CorHealth COVID-19 Cardiac Stakeholder Forum Meeting #13

June 18, 2020 | 8:00-9:00 am

Teleconference: (647) 951-8467 or Long Distance: 1 (844) 304 -7743

Conference ID: 986393473

Agenda

Time	Description	Presenter / Facilitator
08:00	1. **Welcome** • Meeting Objectives	**Sheila Jarvis**
8:05	2. **Ontario Health Memo: Recommendations for Regional Health Care Delivery During the COVID-19 Pandemic: Outpatient Care, Primary Care, and Home and Community Care** • Information Sharing and Q & A	**Dr. Chris Simpson** *Vice-Dean (Clinical) in the Faculty of Health Sciences at Queens University and Chair, Ontario Health COVID-19 Health System Response Oversight Table*
8:35	3. **Cardiac Memo #13: Recommendations for an Ontario Approach to Resuming Echocardiographic Services During COVID-19**	**Dr. Anthony Sanfilippo** *MD, FRCP(C), Clinical Cardiologist Kingston Health Sciences Centre), Professor of Dept. Medicine & Cardiology (Queen's University), Clinician-Scientist (KGHRI)*
8:45	4. **Cardiac Memo #14: Recommendations for an Approach to Resuming In-Person Outpatient Cardiovascular Rehabilitation Services in Ontario**	**Dr. Paul Oh** *MD, FRCPC, Medical Director of the Cardiovascular Prevention and Rehabilitation Program and Senior Scientist at the Toronto Rehabilitation Institute*
08:55	5. **Other Updates and Next Steps** • Updates to Weekly Cardiac Activity Report	**Garth Oakes / Jana Jeffrey**

Welcome

SHEILA JARVIS

Meeting Objectives

- Review and discuss the Ontario Health recommendations for regional health care delivery during COVID-19 for outpatient care, primary care, and home and community care
- Discuss the resumption of services planning with an example from echocardiography
- Provide an update on the cardiovascular rehabilitation guidance memo for the resumption of in-person outpatient cardiovascular rehabilitation services in Ontario

Recommendations for Regional Health Care Delivery During the COVID-19 Pandemic: Outpatient Care, Primary Care, and Home and Community Care

DR. CHRIS SIMPSON | JUNE 2020

Ontario Health

Context

- A follow up document to **'A Measured Approach to Planning for Surgeries and Procedures During the COVID-19 Pandemic**' (released May 7th)
- This document outlines high-level principles that should underpin decision-making, regardless of setting, during the COVID-19 pandemic (focus on outpatient care, primary care, and home and community care)
- Recognizes that these settings differ in their oversight and accountabilities, and in the ways in which they provide care to patients/clients
- Aimed to support resumption of services following the amendment of **Directive #2**
- Aligned with the guidance provided in the Ministry of Health
  - '*COVID-19 Operational Requirements: Health Sector Restart*'
  - '*COVID-19 Guidance: Primary Care Providers in a Community Setting*' and '*COVID-19 Guidance: Home and Community Care Providers*'

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Overview

- Developed by the *COVID-19 Response: Outpatient, Primary Care, and Home and Community Care Planning Committee*, chaired by Dr. Chris Simpson (see Appendix for committee membership)
- It includes:
  - High-level, principles-based recommendations to support the gradual increase, of services offered through outpatient clinics, primary care, and home and community care during the COVID-19 pandemic
  - Also applicable to independent health facilities, out of hospital premises, optometry, and rehabilitation services (this list is not exhaustive)
- Sector-specific plans to operationalize these recommendations should be developed by the regions or other groups (e.g, the Provincial Primary Care Advisory Table, the Mental Health and Addictions Centre of Excellence)

Planning Assumptions

- The pandemic and its impacts in Ontario may last many months to years
- Emergent care has been continuing during the pandemic; urgent care has been continuing at reduced volumes; in some settings, routine care has been continuing virtually
- The health care system is interdependent, and a change in one part of the care continuum may affect delivery of care in others
- Some regions will be better positioned to resume activity than others due to differences in capacity and/or rates of COVID-19 cases (e.g., outbreaks)
- Provision of services will follow an equitable and patient-centred approach, ensuring patients/clients and caregivers are supported across the full continuum of care
- Health care providers and organizations will consider evidence-based recommendations on which services to resume and when, as applicable
- A heightened level of oversight and flexibility will be needed in our system for some time as we move through the full course of COVID-19, as there is uncertainty about the duration and volume of the pandemic waves
- Health care organizations and providers will act as good stewards of available resources, including PPE

