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COVID-19 in Long-Term Care Facilities: An Update

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- Public University with over 25,000 students
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Disclosures

- Dr. Ouslander is a full-time employee of Florida Atlantic University (FAU) and has received support through FAU for research on INTERACT from the National Institutes of Health, the Centers for Medicare & Medicaid Services, The Commonwealth Fund, the Retirement Research Foundation, PointClickCare, Medline Industries, and Think Research.
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- Work on funded INTERACT projects is subject to the terms of Conflict of Interest Management plans developed and approved by the FAU Financial Conflict of Interest Committee.

COVID-19 in Long-Term Care Facilities: An Update

Key Points: THANKS to the Team!

- We all must be thankful for and appreciate team members who are providing direct care, risking their health and the health of their families every day
- We know all are working hard and many will continue to work when staffing is short
- We must therefore pay attention to their concerns and encourage them to stay as healthy as possible in this challenging time

COVID-19 in Long-Term Care Facilities: An Update

Key Points: Support the Team

Team Member Concerns

April 7, 2020

Understanding and Addressing Sources of Anxiety Among Health Care Professionals During the COVID-19 Pandemic

Tait Shanafelt, MD[1]; Jonathan Ripp, MD, MPH[2]; Mickey Trockel, MD, PhD[1]

JAMA. Published online April 7, 2020. doi:10.1001/jama.2020.5893

Table. Requests From Health Care Professionals to Their Organization During the Coronavirus Disease 2019 Pandemic

Request	Principal desire	Concerns	Key components of response
Hear me	Listen to and act on health care professionals' expert perspective and frontline experience and understand and address their concerns to the extent that organizations and leaders are able	Uncertainty whether leaders recognize the most pressing concerns of frontline health care professionals and whether local physician expertise regarding infection control, critical care, emergency medicine, and mental health is being appropriately harnessed to develop organization-specific responses	Create an array of input and feedback channels (listening groups, email suggestion box, town halls, leaders visiting hospital units) and make certain that the voice of health care professionals is part of the decision-making process
Protect me	Reduce the risk of health care professionals acquiring the infection and/or being a portal of transmission to family members	Concern about access to appropriate personal protective equipment, taking home infection to family members, and not having rapid access to testing through occupational health if needed	Provide adequate personal protective equipment, rapid access to occupational health with efficient evaluation and testing if symptoms warrant, information and resources to avoid taking the infection home to family members, and accommodation to health care professionals at high risk because of age or health conditions
Prepare me	Provide the training and support that allows provision of high-quality care to patients	Concern about not being able to provide competent nursing/medical care if deployed to new area (eg, all nurses will have to be intensive care unit nurses) and about rapidly changing information/communication challenges	Provide rapid training to support a basic, critical knowledge base and appropriate backup and access to experts Clear and unambiguous communication must acknowledge that everyone is experiencing novel challenges and decisions, everyone needs to rely on each other in this time, individuals should ask for help when they need it, no one needs to make difficult decisions alone, and we are all in this together
Support me	Provide support that acknowledges human limitations in a time of extreme work hours, uncertainty, and intense exposure to critically ill patients	Need for support for personal and family needs as work hours and demands increase and schools and daycare closures occur	Provide support for physical needs, including access to healthy meals and hydration while working, lodging for individuals on rapid-cycle shifts who do not live in close proximity to the hospital, transportation assistance for sleep-deprived workers, and assistance with other tasks, and provide support for childcare needs Provide support for emotional and psychologic needs for all, including psychologic first aid deployed via webinars and delivered directly to each unit (topics may include dealing with anxiety and insomnia, practicing self-care, supporting each other, and support for moral distress), and provide individual support for those with greater distress
Care for me	Provide holistic support for the individual and their family should they need to be quarantined	Uncertainty that the organization will support/take care of personal or family needs if the health care professional develops infection	Provide lodging support for individuals living apart from their families, support for tangible needs (eg, food, childcare), check-ins and emotional support, and paid time off if quarantine is necessary

Keep the Team Healthy

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COVID-19 in Long-Term Care Facilities: An Update

Key Points: The Setting and Population

- LTCF is a broad term that includes many types of facilities
  - This presentation focuses on LTCFs that are generally referred to as "skilled nursing facilities", "nursing facilities", and "nursing homes"
- People who reside in these facilities are there for different reasons and differ clinically
  - "Patients" who are there for post-acute care after discharge from the hospital
  - "Residents" who require long-term care
- LTCF patients and residents are generally at high risk for complications of and mortality from COVID-19
  - Multiple chronic conditions
  - Advance age with altered immune function

