THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Foundation for Advancing Family Medicine
Fondation pour l'avancement de la médecine familiale

Advancing Family Medicine During the Pandemic: Co-RIG Phase I

Funding Acknowledgement

The COVID-19 Pandemic Response and Impact Grant Program (Co-RIG) was launched by the Foundation for Advancing Family Medicine (FAFM) in 2020 with the generous funding support of the CMA Foundation.

Acknowledgements

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Foreword

The COVID-19 pandemic has disrupted the health and well-being of people around the world and has placed exceptional pressure on the Canadian health care system.

Shortly after the first cases of COVID-19 infection were detected in Canada and the WHO declared a global pandemic, the CMA Foundation and the Foundation for Advancing Family Medicine (FAFM) recognized the need to support family medicine's response. With a generous donation of $5 million from the CMA Foundation, the FAFM launched the COVID-19 Pandemic Response and Impact Grant Program (Co-RIG) in April 2020.

Co-RIG was organized in two phases. The first phase, launched in spring 2020, focused on supporting innovations in family medicine designed to have a rapid impact, and addressing pressing challenges identified early on in the pandemic. The second phase, launched in April 2021, is designed to encourage initiatives of longer-term impact.

The FAFM also designated separate funding to support comparable efforts in medium- and low-income countries. The Co-RIG Global program was administered by the Besrour Centre for Global Family Medicine at the College of Family Physicians of Canada (Besrour Centre) and sustained initiatives in South Africa and Indonesia, which are expected to strengthen the role of family medicine in under-resourced communities.

The *Advancing Family Medicine During the Pandemic: Co-RIG Phase I* report focuses on Phase I of the Co-RIG program and highlights the 15 rapid and responsive funded innovations and their impact. Phase I project teams focused on a range of critical issues, including high-risk and vulnerable populations, continuous care for people with chronic conditions or mental health issues, practice enhancements, and data system integration.

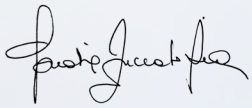
Through their insight and commitment to change and patient care, each of the Co-RIG funded projects has contributed to reducing the impact of COVID-19 on the people living in Canada. It is with profound gratitude that we witnessed these teams take up the torch to strengthen patient care and family medicine in a time of crisis, while continuing to work on the front lines.

We wish to express our heartfelt thanks to the Co-RIG Steering Committee, chaired by Dr. Marie-Dominique Beaulieu, for their expert guidance in the development of the program, and to the Co-RIG Adjudication Committee, chaired by Dr. Ruth Wilson, for their thorough review of more than 100 proposals. Like the project teams, our family physician volunteers carve out precious time to advance critical programs like Co-RIG.

The FAFM is deeply committed to supporting family doctors through research and education initiatives. We invite you to learn more about the overall Co-RIG program and consider how these 15 innovative projects might help you in your own practice.

Sincerely,

Francine Lemire, MD CM, CCFP, FCFP, CAE, ICD.D
Executive Director and Chief Executive Officer
The College of Family Physicians of Canada



Claudia Zuccato Ria
Executive Director
Foundation for Advancing Family Medicine
The College of Family Physicians of Canada

Family Medicine: Central to Canada's pandemic response

> *"The pandemic has caused intense stress and disruption for everyone in Canada, particularly for vulnerable people. Family physicians have been central to Canada's pandemic response and play a critical role in ensuring equitable access to healthcare as we collectively recover from the pandemic."*
>
> —**Dr. Cathy Cervin**, CFPC President
>
> *"The collaboration between the CMA Foundation and the FAFM is a powerful example of what can be achieved when health system partners work together. We are confident that the innovations generated by the Co-RIG program will continue to strengthen family medicine and our overall health system for years to come."*
>
> —**Dr. Jeanette Boyd**, FAFM Board Chair, and **Allison Seymour**, CMA Foundation President

At the outset of the pandemic family physicians quickly responded to the unprecedented shock to the community, health care system, and patient care.

While media headlines report on the impact of COVID-19 in hospitals, most individuals with COVID-19 recover at home with support from their family doctor and other primary caregivers. It is also family physicians and primary care teams who support patients to cope with the indirect impacts of the pandemic, such as anxiety and depression. And as the pandemic regresses, it will be family physicians who support patients to manage the long-term effects of this period of intense upheaval.

Throughout the pandemic, family physicians have been at the centre of Canada's pandemic response. As front-line care providers with broad competencies, family physicians swiftly adapted their practices in the face of the evolving COVID-19 crisis. They worked collaboratively with public health and other health care professionals to ensure patients continued to receive safe and timely medical care. They found innovative ways to connect with their patients, while they pitched in and helped other parts of the health care system.

To enhance family medicine innovation during the pandemic, the FAFM launched a two-phase funding program—the COVID-19 Pandemic Response and Impact Grant Program (Co-RIG) with a generous $5 million donation from the CMA Foundation. The goal of the multi-year Co-RIG program was to support high-impact initiatives in the short term to address pressing patient care needs and, in the longer term, to help prepare family physicians, their teams, and the community to cope with challenges related to the pandemic in the long term.

