Post-COVID Treatment and Management in Primary Health Care

Webinar 2

September 14, 2021
Webinar Series: Post-COVID in Primary Health Care

A two-part CME-accredited webinar series for family physicians, nurse practitioners, family practice nurses and other primary health care providers. Participants will gain an understanding of what post-COVID is, how to assess, manage and monitor post-COVID symptoms, and increase awareness of local resources for patient and provider support.

Webinar 1
July 27, 2021
7:00 - 9:00 pm

Webinar 2
Sept 14, 2021
7:00 - 9:00 pm

Can’t join us live? The webinars will be recorded and accessible online for viewing.

This webinar series is brought to you by the Primary Health Care and Chronic Disease Management Network in partnership with the COVID Network, Doctors Nova Scotia, clinicians and patients.

Primary Health Care Practice Support Program

PHCQuality.ca
PHCPracticeSupport@nshealth.ca
@PHCQualityPSP
## Agenda

**Webinar 2 | Post-COVID Treatment and Management in Primary Health Care**

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Learning Objectives

Webinar 2 | Post-COVID Treatment and Management in Primary Health Care

By the end of the webinar, participants will be able to:

• Explain the preliminary epidemiological trends of post-COVID in Nova Scotia
• Understand the role of the primary care provider in the management of post-COVID, including assessment, management, and monitoring of post-COVID symptoms through case-based learning
• Navigate and refer patients to the MyCOVIDRecoveryNS.ca post-COVID self-management support site
Disclosure of Commercial Support

This program has not received financial support.
This program has not received in-kind support.

Potential for conflict(s) of interest:
• Not applicable
Mitigating Potential Bias

Not applicable
Early Learnings: Post-COVID in NS
Faculty/Presenter Disclosure

Speaker Name: Ashley Harnish

Relationships with financial sponsors:

• No financial sponsors to report
Epidemiology: Literature Findings
Prevalence of symptoms decreases over time

- **31-51%** of positive SARS-CoV-2 patients will experience at least one persistent symptom after **21 days**
- **21%** of positive SARS-CoV-2 patients will experience at least one persistent symptom after **45 days**
- **13.7%** of positive SARS-CoV-2 patients will experience at least one persistent symptom after **84 days**

Most Common Symptoms

>21 days since symptoms onset

- **Fatigue**: 30 – 78 %
- **Cough**: 20 – 27 %
- **Joint or muscle pain**: 19 – 44 %
- **Headaches**: 18 – 50 %
- **Trouble breathing or shortness of breath**: 16 – 55 %

Integrated Chronic Care Service

The Integrated Chronic Care Service (formerly known as the Nova Scotia Environmental Health Centre) provides comprehensive assessments and care planning for individuals with complex chronic conditions such as:

- Chronic fatigue syndrome (CFS)
- Environmental illnesses including Multiple Chemical Sensitivity
- Fibromyalgia
- Functional neurologic and gastrointestinal syndromes

Our model is based on the premise that chronic disease outcomes are better managed by addressing the needs of the whole person with a focus on self-management support. With a team of interdisciplinary health care professionals, we integrate the physical, psychosocial and environmental needs of individuals by focusing on the person instead of the disease(s)/condition(s), improving functional health and quality of life. Our care team includes: physicians, occupational therapists, a nurse practitioner, registered nurse, licensed practical nurse, clinical therapist and a dietitian. Post COVID additions include occupational therapist, post COVID navigator, physiotherapist, clinical therapist.
**Post-COVID Service**

**Outreach screening calls**
- Target to contact all NS residents living in the community, over the age of 16 with previous COVID +
  - All Waves
  - Four questions targeted on symptoms + function

**Navigator screening calls**
- Follow up screening for those patients with symptoms and functional impairments
  - Functions (1) to assist patient navigation within the system (2) gather information in coordinated way for health service planning

**Navigator care plan**
- Navigator will work with patient to determine what their goals of care are and what suite of services may assist with achieving goals

**Coordinated service delivery**
- Agreement from system partners that referrals for services will be accepted by post COVID Navigator.
  - Blended care plans between departments (ex. ICCS & rehab)

