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

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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.

- Dr. Ouslander and his wife receive royalties from FAU and Pathway Health for training on and licensing of the INTERACT program.

- 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

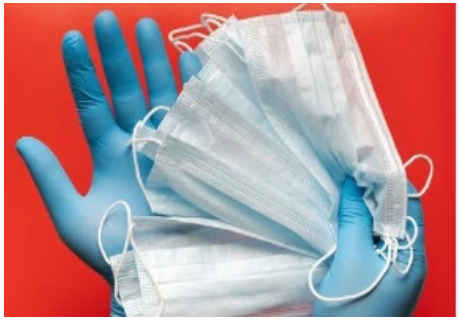
Key Points: The Setting and Population

- LTCF is a broad term that can include 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

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

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

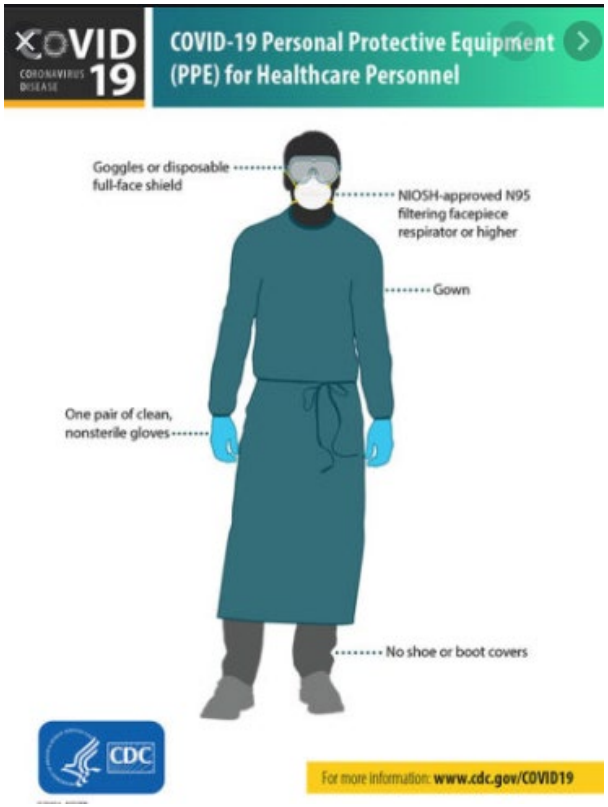
- LTCF patients and residents frequently **do not** have typical symptoms and signs of COVID-19
  - No symptoms – up to 50% or higher
  - Atypical symptoms – e.g. low grade temperature elevation; altered mental or functional status; GI symptoms
- LTCF staff may have no symptoms, no fever, and pass multiple 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 procedures**



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

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
- 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
- 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)
- Isolation can be hard for the patients/residents
  - Use video calls or other strategies to connect with families whenever possible



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

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
  - This further highlights the necessity of intensive infection control procedures

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

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

INTERACT Version 4.0 Tool

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[1]	Rapid onset, OR presence of marked tenderness, fever, vomiting, GI bleeding	Progressive or persistent distension not associated with symptoms
Abdominal Tenderness[1] *(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[3]	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

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

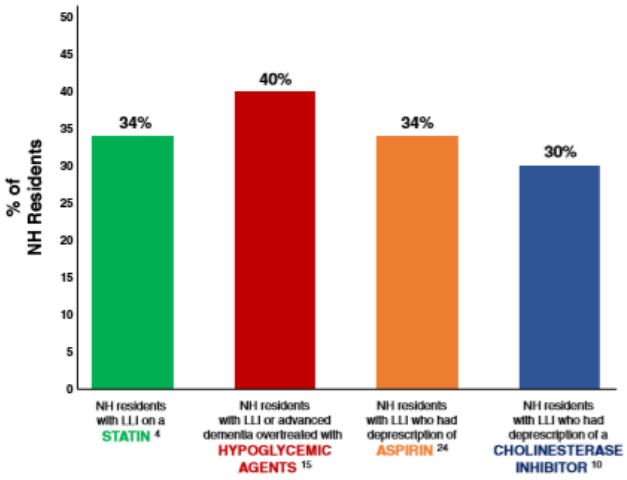
Key Points: Medication Management and Deprescribing

