509-350 Sparks Street, Ottawa K1R 7S8
613-523-3373 caep.ca

CAEP | ACMU

Recommendations for the Canadian Health Care System Regarding COVID-19 and Flu Season

For Immediate Release

Ottawa, ON: September 22, 2020

Recommendations:

In the face of rising numbers of COVID-19 infections and the upcoming influenza season, the Canadian Association of Emergency Physicians (CAEP) makes the following recommendations:

Immediate goals must include:

1. Assuring adequate supplies of personal protective equipment (PPE), negative pressure rooms, ventilators and essential medications
2. Rapid upscaling of off- site COVID Influenza A and B and RSV testing, along with an aggressive national program for isolation and contact tracing of positives.
3. A national effort to achieve a much higher vaccination coverage.
4. Improving facility design and processes to support physical distancing in the both the waiting room and the emergency department (ED), including the continued limitations to visitors in the ED.
5. Providing support for increasing utilization and acceptance of virtual care
6. Providing support for staff wellbeing

Intermediate goals (within 12-24 months) must include:

1. Creating a national Incident Management System (IMS), using the standardized template and methodology for IMS, vertically integrated with provincial and local systems
2. Standardizing public health measures and communication nationally

Long term goals must include:

1. Adequate surge capacity for this and future pandemics, as well as other disasters yet to present themselves. This can never be achieved without an end to hospital crowding.

509-350 Sparks Street, Ottawa K1R 7S8
613-523-3373 caep.ca

CAEP | ACMU

Introduction:

On March 11, 2020, the World Health Organization declared the COVID-19 infection a pandemic. COVID-19 rapidly exposed existing deficiencies in the Canadian health and social safety nets. Canada's already overcrowded emergency departments (EDs) were faced with the potential spectre of being overwhelmed, as was witnessed in the mature systems of both Italy and the United States.

Canada's emergency physicians faced a number of challenges, including inadequate supplies of personal protective equipment (PPE), inadequate facility design to accommodate physical distancing, insufficient numbers of negative pressure rooms, insufficient critical care capacity, a shortage of ventilators and essential medications, limited surge capacity, untested disaster preparedness plans and poor command and control structures, leading to mixed messaging and confusion.

Over the following months, emergency physicians utilized the rapidly expanding literature base on the appropriate use of PPE. New protocols were developed for interventions such as procedural sedation, intubation and the management of cardiac arrest. Hospitals adapted to appropriate screening and physical distancing. Surge capacity was addressed by effectively ending all but emergency surgeries and through the transferring of large number of alternate care patients to other sites. Makeshift ICUs and improvised ventilators were rapidly developed or purchased. Communication with respect to the accessibility of our nation's emergency departments was revised and their use encouraged.

Ongoing concern exists regarding the resiliency and safety of our workforce, the safety of our patients, as well as inconsistent communication and co-ordination among various levels of government and public health agencies.

As of this writing, in the fall months of 2020, a second wave is beginning just as the spectre of seasonal influenza emerges. We have learned much and responded well under trying circumstances, yet much more needs to be done to prepare for the coming months, until such time as a safe and effective vaccine is developed.

The Canadian Association of Emergency Physicians strongly believes that we must prepare for our future by learning from our past and current experiences. We can never again let complacency expose so many of our staff and patients to potential harm.

509-350 Sparks Street, Ottawa K1R 7S8
613-523-3373 caep.ca

CAEP | ACMU

The Convergence of COVID-19 and Influenza:

Traditionally, influenza outbreaks have caused significant stress on the Canadian health care system, given our perennially crowded hospitals and emergency departments. An infectious "double-double" poses a significant risk of our health care system being overwhelmed.

Distinguishing between influenza and COVID-19 may prove to be difficult on clinical grounds and thus more rapid testing will be needed to differentiate the two.

Although supportive care for influenza and COVID-19 is similar, drug therapies for the two are different. For example, with COVID may benefit from the use of remdesivir or dexamethasone, which have not been shown to be effective against Influenza. The potential for wasted and potential harmful therapies thus clearly exists.

Going Forward:

1. Communication, Command, Control and Co-ordination:

Maintaining effective and reliable communication has been challenging during the pandemic because there is a paucity of evidence on many issues, a lack of transparency from various levels of authority on the rationale for their decisions, and leaders have been reluctant or unable to convey uncertainty to the public appropriately. The need for effective communication was also highlighted by a drastic reduction in emergency patient volumes. Fear of contracting or transmitting the virus led to ED visit reductions of as much as 40%, with attendant risk of delayed clinical presentation for time-sensitive conditions.

