MacEachen
INDEPENDENT. INFORMED.

DALHOUSIE UNIVERSITY
FACULTY OF MEDICINE

November 2020

MIPP COVID-19 RESEARCH BRIEFING

COVID-19: Leaders from the Health Community Identify Lessons from the First Wave and Concerns for the Second

Purpose of the Note

On October 2, 2020, Dalhousie's Faculty of Medicine and the MacEachen Institute for Public Policy and Governance (MIPP) hosted a roundtable at which 27 people met online to discuss what went well and what lessons were identified from the health sector's response to COVID-19. Participants included senior representatives from both the public health and healthcare systems of New Brunswick and Nova Scotia, as well as academics. Most of the participants were from Nova Scotia, which was the focus of most of the discussion.

This briefing note starts by highlighting selected observations that were drawn from these discussions. The subsequent pages summarize our goals and methods and the discussions that took place at the session.

About the MacEachen Institute

The MacEachen Institute for Public Policy and Governance at Dalhousie University is a nationally focused, non-partisan, interdisciplinary institute designed to support the development of progressive public policy and to encourage greater citizen engagement.

Authors

Kevin Quigley, PhD
Kaitlynne Lowe

Contact

For more information on this research, contact mipp@dal.ca

Selected Observations

With respect to **Information Management**, we need to:

- Improve systems and methods to address massive information flow with constantly changing circumstances and advice.
- Ensure communications are designed to be delivered effectively by different spokespersons and organizations at various levels (i.e. scopes and jurisdictions) through the appropriate fora and media.
- Improve support and access for those working with and researching vulnerable and equity-deserving groups.

With respect to **Standards**, we need to:

- Ensure that vulnerable and equity-deserving groups remain in focus in decision-making. There should be specific mechanisms to ensure equity factors have been integrated into decision-making in a meaningful way.
- Maintain collaborative practices in the health sector as a habit and limit separation between different types of care.
- Integrate better virtual care into routine practice.
- Ensure that students and trainees in healthcare-related education are better integrated into the system to assist with the second wave.
- Develop a better understanding of the trade-offs inherent in our approaches to COVID-19 and how to reconcile and communicate them.

With respect to **Behaviour Change**, we need to:

- Continue to support individuals in an emergency and mobilize resources to expand research efforts.
- Use COVID-19 as an opportunity to assess the value of specific practices and interventions in healthcare and decide which practices to keep or let go.
- Continue the momentum for change in the health system, while at the same time address individual and organizational fatigue, which also constitute a risk.
- Create roles within incident and emergency management to identify opportunities for innovation in real time.
- Work proactively to manage public expectations, particularly in advance of vaccine distribution.

On October 2, 2020, Dalhousie's Faculty of Medicine and the MacEachen Institute for Public Policy and Governance (MIPP) hosted a roundtable at which 27 people met online to discuss what went well and what lessons were identified from the health sector's response to COVID-19. The roundtable discussion highlighted three important, and sometimes conflicting, priorities of the health system:

1. Preparing for the next wave of COVID-19;
2. "Catching up" with essential medical care delayed or deferred during the first wave; and
3. Redesigning the system so it is adequately resilient and robust to meet similar challenges in the future.

Participants included senior representatives from both the public health and healthcare systems of New Brunswick and Nova Scotia, as well as academics. Most of the participants were from Nova Scotia, which was the focus of most of the discussion. This roundtable discussion followed a panel event hosted by the MIPP and the Faculty of Medicine on October 1, First Wave: Atlantic Canada's Chief Medical Officers Discuss Lessons From COVID-19. Several points raised during the roundtable referred to the panel event the previous evening.

This roundtable is the first of a series of roundtables hosted by the MIPP in partnership with the Faculty of Medicine at Dalhousie University. These events are focused in particular on supporting the Faculty of Medicine's strategic initiative of catalyzing systems change for better health outcomes. (For information about upcoming events, please see our website.)

How We Did It

We invited leaders and decision-makers from the public health and healthcare systems as well as academics who research aspects of healthcare and policy. The discussion lasted about 2 hours with approximately 30 minutes allocated for each question, and questions were distributed in advance of the session.

A note-taker summarized the discussion and produced this briefing note. This note does not attribute comments to individuals during the discussion; it merely summarizes the comments. Participants shared their observations and experiences; we did not confirm the accuracy of their comments.

Participants were asked to discuss the following questions:

1. What has gone well over the last six months?
2. What was not helpful in Wave 1? If we had to do it again, what would we want to avoid?
3. Looking forward to the next six months, what issues concern you? How do we address them?
4. Where are we starting to feel elasticity –a 'pulling back' to *business as usual*—that we need to resist?