Recommendations

1. **Maximize virtual care** services that appropriately reduce in-person visits
2. Conduct an organizational risk assessment and take a **comprehensive approach to infection prevention and control** where care is provided in-person
3. Ensure appropriate **personal protective equipment is available** to all staff wherever there is risk of exposure to an infection
4. Assess the **health human resources** required to increase care activity
5. Work with organizations in the community to **ensure delivery of services that support patient/clients' full continuum of care**, and work to avoid unintended community-wide consequences of resuming care
6. **Communicate regularly** with patients/clients and caregivers
7. **Monitor the level of COVID-19** disease burden in your community
8. Apply an **ethical strategy to the prioritization** of patient/client care activities

A Long-Term Strategy for Virtual Care

- Whenever possible and appropriate, visits should be conducted virtually
- Advantages to using virtual care include:
  - Avoiding unnecessary in-person visits resulting in reduced risk of infection
  - Reduces challenges with travel
  - Expands patients' access to providers
- Services should be expanded beyond telephone and video consultations (e.g., pre- and post-operative surgical care, virtual emergency solutions, remote monitoring for patients with COVID-19)
- A long-term strategy should support high-value virtual care beyond the pandemic

Collaborative Relationships With Local Health Service Organizations, Providers, Other Community Supports, and Patients/Clients

- Ensure delivery of services that support patients' full continuum of care
- Aim to avoid unintended community-wide consequences of resuming care, and to improve the integration of care between sectors and across regions
- Identify partners upstream and downstream of you and the impact that increasing your services may have on their resources (if applicable work with your Ontario health team partners)
- Confirm that partners are available and, when required, care can be coordinated in a timely manner (e.g., assessment centers, community laboratory, pharmacy, home and community care, primary care, rehabilitation services, specialists)
- Consider working with patients/clients and caregivers to codesign any new processes
- Where barriers exist, work with your region to mitigate these

Infection Prevention and Control, Personal Protective Equipment, Heath Human Resources, and Ongoing Risk Assessment and Monitoring

- A comprehensive approach to IPAC should be taken where care is provided in-person
  - Application of the hierarchy of hazard controls
- Ensure appropriate PPE is available and properly used during each patient/client interaction
  - Health care workers should complete a point of care risk assessment before every patient/client interaction
- Confirm availability of health human resources required and make sure appropriate supports are in place to maintain their well-being
- Monitor the rate of COVID-19 cases in your community to determine if adjustments in your service delivery are necessary
  - Refer to data from the Ministry of Health, Public Health Ontario, or local data shared in by your region

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A Strategy For Ethical Prioritization of Patient/Client Care Activities

- Resumption of services should be guided by the following ethical principles: **proportionality, non-maleficence, equity and reciprocity**
- To determine which services should be prioritized, these ethical principles need to be applied using a fair process to ensure legitimacy and accountability in their application
- Conditions to guide a fair process include **relevance, transparency, revision, engagement and enforcement**
- Prompts to support the application of these principles are included in the document

Summary

- These recommendations support key planning criteria for increasing care delivery during the pandemic
- They are guided by ethical principles and planning assumptions that should be considered when using these recommendations to direct planning and decision-making
- As regions actively plan for the resumptions of health care services, organizations and providers are encouraged to collaborate with them and participate in this planning
- Ensure patients/clients and caregivers are actively engaged and aware of new processes
- Where care is delivered in-person ensure the appropriate precautions are being taken to keep everyone safe
- Optimize opportunities to transform care delivery

