COVID Challenges in Caring

Leadership Lessons Learned from Healthcare & Health Professions Education during the COVID-19 Pandemic

CASE STUDY

McMaster University

Leading a Coordinated Community Table Response

Telling the Story of: Dr. Sharon Bal, BSc MD CCFP FCFP
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> **"The global impact of COVID-19 was only beginning to take hold and for medical practitioners like Dr. Bal, this was an all-consuming concern."**

The email marked urgent came through mid-morning on March 19, 2020, just over a week after COVID-19 was declared a global pandemic. Doctor Sharon Bal, a family physician in Cambridge and an Assistant Clinical Professor at McMaster University, was in between patient phone calls and only had a chance to skim the contents of the email. However, its message was clear: Dr. Bal was being asked to be a Community Lead for Waterloo-Wellington region's response to COVID-19. The timing of the request couldn't have been worse. She was grappling with the virtual transition of her family practice and she had just pivoted her courses at McMaster University to online instruction. Could she feasibly take on an additional leadership role and do it the justice it deserved? Under these dire circumstances, however, how could she not rise to the occasion and serve?

Dr. Bal's phone rang and she was pulled away from the email, unable to fully digest its implications. Her smartphone screen displayed that the caller was "Agnes Malhotra[1]". Agnes was a new patient at the clinic with a toddler complaining of an ear ache, presenting with a high fever. Struck by feelings of concern and empathy for this patient, Dr. Bal was brought back to the task at hand. She quickly took a sip of water to collect herself, opened the patient's file and proceeded to take the call. After she ended the call with Agnes and phoned in a prescription for amoxicillin, Dr. Bal returned her attention to the email. The healthcare system seemed to be unraveling before her very eyes. Lately, she had been feeling paralyzed as a medical practitioner, helpless and frustrated by the fact that she could not treat her patients' ailments in person. What was the world coming to if she couldn't look into a toddler's ears to assess for infection? The global impact of COVID-19 was only beginning to take hold and for medical practitioners like Dr. Bal, this was an all-consuming concern. In that moment, she decided that the care of her patients was paramount and that she needed to prioritize her clinical practice in the midst of this healthcare crisis. With that, she was able to push her thoughts about the email to the back of her mind and continue to conduct her over-the-phone appointments. In-between appointments when she was doing her charting, however, the urgent request to lead the Community Table crept back into her thoughts and she found herself contemplating the leadership role once again.

After a day of virtual appointments, Dr. Bal joined a Zoom meeting with several of her associates from McMaster University who were also practicing clinicians. Fortuitously, they were discussing the implications of COVID-19 on congregate settings.

[1] All patient names are pseudonyms.

The grim news from Italy where the novel coronavirus was rampantly wiping out the elderly population had the world on edge, particularly those involved in the care of the elderly. For an hour, they discussed the impending outbreaks in long-term care facilities and questioned how the province was going to contend with it. Doctor Bal left the call knowing what she had to do. She realized that perhaps the best way she could serve during this healthcare crisis was not only through front-line work, but also by coordinating the expertise of professionals across sectors to provide top-down support to those who needed it most. Her previous leadership in the healthcare community coupled with her leadership training and experience as a medical practitioner made her an ideal person to lead a Community Table Response and she felt compelled to do so. Without further deliberation, she opened the email and accepted the role.

Building the Community Table

The Community Table response to COVID-19 for Waterloo-Wellington had the overarching purpose of connecting sub-regional and local sectors and leaders together. In part, the response involved working with local leaders across various sectors and connecting them to local hospitals. The Community Table was also designed to be able to escalate concerns to Regional and Provincial Tables and, in a timely manner, relay guidance and support back to the local structure. The Community Table was intended to be a coordinated response in every sense of the word.

As the lead of this committee, Dr. Bal's first task was to recruit members. The table she envisioned needed to be representative of the various geographical regions within Waterloo-Wellington but it also needed to unite leaders with reputational credibility and expertise across sectors. With this two-fold vision in mind, Dr. Bal set out to find the right people. The first four members she pulled to the table were primary care leaders that were geographically distributed across the region. Next, she recruited representatives from the fields of palliative care, community mental health, paramedic services, Emergency Medical Services, the homeless shelter system, long-term care, and retirement living. Lastly, Dr. Bal prioritized recruiting a liaison with the local hospital to ensure they could provide an integrated response as well as community support services.

