COVID-19 Community of Practice for Ontario Family Physicians

Changing the Way We Work

The vaccine, virus and in-person visits as we head into Fall

August 20, 2021

Dr. Megan Stephenson
Dr. Allison McGeer
Dr. David Kaplan
Dr. Liz Muggah

Family & Community Medicine
UNIVERSITY OF TORONTO

Ontario College of Family Physicians

The vaccine, virus and in-person visits as we head into Fall

Moderator: Dr. Tara Kiran

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Department of Family and Community Medicine, University of Toronto

Panelists:

- Dr. Megan Stephenson, Huntsville, ON
- Dr. Allison McGeer, Toronto, ON
- Dr. David Kaplan, Toronto, ON
- Dr. Liz Muggah, Ottawa, ON

This one-credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada and the Ontario Chapter for up to 1 Mainpro+ credits.

The COVID-19 Community of Practice for Ontario Family Physician includes a series of planned webinars. Each session is worth 1 Mainpro+ credits, for up to a total of 26 credits.

Land Acknowledgement

We acknowledge that the lands on which we are hosting this meeting include the traditional territories of many nations.

The OCFP and DFCM recognize that the many injustices experienced by the Indigenous Peoples of what we now call Canada continue to affect their health and well-being. The OCFP and DFCM respect that Indigenous people have rich cultural and traditional practices that have been known to improve health outcomes.

I invite all of us to reflect on the territories you are calling in from as we commit ourselves to gaining knowledge; forging a new, culturally safe relationship; and contributing to reconciliation.

CFP·MFC
CANADIAN FAMILY PHYSICIAN • LE MÉDECIN DE FAMILLE CANADIEN
The official journal of the College of Family Physicians of Canada

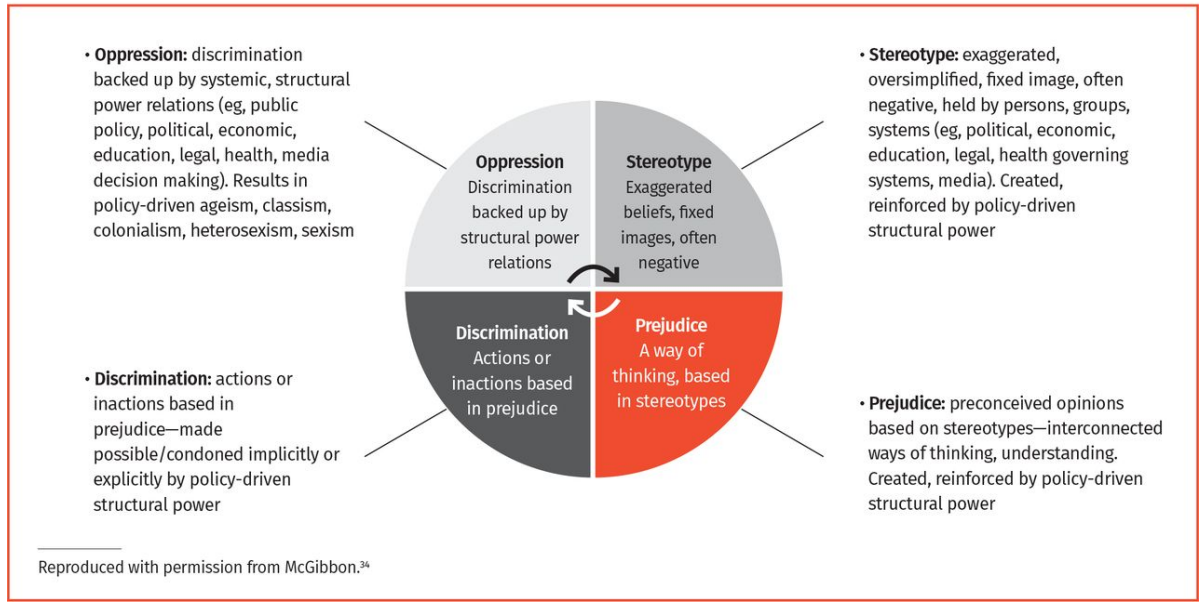
Research Article | Prevention in Practice

Improving preventive screening with Indigenous peoples

Pascale Breault, Jessie Nault, Michèle Audette, Sandro Échaquan, Jolianne Ottawa, Olga Szafran, Neil R. Bell, James A. Dickinson, Rola
Harminder Singh and Earle Waugh

Canadian Family Physician August 2021, 67 (8) 588-593; DOI: https://doi.org/10.46747/cfp.6708588

Figure 2. Cycle of oppression



Reproduced with permission from McGibbon.[34]

Box 1.

Strategies to support engagement of Indigenous community members in screening

- Provide access to relevant educational materials that are adapted to their realities and accessible in local languages
- Seek support in the community for the presence of a community worker able to ease the discussion of complex medical issues in the community's native language
- Promote and empower women's roles as mothers and primary caregivers
- Dedicate resources to hiring of a "navigator" to support patients in the whole experience of care. Train and support health layperson advisors to do home visits to interact with patients
- Recognize the value and importance of having an older relative with the patient to discuss screening and preventive care during the consultation
- Acknowledge that patients may need time to assimilate information and that the decision to screen does not need to be made on the spot
- Encourage talking circles composed of Elders or survivors where positive stories of successful screening can be discussed and commented upon
- Use different reminders to engage with the screening program (eg, text messages [if accessible in the community], community laboratory drop, telephone follow-up by a community member to discuss potential barriers)
- Data from Zhu,[5] Maar et al,[9] Zehbe et al,[16] O'Brien et al,[22] Gifford et al,[48] Browne et al,[49] Cancer Care Ontario.[50]

Changing the way we work

A community of practice for family physicians during COVID-19

At the conclusion of this series participants will be able to:

- Identify the current best practices for delivery of primary care within the context of COVID-19 and how to incorporate into practice.
- Describe point-of-care resources and tools available to guide decision making and plan of care.
- Connect with a community of family physicians to identify practical solutions for their primary care practice under current conditions.

Disclosure of Financial Support

This CPD program has received in-kind support from the Ontario College of Family Physicians and the Department of Family and Community Medicine, University of Toronto in the form of logistical and promotional support.

Potential for conflict(s) of interest:
N/A

Mitigating Potential Bias

- The Scientific Planning Committee has full control over the choice of topics/speakers.
- Content has been developed according to the standards and expectations of the Mainpro+ certification program.
- The program content was reviewed by a three-member national/scientific planning committee.

Planning Committee: Dr. Tara Kiran, Patricia O'Brien (DCFM), Leanne Clarke (OCFP), Susan Taylor (OCFP) and Mina Viscardi-Johnson (OCFP), Liz Muggah (OCFP)

Previous webinars & related resources:

https://www.dfcm.utoronto.ca/covid-19-community-practice/past-sessions

Dr. Megan Stephenson– Panelist

Family Physician, Algonquin Family Health Team

Dr. Allison McGeer – Panelist

Infectious Disease Specialist, Mount Sinai Hospital

Dr. David Kaplan – Co-Host

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Speaker Disclosure

- Faculty Name: **Dr. Megan Stephenson**
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians
  - Others: N/A

- Faculty Name: **Dr. Allison McGeer**
- Relationships with financial sponsors: Novavax, Medicago, Sanofi-Pasteur, GSK, Merck
  - Grants/Research Support: Sanofi-Pasteur, Pfizer
  - Speakers Bureau/Honoraria: Moderna, Pfizer, AstraZeneca, Novavax, Medicago, Sanofi-Pasteur, GSK, Merck
  - Others: N/A

- Faculty Name: **Dr. David Kaplan**
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians
  - Others: Ontario Health (employee)

Speaker Disclosure

- Faculty Name: **Dr. Liz Muggah**
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians
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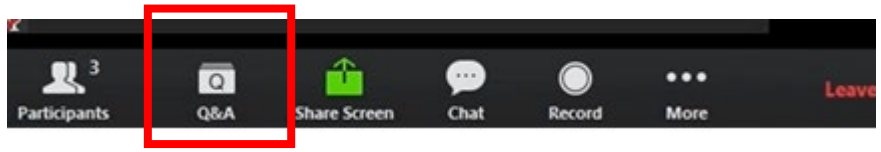
- Faculty Name: **Dr. Tara Kiran**
- Relationships with financial sponsors:
  - Grants/Research Support: St. Michael's Hospital, University of Toronto, Health Quality Ontario, Canadian Institute for Health Research, Toronto Central LHIN, Toronto Central Regional Cancer Program, Gilead Sciences Inc.
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians, Ontario Medical Association, Doctors of BC, Nova Scotia Health Authority, Osgoode Hall Law School, Centre for Quality Improvement and Patient Safety
  - Others: N/A

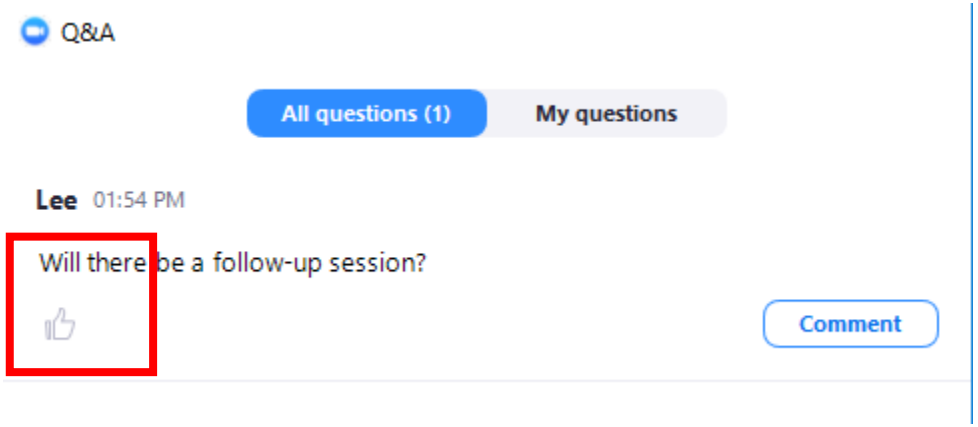
Where are we from (outside the GTA)?

How to Participate

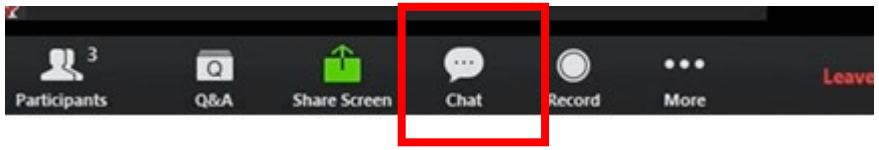
- All questions should be asked using the Q&A function at the bottom of your screen.



- Press the thumbs up button to upvote another guests questions. Upvote a question if you want to ask a similar question or want to see a guest's question go to the top and catch the panels attention.



- Please use the chat box for networking purposes only.



