

COVID-19 Short-Term

Executive Report

August 2020

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Introduction

The first case of COVID-19 was recorded in Canada at the end of January 2020, and by March 2020 it was clear that its impacts on Canada would go far beyond the cases and deaths themselves. As described in this report, the health system has been forced to rapidly transform as a result of the pandemic.

The Canadian Medical Association (CMA) Enterprise has played a strong role in supporting Canadian physicians and the health care system in responding to the pandemic, including working with governments and other stakeholders to represent the interests of Canada's physicians and their patients. This includes both contributing to and influencing the response of the Canadian federal, provincial and territorial governments, as well as working to reduce the strain on the CMA's membership.

As the details of the direct and indirect impact of COVID-19 on the Canadian health care system have emerged in the early months of the pandemic, Canada has begun preparing for the re-entry and recovery phases. This presents a unique opportunity for the CMA to leverage its strengths to play a leadership role and influence the short- and long- term recovery.

The Post-Pandemic Expert Advisory Group

The CMA established the Post-Pandemic Expert Advisory Group (EAG) in April 2020 to develop a holistic position on the impact of the COVID-19 pandemic in Canada by leveraging the expertise of a group of interdisciplinary experts. The EAG's objective is to provide future-focused advice to the CMA board and management on the impact of the pandemic in the short and long term, and what this will mean for the CMA's actions and strategic direction. The EAG's work is rooted in the CMA's Enterprise Strategy Framework and is intended to serve as a key input to the ongoing development of Impact 2040, the CMA's new strategic plan.

The EAG is made up of the following members:

1. **Dr. Andrew Boozary**, executive director of health and social policy at the University Health Network
2. **Ms. Bonnie Brossart**, chief executive officer of the Saskatchewan Medical Association
3. **Dr. Ann Collins**, primary care physician and president of the CMA
4. **Mr. Don Drummond**, Stauffer-Dunning fellow and adjunct professor at the School of Policy Studies at Queen's University
5. **Dr. Jesse Kancir**, final-year resident in public health and preventative medicine at the University of British Columbia
6. **Dr. David-Martin Milot**, professor and researcher at Université de Sherbrooke
7. **Dr. David Naylor**, professor of medicine at the University of Toronto
8. **Dr. Chris Simpson**, vice-dean (clinical) of Queen's University Faculty of Health Sciences
9. **Ms. Claire Snyman**, patient advocate and CMA Patient Voice member
10. **Dr. Suzanne Strasberg (Chair)**, chair of the CMA Board of Directors
11. **Mr. Mike Villeneuve**, chief executive officer of the Canadian Nurses Association

Purpose of the report

As the first of the two planned reports resulting from the CMA's analysis on the COVID-19 pandemic, the purpose of the COVID-19 Short-Term Considerations report is to assess the immediate and short-term impacts of the pandemic on health, the health workforce and the health system in Canada.

The report outlines the early insights of the EAG, various internal and external stakeholders, the CMA's board and management leadership on the COVID-19 pandemic, as well as external research on the subject. The pandemic's impacts are prioritized on the basis of their importance and their relevance to the CMA's mission. In addition, the report articulates opportunities for action by the CMA, in line with the CMA's Enterprise Strategy Framework. The report's scope, both in terms of impacts analyzed and opportunities identified, is restricted to considerations for the short term, defined as the present date out to the next 12 to 18 months.



Through stakeholder engagement, discussions with the CMA's board and management, and facilitated workshops with the EAG, a broad set of COVID-19's short-term impacts were developed. For the purposes of the COVID-19 Short-Term Considerations report, impacts are considered short term if they are presently affecting the health of patients, families or caregivers, the health workforce or the health system or they are expected to have an effect within the next 12 to 18 months.