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Key Points: Presentation of Covid-19 and the Importance of Infection Control

- LTCF patients and residents frequently **do not** have typical symptoms and signs of COVID-19
  - **No symptoms** – up to 50% or higher
  - Atypical symptoms – e.g. low grade temperature elevation; altered mental or functional status; GI symptoms
- LTCF staff may have no symptoms, no fever, and pass multiple screening tests, **and still be infected**
  - They also may be working multiple jobs at different facilities and be at high risk
  - They can therefore infect other staff and residents without knowing it
- The only way to prevent infection and further spread of infection is **behavior** – **intensive infection control**

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Key Points: Use of PPE and Isolation

- All staff must use some form of mask at all times, maintain "social distancing" and wash or sanitize hands frequently
  - CDC guidelines should be followed
  - Repeated education is essential
- As much Personal Protective Equipment (PPE) as is available should be used with any patient/resident suspected of having COVID or has an acute change in condition without an obvious cause
  - PPE should also be used during high risk or close contact procedures, including nebulizer treatments (which should be minimized)
- Because symptoms and signs may be atypical, there should be a **low threshold** for placing patients/residents on precautions, isolation or in quarantine areas
  - Check vital signs and for other changes in condition frequently (e.g. every shift)

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Key Points: Isolation and Quarantine

- Having a low threshold for isolation and quarantine, and isolating new admissions from the hospital will result in many being isolated, which can be especially hard for this population
- Regular contact with family and friends should be maintained using video calls social media – which will require help from staff for many
- Frequent checks are important both for human contact and to identify changes in condition

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Key Points: Availability of PPE and Testing

- Shortages of PPE persist and will recur in many areas
  - CDC guidelines should be followed to preserve PPE
- Availability of testing is variable and is still hard to get in a timely way except during suspected outbreaks
  - Interpretation of single tests is challenging
  - This further highlights the necessity of intensive infection control procedures

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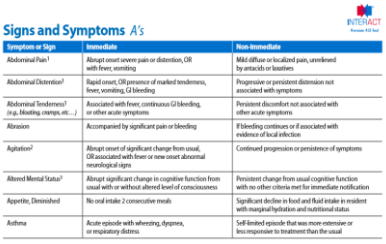
Key Points: Clinician Visits

- Clinicians should do as many visits as possible over the phone or by telemedicine if available
  - CMS has changed payment rules and requirements for in-person visits
- Use available tools to determine what needs immediate vs. non-immediate clinician intervention and what can be evaluated by phone or by telemedicine vs. in person visits
  - AMDA Practice Guideline on Notification
  - INTERACT Change in Condition Cards and Care Paths

Available free for clinical and educational use at:

www.pathway-interact.com



Signs and Symptoms A's

Symptom or Sign	Immediate	Non-Immediate
Abdominal Pain[1]	Abrupt onset severe pain or distention, OR with fever, vomiting	Mild diffuse or localized pain, unrelieved by antacids or laxatives
Abdominal Distention[2]	Rapid onset, OR presence of marked tenderness, fever, vomiting, GI bleeding	Progressive or persistent distension not associated with symptoms
Abdominal Tenderness[3] (e.g., bloating, cramps, etc…)	Associated with fever, continuous GI bleeding, or other acute symptoms	Persistent discomfort not associated with other acute symptoms
Abrasion	Accompanied by significant pain or bleeding	If bleeding continues or if associated with evidence of local infection
Agitation[2]	Abrupt onset of significant change from usual, OR associated with fever or new onset abnormal neurological signs	Continued progression or persistence of symptoms
Altered Mental Status[2]	Abrupt significant change in cognitive function from usual with or without altered level of consciousness	Persistent change from usual cognitive function with no other criteria met for immediate notification
Appetite, Diminished	No oral intake 2 consecutive meals	Significant decline in food and fluid intake in resident with marginal hydration and nutritional status
Asthma	Acute episode with wheezing, dyspnea, or respiratory distress	Self-limited episode that was more extensive or less responsive to treatment than the usual

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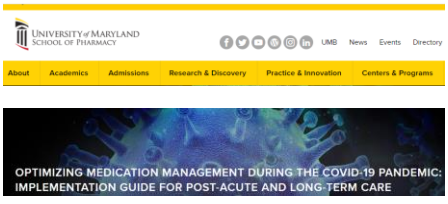
Key Points: Medication Management and Deprescribing