Thankfully, the emergency medicine community has benefited from a strong network of communication and collaboration that predated the pandemic and that helped it stay organized, connected, and consistent. In Canada, the national specialty society (CAEP- Canadian Association of Emergency Physicians) released numerous public statements and organized action-oriented webinars, as well as regional collaboratives on best- practices and simulation training. CAEP also issued a positive statement of reassurance to the public that emergency departments were safe, open and readily available to meet the needs of individual patients. Next steps aim to ensure that more isolated locales and groups are part of the discussion, support all members of our communities equally and improve care for all patients.

As a result of the COVID pandemic there was rapidly increasing utilization and acceptance of virtual care, which helps patients and providers obtain expertise not previously available to them. Though from an emergency medicine perspective virtual care is in its infancy, it has the potential to provide patients and providers with significant benefits. Looking forward, with its

509-350 Sparks Street, Ottawa K1R 7S8
613-523-3373 caep.ca

CAEP | ACMU

greater adoption, we need to ensure that it is done in patient-centered ways rather than in medicine's historically provider-convenient approach.

Lastly, the command and control of the pandemic, a national health emergency of unprecedented proportions, laid bare some of the inherent jurisdictional difficulties of our federation. As front-line health care providers, we noted with concern the apparent lack of national coordination of public health measures, leaving a very confusing and differing set of measures on business closures and public gathering restrictions, varying from city to city and province to province. There must be clarity and federally coordinated messaging with respect to strict and uniform preventive public health measures, including public masking, gathering sizes and travel restrictions.

The importance of consistent messaging for effective communication should outweigh potential jurisdictional concerns. Until now, the federal government has only been one voice among many, which has led to conflicting and confusing direction to the Canadian public and to health care providers. CAEP believes that it could have a partnership role in a more effective federal communications strategy, in that emergency physicians are on the front lines of the battle and generally perceived by the public as knowledgeable and credible.

During a crisis, it is well established that an effective and lean command and control system is critically important; yet we still do not have the ability, nationally, to respond quickly to changing science and circumstances. As a result, we have multiple ministries, departments and agencies involved in a confusing and overlapping span of control. Therefore, we see an urgent need for the following:

- a national incident management system (IMS), vertically integrated with provincial and local systems
- standardization of public health measures and communication nationally
- use of the IMS and the emergency powers act to ramp up domestic production of PPE, equipment and medication, and create a national distribution system to avoid balkanization, and
- Ramped-up national testing capacity and a standardized, aggressive national surveillance strategy for all infectious emergencies, to go along with isolation and contact tracing of positives.

2. Immunization:

Our hospitals and health system routinely face significant issues in dealing with the impact of seasonal surges due to flu; a coincident second wave of COVID-19 would stretch our capacity, worsening the morbidity and mortality of our communities.

509-350 Sparks Street, Ottawa K1R 7S8
613-523-3373 caep.ca

CAEP | ACMU

Accordingly, we need an aggressive provincial influenza immunization strategy to minimize the impact of influenza with all partners participating, including public health, primary care, pharmacists, and employers.

In Canada, around 40% of the population usually gets immunized for influenza. The goal has been to immunize more than 80 per cent of those older than 65 years and adults ages 18 to 64 with chronic medical conditions. The actual immunization rates for these groups in our country are around 70% and 43%, respectively. To achieve population immunity, we would need a much higher vaccination coverage.

3. Testing

On testing, it is important that we draw a distinction between diagnostic testing (likely to remain within EDs/hospitals and assessment centers) and surveillance, with all the controversies over home and point of care tests, pooled testing, wastewater testing. Our concern is strictly regarding the availability of diagnostic testing.

We need both a rapid upscaling of COVID testing and also the ability to test and differentiate patients with COVID from those with Influenza and other viral illnesses. These must be done rapidly to allow for appropriate cohorting and to prevent delays in assigning the appropriate site and level of care. Ideally, we would have access to point of care testing.

4. Crowding

Prior to the COVID pandemic, Canadian hospitals were chronically overcrowded, frequently exceeding 100% bed occupancy. Safe hospital occupancy has long been accepted to be 85%, allowing for the ready transfer of hospitalized emergency patients to the wards and ICUs. It also allows for adequate surge capacity in the case of infectious disease outbreaks and national disasters.

Though there are a number of factors leading to crowded EDs and delayed access to care, above and beyond all others is a crowded hospital. Capacity in the hospital system must be reconsidered to ensure adequate emergency access.

There are multiple consequences to crowding in emergency departments, which have been well-articulated in international studies. Specifically, in the context of pandemic planning, it should be recognized that the crowded emergency department can worsen the transmission of any infectious disease and can become a reservoir of nosocomial infections.