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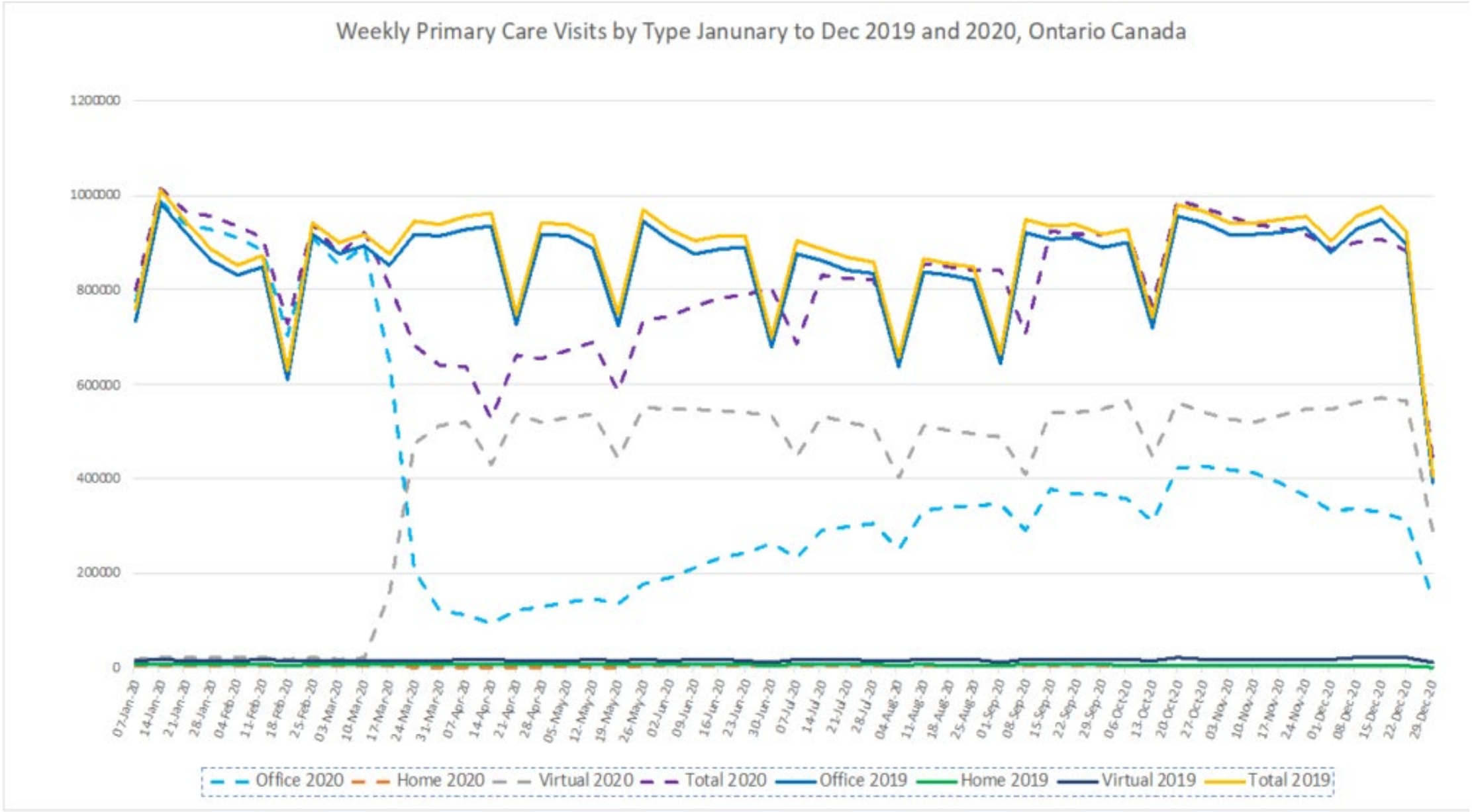


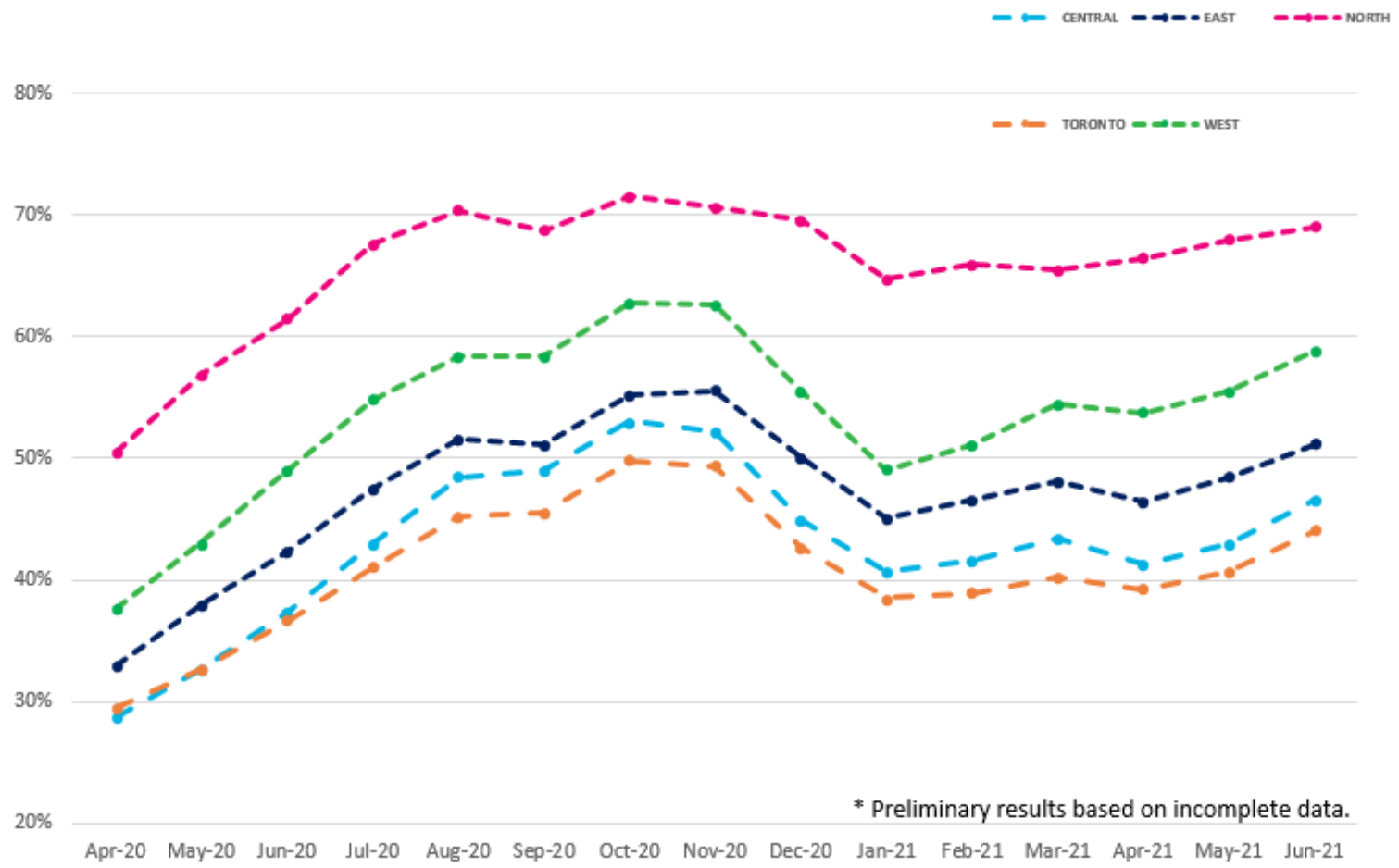
https://maphealth.ca/primary-care-covid-era/


1
3


2

Monthly trend in visits and percent in-person

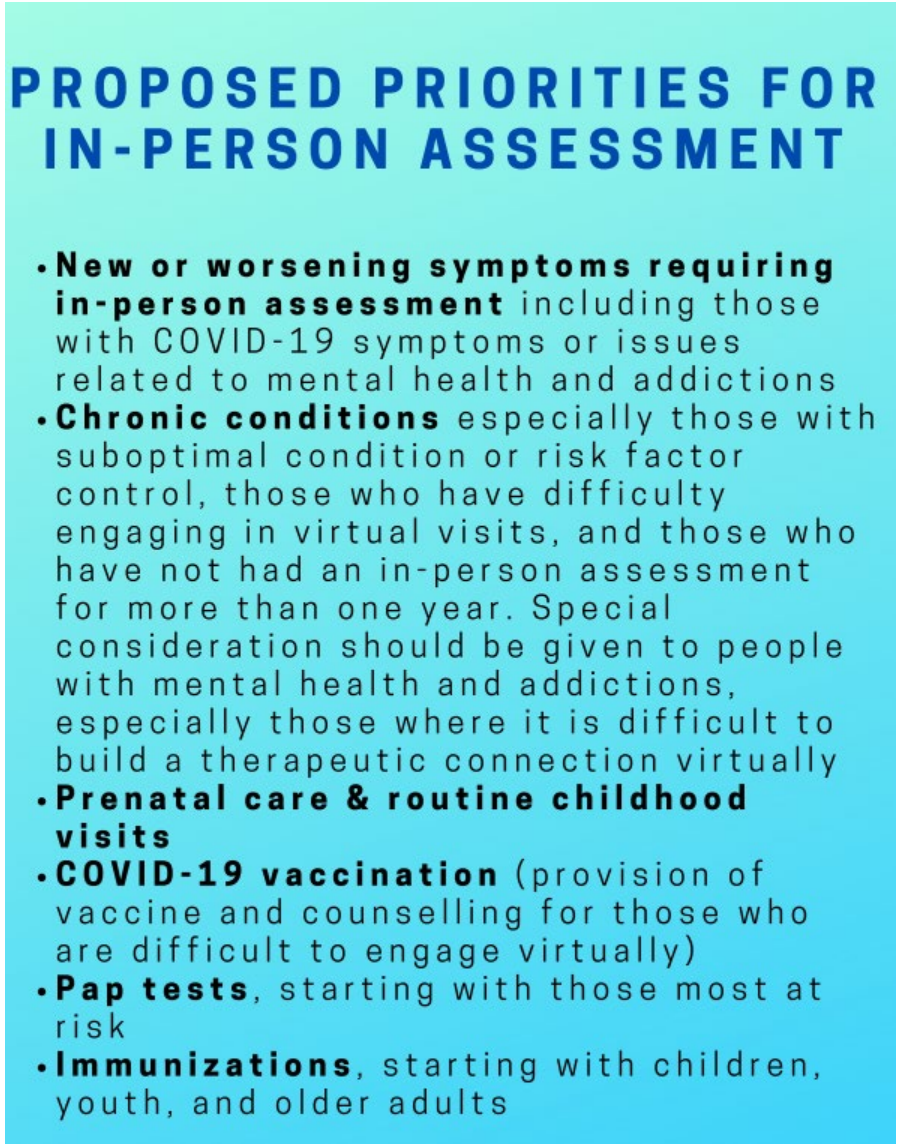
% In-person FY20 and FY21(Apr, May)



Data Source: Claims History Database, MOH: Service dates from April 1 2019 to June 30 2021, assessment dates < July 31st of respective year. Excludes WSIB, community labs, out of province physicians and technical claims. Includes professional, shadow billed and OTN claims. Note: Analysis based on interim data – expected to represent 90%-95% of services provided.

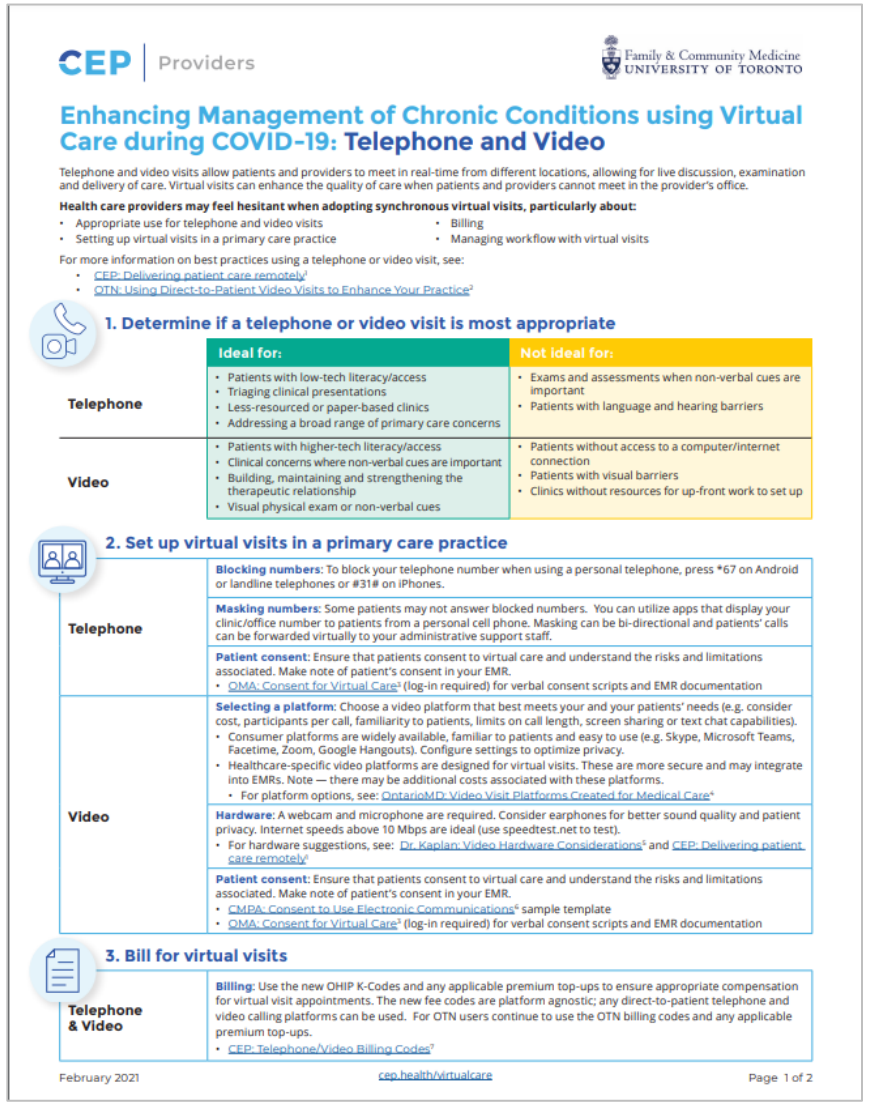
Ontario
Health Analytics & Insights Branch

From virtual-first to patient-directed: a new normal for primary care



https://cmajblogs.com/from-virtual-first-to-patient-directed-a-new-normal-for-primary-care/

Virtual Care: Chronic Conditions



CEP | Providers

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Enhancing Management of Chronic Conditions using Virtual Care during COVID-19: Telephone and Video

Telephone and video visits allow patients and providers to meet in real-time from different locations, allowing for live discussion, examination and delivery of care. Virtual visits can enhance the quality of care when patients and providers cannot meet in the provider's office.