Following the identification of the COVID-19 pandemic's short-term impacts, CMA's management completed a prioritization exercise to develop a short list of key themes. On the basis of this exercise, four themes were prioritized for deep analysis and opportunity development:

1. Backlog of medical services resulting from reduced and postponed access to services

- Explore opportunities to address the backlog of services and wait times in Canada on the basis of the CMA's broader work on access to care

2. Long-term care (LTC) reform

- Explore partnerships with key national and provincial/territorial organizations to investigate and recommend changes to LTC standards and practices across Canada
- Identify opportunities to provide greater support for aging in place and aging with dignity, build at-home supports and protect the family and caregiver to make LTC the last resort instead of the only resort

3. Mental health impacts on the health care workforce

- Partner with key national organizations representing other health professionals to develop a national health care workforce mental health strategy to leverage present momentum and awareness around the mental health of the health care workforce

4. Innovations in virtual care

- Advocate for consistent and permanent adoption of physician billing codes for virtual care and explore options for cross-jurisdictional collaboration on virtual care throughout Canada
- Explore opportunities to expand virtual care access in remote communities in Canada

In addition to the four themes prioritized, the CMA's management continues to recognize the importance of (i) mental health and substance use, (ii) inequities in impact to vulnerable groups and (iii) the increased need for public health. These themes were considered more appropriate for the development of long-term opportunities for the next phase of the CMA's strategy work.

Theme 1

Backlog of medical services resulting from reduced and postponed access to services

Background

The COVID-19 pandemic has taken an unprecedented toll on health care systems across the globe. There have been deferments and delays in some services such as diagnostic and screening tests, preventive care, immunizations and mental health services, to name a few. Many countries have taken proactive measures to increase the capacities of hospitals and other health care institutions, which include the reallocation of resources to manage the influx of patients with COVID-19.

In Canada, a key component of this prioritization process has been the deferment of elective surgeries, which has been a common action across jurisdictions during this pandemic. This was driven by an active effort to “reduce avoidable exposure of patients and health care workers, and to prevent consumption of essential resources.”¹ This added to the backlog and long wait times that existed before the arrival of COVID-19; as an example, in Ontario, mean wait times between January and March for Priority 4 orthopedic surgery (time from decision to treat to surgery) were around 18 weeks, even though a wait of 13 weeks was deemed clinically reasonable.

As the pandemic progressed, the situation was further exacerbated by apprehension on the part of patients to undergo surgeries and even to seek out emergency care. It is important to note that the reversion back to full pre-pandemic capacity is expected to be a slow and arduous process. In the following sections, the various qualitative and quantitative impacts will be delineated and analyzed in further detail.

Opportunities

1. Explore opportunities to address the backlog of services and wait times in Canada on the basis of the CMA’s broader work on access to care

As noted in this report, the broad postponement of surgeries, routine tests and screenings, as well as the reduction in access to primary and mental health care, has inflated the already substantive wait times for health service experienced by many people in Canada. This is a clear example of how the pandemic has served not to create a new crisis but instead to exacerbate an existing weakness in the Canadian health care system.

It is clear that bold and deliberate action must be taken not only to address the backlog generated by COVID-19 but also to do better in terms of reducing wait times for key elective surgeries and important diagnostic tests and providing timely access to primary and mental health care. The CMA can, in the long term, serve as a key leader and advocate for a consistent national strategy for changing the long-standing issue of wait times in Canada.

¹ Jain, A. et al (2020). SARS-CoV-2 impact on elective orthopaedic surgery: Implications for post-pandemic recovery. JBJS, 102(13), e68.

Now more than ever, health authorities and governments are willing to break free of the status quo and try new models of care and wait time management. However, any plan of action must be built on evidence and must address issues such as the following:

- **Appropriateness of care and low-value services:** As highlighted by Choosing Wisely Canada, inappropriate care accounts for up to 30% of tests and procedures performed in Canada. Identifying and diverting wasteful spending and activity by health care providers could dramatically improve the system's throughput, while improving the quality of care delivered.
- **Virtual triage of the waitlist:** While the traditional method using of "first come first served" to work through a waitlist is consistent with the deeply held Canadian value of equality, it fails to consider the varying needs of individuals on the list and how those needs can change with time. Making use of virtual tools and ongoing assessments for those on the waitlist will help address urgent cases before an escalation of care is required.
- **Health equity:** The backlog has affected identifiable and potentially vulnerable groups disproportionately, further exacerbating existing health inequities and disparities. Health equity principles should be applied when managing the backlog to ensure equitable access to care for all people living in Canada, with a particular focus addressing the underlying factors that drove the inequities that surfaced during the COVID-19 pandemic.
- **Greater use of other health professionals to their full scope of practice:** Increasing Canada's capacity for care does not necessarily require more physicians if other health professionals (notably nurse practitioners) are empowered to operate under their full scope of practice. Vigilance is needed to ensure quality of care, meaning the right system and protocols must be carefully considered and implemented.
- **Greater use of central intake systems:** As reported by the Wait Time Alliance, central intake systems for common procedures and diagnostic tests have proven remarkably effective in coordinating the capacity of a multitude of physicians, improving access to care and reducing wait times. Central intake systems connect referrals for procedures and diagnostic tests to a central database that provides information on the wait times of all service providers, enabling patients to book appointments with the providers with the shortest wait times. The broad expansion of these systems across Canada could markedly reduce the COVID-19 backlog.
- **Ethics and vaccine development and distribution:** As vaccines for COVID-19 are in development, there will be geopolitical challenge in procurement globally, as well as challenges related to the distribution of vaccines within Canada. Identification of the ethical considerations will be a necessary first step to help guide the regulation, monitoring, prioritization and equitable allocation of vaccines to ensure public trust and equity.

