Thompson Region
Division of Family Practice
A GPSC initiative

INTEGRATING THE MEDICAL LANDSCAPE:
A Thompson Region Division of Family Practice White Paper Series

03.

The Fog Of Crisis: Engaging Primary Care to Navigate Health Emergencies

Introduction

On March 12, one day after the World Health Organization declared COVID-19 a pandemic, the Province of BC still permitted gatherings up to 250 people, then dropped that number to 50 the following week, and declared a state of emergency a week later. Some 90 nations reported outbreaks totalling more than 100,000 confirmed cases and 3,408 deaths; ports turned away cruise ships; and New York, Florida, California, and Washington declared states of emergency.

Still, there was no shortage of stories about contradictory actions: the Ontario government encouraged families to travel and enjoy spring break, and in BC some 14,000 dental professionals gathered for a three-day conference in Vancouver. At the time, BC had 46 known COVID-19 cases, including an outbreak at a North Vancouver senior care centre where a man in his 80s would become Canada's first coronavirus fatality. Springtime saw the coronavirus crisis creep into communities throughout British Columbia.

In Kamloops, Royal Inland Hospital's Intensive Care Unit received it's first coronavirus patient who was admitted in mid-March. The following month, on April 27, a man in his 70s would be the first person in Kamloops to succumb to the virus; he was the second COVID-19 death in the Interior Health Authority at that point.

Fear and confusion in the general public caused a run on grocery store shelves and shortages of household cleaners, hand sanitizers, masks, gloves, and the infamous hoarding of toilet paper. The value of communicating clear and concise public health policy would escalate, and previously unheard of terms like "social distancing" and "self-isolation" entered the mainstream lexicon as lockdowns, closures, and unemployment turned day-to-day life upside down and into a simmering chaos.

COMMUNITY PRIMARY-CARE PROVIDERS RESPOND

In joining the health crisis, the Thompson Region Division of Family Practice — a primary health care organization of family practice physicians, nurse practitioners, and division staff in Kamloops, Chase, Barriere, Logan Lake, Sun Peaks and the North Shuswap — used its informal seat at meetings of the Interior Health Authority's Kamloops/Thompson Incident Command to help respond to the pandemic in the community.

Giving the Division of Family Practice a place at the Incident Command table in March was a novel approach. Other divisions in the BC Interior weren't as fortunate, and had initial challenges accessing their own Incident Command structures, which left family doctors — who were willing and able partners in the public health battle — sidelined and marginalized during the COVID-19 public health response.

Two challenges surfaced: A majority of community primary-care providers have no knowledge of emergency management and Incident Command operations, much less how their own divisions fit into the emergency response structure; and the Health Authority itself didn't see how to articulate the role of community primary care in the first week that Incident Command was engaged.

Dr. Graham Dodd

In Kamloops, Incident Command (IC) granted access to key Division staff along with Thompson Region Division of Family Practice chair Dr. Graham Dodd, a long-time proponent of involving family practitioners in the coordinated responses to health care emergencies. Dr. Dodd is the physician lead for the Division's SharedCare emergency preparedness and response project, and has a master's degree in Disaster Emergency Management. Dr. Dodd also served on the board of the World Association for Disaster and Emergency Medicine and is a subject-matter expert for the Canadian Centre for Excellence in Emergency Preparedness.

This IC access opened important communication lines between the Division and the Health Authority — an imperative conduit to exchange information during the course of the pandemic response, and a bi-directional channel to help understand each others' perspectives and identify challenges and opportunities. From the work at Incident Command, an Interior Health and Division clinical working group was struck and this — along with the work of the partnership table with the Health Authority's Collaborative Services Committee — led to a coordinated health-care response that ensured that the local emergency department response capacities were not overwhelmed.

Thompson Region Division of Family Practice chair Dr. Graham Dodd, a long-time proponent of involving family practitioners in the coordinated responses to health care emergencies

The Division mobilized its members and physician leadership to shore up community disaster resilience by focusing on three key areas: 1. building networks; 2. fostering partnerships; and 3. communicating effectively. The outcome of these efforts resulted in the centralized procurement of personal protective equipment to support community primary care providers and specialists; respiratory assessment and testing clinics for both pregnant and non-pregnant patients; support for the development of processes to care for patients in community long-term care facilities; a path for rapid access to virtual mental-health services, and the collection and sharing of data with numerous Division stakeholders: the primary care community, health care, and community partners.

