Connected COVID Care



Connected COVID Care focuses on delivering an integrated care experience for patients and their caregivers. The majority of patients with COVID-19 can be cared for at home. This program allows acute care to continue to monitor patients at home while drawing on the expertise and capacity of home & community care supports and primary care where needed.

Connected

COVID Care

The four key elements of the program are:

One team

Patients will have a primary contact to help them stay connected to acute care expertise and coordinate with home & community care as well as primary care where needed.

One point of contact

Patients and caregivers have one place to have their questions and concerns answered

Virtual clinic

Rapid assessment and ongoing monitoring are available through a virtual clinic from Monday to Friday, 8:00am to 4:00 pm.

The clinic is staffed by physicians, nurse practitioners and administrative support.

Digital enablers

A virtual care referral and assessment platform (RCOVID) integrated with a health record; allows care team to stay updated on a patient's progress.

Benefits of Connected COVID Care

Patients and caregivers

- Care is provided in the comfort and safety of the patient's home
- One coordinated team, with a primary point of contact
- One contact point for questions and support

Care providers

- A simple referral process to a virtual COVID-19 care team
- Connection to the virtual care team for ongoing patient consultation
- Ongoing access to patient's COVID-19 care via EPR

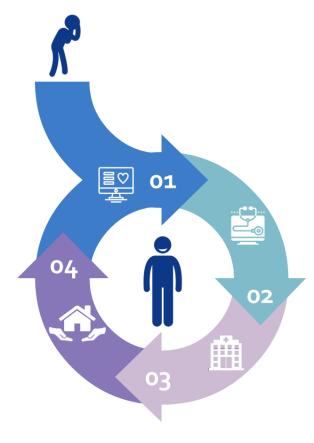
Clinic Number: 437-488-1650 Clinic Email: COVIDCare@UHN.ca

Last updated: July 31, 2020

Connected COVID Care



The Patient Care Experience



01 Identify & Engage

 Patient identified at Emergency Department, TWH COVID Assessment Center, UHN clinic/unit once medically stable from GIM/other clinics, or from Primary Care

02Assess

- Patient tested and care path determined admitted to hospital or instructed to self-isolate and monitor symptoms from home
- Patient referred to virtual clinic (if sent home)

03 Treat

Patient receives an initial assessment within 24-48 hours

04 Ongoing Monitoring & Care

- Patient re-assessed and monitored until recovery
- Patient receives counseling, education and care is coordinated with other facilities, including home & community supports as needed
- If patient is worsening, virtual clinic will determine if home care can support or if patient needs to return to hospital

Key Steps for the Integrated Care Team

01

Patient Identifies Concern & Engages with Care Team

Patient identified at Emergency Department, UHN clinic/unit, or TWH COVID Assessment Center or Primary Care 02 Patient is Assessed

Patient tested and care path determined 03

Patient is Treated (Inpatient and/or Outpatient Care Path)

Patient enrolled into appropriate care path

04

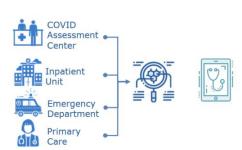
Patient Receives Ongoing Monitoring & Care

> Patient receives support and care until recovery

05

Post COVID Condition Care

Patients with ongoing symptoms (Post 4 wks-18mths) receives additional support and care





Inpatient Care
Path

Patient admitted to hospital

Patient is discharged back to transitional facility or primary care



Virtual & In
Person Care
Initial assessment & ongoing care as needed; links to

specialists (e.g. neuro), rehab, dietician, social work

Outpatient Care Path

Patient sent home to self-isolate & recover with links to primary care, rehab supports, psychosocial supports, transitional facility