FMDA Journal Club

April 1, 2020
Diane Sanders-Cepeda, DO, CMD – Presenter
The Opportunities and Challenges of Treating COVID-19 Residents in Place

This meeting will be recorded and will be available at www.fmda.org/journalclub.php
Agenda

COVID 19 status update
Managing the COVID 19 patient
PALTC preparedness
Tales of a SNF Outbreak
Open Discussion
Florida's COVID-19 Data and Surveillance Dashboard
Florida Department of Health, Division of Disease Control and Health Protection

Florida Numbers:

Positive Residents: 6,490
Total Cases: 6,741
Hospital Admissions: 857
Deaths: 85

New Cases by Day:

March 2020
14 days until peak resource use on April 15, 2020

Hospital resource use

Resources needed for COVID patients on peak date

- **All beds needed**: 220,643 beds
- **Bed Shortage**: 54,046 beds
- **ICU beds needed**: 32,976 beds
- **ICU Bed Shortage**: 13,856 beds
- **Invasive ventilators needed**: 26,381 ventilators

https://covid19.healthdata.org/projections
Hospital resource use

31 days until peak resource use on
May 2, 2020

Resources needed for COVID patients on peak date

<table>
<thead>
<tr>
<th></th>
<th>All beds needed</th>
<th>All beds available</th>
<th>Bed shortage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All beds</td>
<td><strong>17,265 beds</strong></td>
<td>20,184 beds</td>
<td>0 beds</td>
</tr>
<tr>
<td>ICU beds</td>
<td><strong>2,612 beds</strong></td>
<td>1,695 beds</td>
<td>917 beds</td>
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Invasive ventilators needed

2,090 ventilators
Managing COVID – 19 patients in the SNF
FDA authorizes widespread use of unproven drugs to treat coronavirus, saying possible benefit outweighs risk

Millions of doses of anti-malarial drugs hydroxychloroquine and chloroquine will be distributed to hospitals across the country to try to slow the disease in seriously ill patients.
<table>
<thead>
<tr>
<th>Patient group</th>
<th>Current Potential Therapy</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Mild disease:</td>
<td>Supportive care</td>
<td>• Consider discharge if stable clinically</td>
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<tr>
<td>Not requiring hospitalization OR</td>
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<tr>
<td>Hospitalized patient with (SPO2 ≥ 94%), and NO radiographic evidence of pneumonia</td>
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<tr>
<td>Moderate disease:</td>
<td>Start empiric antibiotics.</td>
<td>• Infectious Diseases consult required for all hospitalized patients with confirmed COVID19</td>
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<tr>
<td>Hospitalized patients with hypoxia (SPO2 ≤ 94 %) AND</td>
<td>Consider de-escalation after 48 hours. Refer to Pneumonia PowerPlans™.</td>
<td>• Check EKG prior to hydroxychloroquine initiation for QT prolongation. Risk is increased when used with other QT prolonging drugs.</td>
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<tr>
<td>Radiographic evidence of pneumonia</td>
<td></td>
<td>• Recheck EKG once after drug initiation and manage clinically.</td>
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<tr>
<td></td>
<td>H e d r o x y c h l o r o q u i n e</td>
<td>• Review potential medication interactions and other possible side effects</td>
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<tr>
<td></td>
<td>400 mg PO q 12 hrs. x 2 doses then 12 hours later start</td>
<td></td>
</tr>
<tr>
<td></td>
<td>200 mg PO q 12 hrs. for 5 days</td>
<td></td>
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<tr>
<td>Severe disease with respiratory failure:</td>
<td>Start empiric antibiotics.</td>
<td>• Infectious Diseases consult required for all hospitalized patients with confirmed COVID19</td>
</tr>
<tr>
<td>Patient requiring mechanical ventilation</td>
<td>Consider de-escalation after 48 hours. Refer to Pneumonia PowerPlans™.</td>
<td>• Check EKG prior to initiation of hydroxychloroquine for QT prolongation. Risk is increased when used with other QT prolonging drugs.</td>
</tr>
<tr>
<td></td>
<td>H e d r o x y c h l o r o q u i n e</td>
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<td>• Review potential medication interactions and other possible side effects</td>
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<tr>
<td></td>
<td>200 mg PO q 12 hrs. for 10 days</td>
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<tr>
<td>Evidence of cytokine release syndrome:</td>
<td>Consider Tocilizumab</td>
<td>• Infectious Diseases consult required for all hospitalized patients with confirmed COVID19</td>
</tr>
<tr>
<td>Worsening of respiratory function with evidence of CRS with documented elevated IL-6 levels (results in 3 to 5 days).</td>
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**Other Drug Therapy Notes**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Chloroquine</td>
<td>Available for use once hydroxychloroquine supply has been diminished. Recommended dosing 500 mg PO every 12 hours x 10 days.</td>
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<tr>
<td>Remdesivir</td>
<td>Only available from the manufacturer on compassionate use. Per Gilead, due to overwhelming demand over the last several days, during this transition period we are unable to accept new individual compassionate use requests, with the exception of requests for pregnant women and children less than 18 years of age with confirmed COVID-19 and severe manifestations of disease. We are focused now on processing previously approved requests and anticipate the expanded access programs will initiate in a similar expected timeframe that any new requests for compassionate use would have been processed. Exclusions for compassionate use evidence of multi-organ failure, pressure requirement to maintain blood pressure, ALT levels greater than five times the upper limit of normal, creatinine clearance less than 30 ml/min or dialysis or continuous veno-venous hemofiltration. Inclusion criteria include hospitalized, confirmed COVID-19 by PCR, intubated. Remdesivir cannot be used in conjunction with any other potentially active agents.</td>
</tr>
<tr>
<td>Corticosteroids</td>
<td>Per WHO guidelines, given the lack of effectiveness and possible harm, especially delayed viral clearance, routine corticosteroids should be avoided unless they are indicated for other reasons such as exacerbation of asthma, COPD and refractory septic shock.</td>
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<tr>
<td>Lopinavir/ritonavir (Kaletra)</td>
<td>Based on most recent data, shows lack of benefit in severe COVID-19 cases, not currently recommended.</td>
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<td>Oseltamivir</td>
<td>SARS-CoV-2, the virus that causes COVID-19, does not use neuraminidase as part of the viral replication cycle so oseltamivir is unlikely to be of therapeutic value, and supplies of the drug should be preserved for patients with influenza.</td>
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<tr>
<td>IVIG</td>
<td>IVIG remains on critical national shortage. The benefit in patient with COVID-19 is unclear.</td>
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COVID-19 patient scenarios