When coronavirus landed in BC, there were no coordinated systems in place to include community family physicians in healthcare-led emergency planning response. There is also a lack of training, education, supports, or best practices outlined for family physicians and nurse practitioners to plan, respond, or recover from an emergency. It's not for a lack of trying.

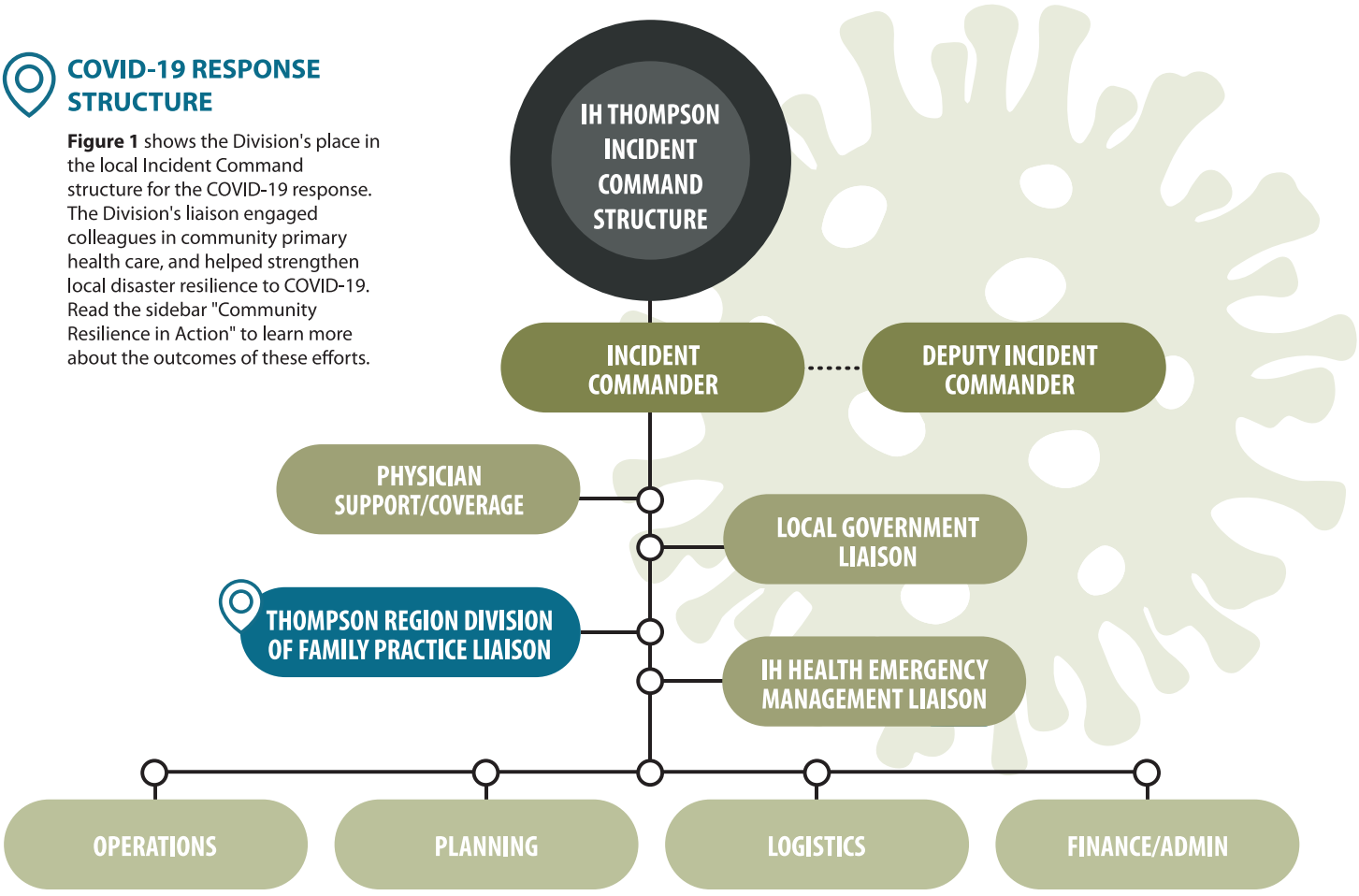
The Thompson Region Division of Family Practice has been advocating for several years to become part of emergency preparedness and response in the region. In the fall of 2019, local health authority emergency planners acknowledged the primary care gap and began paving the way for the Division to access the emergency response structure with the Interior Health Authority. As can happen in emergency planning, an informal consensus was achieved during a period of calm, and ideas and next steps to formally recognize the role of family practitioners was tabled to the following spring (before wildfire season arrived in the Thompson Region). Of course, by March 2020 a different kind of fire raged in the form of the coronavirus, and those plans from the fall were shelved.