- 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
  - Appropriate alignment of medication administration times
- Examples of medications to discontinue:
  - Vitamins, herbals, docusate, appetite stimulants, cranberry tablets, chronic probiotics**
  - Ineffective, potentially harmful medications in residents with life-limiting illness
    - Statins, anticoagulants, cholinesterase inhibitors
    - Overtreatment of hypertension; no benefit and risk of falls, syncope
    - Overtreatment of diabetes – especially sliding scales; high risk for hypoglycemia and too much unnecessary nursing staff monitoring time for BF checks and finger stick glucose levels

**Implementation Guide to Optimizing Medication Management in Post-Acute and Long-Term Care during the COVID-19 Pandemic
Nicole Brandt, PharmD, Michael Steinman, MD et al, in preparation

EDITORIAL

Improving Drug Therapy for Patients With Life-Limiting Illnesses: Let's Take Care of Some Low Hanging Fruit



Journal of the American Geriatrics Society
first published:04 March 2020
https://doi.org/10.1111/jgs.16395

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

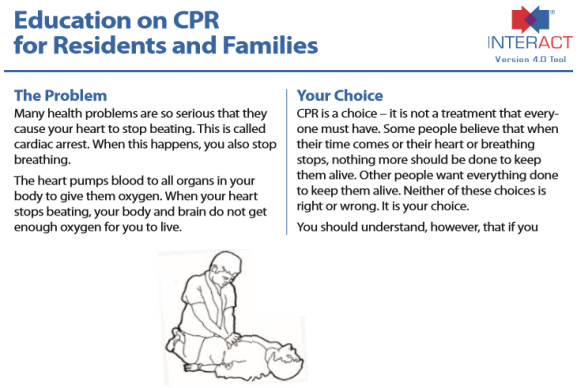
Key Points: Advance Care Planning

- 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

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 languag 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 Version 4.0 Tool

The Problem

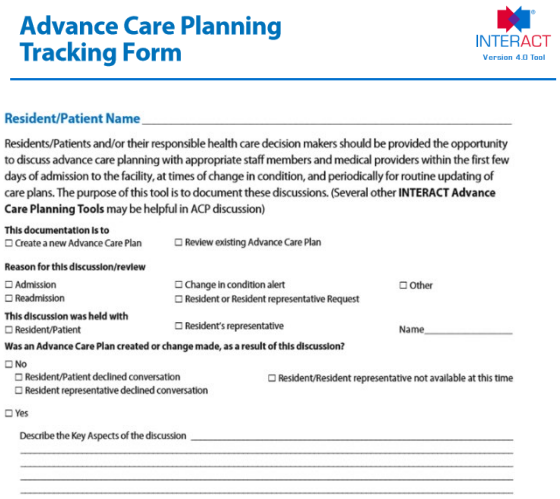
Many health problems are so serious that they cause your heart to stop beating. This is called cardiac arrest. When this happens, you also stop breathing.

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 everyone 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 Version 4.0 Tool

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_____

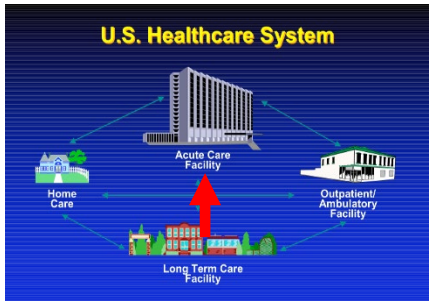
Was an Advance Care Plan created or change made, as a result of this discussion?
☐ No
☐ Resident/Patient declined conversation ☐ Resident/Resident representative not available at this time
☐ Resident representative declined conversation
☐ Yes

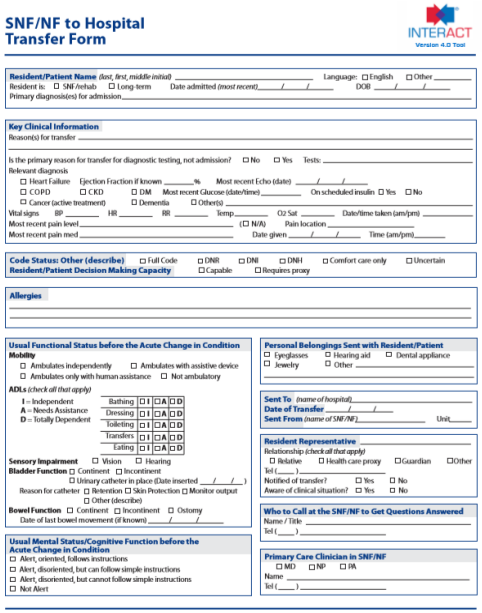
Describe the Key Aspects of the discussion _____

