Emergency Preparedness / Response for Primary Care Providers

A Division Project Sooner Rather Than Later

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Rhonda Eden, MA – Network Lead, Emergency Preparedness, TRDFP

June 25, 2020

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Disclosures:

None

"Appropriately educated and prepared health care professionals are the **most essential components** when it comes to reducing mortality and morbidity following a disaster."

Djalali et al., 2009 – Prehospital & Disaster Medicine 24: 565-569

Less about this…

More about this…

Community Resilience

"Ability for communities to use available resources to respond to, withstand and recover from adverse situations."

- Resources include:
  - healthcare
  - transportation
  - utilities
  - food
  - communications

Ability to build-back Better

Capacity for self-organisation

Effective communication

Developing flexibility

Understanding risks & uncertainty

Collaboration between stakeholders

Use of local knowledge & resources

Preparation engagement

Empowerment

Social connectedness

Specifically about this…

Community Disaster Resilience

Community Disaster Resilience TRDFP In Action

Building Networks

Fostering Partnerships

Communicating Effectively

Definition: What Are Disasters ?

"Predictably Unpredictable Events"

Lac-Megantic,QC rail disaster – July 6th, 2013 – 47 dead

Can Be:

Sudden,

Prolonged,

Small,

Large…

Wildfires, BC 2017, 2018, …

Merritt, BC bus crash – Aug 29, 2014

Hurricane Sandy , NY, NJ Oct 2012

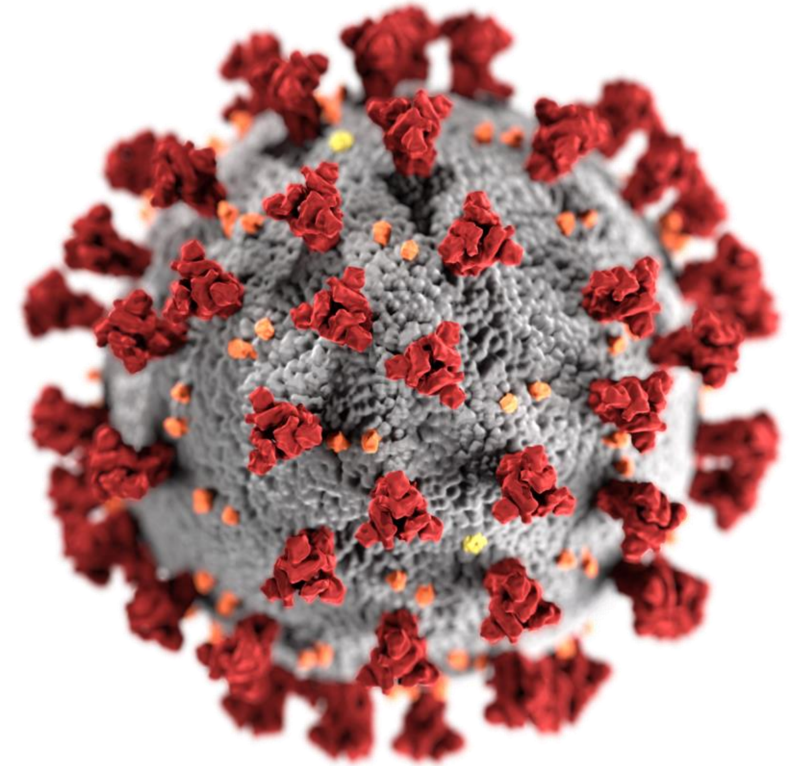
Disasters:

- **All begin as local events first**
  - Involve local resources & personnel first
    - Can spread regionally-provincially-nationally…
- **That local capacity to manage is overwhelmed**
  - Demand > available resources
    - If manageable = defined instead as an “emergency”
- **They are all relative**
  - Depends upon your available resources
  - So your disaster may not be a disaster to another
    - Eg Mill Explosion
  - Provides perspective, understanding

Burns Lake Mill Explosion, 2012 (CTV)

“Predictably Unpredictable Events”