Thank You

Appendix: Committee

Member	Role/Organization
Chris Simpson (Chair)	Vice-Dean (Clinical), School of Medicine, Queen’s University
Aaron Pollett	Provincial Head, Pathology and Laboratory Medicine Program, Ontario Health (Cancer Care Ontario)
Anthony Stone	Chief of Staff, Lakeridge Health; Lead Physician, Clarington Family Health Organization
Carrie Bernard	Assistant Professor, Department of Family and Community Medicine, University of Toronto; Assistant Clinical Professor, Department of Family Medicine, McMaster University
David Pichora	President and CEO, Kingston Health Sciences Centre
Danielle Martin	Executive Vice President and Chief Medical Executive, Women’s College Hospital
Derek McNally	Executive Vice President Clinical Services and Chief Nursing Executive, Niagara Health
Edward Brown	Chief Executive Officer, Ontario Health (Ontario Telemedicine Network)
Garth Matheson	Interim President and CEO, Ontario Health (Cancer Care Ontario)
Howard Ovens	Chief Medical Strategy Officer, Sinai Health System; Ontario Provincial Lead, Emergency Medicine
Jason Bartell	Interim Executive Director/Nurse Practitioner, Chatham-Kent Family Health Team
Jennifer Everson	Vice-President, Clinical, Ontario Health (West)
Julian Dobranowski	Chief of Diagnostic Imaging, Niagara Health; Provincial Lead, Cancer Imaging, Ontario Health (Cancer Care Ontario)
Kimberly Wintemute	Family Physician, Primary Care Lead, Choosing Wisely Canada; Assistant Professor, University of Toronto
Linda Rabeneck	Vice President of Prevention and Cancer Control, Ontario Health (Cancer Care Ontario)
Mary Burnett	CEO, Alzheimer Society Brant, Haldimand Norfolk, Hamilton Halton
Paul Preston	Vice-President, Clinical, Ontario Health (North)
Robert Sibbald	Director, Ethics, Patient Experience/Relations, and Indigenous Liaison, London Health Sciences Centre
Sue Tobin	Clinic Director and Nurse Practitioner, Ingersoll Nurse Practitioner-Led Clinic
Wendy Hansson	President and CEO, Sault Area Hospital

Cardiac Workstream Updates

DR. MADHU NATARAJAN

Guiding Principles

1. Keeping front line health care providers healthy and patients protected is vital.
2. Minimizing the impact of COVID-19 on the mortality and morbidity of patients with cardiac disease is a priority.
3. Aligning with province- and hospital-specific infection prevention and control policies and protocols exist is important.
4. Promoting clinical activities aimed at preserving hospital resources (i.e., health care human resources, personal protective equipment, procedure rooms, intensive care units, emergency departments) while also delivering high-quality care, is a priority.

Cardiac Memo #13:
Recommendations for an Ontario Approach to Resuming Echocardiographic Services During COVID-19

DR. ANTHONY SANFILIPPO

Background

- On May 26, 2020, Directive #2 was amended to “support the gradual restart of all non-essential and elective services provided by Health Care Providers,” thus giving clearance to resume full services within current public safety requirements, given the ongoing pandemic and continuing risk to patients and health care providers.
- Providers of echocardiographic services are now faced with the dual challenges of modifying service provision in a manner that ensures compliance with public health requirements, while engaging the accumulated backlog of deferred examinations.

Recommendations Guiding Resumption of Activity

1. **Hospital-based facilities**, in interpreting their response to the amendment of Directive #2, should be guided by their organizational governance, including compliance with infection control standards.

2. **Community-based facilities** are unconstrained by requirements to ensure surge capacity but must develop individual IPAC processes to ensure compliance with directives from the Medical Officer of Health.

3. **All echocardiographic service providers**, in ensuring compliance with best practices, should be guided by the requirements laid out by the directions in the **COVID-19 Operational Requirement: Health Sector Restart. Version 1 (May 26, 2020)** document provided by the Ministry of Health. For more specific direction, providers are also referred to the comprehensive document recently released by the American Society of Echocardiography and endorsed by the Canadian Society of Echocardiography (**ASE Statement on Protection of Patients and Echocardiography Service Providers During the 2019 Novel Coronavirus Outbreak**).

Recommendations Guiding Expansion of Activity to Complete Deferred Examinations

1. Triaging of deferred examinations is essential. In doing so, providers are directed to the principles outlined in Memo #11.

2. It is recommended that facilities designate an appropriately qualified member of medical staff to oversee triaging and scheduling of deferred examinations.