**Ad hoc navigator support**
- Post COVID Navigator will be key contact for providers should patient not be achieving goals for further planning and case conferencing

Ongoing communication with primary care provider
Post-COVID in Nova Scotia

Outreach screening calls

1,219 fully completed outreach calls completed as of 12:00pm Sept 13, 2021:

- No limitations: 639
- Manageable limitations: 464
- Moderate limitations: 84
- Significant limitations: 32

Approximately 55% of eligible patients have been reached thus far

About 40% of patients screened have identified that they do experience persistent symptoms

Approximately 10% are screening through for navigator follow-up, with about 90% of those managing symptoms on their own or with support as they see fit
50% of patients identify they have persistent COVID symptoms 12 weeks or greater after acute phase of illness.

10% of patients identify as having persistent COVID symptoms and functional impairments 12 weeks or greater after acute phase of illness.
Outreach Team Data Review: COVID Patient Experience

Persons with COVID-19
a. Demographics, Adults over 16
b. Care Experience – Acute Care/RCU, Care at Home, Care in Place

Outreach Team COVID Patient Screening: Post- COVID Patient Experience
Screen: Do you have Post COVID symptoms? Level of impact on function? Access to Health Services?

Persons with Inactive Post - COVID Symptoms

Persons with Active Post - COVID Symptoms

Post- COVID Self-Management Resources
MyCOVIDRecoveryNS.ca

Post- COVID Recovery Navigator:
Assess: All persons with Active Post-COVID (triaged by low, med and high priority) for Post-Covid Recovery Care Needs (i.e., Pathway)

Referral Pathways
- Self-Referral – Active Post - COVID Symptoms
- Provider –Referral (Acute Care/Rehab/PHC/LTC) Active Post - COVID Symptoms
- COVID-Unit Discharge Pathway Referral

Navigator/Provider Referral
Post-COVID in Nova Scotia

Upcoming work

- Ongoing outreach screening calls for NS residents 12 wks or greater after COVID +

- Direct referral from Primary Care Provider to Post COVID Navigator

- Ongoing post COVID Navigator screening calls for those with symptoms and functional impairments

- Patient self screening via common URL located on MyCOVIDRecoveryNS.ca
Faculty/Presenter Disclosure

Speaker Name: Adrienne Benoit

Relationships with financial sponsors:
• No financial sponsors to report
Primary Health Care
Case-Based Learning

Caring for patients with post-COVID

Experience of a Primary Health Care Provider
Patient 1
First Wave
• No hospitalization
• **Initial symptoms:** Fever, cough, anosmia, myalgias, fatigue
• **Persistent symptoms:** Anxiety, brain fog, fatigue, myalgias
• **Current diagnoses:** Fibromyalgia, Chronic Fatigue Syndrome
• **Interdisciplinary care:** WCB, ICCS
Patient 2
Third Wave

- Hospitalized, ICU for Acute Respiratory Distress Syndrome (ARDS)
- **Initial Symptoms**: Fever, myalgias, cough, SOB
- **Symptoms post discharge**: SOB (on home 02), fatigue, urinary retention, abdominal pain
- **Current symptoms**: SOBOE, fatigue
- **Diagnoses**: Pending
- **Interdisciplinary care**: Respirology, Hepatology
Patient 3

Third Wave

- Hospitalized, supportive care
- **Initial Symptoms:** Fever, cough, SOB, fatigue
- **Current symptoms:** Grief, fatigue, joint pain
- **Diagnoses:** Pending
- **Interdisciplinary care:** Rheumatology, IM
Abstract

Background Covid-19 Induced Hepatitis (CIH), is a novel terminology which is used in this article for the first time in the medical literature.

Objective To study the pattern of liver impairment in patients with Covid-19 as well as to find acceptable and practical diagnostic criteria of Covid-19 Induced Hepatitis (CIH). This review article gives new insight and guidance about the diagnosis of Covid-19 Induced Hepatitis (CIH), possible causes of liver damage and review of recently published data about the impairment of liver function in Covid-19 patients.