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

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
- Patients/residents should have clearly documented advance directives if they are transferred to the extent that the patient/resident is capable of making their own decisions or there is a health care proxy available
- 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




SNF/NF to Hospital Transfer Form

INTERACT Version 4.0 Tool

Resident/Patient Name (last, first, middle initial) _____ Language: ☐ English ☐ Other _____
Resident is: ☐ SNF /rehab ☐ Long-term Date admitted (most recent) ____/____/____ DOB ____/____/____
Primary diagnosis(es) for admission _____

Key Clinical Information
Reason(s) for transfer _____
Is the primary reason for transfer for diagnostic testing, not admission? ☐ No ☐ Yes Tests: _____
Relevant diagnosis
☐ Heart Failure Ejection Fraction if known _____% Most recent Echo (date) ____/____/____
☐ COPD ☐ CKD ☐ DM Most recent Glucose (date/time) _____ On scheduled insulin ☐ Yes ☐ No
☐ Cancer (active treatment) ☐ Dementia ☐ Other(s) _____
Vital signs BP _____ HR _____ RR _____ Temp. _____ O2 Sat _____ Date/time taken (am/pm) _____
Most recent pain level _____ (☐ N/A) Pain location _____
Most recent pain med _____ Date given ____/____/____ Time (am/pm) _____

Code Status: Other (describe) ☐ Full Code ☐ DNR ☐ DNI ☐ DNH ☐ Comfort care only ☐ Uncertain
Resident/Patient Decision Making Capacity ☐ Capable ☐ Requires proxy

Allergies

Usual Functional Status before the Acute Change in Condition
Mobility
☐ Ambulates independently ☐ Ambulates with assistive device
☐ Ambulates only with human assistance ☐ Not ambulatory
ADLs (check all that apply)
I = Independent
A = Needs Assistance
D = Totally Dependent

Bathing	☐ I	☐ A	☐ D
Dressing	☐ I	☐ A	☐ D
Toileting	☐ I	☐ A	☐ D
Transfers	☐ I	☐ A	☐ D
Eating	☐ I	☐ A	☐ D

Sensory Impairment ☐ Vision ☐ Hearing
Bladder Function ☐ Continent ☐ Incontinent
☐ Urinary catheter in place (Date inserted ____/____/____)
Reason for catheter ☐ Retention ☐ Skin Protection ☐ Monitor output
☐ Other (describe)
Bowel Function ☐ Continent ☐ Incontinent ☐ Ostomy
Date of last bowel movement (if known) ____/____/____

Usual Mental Status/Cognitive Function before the Acute Change in Condition
☐ Alert, oriented, follows instructions
☐ Alert, disoriented, but can follow simple instructions
☐ Alert, disoriented, but cannot follow simple instructions
☐ Not Alert

Personal Belongings Sent with Resident/Patient
☐ Eyeglasses ☐ Hearing aid ☐ Dental appliance
☐ Jewelry ☐ Other _____

Sent To (name of hospital) _____
Date of Transfer ____/____/____
Sent From (name of SNF/NF) _____ Unit _____

Resident Representative _____
Relationship (check all that apply)
☐ Relative ☐ Health care proxy ☐ Guardian ☐ Other
Tel (____) _____
Notified of transfer? ☐ Yes ☐ No
Aware of clinical situation? ☐ Yes ☐ No

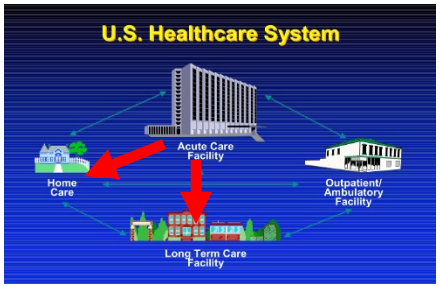
Who to Call at the SNF/NF to Get Questions Answered
Name / Title _____
Tel (____) _____