Theme 2

Long-term care (LTC) reform

Background

Although older adults are more vulnerable to COVID-19 than other demographic groups, it is clear that the concentration of cases and deaths from COVID-19 in LTC homes across the country reflects a deep underlying problem with the way LTC is delivered in Canada. Nursing and retirement homes in Canada have been hit particularly hard by COVID-19 and have accounted for more than 80% of Canada's pandemic-related deaths, which is double the OECD average. This has been attributed primarily to inadequately supported and trained staff in old, under-resourced facilities. This acute staffing shortage has further harmed individuals in need of care at these homes.

Calls for inquests, investigations and reform for LTC homes have been raised in Ontario and Quebec. Critics of those provinces' response to COVID-19 note that funding and effort went into boosting hospital capacity — which was, in hindsight, not needed — instead of protecting vulnerable people in LTC homes, with devastating results. No matter the reason, it is clear that Canada's problems with LTC long predated the pandemic. With COVID-19's spotlight, the very design of congregate settings for those in need of LTC is being questioned and the future of LTC in Canada is uncertain. The Canadian Foundation for Healthcare Improvement has come out with guidelines for the re-integration of family caregivers as essential partners in care and has partnered with the Canadian Patient Safety Institute to issue a report entitled "Reimagining Care for Older Adults" that delineates next steps in the COVID-19 response in LTC and retirement homes.

Opportunities

1. Explore partnerships with key national and provincial/territorial organizations to investigate and recommend changes to LTC standards and practices across Canada

The concentrated impact of COVID-19 in LTC homes, as well as the level of variance in the degree to which LTC homes in different provinces have been affected, has galvanized governments and organizations across the country to push for reform across the sector. As the national voice of physicians in Canada, the CMA can and should play a role in the discussions already taking place to investigate the changes needed for LTC. At the same time, given the more direct role that nursing and personal support plays in these homes and in this sector, the CMA's opportunity lies in close and collaborative partnership with organizations such as the Canadian Nurses Association, among others.

This partnership should look not just to address the immediate causes of the crisis in LTC homes (such as staff working in multiple facilities and a lack of appropriate training) but also to understand the extent to which these homes provide for the needs of their residents. In this process, it will be important to recognize that LTC homes include not only older adults (who make up the majority of residents) but also other vulnerable groups in need of nursing support.

2. Identify opportunities to provide greater support for aging in place and aging with dignity, build at-home supports and protect the family and caregiver to make LTC the last resort instead of the only resort

The COVID-19 mortality rates at LTC homes have called into question the overarching philosophy of “warehousing” those who need nursing care into congregate settings. Canada tends to push more individuals into LTC homes than comparable countries, which some have suggested is due to a lack of sufficient home care supports. For those who remain at home, data show that as much as 75% of direct and community care is provided by family caregivers, who are largely untrained and provide nearly 20 hours of unpaid care per week. The COVID-19 pandemic presents the perfect opportunity for the CMA to push forward with a reform that shifts the focus from congregate settings to new models of care.

The federal government has recently shown interest in advancing home care at a national level. The CMA could develop an advocacy plan focused on providing individuals with what they need to stay at home for longer and, for older adults, with the ability to age in place with dignity. It is clear that this plan must be informed by a cross-section of stakeholders who can champion specific issues, opportunities and solutions.