Methodology Extensive literature review of newly published data and study in PubMed cited journals and other international publisher journals. Research of all studies that reviewed liver derangement in COVID-19 were mainly reviewed. Statistical analysis of submitted data were checked using SPSS. PubMed Chinese language versions were also used.

Results 60% of patients with SARS can have abnormal liver functions. Aspartate Aminotransferase (AST) and Alanine Aminotransferase (ALT) have noticeably been abnormal in around 14–53% of patients with Covid-19 (7/114, 6.14%) (P>0.05). Impairment in liver enzymes, mainly ALT/AST, in severe Covid-19 pneumonia was significantly higher than patients with mild disease, with mean average (37.87±32.17 vs 21.22±12.67; 38.87 ± 22.55 vs 24.39± 9.79, P<0.001). Patients with Community Acquired Pneumonia (CAP) had significantly less impaired liver synthetic function (32/114, 28.07%) compared to Covid-19 pneumonia (60/115, 52.17%), which has been demonstrated with high INR (P<0.01). Mild sinusoidal dilatation with lymphocyte infiltration, minimal, has been displayed in the liver tissue of 114 deceased with Covid-19 and liver impairment, which was obtained in one hour after their death (figure 1). Fatality among Covid-19 and CLD with Child T-P score A was 23.9%, and Child T-P score B

Primary Health Care Case-Based Learning

Reflections
Case-Based Learning: Acute Care
Faculty/Presenter Disclosure

Speaker Name: Dr. Christy Bussey

Relationships with financial sponsors:
• No financial sponsors to report
Acute Care: Post-Infectious COVID-19 Cohort (PIC)

• Patients cleared by IPAC for transfer off acute COVID-19 inpatient unit OR patients presenting for hospital admission who are no longer considered infectious
• Co-location of patients on Unit 8.4
• Staffed by nursing, physicians, allied health experienced in providing acute COVID-19 inpatient care
• Automatic consults to physiotherapy, occupational therapy, social work, pharmacy
• Formal consults to nutrition, psychology, spiritual care, other
PIC Admission Criteria

- Patients cleared by IPAC for transfer off acute COVID-19 inpatient unit OR patients presenting for hospital admission who are no longer considered infectious

- A combination of two or more of the following:
  1) Inpatient medical needs (e.g., oxygen, heart failure management, diabetes management, delirium, etc.)
  2) Rehabilitation goals (including physical rehab, cognitive rehab, functional rehab)
  3) ID follow up (e.g., post-TOCI, ongoing acute infectious complications)
## PIC Assessment

<table>
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<tr>
<th>1 - 10 Borg Rating of Perceived Exertion Scale</th>
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<tbody>
<tr>
<td>0</td>
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<td>1</td>
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**C19-YRS**

**COVID-19 Yorkshire Rehabilitation Scale**

A digital assessment and monitoring tool to help manage individuals with Long COVID.

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Primary Health Care Practice Support Program
**Covid 19 Yorkshire Rehab Screen (C19-YRS)**

Patient name and NHS number:

Time and date of call:

Staff member making call:

We are getting in touch with people who have been discharged after having had a diagnosis of coronavirus disease (Covid-19). The purpose of this call is to find out if you are experiencing problems related to your recent illness with coronavirus. We will document this in your clinical notes. We will use this information to direct you to services you may need and inform the development of these services in the future.

This call will take around 15 minutes. If there’s any topics you don’t want to talk about you can stop the conversation at any point. Do you agree to talk to me about this today? Yes [ ] No [ ]

Opening questions:

Have you had any further medical problems or needed to go back to hospital since your discharge? Yes [ ] No [ ]

Details:

Have you used any other health services since discharge (e.g. your GP)?

Yes [ ] No [ ]

Details:

I’ll ask some questions about how you might have been affected since your illness. If there are other ways that you’ve been affected then there will be a chance to let me know these at the end.