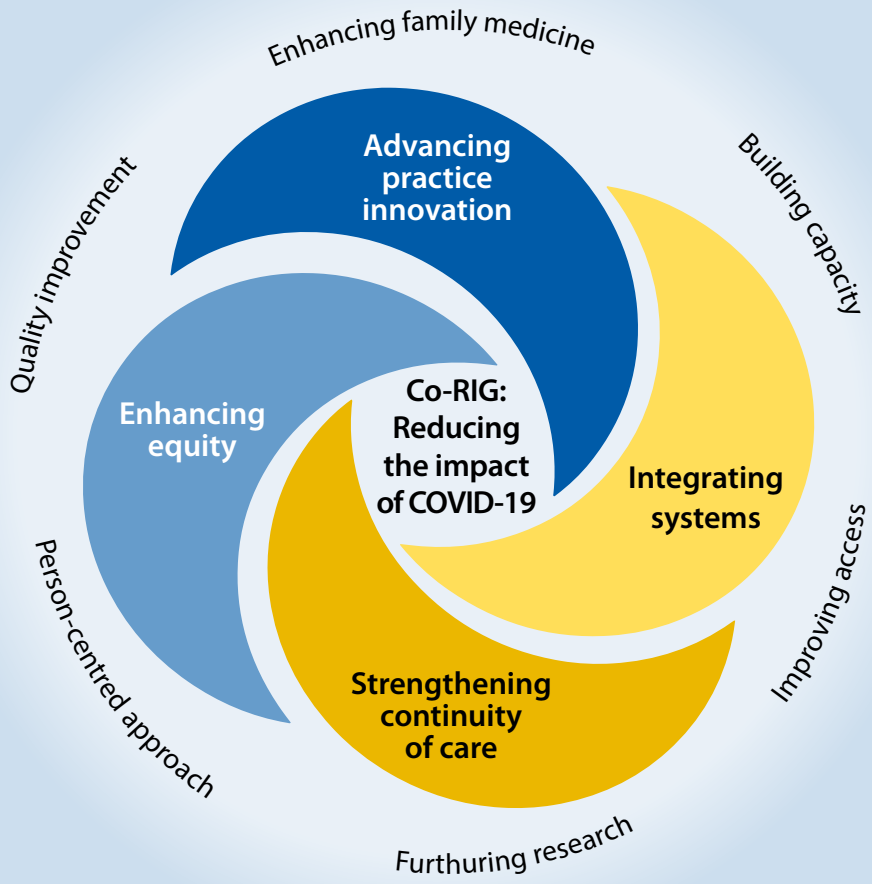
Co-RIG is a two-phase funding program:

- Phase I targeted immediate and short-term innovations that maximize effectiveness of patient care, while guarding the safety of health workers.
- Phase II focuses on innovations and initiatives that prepare family medicine and the community to cope with the challenges related to the pandemic in the long term.

Co-RIG Phase I

> "The Co-RIG program reinforces the importance of funding family medicine research and innovation to improve patient outcomes, population health, and societal well-being."
>
> **Dr. Rick Glazier,** Senior Scientist ICES; Scientist, MAP Centre for Urban Health Solutions, St. Michael's Hospital; Professor of Family and Community Medicine, University of Toronto

Rapid and Responsive Family Medicine Innovations



Phase I Co-RIG funding was awarded to 15 family medicine teams—selected from more than 100 submissions—for their promise to generate rapid and measurable benefits to patients and communities across Canada. Projects got under way in fall 2020 and wrapped up in spring 2021.

Over a span of six to eight months each Co-RIG project supported a multidisciplinary team to rapidly develop or evaluate pragmatic innovations.

While each project was unique in its approach, the combined impact of Co-RIG Phase I projects has reinforced the central role of family medicine in the nation's pandemic response.

Collectively they have reduced the impact of the pandemic by **enhancing equity, integrating systems, advancing practice innovations,** and **strengthening continuity of care**.

A snapshot of impact

Many of the project teams responded to the disproportionate impact of COVID-19 on underserved communities by focusing on **improving access** and **developing person-centred approaches** to enhance equitable care. A team in Alberta recognized that addressing the social determinants of health was necessary to curb outbreaks in industrial workplaces, while a team in Toronto focused on working with homeless shelter operators to support implementation of public health measures and health care outreach. Two Montreal-based projects successfully introduced peer-support—one in the shelter system and the other with LGBTQ2S+ migrants.

Co-RIG Phase I projects also helped to **build system capacity** and alleviate pressure on hospitals. A team in Hamilton developed a protocol to enhance home care for acute COVID-19 patients that included oxygen monitors to identify escalating illness, while a team in Toronto tested the introduction of a self-proning protocol to reduce respiratory issues for patients at home.

A number of project teams focused **on enhancing family medicine** by fostering stronger connections between primary care, the broader health system, and community partners. In Alberta a team worked within a First Nation to reduce the risk of outbreaks through a partnership between the First Nation, primary care, and public health. Another Alberta-based team improved access to care in Calgary by helping connect COVID-19 positive patients to a primary care provider.

