CorHealth Ontario
Advancing cardiac, stroke and vascular care

COVID-19 Vascular Stakeholder Forum #9

MEETING SUMMARY NOTES

DATE: July 15, 2020, 8:00-9:00am

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

System Updates

- Meetings with Dr. Chris Simpson will be reinstated next week to discuss gradual ramp up/ramp down activities as COVID-19 progresses.
- Dr. Sudhir Nagpal and Dr. Tom Forbes will be participating in these meetings.

Meeting Objectives

1. To review vascular backlog modelling and discuss potential waitlist management approaches
2. To have an open discussion around current vascular program/clinic backlog challenges and opportunities

Vascular Activity Report

- Discussed highlights / trends from the current reporting period (*See slides 7-14*)
- It was noted that resumption of vascular activity for this period is 63% (compared to 2019 activity)
    - Question: How does this compare to cardiac or cancer?
    - Response: We do not have insights into the resumption of cancer services but for cardiac we see that some services have resumed at rates that are greater than or equal to the rate of current vascular services; however, volumes of other cardiac procedures continue to show a lower volume and slower recovery of service (e.g., ablations, TAVI).

- It was noted that it could be important and meaningful to measure changes in ED visit rates during the COVID-19 period and correlate ED visit rates with adverse vascular outcomes such as increases in amputation rates.
- Other outcomes for consideration include:
    - Mortality
    - Unscheduled surgery volumes
    - Ruptured aortic aneurysms
    - Length Of Stay
    - Stroke rates

- The *Current Vascular Activity Report* will continue to be provided as a supplementary file with the material for each Vascular Forum. It can be found attached to the Forum invitation

Vascular Backlog Modelling

- Reviewed updated modelling of the accumulated unmet demand for non-urgent (scheduled) vascular procedures in a scenario of continued capacity restrictions until the end of 2020
- Data shows greater recovery of arterial vascular procedures compared to arteriovenous surgery for dialysis and venous surgery. The modelling has been adjusted to reflect the most current rates of procedure activity.
- Participant discussion about approaches to manage the waitlist towards an efficient recovery to pre-COVID-19 levels:

<u>Ottawa</u>

- Are operating on weekends and evenings but a challenge is that after hours support staff may not be as familiar with vascular surgeries.
- Evidence of staff burn-out as 8-10 staff are currently on stress leave.

<u>William Osler</u>

- Noted several current challenges:
    - IR suites might be able to ramp up more easily than an OR but they also have wait lists (might not be as extensive as the OR) but are still behind.
    - Radiology staff were reallocated at the start of the pandemic and they are having trouble getting these staff back in the IR setting.
    - Can operate evenings and weekends but would require more staff.

<u>Southlake</u>

- Reported a major challenge in addressing the backlog is sustainable funding – hospitals are not hiring more staff because there is no security around funding for next year, so the incentive for the hospital is to use existing staff to try and manage the backlog.
- Based on IPAC policies (to reduce ward room occupancy down from 4 to 3 or 2). Reductions in occupancy is also being mandated in LTC. Reduced occupancy in hospital ward beds and LTC places additional constraints on hospitlals abilities to resume activity to a level that will begin to clear the wait list backlog.

- Agree that changes to the vascular QBPs to include day surgery procedures is important

UHN

- Noted they are trying to shift inpatient to outpatient where possible but this shift in volumes still requires staffing resources.
- Mentioned that a change in current vascular QBP funding would promote more flexibility to shift inpatient procedures to outpatient, so there is a large incentive to make this change.
- Are operating on the weekends but are only doing elective cardiac procedures
- IPAC noted that 4-bed ward rooms should ideally be reduced to 2 (or 3), which would equal about 100 fewer beds.

- Discussion around COVID pre-testing:
  - London: getting conflicting messages at times from IPAC perspective in terms of when pre-testing is required vs. bed distancing requirements
  - UHN: pre-testing all surgical patients
  - Ottawa: screening all patients but not pre-testing all surgical patients
  - William Osler: testing all pre-op patients and asking them to self-isolate for 14 days prior to surgery but there is an issue with turnaround time and results might come back same day or post-surgery

Open Discussion

- Discussion Questions:
  - What are the challenges and key learnings as your program/clinic deals with the backlog of vascular patients?
  - What potential efficiencies or new approaches are you considering to optimize resources within existing capacity constraints?

William Osler

- Challenges:
  - Competing with other services for OR time
  - Dimmer switch is easier to turn off than it is to turn on in terms of things like surgical resources or staff
  - Vascular surgeries tend to require inpatient bed use & ICU / DI reliance
  - Staff burn-out has been a concern, particularly nursing staff
  - Pre-op testing turnaround time is also a challenge
- Approaches:
  - Extended OR hours and open weekends & built in emerge time into these hours
  - Shifted volumes from inpatient to outpatient (including EVAR for very specific cases)
  - Extended PACU stay for some cases (e.g. CEA) has enabled to avoid use of step-down unit

  - Moved divisions across 3 hospital locations to try and maximize efficiencies
  - Weekends are dedicated for urgent/emergent general surgery which has opened some time for vascular cases during normal weekday hours
  - Patients are typically those who require their procedure within 7-14 days

- Comment: it was noted that if OR times are booked with only P2/P3 cases there are often unused OR times. These openings could be used to complete a less complicated P4 case; therefore, further increasing efficiencies

UHN
  - OR allocation is capped at 60% until September. Then hopefully will increase further
  - Have seen a reduction in ED visits but a higher acuity in the patients that do present
  - Outpatient clinics are restricted to 8 patients in the morning and 8 patients in the afternoon (rest are done by phone)

Ottawa
  - Getting more elective surgical time but seeing a reduction in urgent time.

London
  - 75% resumption of service.
  - Cancer has been able to better manage their wait list to date compared to cardiac and vascular by negotiating greater access to OR time. Cardiac and vascular are now trying to increase the throughput – doing mostly P2/P3. Noted that it would increase OR utilization and efficiencies if allowed to schedule P4 cases during short breaks in between P2/3 cases.
  - Vascular has been getting extra time in the OR and are operating on weekends
  - Have also seen an increase in patient acuity (e.g., increase in ruptures).

Kingston
  - Have had relatively low COVID-19 cases but have seen a decrease in patients coming into clinics / ED

NEXT STEPS

- Next meeting will be held on **Wednesday August 12, 2020 from 8:00 – 9:00am.**

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