Respond, recover, reset, and then thrive! Building resilient communities during and beyond COVID 19

The second in IFIC's "Care during and beyond the COVID-19 Crisis - Building integrated care as the cornerstone of our new reality" webinar series took place on 24 April. This webinar was organized in association with IFIC Australia and chaired by Professor Nick Goodwin, Chair of IFIC Australia and Director of the Central Coast Research Institute. The webinar focused on "Supporting Community Resilience in times of Public Health Crisis"

Community resilience refers to the sustained ability of a community to respond to, withstand and recover from shocks and stressors. In Australia, and other countries, natural disasters such as drought, bushfires, floods, earthquakes and infectious disease outbreaks such as COVID-19 are likely to have a sustained and negative impact on the health and wellbeing of people over a prolonged period of time. This webinar will explore evidence, and personal experiences, in supporting community resilience - both as a means to strengthen communities to withstand public health crises before they occur, in times of emergency response, and in the aftermath.

The webinar brought together experts from around the world representing patients and community, primary care, system leadership and academia, including: **Vince Barry,** CEO, Pegasus Health, Christchurch, New Zealand; **Dr Antoine Boivin,** Family physician and Canada Research Chair in Patient and Public Partnership; **Ghislaine Rouly**, Co-Lead of the «Caring Community Project», (Antoine Boivin), of the Canada Research Chair in Patient and Public Partnership. Patient partner, Centre of Excellence on Partnership with Patients and the Public (CEPPP), Canada; **Professor David Perkins**, Director, Centre for Rural and Remote Mental Health (CRRMH), University of Newcastle and Director, IFIC Australia; **Dr Ricardo Fábrega**, Senior Adviser, Integrated Health Services, Pan American Health Organization (PAHO); and **Dr Jason Cheah**, Deputy Group CEO (Transformation), National Healthcare Group, CEO, Woodlands Health Campus, Singapore.

Some key themes emerged:

The importance of leadership: Vince Barry told us that "As leaders we cannot miss the opportunity that these crises present to us to change a lot of things that we have dreamt about for a long time." He told us it's a time to "respond, recover, reset and then thrive". He also spoke of the resilience of communities and that systems need to build on and compliment that resilience.

Partnering with patients: Antoine Boivin told us "that frontline physicians and health professionals need to take a back seat to support, build capacity and empower patients, families and citizens who are the real front stage players." He talked about the boundaries between health professionals and patients falling during crisis - "We **care for** one another and we **care with** one another, building on each other's knowledge." Ghislaine Rouly described examples of a programme both her and Antoine work together on in Montreal that is **Linking** people with community healthcare, is **Bonding** community members among themselves to facilitate mutual support for day to day activities and is **Bridging** with community support organizations to ease the psycho-social impact of the pandemic.

Empowering communities: David Perkins told us "when you see one rural town you have seen one rural town". He told us that "it's not about the battery that you have, it's about being able to adapt to change, to support each other and it's about agency - being able to support individuals and businesses, how are we supporting the local mayors, general practitioners, priests, local leadership?. He told us it is not about 'sending solutions' but rather we need to do 'intense listening' and 'get alongside' to understand how to really support vulnerable communities to get on top of a myriad of issues.

New ways of working together: Ricardo Fabrega suggests that the current hospital centric systems of care will not survive this crisis. From the pandemic he hopes "a new health system will emerge based on a prevention approach and a primary care strategy for the 21st century." He told us "If we want to win, we have to have a public health and proactive approach – a solid network focused on correct care. We need to activate the power of the people to help care for themselves and support them in this task. A new approach of integrated care as a complement to self-care. Nobody can work alone; we need to help each other."

The role of government in building resilient communities: Jason Cheah told us how "this crisis has taught us we can't talk about community development or progressing without putting in elements of population health and enablement of the community." He told us the role of government is important in supporting a community fabric that needs to be built over time and allows groups of people to be more resilient. "They should enable things to happen whether through funding, infrastructure or capabilities in terms of public health services, but it is the community itself who must organize services through the use of technology, using volunteers, that will then enable them to withstand these kind of jolts to the system."

