The COVID-19 Pandemic

Overall Impacts on Ontario's Health Care System from a Planning and Functioning Perspective.

Insights from the Catholic Health Association of Ontario

May 2020

ABOUT CHAO

The Catholic Health Association of Ontario (CHAO) represents 29 Catholic health care organizations running 40 sites across Ontario. These hospitals, long-term care organizations, seniors' housing complexes, hospices, home care providers and community services, are located in small towns and large cities and make up $3.8 billion of the province's health budget. They serve Ontario's rich and diverse population, regardless of religion, socio-economic status or culture.

Our institutions always focus where the need is greatest – often the marginalized and disadvantaged populations. This includes working with the frail, elderly, those with chronic disease, mental health issues and palliative care.

As responsible stewards of the health care system, Catholic institutions collaborate with other organizations, and often service as humble partners to enable and enhance the delivery of care and ensure unmet needs are being addressed in the communities they serve.

EXECUTIVE SUMMARY

The Ontario government took dramatic steps to prepare its health care system for the impact of the COVID-19 pandemic and to protect the public from the spread of infection. As the first wave of the pandemic appears to now be behind us, Ontario's leading Catholic health care organizations have conducted an initial review to determine what responses worked well and what needs to be improved going forward. The intent of the document is to provide helpful suggestions as we move our health system forward. While not an exhaustive list, this paper recommends several key areas of focus to ensure a comprehensive approach to COVID-19 and other similar pandemics in the future. This includes:

- Increasing preparedness and early engagement through incident and crisis management models and training;
- Securing domestic supply chains for Personal Protective Equipment (PPE), pharmaceuticals and equipment;
- Developing integrated community responses and a process of staff redeployment;
- Ensuring consistent messaging and directives from the Ministry of Health, Ministry of Long-Term Care, Ontario Health, and Public Health Units;
- Integrating virtual care methods and evaluating new models of care;
- Ensuring the maintenance of acute care capacity to respond to surges in demand and,
- Maintaining some capacity for urgent ambulatory care-oncology and urgent surgeries.

INTRODUCTION

The COVID-19 pandemic has had a profound impact on society and the economy as governments around the world have taken unprecedented steps to protect the public from the spread of infection. Globally, health care systems were challenged to respond to urgent pressures as well as plan for potential demands.

Prior to the pandemic, Ontario's health care system suffered from hallway health care, where the vast majority of hospitals were operating well above 100 per cent capacity, and wait lists plagued the long-term care and home care systems. As a result of this environment, the government took drastic steps to create bed capacity by cancelling all elective surgeries, moving patients into community settings, and providing large funding envelopes to hospitals to build beds.

While much time will be spent in the future reviewing what could have been improved in terms of the response to the pandemic, as the first wave of COVID-19 appears now to be waning, the Catholic Health Association of Ontario (CHAO) provides the following feedback to policy makers on what our members felt went well. This feedback is meant to assist the health system moving forward as it prepares for future waves, or new potential pandemics. It is gathered along three key questions:

1. What was the overall impact on the health system from a planning and functioning perspective?
2. What worked well and do you recommend the province keeps in place going forward?
3. What are the areas of improvement?

This feedback is gathered directly from the senior leadership of Catholic health care organizations across the province.

IMPACT ON THE HEALTH SYSTEM

Q: What was the overall impact of COVID-19 on the health system from a planning and functioning perspective?

Increased Bed Capacity, Affordability, Expedited Process

- The requirement to create bed capacity and the ability to support a co-payment for those who would not normally have the means to move to a retirement facility has given CHAO members the necessary traction to move many ALC patients rapidly into more appropriate community care environments. Similarly, members have been able to expedite the move of some patients to required long-term care environments. This is helpful in getting people to the right place to best meet their care needs and helped members open up significant bed capacity. CHAO members need to maintain this momentum in the future.

Proactive Decision-Making

- Early use of one member's Incident Command Structure has provided an extremely coordinated approach and necessary clarity for the organization about decision-making. This has been extremely helpful for rapid action, but also helped them plan proactively *in advance* of direction from Ontario Health and/or the Ministry, facilitating helpful consultation around potential scenarios that moved to real scenarios. For example, some members predicted that they would be required to reduce visiting/family presence and control access points, so they consulted patient advisors very early on about how they would approach it, what they needed to be concerned about, how best to support the vulnerable, how to communicate, etc.

