COVID@Home Halton

Introduction for the Mississauga Halton Primary Care Network

Dr. Nadia Alam

May 18, 2021

Program Goals

COVID@Home is delivered through the Connected Care Halton OHT. Similar programs are running in jurisdictions within southern Ontario. The goal is to support family physicians with community-based and hospital-based resources so to offload the pressure on the acute care sector by monitoring and caring for patients in the community.

- Group 3 - COVIDCare@Home - early discharge COVID+ patients - already operational through HHS and community partners.
- Group 1 - **Mild to moderate COVID+ patients - expected start date ~2 weeks**
- Group 2 - **Palliative COVID+ patients - expected start date ~2 weeks**

Organizing Team Members

Operational Lead: Heather McAlpine

Primary Care Lead: Nadia Alam

Home & Community Care: Katarina Busija (Director, Professional Practice & Programming), Karin Swift (Patient Care Manager), Odelia Andrea (Director, Strategy Integration & Planning)

Halton Healthcare Services: Jody Strik

Primary Care Advisor: Michelle Gregory-Brooks

Patient Advisor: Dave Fasano

Larger Family Physician/ External Stakeholder Group

Greg Sage, Peter McMurrough - Halton EMS

Halton Hills: Kiran Cherla, Elliot Halparin, Judy Ming, Craig Carson, James Ying.

Milton: Jennifer Wong, Kin Chung, Carolyn Malec, Markus Schatzmann.

Oakville: Adam Chen, Kris Martiniuk, Adriana Dragan, Kristen Kannegiesser, Rosemary Van Straalen, Jane Charters, Corinne Breen, Alex ter Kuile, James Kovacs, Maya Barnouti.

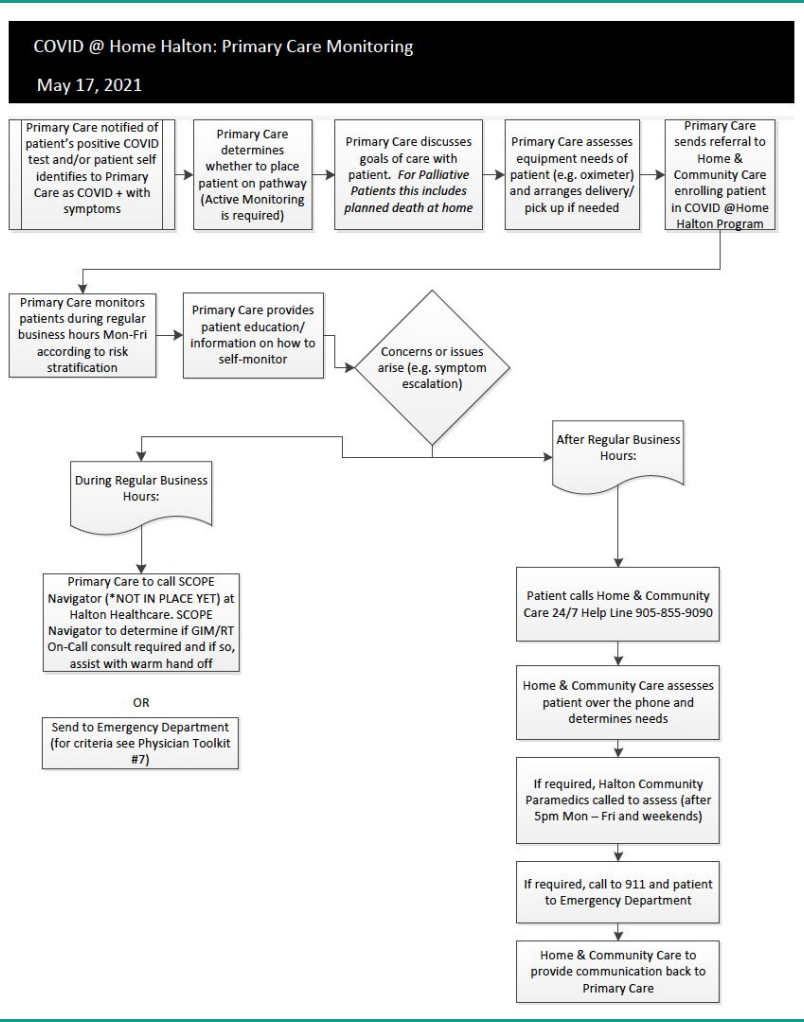
Challenges faced:

- Resources, especially nurses.
- Ability to contact patients securely.
  - Variable patient demographics and social supports, including access to reliable wifi.
  - Telemonitoring options: phone to start, and then?
- Patients who have no family physician.
- After-hours support including weekends.
- Family physicians with limited in-office resources.
- Socializing the program.
  - ~440 family docs across 3 municipalities, from a variety of payment models: FHGs, FHOs, FHTs
  - Goal is evolve C@H into SCOPE.