The objective is to turn LTC homes from the only resort for many older adults transitioning from the hospital or living with chronic conditions into the last resort, after living at home in a supportive environment is no longer an option. Aging self-sufficiently and with dignity will require greater use of at-home physical therapy and occupational therapy and the promotion of physical activity and social engagement. Additionally, it will be important to push for more creative use of virtual care and remote monitoring to make these home supports efficient, effective and widespread.

The CMA may be the best-positioned organization to lead such a national effort and to champion investments for at-home supports and for protections and support for families and caregivers.

Theme 3

Mental health impacts on the health care workforce

Background

The mental health impacts of an outbreak on front-line workers are of national concern because of their intricate relationship with patient outcomes, personal fulfillment and health system strength. The mental health of health care workers was a pan-Canadian challenge long before the COVID-19 pandemic emerged. In 2018, 34% of physicians reported high levels of burnout, marked by reported symptoms of depression and high emotional exhaustion. Alarming, male physicians have a suicide rate that is 70% greater than men in the general population, and the suicide rate among female physicians is 250% greater than among women in the general population. Moreover, almost 40% of nurses experience burnout and approximately 14% of general nurses screen positively for post-traumatic stress disorder (PTSD).

Increased demand for health services during the COVID-19 pandemic has now put unprecedented strain on health care workers in a multitude of ways, with early data demonstrating exacerbation of the afore-mentioned pre-existing conditions.

There are a variety of elements that may contribute to feelings of physical and psychological distress among health care workers on the front lines of the COVID-19 pandemic. Direct sources of anxiety for those on the front lines include providing direct care to patients with COVID-19 for long hours, knowing a loved one or co-worker has been infected by the virus and may be facing severe consequences of the disease, fearing that they themselves or a family member may be exposed to COVID-19, or being sent into isolation because of possible exposure. Additionally, early reports from China highlight feeling of anxiousness and helplessness as clinicians feel they have little autonomy or influence in the decisions taken by managers during the crisis.

Early findings from the first wave of COVID-19 all point to the potential for increased rates of mental illness or elevated rates of affective symptoms among the Canadian health care workforce in a post-COVID environment. While these impacts are being felt in the short term, the lasting influences of the pandemic on health care workers in the form of depression, anxiety or trauma cannot be overlooked. The stresses placed on the Canadian health care workforce today will be felt in the months and years following the pandemic's end.

Opportunities

1. Partner with key national organizations representing other health professionals to develop a national health care workforce mental health strategy to leverage present momentum and awareness around the mental health of the health care workforce

Even before COVID-19, the mental health of health care workforce was under pressure from significant workloads, a difficult working environment, an unsupportive culture and challenges in accessing support. The pandemic has now put additional pressure on the beleaguered workforce in the form of fear of transmitting the virus and the resulting need to socially isolate from friends and family.

At the same time, the pandemic has also brought the struggles and sacrifices of front-line health care workers into the public consciousness, and support for the vital work of physicians, nurses, personal support workers and others is being shared in Canada and across the globe. Of particular note is the recognition — by both the health care workers themselves and others — of the stresses found at work during a pandemic and the need for self-care and mental health support.

While the CMA has worked to support the mental health of physicians by making physician health and wellness a flagship issue of the organization, its efforts have thus far been kept separate from similar work by the representative organizations of other health professionals. The CMA could therefore partner with key organizations representing other health professions (such as the Canadian Nurses Association) to develop a shared national strategy for health care workforce mental health.

The strategy could foster communication and collaboration across the key professions involved in health care to uncover shared wellness challenges and recognize unique difficulties. This is an opportunity to promote mental health and wellness leadership and support at all levels and in all settings. In an era of increasingly team-based and interprofessional care, this is an opportunity to develop a national standard for team-based care based on respect, trust and mutual support.

Theme 4

Innovations in virtual care

Background

In the wake of COVID-19, governments stepped up across Canada to advance the use of virtual care. This was done to minimize the disruption in service caused by social distancing measures. While telemedicine has been available in Canada for a number of years, the onset of the COVID-19 pandemic served as a watershed moment, where patients and physicians were suddenly independently interested in using telemedicine as the primary medium of care. The College of Physicians and Surgeons of Ontario has announced that, even as non-essential care opens up across the province, virtual care should remain the default modality wherever possible.