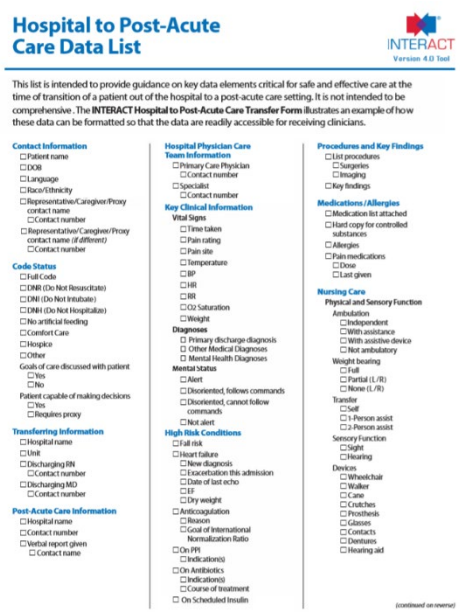
Primary Care Clinician in SNF/NF
☐ MD ☐ NP ☐ PA
Name _____
Tel (____) _____

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 should be presumed to be infected, and isolated for at least 7 days
    - Based on risk of acquiring the virus in the hospital and non-specificity of symptoms
- 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





Hospital to Post-Acute Care Data List

INTERACT Version 4.0 Tool

This list is intended to provide guidance on key data elements critical for safe and effective care at the time of transition of a patient out of the hospital to a post-acute care setting. It is not intended to be comprehensive. The **INTERACT Hospital to Post-Acute Care Transfer Form** illustrates an example of how these data can be formatted so that the data are readily accessible for receiving clinicians.

Contact Information
- ☐ Patient name
- ☐ DOB
- ☐ Language
- ☐ Race/Ethnicity
- ☐ Representative/Caregiver/Proxy contact name
  - ☐ Contact number
- ☐ Representative/Caregiver/Proxy contact name (if different)
  - ☐ Contact number

Code Status
- ☐ Full Code
- ☐ DNR (Do Not Resuscitate)
- ☐ DNI (Do Not Intubate)
- ☐ DNH (Do Not Hospitalize)
- ☐ No artificial feeding
- ☐ Comfort Care
- ☐ Hospice
- ☐ Other

Goals of care discussed with patient
- ☐ Yes
- ☐ No

Patient capable of making decisions
- ☐ Yes
- ☐ Requires proxy

Transferring Information
- ☐ Hospital name
- ☐ Unit
- ☐ Discharging RN
  - ☐ Contact number
- ☐ Discharging MD
  - ☐ Contact number

Post-Acute Care Information
- ☐ Hospital name
- ☐ Contact number
- ☐ Verbal report given
  - ☐ Contact name

Hospital Physician Care Team Information
- ☐ Primary Care Physician
  - ☐ Contact number
- ☐ Specialist
  - ☐ Contact number

Key Clinical Information

Vital Signs
- ☐ Time taken
- ☐ Pain rating
- ☐ Pain site
- ☐ Temperature
- ☐ BP
- ☐ HR
- ☐ RR
- ☐ O2 Saturation
- ☐ Weight

Diagnoses
- ☐ Primary discharge diagnosis
- ☐ Other Medical Diagnoses
- ☐ Mental Health Diagnoses

Mental Status
- ☐ Alert
- ☐ Disoriented, follows commands
- ☐ Disoriented, cannot follow commands
- ☐ Not alert

High Risk Conditions
- ☐ Fall risk
- ☐ Heart failure
  - ☐ New diagnosis
  - ☐ Exacerbation this admission
  - ☐ Date of last echo
  - ☐ EF
  - ☐ Dry weight
- ☐ Anticoagulation
  - ☐ Reason
  - ☐ Goal of International Normalization Ratio
- ☐ On PPI
  - ☐ Indication(s)
- ☐ On Antibiotics
  - ☐ Indication(s)
  - ☐ Course of treatment
- ☐ On Scheduled Insulin

Procedures and Key Findings
- ☐ List procedures
  - ☐ Surgeries
  - ☐ Imaging
- ☐ Key findings

Medications / Allergies
- ☐ Medication list attached
- ☐ Hard copy for controlled substances
- ☐ Allergies
- ☐ Pain medications
  - ☐ Dose
  - ☐ Last given

Nursing Care

Physical and Sensory Function

Ambulation
- ☐ Independent
- ☐ With assistance
- ☐ With assistive device
- ☐ Not ambulatory

Weight bearing
- ☐ Full
- ☐ Partial (L/R)
- ☐ None (L/R)

