COVID CORNER Webinar:
A Comprehensive 360 Approach to Care of the COVID-19 Patient in the Community

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Christine Luelo MD CCFP
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Shawn Dowling MD FRCPC
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Panellists:
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Jake Jennings
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Faculty/Presenter Disclosure

Faculty Jia Hu
• None to Disclose

Faculty Christine Luelo
• Honoraria, other rewards: Medical Director SCPCN
• Speakers' Bureaux, advisory boards: CPSA Assessment Program Advisory Committee
• Grants, clinical trials: Medical Lead PHC ORI Calgary Zone
• Investments in health organizations: TELUS (common shares)

Faculty Rick Ward
• None to Disclose
Faculty/Presenter Disclosure

**Faculty** Linda Slocombe
- None to Disclose

**Faculty** Shawn Dowling
- Grants, clinical trials: CIHR Grant

**Faculty** Parabdeep Lail
- Grants, clinical trials: CIHR Grant

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Public Health meets the Medical Home & AB Contact Tracing App

**Jia Hu MD CCFP**
Zone Medical Officer of Health, Calgary Zone, Alberta Health Services
PRIMARY CARE’S ROLE IN THE PANDEMIC RESPONSE

Dr. Christine Luelo, Medical Director SCPCN, Medical Co-Chair Calgary Zone Operations Coordinating Committee

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April 28, 2020

#10 Leveraged newly-created Calgary Zone Primary Care Business Unit to coordinate pan-PCN activities with AHS — this is a full-time job
Effective Knowledge Translation with Primary Care

- regular weekly PCN newsletter updates
- ‘Red’ priority communications
- Specialist LINK website warehouse
- biweekly Monday night CME webcasts

Developed COVID Primary Care clinical follow-up/care pathway

- 1,627 downloads
- scaled provincially
- EMR templates this week
Established Specialist LINK COVID line
- 173 calls from April 7-26
- 7 days a week
- Now scaled provincially

Repositioned East Calgary FCC as ‘COVID Care Clinic’ single point of AHS contact
- rapid PDSA cycles
- incubated ideas which were then quickly (48 hours) transitioned to PCN’s
- KEY: repatriation to Medical Home
#5 Rapid disposition from Health Link to Primary Care
- < 4-hour
- < 24-hour

#4 Inpatient Hospital Discharge Pathways and processes
- transfer of care for patients discharged from hospital
- establishing the 24-hour guideline for Medical Home to patient contact
Working with Urgent Care and Emergency

- establish a < 24 hour follow up process for patients discharged from ER who need a clinical touchpoint

Worked with Public Health and Community agencies to respond to Cargill (and now other) outbreaks

- Contact tracing is not connection
The VAST majority of care for COVID patients in Alberta can be safely managed in primary care without ever needing to touch acute care. It is not outside the scope of the Medical Home and primary care is ready, willing and uniquely able to respond to the complexities of their patients needs. #wegotthis
THE PATHWAY

OVERVIEW

Background
• For most people infected with COVID-19, this is a mild disease that is self-limiting
• One in five will deteriorate – more common in “high risk” patients
• The cornerstone of management is self-isolation, supportive care and vigilance for deterioration within the patient’s home
• Regular ‘virtual’ contact is preferred over visits in the clinic
• This pathway provides evidence-based support to enable you to manage these patients

Caveats
• The evidence is changing daily, the scope of the pandemic effect on our community is unknown
• This pathway is based on best evidence available, adapted for Calgary Zone resources and our local expert leaders’ judgement
• Things will likely change – monitor your PCN newsletter and Specialist LINK website
• Providing you support for managing your patients safely and effectively is the priority
• Support = Specialist LINK pathway + Specialist LINK tele-advice + Your PCN
INTRODUCTION

Rationale for Primary Care COVID pathway

- Opportunity for primary care to support the majority of COVID + patients that will not need tertiary care
- Identify pathways to obtain help for patients who are deteriorating

DISEASE TRAJECTORY

Rapid deterioration is most common during week 2 from symptom onset
CARE IN PMH

Presumed or confirmed COVID positive patient with identified Most Responsible Provider (MRP)

Virtual appointment booked with MRP

Patients will be transitioned back to the most responsible provider in their medical home or PCN
Appointments should be done virtually

