CMDA April 7, 2020

COVID-19 Update and Q&A

1. Is there any use for N-acetyl Cystine use? (oral)
    a. N/V side effects, may muddy clinical picture
    b. Recs to use mucinex instead
2. Are there restrictions on use of z-pack and hydroxychloroquine use in Colorado?
    a. QT prolongation is of concern. Need CLOSE EKG follow ups. Do we have routine access to this? Consider if there is an outbreak, would the techs come in to do them?
    b. Study is small and limited, quality of evidence is poor
    c. Consider finding a study and enrolling your residents if you want to try
        i. Don't wait for an outbreak to join a study, remember the paperwork!
    d. Many asymptomatic patients, consider R/B and need for use vs potential SE
        i. Right now R/B doesn't line up with use
    e. Create criteria for when you will/should use it, "at what point do we try anything?"
    f. In LTC, consider using azithro only, but consider limitations in our setting to monitor cardiac
    g. Panel consensus- Wait for the data!
3. Other treatment recs?
    a. Be open and honest about prognosis
        i. If over 75 y/o and on vent, 90-95% mortality rates
        ii. If over 45 y/o and on vent, 50% mortality rates
    b. Goals of care discussions are important now
    c. 41 drug or drug combos in testing currently, likely couple weeks out from seeing some results.
    d. Create a one page information document for family
        i. Course of illness (4 course types)
            1. Indolent course, fulminant and fast
        ii. Prognosis
        iii. Type of monitoring and care in place being offered
        iv. Supportive treatment available
        v. Discussion of if/when to transfer or resuscitate
            1. JAMA article suggests 0% survival of resuscitation with COVID
    e. Discuss options with hospice groups early.
        i. Consider quick admissions

    f. Standard order sets for treatment
        i. Morphine, Ativan, o2 tanks (high flow), 10-15L oxygen concentrators, mucinex
4. How to treat the cough?
    a. Use MDI with spacers, avoid nebs
        i. Use disposable water bottle as spacer
    b. Consider Albuterol syrup or tablets (some patients have done well, monitor for SE)
5. Add ppx lovenox?
    a. N-acetyl cysteine + heparin in trial, this is nebulized. Use for mucolytic
    b. Dr. Kadari notes use in China and India 2/2 high rates of thrombosis
    c. Some thought process of use for DVT ppx as pt are "hospital"-like patients
    d. Some small studies looking at D-Dimer levels, use of AC
6. Right now, there is no evidence for any treatments. At what point do we stop looking for the evidence and start treatments based on anecdotal evidence?
    a. Look for CDC and CDPHE guidance
7. How are settings of care handling admissions? (COVID +/-/unknown)
    a. Review AMDA resolution, available on AMDA website
        i. They recommend that COVID naïve facility NOT accept COVID + or unknown patients
        ii. If able to cohort residents, staff and equipment; can offer admission to COVID +
        iii. Vivage has relaxed testing requirements pre-admission. Allowing admissions but isolation x 7 days (even if negative test in hospital)
    b. Biggest threat to bringing in COVID
        i. Staff
        ii. New admissions
        iii. Residents leaving on appointments
        iv. There are not enough tests to check all of these sources, too long for test turn around. Start aggressive screening process (tool available on AMDA website). Two independent reviewers of the chart, need to come to a consensus. If they pass the screen, can still be asymptomatic or pre-symptomatic so need to quarantine them as if +, using PPE, for 14 days
            1. Try to cohort them for #day of quarantine. Ie day 2 with day 2, day 14 with day 14
            2. Temp cut off is 99, not 100
            3. With one index case, gross testing found 8 more asymptomatic patients and 15 positive staff members

8. How to you determine if someone is recovered? Are they immune?
    a. IgG titers being ran, results later this week
9. What do we know about the sensitivity and specificity of the COVID test and antibody testing?
    a. Labs are running secondary assay to ensure positive
    b. Approx 25-30% false negative (collection technique and transport matter!)
        i. If you get a negative but high suspicion, repeat the test
        ii. Technique- be heartless, go back as FAR as you can. Twirl it around. Then switch nostrils. If done correctly, false negative can drop to 5%
10. Best techniques for PPE
    a. Buddy system for don/doff
    b. Don't touch the outside of the mask
    c. WASH YOUR HANDS with don and doff
11. What are strategies for Colorado, given the limited resources of testing?
    a. Quick test may be upcoming with some provider groups (anterior nasal swab, IgM and IgG testing=90% sensitivity)
12. Masks- cloths, surgical, N95. What's the update?
    a. Total face mask best, Goggles next best, Glasses last best
    b. Wearing any mask consistently, with HAND WASHING, is as good as you can get if no N95
    c. N95s limited. Use on COVID units only and re-use (have face shield)
    d. Store N95 in shoe box
    e. Use fabric mask over N95 if can tolerate
    f. If collecting COVID swab, use N95 and face shield as HIGH risk of transfer
13. What can we counsel families about if they opt to transfer to hospital?
    a. No visitation.
    b. May end up on mech vent and pass alone vs compassionate visits at end of life at SNF
    c. If mild sx, hospitals will send them back and now you have increased exposure to several people.
    d. If hospital on surge, they may not have ventilator available for our residents
14. Are hospitals doing compressions on COVID + Patients?
15. When we move patients to cohort them, are we increasing risk of transmission?
    a. If you have one + case, you have more than one. Don't move them to another facility
    b. If cohorting, keep staff consistent
    c. Do emergency preparedness drills BEFORE you get a positive case
16. Projections available online, IMHE: https://covid19.healthdata.org/united-states-of-america