CorHealth COVID-19 Stroke Stakeholder Forum #4

May 14, 2020 - 1:30-2:30 pm

Teleconference: (647)-951-8467 or Long Distance: 1 (844) 304-8099

Conference ID: 965969813

Agenda

Description	Presenter	Time

1. Welcome & Meeting Objectives
• Meeting Objectives
• COVID-19 System Planning Updates
  • OH Framework for Planning for Surgeries and Procedures during the COVID-19 Pandemic
  • Latest COVID-19 ON Epi Data
	Sheila Jarvis/ Graham Woodward	1:30 – 1:40 pm

2. Progress Updates:
• Trends in Presentation of Stroke To the ER
  • eCTAS presentation
  • IDS Hamilton
• Stroke Rehabilitation
• Caregiver Memo
	Joy McCarron, Tamer Ahmed
	Mirna Rahal
	Shelley Sharp
		1:40 -2:10 pm

3. Current and Future Planning • Ensuring continuity of TPA delivery • Virtual Care	Dr. Grant Stotts/ Dr. Leanne Casaubon	2:10 – 2:25 pm
4. Next Steps and Q&A	Dr. Leanne Casaubon	2:25 – 2:30 pm

Welcome & Meeting Objectives

SHEILA JARVIS

COVID-19 System Planning Updates

- Ontario Health released “A Measured Approach to Planning for Surgeries and Procedures During the COVID-19 Pandemic” on May 7, 2020
  - Memo and Framework sent to all hospital and regional leadership
  - Provides guidance for reintroducing scheduled surgical and procedural services including criteria and prioritization considerations
  - Hospitals will be expected to reserve 15% acute care capacity
  - Feasibility assessments and implementation considerations reviewed at the regional level
  - No confirmed indication for when the resumption of services will be triggered
  - Critical supplies, particularly PPE, required prior to resuming services

https://www.corhealthontario.ca/OH-Framework-A-Measured-Approach-to-Planning-for-Surgeries-and-Procedures-During-the-COVID-19-Pandemic-(May-7-2020).pdf

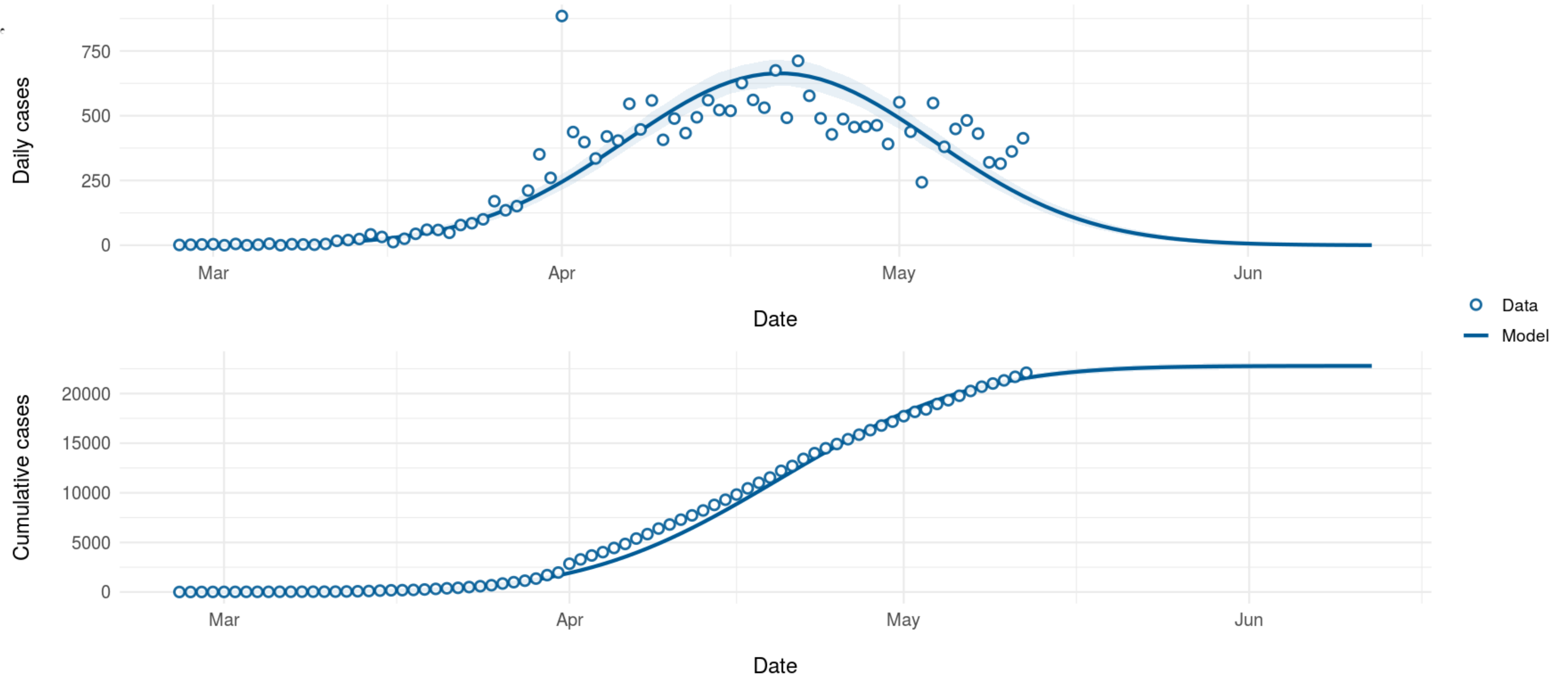
Meeting Objectives

- To provide information on key system planning updates
- To provide progress updates on areas identified at our last Forum meeting on April 23rd
- To continue discussions on planning for the delivery of stroke care across the continuum through the COVID-19 pandemic

COVID-19 EPI Data

Graham Woodward

COVID Cases – Actual and Modeled
Ontario, May 11, 2020



COVID Cases - Community at-large and Congregate Settings Ontario, May 11, 2020

[HowsMyFlattening: New COVID-19 Cases in Ontario]

