CorHealth Ontario
Advancing cardiac, stroke and vascular care

COVID-19 Cardiovascular Forum

MEETING SUMMARY NOTES

DATE: January 13, 2021, 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: Over 100 people joined the call with representation from CorHealth Cardiac Leadership Council, CorHealth Vascular and Stroke Leadership Chairs, Ministry of Health, Ontario Base Hospital-MAC, Ontario STEMI Network, Cardiac Medical Directors, Program Administrators, Cath Lab Medical Directors, EP Medical Directors, interventional cardiologists, and cardiac surgeons, Vascular Leadership Council, Clinical Advisory Committee (vascular & cardiac 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

Meeting Objectives

1. To provide an update on Cardiac and Vascular Activity to date
2. To review and discuss ICES data on COVID-19 Wave 1 impacts on CV Outcomes, and provide a commentary on vascular analyses on COVID-19 impact
3. To Review the Ontario Health Memo on Further Actions for Optimizing Care for All Patients and provide an open forum discussion

Cardiac & Vascular Activity Update

- CorHealth discussed highlights / trends from the current reporting period (See report summary slides 5-13). For further information refer to the Cardiac & Vascular Activity Reports that were attached to the meeting invitation.

Cardiac Mortality on the Waitlist: ICES Data: COVID-19 Wave 1 Impacts on CV Outcomes

***Presentation from Dr. Harindra Wijeysundera**, Chief of the Schulich Heart Program at Sunnybrook Health Sciences Centre (see slides 14-25)*

Summary:

- Waitlists are markedly lower than pre-COVID number of patients on the waitlist

- "vanishing" patients are due to upstream barriers (i.e. reduced number of referrals)
- Wait times for patient once on the waitlist are not significantly prolonged, however, the patient outcomes are worse
  - In terms of implications for care, there is a need for procedural capacity that is sufficiently nimble to respond to urgent patients and to address upstream barriers

Discussion:

- **Question:** Do you think the "vanishing patient "reflects changes in "appropriateness thresholds" for intervention? (i.e. has "appropriateness changed due to COVID)?
  - **Response:** The only change appears to be the % of ACS. The fact that the outcomes are consistent makes me think it is not different appropriateness thresholds.

Overview of Vascular Analyses on COVID-19 Impact

Summary:

- Vascular analyses to model the consequences of COVID-19 on AAA have indicated additional ruptures and death during the first wave of COVID-19. When examining available administrative data, there is an increase in mortality on the waitlist and an increased rate of in-hospital death for AAA.
- In addition, analyses of vascular administrative data that compare a pre-COVID period with the period during wave 1 of COVID-19 indicate an increase in the proportion of major lower extremity amputations that had an attempt at limb salvage and reduction in the proportion of major lower extremity amputations with a previous revascularization. These data suggest a potential consequence of COVID-19 – related delays in receiving or seeking care in the PAD population.

Ontario Health Memo: Further Actions for Optimizing Care for All Patients

***Presentation from Dr. Chris Simpson**, Vice-Dean (Clinical) in the Faculty of Health Sciences at Queens University, Member of the Clinical Science Table and leader at the Ontario Health System COVID-19 Oversight Table.*

Summary:

- Hospitals continue to face capacity challenges as the number of patients continues to
- increase in the community and in hospital
  - On December 15th, Ontario Health released a memo to hospitals with a call to action to create capacity of staffed adult acute inpatient beds for COVID-19
  - On January 1st, the Ontario Critical Care COVID-19 Command Centre requested that hospitals make specific plans to accommodate 115% occupancy of their CCSO baseline critical care capacity and be prepared at all times to receive ICU patients in transfer when directed
- ICU Capacity:
  - As the number of patients with COVID-19 requiring critical care increases, Ontario Health projects that the number of patients requiring care could exceed the

number of ICU beds available over the next two months
    - The projections show that some hospitals could quickly exceed their capacity (if not already exceeded), while other hospitals could retain available ICU capacity in the next two months