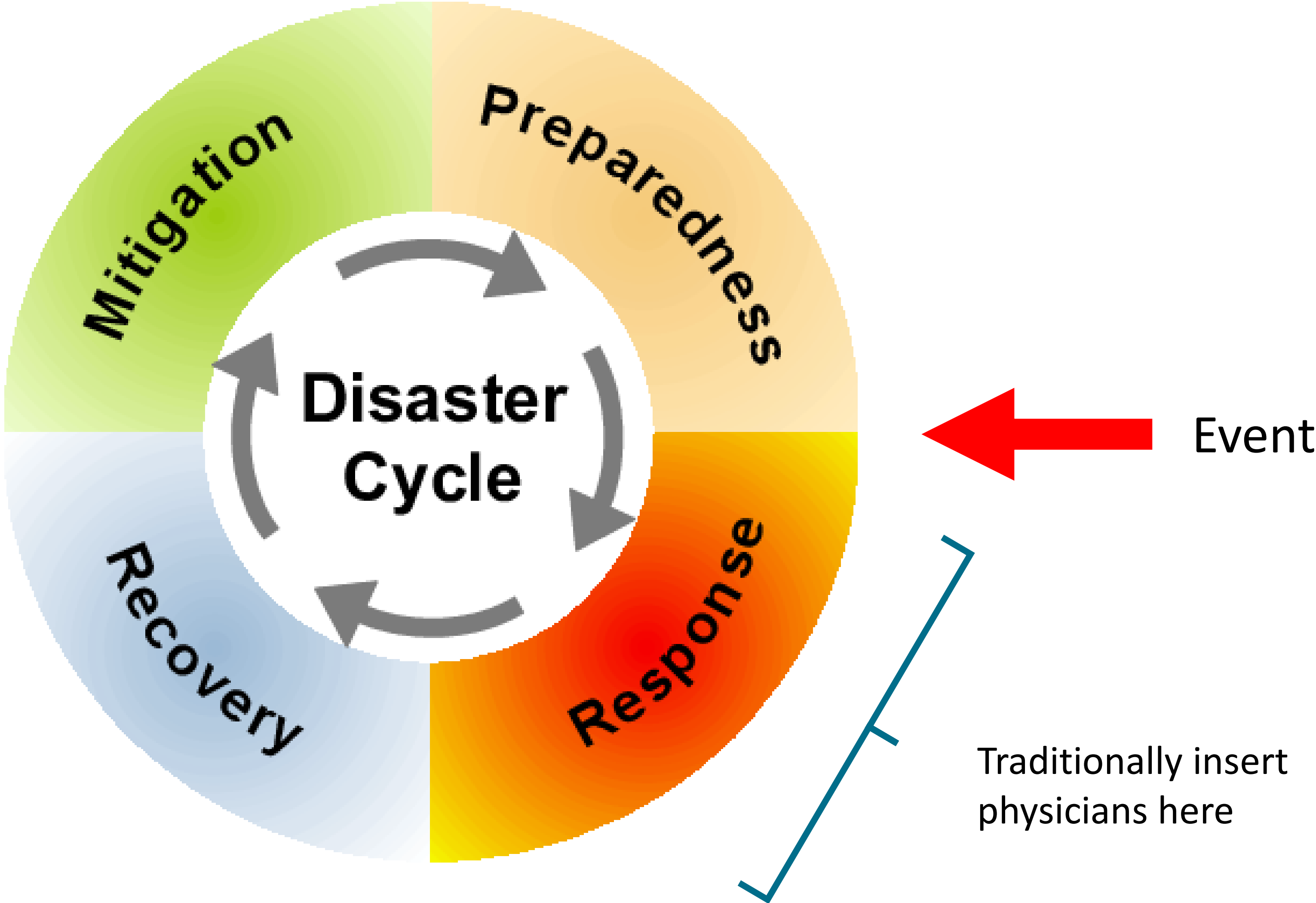
What is happening - now



Healthcare is common to all disasters

- **ALL** involve local hospitals & HCP's FIRST
  - Acute Hospital Care - Immediate Response
- Societal Expectation:
  - Hospitals and HCP's are knowledgeable, prepared and available for any disaster (safety net)
- Not ALL are Public Health Disasters
  - May not have PH (PHO/MHO's) to fall back on

Emergency Management



Health Emergency Management

Hospital Emergency Planning & Preparedness
(code orange, green, red…)

HEMBC
Health Emergency Management

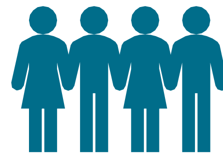
PHSA

Health Emergency Management

Hospital Emergency Planning & Preparedness

Community Practice Planning & Preparedness

Role of the Community Provider
“Save the Hospital”



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What is the Role for Primary Care Providers in a disaster ?

- **Immediate:**
  - All communities – FP's have the potential to reduce hospital burden
  - In rural communities – FP's are EP's
- **After:**
  - Post injury care
  - Chronic disease exacerbations
  - Mental / Psychosocial Health…
  - LTC
  - Displaced people / families / medications / resources

Innovative Forethought
TRDFP EM Preparedness and Response Project for Physicians

Objectives

- Practice/ Clinic Readiness (start in the office)
  - Summer/Fall 2020
- A Network of practices/clinics
  - Fall/Winter 2020 – Spring 2021
- Formalize TRDFP and Interior Health Partnership
  - 2020 - 2021
- Co-designed healthcare emergency preparedness framework with healthcare and community partners
  - TBD

Data to inform the project

- Integrating Physicians in Disaster Preparedness and Health Emergency Management
    - Doctors of BC Policy Paper
    - Thompson Rivers University Community Driven Research Project

Project Partnership in Action
IH-HEMBC, TRDFP, RIH

The Wisdom of Wildfire

Fall 2019

- Explore TRDFP involvement/role Incident Command Structure (ICS)

Spring 2020

- Prepare for Wildfire Season → COVID-19

Covid aside - We Live In An Area of Risk

Ashcroft, 2017

Kamloops, 2003

Cariboo, 2018

Interior Wildfires:

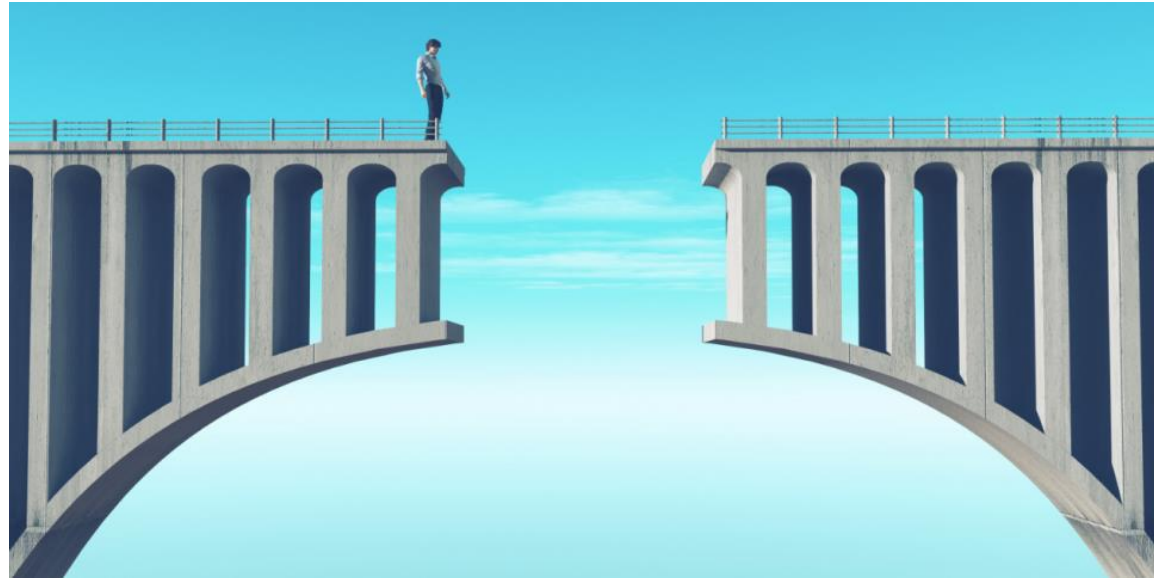
1998 - Salmon Arm, Shuswap *(7000 evacuated, including 1 hospital)*
2003 – Okanagan, Thompson *(50,000 evacuated)*
2017 – Cariboo, Thompson, Kootenays (35,000 evacuated, > 1.1 million hectares)
2018 – Cariboo, Okanagan, Kootenays, Northern BC *(>1.3 million hectares)*

- all declared as provincial states of emergency
- 2017 & 2018 being 2 worst yrs. in BC history

? New normal ?

