Topics specific to practicing in the personal care home (PHC) setting during the COVID-19 pandemic

Speaker: Elizabeth Rhynold MD FRCPC

Planning Committee: no conflicts to disclose: specifically no relationship with any pharmaceutical companies
Elizabeth Rhynold, MD, FRCPC
Christine Polimeni, MD, CCFP
Topics specific to practicing in the personal care home (PHC) setting during the COVID-19 pandemic

By the end of these sessions, the learner will be able to:

• Apply the use of the Clinical Frailty Scale© to describe the vulnerability of older adults to adverse outcomes (Medical Expert, Communicator, Health Advocate)

• Discuss a methodology in approaching difficult conversations with patients, family and staff specifically on COVID related outcomes and goals of care (Medical Expert, Communicator, Collaborator)

• Explain the treatments for symptomatic COVID/palliative care in a PCH setting. (Medical Expert)

• Apply a protocol for usual/ chronic care during Covid-19 pandemic in a PCH setting. (Medical Expert, Collaborator)

• Utilize an Ethical Framework for wandering patients during the Covid outbreak (Medical Expert, Health Advocate)

• Discuss how to address management of delirium and malnutrition under isolation precautions. (Medical Expert)
Chronic care of residents residing in PCH’s:
During the COVID-19 pandemic

Elizabeth Rhynold MD FRCPC
Learner Objectives

• Rationalize the risks vs. benefits of delivering in-person assessments and interventions during the COVID-19 pandemic

• Recognize the 5 M’s as a framework for comprehensive care of residents living in a PCH

• Describe options for incorporating virtual care into the care of residents in the PCH

• List high yield questions when considering a transfer from the PCH to the ED or acute care

• Identify deprescribing as a priority for PCH residents and how the focus of goals has migrated during the pandemic

* Focus on medical comorbidities today is not to undermine the significance of mental health comorbidities
Things can change in the blink of an eye

The “in-person” debate: weighing the magnitude of anguish

• Be it resolved that optimized human contact is essential for the quality of life of frail older adults

• Presenter biases:
  • Affirmative team: Geriatrician
  • Opposing team: Interim PCH medical director

• Guiding document:
    • Staff – includes anyone working in LTCHs
    • Visitors – includes people coming to provide medical care
The “in-person” debate: weighing the magnitude of anguish

Risks of in-person care

• Infected staff is the vector for a PCH outbreak
• Mortality during COVID-19 outbreaks in Canada in LTC are 26 – 29%*
• During outbreaks there are significant challenges to providing care for all the PCH residents

Benefits of in-person care

• Decreased isolation
• Better communication (complicated by masks)
• Increased accuracy of assessments
• Quality over quantity of life
  • Average length of stay in PCH approximately 18 months*

Shared Health recommendations

• COVID-19 Guiding Document on Long-Term Care Communication & Symptom Guidelines:
  • March 31, 2020

Action Plan:
Taking these facts into consideration, the following are recommended:

1) Personal Care Homes (PCHs) should limit the number of physical visits from clinicians (physician or nurse practitioner):
   a. Each PCH should identify one clinician to visit only once per week at a set time and that clinician will cover the entire home for urgent in-person assessments;
   b. PCHs should provide a clear schedule of which clinician is responsible for the weekly on-site visit, what time they will visit, and a mechanism to inform the clinician of each patient that has an urgent need to be seen;
   c. PCHs can choose to have a single clinician cover the home for several weeks in a row for “on-site visits” if they choose;
   d. The clinician who is responsible for the weekly on-site visit should travel directly from their home to the PCH to reduce risks of community contamination; and should not be working across health care facilities, and should not be concurrently providing care to COVID-19 positive patients (i.e. in-patient care);
   e. The clinician who is responsible should only take what they need to make rounds (i.e. properly cleaned stethoscope, pen, phone) and not other bags/items that can be potential vectors of infection; these should be appropriately cleaned between patients;
   f. The remaining clinicians for the PCH should continue to “round” on their own patients through a virtual presence. This can be done at a pre-set time or on a case by case basis. All routine, non-urgent, follow-up, lab tests, and such should go to the regular attending physician for management through telephone/fax communication or to manage through a virtual video consultation. Any patients that require a physical assessment that cannot be completed by the available nursing on site, should be put forward to the identified On-Site Clinician for the week.
Case 1: Mrs. T recently admitted from acute care

Mrs. T is 94 years old. She was living with her daughter prior to a hip fracture. She was not able to regain mobility independence after her ORIF.

