COVID-19 LTC Task Force Recommendations for Physicians
Last updated: July 20, 2020

Physician Interaction with Residents

RECOMMENDATIONS - Memo #8:

1. **All care conferences and medication reviews should continue to be conducted virtually.**
    - Activities that do not require direct patient contact should be done remotely using telephone or videoconferencing technology to reduce the amount of in person exposure to residents and staff in order to reduce risk for viral transmission.

2. **In person site visits by physicians for elective/preventative care is now permissible but not mandatory.**
    - We recognize that some physicians feel they are not able to provide the same level of care using telemedicine in some situations due to limitations of technology at their site or due to other reasons. As physicians, we must continue to use our clinical judgement to evaluate when this is so and act accordingly. ***We strongly recommend that you continue to leverage telemedicine to reduce the necessity for onsite visits as much as possible when clinically safe to do so, in order to minimize the risk of viral transmission.***

3. **Those working in COVID testing sites, COVID specific hospital wards or in any situation for HIGH risk of infection are strongly recommended to continue to see residents virtually through telemedicine.**
    - We suggest when feasible that anyone in this situation should be asking a colleague or their Facility Medical Director, to assist with providing an alternative designate to provide in person care for any medically necessary visits.

4. **For those who work in general hospital wards, community clinics, hospice or other sites that employ approved COVID protection measures, please proceed in the following ways:**
    - There is no longer a need to quarantine yourself, for any number of days, from LTC after such work. Although it is advised to visit your long-term care site first on any day you will be working elsewhere.
    - Through the use of proper PPE and infection control procedures, the risk for physician infection and spread is very low. ***However, we still strongly recommend that you continue to leverage telemedicine to reduce onsite visits as much as possible in order to minimize the risk of viral transmission.***

5. **For those choosing to provide in person elective/preventative care we ask that you limit your visits to each LTC home to once per month.**
    - Preventative health continues to be an important aspect of patient care and we encourage that these proactive visits still occur. Again, when possible this can be provided using telemedicine to reduce the risk of viral transmission.

6. **Those working in multiple LTC homes who choose to do onsite elective/preventative visits should only be attending 1 home per week.**
    - The rational is to reduce the risk of a physician who may be infected but asymptomatic from inadvertently infecting multiple care homes. Although the incubation period is up to 14 days for COVID, we feel seven days is a reasonable timeframe when considering risk versus the need for care. Physicians should continue to limit themselves to one visit per individual LTC home per month for elective/preventative visits.

7. **All URGENT medical visits should continue to occur in person as clinically appropriate.**
    - The patient's primary physician or on call physician ***may and should attend in person at multiple LTC sites on the same day when clinically necessary or to prevent a hospital transfer.***
    - Ensure full use of PPE and infection control measures are taken and consider changing clothes and showering in between visits when practical.

<u>Clarification on single site recommendation for physicians/on-call designate – Memo #5</u>
The recommendation for physicians to only work at a single site doesn't apply if a clinically necessary on-site visit is required that would prevent a hospital transfer.

<u>Clarification about medication reviews and other on-site meetings – Memo #3</u>
In the March 17 memo, it was recommended that all care conferences occur virtually without explicitly naming other meetings.

The Task Force would like to clarify and emphasize that ALL meetings that typically occur at a care home (ie., medication reviews, etc) should take place virtually unless absolutely clinically essential or if the physician is already on-site for a clinically essential visit.

<u>Recommendation for physicians providing in-patient care at a hospital to find a designate for long-term care – Memo #3</u>
Physicians providing in-patient care at a hospital or direct patient care in a high risk COVID-19 setting may potentially encounter patients who are COVID-19 positive. Such physicians who also have residents in long-term care may potentially act as vectors if they were to provide care in both settings. As per our previous communication, we encourage these physicians to continue to provide care to the residents in LTC <u>virtually.</u> However, The Task Force encourages these physicians to try and ask for a designate to provide any clinically essential on-site care at a long-term care home. Similarly, when possible, a long-term care physician should select a single care home to attend in person and seek a designate for other sites where you have patients. It is recognized that this may not be possible in all communities.

<u>All care conferences will take place virtually – Memo #1</u>
Families should be universally requested to attend virtually rather than in-person. Physicians should be encouraged to attend virtually if there is no other reason that they need to be on-site.

<u>Non-essential physician visits should be avoided – Memo #1</u>
Physicians will only physically visit the residents where it is deemed to be absolutely clinically indicated. However, physicians will still be available for their residents as usual (ie., via telephone, SBAR, or other technology as per the care home's existing capabilities). Physicians visit multiple residents potentially across a number of care homes and could act as a vector.

