Health System Fundamentals..

A Primer on Health System Literacy

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Dr. Gillian Kernaghan

President and Chief Executive Officer

St. Joseph's Health Care London

CARING FOR THE BODY, MIND & SPIRIT SINCE 1869

All in the same storm….not all in the same boat

COVID-19 to have unprecedented psychological impact

State of BH[1] pre-COVID

10.6 % Decrease in number of mental health nurses in England between 2009 and 2019

24.4 Average wait time for psychiatry in Canada, from referral by a GP to start of treatment

56% Shortage of mental health care staff in the United States[2,3]

1. Behavioral health.
2. Mental health professionals include psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists.
3. As of January 2017.

COVID drivers of BH need

General population

- Collective grief, fear, and loneliness
- Financial crises linked to increased depression, anxiety, substance misuse, and suicides

50% of Canadians report worsening mental health during the pandemic

People with BH conditions

- Limited access to and reduced usage of BH services and treatment
- Stress, isolation, uncertainty, etc. can trigger or exacerbate symptoms

30 to 50% drop in referrals to children's BH services in England

Clinicians and first responders

- Extreme stress, trauma, and burnout among frontline staff

50% of frontline staff in China reporting depression symptoms

COVID-19 patients and their families

- Stress, confusion, and anger with possible long-lasting effects

25% of patients who survive an ICU stay experience PTSD

Source: "Mental Health Care Health Professional Shortage Areas (HPSAs)," Kaiser Family Foundation; Savage M, "NHS England loses 6,000 mental health nurses in 10 years," *Guardian*, 19 May, 2019; Barua B, Moir M, "Waiting Your Turn: Wait Times for Health Care in Canada, 2019 Report," Fraser Institute, 2019; "Worry, Gratitude & Boredom: As COVID-19 affects mental, financial health, who fares better?" Angus Reid Institute, 27 April, 2020; Thomas R, "Major drop off in referrals to children's mental health services," *HSJ*, 10 April, 2020; Lai J, et al., "Factors Associated With Mental Health Outcomes Among Health Care Workers Exposed to Coronavirus Disease 2019," *JAMA Network Open*, 3, no. 3 (March 2020); "PTSD Common in ICU Survivors," Johns Hopkins Medicine, 20 April, 2015.

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A tale of two workforces

Covid-19 responders

On frontlines in areas with surges

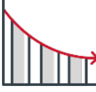
Burned out due to high volumes, emotional stress

Feelings of distrust stemming from PPE shortages, risk of exposure

Sample impacted roles:

- Critical care providers
- Inpatient nurses

Staff relegated to the sidelines


Seeing lower volumes or lack of work altogether

Financially vulnerable due to furloughs, pay cuts

Feelings of distrust stemming from financial insecurity

Sample impacted roles:

- Unlicensed staff
- Ambulatory clinicians

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National Standard for Psychological Health and Safety

Mental Health Commission of Canada- 2013

Organizational culture
Psychological and social support
Balance
Involvement and influence
Civility and respect
Protection of physical safety
Engagement
Growth and development
Recognition and reward
Clear leadership and expectations
Psychological protection
Workload management
Psychological demands

- https://www.mentalhealthcommission.ca/English/what-we-do/workplace/national-standard

What can you do as a leader or as a colleague to support the psychological wellness of your colleagues and those with whom you work?

How can you as a leader be sensitive and responsive to both workforces?

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What about the people we serve?

Patient/Family Caregiver Partnership

- How have we understood the impact during wave 1?
- How can we reduce the impact in wave 2?
- How do we engage them in policies that have changed as a result of covid? (such as visiting)
- How should they inform what we stop if we need to reduce services?

