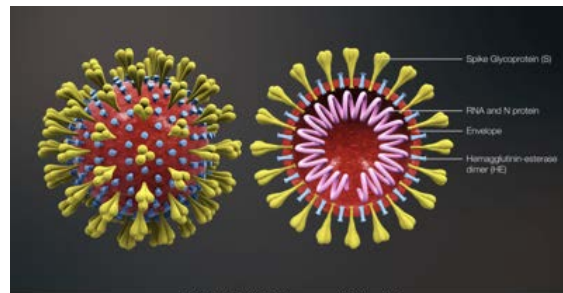


White Paper: COVID-19 Update Post-Acute Care

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SARS-CoV-2 (Source: Wikipedia)

Purpose

The purpose of this document is to assist Post-Acute Care clinicians and operations with COVID-19 matters specific to our arena and in doing so augment the white papers from Emergency and Hospital Medicine.

Clinical Updates

Updates will be posted in the Emergency Medicine White Paper, last updated March 19, 2020, with the following updates:

- CDC Clinical Updates –
 - PUI – changes in criteria
 - Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19
- CMS Updates
 - CMS Guidance for the cancellation of Elective Surgery
 - EMTALA
- TeamHealth Guidance
 - Guidance for Clinicians with Underlying Medical Conditions for COVID-19
 - Guidance for onsite and offsite screening areas and tents
 - Guidance for the use of Telemedicine for onsite patient care
 - Potential impact for ICU and ventilator resources based on CDC's estimates

PAC Updates

- Telehealth is very close to fruition, more to come in next few days.
- With all the information and data out there, please **refer to the TeamHealth COVID-19 updates and white paper, all are to follow the CDC guidelines therein**, despite health department or corporate protocols.
- PPE remains very scarce in Post-Acute, please if you are taking care of **PUI or positive COVID-19** patient's bedside, have the appropriate PPE if possible and mask at a minimum.
- Arrange schedule coverage so that clinicians are only at one facility per day.
- Podcast/information sent to all PAC service line every weekday.

Clinician Preparedness

Regardless if community COVID-19 present or not:

- Know your facility protocols in place for identification, reporting and treatment.
- Know your local/state department of health contact information.
- If responsible for child/elder care arrange for back-up plans for maintaining care and fulfilling rounding assignment. Keep facility abreast of any rounding schedule changes in order to accommodate family needs (i.e. rounding in the afternoon or evening instead of morning).
- Keep your CPM aware of any status **changes in your health** or **first degree exposure**.

Screening for Signs and Symptoms of Possible COVID-19 in Post-Acute Setting

Active Screening of Residents
Evaluate residents for the following every 12 hours
Common Signs and Symptoms
Fever ≥ 37.2°C (99.0°F)
Cough
Shortness of breath. <i>Increased oxygen requirements or increased frequency of nebulizer treatments may be surrogate symptoms of shortness of breath</i>
Less Common Signs and Symptoms
Confusion or change in mental status. <i>If noted, check pulse oximetry to determine if increased oxygen requirements</i>
Muscle aches, headache
Sore throat, runny nose
Chest pain
Diarrhea, nausea and vomiting
<i>Probable case: any two of the common signs/symptoms</i> <i>Initiate contact and droplet precautions</i> <i>Check a room air pulse-oximetry</i> <i>Increase frequency of vital signs, including pulse oximetry to every 8 hours</i> <i>Screen for influenza. If negative, screen for COVID-19 (in areas of community outbreak may consider concomitant testing based on clinicians assessment)</i>
<i>Possible case: any one of the common signs/symptoms and ≥ 1 of the less common signs/symptoms</i> <i>Initiate contact and droplet precautions</i> <i>Check a room air pulse-oximetry</i>

Source — COVID-19 AMDA Update revised 3/18/2020 (found in Zenith PAC Quick Links)

PAC consider: Although visitors and travel restricted, has the patient or roommate had departure/return to the facility in the last 14 days (e.g. dialysis, funeral) or are they or their roommate a new admission?

Differential Diagnosis Considerations

Clinical assessment is the most reliable way to determine if patient is at risk, we cannot solely rely on testing in a timely manner. In addition to S&S above and assessing exposure with first degree contact, consider alternative diagnosis.

Because influenza is the most common alternative diagnosis, here is a comparison of S&S. A reasonable approach for history, in addition to known first degree exposure would be the presence of fever, dry cough and the absence of runny nose, nasal congestion, sore throat and chills.

COVID-19		Influenza A	
Fever	88%	Fatigue	85%
Dry Cough	68%	Chills	80%
Fatigue	38%	Nasal Symptoms	74%
Productive Cough	33%	Dry Cough	73%
Dyspnea	19%	Sore Throat	59%
Sore Throat	14%	Fever	32%
Chills	11%		
Nasal Symptoms	5%		

Lab Findings				CXR Findings	
				CXR can be normal in the early stages, but most commonly 59.1% reveals ground glass or patchy infiltrates. CT scan not required to diagnose disease.	
Lab Finding	All	Mild	Severe	Total Abnormal CXRs	59.1%
WBC < 4,000/mm ³	33.7%	28.1%	61.1%	Ground-glass opacity	20.1%
WBC > 10,000/mm ³	5.9%	4.8%	11.4%	Local patchy shadowing	28.1%
Lymphocyte < 1500/mm ³	83.2%	80.4%	96.1%	Bilateral patchy shadowing	36.5%
Platelet < 150,000/mm ³	36.2%	31.6%	57.7%	Interstitial abnormalities	4.4%
C-reactive protein >= 10 mg/L	60.7%	56.4%	81.5%	No abnormality	41.9%

Presumed PUI or Positive Screening “What do I do next”?