Although the uptake of telemedicine has been significant, it is clear that there is more room for growth and innovation. In a recent survey completed by the CMA, 75% of physicians reported that they were providing patient care over the telephone and 32% by videoconference, while just 18% indicated that they were using secure email/text messaging and only 6% reported the use of remote home monitoring. There is recognition across Canada's health care leadership that greater innovation and adoption of virtual care can be leveraged in Canada so long as the country does not slip back to its pre-pandemic focus on in-person care once COVID-19 passes.

Opportunities

1. Advocate for consistent and permanent adoption of physician billing codes for virtual care and explore options for cross-jurisdictional collaboration on virtual care throughout Canada

When the COVID-19 pandemic began in March, temporary virtual care billing codes were provided by provincial/territorial governments across Canada. These enabled physicians to provide virtual visits and assess treatment needs without pulling patients out of isolation.

However, the pandemic has made the efficiency and safety of virtual care — and virtual care billing codes — quite clear. Patients are able to see their provider without spending time travelling to and from a clinic. The codes have incentivized the mass adoption of virtual care, which has until now been incremental in growth, without evidence to date of any decline in quality of care.

But the permanence of these new codes is still up in the air. Alberta announced on June 8 that virtual care billing codes would be permanent, but other provinces have not followed suit. The CMA could therefore lead the nation in advocating for consistent and permanent adoption of virtual care physician billing codes, as well as lead the discussion of the makeup of the ideal set of virtual care codes for Canada. Consistency in virtual billing codes will have the added benefit of enabling more physicians to provide care virtually in underserved areas across provincial/territorial borders, notwithstanding current licensing concerns.

Virtual care may also pave the way to discussions surrounding national licensure and the potentiality of cross-jurisdictional virtual care. Currently, provincial health care systems are siloed, where each province operates within its own jurisdiction with limited inter-provincial interactions.

However, adoption of cross-provincial virtual care may provide a platform to initiate discussions on streamlining processes across Canada. This could begin with the implementation of a national standardized platform to be used by physicians and patients in all provinces. The CMA can examine further opportunities in this area, such as ensuring the interoperability of virtual care, quality assessment and rigorous evaluation of practices, physician training and patient satisfaction. Further, the CMA could consider examining virtual care holistically beyond the implementation of the technological infrastructure and consider other elements such as physician burnout and working hours and the appropriateness of service by patient type (e.g., pediatric versus adult patients).

2. Explore opportunities to expand virtual care access in remote communities in Canada

As noted in this report, the COVID-19 pandemic has brought to light the growing level of inequity that exists in Canada. The pandemic has had a heavier social, economic and health impact on Canada's vulnerable groups. For people living in rural and remote communities in Canada, the mass adoption of virtual care could serve as a significant boon to their ability to access care, but because of challenges in infrastructure this has not materialized.

Although rural and remote communities have so far largely avoided significant outbreaks of COVID-19, future waves may propagate to these communities and put the health of many at risk. For Canada's remote Indigenous communities in particular, higher frequencies of underlying health conditions, many individuals living in small households, and poor access to care could make COVID-19 potentially devastating.

For these reasons, the CMA could lead the charge in identifying remote communities in Canada that are vulnerable to COVID-19 and explore opportunities to enable access to virtual care before a second or third wave of COVID-19 arrives in these communities. Stable broadband internet and mobile internet access could enable Canada's physicians and health care workers to monitor, diagnose and treat some of the nation's most vulnerable communities, mitigating the risk presented by COVID-19 and promoting greater equity in access to care. The CMA could be in a position to bring these concerns to the federal, provincial and territorial governments to encourage investments in the relevant infrastructure. In executing this opportunity, the CMA must strive to work with these communities, and not to speak for them or represent them without their consent and partnership.

Conclusion and next steps

This report sheds light on COVID-19 short-term considerations and opportunities for the CMA based on discussions with various internal and external stakeholders. The six emerging opportunities delineated under the four priority short-term themes that are outlined in this report aim to provide direction to the CMA's management.

Using the report, the CMA's management will consider the alignment of these opportunities to the CMA's existing initiatives to determine if and how the CMA will modify its approach in the next 12–18 months on the basis of the opportunities outlined in this report. The CMA's management will prepare a briefing note summarizing its recommendations for presentation to the CMA board.