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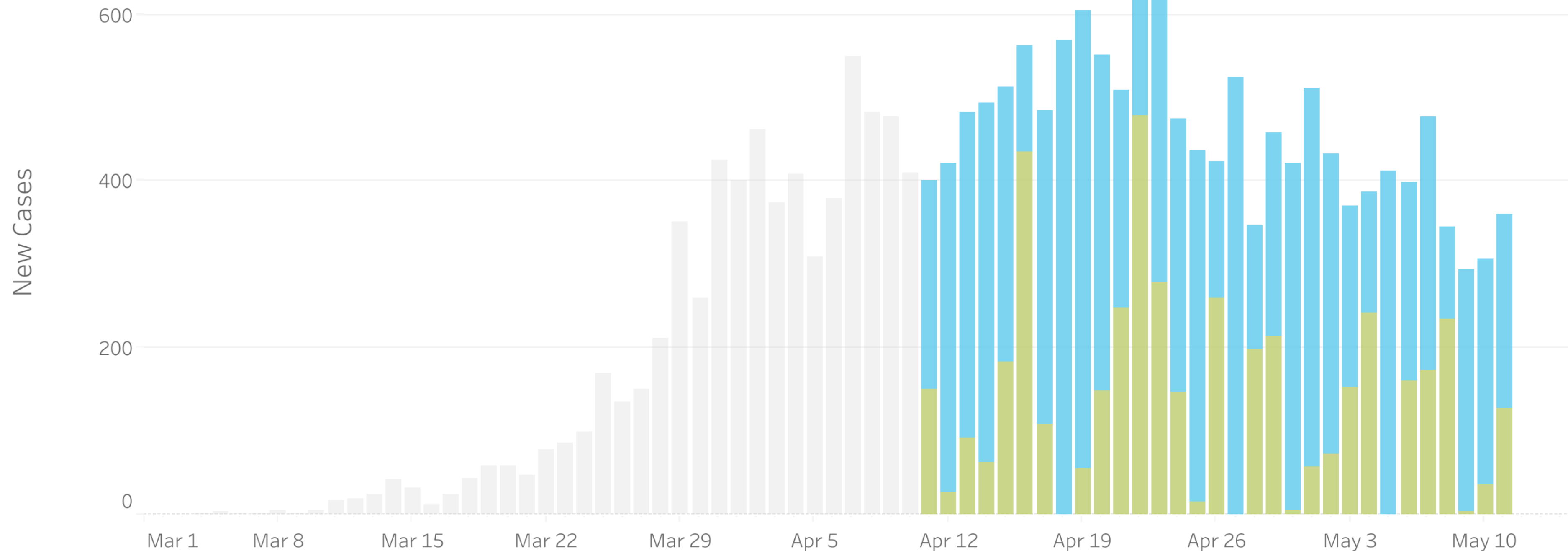
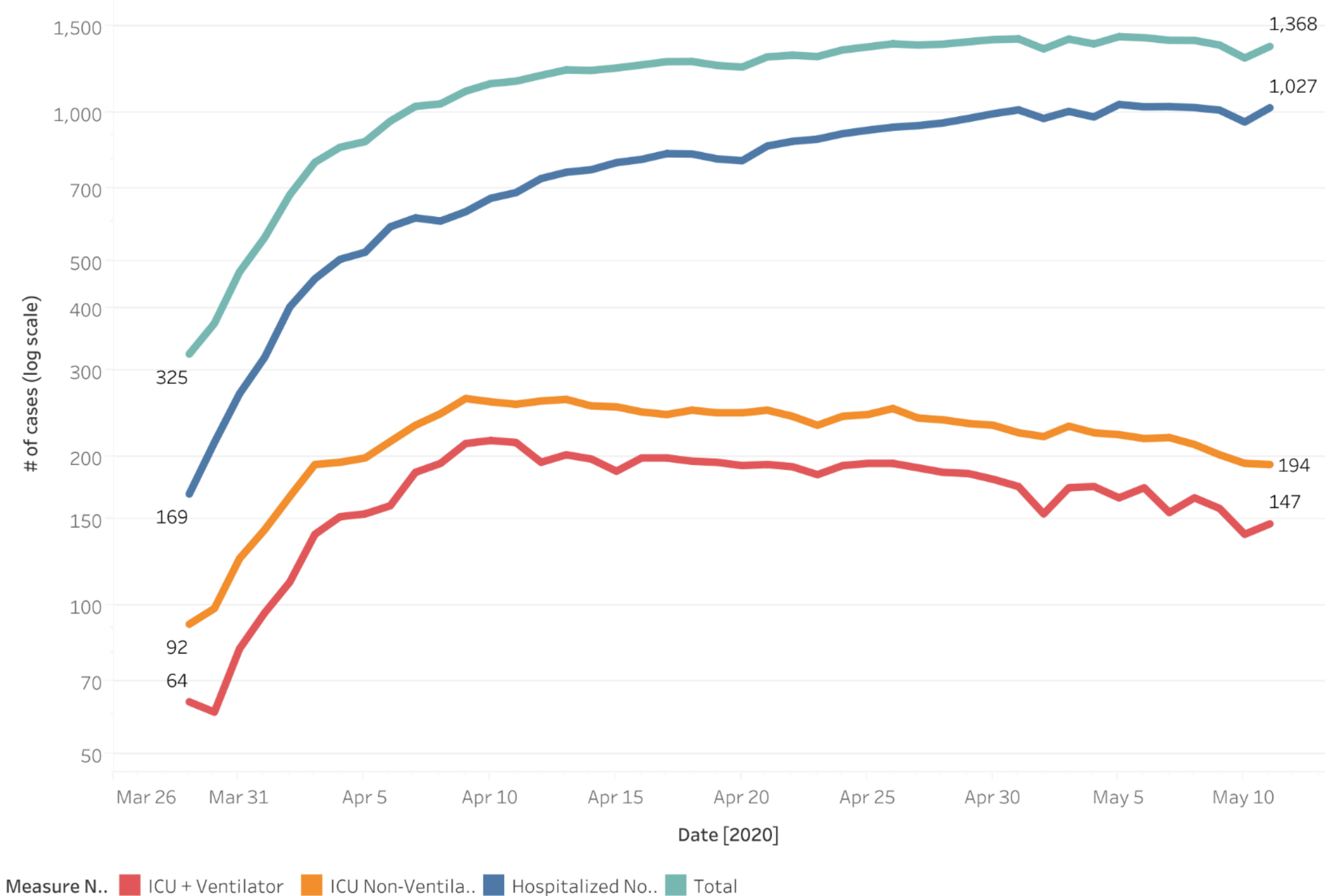


COVID Cases – Hospitalized Status Ontario, May 11, 2020



HowsMyFlattening: Hospital Staging in Ontario

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Progress Updates

JOY MCCARRON, TAMER AHMED, MIRNA RAHAL, SHELLEY SHARP

eCTAS

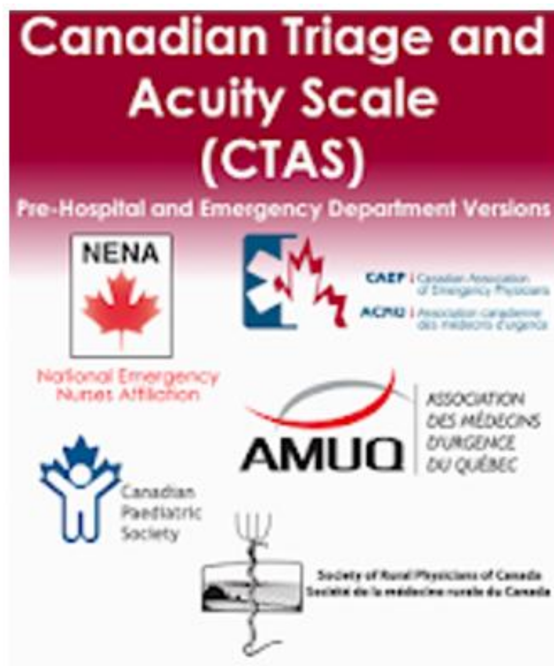
A GLIMPSE INTO THE EMERGENCY DEPARTMENTS

JOY MCCARRON, CLINICAL LEAD ECTAS

TAMER AHMED, MANAGER ECTAS

Ontario Health
Cancer Care Ontario

CTAS : Triage Standard in Canada



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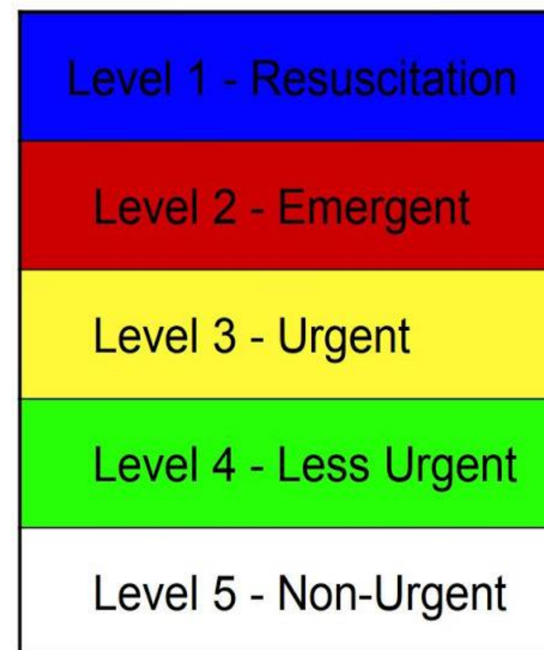
- Patient Stated Complaint
- CEDIS
- Vital Signs
- Subjective and Objective Assessments
- Medical History, Medication and Allergies
- Modifiers