Below, you can read the full transcript of their contributions facilitated by **Professor Nick Goodwin**, Chair of IFIC Australia and Director of the Central Coast Research Institute.

Vince Barry, CEO, Pegasus Health, Christchurch, New Zealand

Nick: Canterbury has had significant experience in responding to crisis particularly with earthquakes and more recently the shooting in Christchurch last year and now with COVID-19 so the residents have gone through a lot so I'd like to ask you the cycles that a community has to go through once the initial impact has passed, and what you have observed as the best way to respond to this in a community setting

Vince: We must accept that communities are naturally resilient, and it is an important message to send and what we need to do is to build and compliment their reliance. There is a lot of literature about disaster response, you go through the heroic phase, then the honeymoon, then there's disillusionment and then reconstruction. In health we focused on response, recover, reset and then thrive. It is really about recovering from the past and transitioning to the future. As leaders we cannot miss the opportunity that these crises present to us to change a lot of things that we have dreamt about for a long time. Its taking the opportunity to build change and adapt because while we have individuals, organizations and systems that are vulnerable it's the best time to remove things that have gotten in the way in the past because its often, people, professionals and organization that get in the way of good things happening.

Leadership is particularly important. We have had a reasonably strong leadership response from our central government. I am quite remarked about what was said on a daily basis from our Prime Minister and we immediately see impact on our health lines. Do not underestimate the importance of what leaders say and the importance of getting messages out to the community that are clear, concise and accurate. Because when we are vulnerable, we are looking for direction from leadership.

A big issue for me is not coming in heroically and assuming what communities need and want. It's about complimenting what they need as they are naturally resilient, and we need to build their capability further. An example in Canterbury, after the earthquake, and is now a national programme for COVID, we started a campaign called 'All Right' which is about psycho-social response to disaster. It's okay to feel the way you are feeling, use your natural resilience and resources but also those of your community. That programme evidences itself by being part of the

recovery phase of existing communities: going to church, being part of community events, talk to each other - work together. But after 12 months we fell back into old behaviors. This is an opportunity to embed those changes. The lessons that were learned about the forgiveness within communities after the shootings [is important].

Nick: When you mention 'remove things that get in the way' – often in integrated care it's not what you add but sometimes it's what you take away that is more important – what have you seen where it's better to get out of the way?

Vince: People, professionals and organizations are what gets in the way and what we need to understand is we must work together. We longed for a shared record across our health system, and after the earthquake we did this within 6 months. People were distressed that their record didn't follow them, and we took the opportunity to build this capability in the aftermath.

Dr Antoine Boivin; Family physician and Canada Research Chair in Patient and Public Partnership

Nick: Welcome to Antoine and Ghislaine who will provide us with an overview and some examples from their experience in Montreal.

Antoine: We live in the Montreal metropolitan region which is at the epicenter of the Covid pandemic in Canada, with reported death rates among the highest in the country. The community spread has been largely controlled because of early warnings from Asia and Australia. Consequently, our primary care, our hospitals and ICUs have been quickly able to adapt so now we see quite empty emergency rooms, family practice clinics and hospital beds. 95% of consultations have changed to phone and video conferences. The immediate tragedy is in uncontrolled outbreaks in long-term care facilities for the elderly where 80% of deaths are concentrated and basic care is hard to offer due to staff shortages. Limited visits from family and loved ones are compounding the grief, suffering and anxiety relating to those deaths.

At the community level those long-term challenges looming ahead related to the health, social and economic impact of the pandemic, including unemployment, isolation and untreated long-term conditions like cancer, heart disease and mental health.

As a frontline physician the question is finding a role within the biggest sanitary challenge in the last century. The immediate reaction is to basically throw ourselves in the fire. This heroic position is tempting and that's the way we have been trained. But we realize that we are not invulnerable. We can fall, breakdown and become sick like any member of the community. And we cannot win this alone.

As I listen and observe the initiatives that are growing naturally, I have come to realize that **frontline physicians and health professionals need to take a back seat** to support, build capacity and empower patients, families and citizens who are the real front stage players.