At the start of Incident Command's COVID-19 response, local emergency planners may not have appreciated the role the Division could play at IC meetings, a seemingly incongruous position given the discussions some six months earlier. There was a general lack of understanding of what the Division could bring to the table. (Historically, emergency response focuses on hospitals and facilities — a siloed habit that is less an error of omission and more a lack of understanding of primary care's potential role in emergencies.)

And therein lies one of the challenges of emergency response planning: Formalizing the relationships deemed essential before the next crisis erupts. As it turned out, five days after Incident Command hesitated to include the Division at the response table, it became clear that community primary care was an important partner in the planning and response efforts coordinated at the table.

COVID-19 RESPONSE STRUCTURE

Figure 1 shows the Division's place in the local Incident Command structure for the COVID-19 response. The Division's liaison engaged colleagues in community primary health care, and helped strengthen local disaster resilience to COVID-19. Read the sidebar "Community Resilience in Action" to learn more about the outcomes of these efforts.



Further up the chain of command, the BC government was managing public health strategies via Emergency Operations Centres located throughout the province, and local emergency response planners from the regional EOC communicated with the Interior Division Network - physician leads and executive directors from Divisions - throughout the Interior Health Authority – through the Thompson Region Division's physician lead, Dr. Graham Dodd. Still, this third-party approach to dialogue leaves gaps in the EOC/community health care chain.

As of this writing, on the one-year anniversary of the COVID-19 global explosion, the second wave of the pandemic crisis grows in communities across British Columbia. The economic re-opening is again threatened, public health guidelines are increasingly restricted, and mobility is being discouraged throughout BC's cities as social bubbles contract. As the health-care community braces, emergency planners try to anticipate what the waves of COVID-19 will look like in schools, homes, and businesses. This time, at the start of 2021, the Interior Division's emergency response has two division primary health care representatives, and a vaccine working group that includes community primary health care. With the benefit of both hindsight and a better-informed outlook on the immediate needs for the months ahead, primary care's role in the next wave of the COVID-19 response is better articulated.

BEYOND A PANDEMIC

COVID-19 revealed the knowledge gaps, communication shortfalls, and the unrecognized opportunities to engage community physicians in BC's emergency structure.

Arguably, what flowed from COVID-19 was a response, not preparedness. Looking back at the various challenges in the province's emergency plans, the crisis illustrates the opportunity to formalize the role of primary care doctors in BC's emergency organizational structures, and suture a gap that would help communities be better prepared for health impacts that go beyond a pandemic. History shows how disasters — predictably unpredictable events — can stun communities. Fierce and sudden tragedies rocked the communities of Burns Lake, BC, Lac-Mégantic, Quebec, and Humboldt, Saskatchewan, with a sawmill explosion, a rail disaster, and a bus crash, respectively.