RISK STRATIFICATION

Risk Stratify Patient
High risk: Monitor Q daily x 14 days
Average risk: Monitor Q2 days x 7 days
Lower risk: Consider self-monitor only
All patients should have self-monitoring checklist with action plan for deterioration

Patients should be risk stratified based on their:
- Past clinical history including COVID and co-morbidities
- Age
- Safety net supports
Patients must be provided information on self care including:
- Isolation
- Monitoring
THE PATHWAY
RISK STRATIFICATION

<table>
<thead>
<tr>
<th>High Risk</th>
<th>Average Risk</th>
<th>Lower Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients stepping down from tertiary care (hospital, Complex Care Hub)</td>
<td>Otherwise healthy children</td>
<td>Otherwise healthy</td>
</tr>
<tr>
<td>Patients lacking ‘safety net’</td>
<td>Pregnant patients</td>
<td>No comorbidities</td>
</tr>
<tr>
<td>Patients with symptom deterioration</td>
<td>Asymptomatic swab positive patients</td>
<td>Appropriate safety network</td>
</tr>
<tr>
<td>Any age with medical comorbidities</td>
<td>40-60 years old</td>
<td>Younger age (&lt;40 yrs)</td>
</tr>
<tr>
<td>Age &gt; 60 lacking medical comorbidities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current smoking or vaping use</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Highlighted factors are the changes

HEALTH ASSESSMENT

Determine health status today. Reinforce self-isolation

- Patient reports feeling worse
- Patient reports feeling unchanged
- Patient reports feeling better
FEELING WORSE

Red Flag assessment

- Severe shortness of breath at rest
- Difficulty breathing
- Pain or pressure in chest
- Cold, clammy or pale molten skin
- New confusion
- Blue lips or face
- Becoming difficult to rouse
- Coughing up blood

- Reduced urine output
- Return of cough after period of improvement*
- Return of fever after afebrile period*
- Oxygen saturation

*may signal development of COVID pneumonia

OXYGENATION

Oxygen Saturation

- Is a helpful tool to indicate disease severity when available
- If previously healthy lungs or previously documented normal O2 sat – a new reading of < 92% is a red flag
- If underlying lung disease with documented low normal O2 sat at baseline – a new reading of < 90% is a red flag
- If patient on home oxygen and there O2 requirements increase with COVID illness – this is a red flag
**OXYGENATION**

Breathing assessment in primary care

Breathing Assessment Questions
- How is your breathing?
- Is it worse today then yesterday?
- What does your breathing prevent you from doing?

Roth Assessment

https://www.youtube.com/watch?v=u3rDdkJ9UI

**RED FLAGS PRESENT**

- Transfer of these patients should be considered based on clinical condition and goals of care
- Specialist LINK COVID + line can support with advice
SPECIALIST LINK

- A COVID + Line supported in rotation by Respirology, GIM and ID will be launched
- Questions appropriate for this line may include:
  - My patient has COPD and I’m not sure if this is COVID or AECOPD. Start on prednisone or not?
  - My patient sounds dehydrated, where should I send them?
  - My patient is older and getting sicker but doesn’t want to go to hospital – is there anything I can do?
  - They’ve had symptoms now for 2 weeks, not getting any worse. Should I do a chest x-ray?

WORSE, NO RED FLAGS

Other things to consider:
- Symptoms – worse respiratory symptoms, GI losses?
- High risk patients requiring closer monitoring:
  - Immunosuppressed or compromised (eg: steroids, chemo, HIV, diabetes)
  - Multi-morbid or frail elderly
  - Those living alone without supports

Rate of deterioration:
- rapid change → ED even if patient “stable” now
- Slow change and patient stable with sats>92%, patient may be eligible for hospital at home / monitoring services.
UNCHANGED OR BETTER

- Importance of strict self-isolation emphasized at every visit
- What if they don’t self isolate?

SYMPTOM RESOLUTION

- Duration of self isolation is 10 to 14 days from onset of symptoms
- Should still practice social distancing after isolation
- But what if they still have cough?
WHAT’S THE FEEDBACK?