Toolkits for Physicians and Patients

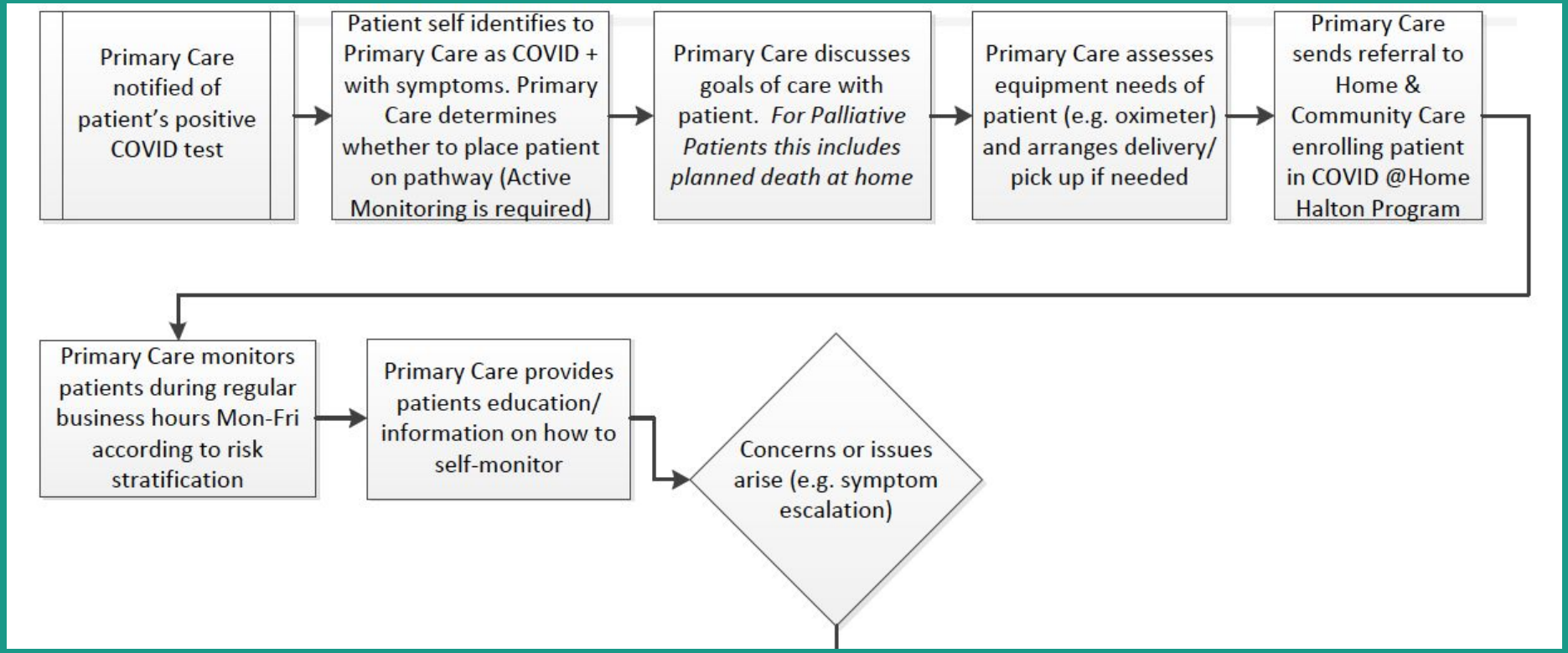
To be disseminated across multiple communication channels.

- Introduction to the program
- Clinical pathways, referral form, ordering supplies, risk stratification, monitoring guidelines, etc.
- Lots of good information out there -- no need to reinvent the wheel, but must create a standardized info package.
- Ease of use was a must.
- Low admin burden.
- In-kind support from community service organizations.



