

Memorandum

SUBJECT: CorHealth COVID-19 Stroke Memo #5 - **RECOMMENDATIONS FOR AN APPROACH TO RAMPING UP IN-PERSON SECONDARY STROKE PREVENTION CLINIC SERVICES IN ONTARIO**

TO: Stroke Prevention Clinic Stakeholders

FROM: Office of the CEO, CorHealth Ontario

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DISCLAIMER: The information in this document represents general guidance based on current practice and available evidence. The document was developed by provincial clinical experts, reflecting best knowledge at the time of writing, and is subject to revision based on changing conditions and new evidence. This information is *intended to be* “guidance rather than directive,” and is *not meant to replace clinical judgment, regulatory body requirements, organizational, or hospital policies*. Reference to Infection Prevention and Control (IPAC) or Personal Protective Equipment (PPE) in this document should not replace or supersede the IPAC and PPE protocols or directives in place at your organization.

Recommendations for an Approach to Ramping up In-Person Secondary Stroke Prevention Clinic Services in Ontario

PREAMBLE

Ambulatory Rapid TIA/Minor Stroke and Secondary Stroke Prevention Clinics play a critical role in supporting patients, who are at high risk for acute care utilization, by limiting recurrent visits to the emergency department and preventing subsequent hospital admissions. There is up to a 10% risk of recurrent stroke within 90 days after a TIA or minor stroke, classifying these conditions as “medical emergencies”. Up to 80% of this risk is preventable with urgent assessment and treatment.¹ Imaging of the brain, as well as, intracranial and extracranial blood vessels using CT, CT angiography, or Carotid Doppler ultrasound, are vital components of the diagnostic assessment. After patients have had imaging to rule out intracranial hemorrhage, those with suspected TIA and/or ischemic stroke, should be started on antithrombotic medication (i.e. anticoagulants for atrial fibrillation or antiplatelet therapy for management of atherosclerosis). Additional treatment options include carotid revascularization for symptomatic carotid artery stenosis and vascular risk factor reduction strategies.

During the initial stages of the COVID-19 pandemic there were significant decreases in access to in-person secondary prevention stroke clinics. While some programs successfully transitioned to providing some clinic services using virtual platforms (computer or phone) and/or maintained essential visits with new restrictions, some

¹ Coutts, SB. Diagnosis and Management of Transient Ischemic Attack Continuum Review Article 2017;23(1):82-92.

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clinics paused or were altered for a variety of reasons. While virtual care continues to be an important aspect of the provision of secondary prevention services, there is recognition that certain in-person stroke prevention services are necessary. In particular, in person visits are needed for new assessments and for access to diagnostics, blood work or specific interventions.

On June 8, 2020, Ontario Health (OH) released the document [Recommendations for Regional Health Care Delivery During the COVID-19 Pandemic: Outpatient Care, Primary Care, and Home and Community Care](#) which provides high-level recommendations to support key planning criteria for resuming in-person care delivery during the pandemic. As Ontario begins the gradual resumption of in-person ambulatory care services, CorHealth Ontario has worked in collaboration with stroke prevention experts and other stakeholders across the province to discuss the gradual return to their full scope of services during the COVID-19 pandemic, including planning for the resumption of in-person ambulatory stroke prevention services. This document reflects advice from this engagement and aims to provide specific guidance and considerations for the stroke sector.

GUIDING PRINCIPLES

It is a priority to:

1. Keep front line health care providers healthy and patients protected.
2. Minimize the impact of COVID-19 on the mortality and morbidity of patients with stroke.
3. Align with province- and organization-specific infection prevention and control policies and protocols.
4. Promote clinical activities while still preserving health service resources.
5. Ensure patients continue to have access to urgent and/or essential care across the continuum.
6. Ensure the best outcomes for patients and preserve best practice stroke care as much as possible.