<table>
<thead>
<tr>
<th>1. Breathlessness</th>
<th>On a scale of 0-10, with 0 being not breathless at all, and 10 being extremely breathless, how breathless are you? (n/a if does not perform this activity)</th>
<th>Now</th>
<th>Pre-Covid</th>
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<tr>
<td>a) At rest?</td>
<td>0-10: ___</td>
<td>0-10: ___</td>
<td></td>
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<tr>
<td>b) On dressing yourself?</td>
<td>0-10: _</td>
<td>0-10: _</td>
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<td>N/a [ ]</td>
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<td>c) On walking up a flight of stairs?</td>
<td>0-10: _</td>
<td>0-10: _</td>
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<td>N/a [ ]</td>
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68-year-old female presents to ED with fatigue, functional decline
- PMH: morbid obesity, OSA, CHFpEF, dysmobility (house-bound but independent on 1-level using 2ww, no CCNS)
- Admitted to COVID-19 Unit from ED on symptom day 7
  - New COVID-19 diagnosis in ED
- Progressive dysnpea and new O2 needs within 48h
- Diuresed for acute CHF decompensation; dexamethasone started
- To 3IMCU for BIPAP on PAD 3
Acute/Inpatient Care: Case 1
Case-Based Learning

- 3IMCU: O2 needs improved, declassed back to COVID Unit
- Recurrent hypoxia up to 12LHFNP, TOCI given PAD 7
- COVID admission complicated by:
  - HHS, new dx DM, new insulin start
  - Recurrent acute CHF decompensation
  - New atrial fibrillation
  - Delirium
  - Secondary cellulitis
- Declassed to PIC on PAD 22
Acute/Inpatient Care: Case 1
Case-Based Learning

• DM:
  • Insulin adjustments + teaching

• CHF:
  • ECHO demonstrated pEF; diuresis; cardiac med adjustments
  • O2 weaning (days 14-17)

• Complex rehabilitation needs
  • Generalized weakness superimposed on chronic dysmobility, lymphedema, anxiety, depressed mood, brain fog

• Lymphedema management
• PT, OT, SW, Psychology support
• Primary barrier to discharge ultimately dysmobility
Acute/Inpatient Care: Case 1 follow up
Case-Based Learning

- Patient transferred to NSRC
  - COVID Unit LOS = 22 days (including 2d IMCU stay)
  - PIC LOS = 66 days
  - NSRC LOS = ongoing (currently at 49 days)
  - Total hospital admission LOS = 137 days to date
- Persistent fatigue, anxiety – ongoing inpatient rehabilitation
Acute/Inpatient Care: Case 2
Case-Based Learning

• 49-year-old female
  • PMH: nil, no home meds

• Admitted to COVID Inpatient Unit (from ED) on day 6 of respiratory symptom onset
  • COVID swab positive in ED
  • Dexamethasone, full dose anticoagulation, TOCI
  • Increasing O2 requirements within 8h, difficulty tolerating prone position – transferred to IMCU for CPAP trial
  • Failed CPAP, to ICU for intubation within 24h
Acute/Inpatient Care: Case 2
Case-Based Learning

- Complicated ICU stay x 30 days
  - Prolonged intubation – tracheostomy (day 20), agitated delirium (clonidine, seroquel), left brachial plexopathy, new dx Hep B (entecavir), VTE (DVT leg - apixiban), UTI + VAP (ceftriaxone), dysphagia + NG feeds, dysmobility

- Declassed to 3IMCU x 11 days
  - Sinus tachy, finished ceftriaxone, NG feeds, decannulated trach July 1

- Declassed to PIC on PAD 41
Acute/Inpatient Care: Case 2
Case-Based Learning

- **Dysphagia:**
  - NG feeds optimized
  - Repeated MBS, NG removed + oral diet maximized post-transfer day 12
  - Trach site healed well
- **Left brachial plexopathy:**
  - OT + PT, pain control
  - Plastics: no splinting required, outpatient follow up recommended
  - Neurology: partial EMG, plan for full EMG once finished DOAC in 3 months
- **Right leg DVT:**
  - DOAC continued, no complications
- **Mobility:**
  - Regained independence with transfers + ambulation using 2ww
- **Persistent dyspnea, fatigue**
- **Tachycardia on exertion**
- **Anxiety:**
  - SW supported
Acute/Inpatient Care: Case 2 follow up