• Specialist Link calls = average 10/day (range 1 – 16)
• Pathway downloads = close to 2000 downloads
• Real world utilization feedback
Supporting the Provincial Response

• The Provincial Primary Health Care program is working with the zones to:
  • Spread & scale the Calgary Zone Primary Care Pathway
  • Supporting safe discharges and transitions in the zone
  • Ensuring reliable processes to notify Primary Care following a positive test result

• Provincially, the program is supporting peer-to-peer specialist advice services for suspected & positive COVID patients in the community

Local Solutions to our common problems

- Appropriate routing of COVID-related lab tests to the Primary Care Physician
- Centralized monitoring of unattached patients, resulting in long-term attachment in a patient’s medical home
- Different zones setting up & using Secondary Assessment Centres
- Leveraging the advantages provided in urban and rural settings
- Steps to support surge capacity planning in the event of Emergency Departments being unable to take all patients

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Primary Health Care Integration Network
#PHCIN

Home to Hospital to Home Transitions: Supporting COVID Patient Management

**Purpose:**
- Verify & validate patient attachment at point of admission & / or point of confirmation of COVID diagnosis
- We recommend attaching unattached patients to support care continuity when the patient transitions into the community, as per each zone’s process

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Primary Health Care Integration Network
#PHCIN

Home to Hospital to Home Transitions: Supporting COVID Patient Management

**Purpose:**
- Ensure a safe transition back into the community with timely discharge information shared with primary care
- Follow up to Primary care within 1-3 days of discharge
- Effective referral process to appropriate community supports for COVID patient management following discharge

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Primary Health Care Integration Network

Home to Hospital to Home Transitions: Supporting COVID Patient Management

**Purpose:**
- Ensure appropriate transition into the community, with risk-assessed follow-up and monitoring, as indicated by the patient’s status at discharge
- Ensure processes are in place to support ongoing management and monitoring of COVID-positive patients, as per the Primary Care Pathway

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Safe COVID Discharge Checklist

- A new Safe COVID Discharge Checklist is being implemented in acute care sites to support the discharge of COVID-19 patients back to their medical home
- Primary Care is mobilizing processes and teams to be ready to receive patients back to community for follow up care even if they currently do not have a family doctor.
- Patient self-management tools are also being created to support discharge readiness

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Peer-to-Peer Teleadvice

- Service available for Primary Care Physicians managing presumed / confirmed COVID-19 patients in the community
- Primary Care Physicians can phone for specialist advice to appropriately support their patients in the community
- The COVID tele-advice line is currently supported by specialists from respirology, general internal medicine and infectious disease

Central, Edmonton, & North Zones

Call or text: 1-844-633-2263
- Hours: Monday to Thursday, 9 a.m. to 6 p.m. and Fridays, 9 a.m. to 4 p.m. (except statutory holidays)
- Providers can expect to receive a call-back within two to three hours

South & Calgary Zones

Call: 1-844-962-5465
- Hours: 8 a.m. to 5 p.m. from Monday to Friday (except statutory holidays)
- Providers can expect to receive a call-back within one hour
When to Use RAAPID during COVID-19:

**In Scope – Higher Level of Care Needs**

<table>
<thead>
<tr>
<th>Referral Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unstable/Emergent patient</td>
<td>Patient requires immediate transfer out of a rural or regional facility to a facility of a higher level of care.</td>
</tr>
<tr>
<td>Stable patient</td>
<td>Need for <strong>same day</strong> consultation that would allow the MRP to proceed with care and/or disposition of care (i.e. admit vs. discharge vs. transfer)</td>
</tr>
<tr>
<td>For Advice only</td>
<td>Phone your usual RAAPID department (North or South) to connect with an Emergency Physician or Specialist for urgent advice.</td>
</tr>
</tbody>
</table>

**In Scope – equal or lower level of care needs**

<table>
<thead>
<tr>
<th>Transfer Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Repatriation</td>
<td>Patients being repatriated to a facility closer to their home site</td>
</tr>
<tr>
<td>Transfer to Community Self-Isolation Sites</td>
<td>This is a new process and needs to be developed between RAAPID and individual Zones.</td>
</tr>
<tr>
<td>Capacity Management</td>
<td>For transfers between equal level of care sites related to full capacity (i.e. rural to rural).</td>
</tr>
</tbody>
</table>

