COVID-19 in LTC – An Update
Webinar on 4-22-2020
Presented by Joseph Ouslander, MD

Response to Q&A

COVID-19 in Long-Term Care Facilities – An Update
Q&A for Pathway Health Webinar April 22, 2020

1. Is there a Carepath for COVID 19?

   I do not know of one, and I don't think one is needed. INTERACT Care Paths should be used for non-specific symptoms that can be manifestations of COVID, including Fever, Shortness of Breath, Symptoms of Lower Respiratory Infection, Altered Mental Status. COVID testing should be ordered when available for these types of symptoms.

2. Has any hospital tried to treat with hyperbaric chamber?

   I have not heard of it but would not be surprised since the primary problem in COVID-19 ARDS is hypoxia.

3. What would be the best use of serum antibody tests--for residents? for staff? Is timing an issue?

   As discussed on the webinar this is very complicated. Presence of the antibody does show a person has been infected (assuming it is not a false positive, which has been reported with at least one rapid test). However the magnitude of the antibody response is variable, we don't know what level is protective, and how long it lasts. The IGM antibody tends to be produced during the first 7-14 days, and the IGG antibody after 7 days. The interpretation of the tests is under study.

   I think the best use of tests is to repeatedly test staff every 7 -14 days when testing is available. This can help guide when people can come back to work and if they may safely care for COVID+ patients. This could result in quarantining a lot of staff, and staff shortages, but it is better than causing preventable spread of the virus and resulting illness and deaths.

4. Is there any criteria for dc of LTC patients back to their homes and society?

   I would use similar criteria as for the hospital. No symptoms for 3 days, onset greater than 7 days prior, and two negative tests. Otherwise I would not be comfortable discharging home, even if it was otherwise safe to do so.

5. Do you support requiring COVID testing in the hospital on all patients prior to discharge to LTC, even if patient is asymptomatic?

Yes, two negative tests and CDC criteria for symptoms. One negative test or no tests, no matter what symptoms should result in isolation for 7-14 days. This is consistent with CDC guidelines which you should check frequently.

6. How will plasma treat positive COVID-19 case?

   Centrifuging blood yields plasma or serum depending on how it is processed. These contain the antibodies which can be injected in to patients with the virus. It has been used in other viral illnesses, but studies are not completed yet on COVID-19.

7. May we share your PowerPoint presentation with our AMDA state chapter members? Some of us were unable to attend your presentation due to scheduling conflicts.

   Yes, that is why we make it available. I'd be happy to do a similar webinar for a state chapter of a mutually agreeable time can be established.

8. Is there a possibility of herd immunity and what impact it can have on the second wave of infection?

   Yes, herd immunity will help, but not enough. Unless social distancing and rapid testing, contact tracing, and isolation are continued, there will be more outbreaks. This is likely because of all the people who are protesting to get life back to normal who will be allowed to do so and more infections will occur.

9. Can you recommend strategies for managing discussions with physicians pertaining to medication overprescribing (in the context discussed today?

   A strong, knowledgeable medical director comfortable making recommendations to primary care clinicians, good relations with them, using evidence and vetted recommendations, and communicating by phone and letter. Some recommendations could be "consider" stopping or tapering a drug, others could be "this drug should be stopped because the risks of this drug outweigh the benefits in this patient".

10. Could you further clarify LTC admissions from Hospital as I understood that LTC/SNF still needed to admit a COVID-19 positive patient unless they do not have PPE/Staffing to properly meet their needs

    Check with state, county and local regulations and policies about this. Facilities should not be forced to accept COVID+ patients in the absence of adequate staffing and PPE.

11. What guidance would you provide in transition a positive COVID resident that is now testing negative in the LTCF back to the general nursing home population?

The most conservative answer is #5 above assuming testing is readily available.

12. When the flu season hits, at what point do we know if it's flu or COVID?

    There are no large studies about this. COVID patients can also be infected with other respiratory viruses, but influenza has not been studied. A small amount of data from China suggests that patients with influenza are unlikely to get COVID. But more research is need on this before assuming a patient who has a positive rapid flu test will be COVID negative.

13. What do you suggest that Assisted Living staff follow to restrict families?

    There is no specific guidance available on this, but would follow any CDC guidelines that apply. The American Geriatrics Society is publishing a policy brief on COVID and ALFs, and it does not make specific recommendations. Optimally, I think visitors and private personal assistants, therapists, etc, should be screened as per CDC and CMS recommendations for SNFs, and if fail the screen restricted.

