COVID@Home for Primary Care

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What is COVID@Home for Primary care

- A community of practice supporting primary are providers with clinical pathways based on best evidence and matching EMR tools so they can use virtual care to monitor their COVID+ patients in their homes as necessary and provide greater equity of care across the province
- Includes centralized procurement and distribution of oxygen saturation monitors (by Ministry of Health) for practices to lend to patients
- Can work in coordination with and/or extend the reach of current remote monitoring (RCM) programs (19 currently serving patient with COVID) funded through OTN and/or serve areas that do not have these

Monitoring frequency, risk assessment and need for escalation pathways clearly identified in clinical pathways- PCP must be able to provide check-ins to patients who require this on weekends as well, oxygen saturation monitors provided by MOH, additional technology not required

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Objective of this initiative

- Reduce avoidable ED visits for those who don't need them; reduce mortality for patients cared for at home through monitoring, early detection and creation of appropriate escalation pathways for those who do require care
- Promote improved integration of care across several settings (hospital, primary care, home care, community paramedicine)
- Provide oxygen as part of care for patients who have goals of care congruent with being cared for at home only and who do not wish to be transferred to hospital (palliative approach to care)
- New: *Support earlier discharge of COVID+ patients from hospital who may be on short-term oxygen and required continued monitoring and oxygen weaning along with any continued medication management

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Phase 1:

- Community-dwelling patients who have tested positive for COVID-19 and the primary care practice has received a notification. They may have risk factors that make them more vulnerable to serious illness and require increased monitoring beyond the advice public health can provide.
- Community-dwelling patients who prefer to have their care needs met in the home setting, whose goals of care do not align with transfer to hospital, and where a palliative approach to care is being used. These patients require increased monitoring but also may require oxygen for management of symptoms and connection to additional supports to ensure they are able to remain at home.

Phase 2:

- Community-dwelling patients who have tested positive for COVID-19 and have been hospitalized but are now stable and can be discharged earlier from hospital or directly from the emergency department if monitoring by primary care is continued. This can include patients who required continued oxygen provision and is planning an eventual weaning in the home setting, continued oxygen saturation monitoring, medication management (e.g., steroids) and/or intravenous (IV) fluids.

Links to COP meeting recording to date:

- March 4th Recording HERE
- March 26th Recording HERE
- April 7th Recording HERE
- **Mainpro+ certified video on COVID@Home, moderated by Dominik Nowak with Dee Mangin and team**: https://www.ontariofamilyphysicians.ca/education/conferences

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Resources: Clinical Pathways

- Assessment Diagnosis and Management of COVID

- Resources for Managing Progressive Life-limiting Conditions (COVID and non-COVID), Palliative

Ordering: Link to O2 sat monitoring survey

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Resources : COVID@Home Resource Toolkit

- English:
- Resource toolkit HERE
- Working with oxygen provider document HERE
- French:
- Soins primaires de suivi COVID@Home
- QUESTIONS À POSER À VOTRE FOURNISSEUR DE SERVICES D'OXYGÉNOTHÉRAPIE

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Frequently Asked Questions

What data should I be tracking:

Overall number of COVID+ patients monitored over time. If possible, broken down as follows:

- # patients monitored (optional: stratified by risk category)
- # patients monitored for post-acute care
- Total number of virtual visits provided to each monitored patient over the duration of their monitoring

- **Total number of patients being monitored who required escalation to hospital and of those, # admitted, #deaths**
- **Various templates to download / modify available hfam.ca / Monitoring / Printable/Downloadable Summary Sheet and EMR Tools**

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Patient level data

- Track currently active patients with category
  - (risk category / hospital step down O_2) and next appt date.
  - Patient level data is in EMR templates.
- OR if No EMR access: Entire patient level data tracking record (google sheets) example on the hfam.ca website. Link HERE
- Information on patient experience: Would it be helpful if OH developed a survey which providers could send out to their patients so we can collect up stories and feedback on their experience. E.g. Did patients feel safer or less anxious because they were being monitored? Were they satisfied with their monitoring experience

Who do I need to involve in this work?

Example: integration and backup

For patients who are COVID+ that you may have questions about their acute care or potential need to transfer to ED. SJHH and HHS have offered the following specific support:

- At SJHH: an Emergency Physician at SJHH is available daily from 4-5 to provide any advice and support needed. To contact this physician, call the SJHH ED at 905-522-1155 x 32043 and a clerk will provide the contact number to connect directly with the ED physician covering that day
- At Hamilton Health Sciences: Family Physicians can reach out to the on-call physician for the Connected Health Hamilton program at HHS by calling the Virtual Command Centre 7 days a week at: 905 577 1409. The VCC nurse will then take the contact details of the Family Medicine doctor and will convey the message to the on-call doctor during their daily check-in (usually between 1pm-2pm unless they have a conflict). The on-call doctor will call the Family Physician directly to discuss any issues /provide support.

Other FAQ ‘s:

- Can I start with ‘phase 1’ monitoring – starting with monitoring for prevention and early detection before I move on to monitoring patients discharged from hospital?
- How do I distribute the O2 sat monitors?
- Who can do the home visits for the patient who is discharged home on continued oxygen?
- How do I develop an escalation pathway with my local hospital?

Renfrew County – VTAC

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Expected barriers or challenges?

Q and A/Roundtable Discussion

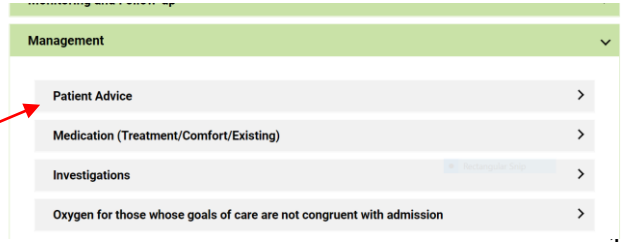
Patient Education Resources

[COVID-19 Symptom Timeline: Why Days 5 to 10 Are So Important When You Have Coronavirus]

[COVID-19 Guide for Patients (includes red flags)]

[COVID-19 Home Monitoring Program: Timed Position Changes Instructions]

*Looking into getting translation of one pager in various lanuages stay tuned!



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