ASSUMPTIONS

This guidance memo was developed with the following assumptions in mind:

- The key planning criteria and associated recommendations for implementation outlined in the Ontario Health [document](#) released on June 8, 2020 are satisfied before any increase in care activities.
- Despite the need to provide the option of virtual stroke prevention care, there are situations where in-person services are necessary. The delivery of outpatient stroke prevention services will consider a hybrid model which includes both virtual (video and phone), as well as in-person care options.
- Some regions/programs will be at different stages of readiness to resume in-person stroke prevention activity due to differences in capacity, organizational directions, and/or rates of COVID-19 cases.
- Local programs and providers are in the most appropriate position to determine which clinical services are best delivered virtually or in-person, assuming patient preference is considered and the necessary provincial, regional, local and applicable health regulatory college requirements are met.
- Resumption of in-person ambulatory stroke prevention services will be a gradual process.
- The increase for in-person visits will be coordinated with other related services, recognizing the interdependent nature of the stroke system (e.g. Emergency Departments, diagnostic services, primary care providers, rehabilitation services).
- The virtual care landscape will continue to evolve (e.g. patient and provider experience, organizational models/workflow processes, health care provider responsibilities, organizational leadership/champions, compensation models, digital health, etc.).
- The delivery of stroke prevention services will need to adapt and accommodate the potential ebb and flow of care delivery restrictions along the COVID-19 pandemic trajectory.
- Although many of the tips and considerations noted below are routine best practices for Stroke Prevention Clinics, they may need to be reinforced during the pandemic.

DIAGNOSTIC TESTING

Access to in-person diagnostic testing (such as brain and vascular imaging, as well as, cardiac testing) should continue to be available to all secondary Stroke Prevention Clinic patients in an urgent manner, as per, the [CorHealth Recommendations for an Ontario Approach for Ambulatory Imaging and Cardiac Investigations for Patients presenting with](#)

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[TIA and Minor Stroke during COVID-19: Memorandum #1](#). This includes CT/CTA, Carotid Doppler, ECG and prolonged ECG monitoring (minimum of 24 hours).

TIPS AND CONSIDERATIONS

- Consider prioritization of patients to determine those who require urgent diagnostic testing.
- Consider making agreements with diagnostic services to have designated patient slots available.
- Work closely with Emergency Departments to have essential diagnostic investigations completed prior to discharge from ED when possible and applicable.
- Establish linkages with external community services such as, outpatient clinics for off-site cardiac testing.

DETERMINING PATIENT PRIORITIZATION FOR WAIT LIST MANAGEMENT

A plan should be in place to manage unanticipated wait times (e.g. for less urgent patients or those requiring follow up) as clinics begin to increase the number of patients assessed/treated in person or virtually. Prioritization decisions should align with the ethical framework outlined in the OH document released on June 8, 2020, to ensure equitable access, and should follow the [Canadian Stroke Best Practice Initial Risk Stratification and Management of Nondisabling Stroke and TIA](#).

TIPS AND CONSIDERATIONS

- Clinical judgement, Canadian Stroke Best Practice triage tool, and additional diagnostic investigations should be used to support decision making for prioritization especially when considering backlog versus current referrals (e.g. phone calls, use of support staff, etc.) Ensure mechanisms are in place for patients to have instructions regarding point of contact in the event of change in health status including ED or their primary care provider.
- Regular monitoring and review of the waitlist.
- Consider utilizing virtual care, as much as possible, to maintain access to stroke prevention services.

LEVERAGING TECHNOLOGY AND HYBRID MODELS OF CARE

A hybrid model of virtual care and in-person services should be considered or continued, as clinics ramp up services and start to see more patient volumes for in-person visits. Virtual care should be used as much as possible, when appropriate, to support/manage patient wait times, human health resources, patient preferences, and safety (infection control and exposure risk).

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CONSIDER THE FOLLOWING CRITERIA/ STANDARDS FOR VIRTUAL CARE:

- Provide access to virtual care education and resources for providers regarding virtual care best practices, stroke specific applications and their organization's virtual care policy and processes.
 - [HSF Canadian Stroke Best Practices - Virtual Healthcare \(Telestroke\) Implementation Toolkit \(June 5th, 2020\)](#)
 - [Health Standards Organization \(HSO\) and Accreditation Canada Virtual Care toolkit](#)
 - [Best Practice for Virtual Care Appointment \(OTN\)](#)
- Utilize the Heart and Stroke Foundation and other websites for resources, education, self-management, and other supports.
- Ensure individual patient needs, ability, characteristics, and preferences are considered prior to making decisions about when to use virtual versus in-person visits (e.g. vulnerable populations such as those who are immunocompromised).