- Mask on patient immediately and yourself.
- Droplet Respiratory Precautions.
- Notify facility infection control/follow facility protocols for health department notification/COVID-19 testing.
- Contact RP (Responsible Party) and inform them that patient is under investigation for COVID-19.
- **Treatment Considerations**
 - Symptomatic treatment: consider OTC antipyretics, antitussive
 - As with any influenza type illness could also consider; additional lab work, treatments such as IV fluid and medications as symptoms and illness indicate.
 - Consider CXR based upon clinical presentation, need for diagnosis clarity and severity of respiratory symptoms.

When to Consider Transfer to Hospital- (need for test or mitigate spread is not a reason to transfer to ED)

- Advance Directives indicate hospital treatment of illness are patient wishes.
- Guidelines for Possible hospital admission:

WHO "Severe" Definition	Other
O2 Sat < 93%	Bilateral or >50% of lung infiltrates
Tachypnea, RR >= 30	Lactate > 4 or Suspected Sepsis
PaO2/FiO2 <300 mmHg	Encephalopathy
	AKI with Cr > 2
	Acute Liver Damage
	(Bili > 2, Plt < 100, INR > 1.5)

- If transfer to ED Necessary:
 - Verify Advanced Directives
 - Keep mask in place and droplet precautions
 - Notify hospital ED prior to transfer, patient is PUI
 - Notify EMS of PUI
 - Follow facility infection control and health department notification of transfer
 - Contact RP and inform them of change in condition

Transfer from Acute to PAC, Facility Accepting Residents with Diagnosed COVID-19 FAQ

When should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital?

CMS guidance states that a nursing home can accept a patient diagnosed with COVID-19 and still under transmission based precautions for COVID-19 as long as it can follow CDC guidance for transmission-based precautions.

- Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes: <https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf>

If a nursing home cannot effectively implement transmission based precautions, it must wait until the resident does not require these precautions. Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a stepdown unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor or returning to long-stay original room).

We have accepted a patient diagnosed with COVID-19 in our facility. When can we discontinue transmission-based precautions?

CDC states that decisions to discontinue transmission-based precautions in hospitals will be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials.

- Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes: <https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf>

Source — COVID-19 AMDA Update revised 3/18/2020 (found in Zenith PAC Quick Links)

What do I do if I have first person exposure or have S&S of COVID19?

ASYMPTOMATIC	SYMPTOMATIC (Exposure or Not Known)
No Symptoms	Fever
	Cough
	Shortness of Breath
Immediately	Immediately
Put on Facemask	Stop Work
Continue to Work	Put on Facemask
Droplet Respiratory Precautions	Notify Facility Infection Control Team/Leave Facility
Note: If both clinician and patient are wearing a mask quarantine is not needed, if one of them is not wearing a mask, 14 day quarantine is indicated.	Notify PCP and follow PCP recommendations for next steps. Notify CPM if return to work with mask is necessary or self-isolation required.

Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance)

Decisions about return to work for HCP with confirmed or suspected COVID-19 should be made in the context of local circumstances. CDC options include a test-based strategy or a non-test-based strategy (i.e. time-since-illness-onset and time-since-recovery-strategy). We have merged these into a single strategy for return to work:

- **HCP may return to work in healthcare settings when:**
 - At least 3 days (72 hours) have passed since recovery, defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g. cough, SOB); **and**
 - At least seven days have passed since symptoms first appeared or 2 negative COVID-19 tests 24 hours apart.
- HCP were never tested for COVID-19 but have alternate diagnosis (e.g. tested positive for influenza) criteria for return to work should be based on that diagnosis.

After returning to work, HCP should:

- Wear a facemask at all times while in the healthcare facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer.
- Be restricted from contact with severely immunocompromised patients (e.g. transplant, hematology-oncology) until 14 days after illness onset.
- Healthcare systems, healthcare facilities and the appropriate state, local, territorial and/or tribal health authorities might determine that the recommended approaches cannot be followed due to the need to mitigate HCP staffing shortages. This should be decided at the local level with the input from occupational health and other local leaders.

Source — CDC update in [TeamHealth Emergency Medicine White Paper](#) revised 3/19/2020

Resources

For immediate clinical/facility questions, clinicians can:

- **Contact us in Perfect Serve under Contact- COVID19 (Monday-Friday, 7 a.m.-10 p.m. ET)**
- **Call the COVID-19 PAC Resource line at 855.250.9709 (Monday-Friday, 7 a.m.-10 p.m. ET)**
- **Please contact HR regarding benefits, PTO, FMLA or Sick Time**

More in-depth information regarding all of the above is available in the following resources:

- [Zenith COVID-19 updates](#)
- AMDA COVID-19 resource channel in [Zenith PAC Quick Links](#)
- [CDC](#)