Identifying the Need to Create an Inclusive Culture at the Table

It took time and tact to build the Community Table, but Dr. Bal knew that it had to be the right group of people to be an effective committee. Once the Table was established, the first step was to come together to define goals. In these early conversations, it became apparent to Dr. Bal that with so many perspectives around the table, there was going to be some competing ideas and the potential for conflict. The diversity of the table was its strength and its weakness at the same time.

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Representatives from the various sectors brought with them their own priorities, concerns, expectations, operational culture and dynamic personalities. Furthermore, each committee member was armed with various resources and represented organizations with varying levels of power and political clout. For instance, some of the larger organizations at the table had representation at the Provincial level and therefore had the ability to advocate for themselves.

As a leader of the committee, Dr. Bal recognized the need to make sure that there was space for all members to ensure that all voices were heard. To garner buy-in and trust from committee members, she positioned herself as an advocate for all the agencies at the table, committing herself to bringing all issues to Regional and Provincial tables. To further complicate these underlying power dynamics, the members of the Community Table did not know one another on a personal level and did not have a full understanding of the culture in which various sectors operated.

Although she felt she had found the right members of the team, Dr. Bal now needed the glue to bind this team together so it could function as a cohesive unit. The voices at the table, no matter how valuable, would fall upon deaf ears if an inclusive environment was not established. As Dr. Bal's focus broadened to include issues of equity around the Community Table, multiple congregate-setting COVID-19 outbreaks were brewing. Within two weeks, the newly established committee was thrown into full-fledged crisis mode.

DISCUSSION

1. Why was effort on the creation of an inclusive environment so necessary to this team's functioning?
2. How was a value proposition for each participant a key strategic priority for the leader of this table, and how might it have led to higher productivity?

Facilitating a Coordinated Community Table Response

While pursuing the committee's urgent agenda to address the COVID-19 outbreaks in various long-term care facilities, Dr. Bal simultaneously worked with the table members to build trust and establish relationships. This was a necessary step as it was only through mutual trust and respect that the committee would be able to effectively collaborate, troubleshoot and respond in a time of crisis. They engaged in trust building exercises at the outset of meetings and allotted time to relationship building.

Doctor Bal worked to dismantle power dynamics in every which way she could. She led by example, opting to position herself as a facilitator of the committee rather than a driver. She made space at the table for all sector representatives, regardless of the size of the organization or its political reach. Of course, there were pressing issues, such as community outbreaks, that would often take precedent, requiring them to slow down progress in other sectors. However, whenever she could, Dr. Bal allotted time in committee meetings for all sectors to have the floor to highlight their sectoral issues and she reiterated time and again, her commitment to escalating all pressing concerns to higher powers. To further ensure that all sectors and organizations were given a voice, Dr. Bal facilitated the development of a weekly newsletter that would highlight the concerns and developments presented by one sector representative at the Community Table.

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She had support in producing a written update and disseminating it to larger audiences with the intention of not only raising awareness about local responses to COVID-19, but also to empower local leaders in a way that they found valuable.

At the get-go, the Community Table's top priority was addressing community outbreaks. Elderly folks were dying and there was no greater priority than mitigating that. One of the first decisions the table had to make was in regards to how information was going to flow between the long-term care facilities, the Community Table, and Regional/Provincial Tables. The frenetic climate brought a barrage of inquiry on the doorsteps of many of the LTCs and in an already stressed setting, it was overwhelming for the LTC staff. The representative from the LTCs who sat at the Community Table stressed the need to control the flow of information to alleviate confusion for LTC staff. With input from Dr. Bal, the committee opted to form smaller teams led by Ontario Health Team (OHT) administrative leaders called "congregate care huddles" to oversee various issues across sectors and to control the flow of information.

Doctor Bal effectively employed a collaborative leadership style. She viewed the committee as a "table of leaders" who brought a great deal of expertise and knowledge to the table.