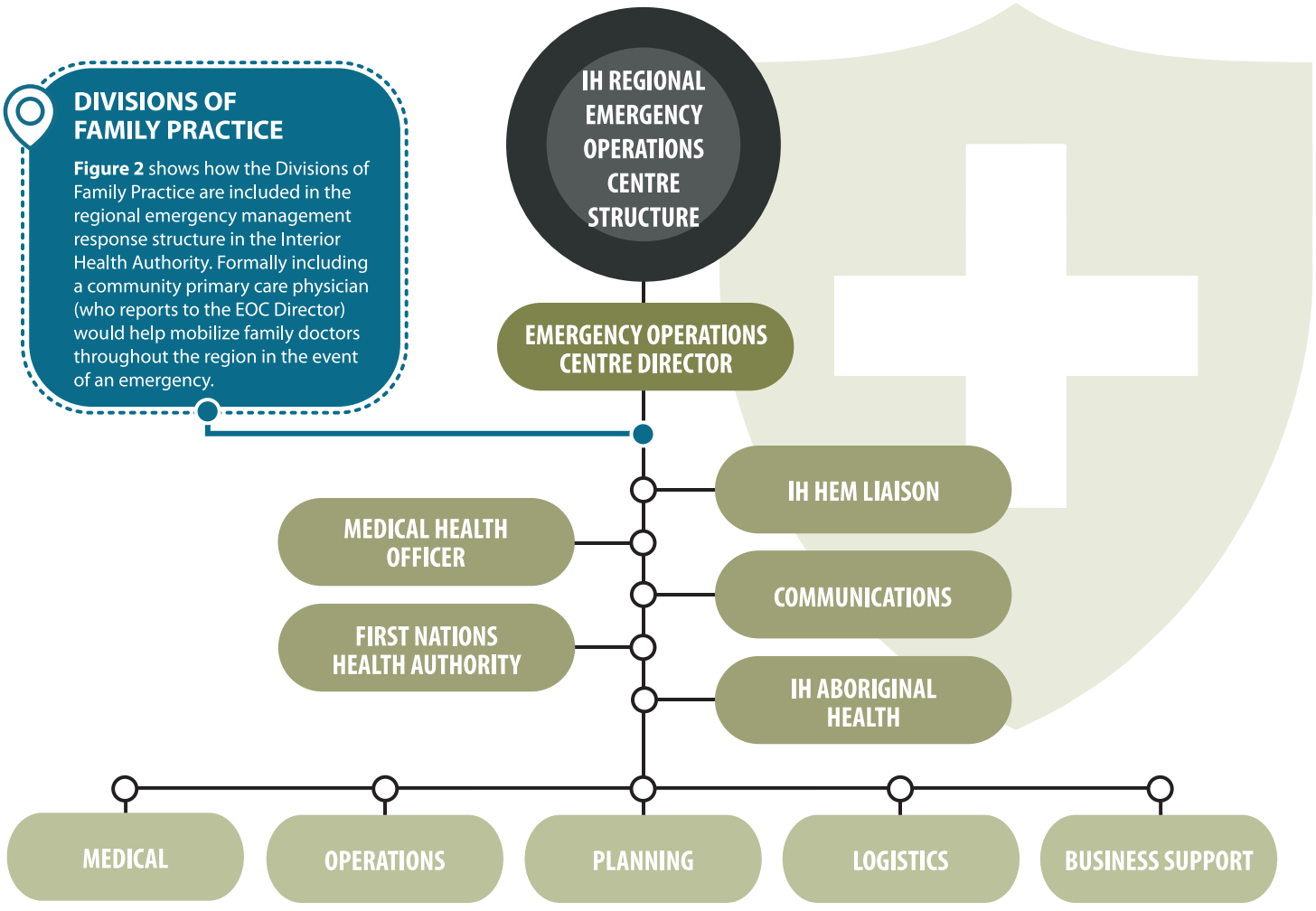
Kamloops, a hub city that is a supply gateway between BC's Lower Mainland and the rest of Canada, could be subject to any of those disasters. The forested region is prone to wildfires, a pulp mill operates within city limits, a busy rail system includes a multi-block rail yard in the heart of the city's downtown core, and two major highways run through the city (Hwy. 1 just west of the city sees an average of 15,858 vehicles per day).