Health care providers may feel hesitant when adopting synchronous virtual visits, particularly about:

- Appropriate use for telephone and video visits
- Setting up virtual visits in a primary care practice
- Billing
- Managing workflow with virtual visits

For more information on best practices using a telephone or video visit, see:

- CEP: Delivering patient care remotely[1]
- OTN: Using Direct-to-Patient Video Visits to Enhance Your Practice[2]

1. Determine if a telephone or video visit is most appropriate

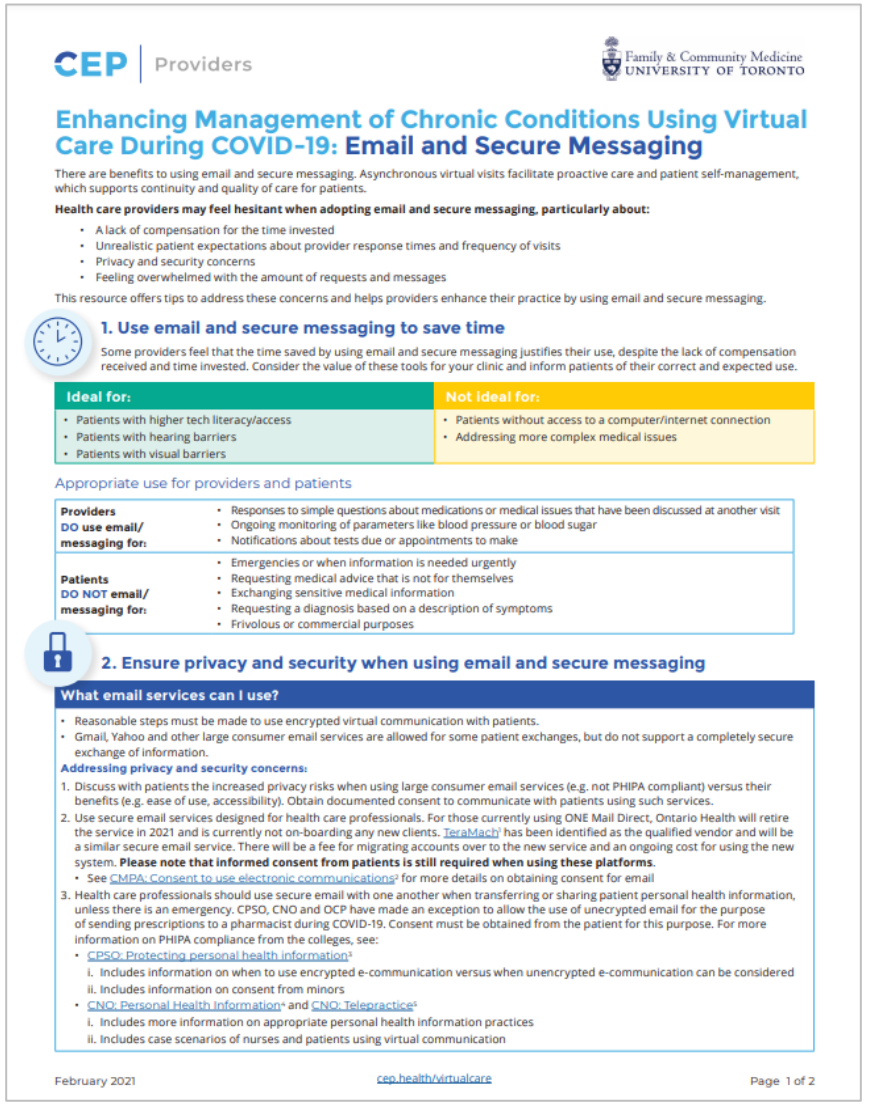
	Ideal for:	Not ideal for:
Telephone	• Patients with low-tech literacy/access • Triaging clinical presentations • Less-resourced or paper-based clinics • Addressing a broad range of primary care concerns	• Exams and assessments when non-verbal cues are important • Patients with language and hearing barriers
Video	• Patients with higher-tech literacy/access • Clinical concerns where non-verbal cues are important • Building, maintaining and strengthening the therapeutic relationship • Visual physical exam or non-verbal cues	• Patients without access to a computer/internet connection • Patients with visual barriers • Clinics without resources for up-front work to set up

2. Set up virtual visits in a primary care practice

Telephone	**Blocking numbers:** To block your telephone number when using a personal telephone, press *67 on Android or landline telephones or #31# on iPhones.
	Masking numbers: Some patients may not answer blocked numbers. You can utilize apps that display your clinic/office number to patients from a personal cell phone. Masking can be bi-directional and patients' calls can be forwarded virtually to your administrative support staff.
	Patient consent: Ensure that patients consent to virtual care and understand the risks and limitations associated. Make note of patient's consent in your EMR. • OMA: Consent for Virtual Care[3] (log-in required) for verbal consent scripts and EMR documentation
Video	**Selecting a platform:** Choose a video platform that best meets your and your patients' needs (e.g. consider cost, participants per call, familiarity to patients, limits on call length, screen sharing or text chat capabilities). • Consumer platforms are widely available, familiar to patients and easy to use (e.g. Skype, Microsoft Teams, Facetime, Zoom, Google Hangouts). Configure settings to optimize privacy. • Healthcare-specific video platforms are designed for virtual visits. These are more secure and may integrate into EMRs. Note — there may be additional costs associated with these platforms. • For platform options, see: OntarioMD: Video Visit Platforms Created for Medical Care[4]
	Hardware: A webcam and microphone are required. Consider earphones for better sound quality and patient privacy. Internet speeds above 10 Mbps are ideal (use speedtest.net to test). • For hardware suggestions, see: Dr. Kaplan: Video Hardware Considerations[5] and CEP: Delivering patient care remotely[1]
	Patient consent: Ensure that patients consent to virtual care and understand the risks and limitations associated. Make note of patient's consent in your EMR. • CMPA: Consent to Use Electronic Communications[6] sample template • OMA: Consent for Virtual Care[3] (log-in required) for verbal consent scripts and EMR documentation

3. Bill for virtual visits

Telephone & Video	**Billing:** Use the new OHIP K-Codes and any applicable premium top-ups to ensure appropriate compensation for virtual visit appointments. The new fee codes are platform agnostic; any direct-to-patient telephone and video calling platforms can be used. For OTN users continue to use the OTN billing codes and any applicable premium top-ups. • CEP: Telephone/Video Billing Codes[7]



CEP | Providers

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Enhancing Management of Chronic Conditions Using Virtual Care During COVID-19: Email and Secure Messaging

There are benefits to using email and secure messaging. Asynchronous virtual visits facilitate proactive care and patient self-management, which supports continuity and quality of care for patients.

Health care providers may feel hesitant when adopting email and secure messaging, particularly about:

- A lack of compensation for the time invested
- Unrealistic patient expectations about provider response times and frequency of visits
- Privacy and security concerns
- Feeling overwhelmed with the amount of requests and messages

This resource offers tips to address these concerns and helps providers enhance their practice by using email and secure messaging.

1. Use email and secure messaging to save time

Some providers feel that the time saved by using email and secure messaging justifies their use, despite the lack of compensation received and time invested. Consider the value of these tools for your clinic and inform patients of their correct and expected use.

Ideal for:	Not ideal for:
• Patients with higher tech literacy/access • Patients with hearing barriers • Patients with visual barriers	• Patients without access to a computer/internet connection • Addressing more complex medical issues

Appropriate use for providers and patients

Providers DO use email/ messaging for:	• Responses to simple questions about medications or medical issues that have been discussed at another visit • Ongoing monitoring of parameters like blood pressure or blood sugar • Notifications about tests due or appointments to make
Patients DO NOT email/ messaging for:	• Emergencies or when information is needed urgently • Requesting medical advice that is not for themselves • Exchanging sensitive medical information • Requesting a diagnosis based on a description of symptoms • Frivolous or commercial purposes

2. Ensure privacy and security when using email and secure messaging

What email services can I use?

- Reasonable steps must be made to use encrypted virtual communication with patients.
- Gmail, Yahoo and other large consumer email services are allowed for some patient exchanges, but do not support a completely secure exchange of information.

Addressing privacy and security concerns:

1. Discuss with patients the increased privacy risks when using large consumer email services (e.g. not PHIPA compliant) versus their benefits (e.g. ease of use, accessibility). Obtain documented consent to communicate with patients using such services.
2. Use secure email services designed for health care professionals. For those currently using ONE Mail Direct, Ontario Health will retire the service in 2021 and is currently not on-boarding any new clients. TeraMach[1] has been identified as the qualified vendor and will be a similar secure email service. There will be a fee for migrating accounts over to the new service and an ongoing cost for using the new system. **Please note that informed consent from patients is still required when using these platforms.**
   - See CMPA: Consent to use electronic communications[2] for more details on obtaining consent for email
3. Health care professionals should use secure email with one another when transferring or sharing patient personal health information, unless there is an emergency. CPSO, CNO and OCP have made an exception to allow the use of unecrypted email for the purpose of sending prescriptions to a pharmacist during COVID-19. Consent must be obtained from the patient for this purpose. For more information on PHIPA compliance from the colleges, see:
   - CPSO: Protecting personal health information[3]
     i. Includes information on when to use encrypted e-communication versus when unencrypted e-communication can be considered
     ii. Includes information on consent from minors
   - CNO: Personal Health Information[4] and CNO: Telepractice[5]
     i. Includes more information on appropriate personal health information practices
     ii. Includes case scenarios of nurses and patients using virtual communication

https://cep.health/clinical-products/virtual-care/

In-person care and virtual care

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- MOH:
  - **Moving to a "patient-centered" approach**
    - "Health Care Workers (HCWs) should use a patient-centered care approach and consider patient preference to determine when to provide in-person care."

- CPSO:
  - **Striking the right balance**:
    - "While virtual care will continue to be a helpful tool to support access to care, in most instances, in-person visits can now be provided safely and appropriately."
  - **Avoiding restricting care to those vaccinated:**
    - "While you can encourage eligible patients to get vaccinated, **patients cannot be denied access to necessary in-person care based solely on their vaccination status**"

IPAC (cleaning)

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Patient screen status is now the basis for cleaning

- For patients who screen **negative:**
  - **"standard cleaning processes**" Per PHO-PIDAC (best practices 2018) based on risk stratification (ie: patient rooms at least daily)

- For patients who screen **positive:**
  - **Patient-contact surfaces** (< 2 metres of patient) disinfected as soon as possible. **Treatment areas**, (all horizontal surfaces, equipment used on the patient (e.g., exam table, BP cuff) cleaned and disinfected before another patient is brought in or equipment used on another patient.

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PPE (eye protection)

- Patients who screen **negative**
  - **Unmasked** eye protection (googles or face shield) **required**
  - **Masked** for entire visit, use eye protection at your discretion.
- Patients who screen **positive**, eye protection is required.

Ventilation

Optimize air flow/ventilation:

- Key → ensure HVAC is properly installed and regularly inspected.
- Additional measures to consider: open doors and windows, use fans, HEPA filter →if very poor/no HVAC or air exchange.
- For info: see OCFP FAQ on IPAC/PPE.

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Changes for fully vaccinated

- **Fully vaccinated asymptomatic "high-risk" contacts do not need to self-isolate** following exposure, **testing** strongly recommended. Contact PHU for more advice.

- **HCW/staff**
  - **Unvaccinated with a high-risk exposure** → self-isolate at home. Continued work *may* be possible in some scenarios if critical to operations.

  - **Fully vaccinated with a high-risk exposure** → may not have to self-isolate, follow directions of public health.

  - **Unvaccinated returning from international travel** → strongly recommended to quarantine x 14d, whenever possible.

