CorHealth COVID-19 Stroke Stakeholder Forum #2

April 3, 2020 - 2:00-3:30 pm

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

Conference ID: 146160803

 Skype Meeting

Agenda

Description	Presenter	Time
1. Welcome • Recap of March 27th Meeting • COVID-19 System Planning Updates • Virtual Care Resources • Rehab Forum Update • Meeting Objectives	Sheila Jarvis/Alex Iverson	2:00 – 2:20 pm
2. Progress Update: • Ambulatory Imaging and Cardiac Investigations for TIA and Minor Stroke • Data to support understanding of current stroke volumes (HSF)	Dr. Leanne Casaubon/ Shelley Sharp	2:20 -2:30 pm
3. Contingency Planning • Implications of OH Clinical Triage Protocol • Limited EVT Resources	Dr. Leanne Casaubon	2:30 – 3:25 pm
4. Next Steps and Q&A	Dr. Leanne Casaubon	3:25 – 3:30 pm

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Welcome

SHEILA JARVIS

Recap of March 27th Meeting

- Key themes discussed:

  - There is agreement and recognition that stroke is viewed as an essential service across sites.

  - May need to be provincial guidance on stroke rehabilitation being seen as an essential service to promote flow through the system into the community.

  - Adhering to stroke best practices is a goal however maintaining stroke expert human resources in a time where resources are limited may be challenging.

- Meeting summary notes can be found on our website: https://www.corhealthontario.ca/COVID-19-CorHealth-Summary-Notes-Stroke-Forum1-(March-27-2020).pdf

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COVID-19 System Planning Updates:

Ontario Health - Critical Triage Protocol for Major Surge in COVID Pandemic

- Released March 28, 2020

- Development led by Dr. James Downar (The Ottawa Hospital) under the Ethics Table of the Ontario COVID Command Structure

- Describes surge and scale up of levels of triage protocol for acute and critical care services guided by ethical principles

- Use of triage protocol should be considered as last resort

- Document can be found on our website: OH Guidance - Clinical Triage Protocol for Major Surge in COVID Pandemic (March 28, 2020)

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Resources and Supports to Enable Virtual or Remote Monitoring, Management and Care

1. **Changes to the Schedule of Benefits for Physician Services in response to COVID-19 influenza pandemic effective March 14, 2020**

   - Providers are being encouraged to use virtual care whenever appropriate, and Ontario's Ministry of Health has introduced temporary billing codes and procedures in support of this effort.
     - Information on the temporary billing codes
     - Information on billing for virtual physician services and technical guidance

2. **Virtual Care Resources**

   - Major sites hosting virtual and remote monitoring and care tools and resources available in Ontario
     - Ontario Telemedicine Network (OTN)
     - OntarioMD
     - Association of Family Health Teams of Ontario (AFHTO)
     - eHealth Centre of Excellence (eCE)
   - Disease specific virtual and remote monitoring care tools and resources available in Ontario
     - MEDLY (heart failure)
     - The Ottawa Heart Institute's Telehome Monitoring Program (heart failure)
     - OTN Telehomecare for COPD and Heart Failure
     - Community Paramedicine Remote Patient Monitoring Program (heart failure)

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Resources and Supports to Enable Virtual or Remote Monitoring, Management and Care

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Advancing cardiac, stroke and vascular care

Repository of Resources & Supports to Enable Virtual or Remote Monitoring, Management and Care Across Stroke, Vascular and Cardiac Patients During COVID-19

DISCLAIMER: This document represents a dynamic, central repository of resources for the enablement of virtual or remote monitoring and is not an exhaustive list of all existing resources. The resources included in this central repository will continue to be updated as applicable.