First, every single human being on earth has a role to play in stemming the virus. 80% of people with Covid have minor illness that recover at home with the support of family and neighbours. Even at the end of life, once we have given mediation to alleviate suffering and pain, what people are looking for is human presence from people that they know and our role is to protect those significant others so they can have contact virtually or in presence.

Strict boundaries between health professionals and the others are falling. We are all playing in the same team, and that team includes all members of our community. On a day to day basis, Ghislaine and I have been working together as a patient and physician duo to care for community members

around us. Our idea is very simple – healthcare professionals, patients and citizens can work together to care for people with complex health and social needs. We care for one another and we care with one another, building on each other's knowledge. We have worked like this for several years, but our collaboration has amplified in the pandemic crisis. We focused our partnership on 3 things:

1. **Linking** people with community healthcare to address COVID and non-COVID health care needs
2. **Bonding** community members among themselves to facilitate mutual support for day to day activities, groceries, communication needs etc.
3. **Bridging** with community support organizations to ease the psycho-social impact of the pandemic

Ghislaine will now provide you with examples of these partnership approaches.

Ghislaine Rouly, Co-Lead of the «Caring Community Project», (Antoine Boivin), of the Canada Research Chair in Patient and Public Partnership. Patient partner, Centre of Excellence on Partnership with Patients and the Public (CEPPP), Canada

Linking with community healthcare: For the last year I have been taking care of an elderly lady older than I am, who just went through major surgery. Talking to her I realized how much pain she was in. I mentioned she should call Antoine, but she refuses because: "he is busy with COVID patients". Being worried I asked her permission to call Antoine as I was worried about the consequences. She agreed and Antoine was able to follow up on her immediately.

Bonding with other community members: I have followed a young lady for the last year and a half. She lived in voluntary isolation for 3 years, had no fridge, no stove, barely any money. She suffered a major car accident and has diabetes. I follow her for the last years face to face and she became more sociable, joining an art therapy group. I call her daily and see that she is now able to ask for help. Together we were in a small video. The journalist who did the video lives next door to her and they have started to have nice conversations. Now she can ask for help. Now he is doing her groceries. Bonding with other members of the community is important.

Bridging with community support organizations: I worked with a lady for two years who has a lot of physical problems, but also mental health issues with drug addiction. I connected her with an organization that can help her with groceries. We gave her food vouchers. It is important to bridge people from their home to community and organizations that can help. Before she never turned up for her appointments and didn't take her medication for lack of money. Now she is one of Antoine's best patients.

We have built a chain of trust amongst these patients.

Nick: The COVID response seems to be acute focused, and we are not seeing so much of the primary and community responses. Can you give me some practical examples of how you are supporting communities to respond to COVID in particular?

Antoine: Our primary care facilities practically emptied, our staff was rerouted, and our patients were reluctant to seek consultations. We are mindful of other conditions that are not being addressed. Our consultation has dropped by 50%. So, we had to switch from a reactive to a proactive care. We have begun pulling out our list of patients and calling those that we thought were most vulnerable. Working with communities and patient partners who would proactively call people and find what their needs of the moment were. Right now, its dealing with the consequences of

social isolation and practical issues (including groceries), but also letting all our patients know that there is still a team behind them if they need it. We have switched to phone consultation, but we are still here if you need it.

Professor David Perkins, Director, Centre for Rural and Remote Mental Health (CRRMH), University of Newcastle and Director, IFIC Australia

Nick: What is your experience of working with rural and remote communities in Australia? There are a lot of different aspects because if you have drought, the drip feed of the impact on the community has a long-term effect and then you have also the short-term shock of fires. Can you talk to your experience?

David: We have a phrase we use in rural and mental health "when you see one rural town you have seen one rural town". The issue of difference in locality and rural ecologies is really important. Our centre is a combination of two things - one is of rural adversity, mental health workers or coordinators who link people to services and partner with local organisations and two, is researchers who work out what the evidence suggests and does what we do actually work.

The perspectives we take is important - the perspective of a politician, these are problems to be addressed, got over, and worked through; the perspective of media, pictures, stories, communications; and the service provider, how can we help, what can we do, how do we stay solvent and relevant; the perspective of a rural community, this is my town, how can I live, how can we thrive.