Case-Based Learning

- Patient discharged home independent
  - COVID UNIT LOS = <1 day
  - ICU LOS = 30 days
  - IMCU LOS = 10 days
  - LOS PIC = 12 days
  - LOS overall = 52 days
- Persistent fatigue
• Frailty
  • Acute on chronic dysmobility and cognitive decline for patients with underlying moderate+ frailty
  • Supportive care, Geriatrics
Acute/Inpatient Care: Autonomic dysfunction in long-COVID
Case-Based Learning

- Orthostatic intolerance syndromes
- Postural orthostatic tachycardia syndrome (POTS)

**Autonomic dysfunction in ‘long COVID’: rationale, physiology and management strategies**

**Authors:** Mireia Daru, Andrea Chironi, Patrica Taraborelli, Mitra Moezikrat, Dimitri Panopoditis, Richard Sullivan and Peony Awan Lam

The SARS-CoV-2 (COVID-19) pandemic has caused unprecedented morbidity, mortality and clinic disruption across the world. Following initial phase, healthcare systems are focusing now on evolving new cases and planning rehabilitation strategies. Post-COVID, orthostatic intolerance, autonomic dysfunction and autonomic dysfunction in long-COVID are important aspects to focus on.

**Introduction**

The SARS-CoV-2 (COVID-19) pandemic has caused unprecedented morbidity, mortality and disruption across the world. Following initial phase, healthcare systems are focusing now on evolving new cases and planning rehabilitation strategies. Post-COVID, orthostatic intolerance, autonomic dysfunction and autonomic dysfunction in long-COVID are important aspects to focus on.

**Results**

The COVID Symptom Study (COSY) is a large-scale, prospective, cohort study in the UK that has identified a range of symptoms that persist after acute infection with SARS-CoV-2. The study found that over 20% of people who had COVID-19 experienced long-term symptoms, including orthostatic intolerance, postural tachycardia, and other autonomic dysregulation.

**Conclusion**

In conclusion, autonomic dysfunction and postural tachycardia syndrome (POTS) are important aspects to focus on in the management of long-COVID patients. Healthcare providers should be aware of these conditions and consider them in the diagnostic and treatment plans for patients with long-COVID.
Post-COVID Provider Discussion Forum

Welcome to the Post-COVID Providers Forum, an online discussion platform aimed at supporting primary healthcare providers in caring for individuals experiencing post-COVID symptoms.

View TimedRight Tutorial Videos

13 Aug 21 4:46 PM AOT
Dr. Christy Bussey created a discussion with the topic: Hello and happy Friday!

14 Jul 21 3:41 PM AOT
NSHA Community Admin created a discussion with the topic: Welcome!
Speaker Name: Dr. Suzanne Salsman

Relationships with financial sponsors:
• No financial sponsors to report
• 57 year old man, RHD
• PMHx: HTN, DLP, DMII, Obesity (~300-lbs)
• Medications: Atorvastatin, Indapamide, Metformin
• SHx: Lives in a 2-level home with stairs to enter. Supportive family. Working in food services prior to illness. Non-smoker. Minimal EtOH.

Timeline

• **Day 1:** Developed symptoms of COVID-19 infection
• **Day 6:** COVID test positive
• **Day 10:** Admitted to hospital with progressive dyspnea
• **Day 13:** Intubated
  • ICU: vasopressors, tocilizumab, steroids
• **Day 24:** Extubated and transferred to IMCU
• **Day 29:** Transferred to home hospital
Complications

- Hypoactive delirium
- Acute kidney injury
- Pulmonary embolism → Apixaban
- Opportunistic infections
- Steroid/critical illness myopathy
  - Proximal > distal weakness
  - EMG: Mild distal polyneuropathy (DM), subacute left C5/6 radiculopathy
Inpatient Rehab Stay

Goals

Intensive rehab program to improve on strength and endurance with goal of returning to independent living.
Physical Exam:

- Alert and oriented, pleasant
- Clear AE to bases, JVP not elevated, no pedal edema
- Normal MSK exam
- Globally diminished reflexes
- Decreased sensation feet
- Grade 2 weakness shoulder abduction and flexion bilaterally
- Otherwise Grade 4 weakness
- Normal cerebellar exam
Rehabilitation
Case-Based Learning