For additional information about the method used, please see Appendix I

Why We Did It

This event represents a partnership between the MacEachen Institute for Public Policy and Governance and the Faculty of Medicine. The MIPP serves as a forum for vibrant public policy discussion and analysis. The Dalhousie Faculty of Medicine has a strategic goal to catalyze systems change to improve health outcomes.

This roundtable session was an opportunity for system partners and academics to discuss issues and lessons identified during the first wave of COVID-19 as we prepare for a second wave.

For additional information about why we held the event, please see Appendix I

How We Framed the Discussion

Opening Comments from Professor Katherine Fierlbeck, Department of Political Science, Dalhousie University

Crises can be catalysts for long-term policy change. Although they can be disruptive and damaging, they also provide opportunities for change. Policy change has to be facilitated through the policy process, and it has to be pushed onto the policy agenda. Crises can be useful in expediting this process. In order to be sustainable, policy changes need to survive the phenomenon of policy cycling. Moving policy forward requires policy networks that are wide and deep, it requires advocacy and interest groups to apply sustained pressure on decision-makers, and it needs the ability to mobilize resistance.

We have learned from past pandemics such as SARS and H1N1. SARS highlighted isolation between units in the healthcare system, which led to the creation of the Public Health Agency of Canada (PHAC). H1N1 provided additional insight on vulnerabilities in such a broad and complex governance system, such as the risks of unclear roles, responsibilities, and delineation of tasks (e.g. many committees had similar roles and tasks that overlapped). COVID-19 has highlighted the need to focus on public health and ensure lasting changes and investments, as public health is often taken for granted until a crisis arises.

COVID-19 has demonstrated that effective communication practices and materials are crucial and challenging to develop. Often, we try to appeal to the public's sense of reason and encourage compliance with regulations. Consistent messaging is difficult because data is limited, continually in flux, and often contradictory. The communications material reflected the best available evidence throughout the pandemic and was grounded in evidence-based approaches. The scientific methods and approaches needed to research COVID-19 rely on scientists being able to update their findings and advice as new evidence becomes available. A key consideration is transparency: what information should be provided to the public? Political judgement is imperative here: too much transparency and public confidence could be undermined by the complexity and uncertainty involved; too little transparency, and public confidence could be undermined by lack of trust in the institutions of governance.

Dr. Katherine Fierlbeck specializes in health policy and is a McCulloch Professor of Political Science at Dalhousie University. She is cross-appointed with Community Health and Epidemiology in the Faculty of Medicine.

Opening Comments from Professor James Barker, Rowe School of Business, Dalhousie University

Emergencies are pivotal times to discuss leadership. There are different aspects to effective leadership in a crisis: people need to understand the right course of action and how best to achieve it. To identify a "right" course of action and an appropriate approach, decision-makers should focus on the impact the action will have and the value of that action to society. The public also needs to understand how the actions taken today can help us move in the right direction. This requires trust and confidence that the actions taken are appropriate and align with the desired direction.

Leaders have many tools at their disposal to communicate to the public an effective way forward. Some key mechanisms include compliance, collaboration, communicating challenges (i.e. transparency), and care. Leaders also have the responsibility to respond and adapt to unintended consequences. The complexity of COVID-19 creates additional challenges to identifying the best course of action and sustaining the momentum necessary to achieve it.

Continued Below

Many decision-makers are so focused on the impacts of COVID-19 that other serious issues, such as climate change, have not received as much attention. We will need to apply what we have learned from the widespread, and often collaborative, responses to COVID-19 to other societal challenges. It will be important to get the most from our collaborative experiences throughout the COVID-19 response and continue the mechanisms that have proven effective. We can learn from the various pressures and interests arising from the COVID-19 response and should apply these to address additional issues.

Dr. James Barker researches complex system dynamics in developing safe and sustainable organizational governance mechanisms, public policies, and industry practices. He is the Herbert S. Lamb Chair of Business Education in the Rowe School of Business.

What We Discussed

What Worked Well

In the first wave, the degree of collaboration between many health officials was strong. Participants emphasized the need for balance – being flexible and collaborative while remaining clear about the delineation of roles, responsibilities, and accountability.

Collaboration between various orders of government worked well, particularly with respect to coordinating communications. COVID-19 was also the first time the Mi'kmaw Health and Wellness Authority, for example, was part of the formal process.