Kamloops, July 2018

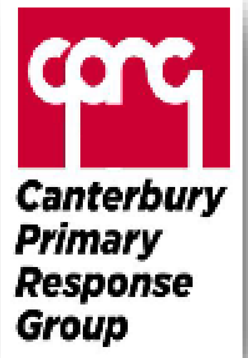
How bridge …. The GAP



Healthcare Emergency Planning

Healthcare Providers

A Role for Primary Care



Oct 27, 2016

Dr. Phil Schroeder
Primary Care Coordinator
Family Practice Lead

Karen Kennedy
Pharmacy Lead

Graeme McColl
Emergency Mngt Lead
(retired NZ lead for Health
Emergency Management

Canterbury Primary Response Group (CPRG)

- Pegasus Division of Family Practice (Christchurch, NZ)
- Community Pharmacies
- formed in 2006 with mandate in a Disaster = SAVE the hospital
- Preparedness
  - Collaborating with Health Board (Authority) and EHS
    - Pre-planning, EOC coordinated EOC, education, communication
- Response - activated
  - Triage & mngt minor injuries/illness in the community
  - Supporting and coordinating community practices / clinics
- Recovery
  - Continue to support & coordinate community practices/clinics to reopen and return to pre-disaster sate

Feb 22, 2011, 12:51pm 6.3 R Earthquake

- 185 deaths
- ~2000 injuries
- 50% of structures damaged

Christchurch, NZ

(pop. ~ 390,000)

EQ Occurred - CPRG Activated their PLAN

- Struck their EOC, linked with HA's EOC
- Assessment of FP offices / community pharmacies
  - Who was damaged & Who was functioning
  - Not functional – where staff / MD's could report to - "response clinics"
- Activating designated Community Triage Stations
  - Serious – to hospital (EHS)
  - Non-serious – managed in community
- Next days – months: EOC coordinated resources
  - Communication: patients, md's, Rx's, media
  - Where resources were available (ie clinics open)

Community Mapping

Shirley-Papanui Ward

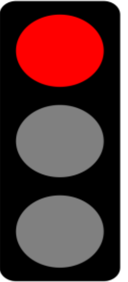
Fendalton-Waimairi Ward

Burwood-Pegasus Ward

Hagley-Ferrymead Ward

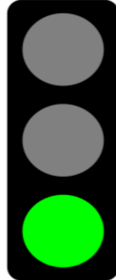
Riccarton-Wigram Ward

Spreydon-Heathcote Ward



Closed

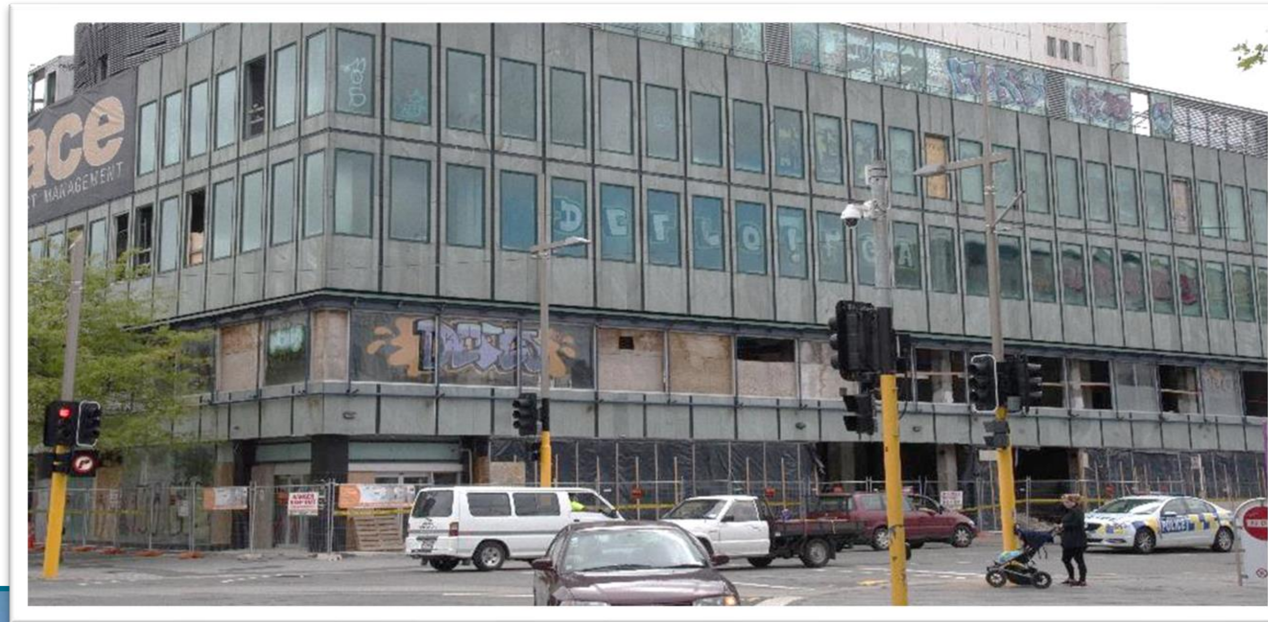
Partially functional

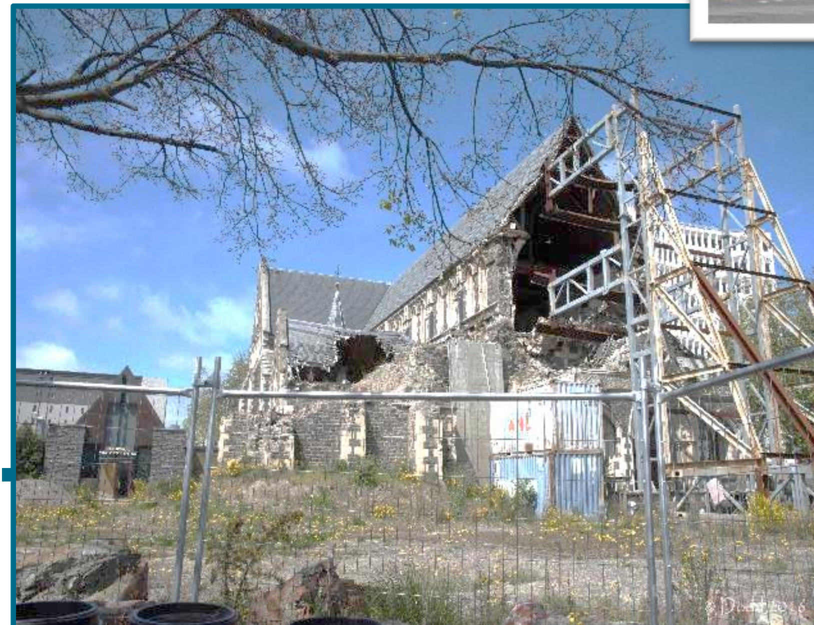


Fully functional

Note: Hypothetical Example (for illustrative purpose only)

Christchurch, NZ - Oct 27, 2016 (5 years later)





- Not just ‘one and done’ events
- Effects can last for years
- Significant social disruption