Changes to the Schedule of Benefits for Physician Services (Schedule) in Response to COVID-10 Influenza Pandemic, effective March 14, 2020

Providers are being encouraged to use virtual care whenever appropriate, and Ontario's Ministry of Health has introduced temporary billing codes and procedures in support of this effort. Information on the temporary billing codes, can be found here: http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4745.aspx Information on billing for virtual physician services and technical guidance, can be found here: http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4746.aspx

Virtual Care Resources

1. **Ontario Telemedicine Network**
   OTN is a provincial platform that enables virtual care through two-way videoconferencing to provide access to care for patients in hospitals and hundreds of other health care locations across the province. For information on virtual care options and guides to support clinicians to use OTN-supported tools to deliver virtual care safely and effectively, refer to: https://otn.ca/

2. **OntarioMD**
   OntarioMD has curated a list of tools that they have visibility to, in order to raise awareness to physicians and their practices regarding tools they might consider in supporting their patient community during the COVID-19 pandemic. Information regarding digital tools, video visit platforms, and other virtual care resources can be found at the link below:
   https://ontariomd.news/?utm_source=link.cep.health&utm_medium=urlshortener&utm_campaign=covid

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4. **Association of Family Health Teams of Ontario (AFHTO)**
   AFTO has developed a repository of virtual care and digital health resources that is updated regularly, in order to assist teams to accommodate care for patients virtually as much as possible. The suite of resources includes, but is not limited to: clinical guidance for adopting and integrating virtual visits into care, telephone and virtual care fee codes FAQ. Refer to link below: https://www.afhto.ca/news-events/news/virtual-care-digital-health-and-covid-19

5. **eHealth Centre of Excellence**
   eCE organization offers support to healthcare professionals and organizations related to the deployment, adoption and appropriate use of digital heath tools. Their current suite of digital health tools include, but are not limited to: eConsult, virtual visits, tablets, tools and coaching for electronic medical records (EMRs), eReferral, and tools of intelligent automation. Information regarding the full suite of digital health tools can be found here: http://ehealthce.ca/Services.htm

Heart Failure-Specific Virtual Care Resources

6. **Medly**
   Medly is a digital program that allows heart failure patients to manage symptoms from home. Medly reduces hospitalizations and improves self care and quality of life. Medly provides heart failure patients with individualized self-care and coordinated clinical support. Patients record and store physiological measurements and symptoms via the Medly app. Medly runs this data through a clinically-validated algorithm which provides instant feedback and push instructions including diuretic dosing tailored to the patients and their clinicians. The model of care delivery incorporates 1 Medly nurse coordinator providing care for up to 350 HF patients. Additional information on Medly can be found at: medly.ca

7. **Ottawa Heart Institute's Telehome Monitoring Program (THM)**
   The Heart Institute's Telehome Monitoring Program (THM) is a nurse-run, intensive, post-discharge home health program designed to improve patient outcomes and reduce hospital readmissions. It is part of the Telehealth Programs run by the Cardiac-Telehealth department. For more information, please visit the website:
   https://www.ottawaheart.ca/healthcare-professionals/regional-national-programs/telehome-monitoring

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8. **Telehomecare for COPD and Heart Failure**
   A free, six-month health coaching and remote monitoring program for your patients with chronic obstructive pulmonary disease (COPD) and congestive heart failure. Not all areas in Ontario provide this service. For more information, please visit the OTN website: https://otn.ca/providers/telehomecare/

9. **Community Paramedicine Remote Patient Monitoring (CPRPM) Program**
   The CPRPM program is an initiative of Community Paramedics across Ontario to keep patients with chronic illness, such as HF and chronic obstructive pulmonary disease (COPD), safe at home and out of the hospital. A unique feature of this program is the addition of highly mobile community paramedics who are able to respond, in real time, to alerts generated by built in program logic. Costs for the system are roughly $70/month per patient. For more information please contact the program lead, Rick Whittaker at rick@wwcf.ca.

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Rehab Forum Update

- CorHealth will be hosting a stakeholder forum to discuss **issues related to the provision of rehabilitation** for cardiac, stroke and vascular patients during COVID-19

- April 9th, 2020

- Co-chaired by Dr. Paul Oh & Dr. Mark Bayley

Meeting Objectives

- To further discussions on contingency planning and implications to the provincial stroke system and the need for guidance on aspects for hyperacute care (e.g. escalation pathways or transfers)

  - If our EVT resources become limited

  - If the newly released Ontario Health Clinical Triage Protocol is in effect for stroke centres.