Medical model

• PMHx: hypertension, hypothyroidism, c-section, right TKA
• Meds: levothyroxine, amlodipine, acetaminophen with tramadol as needed, venlafaxine
• O/E: vitals stable, mild pallor, chest clear, BS clear
• Labs: Hbg 99, MCV low normal, electrolytes normal, creatinine 100, TSH slightly high, T4 normal
Case 1: Mrs. T recently admitted from acute care during the COVID pandemic but no outbreak

Mrs. T is 94 years old. She was living with her daughter prior to a hip fracture. She was not able to regain mobility independence after her ORIF.

**Medical model**
- PMHx: hypertension, hypothyroidism, c-section, right TKA
- Meds: levothyroxine, amlodipine, acetaminophen with tramadol as needed, venlafaxine
- O/E: vitals stable, mild pallor, chest clear, BS present
- Labs: Hbg 99, MCV low normal, electrolytes normal, creatinine 100, TSH slightly high, T4 normal

**Geriatric model supplements medical model**
- Cognition: some repetitiveness when living with her daughter, delirium peri-operatively
- Mobility/falls: fall in acute in the middle of the night going to the bathroom independently
- Nutrition: petite, eats like a bird, encouraged to drink, lost 20 lb peri-operatively
- Elimination: constipated, bladder urgency resulting in incontinence
What is geriatrics? The Geriatric 5 M’s

• In 2017 4 U.S. M’s and 4 Canadian M’s added together to make the 5 M’s launched by Yale’s Dr. Mary Tinetti at the 37th CGS Annual Scientific Meeting

• Originally conceptualized to help explain what geriatricians do during a comprehensive geriatric assessment

• An excellent framework to approach the care of any complex frail older adult

• New admissions are an excellent time to initiate or refresh a comprehensive assessment with a geriatrics approach

• With the team available at a PCH this does not require a specialized geriatric referral – the team is already there!

https://www.cfp.ca/content/cfp/65/1/39.full.pdf

Dr. Frank Molnar
Canadian Geriatrics Society, CME Journal
Case 1: Mrs. T’s 5 M’s guiding initial priorities

- **Matters most:** How is she feeling? What does she want most from our care? For example – does she prioritize fracture reduction? Can she participate in these abstract conversations? Can we involve her family as part of her care team?

- **Multi-complexity:** New diagnosis of osteoporosis. Is her pain well controlled? Is tramadol causing constipation contributing to poor appetite? Is her creatinine increased from pre-op baseline? Is she dehydrated? Is her hemoglobin gradually coming up?

- **Medications:** Is the venlafaxine new? Is it contributing to hypertension resulting in the amlodipine prescription

- **Mobility:** Recent falls – can she participate in gait and balance exercises? Does she have an orthostatic drop?

- **Mind:** Is Mrs. T depressed or can the venlafaxine be tapered at some time? Has her repetitiveness progressed after her delirium. She will be high risk for delirium.
Proposed model for long term care

• Initially, there are a lot of active medical considerations for Mrs. T

• Dr. Janice Legere, a physician splitting her time between long term care and palliative care, proposes a future long term care medical model using the “Bow Tie Model*”

*Philippa Hawley The Bow Tie Model of 21st Century Palliative Care J Pain Symptom Manage. 2014
Proposed model for long term care

- Dr. Janice Legere:
  - Apply this model to medical care after admission building on advanced care planning prior to admission
  - This is a specialized area of medicine because our residents are not going to “recover” to leave the PCH and have a short average life expectancy
  - She emphasizes this is a medical model appropriate for the stage of frailty in the PCH but does not advocate for PCH’s to be mini hospitals
  - The future is in expanding the evidence-base for appropriate disease management for each medical condition

- Discussion continued during the CGS COVID LTC working group because many thought the model applied to the stage of frailty not to where the person was living

Summarized May 29, 2020 at CGS COVID-19 LTC working group meeting
Any proposed model for long term care needs to respond to progressing frailty

- CSHA followed older adults for 5 years. There was an incremental decrease in survival with each stage of frailty (see graph*)
- The resident’s current frailty status and the rate of frailty change helps clinicians apply or modify guidelines for individual medical conditions
- Guidelines are starting to be released with recommendations based on frailty

Disease management in long term care

• Osteoporosis Canada Recommendations for preventing fracture in long-term care 2015 [https://www-cmaj-ca.uml.idm.oclc.org/content/187/15/1135.long](https://www-cmaj-ca.uml.idm.oclc.org/content/187/15/1135.long)
  • Residents at high risk: prior hip or spine fracture or more than on prior fracture, recent glucocorticoids, high risk prior to LTC with treatment
  • Advise active appropriate osteoporosis treatment