The courage and dedication of frontline healthcare professionals to act in the best interest of patients were evident throughout despite uncertainty about the risk and best courses of action. The innovation and adaptive capacity of these workers resulted in new practices that have been scaled up to system-level improvements.

Many in the system also recognized the importance of ethics and decision-making. Healthcare ethical frameworks were helpful to ground decision-making and prioritize given the novelty of the emergency and levels of uncertainty about COVID-19.

There have been openness and collaboration in communication during this pandemic. These practices helped to form trust between practitioners and the public, which resulted from considerable effort to ensure healthcare professionals had the most recent information. In-camera meetings were useful as a space for decision-makers and experts to reach consensus on providing clear direction to the public.

Collaborative leadership approaches in Atlantic Canada have strengthened health systems to prepare for potential outbreaks. For example, recent travel protocols to allow students and workers into the "Atlantic Bubble" have been implemented relatively safely.

With respect to the Federal Government, financial support to citizens and sectors was crucial as were the investments in healthcare and research. The research community mobilized at an unprecedented rate to respond to COVID-19. This same level of support should be continued for future emergency events.

We have learned the importance of formalized organizational learning from past pandemics. We will need a reliable way to formalize our learning from COVID-19, to ensure it is thoughtful and not overly reactive. For example, with SARS we learned there were not enough committees and groups involved in decision-making, so more were created. In H1N1 we learned that there were too many committees and groups responsible for tasks. Although organizational wins are often celebrated while failures are forgotten, organizational learning from failures is key to improvement.

What Did Not Work Well?

There were structural inequities and vulnerabilities across society before COVID-19 and the pandemic further exposed these weaknesses. Attempts to address some of these have not had the system-level support necessary to improve the situation in a meaningful way. We know structural socio-economic inequities result in poorer outcomes and more needs to be done. The structural separation between governance of the healthcare system and long-term care system has also exposed and accentuated vulnerabilities. Meaningfully addressing structural and system-level inequities relating to social and structural determinants of health remains an area in which we need to improve.

Integrating equity considerations into decision-making processes has been a challenge. In the first wave, decision-makers often defaulted to traditional decision-making processes that did not fully account for equity considerations. To ensure vulnerable populations and equity-deserving groups remain a focus in decision-making processes going forward, there needs to be specific mechanisms to trigger equity considerations within these processes. This is especially important as the conversation regarding the social and structural determinants of health grows and there is increasing recognition of the poorer outcomes resulting from social and structural inequities.

COVID-19 has highlighted challenges for decision-makers in balancing competing pressures. While there has been an effort to integrate services and departments across the sector, there is still separation between types of care that creates challenges for successful outcomes. For example, acute care (e.g. hospital) beds have been used to supplement long-term care beds to prevent overcrowding in long-term care settings. This provided more flexibility for family visits because hospitals have less restrictive rules than long-term care facilities, but it further strained the acute care system beyond sustainable levels.

To meet the anticipated surge capacity, large parts of the healthcare system had to be turned off. We have not effectively integrated system resilience and readiness principles (e.g. surge capacity) into the healthcare system. This will be necessary to ensure the healthcare system can respond to a second wave and continue operations without risking system collapse.

Integrating virtual care into the healthcare system has also been a challenge. While there have been investments in technology, they have not been fully integrated into practice. In the first wave, there was also separation between the public health and acute healthcare systems. The acute care system would have benefitted from community surveillance data to prepare more effectively for potential influxes of patients, but this information was not accessible. We also now have a better understanding of the impacts of public health measures, such as the effects of stay-at-home orders on employment opportunities, addictions support, and mental health, which can inform preparations for a second wave.

Communication materials were not as scalable as required and information management was a challenge in the first wave. There was a constant influx of information, and messages and advice changed frequently. Effective information management will be key to mitigating these challenges in future. The public also has high expectations for transparent practices and consistent messages. It is often challenging for public health officials to balance these expectations with the reality of the situation.

There was a dichotomy in the first wave where employees in some government departments were able to work from home and in some cases not fully able to contribute while other departments were pushed to the limits. This resulted in uneven levels of fatigue.

Students in healthcare-related programs were removed from the system when they should have been better integrated to support frontline work. We need to identify ways to integrate students and trainees appropriately into the healthcare system. In a second wave, maximizing human resources (e.g. students and trainees) will be key to ensuring necessary capacity across the healthcare system.

Continued Below

The emphasis on "build back better" highlights that the pandemic has identified opportunities to address vulnerabilities across society. Decision-makers recognize that the collaborative and urgent approaches used throughout the pandemic can be applied to other broad issues, such as vulnerable communities and equity-deserving groups. There are challenges to find a balance to do what is needed while ensuring necessary flexibility.