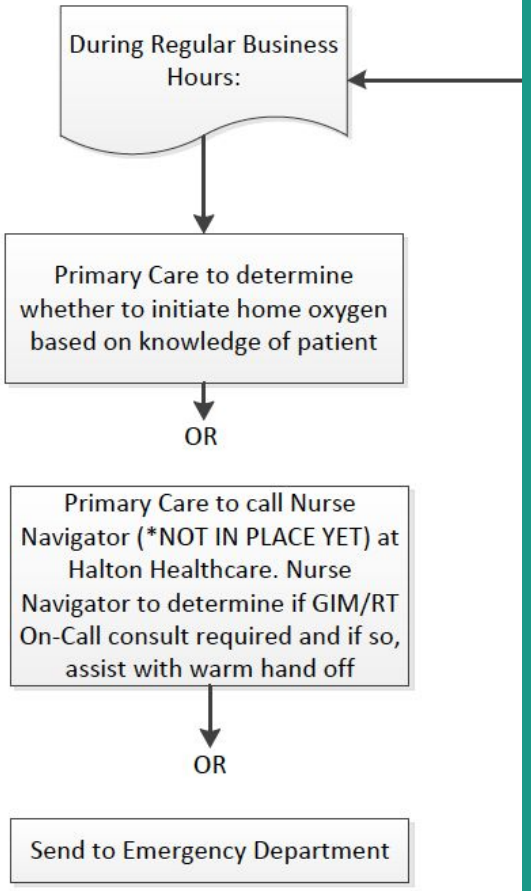
Clinical Pathway for Group 1 and 2 COVID+ Patients

- Similar pathway for family physicians who do not have the in-office resources to monitor patients -- they can apply for home care monitoring.
  - Family physician remains MRP
- Program is referral based. Not all patients will need to be monitored closely.
- Patient self-monitoring key component of the clinical pathway.
- Home Care, EMS and the hospital provide after-hours and weekend support including nurse navigators, specialist back up and a 24/7 line.



In more detail…

Common pathway for Group 1 and 2 patients.

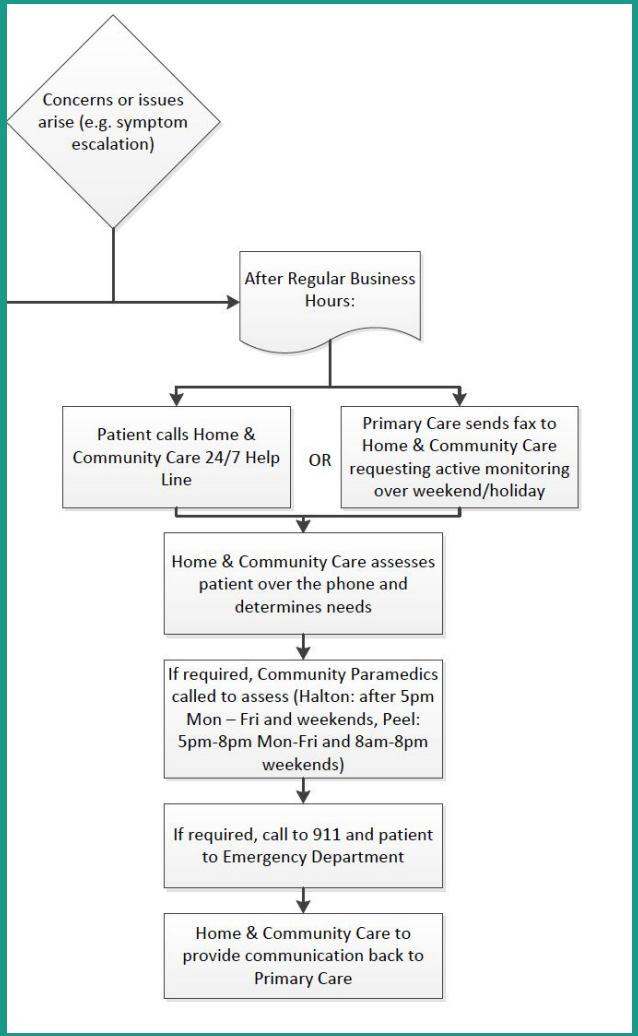


Escalation pathway in more detail…

- Regular business hours: Monday to Friday from 8am to 5pm.