New mandatory vaccination policy for hospitals and home & community care service providers

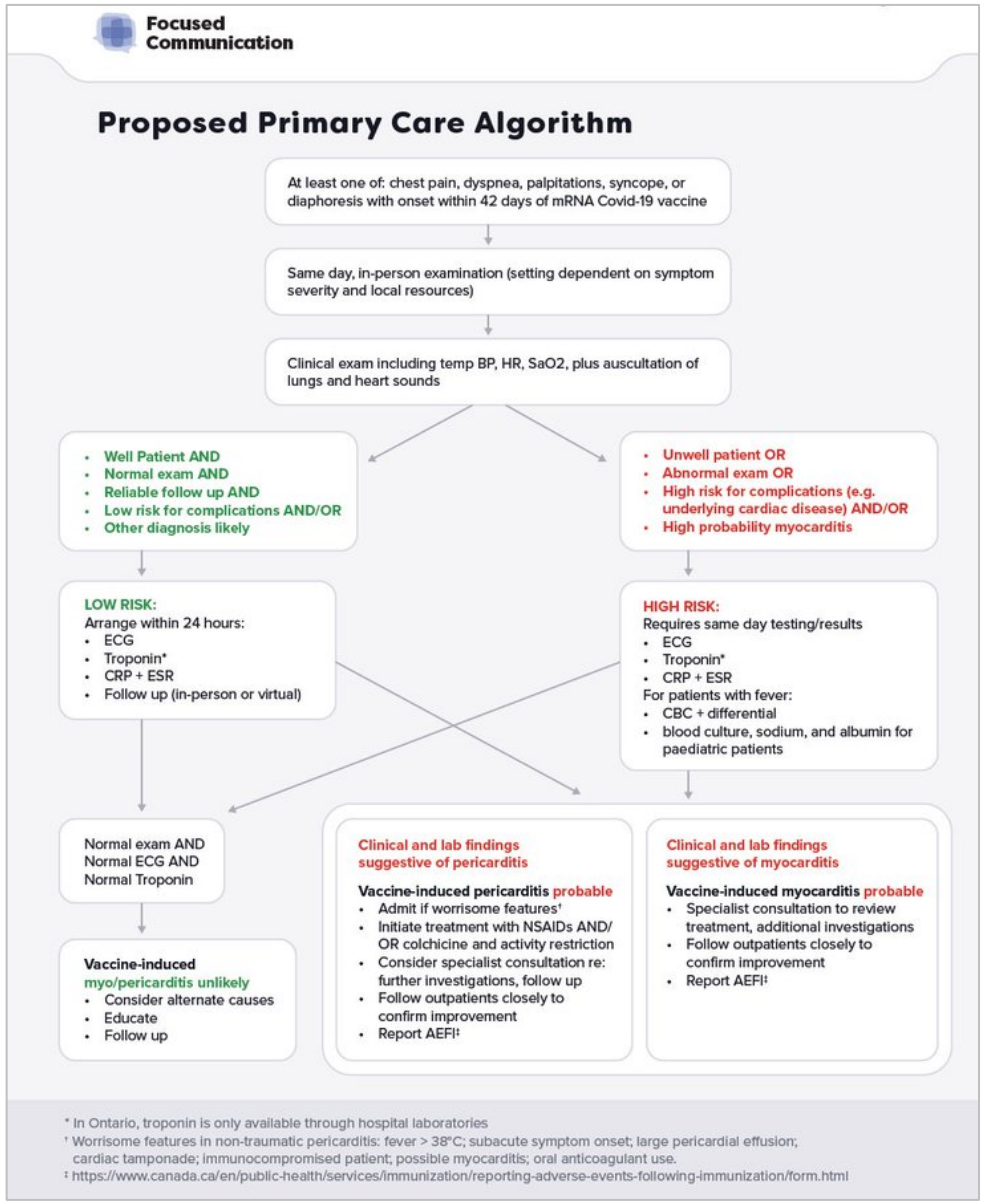
- Policy must be effective no later than September 7, 2021.

- **Employees required to provide proof of one of three things**:
  - Full vaccination against COVID-19; **OR**
  - A medical reason for not being vaccinated against COVID-19*; **OR**
  - Completion of a COVID-19 vaccination educational session*.

- *Individuals **who are not fully vaccinated** will be **required to undertake regular antigen testing.**

- ***Medical exemptions** not yet specified. May include: severe allergy/myocarditis. Consider econsult/referral to clarify.

Myocarditis and Pericarditis After Covid-19 Vaccination

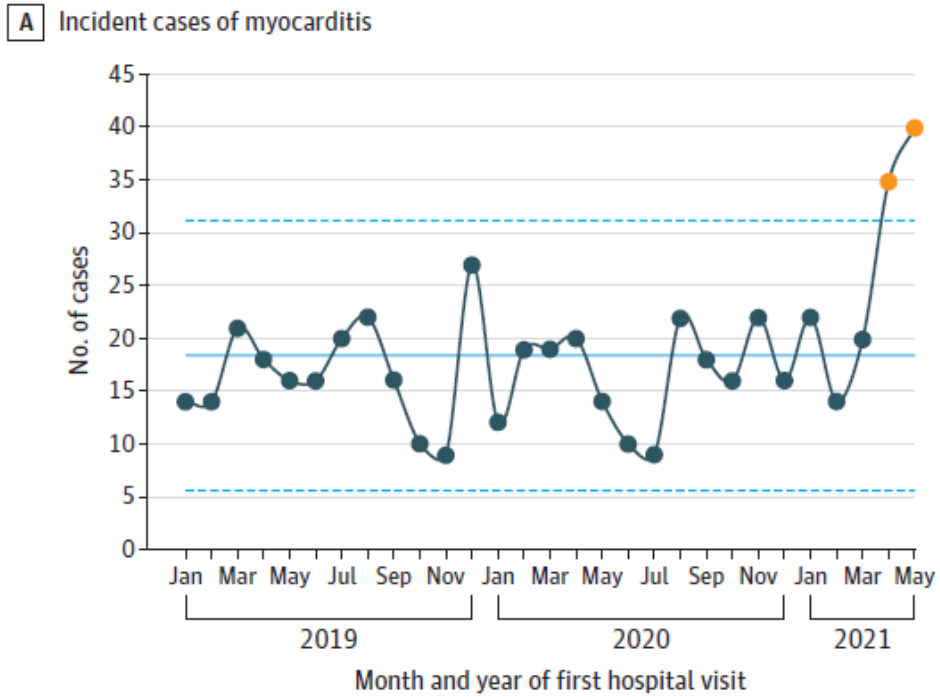


https://uwaterloo.ca/pharmacy/sites/ca.pharmacy/files/uploads/files/myocarditis_and_pericarditis_after_covid-19_vaccination_a_primer_for_primary_care_professionals.pdf

Myocarditis

- No new updates on incidence

- Severity
  - Diaz: 20 myocarditis; 37 pericarditis
    - Median hospital admission 2 days
  - Montgomery 23 myocarditis; 16 resolved in 7 days



Diaz, JAMA Aug 1, 2020; Montgomery doi:10.1001/jamacardio.2021.2833; Kim doi:10.1001/jamacardio.2021.2828

Vaccination and risk of COVID-19 reinfection

TABLE 2. Association of SARS-CoV-2 reinfection* with COVID-19 vaccination status — Kentucky, May–June 2021

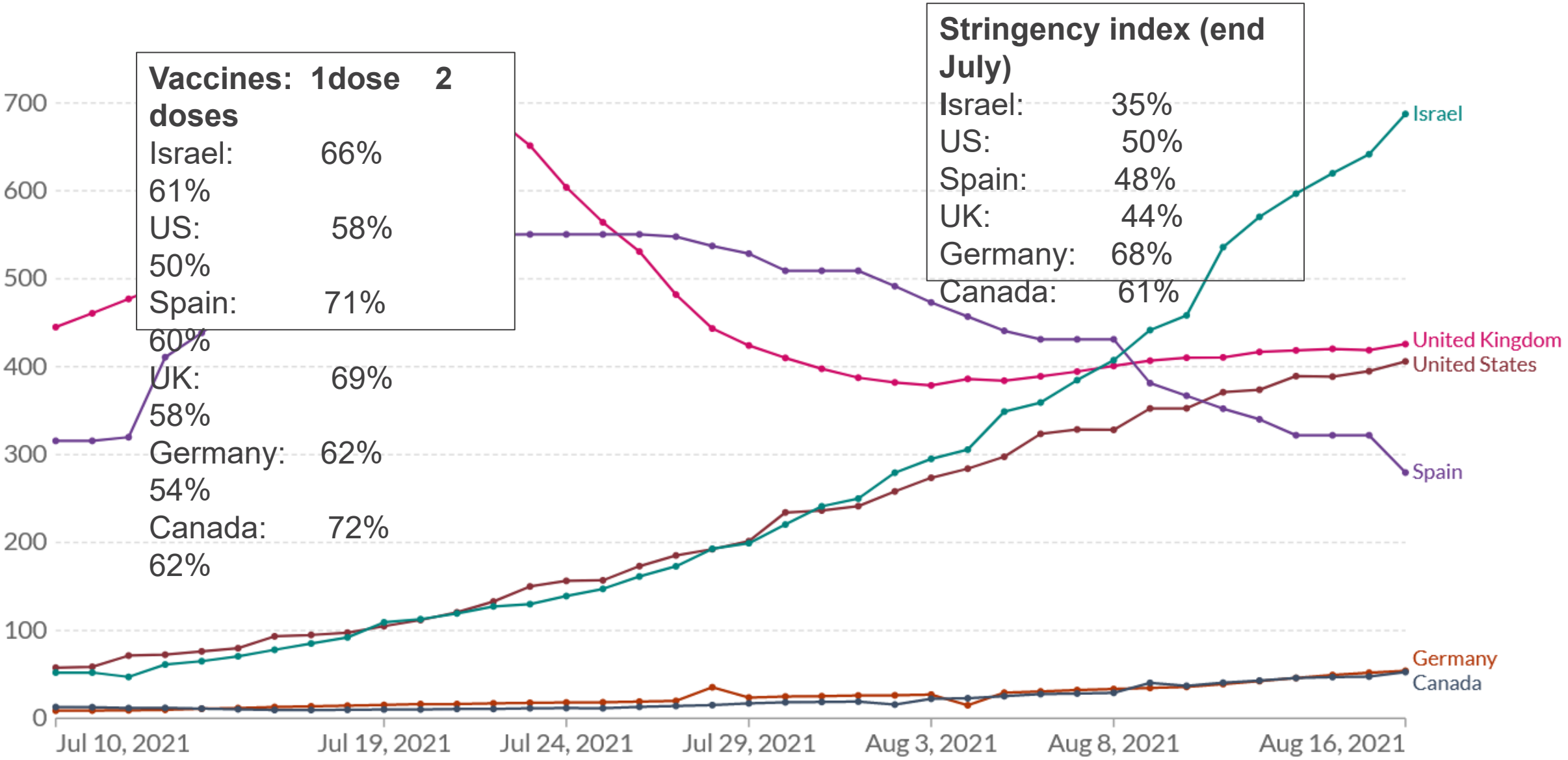
	No. (%)		
Vaccination status	**Case-patients**	**Control participants**	**OR (95% CI)†**
Not vaccinated	179 (72.8)	284 (57.7)	2.34 (1.58–3.47)
Partially vaccinated¶	17 (6.9)	39 (7.9)	1.56 (0.81–3.01)
Fully vaccinated§	50 (20.3)	169 (34.3)	Ref
Total	**246 (100)**	**492 (100)**	—

Cavanaugh MMWR Aug 6, 2021

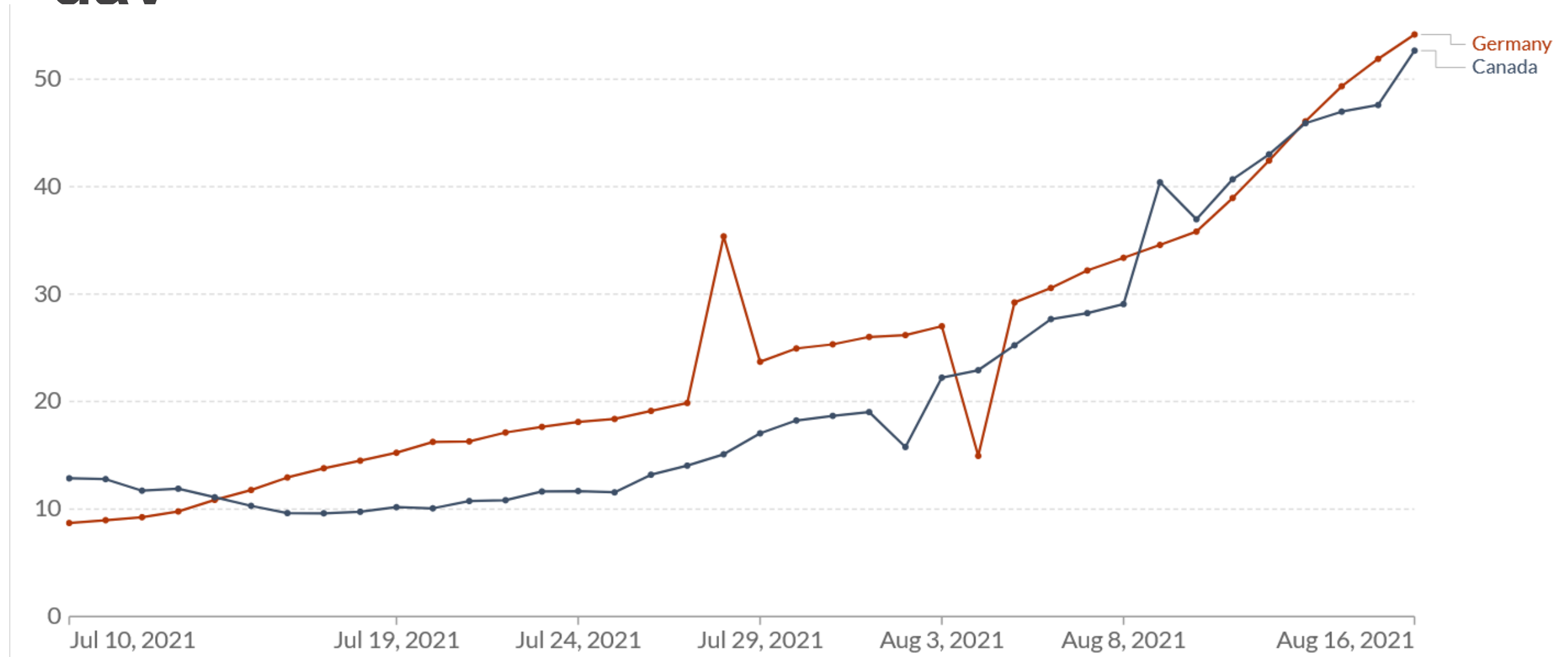
What is different about Delta?