3. It is recommended that, wherever possible, referring physicians be consulted with respect to the current status of patients for whom examinations have been deferred to, and determine if clinical circumstances have changed in a manner that would alter their triaging categorization.

4. It is recommended that facilities schedule examinations with the goal of providing examinations within the following time frames:

   - For Category 1 patients (Critical indication with short term impact on patient prognosis) – within 2 weeks

   - For Category 2 patients (Urgent indication essential to establishing a management decision in a symptomatic patient which, if deferred, could affect patient prognosis, and no alternative imaging methodology is available) - within 1 month

   - For Category 3 patients (as per Category 2 but in asymptomatic patients, or alternative imaging modality readily available, or uncertain impact on patient prognosis) – within 4 months

   - For Category 4 patients (surveillance of known structural abnormality in asymptomatic patients) it is recommended that specific advice be sought from referring physicians as to whether the examination can be further delayed or deferred until next usual scheduling interval.

Recommendations Guiding Expansion of Activity to Complete Deferred Examinations

5. Facilities will need to develop methods to simultaneously process deferred examinations while they resume the processing of new referrals. This will require all facilities to consider methods to expand activity beyond pre-shut down levels, including expanded hours of operation.

6. Where equipment availability is a limiting factor, facilities are encouraged to work with their sonographers and facility staff to develop more efficient means to process and prepare patients for examinations, minimizing machine “down time”.

7. Community-based and hospital-based facilities are strongly encouraged to collaborate in order to manage their deferred examinations efficiently, which includes:

8. Sharing and comparing of deferral lists to minimize duplication and need for repeat examinations, including transfer of examination sites in order to maximize efficiency.

9. Developing technical interfaces to share examinations and reports

10. Providing opportunities for sonographers to work at multiple sites and, where appropriate, during expanded hours of operation

11. Expanding capacity of medical staff to support interpretations at multiple sites.

12. Reduction of service delivery through mechanisms such as shortened scanning times, truncated examinations or use of equipment incapable of providing complete examinations are not acceptable options as they are likely to miss key findings or lead to further need for repeat examinations to follow up on missing information.

Cardiac Memo #14:

Recommendations for an Approach to Resuming In-Person Outpatient Cardiovascular Rehabilitation Services in Ontario

DR. PAUL OH

Cardiac Memo #14
Background

- Participation in cardiovascular rehabilitation is associated with improved quality of life and a decrease in mortality, morbidity and health care utilization.
- Recognizing the importance of providing CR services during COVID wherever possible, CorHealth has released 2 memos:
    - May 12, 2020, a memo to support virtual CR delivery during the COVID-19 pandemic
    - June 17, 2020, a memo to support an approach to resuming in-person outpatient CR services

Recommendations for an Approach to Resuming In-Person Outpatient Cardiovascular Rehabilitation Services in Ontario

MAJOR SECTIONS

- Background and assumptions relevant to cardiovascular rehabilitation
- Patient considerations for in-person cardiovascular rehabilitation programming
- Patient Assessment
- Delivery of Core Components
- Other considerations (e.g., tips to consider when promoting distancing for in-person CR services)

Charts are used to demonstrate an example of a phased approach for resuming patient assessment and in-person activity

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Other Updates and Next Steps

JANA JEFFREY

Changes to Cardiac COVID Activity Report

GARTH OAKES

Proposed Changes to Cardiac COVID Activity Report

1. Weekly Activity Pages
   - Switch to a rolling 4-week activity graph to cut down on the number of bars on the graph
2. Provincial Graphs that Compare Last Year to this Year
   - Remove the urgency breakdown to easier see trends inactivity
3. Table that Compares Activity to Last Week and the Same Time Last Year
   - Introduce a 1 week delay on reporting this data to account for data entry lag

1. Weekly Activity Pages

- The graphs that show weekly activity are starting to get ‘busy’
  - There are approximately 10 lines on them and more will be added
- Proposed changes to have graphs with 6 bars:
  - Rolling 4 week graph (each week add the most recent week and drop the old one)
  - One week before MOH directive went out (for baseline comparison)
  - One week following memo 7 (peak of decreased activity)