Looking Forward – The Next Six Months

A key challenge will be to mitigate isolation across healthcare units to ensure the necessary capacity across the system. Collaboration will need to be the habit of healthcare professionals to avoid returning to an isolated and disconnected system structure. Decision-makers especially need to set system-level goals (e.g. population outcomes, patient experience, value-based care, system readiness), rather than make isolated changes at the unit level.

Decisions made in the first wave seemed to be based on the supply and availability of PPE; in the second wave, we may be more concerned about the scarcity of human resources in the healthcare system. The main vulnerability for Nova Scotia is ensuring a pool of labour with appropriate training to manage the system, especially with the level of individual and organizational fatigue across the sector and the approaching influenza season. Roles and responsibilities within the healthcare system need to be appropriately prioritized and structured.

Changes are needed to prepare for the second wave but the system is currently under considerable pressure, which will constrain our progress. Health inequities are already challenging to address, and although there is considerable strain on the healthcare system overall, we must increase efforts to ensure we are monitoring and addressing equity concerns. Managing fatigue of leaders and workers will also be a key concern as we move forward; 'change fatigue' is also emerging as a concern. We have to be realistic about what we can accomplish in the short term given the challenge of the pandemic and the limits of our system.

Over the next six months, effectively addressing public and political expectations and concerns will be vital, especially to address uncertainty, vaccine distribution, future lockdowns, and the often-used but ill-defined concept of the "new normal." So far, there has been acceptance and appetite for evidence-based policy, but as evidence changes how can the public be kept onside for corresponding policy changes? The degree of uncertainty about COVID-19 is a challenge, as there is no way to identify when changes will happen or if they will be reversed. Information about COVID-19 is continuously changing and unexpected strains on the system have occurred (e.g. post-viral syndrome of "recovered" COVID-19 patients), which further challenge the public's expectation of consistency. Going forward, it will be crucial to outline how vaccine distribution and prioritization will be handled to manage public expectation proactively.

COVID-19 has highlighted the value of the planning process and the relationships developed through that process. These relationships have been key to managing the crisis effectively. In the second wave, there should be specific roles to identify opportunities for innovation within responses in real time, rather than after the event. These new roles should be integrated into emergency management roles, similar to how roles for finance, communications, and basic incident management are set.

There are trade-offs in how we address risks, and it is difficult to manage these trade-offs and communicate them effectively. It is also important to consider the source of the information and what advice is being listened to, particularly when balancing competing interests. The discussion of trade-offs should be explicit and recognize that trade-offs may need to be made within a system (e.g. the healthcare system) and across systems (e.g. public health and economic interests). Trade-offs can have intended and unintended consequences, both of which need to be monitored and mitigated.

Continued Below

In Nova Scotia, the voices of the Premier, public health experts, and the Chief Medical Officer were featured prominently in decision-making and communications practices (e.g. press conferences). A danger of having only politicians and the CMO delivering information to the public is that it can limit the public's understanding of the roles of numerous public health experts and scientists. Politicians also face pressure to deliver what some members of the public want (e.g. low mask restrictions and businesses open) and balance this with the advice of public health experts. Experts have also been challenged regarding their expertise, as politicians have challenged epidemiologists on advice and evidence, which has raised tensions in the public health community.

Going forward, the discussion on trade-offs will need to be clearer. For example, how long do we prioritize the risks of COVID-19 over risks of other health issues and outcomes? This discussion is particularly important as previously closed health services (i.e. as a result of public health orders) are reintroduced and considerations are made about similar closures in a second wave. COVID-19 has also focused attention on value-based healthcare and highlighted the need to decide which interventions to bring back and which to let go (Latham, 2020). It will be important to think about how healthcare professionals can work differently, work to scope, and identify roles in the system that can be made more effective.

Economic concerns and the public's desire to return to the way things were pre-COVID-19 have raised tensions against public health regulations. While economics and public health are not mutually exclusive, decision-makers must effectively balance these competing concerns. Re-opening the economy is more of a possibility given the current state of Atlantic Canada's COVID-19 (i.e. low case rates and capacity to test) compared to other areas in Canada, but there are significant vulnerabilities, such as the degree to which the public will comply with restrictions. Nova Scotia is also particularly vulnerable with limited human resources in the healthcare system, so the primary focus will be to keep case numbers and risks low for the general population as businesses and borders are re-opened.