Variant	Alpha (B.1.1.7) vs. Wuhan	Delta (B.1.617.2) vs. Wuhan
Disease severity Disease severity in children	x1.5 No change	>1.5 (?) ???
Transmissibility (Wuhan R=2.5-3)	(R=4-5)	(R=7)
Vaccine impact on disease Protection against any infection Protection against severe disease	(90%) (95%)	(70%) (94%)
Vaccine impact on transmission Reduced transmission from asymptomatic infection Reduced transmission if (pre-/ or symptomatic)		??? No change

Incident COVID-19 cases per million per day



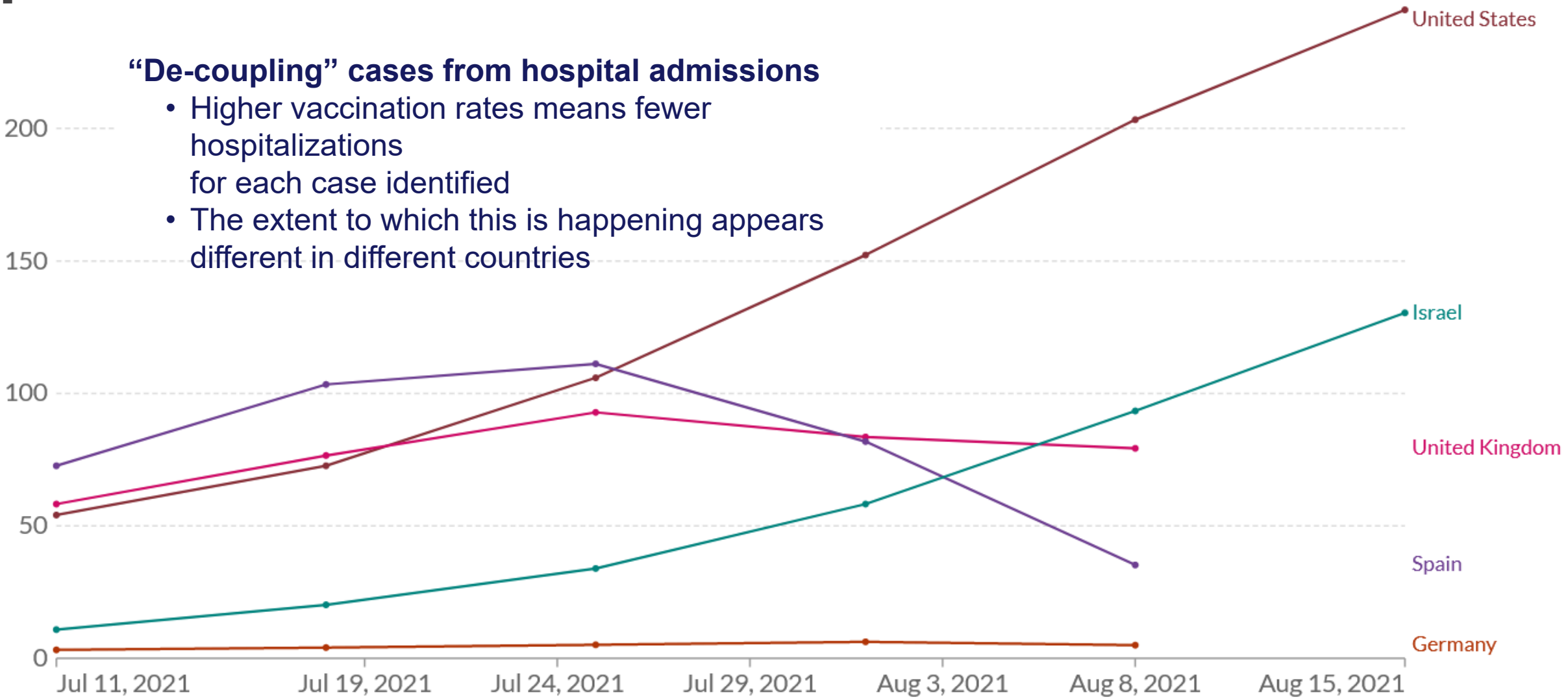
Incident COVID-19 cases per million per dav



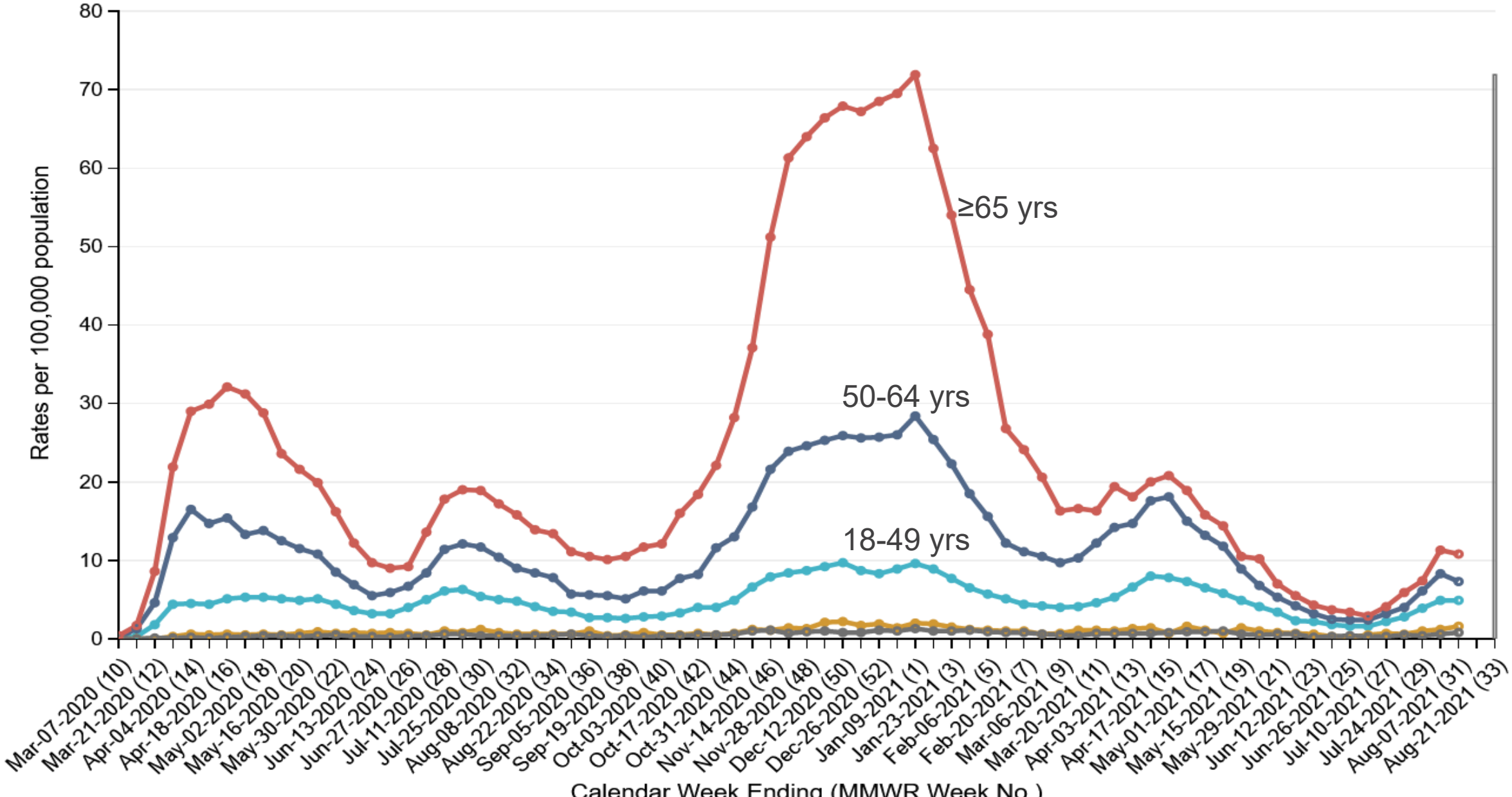
Weekly hospital admissions per million persons

“De-coupling” cases from hospital admissions

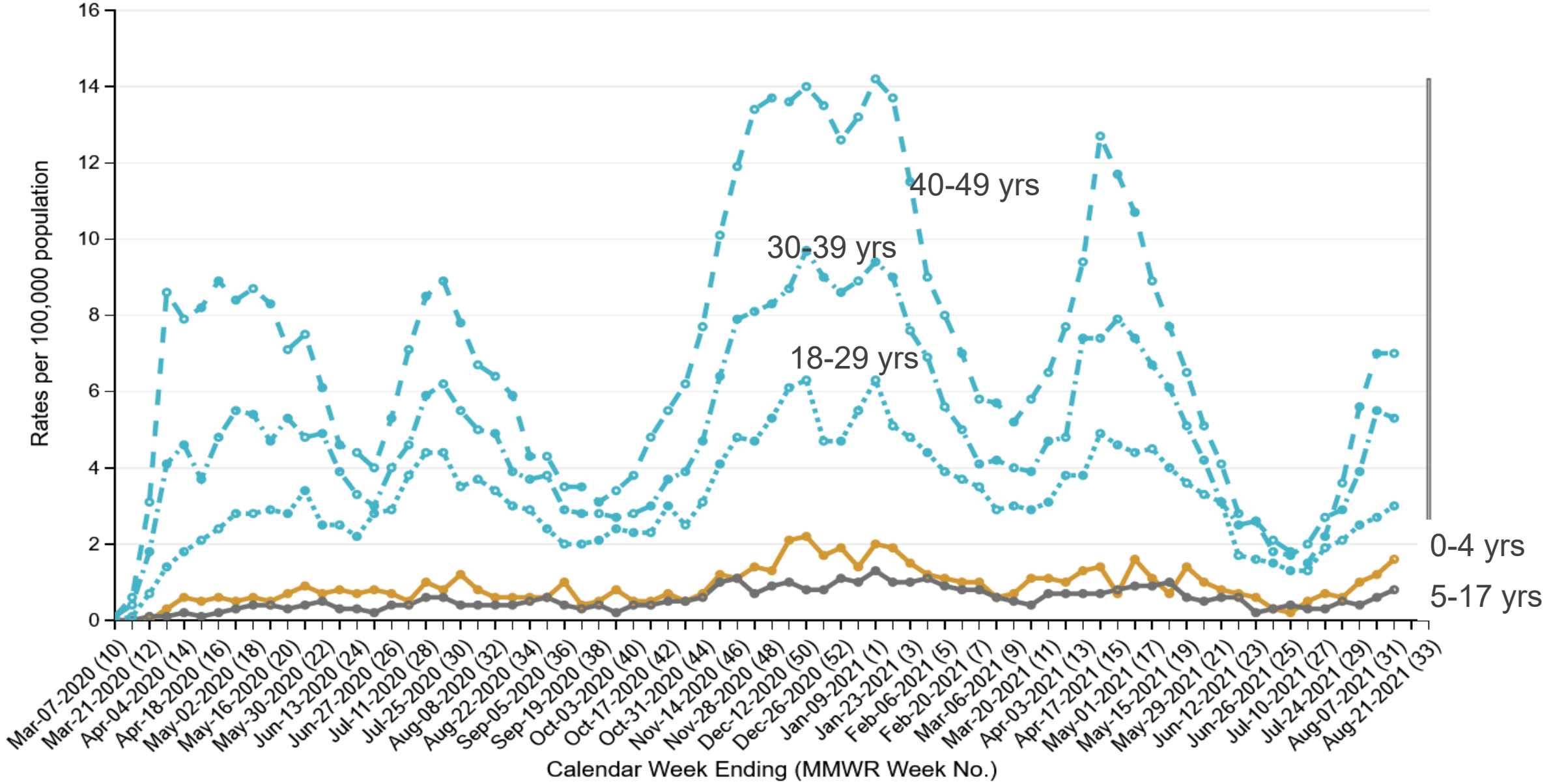
- Higher vaccination rates means fewer hospitalizations
  for each case identified
- The extent to which this is happening appears different in different countries