Other projects **advanced research and supported quality improvement** through data collection and analysis. One Ontario team developed the necessary infrastructure for rapid access to electronic medical record (EMR) data to fuel critical research on the impact of the pandemic at the community level, while another Ontario project examined prescribing practices in long-term care (LTC) homes to improve palliative and end-of-life care during the pandemic.

Improving access to care, and ensuring **safe, continuous care** for people with chronic conditions including mental health was the focus for other projects. A Hamilton-based team developed a protocol to provide virtual health care support for frail adults who have difficulty accessing care, and an Ottawa team developed a virtual concussion exam for use in family medicine. A Windsor team opened a walk-in clinic for those experiencing acute mental health challenges while a Montreal-based project evaluated mental health self-care tools for older adults with mental health challenges. A team in Sherbrooke adapted an existing case management strategy that enabled primary care nurses to assess patient needs by phone and connect them to mental health and other resources as needed.

Stories of innovation

"The Co-RIG Program is providing critical resources to support family medicine innovation that addresses significant patient care and healthcare system challenges."

Marie-Dominique Beaulieu
CQ, MD, CMFC, MSc, FCMF,
Co-RIG Steering Committee Chair,
Professeure émérite, Département de médecine de famille et de médecine d'urgence, Faculté de médecine, Université de Montréal

"These projects are powerful examples of how family physicians across the country are working together to reduce the impact of COVID-19 on the people of Canada."

C. Ruth Wilson
CM, MD, CCFP, FCFP, LLD,
Chair, Co-RIG Phase I Adjudication Committee,
Professor Emerita, Department of Family Medicine, Queen's University

Caring Community:
Integrating peer support in homelessness during the pandemic

Centre-South Montreal, Québec

Project Summary

In the spring of 2020 many people experiencing homelessness were unable to access critical services as the shelters were hard hit by COVID-19 outbreaks and health services were centralized in hospitals.

Dr. Antoine Boivin, Dr. Mathieu Isabel, and local community clinic staff recognized an urgent need to strengthen access to care for this vulnerable population. In response they adapted the Caring Community Model, which is an internationally recognized approach to community care.

The team paired primary care team members with a peer support worker to provide critical community and health services. The peer support worker helps connect with clients, and supports the clinical team in understanding the unique challenges facing marginalized and isolated individuals.

With the pandemic continuing to impact communities across Canada, the Caring Community Model offers community and health system leaders an effective intervention strategy to mitigate harmful impacts of health care crises like COVID-19.

Faces of COVID-19:

Building bridges and offering hope

After a decade of homelessness Daniel Turgeon trained to become a peer support worker in order to help others through guidance and compassion.

His personal experience provides him with the perspective and credibility needed to connect meaningfully with people in his community who have been hard hit by the pandemic.

His work has helped the team connect with individuals who have historically had little trust in the health system.

His impact is captured in three words: Bridge. Hope. Meaning.

> "The integration of a peer-support worker helped all of us – patients and staff alike. It brought us back to our mission and sense of purpose during a dark time."
>
> Faubourgs Local Community Health Centre Staff

Go to the FAFM website to find more information about this project, its partners, and collaborators.

Antoine Boivin, MD, PhD
Canada Research Chair in Partnership with Patients and Communities

Mathieu Isabel, MD, MA, CCFP
Faubourgs Local Community Health Centre

Daniel Turgeon
Peer support worker

Improving Care in the Shelter Community:

The CARE Model

Toronto, Ontario

Project Summary

People experiencing homelessness are at increased risk of hospitalization and death due to COVID-19.

Dr. Aaron Orkin and colleagues at Inner City Health Associates developed the COVID Alert Risk Evaluation and Management (CARE) model to respond to these complexities and risks by offering individual and shelter-level COVID-19 prevention and mitigation interventions and supports in shelters across Toronto.

The innovation uses a risk stratification tool to help primary care teams and shelter partners serve the most vulnerable within the shelter community, mitigate risk, and drive COVID-19 prevention and recovery efforts.

The model has strengthened primary care connections to shelter operators and community partners and has been expanded broadly across Toronto's shelter system. It also built capacity for front-line workers to address infectious diseases in the long term.

Faces of COVID-19:

A multi-layered approach to supporting Maria

Maria works part-time and lives in a shelter. Using the CARE assessment tool, shelter staff identified Maria's elevated risk of severe outcomes from COVID-19 due to her age and health issues.

Maria talked with staff and a population health nurse about COVID-19 prevention strategies. Together they took steps to follow public health measures.

The introduction of the CARE program also helped shelter staff become more aware of residents' substance abuse and mental health needs. With this information they developed an approach to direct clients to resources and housing to prevent a return to homelessness.

> "Inner City Health Associates and the CARE model is a lifeline for the shelter community. They have trained our staff on strategies to educate clients about testing and vaccination and provided hands-on support to mobilize on-site testing and access to beds in COVID-19 recovery sites."
>
> **Dr. Jake Aikenhead**, Director of the Salvation Army Gateway Shelter site

Go to the FAFM website to find more information about this project, its partners, and collaborators.

