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

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- Public University with over 25,000 students
- Fully accredited medical school and internal medicine, emergency medicine, surgery, and neurology, and psychiatry residency programs
Disclosures

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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
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Key Points: Support the Team

Team Member Concerns

Keep the Team Healthy

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

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

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

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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

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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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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

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 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
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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.

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 quarantining 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?
- 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

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

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

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- COVID-19 in Older Adults: Transfers Between Nursing Homes and Hospitals

- Lessons Learned from the COVID-19 Outbreak at Canterbury Rehab, 3/29/2020
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- Post-Acute Care Preparedness in a COVID-19 World
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Questions?  Comments?  Suggestions?

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