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PRIMARY CARE ASTHMA PROGRAM NEWSLETTER

CLINICAL PROGRAMS

VACCINE CONFIDENCE AND LUNG HEALTH DURING COVID-19

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Since the outset of the pandemic, people with underlying lung, respiratory and other chronic health conditions have been at greater risk of serious COVID-19 related complications. Furthermore, short and long-term lung and respiratory complications have been seen in previously healthy individuals with COVID-19. Lives are at risk and COVID-19 continues to place an unprecedented strain on our healthcare system. Our clearest path out of the pandemic is through vaccination.

To date, Health Canada has authorized the use of COVID-19 vaccines produced by Pfizer-BioNTech, Moderna, AstraZeneca/COVISHIELD and Janssen. These four vaccines have undergone rigorous testing in clinical trials and real-world evaluative studies for safety and effectiveness. In particular, the vaccines are safe and effective for people with stable health conditions, including lung and respiratory issues. COVID-19 vaccines protect against severe COVID-19 related illness, including hospitalization and death. Evidence also shows that they prevent COVID-19 transmission. The vaccines are also proving effective against variants of concern currently circulating in Canada.

Surveys have shown that approximately two thirds of Canadians intend to get vaccinated as soon as they are eligible. While only about 5% of Canadians are opposed to COVID-19 vaccines, the remaining roughly one third of our population is hesitant. Promisingly, people who have been 'on the fence' are becoming more confident given vaccine successes in many jurisdictions. Yet vaccine hesitancy remains a significant issue that can potentially compromise herd immunity as a public health goal.

Three factors influence vaccine hesitancy: convenience, complacency, and confidence. As health professionals we play a pivotal role in addressing hesitancy. To focus on convenience, we need to stay informed about and promote the variety of vaccination sites in our communities. In addition, we need to be aware of local strategies to remove vaccine barriers such as mobile vaccinations for homebound patients and accessible transportation options for seniors, people with disabilities and those experiencing poverty. In regards to decreasing complacency, we can ensure that patients understand the potential severity of COVID-19 illness, as well as the importance of protecting themselves, their families and the greater community.

Some of the most effective strategies for increasing vaccine confidence include the use of personal testimony, listening to patient concerns without judgement, and promoting accurate evidence-based vaccine information to counteract the plethora of circulating disinformation. It is important to recognize that people's experiences of racism and discrimination in healthcare often contributes to a lack of trust, impacting vaccine confidence. Taking the time to cultivate trust with patients, particularly those who face discrimination, can help turn vaccine hesitancy into confidence.

The need to focus on vaccine confidence is not new to us in public health, nor is it new to the readership of the Lung Health Foundation. Each year we gear up to promote confidence in annual flu and pneumonia vaccinations. As vaccine information continues to evolve there are many resources available to keep clinicians abreast and help them have meaningful conversations with patients.

The National Advisory Committee on Immunization (NACI) is the front line for information about current recommendations, safety, and regulation related to COVID-19 vaccine products, as well as all other vaccines. Local health units provide quick updates and pull together government recommendations for clinicians' quick reference. For example, Toronto Public Health has compiled vaccine information from various evidence-based sources which are

available on the Toronto Health Professionals COVID-19 website. Regulatory colleges and professional associations synthesize data and regularly make statements to help clinicians with considerations for patients with special circumstances. For example, the Canadian Thoracic Society has published a statement on COVID-19 vaccination specifically in those with lung health issues. Local communities of practice meetings and webinars, such as the University of Toronto's Department of Family and Community Medicine web series, provides a forum for clinicians to consult with their peers. The Centre for Effective Practice compiles academic and government resources to create scientifically sound answers to questions that we are faced with daily. This list is not exhaustive but it does provide important go-to resources.

To confront COVID-19 and adapt to an ever-changing practice environment we need to work together and stay informed. By building trust and communicating effectively with patients we can protect our communities and improve vaccine confidence for the long term.

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TREATING LONG COVID: PERSPECTIVES FROM A PHYSIOTHERAPIST

Jessica DeMars, PT, Owner of Breathe Well Physio, Calgary, Alberta

I've been working with people with breathlessness for over 10 years. It's fringe practice for a physiotherapist in private practice, but I've always been one to push the boundaries. Before the COVID-19 pandemic hit, my caseload consisted of people with unexplained breathlessness – some of whom had respiratory disease, but many who did not. The common factor was that they all seemed to have a breathing pattern disorder that was contributing to ongoing breathlessness, causing a decreased quality of life and activity reduction. I considered myself a "breathing detective," and set out to work with people to get back to what mattered to them.