Transfer
- ☐ Self
- ☐ 1-Person assist
- ☐ 2-Person assist

Sensory Function
- ☐ Sight
- ☐ Hearing

Devices
- ☐ Wheelchair
- ☐ Walker
- ☐ Cane
- ☐ Crutches
- ☐ Prosthesis
- ☐ Glasses
- ☐ Contacts
- ☐ Dentures
- ☐ Hearing aid

(continued on reverse)

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

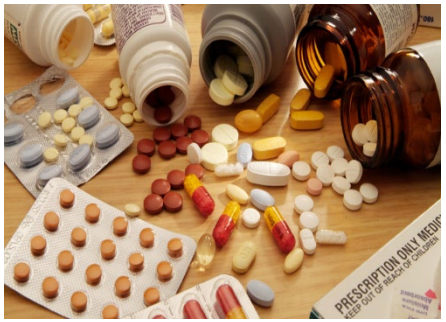
Next Steps and Planning for the Future: Testing and Treatment

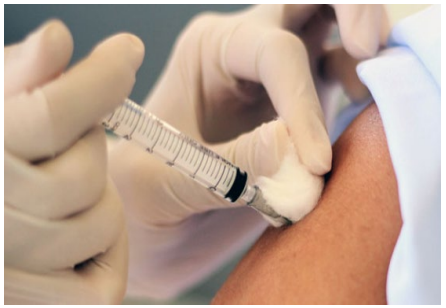
- As rapid testing and self-testing becomes more available, it will be easier to test all patients/residents and staff, and quarantine them as appropriate
- False negative tests do occur
- Testing serum will help identify who has been infected
  - This will help with quarantine and staffing decisions
  - Convalescent serum/plasma may be a therapeutic option, however:
    - Not all people develop high antibody levels
    - Duration of immunity is unknown – may be a few months

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

Next Steps and Planning for the Future: Testing and 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
    - If it is used:
      - Consent should be documented
      - EKG performed before treatment
    - **G**uidance on dosing (intended for hospitals) was removed from the CDC website
  - 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

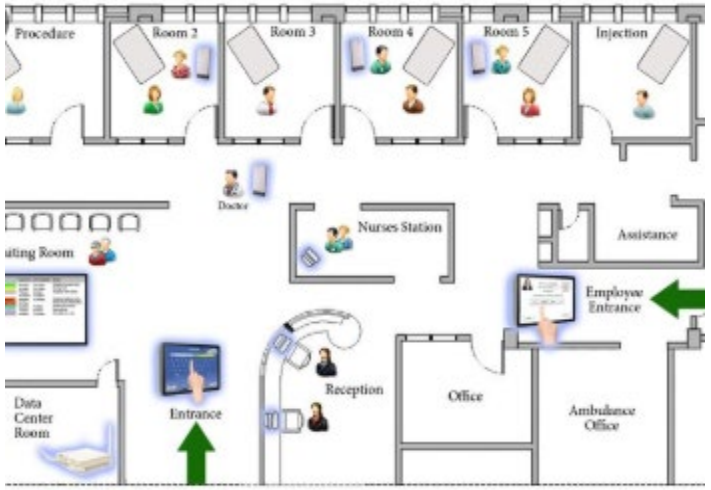




COVID-19 in Long-Term Care Facilities: An Update

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



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

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
IDEAS TO ACTION IN HEALTHCARE & AGING

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

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

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**
  Available at: https://onlinelibrary.wiley.com/doi/epdf/10.1111/jgs.16464

- **Coronavirus Disease 2019 in Geriatrics and Long-term Care: The ABCDs of COVID-19**
  Available at: https://onlinelibrary.wiley.com/doi/10.1111/jgs.16445

- **COVID-19 in Older Adults: Transfers Between Nursing Homes and Hospitals**
  Available at: https://www.acep.org/globalassets/sites/geda/documnets/covid-19-in-older-adults-transfers-between-nursing-homes-and-hospitals.pdf

- **Lessons Learned from the COVID-19 Outbreak at Canterbury Rehab, 3/29/2020**
  Available at: https://cmda.us/resources/COVID%20Lessons%20from%20Battlefield%20Handout.pdf

- **Post-Acute Care Preparedness in a COVID-19 World**
  Available at: https://atiadvisory.com/work/post-acute-care-preparedness-in-a-covid-19-world/

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Questions? **Comments?** **Suggestions?**

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