Baseline Assessment and Rehab Goals

**PT/OT**
- Bariatric MWC, 2ww
- Decreased balance, endurance
- Proximal weakness UE
- Fatigue
- Mod Ax x2 for transfers
- Mod Ax for self-care (shower, dressing, toileting)

**SLP/Dietician**
- Minor issues – no dysphagia or dysarthris
- Nutritional support during ICU stay
- Bone Health – calcium, vit D and multivitamin
Course in Rehab: Medicine

• Early in rehab admission, developed transient delirium and decrease in cognitive function
• Psychotic features
  o Hallucinations/messages from God
• Loud and agitated
  o Became physically aggressive with staff
• Psychiatry Consult
  o Haloperidol short term – d/c’d when delirium resolved
• Work up revealed UTI – treated with Abx
Course in Rehab: Medicine

- Patient embarrassed the next day when LOC/delirium improved
- Apologetic to staff, tearful
- Fatigued
- CT head: Normal
- Cognitive assessment
- MoCA 20/30, with 0/5 for delayed recall
- Slower processing speed
- Apraxia with over-learned functional tasks
Course in Rehab: Physiotherapy

• Improved balance, endurance and strength
• Independent with all transfers
• Independent walking without gait aids 300m
• Decreased speed
• Decreased quality gait with increasing fatigue
• Independent 11 stairs with railing
• Proximal upper extremity strength improved, but requires continued rehab
Rehabilitation
Case-Based Learning

Course in Rehab: Occupational Therapy

- Cognition and memory improved
  - Education on cognitive effect of fatigue and compensatory strategies
  - Memory book
  - Symptom journal
- Improvement in independence with self-care
  - SBA for showering, toileting, dressing with equipment set up
  - Tub-transfer bench, grab bars, raised toilet seat
- Independent and safe on kitchen assessment (stove, sharp items)
- Independent on Ax of household tasks
Course in Rehab: Discharge Planning

- Weekend Pass – successful
- Family Meeting
  - Family members felt able to support him for IADLs (groceries)
  - Felt HCNS not needed at that time
- Discharged home
  - Outpatient physiotherapy – balance, strength, gait speed, proximal arm strength
  - HEP OT & PT
  - Outpatient Vocational Counselling
- Patient goals of care
  - Return to independent life
  - Vocational training to find an appropriate line of work
Outpatient Follow-Up: 3 Months

- Slowly regaining strength
- Fatigued and SOB with increased exertion
  - Deconditioning
- Baseline independence for ADLs & IADLs
- Remains on sick leave from work
- Weight loss (~45-lbs)
- Therapeutic anticoagulation x 3 months for provoked PE → ASA
- COVID vaccination at 3 months post-tocilizumab treatment
Case Summary and Learning Points

• 57 year old man with history of severe COVID-19 infection with complications of prolonged intubation (11 days), PE, and subsequent severe critical illness myopathy

• 2 month inpatient rehab stay with multidisciplinary care lead to improvements in mobility, cognition, and independence with ADLs and iADLs

• Plan for continued outpatient therapies and follow-up with rehab team until rehab goals optimized
Case-Based Learning: ABI Outreach
Faculty/Presenter Disclosure

Speaker Name: Lynn Renton

Relationships with financial sponsors:
• No financial sponsors to report
Acquired Brain Injury Outreach Service

Service Description

ABI Outreach

ABI Outreach is a community-based multidisciplinary service that works with individuals with Acquired Brain Injury. It is under the Rehabilitation and Supportive Care portfolio. The team includes Occupational Therapy, Social Work, Behaviorist, Recreation Therapy and Physiotherapy.