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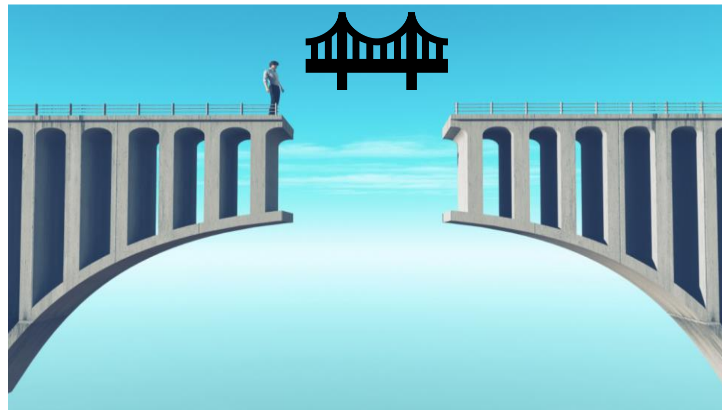
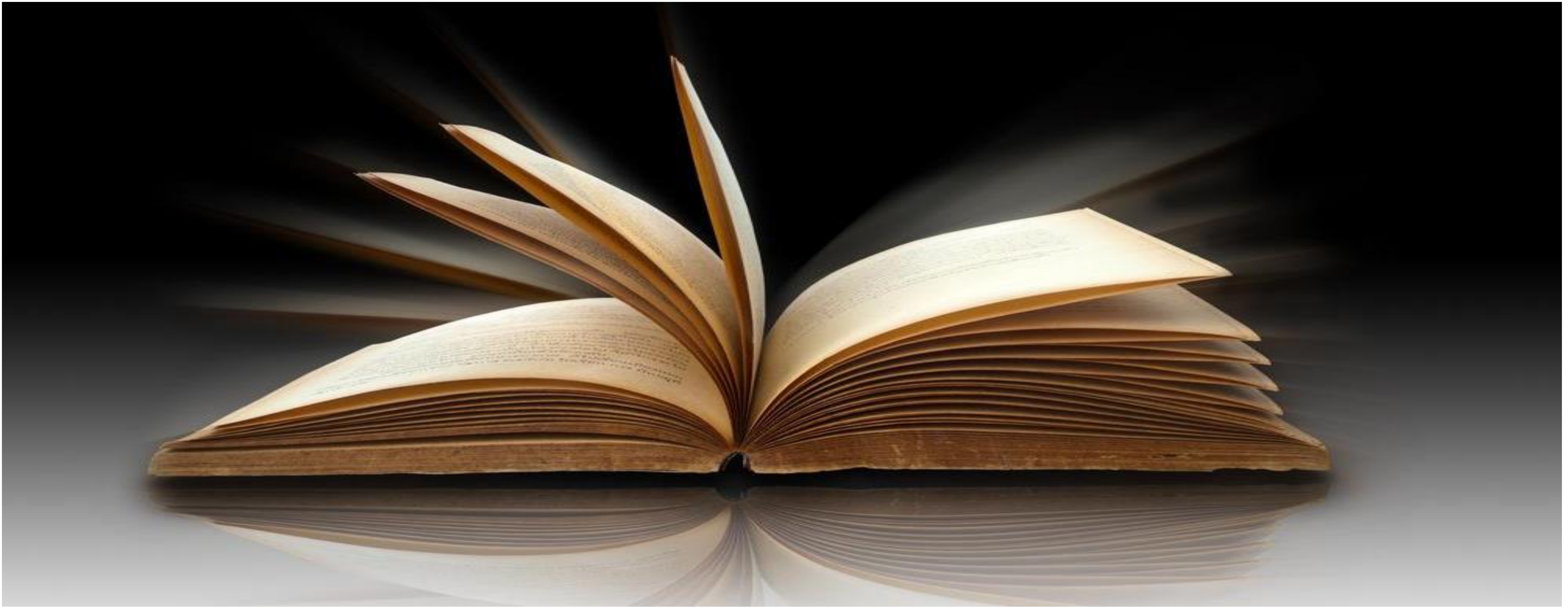
IHA Emergency Mngt: TRDFP Success (PreCOVID)



Recognized the gap…starting to think about the bridge

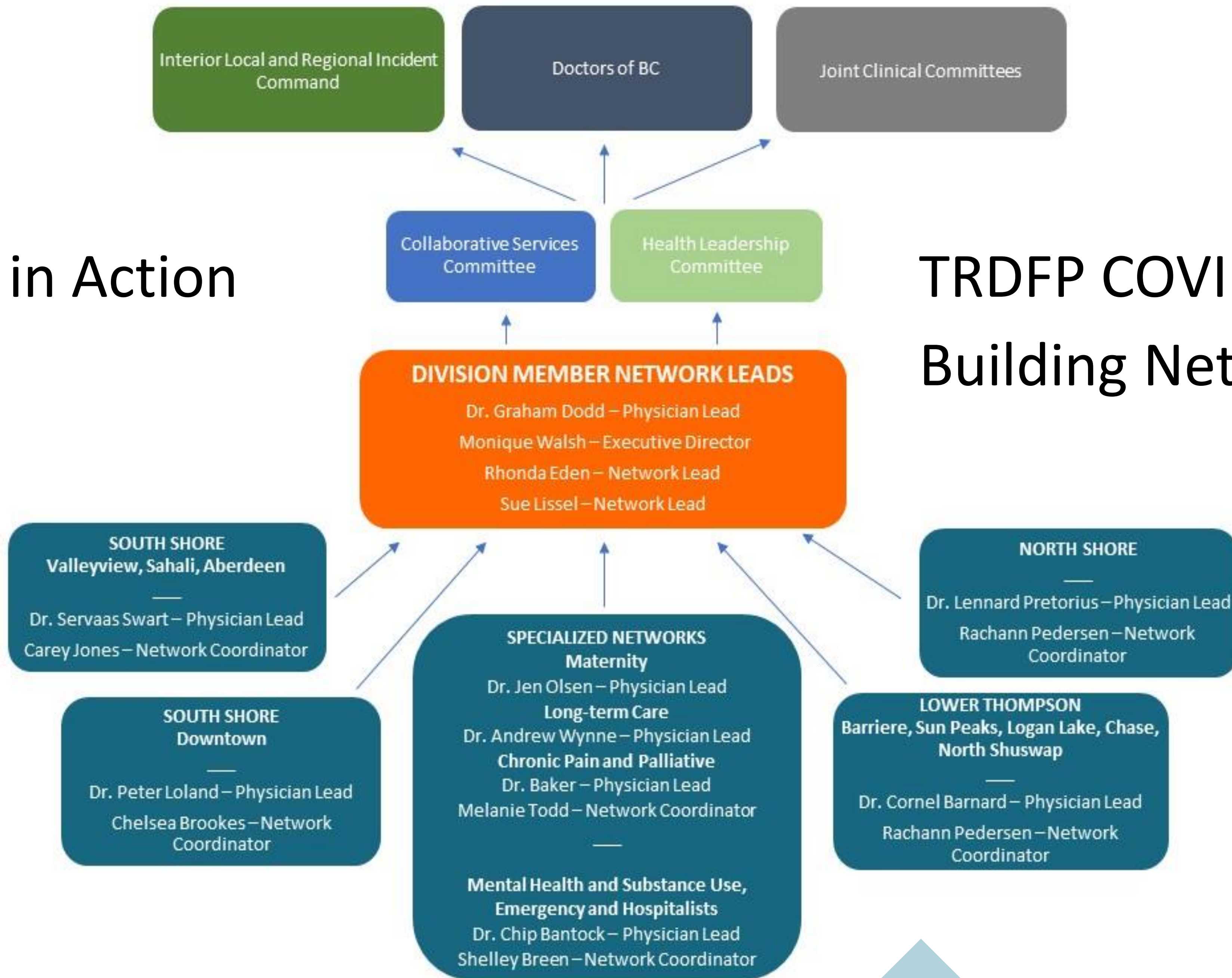
- Initial work - create EM project (Wildfires)
- Physician/Division to understand HA's Emergency Mngt System (potential role for Division)
- Good 2-way communication
- Connected with our members (Feb CME @ SP)
- Plans for Spring/Summer project (prep for Wildfire season)



