IMPACT OF THE COVID-19 PANDEMIC ON HEALTH ORGANIZATIONS:

25 PROPOSALS
FROM WHAT WE HAVE LEARNED
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25 proposals from what we have learned

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Summary table: 25 proposals that will start after the COVID-19 pandemic
The healthcare emergency of the COVID-19 pandemic has tested the professionalism and organizational structures of healthcare systems. Almost from one day to the following, healthcare services have had to change their traditional ways of working to deal with a large number of transformations very quickly, in some cases unforeseen and in others long-awaited.

The response in general terms has been more than satisfactory, but now that lockdown measures and health services transformations are being eased and pressure from infected patients and hospital admission is loosening, concern arises on whether what has happened during the crisis will be incorporated into daily practice, both to correct detected errors and also to incorporate the improvements that have been implemented.

For all this, the Catalan Society of Health Management (SCGS) has considered appropriate to prepare a document that will serve to rethink the health model, taking into account the experience and the needs that will generate the new social, economic and epidemiological situation.
LESSONS LEARNED

A GOOD ORGANIZATIONAL RESPONSE AT ALL LEVELS

Healthcare facilities and services have become virtually monothematic COVID services, from one day to another, which has been an unforeseen shock, not only for organizations and professionals, but for the very essence of each institution. Although imperfectly and unplanned, healthcare organizations have been able to adapt to the changing scenarios and have given a remarkable response that we can be proud of. The main axes of this answer have been the following:

1. **Agility in the management of healthcare centers has allowed them to respond appropriately to the crisis.** The absence or minimization of bureaucratic procedures to hire professionals, acquire materials and make management decisions has led to an increase in effectiveness without which the results obtained would not have been achieved.

2. **Services have been quickly reorganized to meet patients’ needs.** Services, resources, and structures have been reorganized based on patient needs, not based on other corporate, acquired rights, or specialization considerations. From primary care, to emergency services, to hospital beds, to critical care units and to social and health services, health services have transformed, beyond protocols, evaluating each person comprehensively, in order to adjust therapeutic effort according to each person and clinical circumstance. The response and containment capacity of primary care has been relevant, as it has been the performance of social and intermediate health care (long term care and nursing homes).

3. **Management autonomy, clinical management and flexibility have facilitated a fast change.** Crisis committees have been key to coordinating top managers and healthcare directors on management decision making, tailored to available information. This new decentralized way of taking decisions has highlighted the value of trust between healthcare professionals, management, and organizational flexibility.

4. **Healthcare and clinical managing leadership has been key for an effective response.** Healthcare managing leadership along with that of clinical managers, have been decisive elements to build an effective response. Collaborative intelligence and the ability to quickly develop projects to adapt to the new situation have been enhanced, overcoming historical organizational barriers, assigning the decision taking to the highest resolution level. It has been possible to set up new hospital services in sports centers and hotels, with professionals from hospitals and social health centers or primary care.
5. **Healthcare management leadership and healthcare professional's commitment have been decisive.** Healthcare professionals’ response has undoubtedly been a key element in the healthcare system's response to the crisis. To support this response effectively, it has been vital to be able to make important organizational changes: shifts have been reorganized, in many cases 12-hour shifts, and the anachronistic 24-hour medical on-call system has been substantially modified. Permits and holidays have been suspended, recently retired doctors and nurses have been called in and residents, recently finished degree doctors and senior students have been recruited. The commitment of professionals and the understanding and alignment of priorities have been key to being able to carry out all these changes, which otherwise, without a clear, defined and urgent goal, would have been impossible.

6. **Primary care has acted as a gatekeeper for the access to the hospital.** Primary care has had an important role to prevent unnecessary admissions, allowing patients to stay at home or in nursing homes, helping to prevent the collapse of hospitals. Nevertheless, some primary care centers were closed to concentrate face-to-face out-patients visits, and this has not been shown as a successful solution because it was difficult for PC teams to organize themselves according to what they considered the most appropriate way to address their demand. Regarding detection of new cases, highly efficient screening systems were activated by Primary Care Teams (PCTs), to facilitate the identification and isolation of new covid-19 cases in the appropriate hotels or areas adapted for this population.