CONSIDER THE FOLLOWING SERVICE COMPONENTS FOR VIRTUAL VISITS:

- Patient consent/preference should be considered when recommending in person vs virtual care.
- Gathering patient current and past medical history for the purposes of triaging the urgency of the appointment.
- Providing follow-up visits to monitor and determine compliance and effectiveness of the treatment plan and need for changes.
- Providing risk factor and behavior modification education and support. This may utilize a multi-media approach (e.g. video links, apps, group classes, written materials, video conference). Topics that may be suitable for virtual care education and support include:
 - Self-management
 - Lifestyle management (smoking cessation, nutrition, weight management etc.)
 - Medication reconciliation
 - Blood pressure monitoring
 - Baclofen pump refills (e.g., education from nurse re: how to work the pump)
- Return to driving (e.g., general information regarding the process to return to driving)
- Engaging family and care team in meetings to discuss investigation results and care plan requirements.
- Assessing and supporting how caregivers are coping.

TIPS AND CONSIDERATIONS

- Timely and effective communication among clinic team members to ensure collaborative decision making and appropriate triaging of patients to determine who will benefit from a virtual versus an in-person visit.
- Ensure a plan for staff training and support on integrating virtual care in practice. Education should be aligned with best practice and college standards.
- Implement a technical eligibility checklist to ensure basic technology and access requirements are met to host virtual visits ([e.g. OTN's PCVC Technical Readiness requirements](#))
- Contact IT services to establish a standard level of training required for all staff to optimize utilization of virtual platform e.g. virtual care etiquette, how to mute, positioning camera, who to contact for support etc. Some platforms such as OTN may already have content available for training.
- For evaluation and future planning purposes, programs should strongly consider the collection of patient/process outcomes and tracking method of virtual care versus in-person including clinician and end-user feedback.
- Virtual care if appropriate, may be facilitated by providing patients with required technology (e.g. tablet, webcam etc.), if they have internet access. This could be facilitated by Home and Community Care or Primary Care Providers.

CONSIDER THE FOLLOWING CRITERIA FOR IN-PERSON VISITS:

- Patient consent/preference should be considered when recommending in-person vs virtual care.
- Patient does not have access to or is unable to use virtual technology for the purposes of participating safely and effectively and cannot be supported to do so by a caregiver or family member (e.g. privacy, language barriers, technology/internet access).
- Patient requires an in-person clinical assessment and/or intervention by a health care provider to obtain critical information needed to inform treatment decisions which is not possible to gather accurately and confidently using virtual care (phone or video). For example:
 - New/ urgent or complex patients
 - Cognitive, communication and/or perceptual difficulties
 - Patients requiring a neurological exam
 - Patients referred from primary care providers who may not yet have been seen in person previously
 - Patients requiring specialized diagnostic tests to inform the secondary prevention care plan

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- Patients who need to be assessed for return to work and return to driving as part of post stroke recovery (e.g. cognitive assessment that requires in person context)
- Emotional distress (e.g. anxiety/depression) that can not be adequately addressed via virtual care