Aaron Orkin, MD, MSc, MPH, CCFP (EM), FRCPC
Population Health Lead, Inner City Health Associates

Serving Patients with Complex Needs:

An LGBTQ2S+ migrant health clinic and outreach program

Montreal, Quebec

Project Summary

Many people in the migrant LGBTQ2S+ community experience high rates of depression, anxiety, isolation, and suicide. Isolation and job insecurity due to the pandemic has exacerbated challenges facing this vulnerable community.

Dr. Vania Jimenez and her team created Clinique Mauve to provide clinical and mental health care to the migrant LGBTQ2S+ community. The clinic is Montreal's first ever community health clinic and outreach program for this community.

Clinique Mauve includes peer navigators, who are considered particularly important to the success of the program. By building bridges between the client and the clinical team, peer navigators help teams develop person-centred approaches that support clinical care and connect patients to community supports.

The clinic is based on the successful model of the Maison Bleue in Montreal, which offers health and community services to vulnerable pregnant women and their families.

Faces of COVID-19:

Supporting LGBTQ2S+ migrants

Majd is a cisgender gay refugee who has lived through war and multiple traumas in his home country. Since the start of the pandemic he has been socially isolated and was evicted from his apartment after losing his job. He is having increased thoughts of suicide.

Majd connected with an Arabic speaking peer navigator who introduced him to Clinique Mauve. At the clinic an interdisciplinary team assessed Majd and developed an intervention plan that includes a suicidal risk assessment, clinical care to address physical health needs, and supports to stabilize his housing insecurity.

Today Majd has a new home and a plan to manage his mental and physical health.

> "Establishing trust is a major barrier. For many of our clients, physicians in their country of origin had betrayed their confidences, which may have resulted in arrest and violence. The peer navigators are critical to building bridges and helping us explain how care works in Canada."
>
> **Dr. Vania Jimenez,** project lead

Go to the FAFM website to find more information about this project, its partners, and collaborators.

Vania Jimenez, MD, CCFP
Co-Founder, La Maison Bleue and Clinique Mauve

Integrating Urgent Mental Health and Addiction Services:

Supporting vulnerable people in the primary care setting

Windsor, Ontario

Project Summary

Early in the pandemic there was concern that emergency departments would be overwhelmed by COVID-19 patients, and an alternate location for individuals to receive urgent mental health and addiction support would best serve community need.

In response Dr. Mohammed Hussain, along with Hôtel-Dieu Grace Healthcare and the Canadian Mental Health Association Windsor-Essex Branch, established a Mental Health and Addiction Urgent Care Centre (MHAUCC) to provide in-person and virtual mental health and addiction support in downtown Windsor.

The centre operates as a drop-in clinic and is having a positive impact on connecting vulnerable patients to ongoing mental health and addiction services and resources.

On-site crisis social workers and addiction counsellors, supported by on-call urgent psychiatric care, provide specialized and integrated care to the community.

The MHAUCC is having a positive impact in the Windsor community through enhancing access to care for clients, including many young people experiencing mental health and addiction related issues for the first time.

Faces of COVID-19:

Comprehensive care in a crisis

Chris, 21 years old, self-medicates to treat a major depressive disorder.

Unable to see his regular psychiatrist, Chris visited the MHAUCC where a crisis social worker and psychiatrist addressed Chris' acute mental health needs. Follow-up appointments with a community withdrawal management worker provided ongoing support, and details were shared with Chris' psychiatrist.

Chris' immediate physical health concerns were addressed by the clinic's family physician. As a registered client, Chris' ongoing health needs can continue to be addressed in a coordinated way.

Chris is feeling better able to manage his depression.

> "A face-to-face visit helps with non-verbal cues that can be missed in virtual appointments. Natural interaction between care provider and patient allows us to gather more information, which is particularly important for psychiatric assessments. It helps our team make sure it provides the right support for our clients."
>
> **Dr. Mohammed Hussain**, project lead

Go to the FAFM website to find more information about this project, its partners, and collaborators.

Mohammed Hussain, MD, CCFP
Family Physician, Canadian Mental Health Association Health Centre

A First Nation-led COVID-19 Response:

Coordinating integrated primary care

Siksika First Nation, Alberta

Project Summary

With crowded housing and a population working in an industry rife with outbreaks, the Siksika First Nation faced high risk for rapid spread of COVID-19.

Dr. Lindsay Crowshoe and his multidisciplinary team worked with the First Nation to optimize screening and provide support for infected households to implement isolation strategies and provide clinical care for severe cases.

The culturally-attuned education and social assistance—coupled with strong collaboration between public health, First Nation health services, and family physicians—had a positive impact on incident rates and supported equitable care for the community.

Faces of COVID-19:

A Nation-led approach to support Edward and his family

Edward lives in the Siksika First Nation and works at a meat-packing plant where there is a COVID-19 outbreak. He lives with eight other family members and is worried about how his family will isolate and access groceries.