We know rural areas have thin services, generalists rather than specialists, precariousness economically, socially and health-wise. In many rural areas COVID has not had a huge impact. Its drought, fire, floods, issues of demographic change, ageing populations, economic change, business closures, water insecurity, regulation, insurance, rebuilding houses following bush fires - and that takes place on top of normal adversities. People don't stop getting cancer because we live in a rural area. It's not about the battery that you have its about being able to adapt to change, to support each other and it's about agency - being able to support individuals and businesses, how are we supporting the local mayors, general practitioners, priests, local leadership? I see that as different from the conventional approach, which is to send help from the city, send solutions. We have fire councilors, drought councillors and now COVID councillors. We need to oppose the assumption that this is about specialist solutions for short-term acute problems. How can we support locals by firstly intense listening, by getting alongside and seeing what local communities need in order to address this combination of issues?

Nick: When you look at the literature for how you support community resilience, there's a lot in there about how you work with the community, that's often seen as a long-term proposition. My reading of integrated care and crisis response is that those communities that have greater resilience have been able to build the best response. When you get a shock like COVID on top of all these other things – what are the sort of things you can do as a response today – versus what you need to do to build resilience in the future?

David: We must support the local residents, servers, leaders and communities. We have seen in recent times that GPs were not part of the emergency response whereas the GPs are in communities for the long-term, have invested in the community because fire, drought and flood are not going to be resolved in a short time. Sure we have to put the fire out, but then we have to support the community to build and it will be the generalists, the primary care team, the unconventional carers -

spouse, family, neighbour - and important we don't lose local businesses, churches etc. as they are all vulnerable.

Dr Ricardo Fábrega, Senior Adviser, Integrated Health Services, Pan American Health Organization (PAHO)

Nick: Ricardo, you are earlier in the curve, what's your commentary on this issue from a Latin American perspective?

I want to talk about health system resilience. For us resilience is not enough in this moment, we don't just need to endure and get out - we need to leave the hospital centric system behind. We hope the hospital system is not resilient. We hope it will be destroyed from this pandemic and a new health system will emerge based on a prevention approach and a primary care strategy for the 21st century.

In 2018 a commission proposed a new approach to achieving universal access to health and universal health coverage in the Americas and we hope that they will follow the recommendation of our communities, our professionals and our workers. We need to change the focus. We cannot stay waiting for sick people in our facilities. If we want to win, we have to have a public health and proactive approach – a solid network focused on correct care. We need to activate the power of the people to help care for themselves and support them in this task. A new approach of integrated care as a complement to self-care. Nobody can work alone; we need to help each other.

We need a new way of living in the city. We all must adopt physical distance, hand washing, masks in the presence of others. All of this must be supported by rules and regulations of the authorities. We must quarantine high risk people – over the age of the 70 have a high mortality rate. We need to cocoon these people from the disease. They will need support from family, community, local government, help from local primary heath teams. This is necessary to contain the virus. When the normal measures of contagion are not working, or the health system is overwhelmed, these quarantines must be maintained and we must support the most vulnerable people with these basic needs. If we want to contain the spread, we must identify suspicious cases and isolate them but it also means to take care of these people in isolation. We don't have tests [in Latin America] so this task is hard.

Nick: There have been receiving mixed political messages – should we wear masks, should we have a lock down? What time do we start to free up our quarantine and physical distancing measures because of the economic hardship consequences that might be worse than COVID 19?

Ricardo: We have different reactions in our contexts. We don't have the solution for every context, so we can't recommend a lot of things because we are not sure they are going to work. So how can countries decide what to do without the scientific information? We are in a hard moment because the solutions are political and not technical right now.

Dr Jason Cheah, Deputy Group CEO (Transformation), National Healthcare Group, CEO, Woodlands Health Campus, Singapore

Nick: Jason, say a little bit about the response in Singapore which has been very effective and what does all this mean for the future of health and social care more generally?