- Reducing number of medications, number of doses, and monitoring parameters will:
  - Reduce risk of viral transmission
  - Decrease staff burden and time
- Strategies
  - Discontinuation or reduction of unnecessary or minimally beneficial medications and monitoring
  - Changes to medication formulations and dosing regimens to minimize doses and administrations
  - Appropriate alignment of medication administration times
- Examples for discontinuation, at least temporarily:
  - ***Vitamins, herbals***
  - ***Docusate***
  - ***Appetite stimulants***
  - ***Cranberry tablets***
  - ***Chronic probiotics***



https://www.pharmacy.umaryland.edu/PALTC-COVID19-MedOpt

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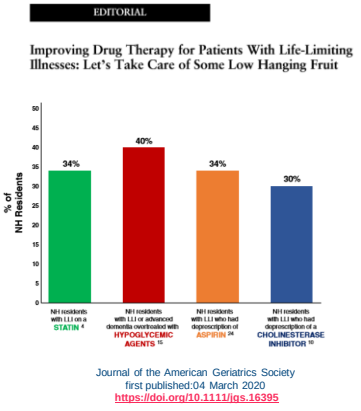
Key Points: Medication Management and Deprescribing

- Examples of medications to discontinue:
  - Ineffective, potentially harmful medications in residents with life-limiting illness
    - **Statins**
    - **Anticoagulants** such as prophylactic aspirin
    - **Cholinesterase inhibitors** – no benefit and several adverse effects
    - **Overtreatment of hypertension** - no benefit and risk of falls and syncope; staff monitoring time for BP checks and hold parameters
    - **Overtreatment of diabetes** –high risk for hypoglycemia and too much unnecessary nursing staff monitoring finger stick glucose levels



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Key Points: Advance Care Planning

- The mortality rate from COVID-19 will be high in the LTCF population, and clinical deterioration can occur rapidly
- Clinicians and LTCF staff should therefore conduct advance care planning discussions and update advance directives in light of the Coronavirus pandemic
  - The pandemic provides an opportunity to hold discussions that may have been difficult previously and to create COVID specific directives
- Advance Care Planning requires a team approach
  - Ultimately, this requires a trusting relationship between the patient/resident and the team
  - Engage local palliative care and hospice clinicians and teams where available

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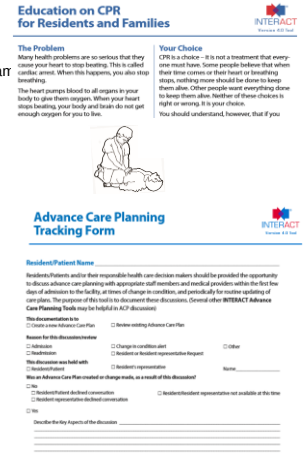
COVID-19 in Long-Term Care Facilities: An Update

Key Points: Advance Care Planning

- Many educational and documentation tools are available
  - Using evidence on prognosis (e.g. www.ePrognosis.com) and simple language descriptions of risks and benefits, such as those available in the INTERACT program are helpful
  - Being clear about the limited meaning of "DNR" is also helpful
  - COVID-19 specific tools are available
    - https://respectingchoices.org/covid-19-resources/
    - https://www.vitaltalk.org/guides/covid-19-communication-skills/
    - https://www.capc.org/toolkits/covid-19-response-resources/
- Documenting and communicating discussions and decisions is critical so that hospital transfers and other interventions are either implemented or withheld based on the patient/resident and family preferences
- **Be prepared for patients/residents dying in the facility**
  - Check emergency kits and stock with medications for comfort
    - ***Liquid morphine*** – injectable and oral/sublingual for respiratory distress
    - ***Lorazepam*** - injectable and oral/sublingual for anxiety/agitation
    - ***Atropine –*** liquid for secretions


Education on CPR for Residents and Families

INTERACT

The Problem

Many health problems are so serious that they cause your heart to stop beating. This is called cardiac arrest. When this happens, you also stop breathing.

The heart pumps blood to all organs in your body to give them oxygen. When your heart stops beating, your body and brain do not get enough oxygen for you to live.

Your Choice

CPR is a choice – it is not a treatment that every-one must have. Some people believe that when their time comes or their heart or breathing stops, nothing more should be done to keep them alive. Other people want everything done to keep them alive. Neither of these choices is right or wrong. It is your choice.