Responding to a social media post, Edward calls the Nation's health services centre. Centre staff are able to arrange for a food hamper to be delivered and access to on-site COVID-19 testing for the same day. Test results are expedited to minimize the pressure of isolating in a small living space.

Edward's doctor checks in regularly with the family to check for symptoms and assess whether anyone requires support to address emergent emotional distress.

Edward feels supported by the care team and feels confident about his family's ability to manage.

> "As family physicians, we often see ourselves as a single doctor, working with a single patient or family. The response needed to help manage the COVID-19 pandemic demonstrates the critical role we can play at the system and population health levels. These learnings are cross-cutting and not just applicable to First Nations."
>
> **Dr. Lindsay Crowshoe,** project lead

Go to the FAFM website to find more information about this project, its partners, and collaborators.

Lindsay Crowshoe, MD, CCFP
Family Physician, Elbow River Healing Lodge,
Urban Aboriginal Primary Care Clinic

Equitable Health Can't Wait:

Insights and recommendations for calming the COVID-19 storm at meat-packing plants

High River and Calgary, Alberta

Project Summary

Meat-packing plants have experienced some of the worst COVID-19 outbreaks in Canada. Many workers are recent immigrants and have difficulty adhering to public health directives due to crowded housing, income insecurity, and language comprehension.

Dr. Annalee Coakley evaluated a primary care pathway that Alberta Health Services Primary Care and Calgary Zone Primary Care Networks had developed to support meat-packing plant employees and their families following a devastating COVID-19 outbreak in their Alberta workplace.

The evaluation demonstrated the positive impact of intentional collaboration between primary care, public health, and community partners on high-risk patients.

Not only did it curb infections and reduce spread, it also supported coordination of resources to help workers access the financial, housing, and social supports critical to addressing social inequities.

The pathway's success led to it being adopted broadly as the response to meat-packing plant outbreaks across Alberta.

Faces of COVID-19:

Caring for the whole person

Asha is a Somali refugee and works at the Cargill meat-packing plant in Alberta. She tested positive for COVID-19 while looking for housing.

Using the Enhanced COVID-19 Primary Care Pathway protocols, the Mosaic Primary Health Network team monitored Asha's symptoms, helped her find temporary housing, and arranged for food and medicine delivery while she self-isolated.

Asha was also referred to a community agency that provided emotional support, helped her apply for income support, and arranged for her to move into a new home once she completed isolation.

Asha was able to return to work and has a better understanding of the social supports available to her.

> "People will not self-isolate if they do not have money to buy food or pay bills. This innovative approach to collaborative care supported meat-packing plant workers with necessary resources to protect their families and mitigate community impacts of the outbreak."
>
> **Dr. Annalee Coakley,** project lead

Go to the FAFM website to find more information about this project, its partners, and collaborators.

Annalee Coakley, MD, CCFP, DTMH
Physician Lead, Mosaic Refugee Health Clinic

Improving Primary Care:

A COVID-19 integrated pathway

Calgary, Alberta

Project Summary

COVID-19 testing is largely managed by public health units across the country, with family physicians responsible for follow-up.

The Calgary Zone's COVID-19 Primary Care Integrated Pathway uses an information referral process to link COVID-19 positive patients to their family physicians. For patients without a family doctor, the pathway connects them to a primary care team who provides care or facilitates attachment to a physician.

This pathway also includes a clinical algorithm that helps family physicians deliver comprehensive care to patients who test positive for COVID-19 with a risk stratification tool and treatment decision tree. It helps identify appropriate treatment protocols and connects patients with public health, specialists, and acute care when needed.

The pathway established a standardized approach to care planning and delivery, and supports continuity of care for patients across Calgary and its surrounding communities.

Faces of COVID-19:

Connecting Salama to a medical home

Salama tested positive for COVID-19 and was told by her local public health unit to isolate at home with her family. Salama generally relies on a walk-in clinic when she needs to see a doctor.

Salama was contacted by a family physician named Anita, who used the COVID-19 Primary Care Integrated Pathway to help Salama manage symptoms and avoid unnecessary visits to the emergency room.

The pathway also helped connect Salama to a community agency, which helped organize food and medication for the remainder of her isolation.

> "Family physicians and primary care teams are best positioned to provide follow-up care for our patients with COVID-19. The standardized pathway equips us with the knowledge and links to effectively support our patients and get them back on their feet."
>
> **Dr. Fariba Aghajafari,** project lead

Go to the FAFM website to find more information about this project, its partners, and collaborators.

Fariba Aghajafari, MD, CCFP, FFCP, MsC, PhD
Associate Professor, Department of Family Medicine and Community Health Sciences
University of Calgary

Brian Hansen, MA, MPH
Evaluation Lead, Business Unit, Calgary and Area Primary Care Networks

Extending Primary Care at Home:

A comprehensive care model for COVID-19-positive patients

Hamilton, Ontario

Project Summary

Approximately 7.5 per cent of people diagnosed with COVID-19 in Canada in 2020 required hospitalization. Others with milder COVID-19 symptoms recovered at home.