• Diabetes Canada Guidelines 2018
  • Frail and/or with dementia CFI (index), high risk hypoglycemia HbA1C 7.1 – 8.5%, preprandial CBGM 6 – 9, End of life individualized [http://guidelines.diabetes.ca/cpg/chapter37#sec6](http://guidelines.diabetes.ca/cpg/chapter37#sec6)

  • Communication strategies, information sharing, accurate weight measurement, education needs, physical activity, practical tips related to nutritional recommendations
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- [https://www.rxfiles.ca/rxfiles/](https://www.rxfiles.ca/rxfiles/)
- Free from any PMH desktop

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Case 1 Part 2: Mrs. T develops acute back pain

• 6 weeks after admission to the PCH Mrs. T was being assisted to the toilet and “plopped down” during hs care.

• She develops acute back pain in her lower thoracic region suspicious for a vertebral compression fracture.

• Her primary care provider is called because she is in intense pain. They wonder if she needs transfer to the ED for x-ray and further assessment.

• She receives 3500 mg daily scheduled acetaminophen since admission. She is on vitamin D, calcium in her diet and 500 mg daily, denosumab because her estimated CrCl is 25 mL/min – first dose 2 weeks ago.
  • She has had blood work approved by the medical director because drawing electrolytes will change her management if she is hypocalcemic due to the denosumab.
  • She does not have hypocalcemia.
Case 1 Part 2: Mrs. T develops acute back pain

• Her admission ACP GOC discussed with her, and her family is M – medical management.

• She is moderately frail with good initial quality of life settling into the PCH – despite the fact the family has not been able to visit.

• After staff gave her the hs pills including acetaminophen 1000 mg and settled her into bed she requested a video call with her family. She was crying when she talked to her daughter.

• The daughter called the nurses desk, grateful her mother is in the PCH and can get help. She asks what was being done about her mother’s back pain – the daughter knows people can have back fractures from osteoporosis.
Virtual care – in PCH - Routine

• PCH care has included collaboration between nursing and practitioners long before COVID-19

• COVID: There is a recent increase in relying on the on site nurse and the weekly visit from a single practitioners which is increasing the feeling of fragmented or incomplete care

• Publication of evidence and tips for providing virtual care is just starting to appear
  • CGS Virtual approaches to cognitive screening during pandemics https://canadiangeriatrics.ca/wp-content/uploads/2020/05/Virtual-Approaches-to-Cognitive-Screening-During-Pandemics_FINAL.pdf
  • GEDC Tips for Emergency Department Telehealth https://gedcollaborative.com/article/jgem_vol1_issue7/
My virtual care tips – staff collateral first

Start a problem list with plans – Addressing geriatric presentations is rarely a single linear intervention

1. Request standard faxed/verbal information ahead of staff collateral – customize so staff knows what you will be wanting on the phone
   - Admission history & physical and operative reports
   - Previous specialist consultations (neurology, geriatric medicine, cardiology etc.)
   - Assessments by allied health (occupational therapy, physiotherapy, speech language therapy etc.)
   - Tests not available on eChart and PlazaWeb (Holter monitor, echocardiogram, ABI etc.)
   - The MAR including PRN and wardstock use for at least 30 days
   - The most current weight and a sample of old weights
   - The vital sign graphics and charting of bowel movements
   - Progress notes if relevant for tracking of challenging behavior and agitation

2. Review of eChart before discussion with staff/resident/family
My virtual care tips – staff collateral

I recognize most PCH primary care assessments will be focused – these are things I find feasible remotely

3. Press for the timeline of changes and patterns (D.O.S. charting*)

4. Ask about changes in the 5M’s along that timeline
   • Review associated changes rather than a symptom in isolation
   • e.g.. edema → nocturia → sleep disruption

5. Pose the potential treatment options explicitly
   • In case some strategies have already been tried
   • To discuss perceived barriers

6. Ask for blood pressure after lying for at least 5 minutes and standing at 1 minute and 3 minutes

D.O.S. charting* is Dementia Observation System weekly one page trend
https://ltctoolkit.rnao.ca/node/1220
My virtual care tips – resident assessment

• In general frail older adults seem to like to book a time for the conversation
• Telephone:
  • Helpful to have someone there who can hear the conversation e.g. speaker phone and repeat questions but I can hear the response
  • Start the visit saying you are going to ask the resident the questions and then get ascent for others to share answers
  • Ask staff to describe any pointing or non-verbal communication
  • I have been frustrated by cognitive assessment
My virtual care tips – resident