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All providers have a new baseline for patient experience

Experience must feel meaningfully different to rebuild patient trust

Implement operations and safety workgroups

Focused on redesigning the entire care pathway to control infection and ensure patient and staff safety

Areas of focus:

- Patient flow for patient arrival and registration
- Social distancing for waiting rooms, parking lots, lobbies, and corridors
- Segments of care episode that can be done remotely
- When and how to communicate safety procedures with patients
- Testing process for scheduled services

Prioritise safety-focused operational changes

- ✓ Schedule fewer procedures to space patients out
- ✓ Test patients in advance and request self-quarantine in interim
- ✓ Complete registration and payment collection online or via phone
- ✓ Adopt universal masking among staff
- ✓ Provide temperature screenings, masks, and hand sanitiser at the door
- ✓ Sanitise spaces continuously (in view of patients)
- ✓ Limit waiting room use with cell phone lots and pagers
- ✓ Use furniture arrangement and floor decals to create one-way flow and two meter spacing
- ✓ Convert pre- and post-op appointments to telehealth visits, when possible

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How can you as a leader or as a health care provider/leader earn the confidence of patients as we continue to live with COVID?

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At minimum, hospitals must proactively prepare for wave two

Covid-19's first wave has revealed 'known' high-risk populations

Risk factors for severe impact from Covid-19[1]

- Severe lung condition
- Immunosuppressed
- Have had an organ transplant
- Aged 70 or older
- Heart disease
- Obesity
- Diabetes
- Chronic kidney disease
- Liver disease

1 Use existing data to identify high-risk individuals

Example: Government of Valencia, Spain

- Using 3M's Clinical Risk Groups (CRGs) classification methodology to identify and prioritise masks for people who, if infected, would be at the highest risk of hospitalisation, admission to ICU, or in need of a mechanical respirator.
- CRGs use claims information, pharmaceutical data, and functional health status to classify individuals based on complexity.

2 Target proactive outreach and support to prevent infection of high-risk individuals

Example: Southern Humboldt Community Healthcare District, California, US

- Intervened with high-risk seniors proactively so they could remain at home.
- Hospital staff and trained volunteers make calls to seniors to determine their needs and schedule drop-offs of essentials such as groceries and pharmaceuticals.
- Redeployed clinicians, medical assistants, hospital registration staff, social workers, and others to assist with calls and deliveries.

1. Select factors based on NHS guidance.

Source: "Who's at higher risk from coronavirus," NHS, 23 April, 2020; Moore L, "A prioritization model for Covid-19", 3M, 22 April, 2020; Moore L, "Webinar: Identifying individuals most at risk of poor outcomes", 3M, 10 April, 2020; "Case Study: Getting in Front of Covid-19: Addressing Social Determinants of Health to Save the Lives of Seniors," American Hospital Association, April 2020.

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Covid-19 forced us to shift the default away from the hospital

Pre-pandemic default to treat in hospital

Patient flow

Hospital

Virtual care and alternative care sites

Pandemic default to treat in alternative sites

Patient flow

Hospital

Virtual care and alternative care sites

DATA SPOTLIGHT

Virtual care explodes as it becomes the clear first choice for care during the pandemic

1,200x Increase in monthly consultations on UK-based platform eConsult

600% Overnight increase in daily volumes on Canadian virtual care platform Maple

5.4M Telehealth consults conducted across Australia in 2020[1]

1. As of 26 April 2020.

Source: Warriner J, "The rise of telehealth in the coronavirus pandemic could lead to a permanent shift in healthcare," *ABC News*, 6 April, 2020; @getmaple, "Today, we were left in awe…" Twitter, 18 March, 2020; Browne R, "Demand for telemedicine has exploded in the UK as doctors adapt to the coronavirus crisis," *CNBC*, 9 April, 2020.

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Persistence of new defaults depends on three factors

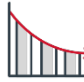
New models likely to stick, but patient demand still a wildcard

Reimbursement parity

Will governments and payers finally introduce reimbursement for new defaults (i.e., telehealth)?

Consumer habits

How long will new defaults be in place for citizens to become accustomed to them?



Patient demand over time

Is the lower demand we are currently experiencing providing a false sense of security in viability of new defaults?

