COVID19 in the Nursing Home: COVID-19 Therapies in SNFs

Jacob Walker, MD
Geriatrics Fellow, University of Chicago – Geriatrics and Palliative Medicine
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Disclosures

- I have no disclosures to report.
Objectives

By the end of the session participants will be able to:

Describe the clinical course of COVID-19

Develop a clinical monitoring plan for COVID-19 patients

Create a care plan for symptom management in COVID-19 patients

Identify potential therapeutic agents for COVID-19

 Appropriately triage patients needing a higher level of care
Disease course

Median time to symptoms of 4-5 days

Older adults appear more likely to present with atypical symptoms

~1 in 5 cases will progress to severe/critical (dyspnea, hypoxia, shock)

Time to onset of severe disease ~7 days from symptom onset

Older adults at highest risk of progression to severe disease

CDC COVID-19 Response Team 2020; Wu & McGoogan 2020

- Fever (83–99%)
- Cough (59–82%)
- Fatigue (44–70%)
- Anorexia (40–84%)
- Shortness of breath (31–40%)
- Sputum production (28–33%)
- Myalgias (11–35%)
Figure 1: Clinical courses of major symptoms and outcomes and duration of viral shedding from illness onset in patients hospitalised with COVID-19
Clinical monitoring plan

**For all residents:**
- Screen daily for fever
- Screen daily for new respiratory symptoms (cough, sore throat, dyspnea)
- Monitor for other changes in clinical status, especially new delirium. Maintain low threshold to notify providers

Notify the health department for any cluster of severe respiratory disease affecting ≥3 residents or staff

Maintain a line list of any outbreak. Templates available at CDC website:
<table>
<thead>
<tr>
<th>CaseID*</th>
<th>Case Initials</th>
<th>Age</th>
<th>Sex</th>
<th>Onset date</th>
<th>Current Status</th>
<th>Location</th>
<th>Case Category</th>
<th>Epi Links</th>
<th>Underlying Conditions</th>
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<tbody>
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For suspected or confirmed COVID-19 cases:

- Implement standard, contact, and droplet precautions and isolate
- Increase frequency of vitals checks and symptom screening to Q4H
- Prioritize pulse oximetry and temperature
- Chest imaging should be performed on case-by-case basis (Not part of standard monitoring)

If possible, assign dedicated staff and equipment for monitoring to reduce contact with other residents
Supportive care

Antipyretics
- Acetaminophen – preferred
- NSAIDs – anecdotal concern for harm, does not require change in chronic therapy

Cough suppressants
- No data on preferred agents in COVID-19
- Non-opioid options preferred in older adults

Decongestants
- No data on preferred agents in COVID-19
Supportive care

Oxygen therapy

Escalating O2 need may be sign that patient needs higher level of care.
Verify sufficient supply of tanks, tubing, other accessories with vendors
High-flow NC not routinely used (may have role in small # of patients)

Hydration

Ensure all patients still have ready access to water
Ensure IV fluids stocked
Respiratory therapies

Consider beta-agonists (albuterol) in patients with bronchospasm

Can add anti-muscarinic if needed (ipratropium)

Ensure spacers available for MDI’s

Nebulizers/masks for those who cannot use MDI – these are AGPs
Supportive care (cont.)

End of life / hospice care
May see more patients than usual needing hospice services
Ensure supply of opiates, benzodiazepines, antipsychotics, atropine, etc.
Revisit and verify goals of care with all residents and families ASAP
Consider partnering with a local hospice agency for support if staff are unfamiliar with medications for end of life care
Hydroxychloroquine

Anti-inflammatory drug used in rheumatologic diseases

Early experiments show activity against SARS-CoV-2 \textit{in vitro}

Evidence for clinical efficacy is anecdotal

Carries known risk of arrhythmia (lengthens QT)

There is currently \textit{insufficient} evidence to support routine use

For patients already taking hydroxychloroquine for other diseases it may be prudent to secure 90+ day supply
Other experimental therapies

Remdesivir - antiviral
Tocilizumab - IL-6 antagonist
Convalescent plasma
Favipiravir - antiviral

Trials ongoing for these and a number of other drugs. SNF patients may have access through associated hospital systems.
Therapies that are *not* recommended

Steroids should *not* be used routinely
Appropriate in *some* patients such as asthma and COPD.
Evidence of harm with steroids in flu, MERS, SARS

Antibiotics should *not* be used routinely
No evidence of efficacy in other viral respiratory illnesses
Should reserve for patients with clear indication (i.e. bacterial infection)
Escalation of care

Severe complications can include pneumonia, sepsis, ARDS, renal injury, cardiomyopathy, and arrhythmia

Shortness of breath and hypoxia among most concerning signs of deterioration

Delirium also likely to herald worsening in older adults

Hypernatremia or worsening dehydration

Always assess if ER/hospital is aligned with patient goals

Mild disease can be managed at SNF

COVID-19 diagnosis alone is not reason to send to hospital


Questions?
Thank you!

For any questions, contact us at echo@bsd.uchicago.edu

Resources & recording of the session
https://www.echo-chicago.org/resources/covid19/