• I have been surprised how many of my video TeleHealth assessments to date have included the participation of the resident
  • Sometimes they do not stay for long
  • If they are not able to participate I consider it a detailed care conference and try to make it clear in my documentation that I have not assessed the resident in person or by virtual technology
My virtual care tips – resident assessment

• Video:
  • Surprisingly helpful for establishing rapport and for comprehension
  • A lot of information to be gained from cognitive assessment
    • Consider the Mini-Cog: Immediate 3 word repeat, Draw a clock hands “10 past 11” and recall 3 words https://mini-cog.com/
• Physical examination:
  • Mental status - repetitiveness, distraction, alertness, agitation, volatility, apathy
  • Language – slur, word-finding, confabulation (better with collateral ahead of time)
  • Respiratory – difficulty with full sentences, tachypnea (dyspnea), tripodding
  • CV – lower extremity edema (if in bed ask about lower back pitting edema)
  • GI – swallowing, icterus, jaundice, asterixis
My virtual care tips – resident assessment

• Video continued:
  • Neurological –
    • Facial symmetry, extra-ocular movements, single eye vision, reading
    • Neck and arm range of motion
    • Motor strength - against gravity with range of motion testing otherwise requires assistance
    • Sensory – only with assistance
    • Tremor – resting (if obvious) and arms outstretched
    • Ataxia – finger nose (with assistance), heal shin
    • Parkinson’s – masked facie, decreased blink, bradykinesia, micrographic, axial rigidity and postural instability. Inadequate assessment of extremity tone and cog-wheeling.
    • Reflexes – upper motor neuron more feasible than lower motor neuron with untrained assistance
My virtual care tips – resident assessment

• Video continued:
  • Changes in transfer independence day-to-day
    • If you are monitoring someone quite closely a change (for better or worse) in independence going from lying/reclining to sitting upright unsupported is a very important prognostic sign
  • This has been validated in acute care as part of the HABAM
• Gait - Timed Get Up and Go*
  • Resident stands from a chair, walks 3 meters, turns, walks back to the chair and sits down
  • Transfers can reveal axial rigidity
  • Standing an precipitate orthostatic unsteadiness
  • Turns can be en bloc or reveal falls risk
• RESPONSIVE TO CHANGE

My virtual care tips – family engagement

• I prefer to talk to the family after I have the collateral from the staff and have assessed the resident
• Ideally, they are expecting my call
• I ask them about their main priorities on behalf of their family member
• I ask them about their observations
• I often start my summary with an overall opinion about the resident’s frailty status because it frames the rest of my recommendations
  • The Frailty Journey http://intranet.pmh-mb.ca/Document_Search/Shared%20Documents/PMH1359.pdf#search=frailty%20journey
  • https://en.horizonnb.ca/media/595643/hhn-0431_frailty__web__.pdf
• Since COVID-19 I am providing more information to families by email
# PCH Billing Codes Introduction

<table>
<thead>
<tr>
<th>Existing Code</th>
<th>New Code (Virtual care)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8511</td>
<td>8527</td>
<td>Chronic care virtual assessment</td>
</tr>
<tr>
<td>8529 (equivalent)</td>
<td>8321</td>
<td>Acute virtual care visit</td>
</tr>
<tr>
<td>8000</td>
<td>8000</td>
<td>Communication initiated by another health care team member</td>
</tr>
<tr>
<td>8473</td>
<td>-</td>
<td>Virtual family conference – submit but may not be successful</td>
</tr>
<tr>
<td>8474</td>
<td>-</td>
<td>Virtual case management conference – submit but may not be successful</td>
</tr>
<tr>
<td>Hourly</td>
<td></td>
<td>Quarterly Medication Reviews as negotiated – virtual included</td>
</tr>
</tbody>
</table>

This information is provided in an attempt to help you in your PCH work. Please do not consider it definitive. Consult the Physician’s manual and Manitoba Health for all you billing clarifications. For more information, contact Roger Jamieson (rjamieson@doctorsmanitoba.ca).
Urgent - virtual care

• I’d like to present a proposed new communication tool for conversations about the urgent management of changes in clinical status

• Would the use of these focused questions on an initial call with staff guide the need for urgent virtual care contact with the resident?
  • If they are able to participate
Case 1 Part 2: Mrs. T’s acute back pain