Suspected COVID-19 patient in SNF

COVID – 19 positive patient discharged to SNF
Cornerstone to Treating in Place

- Advance Care Planning

- Hospitalize vs. Do not Hospitalize?

- Does patient family want resuscitation/intubation vs. DNR?

- Contingency planning - if condition symptoms worsen or condition deteriorates?

- Plan for Symptom Management
Proposed Protocol Treat in Place

- Frequent Vitals (recommend Q 4 hours)
- Supplemental Oxygen O2Sat < 92%
- EKG before & after starting treatment
- Labs: CBC, CMP, CRP, LDH, (PT, D-Dimer?), Flu Swab, COVID – 19 testing
- Start Treatment with Hydroxychloroquine (with Azithromycin in adjunct)
- Deprescribe ICHs, NSAIDs, nebulizers

Isolate all suspected cases
Resident’s decline can progress rapidly.

- Tachypnea
- Respiratory Failure – persistent & worsening
  Shortness of breath, work of breathing, air hunger
- Tachycardia, Tachyarrhythmias
- Hypoxia, severe Hypoxia
- Altered Mental Status
Receiving Patients from Acute Setting
State Advisories re: Hospital Discharges and Admissions to Nursing Homes and Assisted Living Communities

As we anticipate the coming surge in COVID-19 cases in the United States, there is a clear need to balance the issues of patient safety, surge management, and conflicting guidelines and public policy around hospital-to-nursing home or hospital-to-assisted living community transfers. We are in extraordinary times, making highly complex decisions, often without adequate information and data.

We are deeply concerned with the recent New York State order, which states:

“No resident shall be denied re-admission or admission to the NH solely based on a confirmed or suspected diagnosis of COVID-19. NHs are prohibited from requiring a hospitalized resident who is determined medically stable to be tested for COVID-19 prior to admission or readmission.”
PALTC Preparedness
COVID-19 Preparedness Checklist for Nursing Homes and other Long-Term Care Settings

Nursing homes and other long-term care facilities can take steps to assess and improve their preparedness for responding to coronavirus disease 2019 (COVID-19). This checklist should be used as one tool to develop a comprehensive COVID-19 response plan, including plans for:

- Rapid identification and management of ill residents
- Considerations for visitors and consultant staff
- Supplies and resources
- Sick leave policies and other occupational health considerations
- Education and training
- Surge capacity for staffing, equipment and supplies, and postmortem care

The checklist identifies key areas that long-term care facilities should consider in their COVID-19 planning. Long-term care facilities can use this tool to self-assess the strengths and weaknesses of current preparedness efforts. This checklist does not describe mandatory requirements or standards; rather, it highlights important areas to review to prepare for the possibility of residents with COVID-19.

COVID-19 Preparedness Checklist for Nursing Homes and other Long-Term Care Settings. [PDF – 1 MB]
Interim Additional Guidance for Infection Prevention and Control for Patients with Suspected or Confirmed COVID-19 in Nursing Homes

Summary of Changes to the Guidance:

Updated guidance to recommend that nursing homes:

- Restrict all visitation except for certain compassionate care situations, such as end of life situations
- Restrict all volunteers and non-essential healthcare personnel (HCP), including non-essential healthcare personnel (e.g., barbers)
- Cancel all group activities and communal dining
- Implement active screening of residents and HCP for fever and respiratory symptoms

COVID-19 is being increasingly reported in communities across the United States. It is likely that SARS-CoV-2 will be identified in more communities, including areas where cases have not yet been reported. As such, nursing homes should assume it could already be in their community and move to restrict all visitors and unnecessary HCP from the facility; cancel group activities and communal dining; and implement active screening of residents and HCP for fever and respiratory symptoms.

What is the PALTC Continuum?

- SNFs/LTCs
- Assisted Living
- Outpatient office
- Home Care/Home Health
- Hospice
PALTC preparedness

Isolation - Create a plan to Cohort COVID-19 suspected and confirmed cases as well as high-risk populations (Dialysis patients)

Addressing PPE Shortages

Medication authorization

Operationalizing Telehealth
New Rochelle Outbreak

Dr. Elaine Healy
Open Discussion
Thank You for Your Participation!

For additional questions
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