Understandably, a key medical priority during a community emergency is to protect the hospital and its resources. Physicians in family practice are in a unique position to become a guardrail for hospital resources such as emergency rooms. For example, on February 22, 2011, when 185 people died in Christchurch, New Zealand, following a noontime earthquake, local family physicians joined the Canterbury Primary Response Group to assist in Christchurch's disaster response. Thousands were injured, with 164 serious injuries. The primary response group's goal: Save the hospital.

When the earthquake hit, the Canterbury Primary Response Group struck its Emergency Operations Centre, and linked up with with their local Health Board's own EOC. The group assessed its family practice offices and community pharmacies — who was open, and who was damaged —and coordinated response clinics where doctors and staff could report. The primary care group activated Community Triage Stations, sending serious cases to hospital, and managing non-serious patients in the community.

Underground water seeped up through the soil to the surface and caused Christchurch's structures to sink. Of the 100,000 damaged buildings approximately 10,000 had to be destroyed. The earthquake seriously damaged water and sewer infrastructures, and for months the local residents relied on portable toilets and clean water from tankers. In the days and months after the earthquake the EOC continued to coordinate its resources, communicating with patients, doctors, pharmacists, and the media as residents grappled with the aftermath of their disaster.

The Christchurch response articulates how family practice physicians fit into emergency preparedness. When disaster struck, the family physicians understood their role: oversee the triage of injuries, manage the treatment of minor illnesses and injuries outside of the hospital, coordinate and support community health and clinics, and collaborate with the health authority and emergency health services.



DIVISIONS OF FAMILY PRACTICE

Figure 2 shows how the Divisions of Family Practice are included in the regional emergency management response structure in the Interior Health Authority. Formally including a community primary care physician (who reports to the EOC Director) would help mobilize family doctors throughout the region in the event of an emergency.

WINDOW OF OPPORTUNITY

In the emergency structure, community primary care providers deliver both immediate and ongoing health services. In rural communities, family physicians double as emergency physicians, and in all communities the family practitioners have the capacity to reduce the burdens on hospitals. In the wake of a crisis, primary care doctors are there to manage post-injury care, chronic disease exacerbations, mental and psychosocial health, LTC, and assist displaced people and families with medications and health resources.

However, in the fog of an emergency, when planning ends and response begins, the clarity of how corollary services can ease the burdens on hospitals' emergency rooms is blurred when primary care providers have no understanding of their place in the emergency preparedness system.

There are mutual benefits to be realized when hospitals articulate how community primary care fits in the scheme of an emergency: accessible and appropriate patient care during a crisis, optimal use of resources, and effective care that works towards the best outcomes for patients and health care systems alike.

This opportunity can be identified as a crisis recedes, but the window begins to close as communities get further from their crises. Emergency response leads to recovery, which leads to prevention, followed by mitigation, and finally preparedness, which largely lies dormant until the next crisis arrives. A cycle of panic and neglect ensues: an epidemic breaks out, money and resources are mobilized to fight the disease, the emergency ends, and when peace is restored complacency settles in.

Dr. Graham Dodd, Thompson Region Division of Family Practice Chair and Emergency Management Physician Lead, says a potential area for discussion would be to foster local champions and examine the benefit of having a primary care physician formally included in the Health Authority's emergency management structure. Dr. Dodd says one scenario might be a triad structure to the emergency preparedness plans within BC's health authorities: 1. An emergency planner at a health authority's administration level; 2. A hospital ER physician; 3. A community-based physician.

Dr. Paul Mackey

Dr. Paul Mackey, physician lead at local COVID-19 Incident Command meetings, is a voice for Division members on the issues and challenges facing community primary care in the Kamloops and Thompson regions.

"Clear communication during emergencies and throughout the pandemic is vital. Having a seat at the local Incident Command table is key for that," Dr. Mackey said. "Issues we need to address can be promptly escalated to the regional EOC or the clinical working group. This is how we developed appropriate, essential services like the respiratory assessment centres."

These roles would need to be formalized and funded, written into the existing organizational structures that address emergency preparedness at the local, regional (health authority), and even provincial levels. A community primary care provider with expertise in emergency management could also function as a clinical liaison with Health Emergency Management BC(HEMBC), which coordinates emergency preparedness and supports Emergency Operations Centres throughout the province.