In March 2020 at the outset of the pandemic, I realized quickly, that having a public clinic for people with respiratory disease and other co-morbidities during a respiratory pandemic was a bad idea. I closed early; which, I realized would have happened anyway as my two young boys were sent home from school indefinitely.

During those first few weeks, we were inundated with reports from Europe of hundreds of people in ICU units on ventilators, struggling for their life. We braced ourselves for the same; recognizing that our current health system offered very few pathways for people who recovered from respiratory infections and ICU. My colleague and I pivoted early to try to find a way to fill that gap, developing a program in conjunction with a local non-profit clinic that would provide a pathway. And then we waited.

Thankfully, our first wave was small, and we had few ICU admissions. In fact, by June, it seemed that we were through the worst. Referrals picked up again – we had transitioned to a virtual format, and it was working well to address breathlessness while keeping people safe. Then we started noticing a trend that people with unexplained breathlessness and fatigue had a history of a respiratory infection a few months prior. We started to put two and two together and realized that many had likely been exposed to COVID-19 but didn't qualify for testing.

I recalled that in April, I was introduced to Myalgic Encephalomyelitis (ME) – a patient who was referred for breathlessness also had ME. I took a bit of dive into this disease – previously referred to as Chronic Fatigue Syndrome (CFS) and discovered that the people I was seeing with potential COVID-19 infection had a lot of similarities to ME/CFS. At the same time, we started hearing reports of "Long COVID" – people experiencing ongoing symptoms of COVID-19 infection long past the typical two weeks we were told people would be sick for.

This was the start of something very big. Suddenly I was in the middle of it all. My Twitter feed became my own echo chamber of Long COVID, fatigue, post exertional malaise, ME/CFS. I recognized that a significant subset of people who had been infected with COVID-19 would not fit under our traditional Pulmonary Rehab model of "exercise is medicine." In fact, it could be harmful if we did try to push it. Where did that leave me as a physiotherapist trying to help, when that is generally our number one tool?

Further down the rabbit hole I went. I realized that perhaps we have a different role in helping people manage health conditions. Maybe our number one tool isn't to get people moving, but it's to listen, validate and advocate. We need to meet people where they are at, believe what they are telling us, and adjust our own preconceived biases. We need to learn as much as we can about post viral illnesses – ME/CFS – and understand that our traditional model can be harmful.

Working with people with Long COVID has been very humbling. I don't have the answers. I can offer a few tools to help manage symptoms of fatigue and breathlessness, but we are ultimately at the mercy of whatever is causing on-going symptoms. Some will get better with time. Some might never recover. That is a hard reality for many of us in physiotherapy as we are trained to make people feel better, and improve their quality of life. We might not be able to do this with Long COVID.

I have found it easy to get too personally invested in each person I work with – I feel their struggles deeply; sometimes I am their only support as many in the medical field have not yet recognized that Long COVID is real. It is a difficult line to walk, and I know I need to watch my own mental health as I can easily become consumed in trying to find some kind of answer for my patients.

Long COVID will challenge those of us working in rehab – especially those of us who are used to getting our patients who are short of breath moving. But I urge you to think twice and consider there may be something else preventing people from moving. It will not be fear or lack of motivation – one common factor is that these people desperately want to get back to the life they had before. Many are young, previously healthy and very active; the mental impact of dealing with a novel disability with unknown outcomes is quite profound.
We will need to check our expectations of recovery at the door and if I can offer one tidbit of advice to anyone working with people with Long COVID it would be this:
be kind, be patient and believe.

FOR MORE INFORMATION:

Email: breathewellphysio@gmail.com
Twitter: @breathewellPT
Instagram: @breathwellphysio
Other: www.longcovid.physio

INTEGRATED CARE IN KENORA – HOW THE SUNSET COUNTRY FHT AND COMMUNITY PARTNERS HAVE BANDED TOGETHER TO PROVIDE A PULMONARY REHABILITATION PROGRAM FOR PEOPLE LIVING WITH COPD

Colleen Snyder, RN, CRE, Sunset Country FHT

Kenora, Ontario is located 2.5 hours east of Winnipeg on the spectacular Lake of the Woods (LOTW) and 6 hours west of Thunder Bay, ON. LOTW has become known as Winnipeg's cabin country and many travel year round to their 'camps' on the lake and surrounding areas. Kenora is also known for its pristine wilderness, clean waters and outstanding fishing, boating and camping.

The Kenora service area is large and a widely dispersed geographical area with a catchment population estimated at 28,000. Census Canada shows that there are 15,348 people living in the City of Kenora, of which 2800 are identified as First Nation. The Sunset Country Family Health Team (SCFHT) also services Unorganized Territories (East & West), Minaki, Redditt, Sioux Narrows/Nestor Falls and 11 surrounding First Nation communities with a population of approximately 8000.