Communication Guide Re: Mrs. T’s back pain

1. It is reasonable to think about the ED approach to acute back pain
2. She has a recently discussed ACP GOC – Medical
3. An x-ray and IV pain relief cannot be done at the PCH
   • But does she need these interventions?
   • We know the most likely diagnosis
     • Assess for pain with percussion over the thoracic spine
     • Rule out focal motor weakness, sensory deficit
   • We haven’t tried stepping up on site analgesia
   • I feel pretty confident talking to the daughter if she has questions about a plan to treat on site if required
Case 1 Part 3: Mrs. T’s back pain has settled but there is now an outbreak in the PCH

• A month later Mrs. T is back to her baseline prior to her compression fracture
• Mrs. T does not have COVID-19 but unfortunately there are a number of staff and residents who have become infected by the coronavirus
• Infected residents have been cohorted and their care needs are quite high
• Mrs. T’s medications are reviewed again with another view to decreasing the frequency of medication passes
Mrs. T’s medication list

- Levothyroxine 75 mcg daily
- Amlodipine 5 mg daily
- Acetaminophen 1000 mg am, noon, hs and 500 mg at 1600
- Venlafaxine 37.5 mg
- Vitamin D 1000 units daily
- Calcium 500 mg daily
- Hydromorphone 1 mg QID
- Denosumab 60 mg subcut q6 months
- Hydrochlorothiazide 25 mg daily
- Vitamin B12 1000 mcg daily (> 1400 in admission blood work)
- Sennosides 2 at hs
Medication administration during an outbreak

**Goals:**

- Reduce the risk of viral transmission between staff and residents
- Reduce workload demands on staff in anticipation of increased demands during the pandemic
- Minimize PPE use
Checklist for Optimizing Medication Management in Long-term Care Settings during COVID-19 Pandemic
(adapted from https://www.pharmacy.umaryland.edu/centers/lambda/optimizing-medication-management-during-covid19-pandemic/)

Goals: Reduce the risk of viral transmission between staff and residents
Reduce workload demands on staff in anticipation of increased demands during the pandemic

Med Changes should be made using a stepwise approach prioritizing:
1. Changes that are essential for infection control (especially measures to reduce duration/frequency/risk of medication passes among residents with known or suspected COVID-19)
2. Changes that are low risk, easy to evaluate, and can be done immediately
3. While avoiding changes that might be riskier, time-consuming, or necessitate increased monitoring

4 possible review scenarios:
1. During quarterly medication review
2. By the practitioner as time allows prior to an outbreak recognizing work-load for all during an outbreak with be heavy
3. By the consultant pharmacist when they are informed a facility has an outbreak
4. By the practitioner at the time of an outbreak
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- Vitamin B12 1000 mcg daily (> 1400 in admission blood work)
- Sennosides 2 at hs

Not the time:

- Will staffing allow to do regular blood pressures for a short time
- Is she coping with the outbreak adequately,
- is this the time to discontinue the venlafaxine
- Might she then not need the amlodipine
- Might she then be able to get off the hydrochlorothiazide for cosmetic peripheral edema?
This is a list for consideration

Mrs. T’s medication list
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• Amlodipine 5 mg daily
• Acetaminophen 1000 mg am, noon, hs and 500 mg at 1600
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• Hydromorphone 1 mg QID
• Denosumab 60 mg subcut q6 months
• Hydrochlorothiazide 25 mg daily
• Vitamin B12 1000 mcg daily (> 1400 in admission blood work)
• Sennosides 2 at hs

Mrs. T’s care needs cannot be met by discontinuing her:
• Calcium
• Vitamin D
• Blood work for hypocalcemia
• Denosumab
• Adequate analgesia
Conclusions

• There have been changes in the PCH environment due to COVID-19 that are negatively impacting some personal care home residents

• The risk of an outbreak in a PCH in PMH is going to continue for some time and the outcomes can be horrific

• We are all learning new things during COVID-19
  • Virtual care can be used to assess and manage some components of various chronic conditions and urgent changes in health status because of the interdisciplinary nature of the personal care home
  • There may be ways to make rational medication changes that do not change the long term outcomes for our residents but decrease the day-to-day time to pass medications and this may decrease the risk of COVID-19 transmission when the virus is in the building
Time for questions

• Upcoming topics:
  • June 10 – Delirium in the PCH during COVID
  • June 17 – Behavioral support including ethical considerations during COVID
  • June 24 - ???? What else do we need to talk about

• I have a question for you!
  • What other topics would interest you for June 24th?
    • Mental health challenges during COVID-19
    • Rehabilitation after COVID-19
  • If questions or topics come to you email Nancy Stinton