Positive and Negative Impacts of Halting Non-Emergent Care

- The necessary slow-down in non-emergent care has created significant distress for patients, families and care providers who are anxious about those patients who members are not seeing at this time. It is worrying to think about the impact on future wait lists and health outcomes with delays in care for those deemed non-emergent/urgent. Conversely, this prioritization has helped to keep those who otherwise might have deteriorated out of the emergency department so that it remains with capacity to provide care.

Difficulties with Limited Visitation

- It has been very hard for families with loved ones coming for ambulatory visits, procedures, or inpatient stays to have to remain connected only through virtual means due to restrictions on visitors. Staff who are naturally compassionate have also found it very hard to enforce these temporary restrictions, although they understand why they are in place. Some members have protocols in place to ensure that people who are dying have the option of having loved ones with them in their last moments, and spiritual health teams and social work teams have been equipped with iPads and have been supporting virtual visits at the bedside to ensure that people are not alone. Some members have tried to provide clarity around the exceptions process for visitors and a clear escalation process to support those on the front lines.

Shortages of Supplies and Equipment

- There has been an overall strain on supplies and equipment, including availability, pricing, delivery, and non-legitimate entities selling substandard products.
- Some members' protocol following SARS was to ensure they always had a pandemic stockpile. This has served them well and has ensured that they had some capacity in-house to deal with incredible pressures on PPE that were not available in the global supply chain. This supply has been vital in helping these members meet the increased demand for PPE.

Need for Greater System Coordination

- Many lessons can be learned for OHTs on coordinated action and planning such as hospitals supporting long term care, and home care supporting retirement homes, flexible use of space in and between hospitals and LTC, the importance of a workforce that can move between hospitals, long term care, home care, retirement homes, hospices and more, which also has raised the issue of pay equity.
- All organizations (home and community, acute care hospitals, LTC homes) have operated in silos and implemented the daily changes to the directive, guidance document and memorandums individually.
- The highly-regulated long-term care model was vulnerable but not uniformly vulnerable (only about one third of homes seemed to be vulnerable).

Staffing Challenges

- The COVID-19 pandemic has resulted in several staffing challenges, including staff not coming to work due to concerns of bringing the virus from work to their households and a lack of access to child care.
- Early guidelines on testing and screening should have been based on clinical judgement and failed to paint a true picture of the outbreak, leading essential workers to self-isolate for 14 days rather than swabbed for a prompt return to work.

Communication and Directives

- Communication from multiple sources has been overwhelming and it has been difficult to decipher new information. In addition, statements in the guidance documents have been open to interpretation. For instance, an April 29th, 2020 memorandum stated, "a more appropriate arrangement may be to keep residents with frequent hospital visits in hospital". This statement is subject to interpretation and the ministry has a responsibility to provide clear and concise direction to the licensee when it is appropriate to keep a resident in hospital.

- There have been challenges with local Public Health Units in that they have not been in line with directives and not working with the LTC individual needs. The local Health Unit have seemed disorganized at times with their messaging to LTC homes and to one member's Continuing Care Rehab Hospital. There has also been a lack of support from Local Public Health and Ontario Health and there was no structure in place and no clear protocol on appropriate contacts related to PPE, swabs, funding, etc.

Q: What has worked well and recommended to keep in place?

Virtual Care

- Virtual care has allowed CHAO members to continue with many visits that were necessary and allows for additional participative family presence when the patient at home wishes their spouse or other loved one to be part of care. This has also added a level of convenience and a feeling of safety to patients who do not have to travel for care. The question is whether this is accessible to all or whether there are more vulnerable populations still unable to access care because of lack of technology or lack of high-speed internet which is a reality in some rural areas.
- Members have purchased iPads to facilitate virtual visits with families and have offer families the option to email a request to have a virtual visit with their loved one or it can be initiated by the patient. Spiritual health and social work support these visits and also have chargers available to those who come to hospital with a device but no charger.
- Virtual connection with loved ones in the care of residents/patients, including group family email communications have been of great importance.

Emergency Department Volumes

- CHAO members have seen a decrease in the number of people coming to their UCC and ED for care. The upside is that some who could have sought care through Telehealth Ontario or a family doctor may be more seeking that first now (more than usual). The worry is that members have had people avoiding the ED/UCC who actually should be coming for care, such as those with serious illness in which time is of the essence such as stroke or MIs.
- Having ALC patients in the right environment has helped members create and maintain capacity and enhance flow between ED, surgery and inpatient units.