=



eCTAS Highlights

8.5 Million patients triaged!

MEDITECH
Epic
wellsoft EDIS at its BEST
ANZER IT SOLUTIONS
picis
Cerner
MEDHOST
Allscripts

- 115 hospitals sites are live with eCTAS!
- 3 Integration Options in place
- Integrated with 9 different EDIS vendors
- 10 updates to Infection Control Alerts since Jan 1
- 1st Live Data Connection with KFL&A- Apr 20

eCTAS Application

eCTAS PRODUCTION

McCarron, Joy @ CCO Sign Out

1

New Patient | Pretriaged Patients 0 | Triaged Patients 1

Total Patients: 1

Triage Assessment

Test, Test
Adult | 43 yr | Routine Practices

2

Presenting complaint

Patient's Stated Complaint
headache, loss of vision Rt eye

Nurse Assessed Complaint

Chief CEDIS Complaint
Extremity Weakness / Symptoms of CVA

Notes
Indicate 'Suspected COVID' in Subjective Notes as appropriate.

EMS | Subj | Obj | Tmt/Int | Med Hist | Meds | Allergies

Patient woke up with a severe headache this morning. No history of frequent headaches. Pain worsened over 2 hours and now has loss of vision in Rt eye. Vision normal in left eye.

Vital Signs

Temp	37.4°C
Pulse	97 Reg
Resp	18
BP	187/78
Sp02	99
Pain	10/10

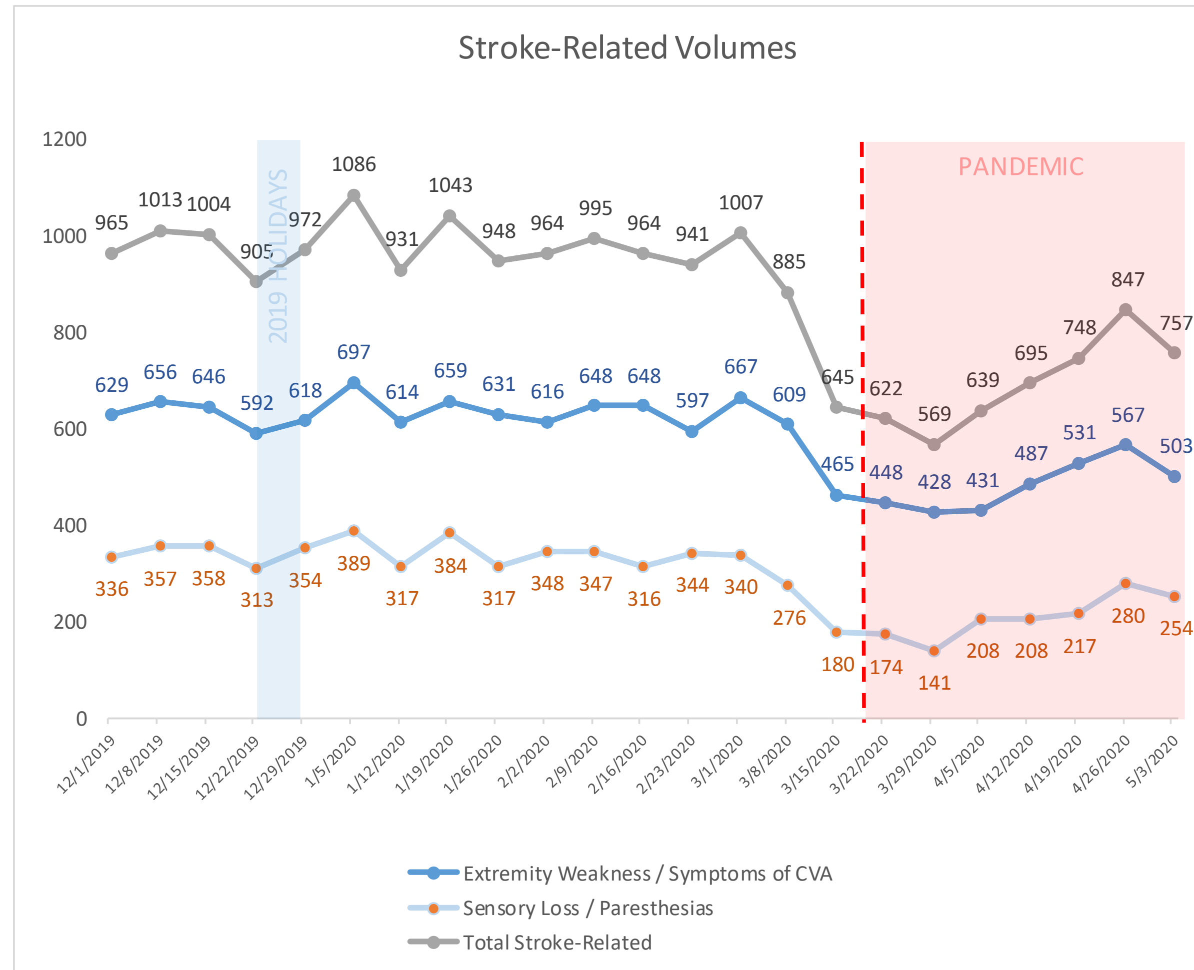
GCS
Capillary Refill
Blood Glucose
Weight
High MOI
Immunocompromised
Blood Disorder