509-350 Sparks Street, Ottawa K1R 7S8
613-523-3373 caep.ca

CAEP | ACMU

Adequate surge capacity for this and future pandemics, as well as other disasters yet to pronounce themselves must be a priority and the Canadian health care system must commit to ending hospital crowding.

5. Emergency Department Design and Assessment Centers

Canadian EDs responded rapidly and well to the demands placed on them by the pandemic. Pre-registration screening was done at a distance from the emergency department. Waiting areas were adapted to promote adequate physical distancing. "Hot" and "Cold" zones were instituted. Separate rooms for COVID suspects were improvised. This led to enhanced safety for both patients and staff. This must be consolidated.

A crowded emergency department can be a nidus for infectious disease transmission. This was identified in the SARS outbreak of 2003, which was centered in Ontario. This led to a rapid redesign in Ontario emergency departments for negative pressure rooms in every department. Regrettably, COVID has demonstrated that we need more than the current allotment.

We must also not go back to the era of the continually crowded waiting room. Adequate physical distancing must become the new normal. Canada's emergency physicians have a role to play in reducing crowding in the waiting room. Some have embraced the practice of virtual care, other have called for enhanced telephone triage. Traditionally, Canada's EDs have welcomed all comers, but we can and must consider active ways of patient diversion to more appropriate points of care.

One such strategy is to consider the expansion of off-site assessment COVID testing centers or to more all-encompassing acute respiratory illness centers, to include influenza A/B, RSV, and COVID-19, for the fall. This will need to include a 'four-test PCR' platform from a single swab or other reliable point-of-care testing. This platform enables differentiation between these four major pathogens, appropriate treatment, and cohorting to minimize the isolation times specific for the pathogens, both at home and, if required, in hospital.

Keeping these centers open will decrease the burden on EDs and primary care while streamlining the use of personal protective equipment (PPE) and testing.

6. Infection Control

As a society we must reduce the potential burden of concomitant COVID and Influenza infections and, as noted previously, we must therefore consider markedly increasing the extent to which we vaccinate the general population.

509-350 Sparks Street, Ottawa K1R 7S8
613-523-3373 caep.ca

CAEP | ACMU

Within the emergency department itself, we must continue the practice of physical distancing in the both the waiting room and the department itself. Furthermore, while acknowledging the associated stress, there must be continued limitations to visitors in the department.

We must be assured of the continuous availability of Personal Protective Equipment and combat PPE fatigue.

Hospital bed occupancy must be maintained at a level that promote good infection control and the abandonment of four-patient wards must become a priority.

7. Maintaining staff resilience

Canadian emergency departments are already threatened by a national shortage of emergency physicians. Canada has an estimated shortfall of 1,000 emergency physicians, insufficient numbers are being trained and the burnout rate of those practicing emergency medicine is estimated at an astonishing 86%.

Without sufficient staff, the burden of the pandemic due to either illness or moral injury, will threaten the continued integrity of our emergency health care system. The demands on ED staff due to anticipated sick calls, as well as isolation of school aged children will be large.

The high morale we have seen in colleagues through this unprecedented world crisis, along with the collaboration between disciplines, professions, and communities, have helped members of the medical community reaffirm a sense of purpose and reassured us that the risks we take daily are not going unnoticed.

Unfortunately, we also know that many health care providers have suffered and will continue to suffer from ongoing mental health consequences as a result of this pandemic.

Leaders have a responsibility to foster an environment in which they support their teams while making it acceptable for members to voice cries for help. They must demonstrate visible and authentic leadership, not only in words, but by offering formal psychological support in stepped ways (e.g., information, support, first aid, intervention) though national programs designed to support emergency physicians and other front-line staff at risk, regardless of location.

Our teams are our most precious resource; we must ensure we keep them healthy and well so they can continue to provide care for Canadians on this challenging journey.

509-350 Sparks Street, Ottawa K1R 7S8
613-523-3373 caep.ca

CAEP | ACMU

Summary:

COVID-19 rapidly exposed existing deficiencies in the Canadian health and social safety nets. While the pandemic is far from over, and while future crises will undoubtedly occur, we are at a juncture where we must pause to reflect on what has been done and identify further actions that must be taken before the anticipated resurgence of COVID and onset of flu season. The recommendations and goals posted above must be resolved promptly to ensure best possible outcomes in the coming fall.

****

CAEP would like to thank Dr. Kieran Moore, Medical Officer of Health, KFL and A Health Unit, for his contributions to the manuscript.

If you would like more information about this topic, please contact Christina Bova at 613-523- 3343 x17 (office), or email at cbova@caep.ca