- Critical Care Capacity
    - Hospitals with adult ICU bed capacity must reserve approximately one third of that capacity for ICU transfers from hospitals who are exceeding their capacity.
        - Ontario Health is working with the Ontario Critical Care COVID-19 Command Centre to provide guidance to hospitals on ICU bed reservation. Guidance will be updated regularly as the provincial situation and hospitals' individual situations change.
        - Ontario Health is closely monitoring COVID-19 hospital utilization across the province and will be updating projections at least weekly
    - All hospitals are asked to review and standardize their critical care admission criteria in consultation with the Ontario Critical Care COVID-19 Command Centre
    - The process to transfer ICU patients between hospitals will continue to be managed by the Ontario Critical Care COVID-19 Command Centre

- To meet these urgent challenges, we must continue to work as a single, seamless hospital system so that we can provide safe, effective care to both COVID-19 and non COVID-19 patients across the province

Open Forum Discussion

- **Question:** Has the issue of consent for transfers between regions been resolved?
    - **Response:** This situation is very similar to LTC decisions / availability. Currently, if a patient refuses to go to the first available resource there is no standard resolution at the moment, but we are hoping that patients and families will understand that the resources they need access to may be in another facility due to the impact of COVID-19.

- **Question:** How is ICU admission being standardized?
    - **Response:** All hospitals are asked to review and standardize their critical care admission criteria in consultation with the Ontario Critical Care COVID-19 Command Centre. It is likely that medium sized hospitals will need to share the load and not necessarily take COVID patients but take other (non-COVID) patients that require an ICU bed.

- **Question:** For cardiovascular patients that are already admitted to a hospital, would these patients be transferred to another cardiac program if resources were required?
    - **Response:** we are trying to minimize transfers wherever possible, so for example post MI patient waiting for a Cath before discharge would do it at the local program and not transfer but there may be some scenarios where these transfers make sense.

- **Question:** What will be the role of attending physicians in determining/signing off on patient suitability/safety for transfer? Will they need to sign off?

  - **Response:** It is likely that the command table will ask a hospital to transfer a certain number of patients to another hospital and then the respective clinical teams would make those decisions

- **Question:** Any work with unions to allow incentives for work in ICU?
  - **Response:** Would be surprised to see incentives but these are unusual times, so this may be something that is possible in the future

- **Question:** Is there talk about transferring patients for Caths between hospitals if the patient cannot be accommodated in a timely manner?
  - **Response:** It is possible we could see inpatients awaiting cath being sent to another centre if that will create capacity in the system overall

- **Comment:** I want to flag for the group that there is reliance on ambulance services to support these transfers while at the same time ambulance is experiencing very increased offload delays at hospital thereby decreasing our capacity

- **Question** Some hospitals have created bed capacity by opening temporary "MASH-like" units. Is this something that you see being encouraged?
  - **Response:** some things we may see in terms of capacity building could be repurposing of space, for example, in Toronto some hospitals set to open may likely be opened early and repurposed for the time being. However, health and human resources tend to be the rate limiting step for more capacity in the system.

- **Question:** How are others approaching the selection of which patients get prioritized or access to a resource and who gets delayed? Especially in cases where patients have equivalent clinical needs?
  - **Response:** Andrew Baker and other critical care folks are currently having discussion and developing a prioritization process / protocol for resource limitations or decisions

- **Question:** acute care presentations decreased in wave 1 and in wave 2 we are seeing STEMI rates decrease – is there a concern with the current lock-down and stay-at-home order that people will not seek urgent care due to mixed messaging – is OH doing something different this time around?
  - **Response:** OH is trying to work this narrative into public messaging in terms of safety of hospitals and that patients should continue to seek care if required. However, the fear is out there and we may see people resistant to go to the ER again in wave 2.

NEXT STEPS

- Next meeting dates are still to be determined

If group members would like to share or suggest any future agenda items, please email jana.Jeffrey@corhealthontario.ca or mike.Setterfield@corhealthontario.ca for future forum meetings.