Modifiers

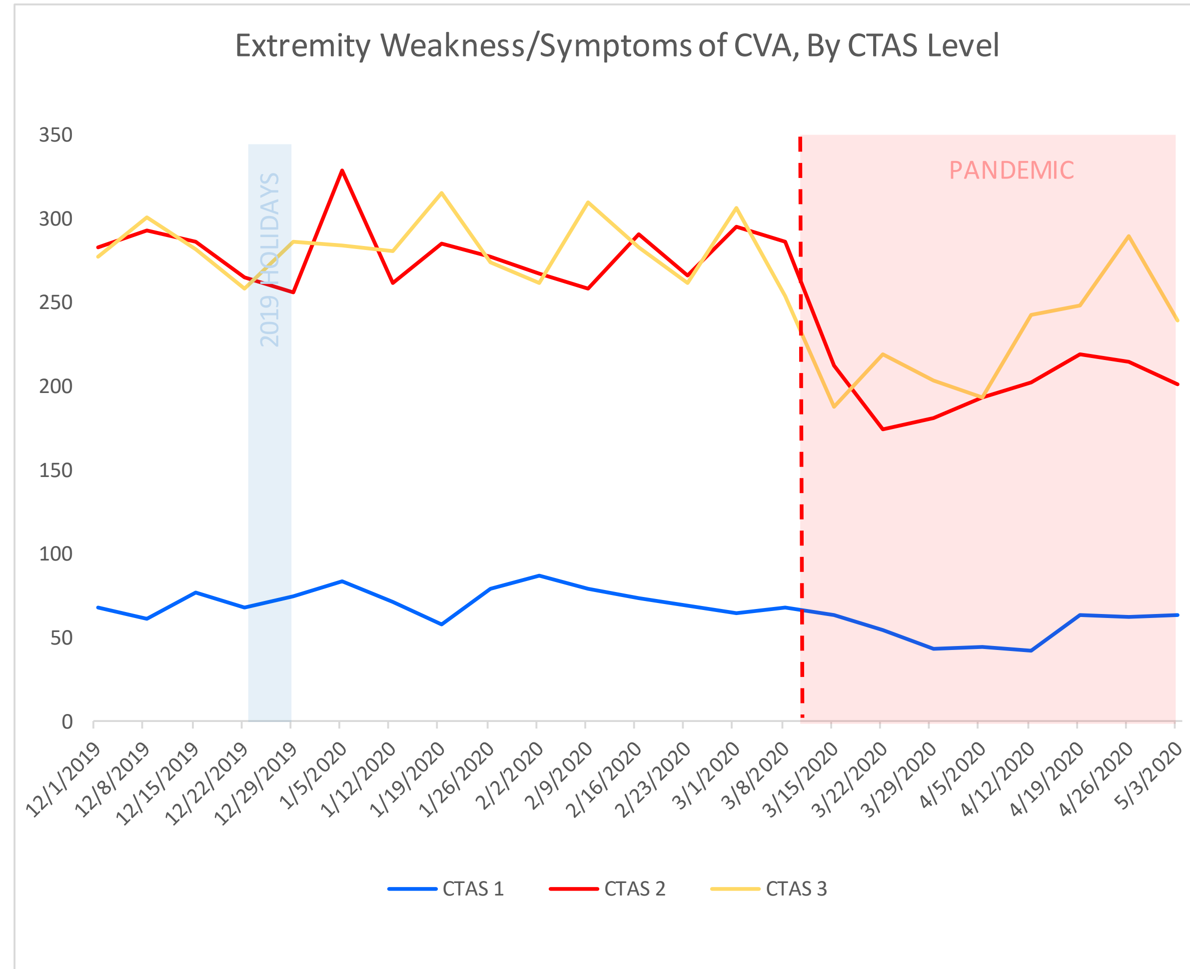
- [ ] Severe Respiratory Distress
- [ ] Shock
- [ ] Unconscious (GCS 3-9)
- [ ] Moderate Respiratory Distress
- [ ] Hemodynamic Compromise
- [ ] Altered Level of Consciousness (GCS 10-13)
- [ ] Fever, Immunocompromised
- [ ] Looks Septic (3 SIRS Criteria)
- [x] Acute Central Severe Pain (8-10)
- [ ] Bleeding Disorder (Life or Limb Threatening Bleed)
- [x] Wakeup Stroke or Within the Therapeutic Window
- [ ] Mild Respiratory Distress
- [x] Pulse Rate / Pressure Abnormal (Hemodynamically Stable)

Discard Draft | Update Pretriage | I'm Done Triage

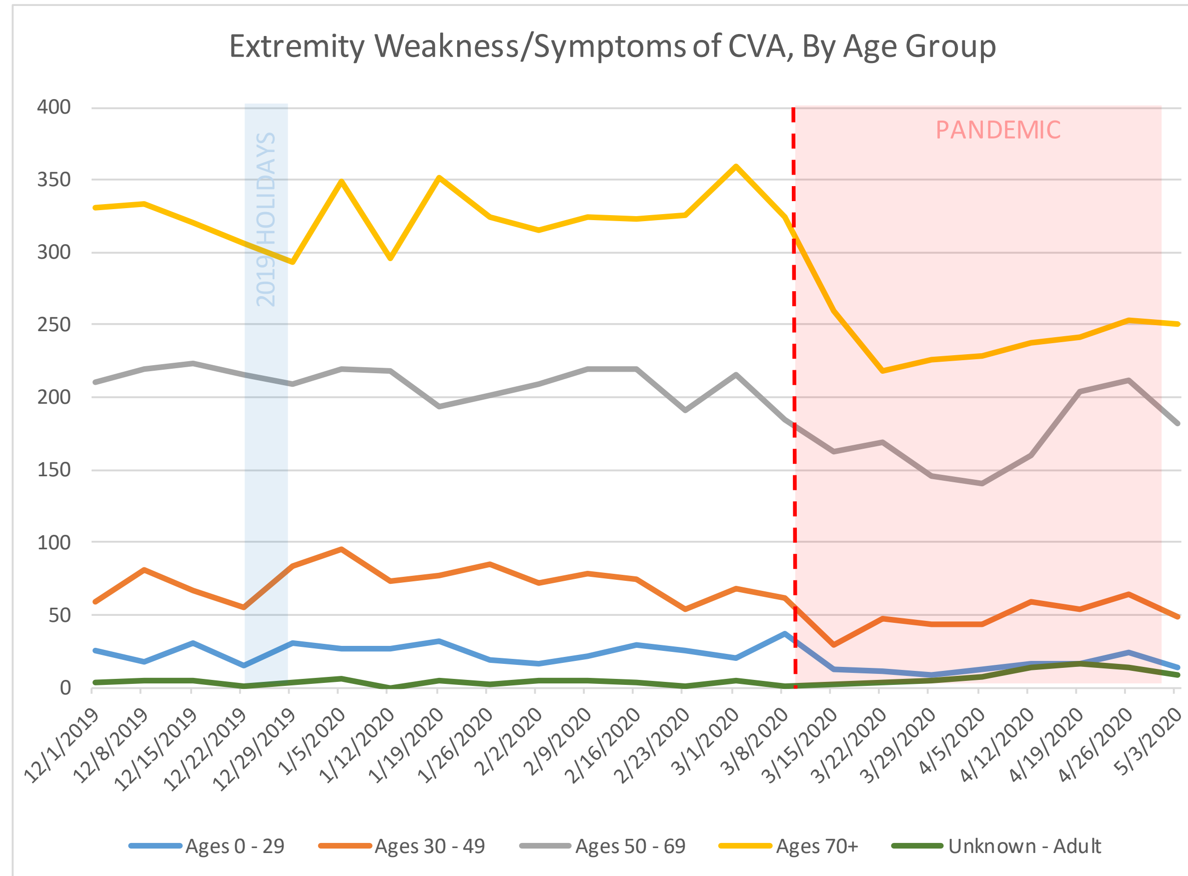
Stroke-Related Presentations



Stroke-Related Presentations



Stroke-Related Presentations



Stroke Data: IDS Hamilton

Mirna Rahal

Stroke Data IDS Hamilton

- Integrated Decision Support Business Intelligence Solution, Hamilton Health Sciences supports planning, system improvement & performance monitoring, outcome measurement, and population health equity across the continuum of care
- Hospital ED visits and resulting admissions based on NACRS and DAD data from a subset of Ontario Hospitals across 4 LHINs : Erie St Clair, HNHB, South West and Waterloo Wellington LHIN
  - by end of May, March 2020 IDS Hamilton data should include the remaining hospitals in these four LHINs as well as all hospitals in the TC & MH LHINs, covering up to ~50% of provincial volumes
  - By end of June, April 2020 data should be available for all IDS Hamilton hospitals, representing ~50% of provincial volumes