COVID made us turn to the end of the book FIRST

Innovation in Action

TRDFP COVID Response
Building Networks



Thompson Region COVID PCN Weekly Survey

Month 1 Highlights

April 19, 2020

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75 physicians and 19 Nurse Practitioners receive the weekly survey (family longitudinal practices)

- **69 physicians and 4 NPs have participated at least once**
- 4 physicians have not responded at all
- The Division is actively reaching out through our NP lead to boost NP responses
- Many other members' work is being captured in the specialty networks summaries.

Data clarity – for consideration

- One physician may respond as a single physician or on behalf of multiple physicians in a clinic
- A MOA or office manager may respond from their perspective, for one physician or for all physicians in a clinic
- Who responds (on behalf of whom) can change from one week to the next

Personal follow up with members from their network coordinator has:

- Opened up communication in a very positive way beyond the survey and COVID response.
- Helped reinforce why we are collecting survey responses each week (to provide the best support for members during this difficult time).
- Resulted in a boost for survey responses each week (even for a member who was previously deleting all their TRDFP e-mails during COVID).

Highlights

Development of a new positive working relationship with NorKam clinic staff.

- Accepted a PPE delivery for us
- Provided local PPE supplier contact information through which the Division was able to connect and purchase PPE for membership.

Flowchart was drafted and finalized for the Chase clinic to see referred patients from North Shuswap who need to be tested for COVID. This was then shared with the North Shuswap Health Centre.

More Division staff are creating positive working relationships with members and their clinics.

"Great job, this will advance care in Kamloops down the road; you are catching doctors off guard who hate change and this is a good thing."

"Thank you so much for this amazing support!"

"I didn't understand the point of the Division but now I am so grateful for all the work and time you've spent helping our clinic"

"I think it's great that you're taking the time to reach out to each one of us and see what we need."

No new survey distributed

Thompson Region COVID PCN Weekly Survey

Week 4 Report – April 19,2020

WEEK 3 SURVEY UPDATE

Division network coordinators followed up with physicians/clinics in their network who did not respond to the week 3 survey. Twenty additional responses were recorded as a result for a total of 58.

The green sections of the report highlight collated survey data where changes were greater than 4% only.

- This applies to 3/16 questions.
- Other collated responses remain very similar (within 1-4%)
- Additional comments remained within the same thematic categories as reported in the week 3 report

Specialty Clinic Shifts

14 (*up from 10*) members indicated they have capacity to take shifts in the respiratory clinic.

Patient Volumes are changing:

- 28% much less than usual *(previously 33%)*
- 42% less than usual *(previously 33%)*
- 21% the same *(from 25%)*
- 7% more than usual (*previously 9%*)

Centralized Non-Respiratory Clinic Inquiry

17 physicians (*previously 10*) would be willing to work in a clinic like this.

8 private offices (*previously 4*) are willing to be a clinic site.

Respondents say:

- 47% use the UPCC (*previously 55)*
- 27% network private offices (*previously 25)*
- 19% convert the KUCC *(previously 15)*

PPE

The Division is currently working to obtain PPE through three different avenues:

- IH order has been submitted;
- Division has purchased directly from suppliers; and
- Division has partnered with RIH Foundation to cold call for donations (ie: dentists, ortho, etc.)

The Division anticipates receiving all PPE within the next week and half.

Division staff will be putting packages together and personally delivering to all members and/or clinics.

All physicians will have the opportunity to receive a PPE package to ensure fair distribution, which will be coordinated through personal reach outs.

UPCOMING

Community & Local Health Tables

The second COVID Community reach-out meeting is scheduled for April 23.

Direction for Week 5:

Further inquiry into how physician offices are operating:

- Patient volume
- Practice capacity
- Staffing levels

Allied Health Community meeting scheduled for April 23 from 5:oo-6:30pm.

Specialty Networks

MATERNITY

The next Maternity Network COVID-19 Working Group, with representation from OB, Midwifery, FP, and IH, is scheduled for April 22nd.

As of April 17th, the Maternity Care Respiratory Assessment Clinic has received no referrals.

MOA meeting highlights:

- Most said their clinics are seeing a similar volume of patients.
- Virtual care provides an opportunity to be proactive with tasks and patient reach out.
- Some challenges managing time and expectations with virtual appointments.

LONG-TERM CARE

The next LTCI project meeting is scheduled for Thursday, April 23rd.

No significant updates to report.

PALLIATIVE

Palliative care from a COVID-19 perspective has been quiet.

Visitor restrictions at hospice have been lifted slightly, however, continue to promote virtual care visiting options for providers and family.

MHSU

Week three survey results have been discussed with both MHSU and some members of the psychiatry team.

There is a meeting scheduled for April 24 where the results will be shared with a broader group including MHSU, clinical staff, psychiatry and family physicians to formulate a plan to address these issues.

Work continues on the virtual Rapid Access to Psychiatry program. Scope of work, goals and resources have been addressed and as there is no existing program, a framework and processes are currently the main focus of the work.

SPEACIALISTS

A specialist survey was sent to 62 outpatient practitioners

- 16 replies collected (in the first two days)
- PPE Requests collected

Of note:

- 15/16 are not providing care as usual
- 6 are only seeing patients virtually
- 9 are seeing patients in a combination of virtual and in-person.