Escalation pathway in more detail…

- After hours, including weekday evenings and weekends.



Monitoring according to risk stratification

- Once daily
- Twice daily
- PRN
- Patient self-monitoring protocol
- Family physician remains MRP

https://hfam.ca/clinical-pathways-and-evidence/covid/assessment-diagnosis-and-management-of-covid/

High Risk	Average Risk	Low Risk
Patients with any of the safety net flags		Otherwise healthy adults; asymptomatic adults
Patients with symptom deterioration	Pregnant women	No comorbidities
Any age with medical comorbidities		No safety net flags
Age > 60	40-60 years old with no medical comorbidities	Age 1-39 years old with no medical comorbidities
MONITOR Daily for 14 days	MONITOR Every 2 days x 7 days; then recommend self-monitor for additional 7 days depending on progress	MONITOR Consider self-monitoring only; check-ins determined by individual patient. (Consider at 7 days)

NOTE *patients in the low risk category with increasing symptoms move to the high risk/daily monitoring (including pulse oximeter) category. Asymptomatic patients should have their risk category reassessed if they develop symptoms.

NOTE in patients with significant fatigue in the low risk category, consider using pulse oximetry to determine this is not due to hypoxia.

*In patients who required hospitalization, the median time from symptom onset to dyspnea was 5 days.
In patient who developed ARDS the median time to onset was 3 days after development of dyspnea (around 8 days after symptom onset).

Sending patients to ER

Consider emergent transfer to ED (unless not congruent with goals of care*) if:

- HR >110, SPO2 consistently ≤ 92%, RR >24
- Severe shortness of breath at rest (e.g. Breathlessness RR >30 despite normal O2 sats)
- Difficulty in breathing (work of breathing)
- Reducing O2 saturation (see guidance under Examination/Assessing Vital Signs on this page)
- Pain or pressure in chest
- Decreased oral intake or urine output (dehydrated, needing IV fluids)
- Cold, clammy or pale mottled skin
- New onset of confusion, becoming difficult to rouse, syncope
- Blue lips or face
- Coughing up blood

Other symptoms indicating severe illness, or significant or rapid deterioration including markedly increased fatigue if O2 Sats are not available.

The patients risk factors for more severe illness should be considered in making the decision to refer to ED: age (>65), comorbidities as above, immunocompromised, higher frailty score. In addition inability to self-isolate or lack of support at home may be other reasons to consider ED referral.

Oximeters

- Physician offices can order funded supplies from Ontario Health:
  - https://survey.alchemer.com/s3/6240240/O2-Saturation-Monitor-Survey
- What about patients who can't get to the office to pick up the oximeter?
  - Links2Care is providing assistance delivering oximeters to house-bound patients.

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Patient self-monitoring

- Limited clinical resources in the community to call every patient who is COVID+ according to risk stratification.
- So we are asking patients to self-monitor and check in if they have symptom deterioration.

What to expect

Your Primary Care physician will meet with you to review your care plan and set up monitoring for you at home.

You will be given a fingertip pulse oximeter and will need to monitor your oxygen levels, up to six (6) times a day, especially after any physical activity, and record this into your exercise/activity log.

You will be monitored daily (Mon-Fri) to check how you are feeling. You will also have access to the 24/7 Home & Community Care Line.

If your condition worsens

If your symptoms get worse and if you are not feeling well, review your symptoms by using the scale below:

I feel ok...
My oxygen level is **consistently greater than 92%** (Continue with exercise/activity log)

I feel worse...
Worsening cough, fever returns and/or more short of breath than usual **for 24 Hours**
OR
My oxygen level is **consistently less than 92%**
(Contact the Home & Community Care 24/7 Line at: 905.855.9090)

I feel much worse...
My oxygen level is **consistently less than 88%** with severe shortness of breath, drowsiness or chest pain. (**Call 911**)

Contact Us:

Home and Community Care Support Services Mississauga Halton
24/7 Home & Community Care Line
T: 905.855.9090

Thank you for your attention. I am looking for feedback!

Please email me at **nalam@dal.ca**