Dr. Dee Mangin's Extended Care in Hamilton project provided pathways that help family physicians care for patients with mild or moderate COVID-19 at home.

The pathways integrate evidence, tools, and EMR templates, and they enable family physicians to monitor patient symptoms remotely through regular phone calls.

A key component of the innovation is the use of pulse oximeters that monitor a patient's oxygen levels to help detect deterioration early and expedite necessary hospital transfers.

The pathways strengthen a patient-centred approach by supporting the team to monitor disease progression while the patient recovers at home.

COVID-19 Stories:

Worsening COVID-19 or not?

Julia is a family physician and used a clinical pathway available as part of Ontario's COVID@Home program to assess a COVID-19-positive patient by phone.

Categorizing the patient as high risk, Julia's team arranged for delivery of a pulse oximeter and coordinated training on its use. Two days later the patient reported significant breathlessness and wanted to go to the hospital.

Julia checked oxygen levels and other vitals, and found the patient to be stable. She explained to him that the breathlessness was likely a result of increasing anxiety, and did not require a visit to urgent care. The patient agreed he would continue to be monitored at home and was connected with virtual supports to help manage his stress and anxiety.

> "After I tested positive for COVID, I found it reassuring to receive follow up from my family doctor's office. They focused on how I was feeling and made sure I knew how to monitor myself and when to reach out for help. I really appreciated that."
>
> A patient in Hamilton, Ontario

Go to the FAFM website to find more information about this project, its partners, and collaborators.

Dee Mangin, MD, MBChB, DPH, FRNZCGP
Family Physician and Professor, Department of Family Medicine McMaster University

Enhancing Support for Frail Adults During COVID-19:

A contact monitoring pathway

Hamilton, Ontario

Project Summary

Early in the pandemic Dr. Henry Siu noticed that many frail patients were avoiding or delaying seeking care—a scenario that could increase the likelihood of negative health outcomes.

To respond to this gap in care, Dr. Siu and his project team developed a contact and monitoring pathway to help family physicians proactively identify older adults with frailty.

The pathway supports patient assessment, including COVID-19 risks and overall mental and physical health, and helps family physicians link patients to the appropriate care and supports.

The pathway has enhanced the patient and provider relationship and enabled family physicians to improve the care they provide patients during the pandemic. It has also alleviated pressure on hospital and secondary health care systems.

Faces of COVID-19:

Catching cancer early

Mr. Asher, age 70, was contacted by his family physician as part of the proactive contact monitoring pathway being used at his medical clinic for older frail adults.

During a telephone appointment, Mr. Asher told his doctor that he had significant bowel problems and some blood in his stool. He had been putting off calling the doctor because he was worried about catching COVID-19 and did not want to bother the doctor.

His doctor immediately scheduled Mr. Asher for diagnostic tests, which resulted in a diagnosis of stage II colon cancer.

Because of this pathway, Mr. Asher was not overlooked and is now receiving care that is in line with his goals and wishes.

> "Family medicine and primary care are the foundation of an effective health system. By proactively identifying and reaching out to our frail and at-risk older patients, we are helping them maintain optimal health, and reducing the burden of disease downstream."
>
> **Dr. Henry Siu,** project lead

Go to the FAFM website to find more information about this project, its partners, and collaborators.

Henry Siu, MD, MSC, CCFP (COE)
Associate Professor, Department of Family Medicine
McMaster University Family Health Centre

Innovating Case Management:

Telehealth support for patients during COVID-19

Quebec, Nova Scotia, New Brunswick, Newfoundland and Labrador

Project Summary

Many patients with complex and chronic conditions, mental health issues, and social vulnerability struggle to receive needed care during the pandemic.

Dr. Catherine Hudon adapted an existing case management (CM) strategy for virtual use to connect patients with important health and support services. A collaborative, client-driven approach, CM is an efficient and effective way for primary care providers to help patients achieve their health goals.

Dr. Hudon's innovation supports primary care nurses who serve as case managers, to assess patients' needs by phone and connect them to mental health and other health or community resources as required.

The approach serves as a model for person-centred care when access to face-to-face care is disrupted.

Faces of COVID-19:

Putting Meredith at the centre of her care

Meredith is 76, lives alone, and has multiple chronic illnesses. Her anxiety and fatigue have worsened during the pandemic. She does not feel comfortable visiting her doctor due to worries about COVID-19 exposure.

Using the telehealth case management strategy offered by her primary care team, Meredith speaks regularly with a nurse who reinforces the importance of medication compliance and links her to community resources for exercise and meditation.

Meredith is more engaged in her own care and feels confident in decisions relating to her health.

> "Our approach to case management encouraged more interprofessional collaboration and coordination of care delivery. It broke down silos between providers of different settings and helped us better care for our most complex and vulnerable patients."
>
> **Dr. Catherine Hudon,** project lead.

Go to the FAFM website to find more information about this project, its partners, and collaborators.