7. **There has been an extraordinary increase in healthcare services at home, in which nurses have played a key role.** Home care for chronic and frail patients has been enhanced, both by primary care and hospital’s home-hospitalization programs. Work, dedication and competencies role of nurses and social workers has been very important in both types of services.

8. **Multidisciplinary approach of healthcare, a long-awaited change.** Clinical work has been successfully focused on the pursuit of effectiveness: "preventing infection, saving lives." In this sense, multidisciplinary teamwork has been seen as the only way to act in a coordinated and efficient manner. Anesthesiologists, intensivists, internists and other specialists, including surgeons, have been seen collaborating in COVID units – emergency rooms, in-patient boards and intensive care units, which was unthinkable before the pandemic. It seemed that many specialists have recovered the essence of the foundation of medicine and it seems that the experience has proved not only useful, but also satisfying.
9. **Telemedicine and teleworking have arrived to stay.** In primary care and in hospital outpatient clinics, the telephone and telematics services have been put in place surprisingly quick and effectively. This helped to sort demand, for home follow-up of at-risk patients, with complications generated by COVID and with other pathologies that couldn't be referred to hospital. Also, these tools had extraordinary "de-bureaucratization" effect.

On the other hand, teleworking, carried out from home by confined professionals, has helped to avoid losing productivity in times of great scarcity. Information systems, networking, through unsafe but widespread applications (whatsapp, microsoft teams, zoom, etc.), have been decisive for the effectiveness of healthcare services as well as for managerial work and proper functioning of crisis committees.

10. **Public-private collaboration has been successful and should not disappear.** Collaboration between public services and private healthcare services and also other economic sectors, has been not only possible, but crucial to the success in this crisis. The linking of private centers to public hospitals and the diversity of formulas to include the use of private facilities to face the pandemic, have allowed COVID and non-COVID activity to be delivered putting the patients' needs in the center, especially of those with serious, unavoidable problems. Likewise, the social support for professionals and healthcare centers has been fundamental, not only at an emotional level, but also to open the mind of the public administration to eliminate administrative barriers in innovation and to promote material donations and help in all sorts of companies and also philanthropical organizations.

11. **The decrease in low value-added activity should be assessed in the future.** In both hospitals and primary care, there has been a significant decrease in activity in the emergency rooms, out-patients activity or avoidable tests. In addition to the rescheduling after the pandemic, it will be necessary to re-evaluate the value of many healthcare interventions that have shown to be not essential: many low value-added clinical activities have been identified that should be reduced or eliminated.
INEFFICIENCIES AND DEFICIENCIES

Despite a positive overall diagnosis of the pandemic response, shortcomings have been identified that should be highlighted in order to prevent future errors. The population beliefs have realized that we weren’t prepared for a pandemic of this size and that the healthcare system did its best to thrive in this crisis. But they will not pardon that, in a second wave, we will have not corrected the inefficiencies and shortcomings detected.

1. **The supply of critical materials has been one of the weakest points.** Despite the agility shown by the organizations, the lack of sufficient stocks of personal protective equipment (PPE) has been a black spot that will never be understood to happen again. It has been dramatically perceived that the safety of professionals is the safety of patients and vice versa. The insufficiency of PPE, especially at the beginning of the epidemic, has forced a daily rethinking of protection protocols, having to oppose, too often, the right to safety of the worker to that of care for the sick. The lack of diagnostic tests and insufficient stock of ventilators has been another weakness that should not be repeated.

2. **Public health services have lacked connection to the health reality.** Integration of Public Health and Primary care was not achieved. The first health protocols released by the Health Ministry, established that only hospitals could prescribe PCR test and centralized the results in the Emergency Epidemiological Surveillance Service of Catalonia (SUVEC). This decision did not take into account the magnitude of the problem and its community dimension and greatly delayed testing at the onset of the pandemic, underestimating the resolving capacity of primary health and community health care.