TIPS AND CONSIDERATIONS

- Ensure risks, benefits and updated safety practices are clearly stated and explained to patients and families to emphasize the importance of attending appointments either in-person or virtually. Messaging from clinicians to patients/families/caregivers should be consistent and include key messages such as:
 - Hospitals are safe and remain open for urgent and emergency care. In the case of an emergency, call 911 or go to an Emergency Department.
 - Following provincial directives and regional approval, organizations will move forward with plans to gradually and carefully expand some clinical services that were paused during the pandemic. Prioritization of services is based on clinical evidence and need.
 - The pandemic situation will continue to evolve in Ontario. It is important that we balance resumption of scheduled in-person care and being ready for changes from a second wave of COVID-19.
 - Patients, families and caregivers coming to the hospital may have a different experience than they might anticipate. This includes screening at the doors, physical distancing measures, changes in visitation policies, and other processes.
 - Recognize that changes in service delivery cause uncertainty and anxiety for patients and caregivers. Waiting for care can be very difficult. All treatment decisions are being carefully reviewed by the health-care team and they will continue to monitor health risk closely.
 - Patients will be notified of the need to reschedule procedures and other appointments. They will hear directly from their physician's office or other provider when their appointment(s) can be rescheduled. Patients should be provided with instructions on who to contact should they experience changes in health status.

COORDINATION AND PLANNING WITH PRIMARY CARE SERVICES AND EMERGENCY DEPARTMENT

The increase of in-person visits should be coordinated with other related services, particularly primary care providers (PCPs) and emergency departments, recognizing the interdependent nature of the stroke system.

TIPS AND CONSIDERATIONS

- Establish method(s) to regularly connect with PCPs (phone, email etc.).
- Provide summary report to patient's PCP highlighting details of visit (#visits/education/phone call check ins/follow up recommendations), request for follow up, monitoring and/or reinforcement of recommendations.
- Create links to education materials to be shared with PCP and Emergency Departments.
- Liaise with Emergency Departments to coordinate expedited diagnostic imaging and lab tests.

ADDITIONAL CONSIDERATIONS FOR RAMPING UP SERVICES

While recognizing that requirements and planning criteria outlined in the [COVID-19 Operational Requirements: Health Sector Restart](#) guidelines on May 26, 2020 (Version 1.0) as well as the OH [document](#) released on June 8, 2020 must be met, the following list provides additional considerations for resuming in-person stroke prevention services.

HUMAN RESOURCE CAPACITY

An appropriate staffing plan, including admin support, should be in place to allow secondary stroke prevention services to operate and gradually ramp up services. This plan should consider several factors including:

- The impact of expected and unexpected physician and staff absences
- Backlogs resulting from the reduction of services and reduced referrals/cancellation of visits due to fear of exposure to COVID-19
- New volume of referrals post-first wave of COVID-19, due to reduced hospital visits during the pandemic or cancellation of in-person visits due to fear of COVID-19 exposure
- Additional or alternative administration hours and/or personnel to manage hybrid model of service (virtual care and in-person)

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TIPS AND CONSIDERATIONS

- Consider adjusting clinic days/hours to optimize access to diagnostic imaging services.
- Consider, if appropriate, staggering start times amongst staff/physicians.
- Consider additional administrative responsibilities and prep time for completing virtual care “tests calls” and/or education with patients regarding virtual connection prior to their appointment.
- Consider different modalities of education/training for staff to support virtual care learning, develop and refine skills through IT to optimize service delivery (platform, safety, privacy, cyber security, college standard requirements etc.)
 - Resources and Links:
 - [OTN Direct- to-Patient Video Visits](#)
 - [Ontario MD Resources - Virtual Care the 2019 Novel Coronavirus \(COVID-19\)](#)
 - [Health Standards Organization \(HSO\) and Accreditation Canada Virtual Care Toolkit](#)
 - [CorHealth Ontario – Repository of Virtual Resources & Supports](#)

EVALUATION

Evaluation and methods to track and measure virtual care versus in person visits should be strongly considered to inform future planning. These should include clinician and end-user feedback.

TIPS AND CONSIDERATIONS

- The following basic information could be considered as a starting point: Type/mode of visit (including phone/video/in-person); TIA triage level; referral to SPC visit time; duration/repeated visits; stroke symptom onset to first contact, stroke severity, age, gender, distance from clinic/postal code.
- Obtain patient feedback at end of each visit (rating scale to determine satisfaction and if needs were met)
- Clinician satisfaction and experience with virtual care technology (eg. audit, quarterly survey, compare virtual with face-to-face).
- Monitor if best practice standards are being met through virtual care implementation.
- Monitor quality of service (in person vs. face to face).