Supports needed include: Possible locum coverage, PPE

Concerns:

- Timely access to abortion care during COVID
- Missed diagnoses without physical assessments

CHRONIC PAIN

Last update March 30

- No changes

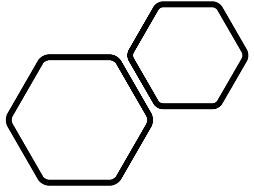
LOCUMS

Last update April 6

- No changes

EMERGENCY and HOSPITALISTS

- No Update



Innovation in Action
TRDFP COVID Response – Building Networks

MOA network → Thompson Region Community Network → Thompson Region Allied Health Network → Future opportunity: Pharmacy Network

- Centralized PPE
- Respiratory Assessment Clinic
- Maternity Respiratory Assessment Clinic
- Rapid access to psychiatry
- Incident Command
- Regional EOC
- Interior Divisions Network
- Special COVID Collaborative Services Committee
- IH EM Table Top exercise
- IH regional EOC EQI project

Innovation in Action – Effective Communication

As we physically distance, we've switched to **"virtual care"** for **regular appointments.**

A message from your family doctors & nurse practitioners in Kamloops and the Thompson Region

NEED CARE?

CALL YOUR DOCTOR OR NP FIRST.

We know you best!

#VirtualCARE

- Yes! You can still access medical care
- Virtual appointments do protect your privacy
- Virtual appointments are covered by MSP
- No downloads or pre-registration needed

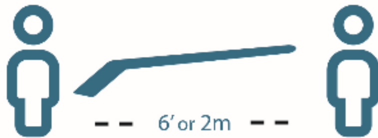
CALL YOUR DOCTOR OR NP TO ARRANGE YOUR APPOINTMENT

If an in-person appointment is required, we will tell you what to do.

We are doing our part to stop the spread of the COVID-19 virus, we need you to continue to do yours.

STAY HOME

PHYSICAL DISTANCING



SOCIAL DISTANCING

NO group gatherings

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We are here for you.
We know these are anxious times for all.

THOMPSON REGION, WE THANK YOU

"...*for* **your support.**"
Dr. Chip Bantock, Family Physician

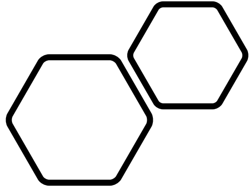
"...*for* **physical distancing.**"
Dr. Joslyn Conley, Specialist

"...*for* **keeping us safe.**"
Natalie Manhard, Nurse Practitioner

"...*for* **making our jobs easier.**"
Dr. Liz Parfitt, Infectious Diseases

#COVID**kindness**

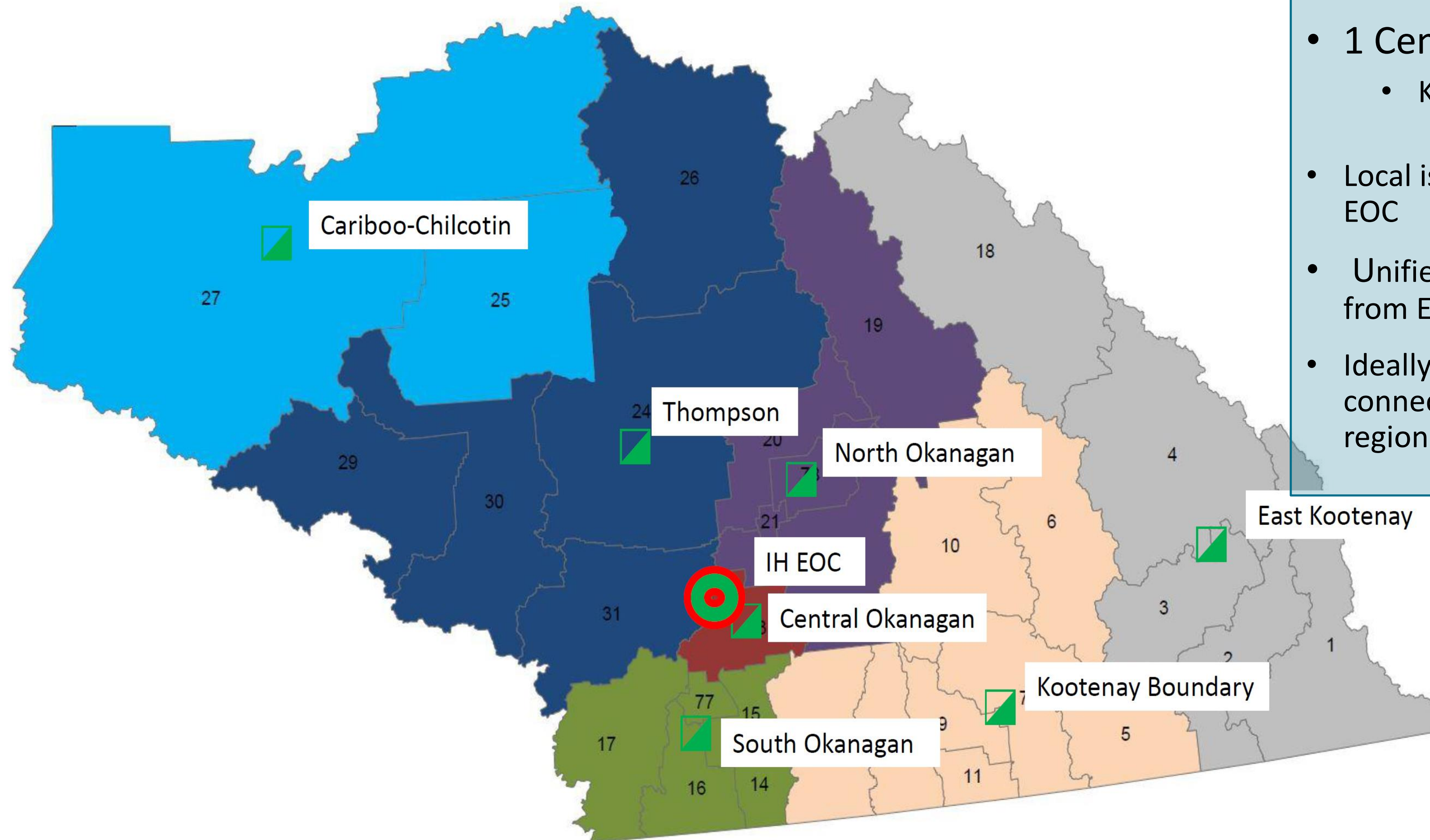
Thompson Region Division of Family Practice