Weekly Activity for PCI – New Rolling 4 Week Graph

Number of Procedures Performed

160
140
120
100
80
60
40
20
0

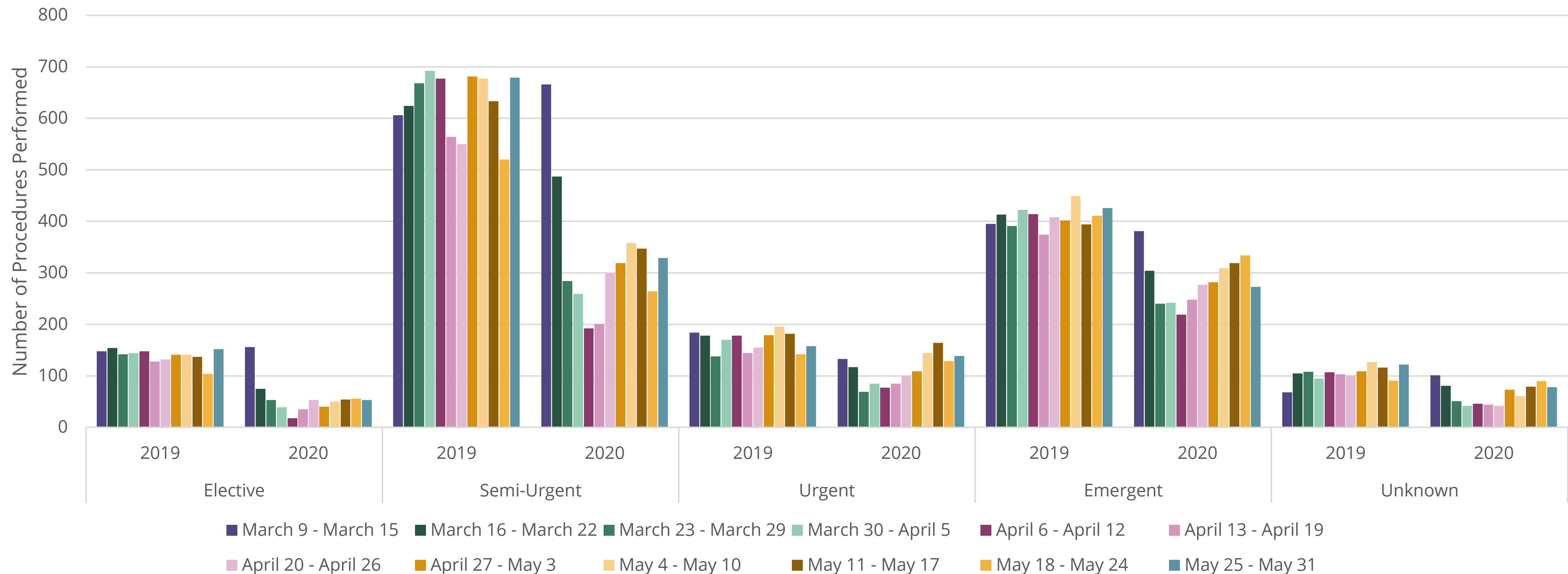
HHS HSN KGH LHSC MGH NHS PRHC RVH SAH SHN SHSC SMGH SMH SRHC TBRHSC THP UHN UOHI WOHC WRH

March 9 - March 15 | April 6 - April 12 | May 4 - May 10 | May 11 - May 17 | May 18 - May 24 | May 25 - May 31

2. Provincial Graphs that Compare Last Year to this Year

- Changing the graphs for CATH, PCI, CABG and Device Implants
  - These graphs have weekly volumes at the provincial level broken up by urgency
  - All other procedures do not have the data broken up by urgency
- Propose removing the urgency breakdown for CATH, PCI, CABG and Device Implants
  - Trend in activity is much easier to see when there is only one data series