Internal Communications and Morale

- Some members have implemented a daily Zoom video meeting with all of their operational and medical directors and members of incident command (all executives). This has helped to dispel rumours, respond quickly to needs/questions, provide support, and ensure strong engagement of leaders. Feedback to date has been consistently extremely positive and something that has helped members do just-in-time problem solving, updates, etc.
- The amount of teamwork members have seen is astounding and something of which they should all be very proud.
- Having hospital ethicists (one at the secular site and one for a Catholic site) has been incredibly helpful to navigate the many complex ethical issues related to COVID including how to plan for ICU surge (insufficient ventilator capacity), how to make decisions ethically across both sites, and more. Work was underway at one member's hospital before the province came out with its ethics pandemic framework and had been aligned to both the KHSC ethics framework and mapped against the Catholic Health Ethics Guide. Many of their local partners have no ethics

experts in their facilities, so they have been helping with a regional ethics table. Smaller hospitals need access to ethicists, but rarely have the budget or the ongoing requirement to have this available on a full-time basis. When there is a crisis, it is a vital service that many are without.
- Some members' Medical Directors providing 100% of their time to support during the initial outbreak and communicating directly with families by telephone within the first day of outbreak announcement was very beneficial.

Infection Control

- Members have been limiting the items that come in with and for patients and sanitizing all items that do come (e.g. eyeglasses cases, etc.), which is likely good practice in many aspects to reduce risks related to items going missing or being contaminated.
- Some CHAO members have implemented good tracking processes for who is in the building, which supports contact tracing (if required) in the case of an infection concern, but also helps them know who is visiting/attending where in the building and for what purposes.

Community, Regional, and Sectoral Partnerships

- Members have worked very closely with Public Health and local partners. They have had terrific support from the community (City, local university, school boards) around needed items, support for staff, parking and public transportation, etc.).
- A working relationship with members' management team and community has been valuable. This includes paramedics assisting with testing of residents and staff, agency organizations, virtual visits with residents and families, donations from a number of local business and university).
- Some members have been working at various levels in regional planning, which has been helpful given their regional role.

Ministry Communications

- Regular communication and updates from the Premier and Minister of Health were helpful, reassuring and clear. Decisive action from the Chief Medical Officer of Health, MOH and Premier created consistency across the hospital sector, which was both necessary and helpful.

LTC Red Tape

- The relatively quick changes to mandatory obligations implemented by the MLTC for long-term care homes (ie. level of documentation, reporting and submitting of data, etc.) has worked well and demonstrates there may be ways to streamline essential compliance requirements and enhance access to infection prevention and control best practice processes and training.

Redeployment of Staff

- Many staff have been redeployed (n= 200) and have done wonderful work in new areas – all with positive attitudes and cheerfulness!
- Members have found that the ability to redeploy staff as needed to different areas of their hospital, as well as to support the community in swabbing and supporting long-term care/retirement homes/ hospices and swabbing, isolation, and support of the homeless community was very helpful.

Q: What are areas for improvement?

Securing a Steady Supply Chain

- Global disruptions in supply chain have caused tremendous concern at all levels and will need to be considered as members evaluate ramping back up services. PPE is still not as stable as it could be and there are some shortages in the global supply chain for cleaning items such as wipes, pharmaceuticals, etc.
- Canada MUST become more reliant on its own supply chain. Swabs used to test for COVID made in Italy were unavailable; PPE coming from China was unavailable or of such poor quality that it could not be used; pharmaceuticals are often made in India and so have slowed down in availability. All of these issues have created significant challenges to hospitals (and terrible stress for staff) during COVID.
- Suppliers in the early stages of the pandemic could not meet the needs of appropriate required PPE. It has been an exhausting process to get PPE and most PPE received was mostly donation from community partners and public donations.
- Not all partners in some members' regions had pandemic plans in place or pandemic supplies. This then became very difficult when PPE was in short supply as those who had chosen not to participate in these regional efforts were caught short. Consideration should be given to ensuring that every health care organization has a rotating stock of pandemic supplies for emergency purposes as part of their regular emergency plans to offset any supply chain challenges.
- There needs to be a single source in each catchment area to reach out to for help. Homes in outbreak do not have the available staff or time to reach out to multiple organizations for PPE, additional staff (redeployment).
- Members identified a lack of PPE supply and availability on a regional, provincial, and national level as a concern. Going forward, a larger pandemic stock of PPE needs to be secured, with increased monitoring of expiration dates.

