Notes from our Webinar

Dr. Kevin Katz – opening

- Coronaviruses circulate every year, COVID-19 is unique, as it only circulated in humans – made a jump from other species to humans
- causes unpredictable effects when it jumps to humans
- wide range of symptoms – asymptomatic to shortness of breath, to respiratory symptoms requiring machines, including death, different symptoms – affecting smell, taste, toes of kids
- Outcomes of the virus – much more sever than average influenza strain, of people tested, mortality rate is 2-3% overall, 18 and under, almost no symptoms, 15-20% for over 80, adults around 0.5%
- No one has any immunity, and as we get older, our immune systems are weaker – why the elderly have more severe outcomes
- Treatment – most treatment is supportive, new anti-viral treatments being investigated – promising but are not a panacea, tend to improve things a little bit, but not a salvation for those on the more severe end of the spectrum
- Hoping for a vaccine that can be used worldwide
- LTC – elderly have a weakened immune response, even to vaccines, so important for everyone to get vaccinated so as not to transmit to elderly loved ones

Dr. Michael Lamb – opening

- Treatment is supportive care for majority of cases – also true for LTC
- Started to learn about outbreaks in LTC – March 24th convened a working group at our hospital to support LTC homes in the community – have met with all medical directors of LTC,
- Initiated a plan with palliative care teams to ensure there is a support network for the physicians in the care homes
- Support residents to ensure medical issues are addressed, including palliative care where needed = 24/7 support model for all LTC in North York
- Have been visiting our LTC and Retirement homes to try to understand how the infections are spreading, to try to clear the outbreaks from LTC homes
- It has been nice to see how everyone has come together between LTC and hospital teams to work collectively

Dr. Niren Shetty

- Difficult conversations to have even during normal times, these are sensitive topics, but we do need to discuss these things
- You should have conversations with family, friends about what they want and don't want in terms of their medical care, so we can avoid doing things to people and do things FOR people
- question to ask oneself:
    - Is my loved one (or am I) satisfied with the quality of my life and is it acceptable to me?
- If patients don't have these conversations, they may have very aggressive measures that they may not want: i.e. resuscitation , intubation, defibrillation (shocking heart with electricity)
- talk to your doctor about the potential outcomes

- trying to avoid having someone come to the hospital, have these things done and then find out the patient didn't want these things to be done
- Try to have the conversations beforehand and inform the care team
- if doctor is telling you that after this is done, and they wouldn't get back to a quality of ife that is acceptable, shift in approach towards comfort – less poking and prodding, transitions to hospital

Question and Answer Period (based on submitted questions)
Turnaround time for tests:

- Average as of today is 28 hours but really depends on the lab, the time tests are collected and transportation. Province has dramatically expanding testing criteria so it changes day to day and it may exceed testing capacity of the labs

Best practices between waiting for test results or if positive:

- When a test is collected it would depend on the reason. If they have a fever or symptom then additional conditions be put in place with PPE. In the past couple weeks government has asked all staff and residents to be tested. Have everyone wear masks to protect residents and staff if they are asymptomatic.

Re-testing of the residents:

- Dependent on factors; as we are going into the homes its used to inform infection control practices. We are re-testing around 2 weeks if there are no new cases to ensure outbreak is over.

Best practices for LTC settings while awaiting test results? What precautions should be put in place?

- depends on reasons for testing:
    - if they have symptoms, additional precautions should be put in place – ie. providers should wear gowns, masks, gloves
- Government has recently announced that everyone in LTC should be tested – if asymptomatic, then no additional precautions are needed
- all staff are wearing masks – intended to protect residents in LTC in case staff are asymptomatic

Retesting of residents – when and how often?

- Depending on a number of factors:
    - Goal is to contain outbreaks and call them "over"
    - Re-testing is to help inform how we are doing with the infection control – usually around 2 weeks

What about false positives?

- Test is very good with positives, there was a lab in Peterborough that had some false positives, test is very sensitive and amplifies the virus, one risk is if the samples jump from one to the other, but from errors in lab procedures – very rarely happens

False negatives?

- Test sometimes comes up negative – depends on where the virus is (ie. nose vs. lungs), or quality of sample

What contributes to spread in LTC settings?
Depends on the site, but:

- Enclosed space with people moving in and out, hospitals also experience this, outbreaks occur when people are in close proximity
- People are also asymptomatic, we are doing active screening of people coming and going
- also equipment going in and out of the rooms

What about opening windows?