Catherine Hudon, MD, PhD, CCFP
Professor, Family Medicine and Emergency Medicine Department
University of Sherbrooke

Enhancing Mental Health Supports During COVID-19

Evaluating self-care tools for older adults

Montreal, Quebec

Project Summary

Older adults with chronic illness and restricted to home during the pandemic may experience increased anxiety and depression during the pandemic.

To support family physicians in providing care for this group of patients, Dr. Mark Yaffe and a multidisciplinary team adapted an existing approach to care that uses telephone coaching by trained non-health care personnel and self-care tools.

The approach has proven useful in other settings in supporting patients and physicians as they address undermanaged mental health symptoms.

Faces of COVID-19:

Helping patients with mental health challenges

Louise has heart disease and has been anxious since the start of the pandemic. To help assess and manage Louise's anxiety and depression, her family doctor suggested that she might benefit from self-care tools.

Louise was assessed and then given a workbook to help her understand her feelings and practice strategies to better manage her worry. She also worked over the telephone with a lay coach who helped her get the most out of the workbook.

Two months later Louise said she was feeling less anxious and more supported.

> "Many people with chronic illness have some associated mental health symptoms and the pandemic has made this worse. Family physicians may identify such individuals who would benefit from broadened mental health support. Our program provides patients with tools to help them work on their own mental well-being in the longer term."
>
> **Dr. Mark Yaffe,** project lead

Go to the FAFM website to find more information about this project, its partners, and collaborators.

Mark Yaffe, MD, CM, MCISc, CCFP, FCFP
Full Professor, Department of Family Medicine, McGill University
St. Mary's Hospital Centre of the Integrated University Centre for Health and Social Services of West Island of Montreal

Reducing the Likelihood of Critical Illness:

Assessing effectiveness of self-proning in COVID-19 patients

Toronto, Ontario

Project Summary

As COVID-19 continues to spread, health care providers need more outpatient therapy options to prevent mild cases of COVID-19 from becoming more severe.

Dr. Roisin McElroy explored the potential for a self-proning and repositioning protocol to help family physicians support symptomatic COVID-19 patients in the home.

These simple physical maneuvers may be effective in preventing severe disease, allowing patients to recover at home without the need for hospitalization. A pilot trial will determine if this intervention can be tested in patients with COVID-19 being managed in the community.

A compelling aspect of this project is its practical contribution to research and testing of outpatient management strategies, which are critical tools in mitigating the impacts of COVID-19 and protecting resources.

Faces of COVID-19:

Supporting COVID-19 patients at home

Chang was diagnosed with COVID-19. His condition was considered stable so he was sent home to recover under the supervision of his family physician.

During a video appointment with his doctor, Chang reported extreme fatigue, cough, and that he spends most of his time lying on his back.

His doctor suggested that he lie on his belly or side to improve airflow to his lungs. Chang was guided through the protocol.

The health care team checked on Chang regularly and after two days he reported that his cough had improved and he could interact with his family for brief periods of time.

> "A self-proning protocol may allow patients and health care teams to manage mild to moderate COVID-19 respiratory difficulties at home. This is better for patients and the health system."
>
> **Dr. Roisin McElroy,** project lead

Go to the FAFM website to find more information about this project, its partners, and collaborators.

Roisin McElroy, MD, MPH, CCFP (EM)
Emergency Physician, St. Joseph's Health Centre

Innovating Concussion Assessments:

A concussion exam tool for virtual visits in family medicine

Ottawa, Ontario

Project Summary

Timely treatment of concussions is critical to positive patient outcomes and the shift to virtual care during the pandemic introduced a gap in primary care.

Dr. Sharon Johnston's adaptation of a concussion exam for virtual use supports family physicians in the rapid assessment of concussions.

The virtual concussion exam provides comprehensive instructions to help family physicians identify concussion symptoms and determine a treatment plan in non-face-to-face patient encounters.

It can be conducted in as little as 15 minutes, a modification of the in-person approach that increases its value to the primary care community.

For patients, the virtual concussion exam helps get them back to their daily routines and avoid unnecessary hospital visits during the pandemic. In the future it can also be used to support remote or rural patients who are experiencing concussion symptoms.

Faces of COVID-19:

A timely concussion diagnosis

Teresa hit her head slipping on ice in her driveway. Experiencing significant dizziness, she was able to get a virtual appointment with her doctor the same afternoon.

The doctor conducted a virtual concussion exam, confirmed the diagnosis and was able to rule out the need to visit an emergency room.

A management plan based on her symptoms was started immediately, and four days after her concussion Teresa was able to return to her priority activities.

> "Concussions need rapid assessment so that patients get emergent care if necessary and are equipped for optimal recovery. Many patients will need guidance and/or medical clearance to return to their sports and activities. This flexible and adaptable approach means family physicians across Canada can gain the necessary skills to conduct virtual concussion assessments."
>
> **Dr. Sharon Johnston,** project lead

Go to the FAFM website to find more information about this project, its partners, and collaborators.