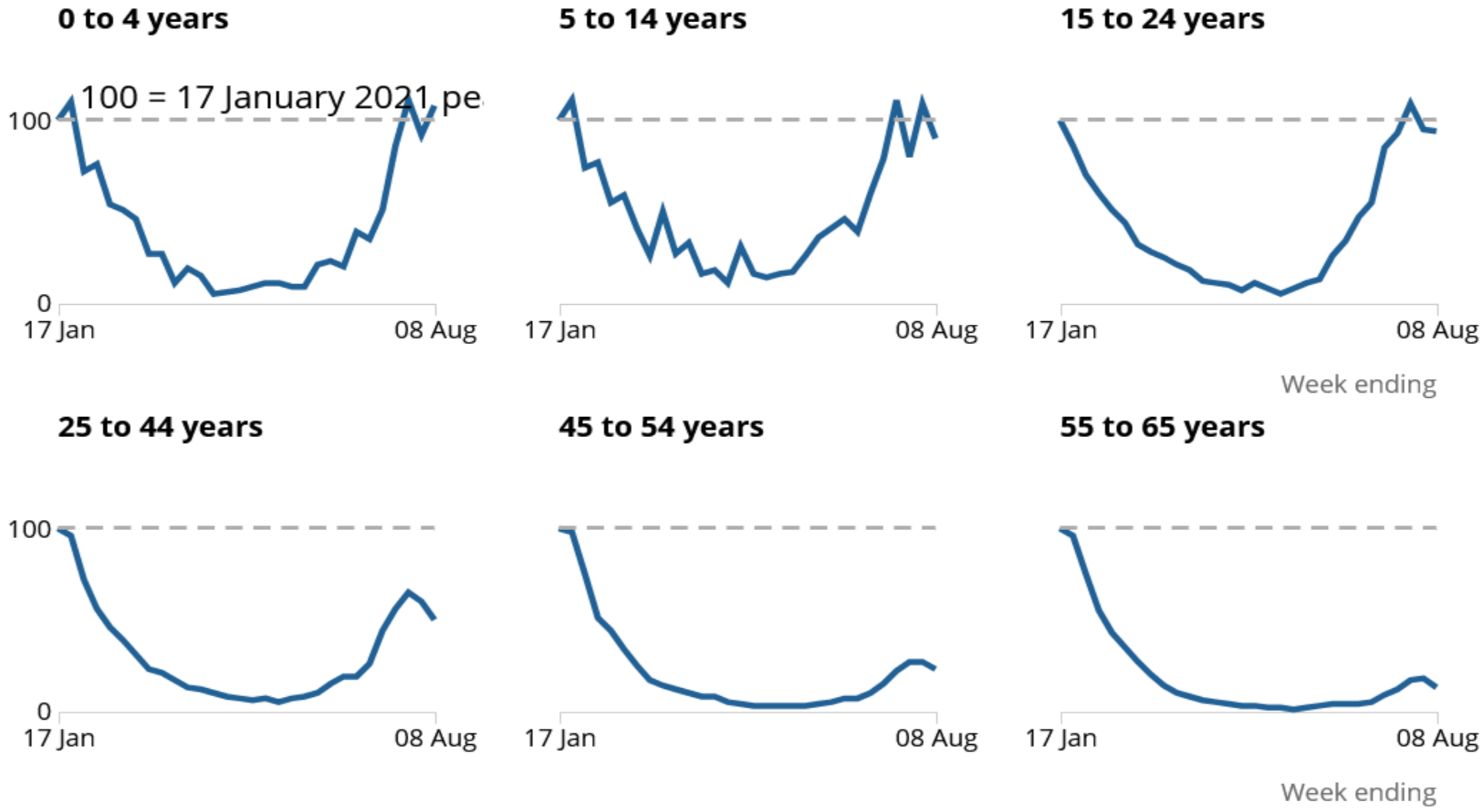
US hospitalization by age groups



US hospitalization by age group, population <50yr



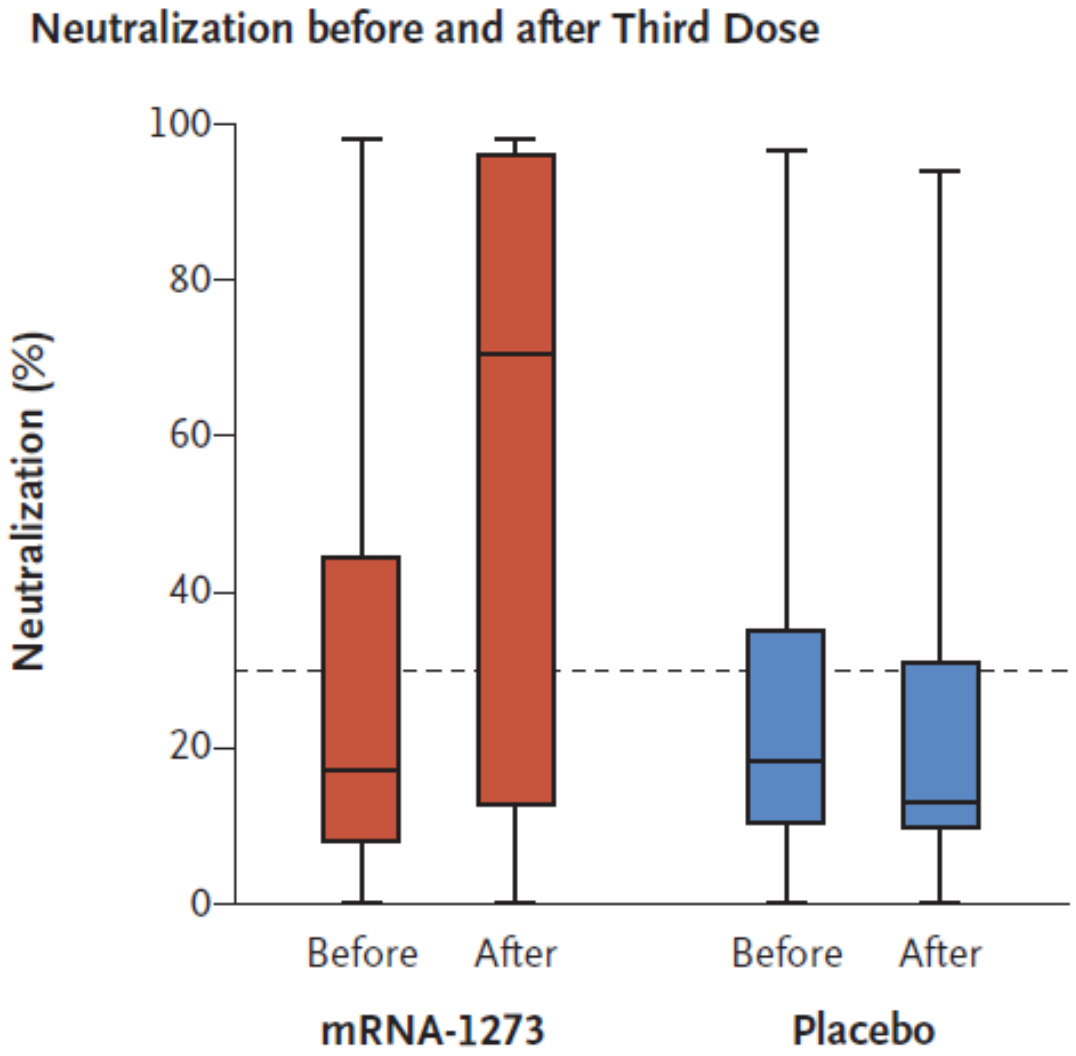
UK Hospitalization rate, August versus January



Vaccine efficacy, symptomatic infection Pfizer phase III trial

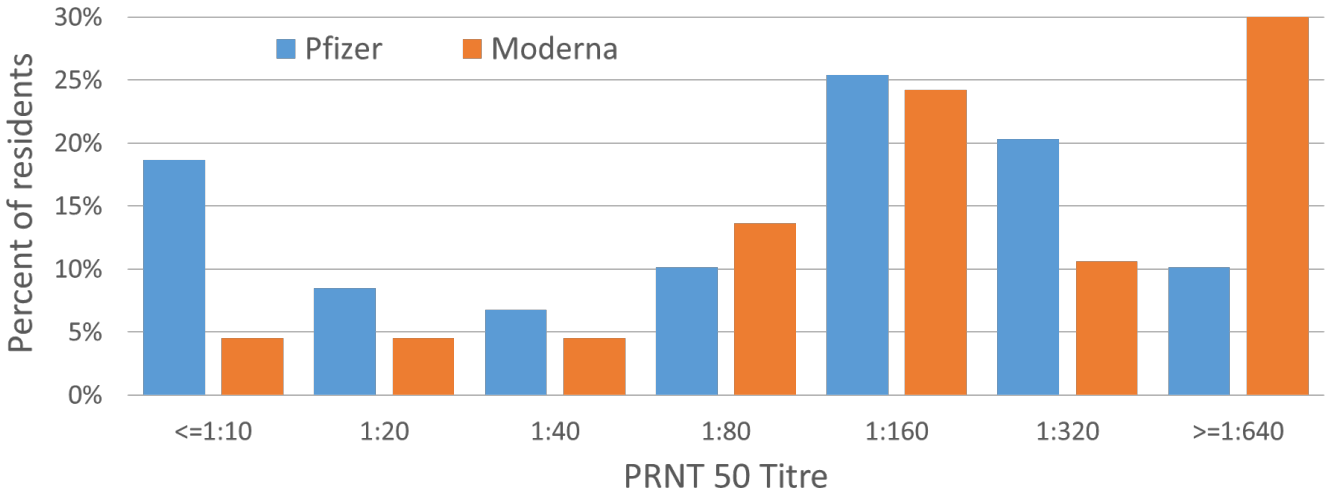
Efficacy Endpoint Subgroup	Vaccine Group				VE (95% CI)
	BNT162b2 (N=23,040)		Placebo (N=23,037)		
	No. of participants	Surveillance time (no. at risk)	No. of participants	Surveillance time (no. at risk)	
First COVID-19 occurrence after dose 1	131	8.412 (22,505)	1034	8.124 (22,434)	87.8 (85.3, 89.9)
After dose 1 to before dose 2	46	1.339 (22,505)	110	1.331 (22,434)	58.4 (40.8, 71.2)
After dose 1 to <11 days after dose 1	41	0.677 (22,505)	50	0.675 (22,434)	18.2 (−26.1, 47.3)
≥11 Days after dose 1 to before dose 2	5	0.662 (22,399)	60	0.656 (22,369)	91.7 (79.6, 97.4)
Dose 2 to 7 days after dose 2	3	0.424 (22,163)	35	0.422 (22,057)	91.5 (72.9, 98.3)
≥7 Days after dose 2	82	6.649 (22,132)	889	6.371 (22,001)	91.2 (88.9, 93.0)
≥7 Days after dose 2 to <2 months after dose 2	12	2.923 (22,132)	312	2.884 (22,001)	96.2 (93.3, 98.1)
≥2 Months after dose 2 to <4 months after dose 2	46	2.696 (20,814)	449	2.593 (20,344)	90.1 (86.6, 92.9)
≥4 Months after dose 2	24	1.030 (12,670)	128	0.895 (11,802)	83.7 (74.7, 89.9)