Supporting Vulnerable Communities

- While there was initially considerable worry about the homeless population and vulnerability to COVID in shelters, the City organized early (some members were partners in this) to set up isolation shelters to reduce risk. There have been, however, many more people living on the street than usual for a variety of reasons. Some members have also had to close their usually

open lobby to homeless/vulnerably housed people, which has been difficult. These settings have always been a safe place for people to use a restroom, come in from the elements, and rest peacefully for a few hours, but this has been simply not possible at the moment due to building restrictions.

New Models of Care and LTC Red Tape

- There are some excellent examples of the role home care can play, including 'ALC at home' models and stepping in to support retirement homes. All LTC has been treated the same but some LTC homes have been very resilient and are an important option for ALC to ensure hospitals can maintain 85% occupancy.
- Members believe it is possible to streamline essential compliance requirements in LTC and make it easier to get additional temporary licenses to allow for surge.
- Staffing standards in LTC must be reviewed, including ratios of staff to residents and the need for full-time staff. Additionally, there should be improved accountability measurement to monitor these standards regularly.
- There is an opportunity to revisit OHIP model, even if it cannot be changed now, to set principles/directions for the future evolution of the model so that negotiations have a goal to head toward.

Physical Challenges to Social Distancing

- The physical structure of some members' hospitals have created significant challenges for them relating to physical distancing and isolation. For example, open NICU units have been in surge during COVID, creating significant challenges for one member. While this may be addressed through an upcoming capital redevelopment, they are some years away from this still. Furthermore, given the volumes in some of this member's ambulatory areas, they will not be able to resume normal volumes and maintain physical distancing – it will need to be one or the other, even replacing some in-person care with virtual care. Even ongoing restrictions to family presence will not resolve this – many waiting areas are tight and full from open to close every day.

Funding

- It must be assured that sufficient funding dollars are available during times of health emergencies to enable the accommodation of the following:
    - Provide wage increases for front line staff as well as funding for increased operational costs at the beginning of any emergency
    - Childcare centers should be setup or kept open and designated to support essential workers at the beginning of any emergency.
    - Additional care equipment costs, including technology, to accommodate the possibility of virtual levels of care as required at the front end.
- A clear funding model and budgetary information is needed for flow of funds to support organizations, as they are depleting budgets to outlay for PPE and additional resources.

Ministry Communications

- The volume of changes within the directives and guidance documents has been overwhelming at times and sometimes seems to contradict. LTC homes were not given time to digest the latest guidance document and an update would appear with slightly stricter measures. Optically this looked like the government was reactive rather than pro-active.
- Better coordination between agencies (Ontario Health, MLTC, MOH, Public Health) is required to ensure that messaging is consistent and a single source of contact is available for each area.
- Directives from the province put acute care hospitals in charge which led to some members experiencing a lack of respect from the acute care sector to the non-acute care sector. LTC homes have outbreaks annually and are well education on isolation procedures. They do not require hospitals to come in and analyse and provide education on isolation procedures. Once hospitals were given this authority, they were asking to be part of operational meetings within LTC homes. The province should have allowed for LTC homes to reach out to hospitals for help when needed.

Redeployment of Staff

- Health Human Resource Planning has been exasperating when trying to have staff redeployed from hospital, agency, and Home and Community Care to long-term care or to the transitional facilities set up at hotels for the surge capacity at hospitals.
- Redeployment of staff from hospital to LTC homes is not an easy process. There are collective agreements, wage discrepancies, availability, etc. In the future, these types of redeployment measures should be set up in advance to ensure a process is available if emergency orders or pandemics arises.

Community Preparedness and Ability for an Integrated Response

- Some members indicated that not having a plan already in place, such as the Incident Management System (IMS) that allows for quick and effective decision making, was one of the biggest learnings. They feel that the community has not moved to an IMS model soon enough and that the community has not exhibited a high level of readiness around incident/crisis management. Going forward, having these procedures in place and having individuals trained in IMS was identified as a need.
- Some members found that a disjointed community response and lack of community readiness has led to gaps and duplicated efforts. A consistent system-based approach (i.e. IMS), a higher level of coordinated preparedness, and better information sharing between community partners should be considered.

Supporting Long-Term Care

- Some members felt that going forward, the most helpful policy change to support long-term efforts would be to strengthen the LTC/RH sector. This includes better staffing models, pay equalization, and increased IPAC standards that need to be enforced. Additionally, increasing provincial preparedness and IMS education and readiness were highlighted.