Jason: Everyone knows that this virus, if anything, it has highlighted a number of things that countries all over the world already know. First, when it comes to the issue of resilient communities - health and social care all have to come together. There isn't a possible divide when you come to

talk about health and social issues. The one thing about COVID that amplifies this point is a crisis like this hits all countries, and whether you are urban or rural, the impact is the same. Whether you talk about vulnerable populations, urban populations, rich or poor countries, this crisis has taught us we can't talk about community development or progressing without putting in elements of population health and enablement of the community. I refer to things like technology, just simple things like befriending in the community. All this has to come together in order for a country to respond to the crisis. In Singapore we are a small country with a dense population. For us in Singapore a key aspect is that because this virus is an invisible enemy and it doesn't discriminate between rich and poor, or ethnicities, it has strangely brought the world together because it is a common enemy.

There are different reactions because politicians respond differently. Here in Singapore we took the opportunity to address the acute problems at hand which is the onset of the disease which involved mobilizing the whole system together to meet the demands of the virus. But beyond this the important aspect which countries deal with a later stage, in the battle against corona, is that we need to think of different ways to manage the delivering of health care and health and social care for vulnerable populations. Much of the world is enforcing physical distancing - we use the word safe distancing. How do you deliver health and social care in the community within these restrictions? By thinking outside the box - how do you do these things in a less conventional way. The importance of neighbours and the importance of neighbourhoods. We haven't emphasized this enough. COVID has highlighted this as a key issue as neighbours play an important role to protect vulnerable populations who are isolated. We have this in Singapore too and it is a community fabric that needs to be built over time and allows groups of people to be more resilient.

Governments have an important role. They should enable things to happen whether through funding, infrastructure or capabilities in terms of public health services, but it is the community itself who must organize services through the use of technology, using volunteers, that will then enable them to withstand these kind of jolts to the system. COVID 19 changes the way we think about things.

Nick: Through integrated care we want primary, community and self-care to take on the mantel but often that capability isn't in place, so we put added burden and don't provide enough support for that. Do we invest in the measures to manage to COVID 19 or do we see good health as essential for economic recovery in its own right? The people who are the sickest are the deficits in our community rather than assets. Do we do enough internationally in investing in health to support better economic outcomes?

Jason: We haven't done enough. Internationally health systems have been seen as enabling better economics, but perhaps it takes a crisis to open the eyes of government all over the world to the reality of this fact. One of the things you will see is that if one thing is to change is that health becomes a lot more front, left and centre of considerations of all governments moving forward. One point that should be made is that governments have learnt from this is the need for pandemic preparedness. Not just governments but communities need to be on alert for these kinds of crisis to happen. Whether it is natural disasters [or something else], some are much better prepared for dealing with pandemics. But even countries who have long enjoyed economic success, all our memories are finite and short. Even in Singapore we had forgotten some of the lessons from SARS and we are now remembering and putting the lessons into implementation.

Final Comments from All Panelists

Nick: What are one or two things you would like to see change? And what are the things that will actually change?

Vince: I would like to see change to a primary, community care led health system and preserving our limited hospital resources for the real emergencies. We are going down that pathway but haven't had full appreciation. I think we have to be clear that this is about transitions and for us the government led the initial stage and now we need to build the reliance more locally and build the capacity for the future.

Antoine: I would like to see a stronger sense that we are both care givers and care receivers, that we need to care for one another. Health professionals are vulnerable and need to be supported but can also provide care beyond their role as health professionals. We are part of the community we serve. We are on the same team. What I think will remain is a different sense of distance and proximity. A new sense of the importance of neighbourhoods. The support networks in the proximity, but the closeness of those that are far way when we can gather people from around the world more easily. The idea of what is close and what is far away – how can we provide support to those who are physically distant from us?

It has been incredibly helpful to take a step back from what is happening on the ground here [in Montreal] - in our little corner of the world - and to reflect on how this relates and connects with experiences abroad.

I have found a lot of resonance and taken a number of key words from our talks: the need for "intense listening" and the risks of simply sending help from the outside rather than supporting communities from the inside, "moving from heroism to reconstruction", the importance of neighbours and "unconventional caretakers", the need to look at long-term consequences after the fire is out, and the importance of (distributed) leadership to leverage opportunities for system change throughout the crisis.

