Post-COVID primary care reboot?

by Kimberly Wintemute MD CCFP FCFP; Guylène Thériault MD CCFP

The COVID-19 pandemic has made the "Less is More" message of Choosing Wisely Canada particularly salient. We are providing more robust primary care in fewer weekly hours, with fewer physical examinations, with fewer in-office staff.

We have halted preventive care, including cancer screening, office blood pressure checks, diabetes and cardiovascular risk screening. We have increased the intervals for office-based infant and child development checks, prenatal visits and chronic disease monitoring.

There is a possibility of being "flooded" when things "re-open". We feel we should consider implementing a stepwise return to primary care services. Prioritization would stem from an evidence-based - and thereby ethical - framework.

Our table on prioritization is inspired by Korownyk et al., who have ranked primary care activities by effectiveness[1]. Other principles to consider at this time are maintenance of physical distancing in the office and preservation of personal protective equipment, such as masks. We therefore recommend continuing to use virtual care, and being selective about in-person visits.

The phases outlined in the table below might be useful for yourself, allied health professionals and support staff. It is not possible to provide an exact timeline; at best, we might consider our work relative to the evolution of the pandemic. This will vary according to the epidemiology of your region now and during the reopening phases; and according to the nature and demographics of your practice.

Table: Suggested prioritization of clinical services in returning to Primary Care during COVID-19 Pandemic. Offer these services, virtually or in-office, as deemed appropriate, prioritizing by phases over time, and scheduling in-person visits so that your waiting room is not crowded. Until the epidemiology tells us otherwise, wear a mask and practise diligent hand hygiene in the office.

Phase 1 **When businesses and schools reopen**	• **acute or subacute symptoms** • **potentially unstable chronic disease, such as post-myocardial infarction, post-stroke, congestive heart failure (CHF), uncontrolled diabetes, cancer** • **severe or unstable mental health diagnoses** • **pre-existing developmental concerns among infants / children** • **pregnancy care** • **other matters presenting risk, for example addiction, at-risk sexual practices**
Phase 2 **When pandemic epidemiology is stable**	• **chronic symptoms** • **well infant / child visits** • **contraception**
Phase 3	• **chronic diseases previously well controlled,**

When pandemic epidemiology is stable and most activities have returned to normal	**requiring interval follow-up (diabetes, hypertension, renal insufficiency, stable CHF, mental health diagnoses)**
Phase 4 When physical distancing requirements are lifted	• **Blood pressure checks for those without chronic disease** • **Sexually transmitted infection screening in average risk individuals** • **Cancer screening: cervix and colon (known to have greatest effect) [2], then breast [3]**
Phase 5 When physical distancing requirements have been lifted, Phase 4 has been implemented, and capacity exists	• **Patient-initiated health promotion (smoking cessation, etc)**

This is a situation that we have never experienced, and there is much to learn. First, virtual visits have been under-utilized. For certain clinical presentations, they can decrease the burden on patients without substantially increasing our workload. They should probably be integrated into daily practice.

Second, we have noticed that although many of our patients did not access care as usual, they remained well. No harm came about for the vast majority of them. Perhaps more is not always better, after all.

Dr. Kimberly Wintemute is an Assistant Professor at the University of Toronto and Primary Care Co-Lead at Choosing Wisely Canada

Dr. Guylène Thériault is in the Department of Family Medicine at McGill University and Primary Care Co-Lead at Choosing Wisely Canada

References

1. http://www.cfp.ca/content/cfp/63/9/664.full.pdf

2. For cervical cancer screening in individuals without a history of abnormal lesions there is no rush to do a Pap test even if it has been a bit more than 3 years. Some countries do Pap tests every five years, with no difference in cervical cancer mortality https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3385017/pdf/milq0090-0005.pdf

3. Considering low effect size of screening and CTFPHC recommendation for q2-3 year screening, this could wait until 3 years https://canadiantaskforce.ca/guidelines/published-guidelines/breast-cancer-update/