ENVIRONMENTAL MEASURES/ PHYSICAL DISTANCING

Where in person visits are deemed appropriate, programs must comply with environmental, screening and infection control measures that meet the Ministry of Health directives and recommendations, as well as organizational and IPAC policies. Organizations should follow an appropriate hazard assessment methodology such as RACE (Recognize, Assess, Control and Evaluate) with regular monitoring to ensure existing controls are appropriate. These processes will reduce the risk of exposure for patients, caregivers, visitors and staff.

Treatment space:

- Staff should be physically distanced from patient during portions of the in person visit provided that the patient is independent/safe. Consider availability of ample clinic space for physical distancing.
 - Spread out equipment and tables in clinic area
 - Consider adding clinic rooms to assist with workflow
- Suspend group programming and consider virtual groups.
- Establish a maximum number of people allowed in the reception area at all times.
- Remove unnecessary items from the environment (e.g. equipment/decorative accents, newspaper/magazines).
- Establish flow control (tape on floor that promotes physical distancing and guides patients on where to go etc.).
- Use of plexiglass partitions in reception space.
- Do a walk-through of clinic area to help with planning optimal physical distancing.

Waiting areas/ Hallways

- Installation of plexiglass barriers if possible.
- Directional traffic in hallway/exits and/or staff meet patients in waiting room to escort patient to the clinic area.
- Advising patients/caregivers to arrive no earlier than 5 minutes prior to appointment and not to be late, as this can impact physical distancing plan.
- If travelling in their own vehicle, advising patient to wait in their vehicles until the clinic is ready to see them. The clinicians can call/text patient/caregiver on their cell phone when the space is open.
- Inform patients/caregivers of risks and benefits of attending appointments, as well as updated organizational safety practices/restrictions.

Scheduling:

- Stagger patient appointments

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- Stagger staff schedules, including, breaks and start times (e.g. schedule into early evening to allow for more overall volumes in light of physical distancing and enhances safety measures).
- Schedule vulnerable patients as first appointment of the day.
- Coordinate staff duties (ie. have some staff work virtually at specific time/days while the other portion is working with patients in-person).
- In-person visits can be alternated with virtual visits to allow for room cleaning.
- Consider flexibility for time slots and more room allocation to allow extra time for cleaning/infection control
- Consultation with Environmental services/Organizational cleaning services to increase and plan for scheduled cleaning in highly frequented areas such as clinic area, hallways and washroom facilities (e.g. cleaning between morning and afternoon treatment sessions).

Visitors/Caregivers:

- Approved visitors/caregivers should only attend secondary prevention clinic visits if needed.

SCREENING, INFECTION CONTROL AND USE OF PPE

- Pre-screening at the time of booking of all persons planning to be present at the visit, and again upon presentation at the clinic for the visit.
- Designated person doing all screenings prior to patient appointments
- Use consistent method of communicating patient expectations regarding masks, hand hygiene etc.
- Active patient/caregiver and staff screening on entry as per IPAC guidance.
- Passive screening (sign on door, wall) ONLY in conjunction with active screening.
- Process in place to communicate outcome of patient screening (+/-) from hospital door to outpatient clinic entry (e.g. checkered arm band if positive screen).
- Point of care risk assessment i.e. actions and follow up (switch to future virtual care, don PPE etc.)
- Ensure access, availability and knowledge of location of PPE and disinfectant.
- Handout for patients explaining why the provider is wearing (or not wearing) PPE or why they need a mask; use of aphasia-friendly handouts where appropriate.
- Observation of PPE donning and doffing by colleague to ensure proper procedure (especially when not regular use).

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RAMPING DOWN

SPC programs will need to take stock of lessons learned from the pandemic in preparation for a second wave or other unprecedented public health event. As such, each SPC site should develop a plan supporting the management of patients referred for SPC services, preferably within local and internal resources. Each organization should evaluate individual access to internal resources such as alternate physician support and diagnostic imaging and develop a plan accordingly.

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