Unexpected Outcomes - TRDFP COVID Response

- Interior Division Network
- Thompson Region rural physician network
- Partnership work with Rural and Remote Division
- Thompson Region member network is here to stay

Health Authority Emergency Management - IHA



IHA

- 7 Regions
  - Each with its own ICS
- 1 Central EOC
  - Kelowna
- Local issues fed <u>UP</u> from ICS's to EOC
- Unified message fed <u>DOWN</u> from EOC to ICS's
- Ideally, each Division connected/participates in their regional ICS

Innovation in Action – Effective Communication

Thompson Regional COVID-19 Incident Command Structure – Effective: 0800 hrs 02April 2020

IH EOC Clinical Operations

Incident Commander
Admin/Physician Dyad

Deputy Incident Commander
Administrator on Call
(DOC/MOC on call)

- SET on Call

Physician Support/ Coverage
Dr. T. Ring/Dr. S. Tsuchiya/Dr[illegible]
MacGr[illegible]or

DOFP-Rural and Remote
C. Kearns
Dr. John Soles

DOFP-Thompson
Monique Walsh
Dr. Graham Dodd

IH HEM Liaison
Colin Swan

Local Government Liaison
Jenny Green

Allied Health/LTC/ Kamloops HH
Karen Cooper

- Ponderosa Lodge
- OEC

Community
Berni Easson

- Ashcroft
- Clinton
- Logan Lake
- Merritt
- Lillooet
- Lytton
- Blue River
- Clearwater
- Barriere
- UPCLC
- Chase

MHSU/Public Health
Debi Morris

- South Hills
- Hillside
- Acute Psychiatry
- Community MHSU
- Rural Thompson MHSU
- Public Health

RIH
Tracey Rannie

- Acute
- Renal
- Diagnostic Imaging
- Pharmacy
- Allied Health
- Lab Services
- Chief of Staff/Site Medical Director

Plans Section
Kory Strande

Logistics Section
TBD

Support Branch
Dan Hildenbrand

Services Branch
Reggie Black

Pharmacy
Brady Magneson

Security
Daniel Semenoff

Finance/Admin Section
TBD

Staffing Services
Rebecca McGifford

Human Resources
Lana Mathers
Cory Burnett

Example of Effective Incident Command Structure: Thompson

Issues brought to ICS by Division

1. **Testing**
   - PCP offices ill-prepared to test (confusion, safety & consistency concerns)

     RESPONSE → UPCC become single site for community testing

2. **PPE's**
   - Lack of PPE's and access to PPE's in community
   - could lead to patient's being directed to Emergency

     RESPONSE → process developed for Division to access HA's PPE supply for private offices

3. Community Respiratory Complaint Patients – initial triage by PCP done by virtual care

- With shift towards VC & the lack of adequate PPE's in the community
- How to safely see patients with mild-moderate respiratory complaints in the office ?
- How to avoid sending all to the ED ?

RESPONSE → Community & Maternity Respiratory Assessment Clinics

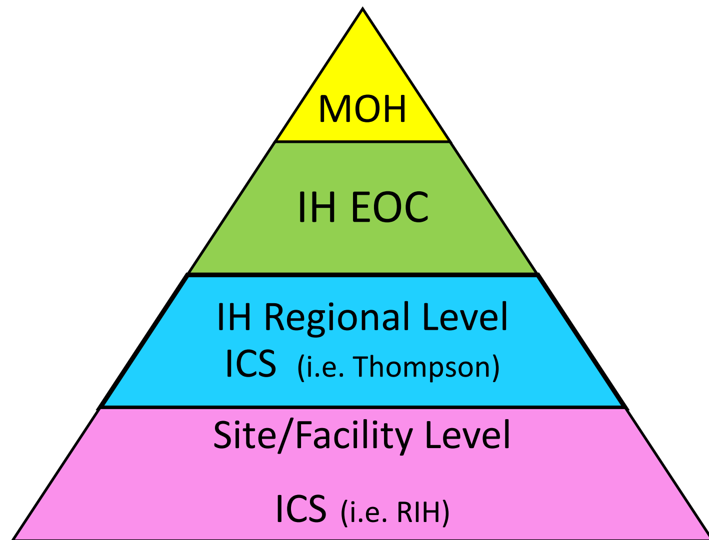
- Repurposed existing IH Clinic & supplied with adequate PPE's from IH supply
- Safety & referral process developed for staff, MDs & patients
- Solution went up to IH EOC – shared across HA

4. LTC Sites – how to reduce #'s of MD's visiting & potential transfers to ED

RESPONSE →

- LTC Leads – Drs Andrew Wynne & Phil Sigalet
- Single MD/site (sites' medical director)
- Development of "jump kit" (sutures, splints, etc.)

Challenges: Emergency Management Structure (IHA)