You should understand, however, that if you

Advance Care Planning Tracking Form

INTERACT

Resident/Patient Name

Residents/Patients and/or their responsible health care decision makers should be provided the opportunity to discuss advance care planning with appropriate staff members and medical providers within the first few days of admission to the facility, at times of change in condition, and periodically for routine updating of care plans. The purpose of this tool is to document these discussions. Several other **INTERACT Advance Care Planning Tools** may be helpful in ACP discussion)

This documentation is to

☐ Create a new Advance Care Plan ☐ Review existing Advance Care Plan

Reason for this discussion/review

☐ Admission ☐ Change in condition alert ☐ Other

☐ Readmission ☐ Resident or Resident representative Request

This discussion was held with

☐ Resident/Patient ☐ Resident's representative Name:

Was an Advance Care Plan created or change made, as a result of this discussion?

☐ No

☐ Resident/Patient declined conversation ☐ Resident/Resident representative not available at this time

☐ Resident representative declined conversation

☐ Yes

Describe the Key Aspects of the discussion

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Key Points: Inter-facility Transfers

- Federal, state, county, and local regulations and guidance varies relative to inter-facility transfers
- LTCFs should limit transfers to Emergency Departments and hospitalizations to clinical conditions that require specialized testing and/or and acute or ICU level of care
- AMDA Clinical Practice Guidelines, the INTERACT program, and other similar tools should be used to help manage patients/residents in the facility whenever safe and feasible
- Complete critical clinical information should accompany patients/residents using state mandated forms, the INTERACT transfer form, or a similar form that includes the information listed on the INTERACT transfer data list
  - Advance Directives should be documented and sent to the hospital so that preferences are known and honored


SNF/NF to Hospital Transfer Form

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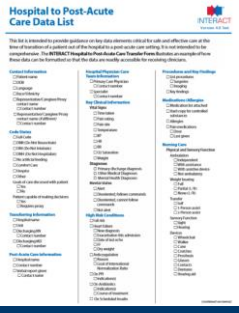
COVID-19 in Long-Term Care Facilities: An Update

Key Points: Admissions to LTCFs from Hospitals

- Hospital patients should be discharged home whenever enough support is available to manage them safely outside of a post-acute facility
- Unless otherwise overridden by state, county or local regulations:
  - COVID-19 positive patients should no longer have symptoms and two negative tests 24 hours apart before being transferred from hospital to LTCF or meet CDC criteria
    - No fever or respiratory symptoms for 72 hours and 7 or more days since onset of symptoms
  - Any patient being transferred from hospital to LTCF for any condition without a COVID-19 test result, or only one test result, should be presumed to be infected, and isolated for at least 7 days
    - Based on risk of acquiring the virus in the hospital, the non-specificity of symptoms, and the false negative rate of testing
- Hospitals should provide critical clinical information to post-acute settings using state information should accompany patients/residents using state mandated forms, the INTERACT transfer form, or a similar form that includes the information listed on the INTERACT transfer data list
  - This is especially important in settings where clinicians and other health professionals cannot access the hospital electronic medical record
  - Advance Directives should be documented and sent to the LTCF so that preferences are known and honored


Hospital to Post-Acute Care Data List

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Next Steps and Planning for the Future: Testing

- As rapid testing and self-testing become more available, it will be easier to test patients/residents and staff, and quarantine them as appropriate
- Many different tests for the virus are available, but false negative and false positive tests occur frequently enough to make interpretation and decisions challenging
- Testing serum for antibodies will help identify who has been infected
  - This may help with quarantine and staffing decisions, however, levels needed for protection and duration of immunity are not known
  - Convalescent serum/plasma may also be a therapeutic option, however:
    - Not all people develop high antibody levels
    - Duration of immunity is unknown – may be a few months
- Until we have better tests, the best testing strategy is unclear
  - Test all staff and patients/residents regardless of symptoms?
  - Test all staff and only test patients coming from the hospital and those with symptoms?
  - What about those that go out for tests and treatment, e.g. dialysis?
- New CMS reporting requirements issued April 20, 2020
- Regulatory and legal liability are legitimate concerns

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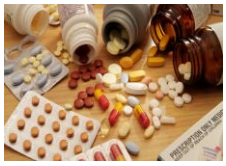
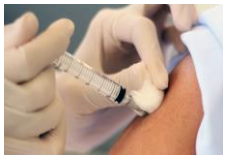
Next Steps and Planning for the Future: Treatment