3. **Coordination between networks (healthcare services) and healthcare levels (primary care, secondary care and tertiary care) has not worked well enough.** Primary care, hospitals, long term care and, especially, social service networking have not been successful enough, and we’ve seen a great variability in the agility of the circuits and the criteria used among different parts of the country. Mandatory public health communication channels, focused on isolating cases, have lacked the community dimension of the epidemic, and this has hindered the proper search for contacts, especially at the beginning of the crisis.
4. **Care in nursing homes was not prepared to deal with a health crisis such as this one.**
   Nursing homes had neither enough support from healthcare services, enough material, enough knowledge nor strength to cope with the burden of the disease, taking into account that in these facilities house the majority of at risk people. There are many different causes why this has been so, but it is true that the relationship between the Health services and social services must improve, to better integrate services and take care of the elderly and chronically ill in a holistic way.

5. **Mental health care has suffered with the confinement.** Mental health services, which base their work on integrating patients into society, have suffered a lot with the lockdown, which has generated unwanted institutionalization for many sick people.
The crisis has taught us that healthcare organizations require robust and reliable structures based on distributed leadership and professionalism in order to respond quickly and effectively to the challenges that may appear in the near future, especially if other health crises appear. For this reason, we have developed the following proposals to strengthen health organizations:

I. TOWARDS A MORE ENDOWED, EFFECTIVE AND AGILE HEALTHCARE SYSTEM

1. The health budget needs to be substantially increased in order to meet the challenge of health care during and after the pandemic. Our underfinanced health system has shown weaknesses during the crisis, although additional resources were allocated to address pandemic effort. In any case, an underfinanced system will always be weak in the face of a recovery from the crisis and the risks of new outbreaks. It is the economic momentum, as citizens and politicians have perceived the importance of the health system as never before.

2. Long and hard administrative procedure burdens, bureaucracy and budgetary controls (before performance) hinder flexibility and quick and accurate decision-making. Focus on results, accountability and transparency should be adopted. The agility of the centers will probably disappear as the alarm rules wear off. The paradox could be that, in the face of a second wave, organizations would have less management tools, due to the recovery of all bureaucratic systems and administrative controls, which would lead to slow and cumbersome decision-making. It must be possible to be transparent and efficient, without having to follow budgetary management or current procurement processes, designed to protect suppliers more than citizens. The high cost of bureaucracy must be devoted to improving the efficiency of the system.

3. We advocate for a new way of contracting health services to healthcare organizations that deliver health services for the public health care system. It is necessary to incentivize measures to address value of clinical activities, improve the role and resolution of primary care, multidisciplinary teamwork, integration of home services, both social and health care, cooperation in complex clinical processes and, ultimately, the achievement and evaluation of outcomes that truly concern to people.
II. MANAGEMENT MATTERS... A LOT

4. **Management autonomy for healthcare (clinical) teams.** One of the lessons learned has been the importance of clinical management units, hospital or primary care services, and their leaders, within organizations. Professional selection of key positions should be strengthened, as well as a continuous assessment of competencies in the management and leading teams.

5. **Promote integrated care** and evolve towards collaborative management with joint decision-making, in response to common objectives and needs. As well, promote multidisciplinary teams as a way of addressing key objectives, promoting scientific evidence-based activities and shared decision-taking and accountability according to the results that really interest people.

6. **Administrative tasks in clinical work should be reduced to those essential for their practice,** as has mostly been done during the crisis, especially in primary care. Clinical units must define the expendable routines and procedures and rearrange the delegable ones, making proposals along the lines of “zero bureaucracy”. The creation of the role of clinical assistant, which supports health professionals, should make it possible for them to focus on the clinical work that generates added value.

7. **Telematic clinical care should be promoted, in opposition to face-to-face care,** both in outpatient consultations and in primary care, when possible. Face-to-face care should be used for situations that require it. To make this strategy feasible, it is necessary to invest clearly in digital solutions and technology to facilitate and make safe telematic systems. The Health Administration should push for the digital transformation of health care services with transformative strategies, right incentives and specific investments.