**Out of Scope for RAAPID during COVID-19**

<table>
<thead>
<tr>
<th>Out of Scope</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital to Alternate Care Living</td>
<td>These transfers continue to be facilitated by hospital transition services as they do not involve a MD to MD handover.</td>
</tr>
<tr>
<td>NICU Level 3 to Level 2</td>
<td>Lower level of care transfers between nurseries.</td>
</tr>
<tr>
<td>Equal level of care MH</td>
<td>Movement of a mental health patient between facilities that provide an equal level of care.</td>
</tr>
<tr>
<td>Appointments/DI</td>
<td>Any patient movement related to an appointment or scheduled process via a department.</td>
</tr>
<tr>
<td>Non-Urgent COVID-19 Advice for Community Providers</td>
<td>Calls regarding COVID-19 can be directed to ConnectMD (North, Edmonton and Central Zone) or Specialist Link (Calgary and South Zone).</td>
</tr>
</tbody>
</table>
Discharge Planning and Process – Emergency Room

April 29, 2020
Shawn Dowling, MD FRCPC
Emergency Physician, Foothills Medical Center and Alberta Children’s Hospital
Quality Improvement Scientist, Department of Emergency Medicine
Assistant Dean, Physician Learning Program, Cumming School of Medicine

ED’s are OPEN and a safe space for patients

- Calgary ED’s
  - 32% volume at Calgary adult ED’s
  - Proportion admitted, but overall admitted numbers 35 admissions/day
  - 50% in pediatric ED’s volumes

- Perceptions from the public/providers of ED capacity or safety may be resulting in some patients not seeking care when they should have
ED Pre-triage process → yellow zone and red zone

Provincial Pre-Triage for COVID-19 for Adult and Pediatric Patients in Emergency Departments/Urgent Care Centres

Community to ED
- If you are sending a patient to the ED from the community – please use RAAPID
- If possible, establish Goals of Care and communicate them with ED
- Ensure to communicate COVID status/ILI status with ED even if reason for referring patient to ED is not COVID related

ED to Community
- Process being created to arrange timely follow up post ED discharge by medical home (PCN/family physician)
- ED discharge notifications available in Netcare
  - FMC discharge notifications are sent directly to family physicians offices
Homeless/No fixed address patient population

- **Suspected/COVID patients**
  - If the patient cannot be safely isolated in their current housing situation*. Contact RAAPID – to determine if ASIS has capacity
  - If no capacity at iso-hotel and no other isolation option – consider admission to hospitalist service (if no other medical/psychiatric needs) until patient can be safely discharged
  - **Unsure if the patient requires isolation** – can contact MOH for further guidance

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**Discharge Checklist**

April 29, 2020

Parabhdeep Lail MD, FRCPC, ISAM(C)
Learning Objectives

1. Provide information for the processes and considerations of discharging COVID positive patients

Discharge Checklist

- Isolation
- Home oxygen
- Transportation
- Medications
- Equipment
- Follow up
- Considerations for special populations
Isolation

• Discharge **home** before isolation complete
  • Remain on home isolation for **10 days from onset of symptoms** OR until **48h after symptoms have resolved**
  • **Whichever is longer**, after arrival at home

• Provide guidance on self isolation at home

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Isolation

• Discharge **long-term care facilities/continuing care/group homes/shelters** before isolation complete
  • Remain on home isolation for **14 days from onset of symptoms** OR until **48h after symptoms have resolved**
  • **Whichever is longer**, after arrival at facility
Oxygen

• If Arterial Blood Gases are unavailable, **oximetry showing hypoxemia will be accepted**.
• Pulmonary Function Tests, Spirometry, and PSG’s **will not be required** for funding, at this time.
• If a Respiratory Therapist is not available - then can still discharge with home O2 but will be assessed as outpatient.
• Need to write DATE of discharge and will be assessed as outpatient within 48h
  • [Alberta Aids to Daily Living Bulletin #80 - General Information on Coronavirus and Alberta Aids to Daily Living (AADL)](https://www.alberta.ca/)

Transportation

• Non-exposed family member available can pick up patient at hospital entrance (preferred)
  • Non-exposed family member should wear a mask and gloves. Patient should wear a mask and gloves and sit in the back of the vehicle.
• If no non-exposed family member is available, then arrange for Intra-facility transport (IFT) by notifying the charge nurse
  • * Pending ability to specify a taxi group able to manage the cleaning and isolation requirements to transport COVID patients from hospital.
• If returning to LTC use IFT as per usual and LTC isolation process.
  • Need 24h notice
  • Confirm that LTC not on outbreak measures
Medications