- Currently **there is no evidence-based drug treatment for COVID-19**
  - ***Hydroxychloroquine***, with or without azithromycin may be helpful in treating the intense inflammatory response, but:
    - The data are basically anecdotal; results of controlled trials are pending but unlikely to include LTCF patients/residents
    - The drug has numerous potentially severe adverse effects, including sudden death in people with prolonged QT interval, and electrolyte and liver function abnormalities
    - Several potentially serious drug interactions
    - Guidance on dosing (intended for hospitals) was removed from the CDC website
    - If it is used:
      - Consent should be documented
      - EKG performed before treatment
      - Preferably in the context of a clinical study
  - Other drugs, including antiviral agents and immune modulators are under investigation as is convalescent serum/plasma
  - Vaccines are under development and should help prevent future waves of COVID disease





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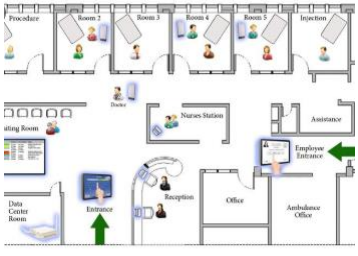
Next Steps and Planning for the Future: Alternative Sites of Care

- Many areas are developing plans for alternative sites of care for patients who are suspected of or are recovering from COVID-19
  - Converting entire LTCFs
  - Using unoccupied wings of existing facilities
  - Critical access hospitals with swing beds
  - Temporary facilities
- Planning is complicated and requires cooperation between LTCFs, hospitals, county and state authorities
  - Regulatory, financial and liability issues need to be addressed
- Staffing and adequate PPE will be challenging



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Next Steps and Planning for the Future: A Framework for Preparedness

Framework for Post-Acute Care Preparedness in a COVID-19 World: Key Strategies

Stage One: Survive the Surge	Stage Two: Regroup and Prepare	Stage Three: Restructure to Recovery	Stage Four: Redesign to Reality
1. Outplace non-COVID patients in non-acute hospitals	1. Protect vulnerable populations from COVID infection	1. Tap post-acute providers to participate in front lines of distribution and administration of prophylaxis, vaccinations	1. Create local hospital/ post-acute/public health advisory bodies
2. Assess capacity of SNFs and HHAs and other sources of care to enable hospital discharges for non-COVID patients	2. Prepare treat-in-place protocols for non-COVID admissions	2. Continue and deepen strategies to deliver non-COVID related medical care at home and in residential care communities	2. Identify opportunities to optimize post-acute care at market level for system performance moving forward
3. Direct regional post-acute care providers to identify separate, specialized capacity for COVID-positive discharges	3. Create and formalize post-acute care COVID designations and create transfer protocols for various designations	3. Prepare strategic plan for transition	3. Create, revise, and revisit pandemic response plan to include optimal use of all delivery system resources, supplies/equipment, and staff necessary to meet demand

ATI ADVISORY

Available at:
https://atiadvisory.com/work/post-acute-care-preparedness-in-a-covid-19-world/

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Next Steps and Planning for the Future: Opportunities for Research

- The pandemic provides many opportunities for research
- We can continue to learn for years, and be better prepared for future pandemics
- The development of highly accurate rapid tests can help understand the spread of the virus and prevent future outbreaks and clusters in LTCFs
- The development of effective treatments, including antiviral drugs and vaccines can help eradicate the virus and prevent future waves of this and other deadly viral diseases
- Many other areas of research are evolving, e.g.
  - The effects of social distancing on mood and behavior
  - Changes in preferences for intensity of care in the presence of life-limiting illness during a pandemic
  - Effectiveness of innovative virtual teaching strategies
  - Many others

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Selected References

- **Websites**
  - **CDC, CMS**
  - **American Geriatrics Society**
  - **AMDA/The Society for Post-Acute and Long-Term Care Medicine**
  - **Center to Advance Palliative Care, Vital Talk, Respecting Choices**
- **Coronavirus-19 in Geriatrics and Long-Term Care: An Update**
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- **Coronavirus Disease 2019 in Geriatrics and Long-term Care: The ABCDs of COVID-19**
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  Available at: https://www.acep.org/globalassets/sites/geda/documnets/covid-19-in-older-adults-transfers-between-nursing-homes-and-hospitals.pdf
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Questions? Comments? Suggestions?

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