The referral form is available on the Nova Scotia Health website and can be faxed to the Coordinator, ABI Ambulatory Care Teams.
Acquired Brain Injury Outreach Service

Eligible Clients

To be eligible for services of the ABI Outreach team, clients must be:

- Diagnosed with an acquired brain injury (e.g., traumatic brain injury, stroke, brain tumors, meningitis/encephalitis, lack of oxygen to the brain)
- 18 years of age and older
- Living within Central Zone
- Requiring a **coordinated, multidisciplinary** approach who are:
  - Recently discharged from hospital and require services to support successful transitions, OR
  - Are community dwelling but have had a recent change in circumstances (e.g., change in living situation)

**AND:** Would be at risk of harm/safety concerns, ER visits, hospital admission, or a discharge plan falling apart if they do not receive ABI Outreach services
Acquired Brain Injury Outreach Service

Post-COVID Experience

**Referrals**

To date, Outreach has received two referrals for individuals with Post-COVID syndrome.

**Management**

They were both discharged with referrals to outpatient OT as part of their discharge plan, then were referred on to Outreach.
• 52 year old male found down at home, brought to ER by ambulance on Jan 29/21. Tested COVID positive.
• Intubated in ER, prolonged ICU admission with mechanical ventilation for COVID related pneumonia and respiratory failure.
• Multiple medical complications including ARF, dysphagia, GI bleed, anemia, elevated liver enzymes, pruritis.
• Once medically stable, noted to have generalized weakness, deconditioning, cognitive difficulties.
• Lived alone in 3 story home with 2 cats. Limited supports. Was working from home in banking prior to his illness.

Transferred to inpatient rehab Day 61

Functional status on admission:

• **Mobility:** Independent for wheelchair for mobility, transfer Ind. with 2ww, decreased balance.
• **ADL’s:** Bathing/Dressing/Grooming: Min Assist d/t impaired balance; cueing to initiate.
• **IADL’s:** Mod-max assistance d/t mobility/balance and cognition.
• **Cognition:** MoCA 27/30. Observed poor STM, slow processing, decreased initiation.
• **Mood:** Low mood identified as a concern.
ABI Outreach Service
Case-Based Learning

Timeline

- **Day 80**: D/C self AMA with:
  - Follow up with VON for daily injections X 6 weeks
  - Referred to Outpatient PT and OT
  - Follow up with Physiatry and Hepatology

- **Day 104**: Outpatient PT started and still going

- **Day 125**: Saw outpatient OT, completed COVID Yorkshire Rehab Screen:
  - Endorsed 13/18 components

- **Day 147**: Referred to ABI Outreach, completed Intake

- **Day 168**: ABIO Initial visit, involvement ongoing
Acquired Brain Injury Outreach Service

Goal Areas

1. ADL’s
2. IADL’s
3. Cognition/ Organization
4. Physical Exercise
5. Fatigue Management
6. Financial Resources
7. Meaningful Activity
8. Mood/Adjustment to Change/Loss
9. ABI Education and Support
Acquired Brain Injury Outreach Service

Insights

Reflections:

• Complex medical issues with multi-system involvement
• Severe sudden onset fatigue – physical and cognitive that impact function & rehabilitation
• No clear diagnosis of ABI but have cognitive changes – significant issues with attention, initiation, STM, executive function
• Cognitive screens may not detect higher order cognitive impairments
• PTSD type features – memories of hospitalization
• Feelings of isolation and shame
• The newness of the illness and the unknown nature of the prognosis
Speaker Name: Sarah Manley

Relationships with financial sponsors:
• No financial sponsors to report
Dr. Maria Alexiadis

Wrap Up
Support Resources for Providers

Post-COVID Resource Hub

- PHCQuality.ca
- Resources and tools for providers and patients: CPGs, literature, tools and more
- Webinar recordings and slide decks
- Learning modules
- Additional support resources

Post-COVID Providers Forum

- Online discussion platform to connect providers virtually
- Ask questions; share expertise, experience, and the latest evidence; give and receive support related to post-COVID
- Moderated by clinician peers with experience caring for patients experiencing post-COVID symptoms
- Interested in joining?
  - Email PHCPPracticeSupport@nshealth.ca
  - Link will be available in post-webinar evaluation
Thank you for joining us!

Please complete the evaluation for Webinar 2

Webinar recordings will be posted online

Link in chat box and will be sent via email
Question & Answer Period

Webinar 2
Thank You