In the fall of 2019, the Division applied to SharedCare (a joint partnership between the government of BC and Doctors of BC) for funding to support an emergency preparedness and response project for family physicians. In its application, the Division stated that all patient populations stood to benefit from the addition of family doctors into the Interior Health Authority's emergency preparedness plan.

This is the same project that received local emergency planners' support last fall but was tabled to the spring. At the time, the Division stated that the biggest impact on improved patient outcomes could be with vulnerable groups, such as the elderly, people with complex conditions, and those requiring specialized services such as dialysis, maternity care, mental health access, and substance abuse services. COVID-19 illustrates that case.

The best time to formally recognize BC's family practitioners at the Incident Command and EOC levels is before the next crisis consumes the attention of provincial health and emergency response organizations. Before the next wave rolls into BC communities.

As much as COVID-19 puts communities' pandemic response capabilities at the forefront, the coronavirus really shows the need to look at the broader picture for all sorts of catastrophes —wildfire, flood, earthquake — and reminds us that emergency management is about being prepared, not reactive, in the midst of the response.

Community Resilience in Action: Fostering Partnerships, Communicating Effectively, and Building Networks

All hands on deck: At the start of the COVID-19 outbreak in BC, the Division activated its members and strong relationships throughout the Interior Health Authority. Initiatives were borne from the Division's membership, including the Health Leadership Committee, existing emergency management work with Interior Health (including the clinical working group that was struck), the Collaborative Services Committee, and involvement at the Incident Command table. Numerous innovative health care actions were critical to the success of the "Wave One" response and achieved through these partnerships. The current "Wave Two" response continues to benefit from these early efforts, resulting in better partnerships and communications, and stronger networks to tackle the vaccine rollout.

Fostering Partnerships

Centralized Personal Protective Equipment: The Division conducted extensive work with Interior Health to centralize sourcing and obtaining PPE for its members and community specialists through the health authority's PPE supply. PPE was distributed to over 150 primary care providers and community specialists, which enabled practitioners to continue in-person visits when appropriate, providing optimal longitudinal care, and mitigating added pressure to the hospital emergency department and urgent primary care clinic.

Kamloops Primary Care Respiratory Clinic: The use of virtual care was very quickly adopted by family practitioners, driven largely by the scarcity of PPE's, the unknown's of the virus and the levels of anxiety within the population. However it was recognized that some patient needed to be seen in person and was their an alternative solution to just going to the local emergency department. This challenge was collaboratively accepted by the Division.

Maternity Respiratory Assessment Clinic: The Division mobilized the existing maternity care clinical network, which includes obstetricians, family physicians providing maternity care, midwives, and health authority management from acute care and public health, to support the development of this clinic. Like the primary care respiratory clinic, this clinic focused on conducting in-person appointments to assess and test pregnant or postpartum patients with significant respiratory symptoms.

Dr. Joslyn Conley

Dr. Joslyn Conley, Community Nephrologist at Royal Inland Hospital and Chair of the Royal Inland Hillside Physician Association, sees the necessary connection between hospital-based physicians during times of emergencies, and their physician counterparts in the primary care community.

"In the past, local physician groups have not been drawn into the planning, decision making and distributing of information from the emergency response teams," Dr. Conley said. "Physician groups are resourceful and strong teams that can be an integral part of the success in supporting the community. For example, at a time when the public is at its most vulnerable in terms of understanding and navigating the information being shared through personal networks, mainstream and social media, trusted individuals such as local care providers play a crucial role in clarifying the messages to the public. Specialists and primary care providers can coordinate efforts to ensure patients are receiving the right care at the right time and in the right place. This enables greater consistency in care, and decreases the unnecessary burden often placed on Emergency Departments."

Sun Peaks COVID-19 Testing Site: A unique partnership between the Division, Interior Health (IH), the municipality of Sun Peaks, and the Sun Peaks Community Health Centre (SPCHC), a testing site was mobilized that enabled residents and guests to have timely access to COVID screening and follow-up from the health centre. The testing site not only helped to remove transportation barriers at the resort, it also ensured continuity of care for the patients. Having the results provided to the health centre allowed the Medical Director to follow-up on results and the opportunity to provide help with problem solving and support where needed.