19

Summary: March 2020 compared to March 2019

- 27% decline in Stroke related ED visits in March 2020 compared to March 2019, consistent with reductions in total ED visits (25%)
  - Reduction is greater among patients aged 60 years or less (34%) compared to patients older than 60 years (26%)

- 22% decline in stroke related hospital admissions in March 2020 compared to March 2019
  - Reduction is greater among patients aged 60 years or less (38%) compared to patients older than 60 years (18%)

Data source: IDS, National Ambulatory Care Reporting System (NACRS) & Discharge Abstract Database (DAD), March FY 2019/20 vs March FY 2018/19
Limited to facilities with complete NACRS & DAD data submitted for March FY 2019/20.
Accessed May 7, 2020
Data represents 21 Facilities

20

Activities Related to Public Awareness

- Heart and Stroke Public Service Announcement (coming soon!)
- CorHealth & Heart and Stroke collaborated to create a poster for hospitals
  - On CorHealth COVID-19 Resource Centre & Heart and Stroke Website
  - The poster is being added to the HealthLine websites at the top of the stroke Resources page. https://www.thehealthline.ca/

Stroke Rehabilitation Memo: Implementation Update

Shelley Sharp

Stroke Rehabilitation Memo: Implementation Update

- Implementation strategies to support the recommendations in the Stroke Rehabilitation Memo released on April 20 have been developed by the Stroke Rehabilitation Coordinators and shared with RDAC.
- A summary document has been attached to the meeting invitation and will be posted shortly to the CorHealth COVID-19 Resource Centre.
- Ongoing challenges
  - Integrated/ system approach required for bringing rehabilitation staff who have been redeployed back into their roles
  - Sustaining new processes (e.g. physical distancing, virtual care) and aligning with best practice (e.g. rehab intensity)
  - Maintaining key activities (e.g. enhanced communication efforts) that support more integrated care and have demonstrated direct benefit on supporting patients and families
  - Planning to ensure stroke expertise is maintained throughout the continuum of care and that access to in-person rehab remains an option for patients.

Stroke Caregiver Memo

Shelley Sharp

Stroke Caregiver Memo

- The opportunity to develop guidance to support caregivers of persons with stroke was identified as a need at our last meeting.
- The stroke network regional community and long-term care coordinators, led by Margo Collver and Gwen Brown have drafted a guidance, with the support of CorHealth to address this need.
- The memo has been reviewed externally by Dr. Jill Cameron and the Change Foundation.
- CorHealth is finalizing the draft memo and will post shortly to the CorHealth COVID-19 Resource Centre.

Does anyone have questions or comments about this memo?

Contingency and Future Planning

DR. GRANT STOTTS/ DR. LEANNE CASAUBON

Ensuring Continuity of tPA Delivery – Dr. Grant Stotts

- Ontario Stroke Systems of Care Contingency Pandemic Planning For Hyperacute Stroke Care – May 2020

CorHealth Ontario

Virtual Care – Current & Future Planning

Dr. Leanne Casaubon

Virtual Care

- Virtual care has been leveraged for Stroke Secondary Prevention Services, Stroke Rehabilitation as well as other stroke care in response to the COVID-19 pandemic.
- A continued reliance on virtual care will likely remain as we move through the phases of reopening services across the continuum:

1. Is there an opportunity to provide provincial guidance as we think about virtual care and reopening of stroke services across the continuum?
2. What can we continue to do virtually? What is working well? What is not working?
3. What are some of the considerations that should be brought forward? (e.g. hybrid models)

Next Steps and Q & A

DR. LEANNE CASAUBON

Questions

- Are there other stroke system pressures that you are currently concerned with?

CorHealth Ontario

Next Steps & Wrap Up

- CorHealth to schedule next stroke forum

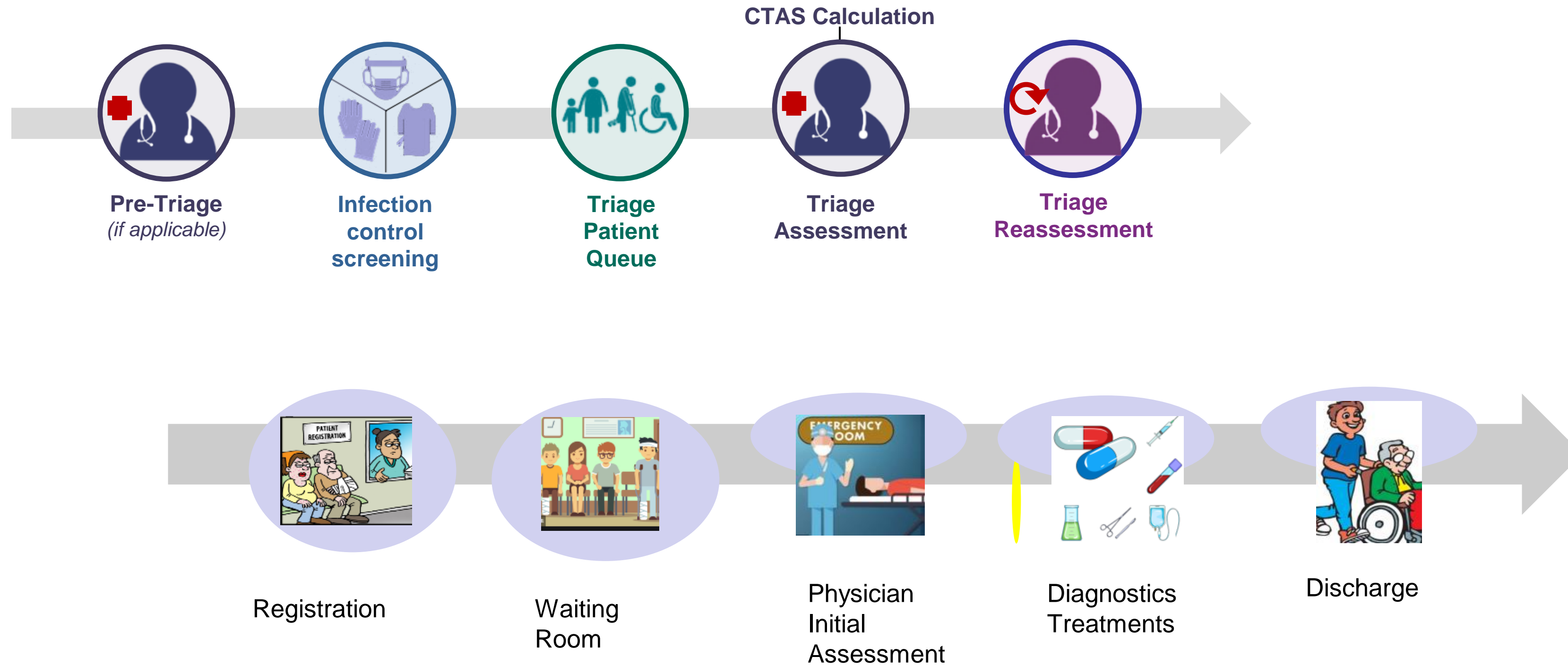
* Stay Tuned *

  - You will be receiving a short survey in the next week from CorHealth to get your feedback into the Stroke Forums for future planning

