CorHealth Ontario
Advancing cardiac, stroke and vascular care

COVID-19 Vascular Stakeholder Forum #6

MEETING SUMMARY NOTES

DATE: May 27, 2020, 9:00-10:00am

DISCLAIMER: The information in this document represents a high-level summary to capture the discussion at the point of time of the meeting and is NOT general guidance.

GROUPS REPRESENTED: Vascular Leadership Council, Clinical Advisory Committee (vascular members), Vascular Surgery Program & Medical Leadership from 20 hospitals with vascular programs, Vascular Interventional Radiology Program & Medical Leadership from 20 hospitals with vascular programs, CritiCall Ontario, Heart & Stroke Foundation, Ministry of Health, CorHealth Ontario

HIGHLIGHTS

Health System Updates

- On May 26, 2020, the Chief Medical Officer of Health issued an amendment to **Directive #2 for Health Care Providers (Regulated Health Professionals or Persons who operate a Group Practice of Regulated Health Professionals)**
- All deferred and non-essential and elective services carried out by Health Care Providers may be **gradually restarted** subject to the requirements of this Directive.
- Gradual restart must comply with all requirements set out in the **COVID-19 Operational Requirements: Health Sector Restart** document.
- Operational requirements include:
    - Organizational Risk Assessment & Point of Care Risk Assessment
    - Engineering, Systems, & Administrative Control Measures (i.e., plexiglass barriers for administrative staff; signage, restricted visitor policies)
    - Critical Supplies & Equipment (drugs, PPE, etc.)
    - Screening (active & passive)
    - Health Human Resources
    - Infection Prevention & Control
- Subject to requirements, Health Care Providers are in the best position to determine which services should continue to be provided remotely vs. in person.
- It was also noted that service providers should be prepared to scale up and/or down to address potential surges in COVID-19 patients.

Update on Vascular Activity Level

- Data was presented that reported the differences in vascular procedure volumes between February – May 2019 and February - May 2020 as well as change in procedure volumes done during the week of May 11-17, 2020 compared to May 4-10, 2020 based on Access to Care wait time data and procedure categories.

Discussion around vascular procedure volumes:

  - Some programs noted that they have relaxed criteria for patients to get access to surgery as they have now waited beyond the recommended wait times (e.g., beginning to prioritize patients with a 6 cm AAA that were on the wait list and have now waited an additional two months for their procedure).
  - It was also noted that a significant limitation is the ability to schedule patients into the Operating Room (OR).
  - Some areas have designated day surgery time in the OR but others have not and patients would require an inpatient stay (these resources are in high demand).
  - PPE is still problematic for several programs and resulted in decisions to prioritize cases that require less PPE resources such as day cases and cases that do not require general anesthesia.

Update on Planning for Vascular Surgery Backlog Mitigation Post-COVID

- Data was presented that modeled the vascular backlog in a scenario of a longer and sustained ramp-down period including:
  - Slowdown by Region (% of historical Priority 2-4 vascular volumes)
  - Model Assumptions
  - Expected Wait List Volumes
  - Number of Weeks to return to pre-COVIC wait list under 20% surge scenario starting January 2021
  - Resource Estimates
  - Model Limitations

Discussion around vascular procedure backlog mitigation:

- Question: *Is it possible to get some insight into what is happening across other surgical programs and how does vascular fit into the overall wait time across all procedures? Is it possible to estimate the risk of vascular disease progression whereby patients waiting for a procedure become emergent and how vascular patients compare to patients requiring other surgical/interventional services?*
- Comment: *Hamilton currently has 13 inpatient vascular beds and manages a significant number of patients – would be happy to share learnings/ processes and practices regarding program management from a throughput perspective. If programs are able to safely reduce patient length-of-stay, this may be one opportunity to increase patient throughput.*
- Question: *For LEOD patients, if we formalized PRE-procedure rehabilitation for them, would we be*

able to reduce the number of patients on the wait list or increase the time they are able to wait for a procedure?

  - Rehabilitation should be a recommendation (as per current guidelines that indicate a 3-month trial of supervised exercise prior to revascularization) but there generally aren't many formal supervised exercise programs for this patient population. There are some outpatient cardiovascular rehabilitation programs that do accept LEOD patients however many are currently closed as staff have been redeployed.
  - Risk-factor optimization in addition to exercise programming should be part of standard care for all LEOD patients and may delay progression from claudication to critical limb ischemia; unfortunately, many patients on wait lists are CLI patients
  - Some hospitals are able to utilize short-stay inpatient rehabilitation beds to increase their inpatient ward capacity. This has helped to increase throughput of prioritized patients on the wait list.

- Question: *How is urgent defined here?*
  - For Access to Care data, urgency is considered within Priorities 2-4, where Priority 2 is considered higher urgency (requires procedure between 7-56 days of decision to treat) and Priority 4 is lowest priority (can wait up to 182 days from decision to treat).
  - Priority 1 is not calculated here (Priority 1 is through the ED or scheduled within 7 days of decision to treat).
- Question: *Will we continue to see this data as it come in?*
  - Yes, CorHealth plans on providing the updated data on a regular basis.

Open Discussion

- Question: *Have hospital administrators had conversations about not meeting funded volumes and what that means for this year's funding envelopes / QBPs etc.?*
  - The LHIN initial funding packages were developed pre-pandemic and are almost through MOH approvals. Given that QBPs are LHIN-managed, there will likely be room for the LHINs to manage volumes between hospitals that are in various stages of ramp-up / down.
- Comment: the tool developed several weeks ago to prioritize vascular patients may be useful moving forward, as hospitals plan for resumption of services.
- Comment: Ambulatory vascular clinics are also facing many challenges from being able to offer virtual care to continued reductions in surgical outpatient clinic activities.
  - Well-coordinated home and community care support may be enablers to support ambulatory clinic activity such as assisting with virtual care (e.g. assisting patients with use of technology).

NEXT STEPS

- Next meeting will be held on June 10, 2020.

Please submit your requests for discussion topics, questions and concerns for inclusion in the next forum to Mike Setterfield at mike.setterfield@corhealthontario.ca.