Long Term Care: The Division, as a partner in the LTC network, coordinated a series of meetings that enabled the network to plan and implement the single-site delegate model, whereby one primary care provider was assigned to a care home to conduct all in-person visits. Furthermore, the network also focused on reviewing the PMO and MHO orders related to resident transfers to and from acute care, PPE availability, staffing, virtual care, resource allocation, and communications.

Communicating Effectively

Interior Health Kamloops Emergency Response: Due to the Division's prior work with local emergency health care representatives, the Division participated at the Interior Health Local Incident Command, which includes various health authority representatives, Royal Inland Hospital, and the Thompson and Rural and Remote Divisions. This table met daily to report out on challenges and opportunities for actioning or escalating to the Interior Health Regional EOC and was a critical piece to the success of the initial community response. The Division was also instrumental in advocating for all divisions in the BC Interior to be included at their local ICs. Most recently, the Division sits at the Interior Health Pandemic Response Planning Committee (a similar structure to Incident Command in the initial response) and is active with the Interior Health COVID-19 Immunization Response Steering Committee.

Interior Division Network (IDN): The Thompson Division championed meetings with 7 other Divsions within the interior (forming the Interior Division Network), their Division partners throughout Interior Health, which they agreed was important in creating a united front. These meetings were effectively coordinated by the Interior region's GPSC Liaison and provided an opportunity to discuss the Divisions' COVID responses at a regional level. The IDN supported each other to problem solve, share successes and advocate provincially for challenges facing primary care providers. The IDN formed a working group to collect and evaluate data during the first wave of the pandemic and participated in provincial lessons-learned evaluation and quality improvement initiative. This network lobbied for a seat at the regional EOC but were denied. The IDN then advocated for a review of community primary care's role in Interior Health's emergency structure and have been working with Interior Health to develop a Divisions of Family Practice Primary Care Liaison Role as part of the health authorities regional EOC. Currently, in the "Wave Two" response to COVID-19, the IDN has physician representation at the Interior Health Pandemic Response Coordination Centre.

Media and Public Communications Campaigns: The Division, in collaboration with the Royal Inland and Hillside Physicians Association, took the lead on developing and executing a series of public health media campaigns to reach the general public: "Call Your Doctor" encouraged residents to continue to connect with their doctors during the pandemic and use virtual care, and a "Thank You" campaign from local doctors thanked the public for following health guidelines and protecting local health care workers. The messages also encouraged people not to put any health issues on hold during the pandemic response. Local media — including radio, TV, social media, news media, out-of-home, and print media — embraced the campaigns and gave more than six times the value of the plans to help keep public health education in the foreground.

Building Networks

Thompson Region Division COVID Member Network: One of the Division's most successful endeavours was the formation of an internal member network, including primary care providers, nurse practitioners and sub-specialities (hospitalists, emergency, long-term care, maternity, cancer, community specialists, etc.). The region was divided into sub-sectors under Division coordinators and physician leads. Support included physician wellness, PPE needs, clinic operations, transitioning to virtual care, etc. The Division saw an overwhelming increase in member engagement, including a 90-per-cent response rate to surveys.

MOA Network: The Division utilized a pre-existing network of medical office assistants (MOAs) to better support practices through the pandemic. The Division hosted bi-weekly virtual meetings for the community of MOAs to share items that are working well in their clinics and give them an opportunity to ask questions or share suggestions with others. The Division also distributed information to the MOA network about referrals, testing guidelines, additional support sessions, and other pertinent memos to ensure practices have the most current information about COVID-19. The MOA network also met to discuss COVID-19 Safety Plans and changes to practice.

Community Network: The Division hosted three meetings to bring its community partners, such as local community health tables, Interior Health, and local, regional, and provincial government representatives from the Thompson region together. The focus of the meetings was to provide them with updates from the Division and as a way for them to share challenges and opportunities they were having in their communities, both as it relates to health care and the social determinants of health. The Division also conducted a bit of a focus group with partners to get feedback on what they saw as the opportunities and challenges with virtual care, as well as their experience accessing health care during the pandemic. Similarly, the Division also hosted a meeting to bring community allied health professionals together to provide them with a Division update and to understand their challenges and opportunities, as well as the status of their practice.