Provincial Graphs that Compare Last Year to this Year for CATH – Original Graph



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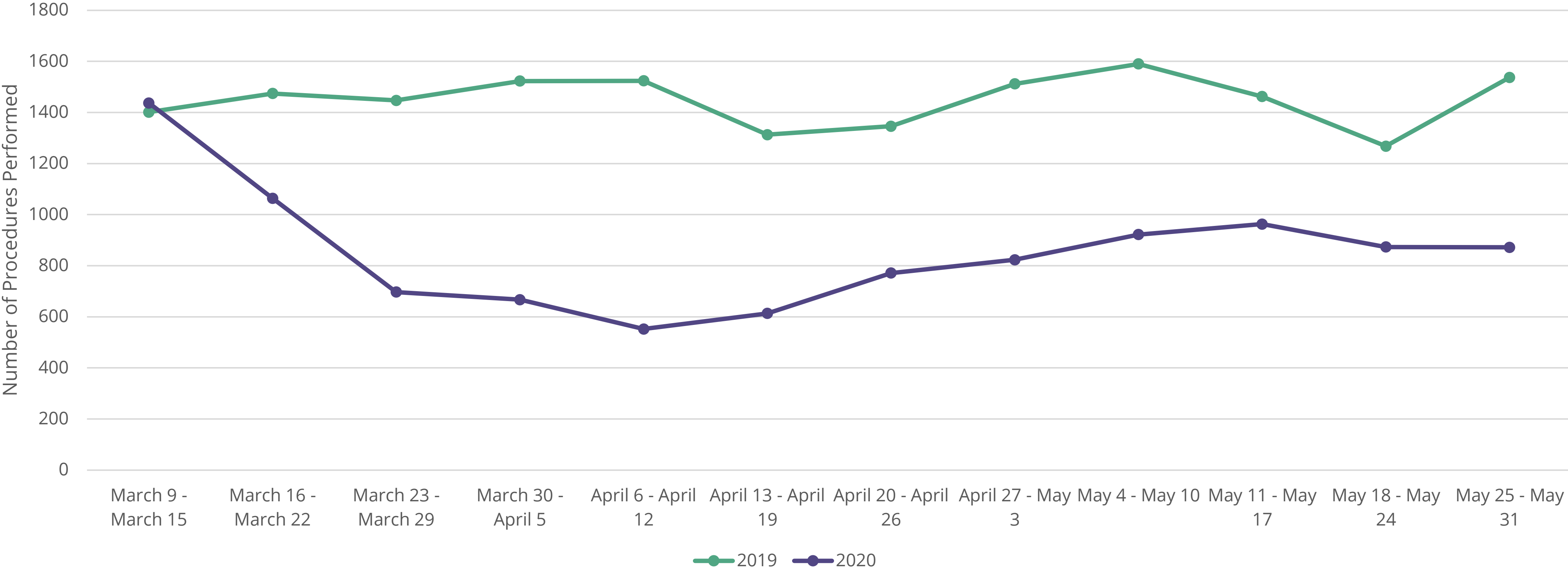
Provincial Graphs that Compare Last Year to this Year for CATH – Proposed New Graph Option 1



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3. Table that Compares Activity to Last Week and the Same Time Last Year

- Due to data entry delays each week, activity is not as low as originally believed

Percentage Reduction in Activity May 18 - May 24, 2020 Compared to 2019		
	% Reduction (data extracted on June 1)	% Reduction (data extracted on May 25)
CATH	-31%	-43%
PCI	-20%	-39%
CABG	-42%	-50%
Valve Surgery	-20%	-22%
CABG + Valve	-15%	-25%
TAVI	44%	12%
Electrophysiology	-54%	-76%
Device Implants	-28%	-61%

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Other Updates and Next Steps

- Next COVID-19 Cardiac Forum Meeting: Thursday, June 25, 8:00 – 9:00 AM

Appendix

Cardiac Workstreams

Cardiac Workstream	Moderator(s)
Echocardiography	Dr. Tony Sanfilippo Dr. Howard Leong-Poi
Rehab	Dr. Paul Oh Dr. Mark Bayley
Cardiac Surgery Cath/PCI	Dr. Chris Feindel Dr. Eric Cohen
Heart Failure	Dr. Heather Ross
STEMI	Dr. Steve Miner
Cardiac Electrophysiology	Dr. Atul Verma
Structural Heart (TAVI, Mitral Clip)	Dr. Sam Radhakrishnan
Managing Referrals	Dr. Chris Feindel Dr. Eric Cohen

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