Appendices

Appendix 1 eCTAS

The ER Patient Journey



NACRS vs. eCTAS

	NACRS	eCTAS
Primary Purpose & Use of Data	• National data collection and reporting • Monthly Ontario ED data collection and performance reporting, including P4R funding program and public reporting	• Triage clinical decision support • Data used for diverse purposes (research, real-time and Covid-19 reporting, etc.) • Not used for ED performance reporting
Timeliness	• Monthly ED wait times data • Quarterly or longer for full clinical data	• Real-time data entered by triage nurse
Dataset & Submission	• Ambulatory care data across Canada • Established minimum dataset submitted monthly by 125 Ontario EDs • Minimum dataset does not include full clinical data (vitals, diagnosis, etc.)	• Real-time triage data only submitted by 115 Ontario EDs (triage time, CEDIS complaint, vitals, etc.) • Data beyond triage not included (disposition decision, diagnosis, etc.)
Data Quality & Compliance	• Ministry-established DQ standards • Data assessed twice monthly for completeness and fit-for-use • DQ issues addressed and corrected • Compliance escalations if issues persist	• No formal DQ standards or compliance processes • Retrospective data entry and corrections not required

Ontari
Cancer

Stroke ED Visits and Hospitalizations, IDS Hamilton Methods Summary

Report generation Date

- 5/7/2020 9:24:21 AM

Data Sources

- IDS, National Ambulatory Care Reporting System (NACRS) & Discharge Abstract Database (DAD), March FY 2019/20 vs March FY 2018/19
- Limited to facilities with complete NACRS & DAD data submitted for March FY 2019/20.

Methodology Notes

- Stroke ED visits are defined as those with a NACRS Main Diagnosis of stroke/TIA = I60 (excl. I608), I61, I63 (excl. I636), I64, H341, H340, G45 (excl. G454).
- ED visits and hospital admissions through ED are reported by the month and year of ED registration.
- ED visits resulting in admission are defined as ED visits with a discharge disposition of:

  06 - Admit to reporting facility as inpatient to special care unit or Operating Room from ambulatory care,

  07 - Admit to reporting facility as inpatient to another unit of reporting facility from ambulatory care, or

  08 - Transfer to another acute care facility directly from ambulatory care.

Appendix 3

A Measured Approach to Planning for Surgeries and Procedures During the COVID-19 Pandemic

MAY 13, 2020

Ontario Health

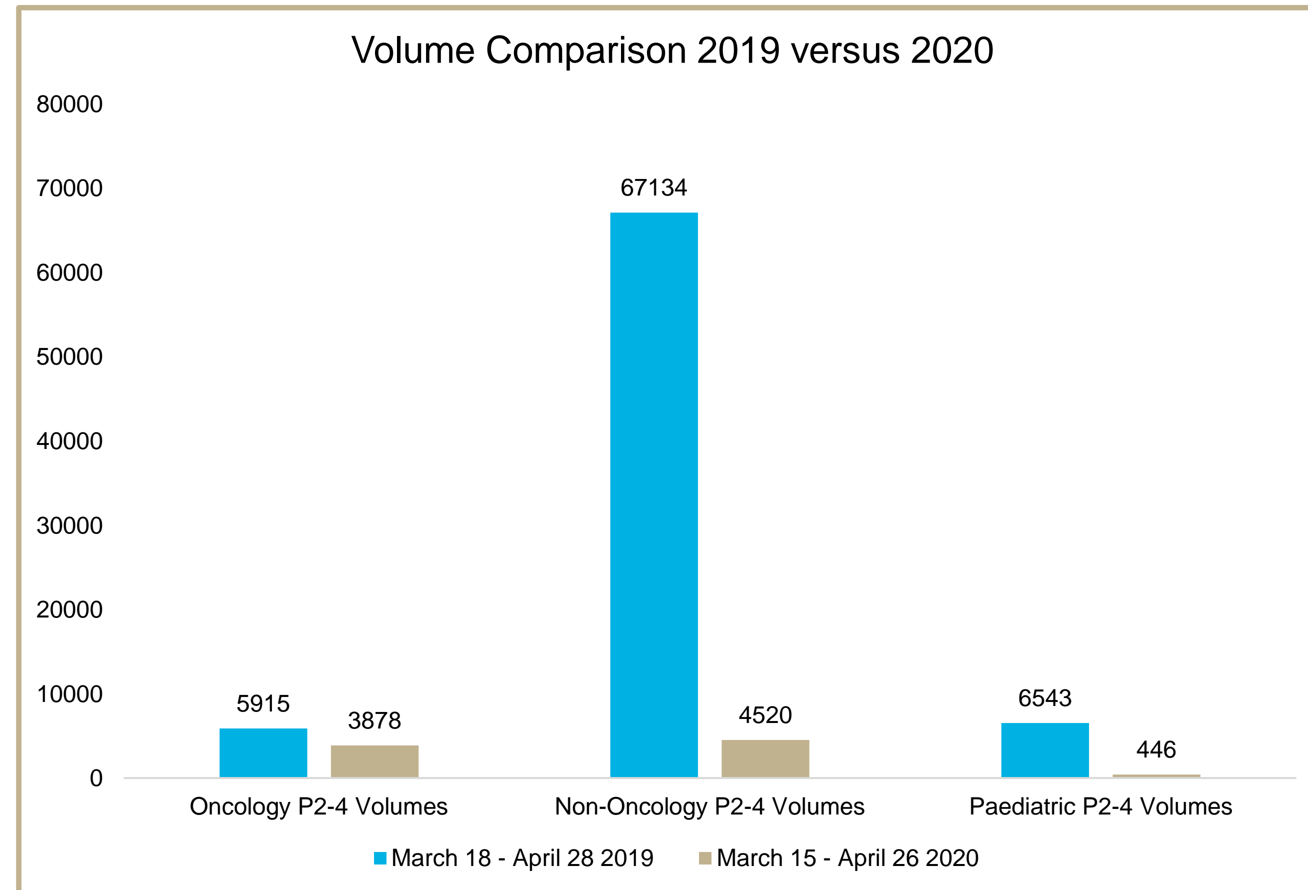
Background

- On March 15, 2020, following the release of a memorandum from the Ministry of Health and then Directive #2 by the Chief Medical Officer of Health, hospitals began to significantly decrease scheduled surgical and procedural work to create capacity to care for patients with COVID-19
- Not only are surgeries and procedures delayed, but also many other services such as diagnostic imaging, laboratory services, and anesthesia services
- As the COVID-19 pandemic evolves, it is important to consider the impact of deferred care and develop a plan to resume services while maintaining COVID-19 preparedness

Context: Surgeries Completed Since March 15, 2020

The cumulative impact to patients from delayed care is growing. Fewer surgeries were completed in this time period in 2020 compared to 2019. For example:

- 3,878 adult oncology surgeries (34% fewer)
- 4,520 adult non-oncology surgeries (e.g., hip and knee replacement, eye, and hernia surgeries) (93% fewer)
- 446 paediatric surgeries (93% fewer)



Source: Ontario Health – CCO Wait Time Information System (WTIS) for March 18 to April 28, 2019 (42 days) and March 15 to April 26, 2020 (43 days)