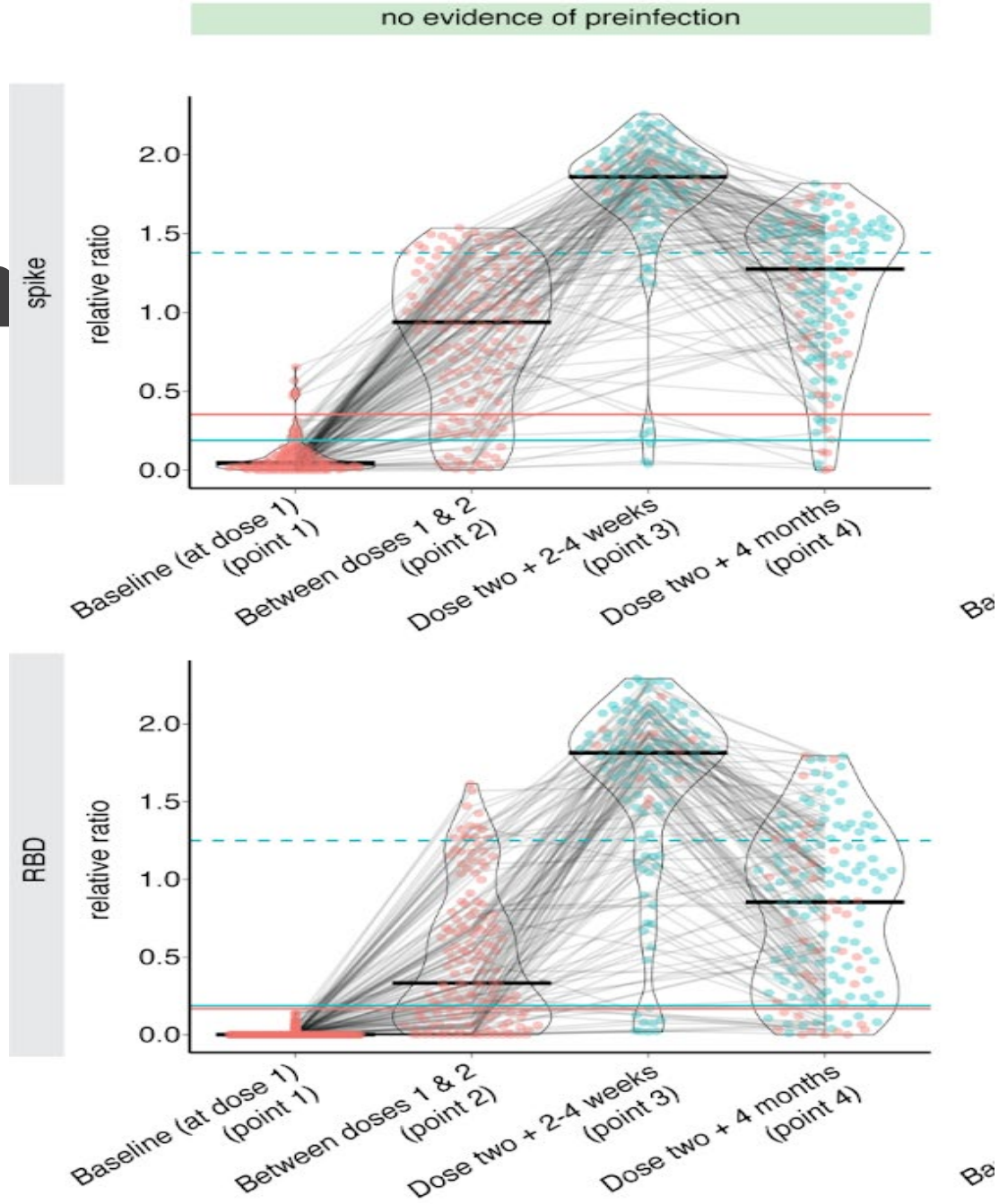
Third dose immunogenicity in transplant patients