If it is helpful, I copy a link to a description of the caring community project that Ghislaine and I are co-leading, a BMJ thinking piece on our local community partnership initiatives within the COVID context and a list of community partnership ressources that our research chair team is offering.

Ghislaine: I would like to see more humanity and more trust among us. I can see it, quite frankly. Like somebody who years ago said yes, we can. I believe we can. Give us patients the chance to be part of your team. We are with you; we are not against you. We are a team. One day you will be a patient and realise that you can trust us. Find a way to reach out to us and you will be surprised, I think. With COVID we see a lot of bad things, but I don't want to look at that. All of sudden people are coming together by telephone and video conferencing. They are worried about people and I hope that will stay. Very quickly I am at the same table with our ministry for health and now they are asking what do patients think, and asking are we writing things in the right way, is it ethical? I hope these things will stay.

David: I just want to encourage us to look to the medium and the long-term. Some communities are resilient and will be able to move forward. Some have suffered disadvantage and they will suffer, and we need to support them. If we just send services, we won't enable them. We need to support them to take control, have agency and move forward.

Nick: I'm reminded of the inverse care law – the ones in our society who are most vulnerable need the most support but are least likely to get it. Inequalities may only be widened by this. When we

see the aftermath of this, we will see the important issue of inequalities staring us in the face because of the way our systems are set up.

Ricardo: It is an opportunity to put access to health at the centre and we need universal health systems. All the governments sign up for it but this is the moment to push for it.

Jason: It is most heartening that there is much work that is still going on to enable seniors and the elderly and vulnerable populations continue to live well and cope and adapt even during this COVID-19 pandemic.

My concern has been that there is and will continue to be a great deal of shifting of resources to hospitals to deal with the acute outbreak, and hence, neglecting the community services. At some point, this will then result in negative repercussions on the health system as more and more of these vulnerable patients decompensate, resulting in more hospital admissions. Community crisis management teams also need to continue to "catch" those with "fragile" multi-morbidity conditions, as well as those who are at EoL and / or with mental health issues. We are already seeing that in Singapore (though not a lot, thank goodness), but I'm sure it is also happening on the ground in many of the affected countries. I don't yet know how much of this has been reported though.

It is because of this that I advocate the need to strengthen the neighbourhood fabric and support systems to be a form a surveillance for the vulnerable patients and frail elderly. I think this is an untapped resource which a number of communities have not yet realised. However, even neighbours and volunteers need to be trained and enabled with simple tools and a way to escalate. Hence a form of virtual consult care centre would be highly beneficial.

Antoine: Jason, I fully share your concern. Vince's comment about the "heroic" phase resonated a lot with me because our primary care team in Montreal has been "pulled into the fire", with a number of primary care professionals (nurse practitioners, physicians, nurses, social workers) being relocated in hospital care and long-term care facilities that are most acutely affected by the short-term effects of the pandemic, with longer/indirect psychosocial and health consequences being left largely unaddressed. As a consequence, "routine primary care" has been perceived as "dull" and unexciting, and the empty waiting rooms interpreted as a sign that this is no longer a service that is necessary.

One point that struck me recently is the "delocalization effect" that the pandemic has had on primary care. We used to define our service by the 4 walls of the primary care clinic. The past weeks have had a profound effect on our sense of "space", with primary care services being delivered through:

- Distant care (through phone/video consultation)
- "Reaching-in" (convincing some selected patients to come to the clinic for face-to-face evaluation and treatment)
- "Reaching-out" (moving health professionals out in the community, through home-care and long-term care service)

Jason: I couldn't agree with you more. Indeed, this entire COVID-19 pandemic crisis will change the face of many aspects of healthcare provision forever, or for at least a long time to come, hopefully at least some for the better. Certainly in primary care, there are and will be a number of new innovations or previously rejected processes which will become the norm, such as virtual consults and tele-monitoring, "on-demand" services, and even the old "visiting community nurse" concept may well make a comeback after this. Certainly, our primary care practices will undergo a

tremendous change in terms of physical infrastructure such as waiting areas, segregation of “hot” vs “chronic repeat cases”, provision of fever screening areas, etc.