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Progress Update

DR. LEANNE CASAUBON/ SHELLEY SHARP

Ambulatory Imaging and Cardiac Investigations for TIA and Minor Stroke
Dr. Jennifer Mandzia, Dr. Wes Oczkowski, Dr. Grant Stotts, Dr. Leanne Casaubon

- **March 28-30:** CorHealth drafted a document based on best practice and discussion from first Forum. Stroke clinical stakeholders provided email dialogue around brain imaging, cardiac investigations and time frames for TIA and minor/nondisabling stroke diagnosis and interventions to ensure continued access to care while minimizing patient exposure to the COVID-19 environment.

- **March 31:** CorHealth COVID-19 Stroke Memo #1 – Ambulatory Imaging & Cardiac Investigations for TIA and Minor Stroke During COVID-19 posted to CorHealth COVID-19 Resource Centre

- **Question –** Are there any comments about this guidance document?

Memo #1 RECOMMENDATIONS FOR AN ONTARIO APPROACH FOR AMBULATORY IMAGING AND CARDIAC INVESTIGATIONS FOR TIA   AND MINOR STROKE DURING COVID-19

Data to Support Understanding of Current Stroke Volumes (Heart and Stroke Foundation)

Update

- Heart and Stroke Foundation is engaging stakeholders and data partners to better understand the impact of COVID-19 outbreak on the volumes of patients using 911 and/or going to an ED for stroke.

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Contingency Planning

DR. LEANNE CASAUBON/ SHELLEY SHARP

Insights from Italy: A neurologist perspective on hyperacute stroke care in COVID 19 pandemic

Emergency Department:

- Patients arrive with less information (no family to support); patients with aphasia
- Patients may have pre-existing respiratory condition – time spent excluding COVID 19

Neuroradiology:

- Reduced access to brain CT (CT thorax needs)
- Shifted resources to other duties
- Imaging decisions (as a team) need to be immediate and final

Transfers (e.g. drip and ship) more complicated:

- Status of ED at receiving hospital is a question
- Exposing patients to more health care providers = more risk
- Impact on EMS resources – and they may also be compromised/reduced

https://strokefocus.wordpress.com/2020/03/17/stroke-care-at-covid-time/

OH Clinical Triage Protocol

Contingency Planning

OH Clinical Triage Protocol for Major Surge in COVID-19 Pandemic – Stroke criteria for exclusion

Level 1 Triage Scenario (Aiming to exclude people with >~80% predicted mortality)	**Level 2 Triage Scenario (Aiming to exclude people with >~50% predicted mortality)**	**Level 3 Triage Scenario (Aiming to exclude people with ~>30% predicted mortality)**
H. Severe and irreversible neurologic event with >80% risk of death or poor outcome based on: • For Intracerebral Hemorrhage a modified ICH score of 4-7 • For Subarachnoid Hemorrhage, a WFNS grade 5 (GCS 3-6) • For Traumatic Brain Injury, the IMPACT score • Acute ischemic stroke alone would not be excluded at this level	H. Severe and irreversible neurologic event with >50% risk of death or poor outcome based on: • For Intracerebral Hemorrhage a modified ICH score of **3-7** • For Subarachnoid Hemorrhage, a WFNS grade 3-5 (GCS 3-12 OR GCS 13-14 AND focal neurological deficits) • For Traumatic Brain Injury, the IMPACT score • For acute ischemic stroke, an NIHSS of **22-42.**	H. Irreversible neurologic event/condition with >30% risk of death or poor outcome based on: • For Intracerebral Hemorrhage a modified ICH score of **2-7** • For Subarachnoid Hemorrhage, a WFNS grade 2-5 (GCS <15) • For Traumatic Brain Injury, the IMPACT score • For acute ischemic stroke, an NIHSS of **14-42.**

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Contingency Planning: OH Clinical Triage Protocol in Effect

What are the clinical and provincial system implications when/if a region(s) or stroke hospitals need to escalate to one of these triage levels to address critical care bed crisis?

What are the communication needs associated with implementation of the triage levels?

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EVT Referral Process

Contingency Planning

What is our provincial strategy for limited EVT resources?
(e.g. reduced access to CT, loss of interventionalists)

Current Practice

- Current transport and referral process is facilitated through CritiCall Ontario

- All referral site have been mapped to a primary and secondary EVT site (i.e. R1 and R2)

- R2 is only activated when:

  - R1 is consulting with or has accepted another patient for EVT

  - R1 is experiencing an interruption in services

    - (CritiCall and R2 site are pre-notified in these circumstances)
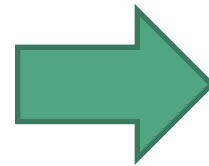
Future State Contingency Plan

- What if R1 is unable to provide services due to COVID-19 circumstances?