8. **We propose to assign hospital leading doctors to the hospitalization units,** with full dedication and ability to lead the multidisciplinary teams clinically, mirroring the operation observed in the COVID plants.
9. **Primary care should organize its work according to people core needs**, as it has been done during the pandemic. The professional triage of demand may not be a good way to address needs, but demand that is not usually fully well-focused. Structural changes will be needed in primary care centers to facilitate functional changes in equipment for more appropriate care in the triage, with new spaces and new, more decisive professional roles.

10. **It is necessary to consolidate a strong model of community health**, with Public Health services, community, social and primary health care services also addressing the determinants of health, adapted to each territory and its social and health assets, establish transversal programs appropriate to local characteristics, which should allow to adapt services to changing needs and local characteristics and respond effectively to critical situations. All health and social integration initiatives need to be valued.

11. **Professional-led innovations must be endowed with a prone climate from top managers**, making it as easy as possible for the ideas proposed to be tested and evaluated, and for the co-creation processes to be promoted, with the participation of citizens.
III. SPECIFIC MEASURES: DURING CURRENT PANDEMIC AND TO BE PREPARED FOR A SECOND WAVE.

12. **Primary care should have teams of expert professionals**, who have all the necessary safety requirements and who are in charge of monitoring COVID patients at home for the duration of the epidemic. Telemedicine can also contribute to this follow-up at home.

13. **COVID diagnostic tests must be available to primary care** and hospitals in order to be able to be used, without hindrance and with maximum agility, in accordance to the recommendations of the protocols at any given time.

14. **Hospitals should have contingency plans for the rapid expansion of critical beds and reorganization of emergency rooms** and facilities, taking into account lessons learned, and should have an appropriate stock of PPE and ventilators prepared for new crisis situations.

15. **It is necessary to establish a production strategy with the local industry, vendors of the essential materials in case of a new crisis (PPE, ventilators, advanced monitoring or certain drugs or diagnostic medical products).** For this reason, it is necessary to count on the support of the Government and Health Authority. When it comes to the supply of key materials, it is important to learn from what has happened in this crisis and make sure that in case of a new resurgence of the infection, the logistics are in the hands of resolving companies. A centralized stock and a minimum stock per center would be recommended, till the pandemic is over.

16. **The health technology tools should be updated to face the future.** This crisis must spur the entire sector to overcome the backlog of investments in recent years in electro-medical devices and other more basic healthcare technologies.

17. **From the point of view of ethics and the social and professional debate, it will be necessary to make progress in less drastic criteria for the isolation of patients.** During the crisis, the common good has been prioritized over individual rights, having reached extreme situations of isolation in patients who were dying, which have shaken society. For future crises, it will be necessary to think of more elaborate guidelines for action.
IV. PROFESSIONALS: LOOKING FOR A MORE ADAPTABLE WAY TO ENGAGE THEM

18. **The civil servants service model** (in healthcare providers managed directly by the healthcare administration) and the current salary conditions of all professionals must be progressively replaced by **an employment contract along with an improvement in working conditions, with all the guarantees, based on accreditation, competence and experience**. The civil servants model has many conditions and rigidities. It is a burden for clinical and organizational management usually and in this crisis management, in particular. Labor regulations should facilitate flexibility in the creation of as many multidisciplinary teams as situations require. Likewise, it is necessary that health managers do not have a political link, to become professionals selected and evaluated by their competencies and merits and development of their function, as are other professionals.

19. **In relation to professional training**, it should promote versatility of competencies. Training plans must be reviewed, to include other competencies like multidisciplinary teams, in situations of public health crisis, in the use of telematics and also to promote improvements in communication skills in the digital environment.

20. **The system needs to have more nurses and well trained so they can play a more relevant role in multidisciplinary teams**, both in primary care, in hospitals and health centers. It is necessary to create training itineraries like family and community nursing and geriatric nursing, and to move forward in nursing prescribing.

21. The role of **administrative professionals** at all levels of healthcare organizations should be strengthened, as clinical work support services with greater training similar to that of medical secretaries who have proved essential to deal with the most difficult situation, to do their work closer to patients and their families.
V. TOWARDS A NEW MODEL TO ADDRESS THE ELDERLIES’ NEEDS.