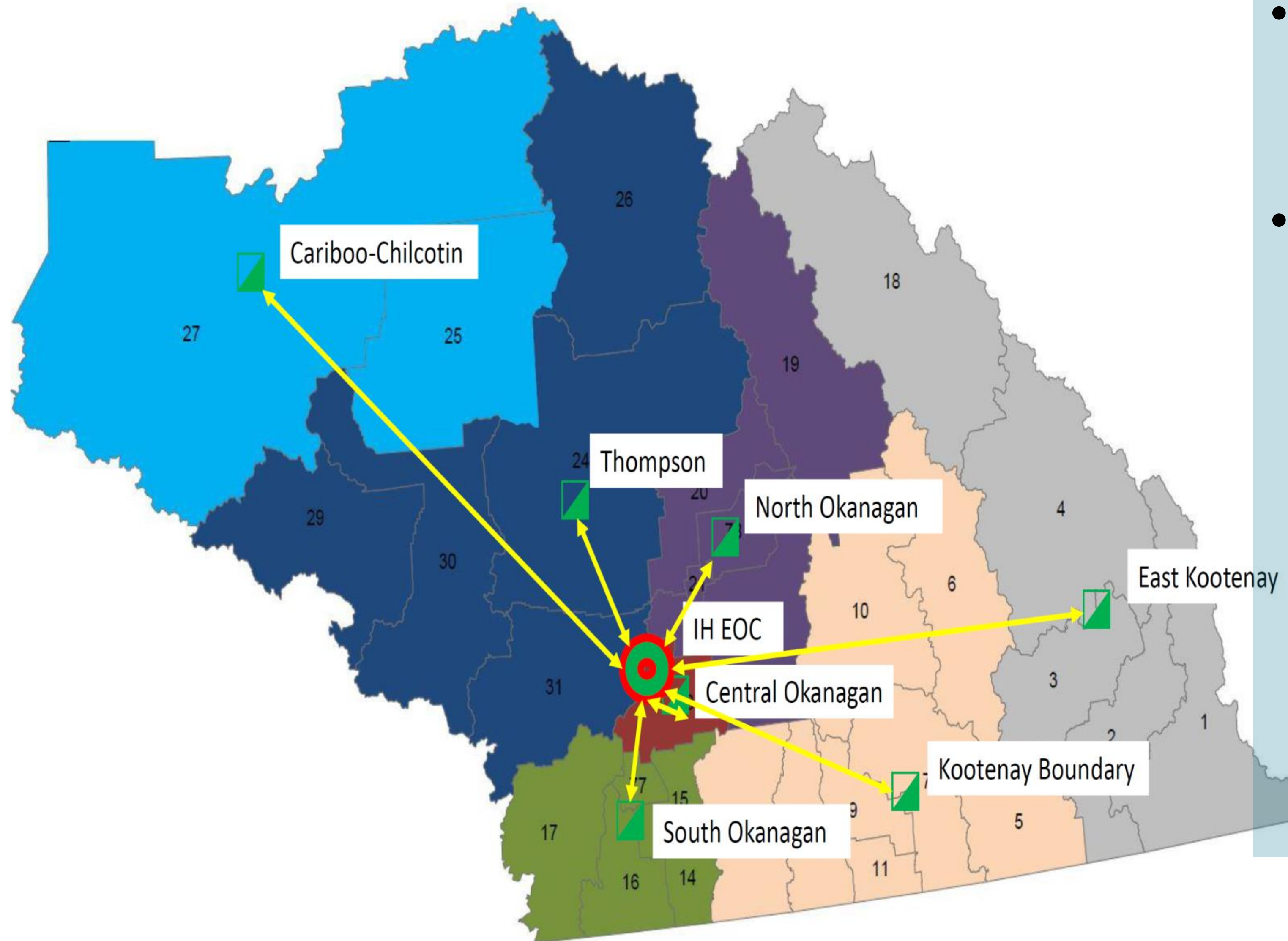


- Emergency Management Structure is different from day-to day
  - NOT a collaborative, consensus driven approach
  - Designed for rapid change – command & control
  - Hierarchical, “militaristic”

- Divisions:
  - Lacked prior understanding of EMS (like most physicians)
  - Many Divisions not initially included in their local ICS’s
    - Both sides
    - Led to delays
  - Divisions lacked formal representation at IHA’s EOC
    - Tried adhoc – indirectly – single MD represent all FP’s in HA
      - Credit to HA for recognizing need for community input & trying (began mid-March (late))

    - Difficult
      - IHA large, heterogenous communities
      - No prior structure / support for such a position
      - Something to further explore
        - E.g. Covid Care Centre rollout

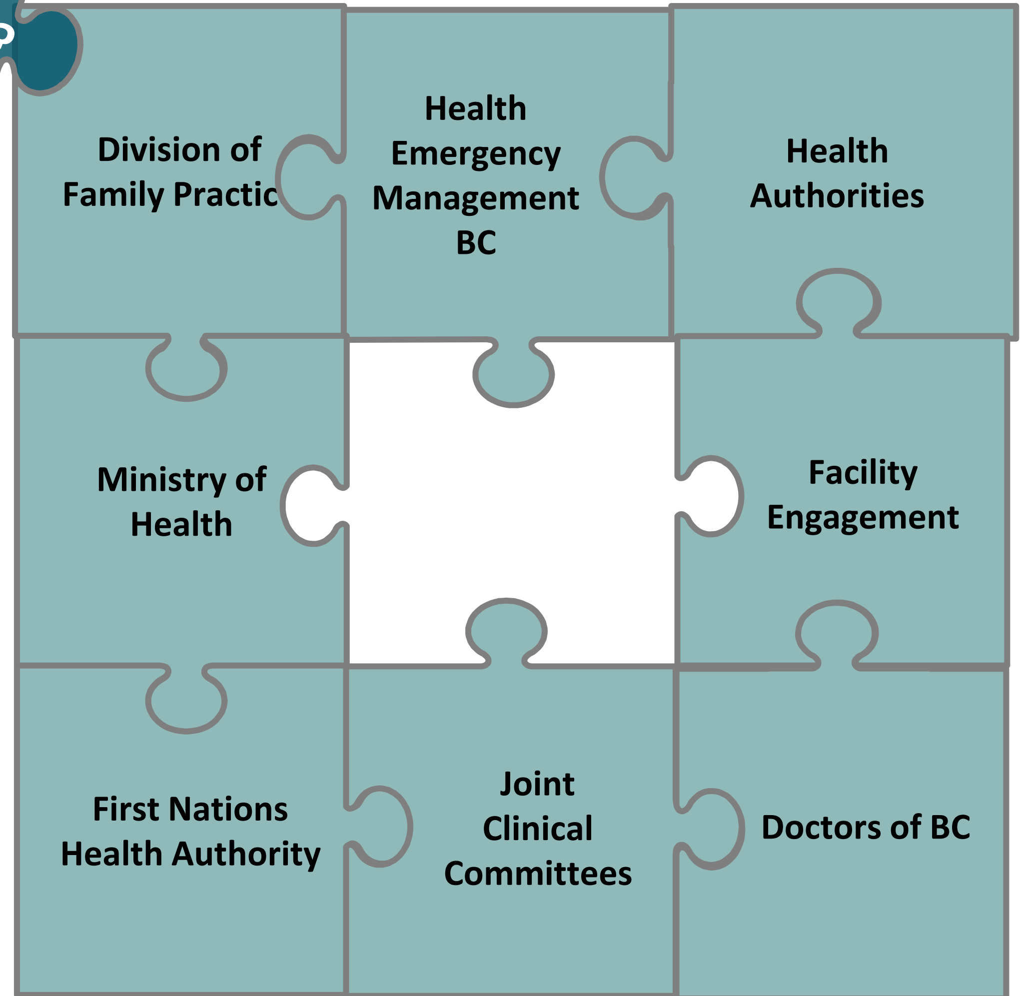
Future: What could be ?



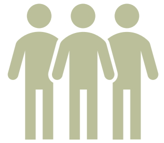
IHA

- 7 Regions = 7 Divisions
  - (8 including rural & remote)
- Goal
  - Each Division (Lead & ED) would connect early & participate at their Regional ICS (direct)
  - Consider supporting a physician (s) liaison position to the HEM Team
    - HA level
    - Regional Level
    - Facility & Community perspective
    - Physician “champions”
    - Educators, engagers…
    - The bridge to the gap

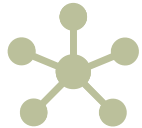
MOVING FORWARD



Getting there



Collaboration



Integration

Innovation

Education

Funding

Thank you for your time

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