- Prescriptions faxed to usual pharmacies if they can provide pick up or delivery.
  - Provide 72-hour medication supply for patients unable to get pharmacy pick up or delivery over weekend or limited pharmacy hours in general.
- Prescriptions to REXALL on site (PLC, FMC, RGH, SHC) for supply prior to discharge if during REXALL hours (0800-1700 M-F)
- Prescriptions to quadrant-based pharmacy that provides delivery for patients without support for medication pick up (call ahead to pharmacy to see if delivery available)

Learning Objectives

- Prescriptions faxed to usual pharmacies if they can provide pick up or delivery.
  - MD or pharmacist to call to check timeline to fill prescription
  - Provide 72-hour medication supply for patients unable to get pharmacy pick up or delivery over weekend or limited pharmacy hours in general.
- Prescriptions to REXALL on site (PLC, FMC, RGH, SHC) for supply prior to discharge if during REXALL hours (0800-1700 M-F)
- Prescriptions to quadrant-based pharmacy that provides delivery for patients without support for medication pick up (call ahead to pharmacy to see if delivery available)
Equipment

- Refer to occupational therapy and physiotherapy per usual practice
- Contact OT/PT for guidance for patient/family who are not able to pick up equipment because of isolation requirements via site and home/care as this will vary across the sites.

Special Populations – Vulnerably Housed

**High-level criteria to be considered eligible for the assisted Self-isolation**

(see full client flow for more details)

Client is experiencing homelessness, has no fixed address

And meets one of the following health criteria:

- Have a confirmed diagnosis of COVID-19 and are actively ill with the virus; or
- Are experiencing symptoms of COVID-19 and are awaiting medical testing or the results of medical testing; or
- Have received a diagnosis of COVID-19 and are in a period of recovery, before transitioning to different accommodations; or
- Have been in close contact with confirmed positive cases, exclusion order mandates isolation from public for 14 days from date of exposure

*Admission to the site is entirely voluntary on the part of the patient. It is not a locked facility. Anyone unable to stay in this capacity may not be a good fit.*

*Referral to ASIS must be completed by a Physician/health care professional as described within next section*
Special Populations – Long Term Care

**Early in Admission**
- Early Consult to Transition Services Team
- Clarify baseline cognitive and functional status from the facility and level of function they can accept upon return to facility

**Prior to discharge:**
- Check with Transition Services re: Facility Outbreak Status
- Ensure current cognitive and functional status can be supported at facility

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Special Populations – Long Term Care

**If medically stable and functionally ready to return:**
- Check for new CMOH Orders and Updates re: LTC/AL
- **Must complete “Client Admission/Discharge/Transfer Screening Questionnaire”**
  - Found here: [Client Admission/Discharge/Transfer Screening Questionnaire](#)
- Complete Medication Reconciliation
- Update any changes to Goals of Care
- Complete Discharge Summary
  - Include a clear follow-up plan for staff at the facility, including any new orders for monitoring, testing and appointments.
  - If unclear re: what a facility can manage – ask Transition Services
Special Populations – Immigrants and Refugees

• Southern Alberta Crisis Response Protocol for Immigrants and Refugees.
• Areas of focus include Resettlement, Family Violence, Mental Wellness, Health, Housing, Finances and Food Security.
• Centralized referral form:
  • https://www.ccisab.ca/sa-response.html#referral-form

Thank you!

• All of this information is available on the Department of Medicine Website
  • https://www.departmentofmedicine.com/meoc/covid_discharge_plan.pdf
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- I have properly cited third party material in one of the ways outlined below.

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Panellist/Presenter Disclosure

**Faculty** Denise Campbell-Scherer

- Grants, clinical trials:
  - Obesity Canada via Novo Nordisk - unrestricted educational grant to support physicians and teams with training in obesity prevention and management.
  - NOVAD (University Hospitals Foundation, Novo Nordisk, Alberta Government) – grant awarded by private/public consortium in obesity prevention and management.

**Faculty** Mona Delisle

- None to Disclose

**Faculty** Jake Jennings

- None to Disclose

**Faculty** Paul MacMullan

- None to Disclose