Why we're betting new defaults will stick

Rapid expansion of billing codes well underway

- Australia extended telehealth reimbursement until fall
- Ontario Virtual Care programme issued new billing codes for telehealth visits

Vaccine to be available in 2021 at the earliest

- Defaults will need to remain in place until vaccine developed, which will take 12-18 months according to experts
- Timeline to vaccinate majority of population to take several years

WILDCARD

Too early to call

- Currently experiencing reduction in hospital and GP volumes of up to 60%
- Early assumptions of defaults' 'stickiness' fail to account for demand overwhelming their supply post-Covid

Source: Grattan M, "All Australians will be able to access telehealth under new $1.1 billion coronavirus program", *The Conversation*, 28 March, 2020; Sunshine R, "Ontario Expands Access to Telemedicine in Response to Covid-19", *Rosen Sunshine LLP*, 17 March, 2020; Ridley D, "Don't count on getting a coronavirus vaccine in 2021. Testing and production take time.", *USA Today*, 5 May, 2020.

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Figure 1: Quick Reference of Goals and Recommendations for Each COVID-19 Transmission Scenario

	Plan	Ready	Implement	Scale Up	Intensify
	Scenario 1: No Cases	**Scenario 2**: Sporadic Cases	**Scenario 3**: Clusters of Cases	**Scenario 4A**: Moderate Community Transmission	**Scenario 4B**: Widespread Community Transmission
Optimizing Care Goals	• Resume/accelerate health care services	• Resume/accelerate health care services	• Maintain health care services • Resume/accelerate if there is adequate system capacity and resources	• Modify scheduled acute inpatient services in proportion to available resources and according to key metrics • Maintain/resume/accelerate other care to ensure adequate capacity for COVID-19 patients	• Defer scheduled acute inpatient services in proportion to available resources and according to key metrics • Maintain/resume/accelerate other care to create capacity for COVID-19 patients
Regional or Sub-Regional Steering Committees	• Determine COVID-19 transmission scenario • Monitor health system metrics • Coordinate with health care organizations, providers, and sectors outside of health care to: optimize capacity and maintain care services; optimize health human resources (HHR) across the region; protect vulnerable populations; reinforce immunization programs; support consistent communication				
All Sectors	• Resume/accelerate scheduled care • Standardize process improvements • Strengthen partnerships • Prepare surge plans (to optimize capacity and HHR, protect vulnerable populations, and refresh visitor presence guidelines) for all transmission scenarios • Reinforce immunization programs	• Resume/accelerate scheduled care • Ready surge plans • Manage COVID-19 • Reinforce immunization programs	• Maintain/accelerate scheduled care • Implement and enhance surge plans • Manage COVID-19 • Reinforce immunization programs	• Prioritize time sensitive scheduled care • Scale up surge plans	• Defer scheduled care as required • Intensify surge plans
	• Use virtual care	• Monitor health system metrics	• Support care partner participation	• Standardize communications	• Train on IPAC
Hospital-Based Care	• Review and reprioritize wait lists • Address time-sensitive care backlog • Review surge plans • Plan for COVID-protected wards, where feasible • Refresh visitor policy • Reduce unnecessary tests and treatments		• Create capacity • Collaborate with primary care and home and community care	• Prioritize time sensitive surgeries and procedures • Consider deferring non-time sensitive surgeries and procedures • Implement COVID-protected wards, where feasible	
Primary Care & Out of Hospital Ambulatory Care	• Determine services to prioritize for in-person care • Reduce unnecessary tests and treatments • Identify required resources to support services in each scenario		• Assess capacity and set appropriate priorities of care • Collaborate with hospitals and home and community care	• Assess capacity and set appropriate priorities of care • Collaborate with hospitals and home and community care	
Home and Community Care & Community Support Services	• Identify required resources to support services in each scenario		• Ensure services continue • Cohort care teams	• Ensure services continue	

https://ohwestcovid19.ca/optimizing-care-through-covid-19-transmission-scenarios/

Living with COVID-19

Given the complexity….

What are the silver linings you see that you want to hardwire into your practice, department, organization?

Understanding the uncertainty and complexity what positive steps can you take aligned to the Quadruple Aim?

What you do speaks so loudly I cannot hear what you say!!

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