Ontario Health

A Measured Approach

- "**A Measured Approach to Planning for Surgeries and Procedures During the COVID-19 Pandemic**" identifies criteria for safely reintroducing scheduled surgical and procedural care
- While the spread of COVID-19 continues to be a challenge for residents in long-term care and other group living facilities, it may now be possible for hospitals to begin planning for the gradual resumption of surgeries and procedures that have been postponed, as long as plans are executed to assist with the situation in long-term care
- Although Ontario may be very slowly gaining the upper hand in this pandemic, there is an ongoing risk of local, rolling mini-surges in either community or congregate settings
- A pre-condition for increasing surgical and procedural activity is the requirement that *regional or sub-regional COVID-19 Steering Committees* and hospitals **jointly sign-off** on the hospital's plan to resume elective surgeries and procedures and this plan is reviewed and reconfirmed on a weekly basis by the hospital and region/sub-region
- In addition, this is about **planning for resumption**. While Directive #2 is still in effect, **no hospital should be resuming scheduled surgery and procedural care**

Ontario Health

Core Assumptions

- The pandemic and its impacts in Ontario may last many months to years
- Emergent surgical and procedural care has been continuing during the pandemic
- Urgent surgical and procedural care has been continuing at reduced volumes during the pandemic
- Capacity has been appropriately created in hospitals during the acceleration phase of the pandemic, and this capacity should be considered for use when planning to increase surgical and procedural activity if we ensure ongoing capacity to care for patients with COVID-19
- Changes to surgical and procedural activity (including increasing and decreasing activity) will be asymmetrical between organizations and regions based on their local context
- Hospitals may have staff redeployed to other settings and this may impact planning to increase surgical and procedural activity
- The need for emergent or urgent surgery or procedures for patients with COVID-19 is determined on a case-by-case basis, weighing the risk of further delay of treatment against the risk of proceeding and the risk of virus transmission
- Plans for increasing surgical and procedural care includes existing backlog and delays since March 15, 2020

Expectation of Hospitals

- Reserve 15% of acute care capacity (i.e., 85% occupancy or ability to immediately create an additional 15% capacity when needed), subject to any alternate agreement at the regional or sub-regional tables for securing sufficient regional capacity
- Attain sign off from the Regional COVID-19 Steering Committee on planned resumption
- Planning for the resumption of elective surgeries and procedures at any hospital must consider:
  - Conventional in-patient space is available for care, and this space is evaluated in the context of physical distancing for both patient flow and outpatient activity. This space cannot include care in hallways
  - Confirmed critical supplies, including PPE, swabs, reagents, and medications, exceed both current usage and projected requirements for elective surgical and procedural work. **There should be no dependence on emergency escalation to source any of the above while providing elective care**. Stock of critical supplies needs to be confirmed with your regional or sub-regional table weekly. The target for PPE is a rolling 30-day stock on-hand, that includes the current usage rate plus forecasted additional requirements
  - Health human resources that are available for urgent and emergent care are not unduly impacted. This includes consideration of overall workforce availability, as well as health human resources being directed to support long-term care

Expectation of Regions/Sub-Regions

- A regional or sub-regional approach is taken for managing surge capacity *and* the resumption of elective surgeries and procedures:
  - Maintain an aggregate 15% percent of acute care capacity
  - Take a regional or sub-regional approach for managing surge capacity **and** the resumption of elective surgeries and procedures
  - Collaborate across hospitals to arrive at coordinated and committed plans
  - Ensure the hospital remains committed in their plan to support long-term care
  - Monitor surgical and procedural activity across their territories, working to balance:
    - Wait lists
    - Equitable access to care
    - Regional resource availability in primary care, home and community care and rehabilitation with a view to virtual care options

Objectives of the Recommendations

- To ensure an equitable, measured, and responsive approach to planning decisions for expanding and contracting surgical and procedural care, while continuing to reserve capacity for any COVID-19 surge

The recommendations recognize:

- The priority of the health, well-being, and safety of both patients and health care workers
- The need to weigh the therapeutic benefit of treatment against the potential risk for COVID-19 transmission to both health care workers and patients
- The importance of following guiding ethical principles (i.e., proportionality, non-maleficence, equity, and reciprocity) when making decisions

Recommendations

1. Use the **existing regional or sub-regional COVID-19 steering committee** to provide oversight in partnership with an **organizational (hospital) surgical and procedural oversight committee**

2. Conduct a **feasibility assessment at the hospital level** and communicate results to regional leadership before increasing surgical or procedural activity

3. **Attain joint sign-off** from both the regional or sub-regional COVID-19 steering committee and hospital surgical and procedural oversight committee

4. **Review and re-conduct the feasibility assessment on a weekly basis** to identify changes in the assessment and recognize when a change in direction is required

5. Follow a **fair process for case prioritization** that is grounded by a set of ethical principles as a part of the implementation plan

6. Consider how to **leverage opportunities to redesign care**

Feasibility Assessment Decision Criteria

1. The community has a manageable level of disease burden or has exhibited a sustained decline in the rate of COVID-19 cases over the past 14 days
2. The organization has a stable rate of COVID-19 cases
3. The organization and region have a stable supply of PPE
4. The organization and region have a stable supply of medications
5. The organization and region have adequate capacity of inpatient and ICU beds
6. The organization and region have adequate capacity of health human resources
7. The organization has a plan for addressing pre-operative COVID-19 diagnostic testing (where appropriate, in consultation with local IPAC)
8. The organization has confirmed the availability of post-acute care outside the hospital that would be required to support patients after discharge (e.g., home care, primary care, rehabilitation)
9. The organization and region have a wait list management mechanism in place to support ethical prioritization

Process for Case Prioritization

- Follow ethical principles to guide a fair process
- Criteria for surgical and procedural case prioritization include:
  - Patient factors (e.g., condition, co-morbidities)
  - Disease factors (e.g., non-operative treatment options, risk of surgery delay)
  - Procedure factors (e.g., inpatient vs. outpatient or day procedures, operating room time, length of stay, anticipated blood loss, intubation probability)
  - Use of resources (e.g., PPE, medications, ICU and other postoperative care needs)
  - COVID-19 exposure/virus transmission risk
- In the context of resource constraints, consider a staged or stepwise approach to begin the resumption of services gradually
  - A hospital may choose to begin by offering services that require none, or a minimal amount, of a constrained resource e.g., a hospital may choose to begin with outpatient procedures, followed by day surgeries, followed by inpatient surgeries as resources become available

Implementation Considerations

- Consider the interdependence of our health care system and assess and monitor health care utilization impacts to ensure there are no unintended community-wide consequences
- Ensure continuous communication and follow-up with patients
- Leverage opportunities to improve care
  - What do we want to keep doing?
  - What do we want to stop doing?
  - What we are leaving behind?