Sharon Johnston, MD, LLM, CCFP
Clinical Investigator, Institut du Savoir Montfort and Bruyère Research Institute

Supporting Palliative and End-of-life Care During COVID-19:

Prescribing practices in long-term care homes

Ontario

Project Summary

Nearly all residents in long-term care (LTC) homes can benefit from palliative care and end-of-life symptom relief, yet many prior to, and especially during, the COVID-19 pandemic did not receive such care.

Recognizing the impact of the pandemic in LTC homes, Dr. Peter Tanuseputro's team examined prescribing medication practices and mortality data from all Ontario LTC homes. Their goal was to understand and address gaps in delivery of high-quality palliative and end-of-life care in LTC homes by using end-of-life prescribing as an indicator of care quality.

The team identified a high degree of variability in prescribing rates across LTC homes, suggesting the possibility of under-managed symptoms and mental/emotional discomfort at end-of-life.

This work will support quality improvement through targeted education in the province's LTC homes and focus additional supports where they are most needed.

Faces of COVID-19:

Quality of life until the end of life

Isabelle moved into an LTC home after breaking her hip. In stable health she contracted COVID-19 in the home.

Throughout the pandemic the home has provided care for COVID-19-positive patients. As Isabelle's condition worsened her care was modified to include injectable medications to control her pain, agitation, and shortness of breath.

Her care was facilitated by a palliative care symptom relief kit, ordered by her physician through a standard order sheet. She died peacefully in the home.

> "This project is an example of the innovative ways that data can shine light to an important issue—to highlight areas where physicians and other health care practitioners can work to improve the quality of life of those under their care."
>
> **Dr. Peter Tanuseputro,** project lead

Go to the FAFM website to find more information about this project, its partners, and collaborators.

Peter Tanuseputro, MD, MHSc (Epi), CCFP, FRCPC (Public Health)
Scientist, Clinical Epidemiology, Ottawa Hospital Research Institute

Revolutionizing COVID-19 Data Collection:

Infrastructure for rapid access to EMR data

Ontario (Toronto, Hamilton, Eastern Ontario) and British Columbia

Project Summary

An effective response to COVID-19 requires access to real-time information on disease spread and its community impact.

Practice-based research networks (PBRNs) use EMR data to answer community-focused health care questions and translate findings into practice, a critically important function during the pandemic. Historically, uploading data to PBRNs is time-consuming, costly, and infrequent.

To enhance the speed at which PBRNs can access EMR data, Dr. Noah Crampton and partners leveraged new technology to develop a software tool that allows for the daily, automated, privacy-compliant upload to PBRNs.

This innovation will directly support researchers to map pressing needs of COVID-19 hotspots to support testing, vaccination, and mental supports. Long-term health applications include understanding how the pandemic is affecting communities across the country, which will inform local and national responses to future COVID-19 waves or other pandemics.

Faces of COVID-19:

A tale of two communities

John lost his job as a result of several strict local lockdowns. His family doctor diagnosed him with depression and prescribed him medication.

Rob lives in a different community. He works in a similar job to John. However, his community has only been through brief lockdowns. He has continued to work and his mental health is stable.

With pooled and timely health data from PBRNs it is possible for researchers and health care providers to compare patient data from different communities and act on it. This information can help researchers understand the impact of different public health measures, such as extended lockdowns, and can inform researchers and policy-makers about how and where to deploy additional mental health resources.

> "COVID-19 will likely be circulating in the community for years to come. This tool will help us understand which interventions work in different settings and identify lessons learned to readily apply to future waves."
>
> **Dr. Noah Crampton**, project lead

Go to the FAFM website to find more information about this project, its partners, and collaborators.

Noah Crampton, MD, MSc, CCFP
Family Physician-Lecturer and Clinician Investigator, Toronto Western Family Health Team
University Health Network, Department of Family and Community Medicine, University of Toronto

Co-RIG Phase II

> "As we move from pandemic into recovery, the Co-RIG program is giving us the research and historical record of family medicine's response we need to learn and prepare for future crises."
>
> **Steve Slade,** Director of Research, Academic Family Medicine Division, CFPC

Building on the success of Phase I, Co-RIG Phase II launched in spring 2021. It focuses on innovations that prepare family physicians and interprofessional teams to cope with emergent challenges related to the pandemic and its longer-term impact.

Twelve Co-RIG Phase II projects are receiving funding and will focus on a range of issues:

- Responding to priority populations including long-term care residents, Indigenous peoples, people experiencing homelessness, individuals suffering from addiction issues, people who are new to Canada, and people living in remote communities
- Establishing effective intersectoral and interdisciplinary collaboration with a focus on the connection between primary care and public health
- Implementing pandemic planning and response training for current and future family physicians
- Developing innovative practice models to ensure safe, continuous, accessible, and comprehensive care for all patients, especially those with chronic, comorbid, and mental health and substance abuse issues
- Safeguarding the health and safety of health care providers and team members.

Phase II projects are expected to wrap in winter 2023. Details about the projects are available on Co-RIG Program: Phase II on the FAFM website.

Co-RIG Phase I Contributors

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