> ***"Interior Health has extensive organizational reach and oversight in a crisis," Dodd said. "In addition to emergency physicians, community primary care providers often find themselves on the front line in responding to disasters affecting their communities. If formally included in the planning stages and emergency preparedness activities, community care providers could be an additional first point of contact to help manage local emergencies. Furthermore, the care they provide can protect valuable hospital emergency services from becoming overwhelmed and to ensure continuity of care for patients. The key is to bring primary care into existing emergency management structures, and work with doctors and nurse practitioners to help them understand their roles in emergency responses."***
>
> ***– Dr. Graham Dodd***

ADDITIONAL SOURCES:

https://www.pdconf.com/ncs2020/covid-19.jsp

https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/pandemic-provincial-coordination-plan.pdf

https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/covid-19-technical-briefing.pdf

https://www.citynews1130.com/2020/04/01/kamloops-icu-covid-19-patient/

https://www.cbc.ca/news/canada/british-columbia/covid-19-bc-timeline-1.5520943

https://www.nbcmiami.com/news/local/carnival-cruise-line-changes-stops-for-2-ships-amid-coronavirus-concerns/2200429/

https://www.theweathernetwork.com/ca/monthly/ontario/toronto?year=2020&month=1&dispt=calendar-container-monthly

https://nationalpost.com/news/politics/the-birth-of-a-pandemic-how-covid-19-went-from-wuhan-to-toronto

https://ottawasun.com/news/local-news/first-canadian-study-of-covid-19-patient-says-important-lessons-learned-from-sars/wcm/038c0158-1f9e-4f0a-8575-6a7d77d9a3f7

https://nationalpost.com/news/canada/covid-19-lessons-from-a-pandemic

https://www.kamloopsthisweek.com/news/second-covid-19-related-death-in-interior-health-was-patient-at-kamloops-hospital-1.24125963

http://www.phsa.ca/about/news-stories/stories/the-critical-role-of-our-emergency-operations-centres

https://prdoas3.pub-apps.th.gov.bc.ca/tig-public/Report.do?pdbSiteId=15712

https://www.kamloopsthisweek.com/news/railway-woes-in-kamloops-delays-are-part-of-daily-commute-1.23907907

https://www.domtar.com/sites/default/files/2019-05/Domtar-Kamloops-Mill-Fact-Sheet-2018.pdf

https://www.theatlantic.com/science/archive/2017/10/panic-neglect-pandemic-funding/543696/

https://my.christchurchcitylibraries.com/canterbury-earthquake-2011-for-kids/#:~:text=On%2022%20February%202011%2C%20at,there%20was%20major%2C%20widespread%20damage.

https://globalnews.ca/video/6668414/coronavirus-outbreak-doug-ford-tells-families-to-have-fun-and-travel-during-march-break

Doctors Without Borders/Médecins Sans Frontières (MSF Canada), Emergency Preparedness, The Spirit and the Toolkit, January 2016

http://www.sharedcarebc.ca/about-us

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4311332/

Thompson Region
Division of Family Practice
A GPSC initiative

The Thompson Region Division of Family Practice strives to be a community with optimal delivery of family medicine and primary health care in British Columbia.

OUR VISION:

A community of family physicians and nurse practitioners working collaboratively with community partners focusing on wellness, satisfaction, and sustainability for both the patient and the primary care providers.

OUR MISSION:

- Support the Thompson Region community of family physicians and nurse practitioners in their pursuit of excellence and innovation in family medicine and patient care;
- Be the place where family physicians and nurse practitioners go to identify their needs, engage in learning and participate in collaborative community-based solutions;
- Provide physician leadership in systems and clinical improvements and participate in collaborative quality improvements in family medicine and primary care;
- Promote physician and nurse practitioner wellness and collegiality; and,
- Advocate for the essential role of family physicians and nurse practitioners in the delivery of health care.

Your feedback on this white paper is welcomed. Contact Rhonda Eden, reden@divisionsbc.ca