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Wanting to capitalize on this wealth of knowledge, Dr. Bal adopted a relational approach to leading the committee, offering opportunities to co-design, co-determine, and co-create initiatives, strategies, priorities, and procedures. The collaborative leadership model that Dr. Bal implemented worked to dismantle some of the implicit power dynamics that permeated the table in its infancy and, ultimately, contributed to their overall success as a united front.

The members of the Community Table were passionate and incredibly invested in advocating for their sectors. As a result, there was often a great deal of emotionality driving discussions and at times, conversations had the potential to become heated. As the facilitator, Dr. Bal found herself becoming a mediator to ensure that the table remained a safe space for all members.

Both publicly and behind the scenes, the repair and restoration of relationships became part of her role and called for a great deal of empathy and sensitivity on her part. At the end of the day, the committee shared the ultimate goal of the safety and wellness of their respective sectors and the survival and well-being of society at large. Bringing discussions back to this global perspective was an effective approach to grounding heated debates.

Forging a Shared Path Forward

Doctor Bal took her seat at the table as other members of the committee continued to filter into the meeting room. It was a welcome change to be able to conduct their meetings in person. She waited a couple minutes more as the last committee members trickled in and then called the meeting to order. Directing attention to their agenda for January 28, 2021, she invited the committee to begin her favourite part of their weekly meeting: the check-ins. In this segment of the meeting, each member of the Community Table was invited to share a highlight from their previous week. Doctor Bal enjoyed starting their meeting on a high, despite the turbulent topics they inevitably encountered soon after. For Dr. Bal, it was important that they both started and ended their meetings in a positive way to ensure the table served as a welcoming sounding board that all members wanted to return to the next week.

The first pressing item on the agenda was an update from the LTC representative regarding the repercussions of an outbreak in one of the retirement homes. It was a topic in the forefront of every mind in the room. The LTC representative spoke at length about the tremendous suffering that families experienced and how these devastating feelings of loss extended to the staff working in the retirement home who had become so attached to their patients. She described the incredible bond that had formed between the patients, the patient families and the staff to the point that the staff, along with families, required bereavement support from the community mental health agency when a patient died. The community mental health representative at the table then entered the discussion and happily confirmed that a beautiful partnership between long-term care staff and the community mental health agency was blossoming. Even though it was happening under the direst of circumstances, Dr. Bal felt a sense of pride over this example of collaboration across sectors. Ultimately, this is what the Community Table set out to do. It was a silver lining that provided some light in the darkest of hours.

As the meeting was coming to a close, Dr. Bal looked around the table as each member recapped their action items. At that moment, she felt a real sense of connection across the group as they smiled and acknowledged one another's contributions and efforts. They had come a long way as a committee and although they still had a long way to go, Dr. Bal felt that they had, in a sense, succeeded thus far. Granted, this was a journey wherein they witnessed death and suffering which was incredibly painful and not something to be deemed a success. Nevertheless, they had persevered and learned to come together as a team to advocate for their communities. This was worth celebrating. Committee members learned to set egos aside and find ways to wrap supports around those who needed it the most, regardless of what sector or jurisdiction they fell in. Through collaborative leadership tactics, Dr. Bal supported an incredibly diverse group of experts to unite based on their shared passion to serve people and the community and together, they forged a shared path forward.

CLOSING DISCUSSION

1. How was a horizontal (within the table) and vertical (to regional structures) integration a key part of this table? What do you think were two of the biggest challenges that Dr. Bal and her colleagues encountered when trying to connect congregate settings to community health-care leaders and the health system?

2. How did the Community Table ensure it met the needs of all within the community? What did it do to help those people (e.g. vulnerable populations) who did not have as much power at these traditionally political tables? What are other measures that might have been taken?

To see **Dr. Bal** tell her story, you can view it by clicking on the **QR Code** below. You may also access it by going to **https://www.youtube.com/watch?v=p3S41CK-_Ck**

This project is made possible with funding by the Government of Ontario and through eCampusOntario's support of the Virtual Learning Strategy (VLS) and Central Virtual Learning Platform (CVLP). To learn more about VLS and CVLP visit: https://vls.ecampusontario.ca