14. What is the criteria in COVID testing an elder? fever alone

    Because the symptoms of COVID can be nonspecific any acute change in condition should prompt consideration of COVID testing and isolation until the results are known. Certainly a fever should prompt testing if available because it may an early and only manifestation of COVID.

15. Is there Immunity after having COVID-19?

    See answer to #3 above.

16. Why do people respond differently to covid-19? So people have it and recover, others have it and get really sick and die within a few days. is there a reason for this difference, apart from underlying illness. Is there immunological reaction going on?

    I'm not sure the answer is known. But, similar to many other diseases it is a combination of genetic susceptibility, comorbidities, medications, and the environment. Many older people have reduced immune function which may make them more susceptible. On the other hand many have evidence of excessive inflammation and that may either help or hurt depending on the exact nature of the response.

17. Do you prescribe anticoagulation like enoxaparin or Xarelto to all COVID positive patients in the LCTF?

    I just learned today that hypercoagulable states including DVT and stroke have been reported with COVID. However I don't think there is enough evidence to warrant the risks of anticoagulation for all. Like other illnesses, if a patient goes from mobile to immobile, prophylactic anticoagulation should be considered. If

you have a patient you are really worried about due to risk factors, it might be reasonable to order fibrinogen and d-dimer testing to help determine if anticoagulation should be prescribed.

18. **What is your stance on converting a LTCF to an ALL COVID facility to help minimize spread to other residents, hopefully reduce deaths, and help hospitals free up beds for ICU pts?**

    This was discussed on one slide. It is a local or regional decision and implementation is complicated. I will attach recommendations from the California Association of Long-Term Care Medicine that address approaches to this.

19. **Do you still recommend testing for COVID-19 if the resident is Influenza positive? I have spoken to some that stop screening for any other diagnosis if Influenza is positive.**

    See answer to #12. There are not enough data to support stopping testing for COVID if flu test is positive. More research is needed.

20. **Do we need to screen test our presumptive residents who are already on our COVID unit?**

    If you are creating a COVID unit, you should have the capacity to move all residents without COVID to another area with separate staff, preferable a separate entrance, etc. I'm not sure what "presumptive" means, but if they have suspicious symptoms you could isolate them if possible before transfer to the unit pending the results of COVID testing. But also remember 1 in 3 tests may be falsely negative, so you may need to test twice. That is the safest if practical to avoid exposing a presumptive resident to getting infection on the unit if they were negative in the first place.

21. **Just wanted clarify testing of staff for COVID....should we plan to test all direct care every staff every 7 days during an outbreak or until a vaccine?**

    I am not sure of the right answer because of what is mentioned in the answer to #3. Right now, I don't see any other way to prevent recurrent clusters than to continue all the CDC and CMS recommendations and repeatedly test staff every 7-14 days. This could result in quarantining a lot of staff, and staff shortages, but it is better than causing preventable spread of the virus and resulting illness and deaths.

22. **Do you think one of the reasons for the severe outbreaks in LTC could be from the airborne component of Covid-19 and the poor PPE allocated to LTC? Most LTC use procedure masks if available, not even surgical masks let alone N95's or PAPR's.**

Like in any other setting, lack of adequate PPE can result in clusters of infections. PPE must also be used properly and social distancing and other intensive infection control measures are important as well. Emory University has produced and excellent series of PDFs and videos on how to properly use PPE.

https://med.emory.edu/departments/medicine/divisions/infectious-diseases/serious-communicable-diseases-program/covid-19-resources/conserving-ppe.html

23. Once you have a COVID positive patient finish theory 14 day quarantine when would you take them out of quarantine back into the general community

    See answers to #5 and #11 above.

24. What is your thoughts about using Pronation as an intervention in addressing decrease in oxygenation

    I do not know enough about that to answer.

25. What do you think of anticoagulant therapy and Diemer testing?

    See answer to #17

26. Should pharmacist roles be expanded for prescriptive authority during this time to reduce stress on caregivers in the area of deprescribing and therapeutic substitutions during a drug shortage?

    I am not sure this is necessary. I think consultant pharmacists should work closely with their facilities on rapid cycle QI project to implement the deprescribing guidance that is referred to in the presentation. This is what we are pursuing in our facilities.