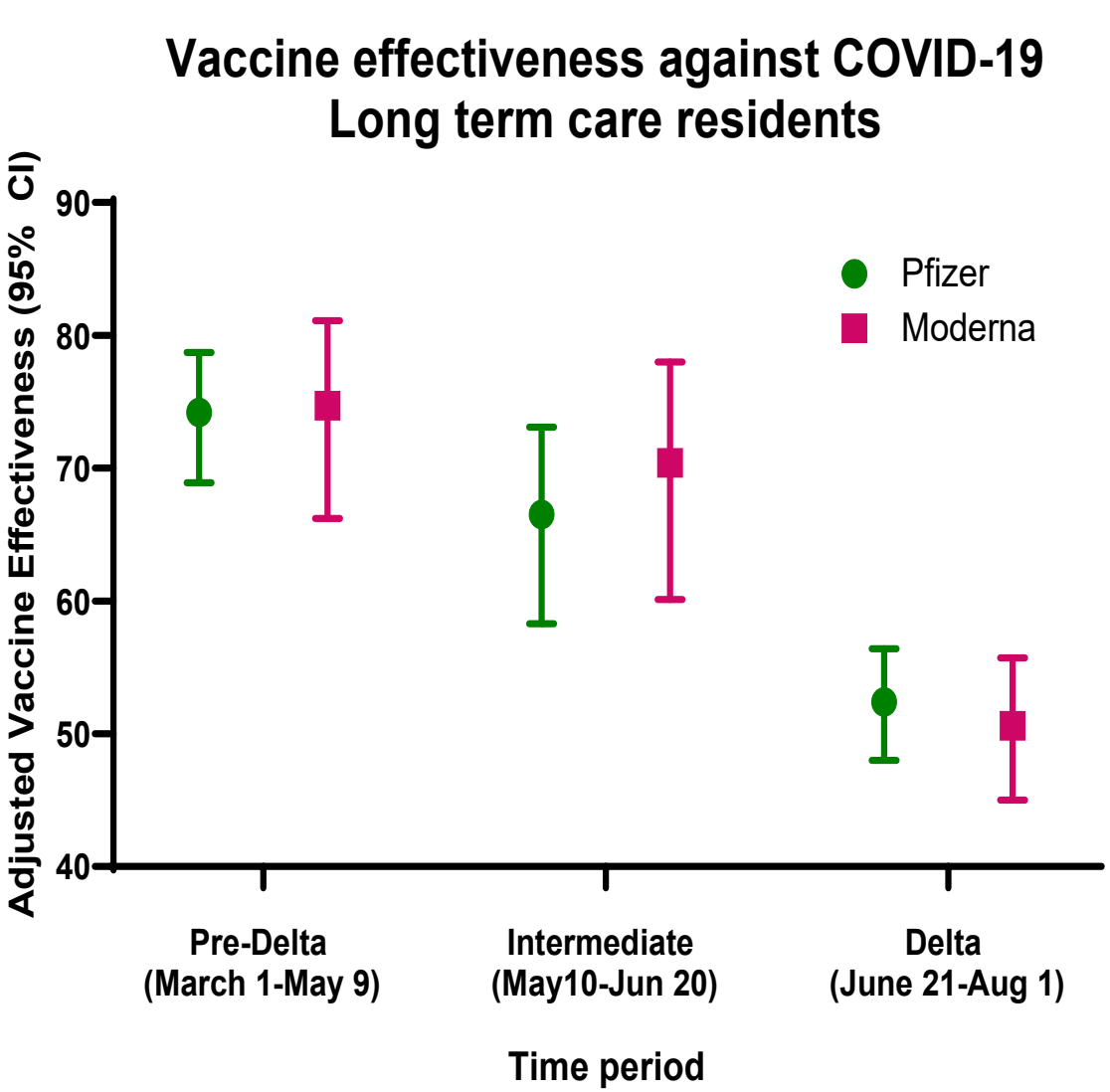


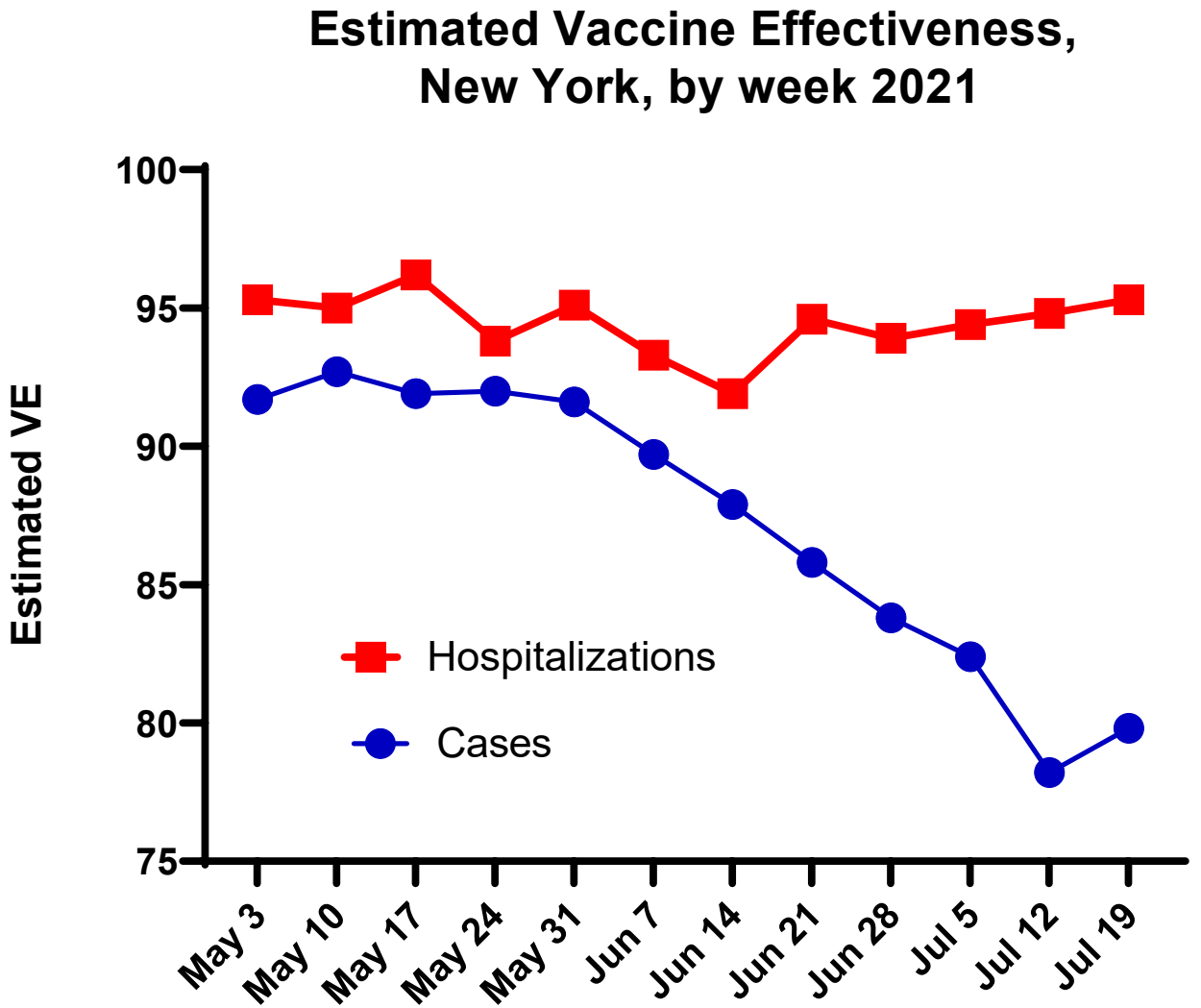
Hall VG NEJM Aug 2020

Vaccine response
Long term care residen







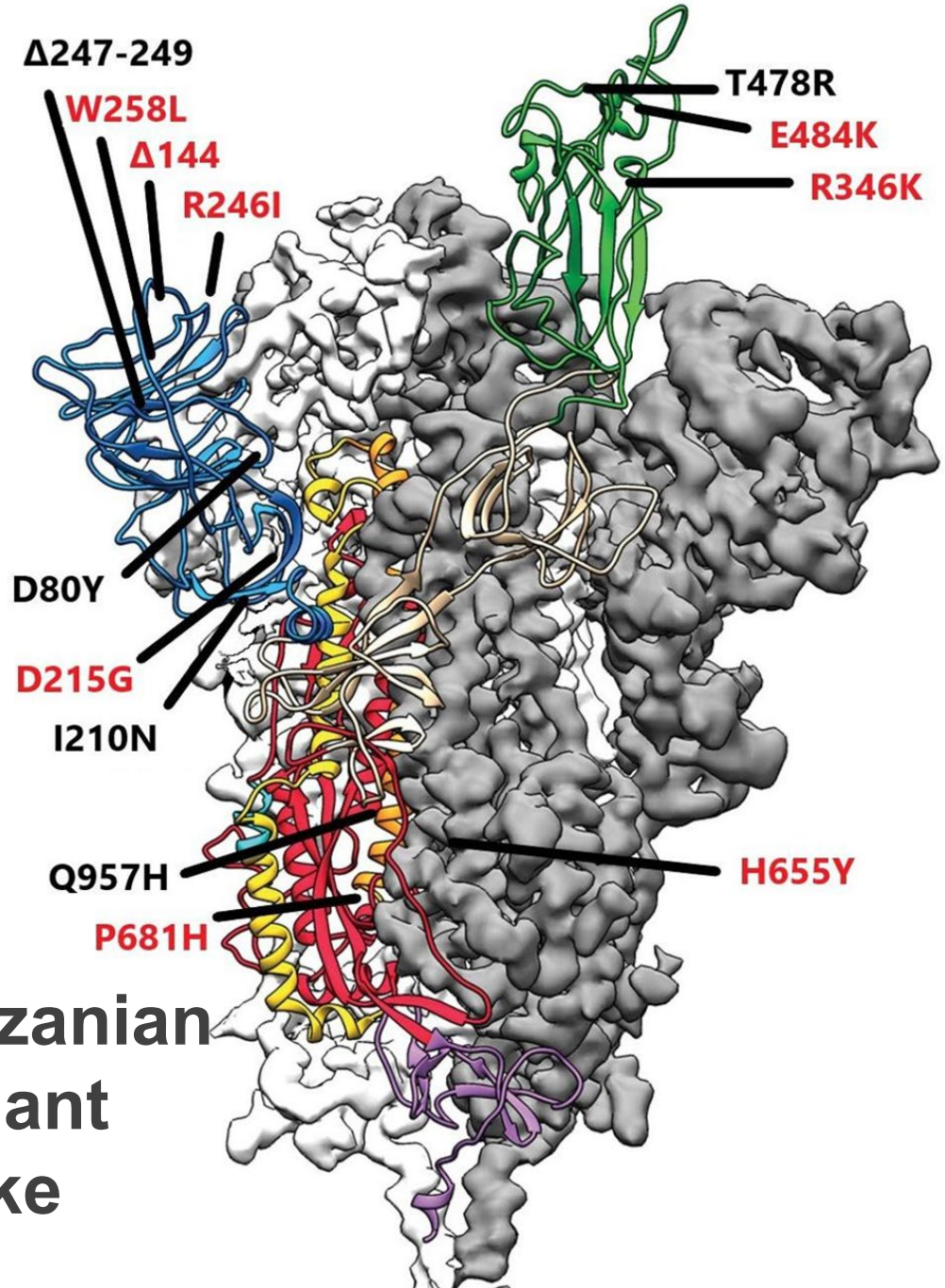


Rosenberg MMWR 18 Aug 2021. DOI: http://dx.doi.org/10.15585/mmwr.mm7034e1
Nanduri MMWR 18 Aug 2021. DOI: http://dx.doi.org/10.15585/mmwr.mm7034e3

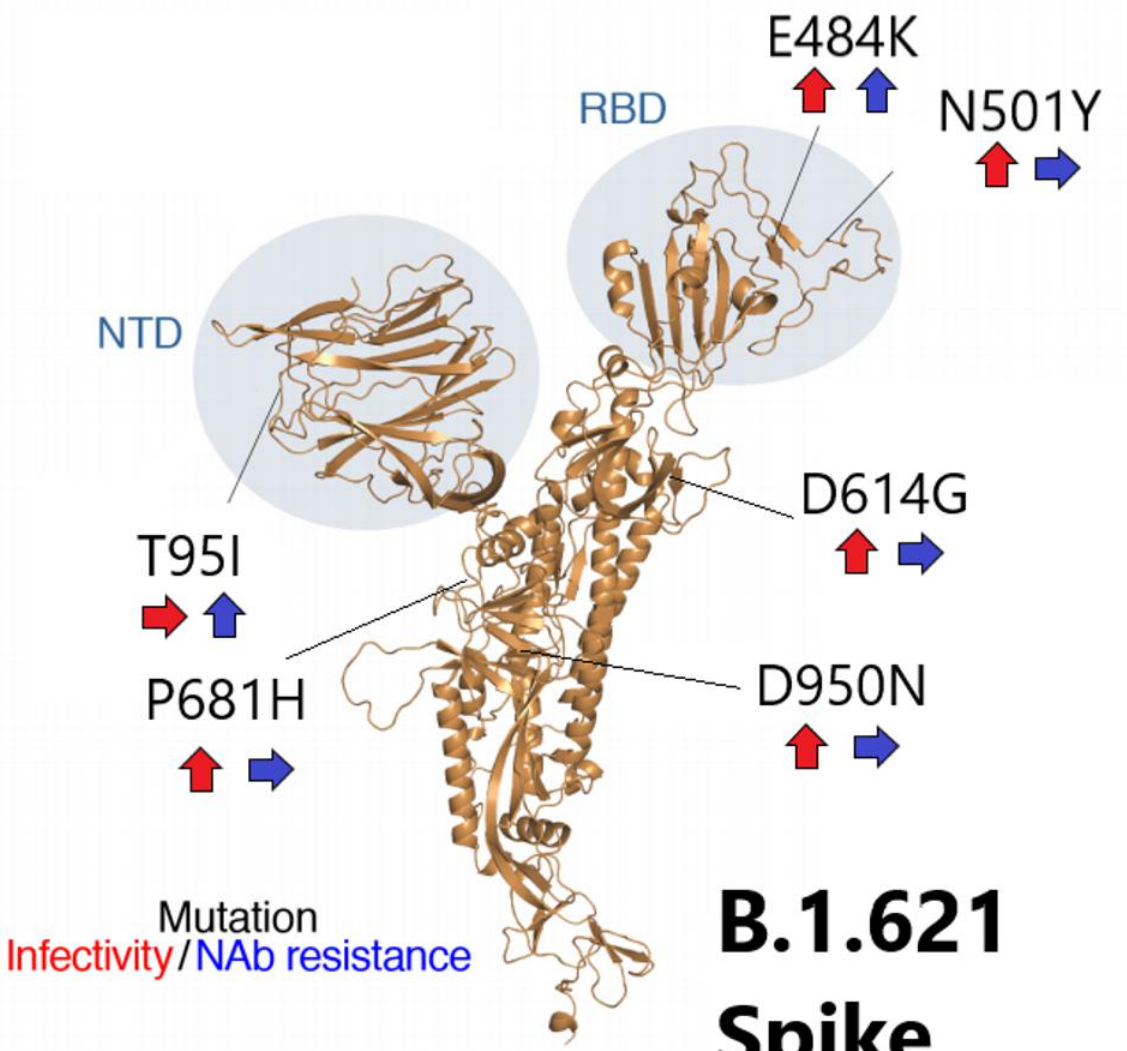
Third doses in Ontario

- Immunocompromised: 8 weeks or more after second dose
  - Transplant recipients (solid organ and stem cell)
  - Patients with hematological cancers (examples include lymphoma, myeloma, leukemia) on active treatment (chemotherapy, targeted therapies, immunotherapy)
  - Recipients of an anti-CD20 agent (e.g. rituximab, ocrelizumab, ofatumumab, obinutuzumab, ibritumomab)

- Residents of high-risk congregate settings: 5 months after 2nd dose
  - long-term care homes
  - higher-risk licensed retirement homes
  - First Nations elder care lodges.



Tanzanian Variant Spike



B.1.621 Spike

Myocardial Injury and Outcomes Following COVID-19 Vaccination (MYOVAX Study)

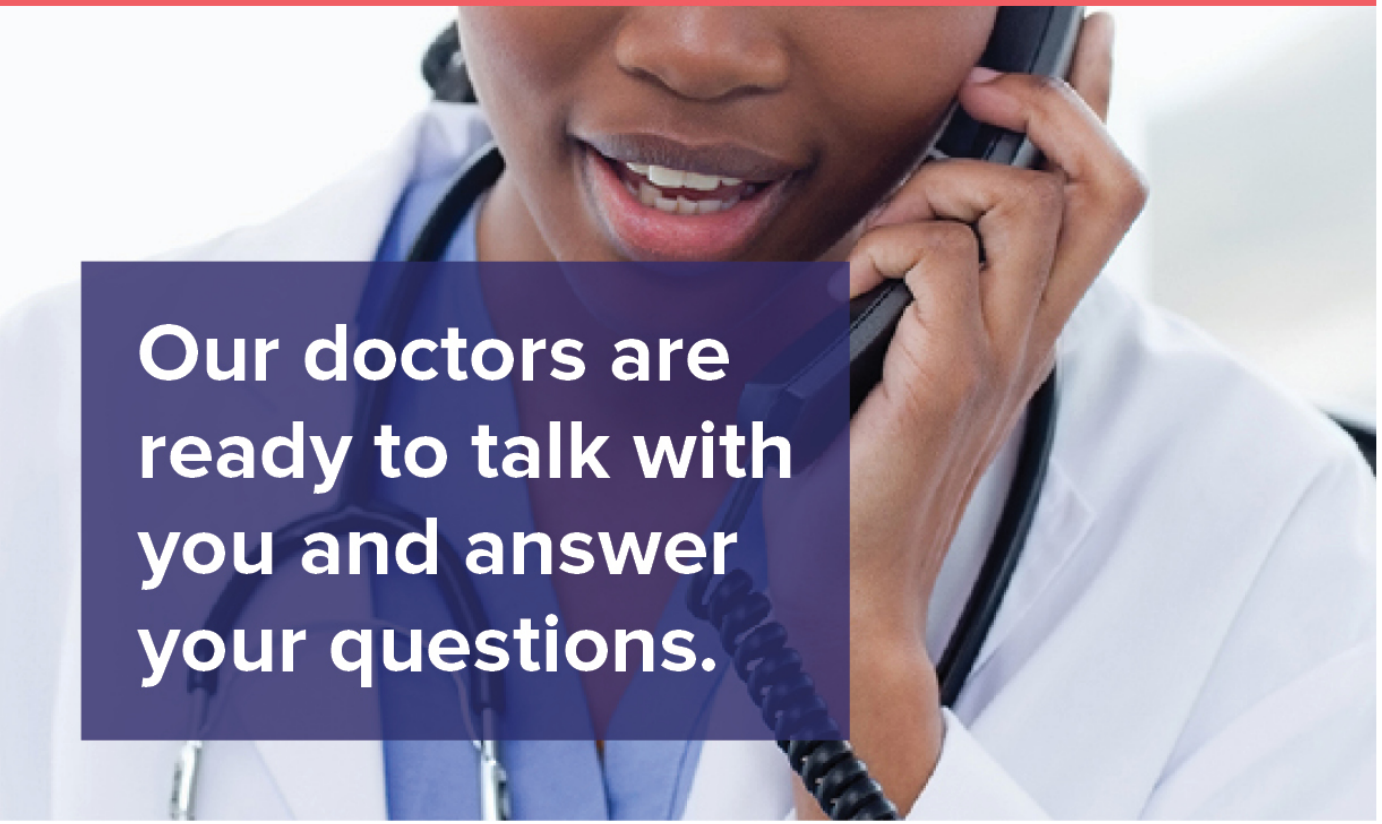
- Recruiting participants:
  - Clinical suspicion of **myocarditis presenting with new cardiac symptoms**, **ECG abnormalities** or **positive troponin levels** within 3 months of COVID vaccine administration (either dose).
- Study procedures:
  - combined PET/MRI, and blood collection

Contact:

To refer a patient: Rachel Hong, at rachel.hong@uhn.ca or 416-340-4800 x 6101

To ask questions: Kate Hanneman (kate.hanneman@uhn.ca) or Dinesh Thavendiranathan (dinesh.thavendiranathan@uhn.ca)

Want to know more about the COVID-19 vaccine?



Book a one-to-one phone conversation with one of our doctors so that you can make an informed decision:

shn.ca/*Vax*Facts

416-438-2911 ext. 5738

SHN SCARBOROUGH HEALTH NETWORK | VaxFacts CLINIC

University of Calgary: Vaccine Hesitancy Guide

https://www.vhguide.ca/

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Your Community of Practice

August 25, 2021

Are you looking to integrate mindfulness into your practice? Dr. Mel Borins, Dr. Martin Lees & Dr. Shira Taylor reflect on how mindfulness has impacted their patient care at our next Practising Well CoP. **Join us!**

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Questions?

Webinar recording and curated Q&A will be posted soon
https://www.dfcm.utoronto.ca/covid-19-community-practice/past-sessions

Our next Community of Practice: **TBD**

Contact us: *ocfpcme@ocfp.on.ca*

Visit: https://www.ontariofamilyphysicians.ca/tools-resources/covid-19-resources

This one-credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada and the Ontario Chapter for up to 1 Mainpro+ ®credits.

The COVID-19 Community of Practice for Ontario Family Physician includes a series of planned webinars. Each session is worth 1 Mainpro+®credits, for up to a total of 26 credits.

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