Due to the importance of the situation of nursing homes during the pandemic, we believe that we run the risk that an overreaction will end up in over-medicalizing the centers for the elderly, transforming them into pseudo-hospitals. From the SCGS, we want to contribute to the debate in order to help define the new model of support for the elderly. We have to design a new model of healthcare support for nursing homes. Consequently, we believe that now is the time to draw up a multi-sectoral plan based on the following points:

22. **Home must become the center of care for the elderly in a situation of fragility and vulnerability, which will require individualized plans drawn up in a collaborative manner between local social services and primary health care.** These plans should aim to provide coordinated and proportionate home services and thus avoid as many institutionalizations in nursing-homes as possible. Family and community nurses and social services could play a key role in these programs, as well as a technological endowment that coordinates social and health services in near real time. **Apartments for the elderly with social and health support services are an alternative to promote,** in addition to common spaces for social activities and community services, and the technological endowment of essential support. It may be promoted through provided public ground, as well as a stimulus to public-private collaboration.

23. **Primary care should deploy multidisciplinary teams, with a large role for nurses,** to improve home care and with more determined support from the administrative and social workers. These teams should cater to the elderly who meet the criteria of fragility, both in their own homes and in nursing-homes. Nursing-homes usually have Healthcare professionals of their own (doctors and nurses). These professionals should be integrated into these teams, a sensible way to equate the quality of health services between institutionalized people and those living in their homes.
24. **Nursing homes, unprepared for responding to the crisis on their own need to improve their coordination with the health system.** Despite efforts, institutionalization is sometimes inevitable. That is why it is necessary to review the model of social services and how to better integrate social and healthcare services. It is key to have enough caregivers with the right competencies and well managed nursing-homes. Geriatric nurses should play a key role in the management of nursing-homes and integration of all kind of services needed to ensure the well-being of residents.

25. **It is necessary to maintain and strengthen specialized units with multidisciplinary teams dedicated to serve people in end-life situations.** At this point, we believe that, in our country, there are many units that combine social and health services units that do a great job and that, in any case, should be maintained and strengthened.
TOWARDS A MORE ENDOWED, EFFECTIVE AND AGILE HEALTHCARE SYSTEM

1. Substantially increase health budget to overcome the chronic under-funding of our healthcare system.
2. Improve management flexibility, changing bureaucracy to focus on results and transparency.
3. Adapt a new model of contracting services to the healthcare providers that deliver services to the public health care system, focus on achievement of results and a fair allocation of resources.

MANAGEMENT MATTERS ... A LOT

4. Management autonomy with accountability to healthcare clinical teams.
5. Promote integrated care and evolve towards collaborative management.
6. Reduce administrative tasks in clinical work.
7. Promote telematic clinical care.
8. Assign hospital doctors to lead hospital units.
9. New organization of Primary Care (PA) focusing on new needs.
10. Consolidate a community health model.
11. Create a climate for innovation and co-creation with citizens.

SPECIFIC MEASURES: DURING CURRENT PANDEMIC AND TO BE PREPARED FOR A SECOND WAVE

12. Properly equip the PC for the follow-up of patients with COVID-19.
13. Have diagnostic tests available in the PC and in hospitals.
15. Establish PPC proximity production strategies and with appropriate logistics.
16. Update health technology in healthcare organizations.
17. Advancement in a more appropriate way of addressing the needs of isolation criteria, from an ethic and social point of view.

PROFESSIONALS: LOOKING FOR A MORE ADAPTABLE WAY TO ENGAGE THEM

18. Replace the civil servant's services model with employment contracts along with an improvement in working conditions based on merit, competence and experience.
19. Adapt training programs of healthcare professionals to include more competencies.
20. More nurses, better trained and with a relevant role.

TOWARDS A NEW MODEL TO ADDRESS THE ELDERLYIES' NEEDS

22. Home as the center of care for the elderly in a situation of fragility and vulnerability, which will require individualized plans drawn up in a collaborative manner between local social services and primary health care.
23. Primary care should deploy multidisciplinary teams, with a large role for nurses, to support nursing-homes health needs.
24. Improve the model of management, coordination and staffing of nursing home professionals.
25. Maintain and strengthen specialized units with multidisciplinary teams dedicated to serve people in end-life situation.