see some kind of policy nationally or statement on accommodation
- There is prescreening on calls and point of care at calls find folks are lying to 911 and on scene about their symptoms—in the more extreme cases advocating that folks should be charged/fined for lying
- One air medivac from Florida—told person had been swabbed and negative but on way home found they hadn't been as they knew they wouldn't get home—3 days later found out they were COVID and the person actually died so when people are particularly egregious would like to see them charged
- No paramedics positive and very few have had to self-isolate

Jason Soklofske:

- Interesting about lying on screening—if casuals get a “tickle” will they work through it because they don’t get paid sick leave until visibly ill
- In NS if you have symptoms and have to isolate it is paid administrative leave so not as big a concern

Bert Blundon:

- In NL have air ambulance
- 3 unions on same plane—NAPE (pilots), Allied Health(response crew), RNs
- What is happening elsewhere?

Mike Parker:

- This brings up the cross jurisdictional issue talked about earlier and getting more to the table. Some fly under AHS banner, some under Stars banner who are not unionized workers. A lot of interactions and pieces that create the complications in EMS which is why there are issues with standards across the country. Tried working on the worker portability piece—college issue and not sure where that is at. A lot of pieces, outside of COVID issue, so appreciate hearing from across country.
- Hope that from this the conversation doesn’t end there. Seems MB has your hands full. Similar conversation across the country.
- Important to capture things starting to happen before they become a nationwide issue like the long-term care did.

Larry Brown:

- Things on calls frustrating—what really sticks out is people personally buying same equipment used by others but disciplined by employer is a head scratcher
- Access to accommodation important point—need best models for accommodations and not exposing family members
- Struggling question on engaging other unions—tried to invite another one to call, inter-union issues are complicated

- Try to make a connection on a national basis—may not be able to have a call such as this one as may be too complicated but can take some of the messages we got today and talk to national leaders and make connections that way
- If you think this was a good call—let us know if you would like to have another call in a few weeks—helpful if you help us make that decision
- Greatly appreciate your time and engagement. Those of you on the frontlines really appreciate what you do every day—not just now—but especially now. Thank you
- People not on the frontlines but supporting them—you do an important job too
- These are trying times. Trade union movement has an ability to rise to the challenge and we are showing it in these areas

Any documents please share and we will get it out to others for sharing. Good to get best practices out to everyone.

national union

NATIONAL UNION OF PUBLIC AND GENERAL EMPLOYEES

- B. C. Government and Service Employees' Union (BCGEU)
- Health Sciences Association of British Columbia (HSABC)
- Health Sciences Association of Alberta (HSAA)
- Saskatchewan Government and General Employees' Union (SGEU)
- Manitoba Government and General Employees' Union (MGEU)
- Ontario Public Service Employees Union (OPSEU)
- Canadian Union of Brewery and General Workers (CUBGW)
- New Brunswick Union of Public and Private Employees (NBU)
- Nova Scotia Government and General Employees Union (NSGEU)
- PEI Union of Public Sector Employees (PEI UPSE)
- Newfoundland & Labrador Association of Public and Private Employees (NAPE)

The National Union of Public and General Employees is an affiliate of the Canadian Labour Congress and a member of Public Services International.

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