Opportunities to Improve Care Delivery for Scheduled Surgical and Procedural Care

- Use services that reduce patient time spent in acute care settings
  - Virtual care, post-op remote monitoring programs, care in the community, outpatient care
- Ensure the appropriate use of tests, treatments, and procedures
  - Choosing Wisely Canada recommendations, e-consults services, virtual medical assessments and triaging
- Consider redesign of care
  - Designate hospitals/units for surgical and procedural care (COVID-protected sites)
  - Centralize waitlists for surgeries and procedures, if feasible
  - Extend operating room schedules
  - Organize the pre- and post-operative care pathway, leveraging virtual care solutions

Conclusion

- This is about a measured approach to planning for resumption of scheduled surgeries and procedures
- This planning must take place at a hospital level in collaboration with and sign off by the already established Regional COVID-19 Steering Committee
- Due to many of the pre-conditions required, resumption of services may be asymmetrical due to local context
- No actual activity should start until such time that Directive #2 is revoked or amended

Appendix

Surgical and Procedural Planning Committee

Name	Title(s) and Institution(s)
Chris Simpson (Chair), BSc, MD, FRCPC, FACC, FHRS, FCCS, FCAHS	Vice-Dean (Clinical), School of Medicine, Queen's University
Connie Clerici, RN, BScN	Executive Chair, Closing the Gap Healthcare
David Musyj	President & CEO, Windsor Regional Hospital
David Pichora, MD, FRCSC	President & CEO, Kingston Health Sciences Centre
Derek McNally, RN, MM	Executive VP Clinical Services and Chief Nursing Executive, Niagara Health
Garth Matheson, MBA	Interim President & CEO, Ontario Health (Cancer Care Ontario)
Howard Ovens, MD, FCFP(EM)	Chief Medical Strategy Officer, Sinai Health System Professor, Department of Family and Community Medicine, University of Toronto and Sr. Fellow, IHPME Ontario Provincial Lead for Emergency Medicine
Janet Van Vlymen, MD, FRCPC	Anesthesiologist, Program Medical Director, Perioperative Services, Kingston Health Sciences Centre Associate Professor, Department of Anesthesiology and Pain Medicine, Queen's University
Janice Skot, MHSc, CHE	President & CEO, Royal Victoria Regional Health Centre
Jennifer Everson, BScN, MD, CCFP, FCFP	Vice-President, Clinical, Ontario Health (West)
Jim Rutka, MD, PhD, FRCSC	R.S. McLaughlin Professor and Chair, Department of Surgery, University of Toronto Director, Arthur and Sonia Labatt Brain Tumour Research Centre, The Hospital for Sick Children

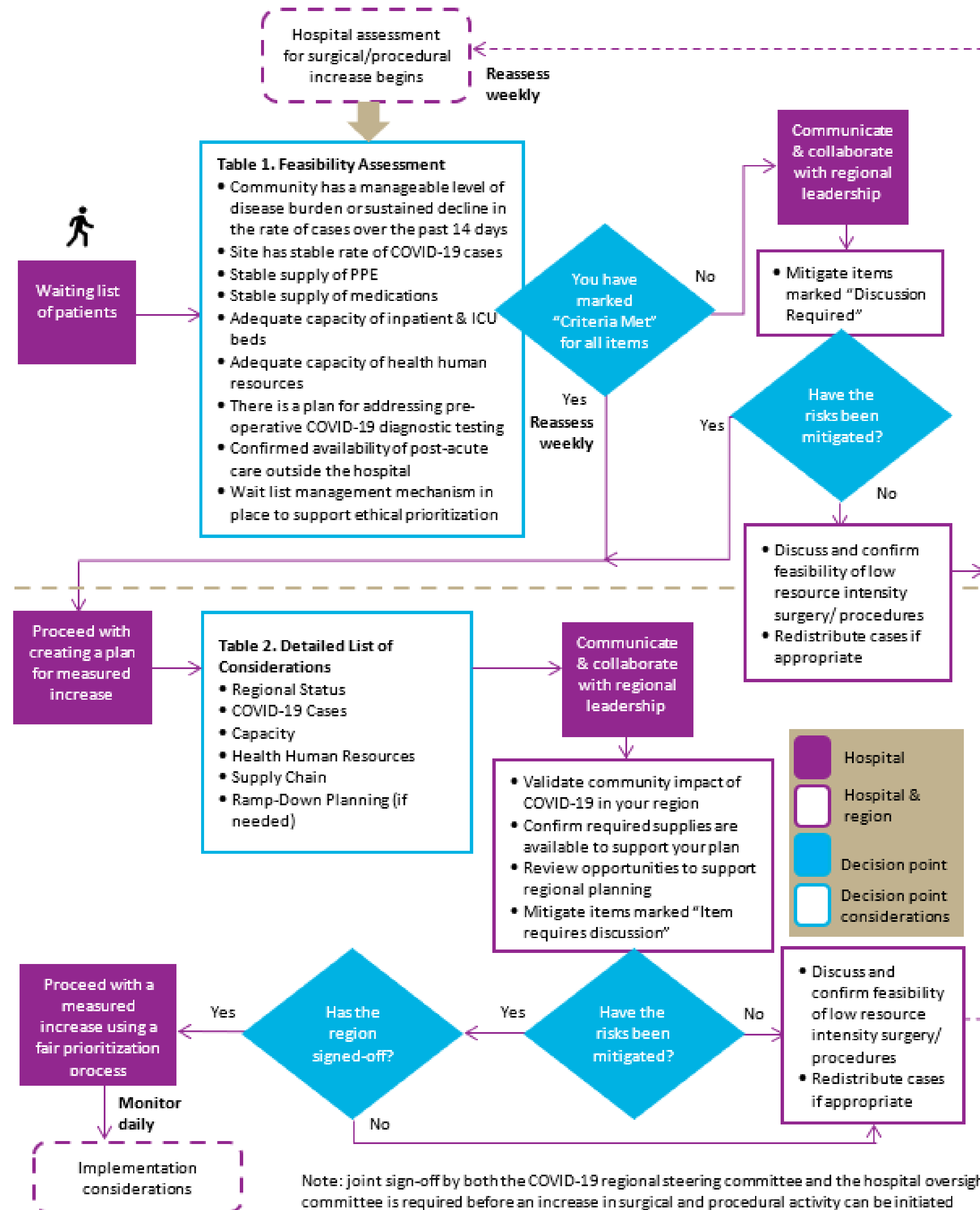
Ontario Health

Surgical and Procedural Planning Committee

Name	Title(s) and Institution(s)
Jonathan Irish, MD, MSc, FRCSC, FACS	Provincial Head, Surgical Oncology, Ontario Health (Cancer Care Ontario) Clinical Lead, Access to Care, Ontario Health (Cancer Care Ontario)
Julian Dobranowski, MD, FRCPC	Chief, Diagnostic Imaging, Provincial Lead, Niagara Health, Ontario Health (Cancer Care Ontario)
Karen Devon, MD, FRCSC	Assistant Professor, Department of Surgery and Joint Centre for Bioethics, University of Toronto Endocrine Surgeon, Women's College Hospital and University Health Network
Michael Gardam, MSc, MD, CM, MSc, FRCPC	Chief of Staff, Humber River Hospital
Mike Heenan	Assistant Deputy Minister (Hospitals and Capital), Ministry of Health
Neva Fantham-Tremblay, MD, FRCSC	Medical Director of Surgery and Head of Obstetrics and Gynecology, North Bay Regional Health Centre
R. Sacha Bhatia, MD, MBA, FRCPC	Chief Medical Innovation Officer, Women’s College Hospital
Sarah Downey	President & CEO, Michael Garron Hospital
Shaf Keshavjee, MD, MSc, FRCSC, FACS	Surgeon-in-Chief, Program Medical Director, Surgery, Anaesthesia, and Critical Care, University Health Network Director, Toronto Lung Transplant Program
Tim Jackson, BSc, MD, MPH, FRCSC, FACS	General Surgeon, University Health Network Provincial Surgical Lead, Ontario Health (Quality) President, Ontario Association of General Surgeons
Wendy Hansson, BSc, MHA, CHE	President & CEO, Sault Area Hospital

Ontario Health

A Measured Approach to Planning for Surgeries and Procedures during the COVID-19 Pandemic Flow Chart



Ontario Health