In 2019, All Nations Health Partners (ANHP) became one of the first Ontario Health Teams, as well as the first from the North, the smallest, and the only team with full Indigenous and community partners. ANHP started as the Kenora Area Health Care Working Group, which formed in 2015 to address a critical doctor shortage and cross-border issues. The ANHP include Indigenous, municipal and health care leaders who signed a Resolution in ceremony in 2017, to work towards the development of a seamless, patient-centred health care system. The ANHP aim to provide the right service, at the right time, in the right setting, for everyone in the Kenora region. Cultural safety will allow the blending of traditional and mainstream medicines for holistic healing. SCFHT is one of many ANHP partners working to integrate care for those living with lung disease.

The SCFHT Lung Health Program consists of spirometry screening of patients suspected of having asthma or COPD, comprehensive assessment, self-management education, smoking cessation, individualized care plans that are completed in collaboration with the patient's primary care provider and regular follow-up. Though the team offered disease management, there was an identified need to support our patients in exercise and activity.

Over the past year, the SCFHT Certified Respiratory Educators (CREs) and the outpatient rehabilitation department at Lake of the Woods District hospital (LWDH) have been meeting to design a new outpatient pulmonary rehab exercise program to replace the now defunct Fitness for Breath (FFB) program that was running in conjunction with the Kenora Recreation center. The one part-time physiotherapist at LWDH had previously worked in Dryden, ON and provided the FFB format at their local hospital.

She has developed a 6-week pulmonary Rehab program that will consist of:

- Subjective assessment
- Objective measurement of baseline HR, O2 saturation; BP, 6 minute walk test while monitoring O2 saturation
- Review of a Home Exercise Program including exercise execution / follow up and handouts
- 6-week course of twice weekly appointments for the monitored cardiovascular component

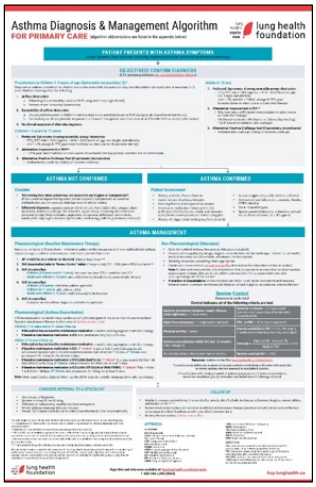
TOPICS INCLUDE:

- Breathing Control and Exercises
- Breathing techniques - Active cycles of breathing, Pursed-lip breathing and Diaphragmatic breathing exercises
- Energy Conservation
- Stress/Anxiety Management
- Yoga, Meditation and COPD

The SCFHT CREs and primary care providers can refer eligible and willing patients to the program through one referral form with consent from the patient. The LWDH physiotherapy department contacts the patient to set up the initial intake appointment and to review the program components.

We will be meeting again shortly to review the current objective measures, client satisfaction surveys, successes, ongoing issues/challenges and working collaboratively to find successful solutions to allow the program to move forward and grow.

UPDATE PCAP TOOLS – ASTHMA DIAGNOSIS AND MANAGEMENT ALGORITHM AND ASTHMA CARE MAPS



The Lung Health Foundation is the credible and trusted organization for best practice guidelines on asthma and COPD. The Primary Care Asthma Program (PCAP) provides evidence-based information, tools and resources to help providers diagnose and manage the growing number of people living with chronic lung disease. It is a one-stop shop for resources, clinical practice tools, as well as programs and supports for patients and healthcare provider education.

The clinical tools for providers are updated as new evidence and guidelines emerge. With the updated **2021 Canadian Thoracic Society Guideline – A Focused Update on the Management of Very Mild and Mild Asthma**, the Lung Health Foundation has started the process of updating the asthma clinical tools to align with these guidelines. These updates include changes to the control criteria and changes to the medications suggested for people with very mild and mild asthma. We have updated the Asthma Care Maps and the Asthma Diagnosis and Management Algorithm and are in the process of reviewing our Asthma Action Plan for adults (16 years and older) and the Asthma Action Plan for Pediatrics (1-15 years). The Asthma Care Maps (**initial** and **follow-up visit**) are assessment forms that guide the provider in asking their patients the right questions to support best practice. The **Asthma Diagnosis and Management Algorithm** is a decision support tool. The algorithm was developed and designed to assist healthcare providers in following the latest CTS guidelines and to objectively diagnose, manage, and provide appropriate education to their patients with asthma.

For more information on PCAP and if you would like to implement the program, please contact Sara Han, Provincial Coordinator, PCAP at **shan@lunghealth.ca**