- What if R2 is unable to provide services due to COVID-19 circumstances?

- What if both R1 and R2 is unable to provide services due to COVID-19 circumstances?

Discussion Questions

- Do we need additional escalation pathways beyond Referral 2? (e.g. R3)

- What criteria should be used to inform decisions related to transfers for EVT?   Are they different for R2?

- What additional/enhanced communications need to occur?

  - Clinical information (e.g CT thorax)

  - General communication between hospitals regarding status of programs

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Next Steps and Q & A

DR. LEANNE CASAUBON/ SHEILA JARVIS

Questions

- Are there other issues that we should be considering/discussing?

- Are these meetings still helpful? How could they be improved?

Next Steps & Wrap Up

- CorHealth will be hosting a stakeholder forum to discuss **issues related to the provision of rehabilitation during COVID-19**: **April 9th**

- **Central Repository of Resources & Supports to Enable Virtual or Remote Monitoring and Management** of Patients During COVID-19 is available at CorHealth's COVID-19 Resource Center: https://www.corhealthontario.ca/CorHealth-Resources-Central-Repository-of-Virtual-resources-(March-30-2020)-Version-1.pdf

- CorHealth to schedule next stroke forum if required

Appendix

CorHealth COVID-19 Resource Centre

- Accessible from the <u>CorHealth homepage</u>

- Updated twice a day at 10:30am and 5:30pm

- Includes:

  - General COVID-19-related documents

  - CorHealth Guidance Documents

  - **Presentations & Summary notes from Cardiac, Stroke, and Vascular Forums**

  - Cardiac-, Stroke-, and Vascular-specific COVID-19-related documents

- Organized from most recent resources at the top to oldest at the bottom of each page