Public health regulations have had both positive and negative unintended impacts. For example, orders to work from home have contributed to meeting environmental/climate goals. While there are benefits to some of the regulations, there have also been some harmful consequences, such as remote working resulting in downtown businesses struggling. COVID-19 has presented an impetus to further integrate technologies across sectors. The emphasis to "build back better" highlights that the pandemic has identified opportunities and can be a catalyst to address vulnerabilities across society.

References

Latham, Stephen R. (2020). Avoiding Ineffective End-of-Life Care: A Lesson from Triage?, *Hastings Center Report* 50, no. 3: 71– 72. DOI: 10.1002/hast.1141

Quigley, Kevin, Bisset, Ben, and Mills, Bryan. *Too Critical To Fail: How Canada Manages Threats to Critical Infrastructure*. MQUP. 2017.

Appendix I: Additional Information About Method

How We Did It

We invited leaders and decision-makers from the public health and healthcare systems as well as academics who research aspects of healthcare and policy. We distributed questions to participants in advance of the session.

We started the event by asking two professors, Katherine Fierlbeck and James Barker, to provide opening remarks about the panel event the night before and the issues the Chief Medical Officers raised. Following their comments, we started the discussion.

A note-taker summarized the discussion and produced this briefing note. Aside from summarizing the comments of Professors Fierlbeck and Barker, this note does not attribute comments to individuals; it merely summarizes the comments. We also recorded the session to ensure we described the discussion accurately. Participants shared their observations and experiences; we did not confirm the accuracy of their comments.

The discussion lasted about 2 hours with approximately 30 minutes allocated for each question. Participants were asked to discuss the following questions:

1. What has gone well over the last six months?
2. What was not helpful in Wave 1? If we had to do it again, what would we want to avoid?
3. Looking forward to the next six months, what issues concern you? How do we address them?
4. Where are we starting to feel elasticity –a 'pulling back' to *business as usual*—that we need to resist?

Having a conversation is not the same as writing a summary. We edited the document to make it as succinct as possible. We tried to position comments in the most appropriate places. For example, some comments made early in the session may appear towards the end of the note. We did not intentionally leave out any substantive comments. Members of the Catalyzing Systems Change Committee at the Faculty of Medicine (Jennifer Payne, Gaynor-Watson Creed, Shawna O'Hearn, and David Petrie) and Katherine Fierlbeck from the Department of Political Science reviewed early drafts of this briefing note to contribute to its accuracy. We underscore that this is a summary of a brief, far-reaching discussion on a very complex situation that continues to evolve. This was not an exhaustive discussion; many of the terms and ideas require further elaboration and reflection. In sum, our intention was to flag – however imperfectly – some important issues at a key point in the pandemic response in the Atlantic region.

We organized our recommendations according to a cybernetic understanding of how to control a system: information, standards and behaviour. Cybernetics is helpful to discuss thematically how a system such as healthcare is managed (i.e. remains in a desired state) (Quigley et al., 2017).

Why We Did It

This event represents a partnership between the MacEachen Institute for Public Policy and Governance and the Faculty of Medicine. The MIPP serves as a forum for vibrant public policy discussion and analysis. Health Systems and Governance is a research priority for the Institute.

The Dalhousie Faculty of Medicine has a strategic goal to catalyze systems change to improve health outcomes. The aim is to work with key community partners to influence health and societal systems for change, with the overall goal of being a valuable agent of socially responsible change for Atlantic Canada's health systems.

This roundtable session was an opportunity for system partners and academics to discuss issues and lessons identified during the first wave of COVID-19 as we prepare for a second wave, particularly with the healthcare system already under enormous stress. While crises can be disruptive and damaging, they also provide opportunities for change. The interconnectedness and interrelatedness of our society and systems have made responding to COVID-19 especially complex. As we move forward, it will be important to consider how we can maintain the positive changes have made in response to COVID-19, such as improved collaboration practices. COVID-19 is unlike anything we have experienced and will continue to affect us for years to come.

More from the MacEachen Institute

The Institute is working to create resources and policy discussion around the COVID-19 crisis. These include briefing notes like this one as well as panel discussions, videos and media commentary. You can find all resources related to COVID-19 on our website.

Other briefing notes in this series

- Halifax Tourism and COVID-19: Scenario Planning Exercises for Summer 2021
- COVID-19 Media Coverage
- Labour Issues and COVID-19
- Quarantine and COVID-19
- People with Disabilities and COVID-19
- Observations from Toronto's Tourism Recovery Post SARS in 2003