- fresh air is good for other reasons, this is a respiratory virus spread by droplets and those droplets fall by gravity
- most common reason is taking someone's hand who is infected and touching your own face, hand hygiene is so important

Visitation – when might we be able to visit again? What protocols?

- This comes from the government – they have recommended visitor restriction
- Hospital hasn't' been allowing visitors as well
- Continue for some time until outbreaks have been contained and community spread decreasing
- Ensure protocols and strategies will be in place when visitors are allowed
- Understand how difficult it must be for families, we will do our best

What are effects of isolation on residents?
Quite profound effects on patient and family and on care team as well

- Hard to deal with dying in isolation as well
- most institutions have had to take a step to limit visitors, unless the patient is actively dying
- Not the kind of medicine we want to be practicing
- Maximize virtual visiting as much as possible – phone, tablet, videoconferencing
- Don't want to minimize the lack of physical presence
- Number of ways to make the best of an awful situation – give patient as much control as possible, including having tough conversations – instinct is to shelter patients from bad news, but patients who have more information and know what's happening are in better shape
- Try to interact virtually as much as possible, and talk about things other than COVID
- Stay in touch with their caregivers/nursing staff helps, tell us about them, what they like

What determines is a patient gets transferred to hospital?
Many factors:

- What their symptoms are (they may have mild symptoms, wouldn't require a transfer), LTCs can manage, we are trying to help them feel confidence
- If they have more severe symptoms – some can still be supported in LTC (i.e. with oxygen)
- What their wishes are, their goals of care
- Would there be a benefit to what hospitals can provide to them
- Advocated that nurses and doctors in LTC have had the goals of care
- Usually supportive care in the majority of cases – provide extra support to LTC (oxygen), in lieu of mechanical ventilator, using medications to support them
- Clinical trials going on across the world, NYGH is involved in 2 of these right now
- Vast majority of cases, LTC residents aren't included in these trials

Use of vitamins C,D supplements?

- Vitamin D – 400 IU/day as recommendation, including residents in LTC
- Vitamin C = no real evidence to support its use

Comfort Measures vs. Aggressive Measures

Comfort:

- Alleviate symptoms, numbers like blood pressure, heart rate don't tell us about their comfort level
- best way to assess whether they are comfortable, ask them, if they can't speak, then we go with what we see (do they looked panicked or distressed), rather than go with what we can measure with a test
- Often keeping someone comfortable doesn't require hospitalization, usually can be done in LTC, be able to use Opioids can be valuable in treating pain but also shortness of breath
- There is also fear of these medications, in general population worry about addiction, but in these situations, don't think we will be seeing a lot of addiction due to severe COVID-related symptoms
- There is a need to add anti-anxiety medications along with opioids, without that they would have been distressed in last hours

Aggressive-

- Going to ICU to get meds to drive blood pressure up, intubation
- Typically not a comfortable experience

"When I worked with the community" - Anecdote

- Ask people when I gave lectures/talked to community members, most people didn't want aggressive measures to be performed, but not always same answer from family members

What might affect seniors' survival with COVID

- Like other respiratory viruses, weakened immune system, more conditions, more medical issues
- Elderly more likely to succumb to the disease
- 90% of flu deaths are over 65

Recovery – what might this look like?

- Disease is unique, trying to learn about it everyday
- Recovery dependent on how symptomatic people are
- Vast majority of individuals are asymptomatic
- With cough, breathlessness may take a few weeks
- Post viral cough, shortness of breath in recovery is common

Spread of COVID from patients not showing symptoms

This topic of wide interest

- asymptomatic:
    - they can either stay asymptomatic
    - within a few days, they develop symptoms within 2-3 days (pre-symptomatic)
    - had the disease, but are asymptomatic after recovery (post-symptomatic)
- For pre-symptomatic – they are quite infectious

- For the real asymptomatic, they are able to pass it on, but much lower, 5-10% of spread

Antibodies for people who recover

- Not 100% clear, some reports from Korea, Germany, some people who had COVID, recovered and had symptoms again, and they tested positive
- Not sure if it was a relapse or a re-infection?
- Re-infection would be if they are infected by a slightly different virus, but we don't know yet

We hopeful that there is immunity (usually there is), question is how long lasting is the immunity? A month? A year? For life?