COVID-19 Resource Centre Sections

COVID-19 Resource Centre

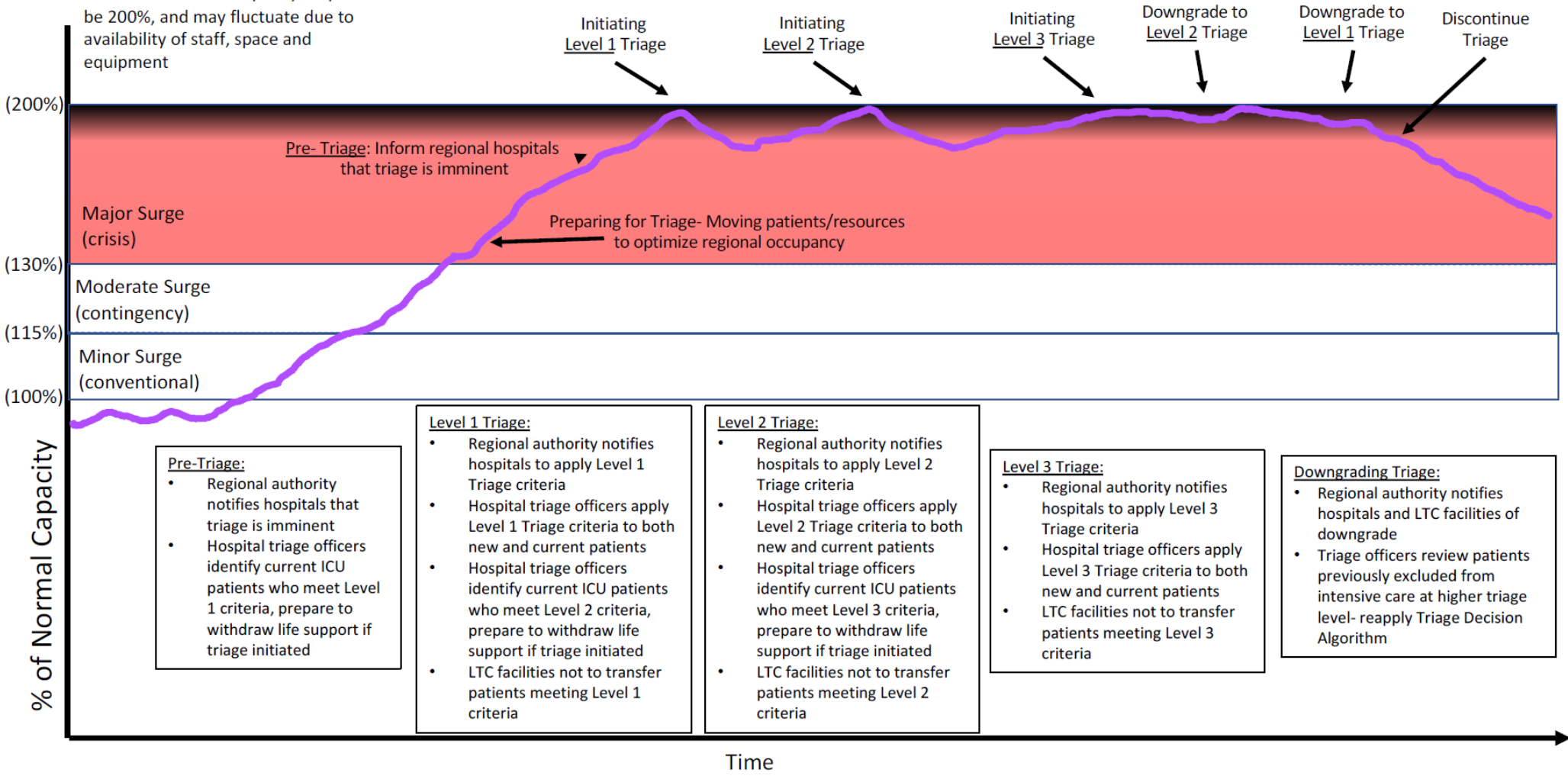CorHealth Guidance Documents

CorHealth Stakeholder Forum Meetings

General Cardiac Resources

General Stroke Resources

General Vascular Resources

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Surge and Levels of Triage in a Pandemic

NB- Actual Limit of Capacity may not be 200%, and may fluctuate due to availability of staff, space and equipment

Initiating Level 1 Triage

Initiating Level 2 Triage

Initiating Level 3 Triage

Downgrade to Level 2 Triage

Downgrade to Level 1 Triage

Discontinue Triage

(200%)

Pre- Triage: Inform regional hospitals that triage is imminent

Major Surge (crisis)

Preparing for Triage- Moving patients/resources to optimize regional occupancy

(130%)

Moderate Surge (contingency)

(115%)

Minor Surge (conventional)

(100%)

% of Normal Capacity

Time

Pre-Triage:
- Regional authority notifies hospitals that triage is imminent
- Hospital triage officers identify current ICU patients who meet Level 1 criteria, prepare to withdraw life support if triage initiated

Level 1 Triage:
- Regional authority notifies hospitals to apply Level 1 Triage criteria
- Hospital triage officers apply Level 1 Triage criteria to both new and current patients
- Hospital triage officers identify current ICU patients who meet Level 2 criteria, prepare to withdraw life support if triage initiated
- LTC facilities not to transfer patients meeting Level 1 criteria

Level 2 Triage:
- Regional authority notifies hospitals to apply Level 2 Triage criteria
- Hospital triage officers apply Level 2 Triage criteria to both new and current patients
- Hospital triage officers identify current ICU patients who meet Level 3 criteria, prepare to withdraw life support if triage initiated
- LTC facilities not to transfer patients meeting Level 2 criteria

Level 3 Triage:
- Regional authority notifies hospitals to apply Level 3 Triage criteria
- Hospital triage officers apply Level 3 Triage criteria to both new and current patients
- LTC facilities not to transfer patients meeting Level 3 criteria

Downgrading Triage:
- Regional authority notifies hospitals and LTC facilities of downgrade
- Triage officers review patients previously excluded from intensive care at higher triage level- reapply Triage Decision Algorithm

Reference Links

- OH Clinical Triage Protocol for Major Surge in COVID Pandemic

- NHS Clinical Guide for the Management of Stroke Patients During the Coronovirus Pandemic

- Temporary Emergency Guidance to US Stroke Centers During the COVID-19 Pandemic On Behalf of the AHA/ASA Stroke Council Leadership

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