Testing

Clarification on exclusion of GI symptoms as a suspected symptom for swabbing – Memo #6
Dr. Larder recommends continuing to swab for GI symptoms as we want a lower threshold of symptoms for LTC. It is, however, unusual to have only GI symptoms as COVID-19 typically presents with other symptoms.

If a resident only exhibits GI symptoms, testing is at the discretion of the MRP.

Process for Facility Medical Director involvement in decision for blanket swabbing at outbreak sites – Memo #6
Whether an active outbreak site should be blanket swabbed or not is a case-by-case decision made by the MHOs based on a number of factors such as site layout, staff cohort, and resident makeup.

If a Facility Medical Director strongly feels that blanket swabbing should take place, please get in touch with Dr. Larder directly via phone/text at 604 418 7497 or via email at andrew.larder@fraserhealth.ca.

Once an order for blanket swabbing has been made, the FH Site EOC Lead will be in touch with the care home to explain the process.

Clarification on swabbing – Memo #5
Symptomatic residents should be swabbed immediately and placed on droplet precautions. Those who test negative should be monitored closely with droplet precautions continued. Given the chance for false negatives, the MRP should be consulted and repeat swabbing should be considered before removing precautions.
Because little evidence currently exists, the Task Force has created a simple algorithm as guidance.

LTC Physician Task Force COVID-19 Swab Flowchart
(this document can be found under the Testing and caring for patients with COVID-19 header)

Recommendation to use "LTCF" on testing requests for Assisted Living and Convalescent Care residents when co-located with long-term care – Memo #2
Assisted Living and Convalescent Care residents fall under the lowest priority for testing. "LTCF" will group requests under the second highest priority group.

Recommendation to conduct post-mortem swabbing – Memo #2
In the event that a resident has passed away with preceding possible COVID-19-like symptoms but has not been swabbed, an NP swab testing for COVID-19 should be done post-mortem. This is useful for COVID-19 or other respiratory pathogen identification. Inform family and mark requisition as post-mortem.

Goals of Care and End of Life Care

Clarification on recommendation to have proactive goals of care conversations – Memo #4
The intention of the previous recommendation to proactively have goals of care conversations with families around COVID-19 was to discuss the experiences of the frail and elderly who become infected with the disease at other care homes as well as to raise awareness about the appropriateness of ED

transfers. It was NOT to recommend that new admissions or current residents must have a specific MOST designation. We would like to urge physicians to have goals of care conversations with families around COVID-19 and where appropriate, access the palliative care support system as outlined in our previous memo.

Recommendation to utilize the LTC Actively Dying Protocol for seriously ill residents with COVID-19 – Memo #3
Based on physicians' experiences at Lynn Valley and other care homes, the current protocol is sufficient for comfort measures. FH Palliative Care physicians are available for clinical case support when required.

An intensive symptom management pathway developed by Palliative Care physicians (mostly for acute care) is attached as an additional resource. The Task Force recognizes that the suggested measures will be challenging to implement in most LTC homes.

Dr. Nick Petropolis, Palliative Approach Lead, is available to mentor physicians in goals of care conversations or to review difficult MOST and goals of care cases at nick.petropolis@fraserhealth.ca. He will also be hosting a webinar for long-term care physicians to share goals of care conversation tips related to COVID-19.

Recommendation to proactively have COVID-19-related goals of care discussions with families – Memo #2
Proactively educating families that there is currently no medical treatment beyond supportive care for COVID-19, and that supportive care can be provided more effectively in the care home, will give families time to digest the information when they are not in a crisis situation. Should an outbreak happen, it will be difficult to manage all of the conversations at once. Start with M3 or higher residents and with families who may already be anxious.

Medications

Direct-acting oral anticoagulants now covered by Pharmcare for new patients – Memo #3
Effective March 30, 2020:

- PharmaCare's Limited **Coverage Criteria for direct-acting anticoagulants (DOACs) are changing** for the duration of the COVID-19 pandemic.
- Patients newly starting anticoagulation treatments are **no longer required to try warfarin.**
- Warfarin is the long-established anticoagulation treatment for the prevention of ischemic strokes in patients with atrial fibrillation (AF), and the treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE). However, its use requires frequent lab testing when therapy is started, which may not be desirable for social distancing during the COVID19 pandemic.
- **DOACs are as effective as warfarin in treating the aforementioned indications and do not require lab testing as frequently**.
- Residents in LTC who are **already on warfarin may be switched to DOACs where it is clinically indicated** as determined by the physician.
- A **Special Authority Form will still be required** and faxed to Pharmacare with a turnaround time of less than 24 hours.
- Please indicate the following note in section 5 of the form: "INR testing cannot be accomplished due to COVID-19"

Death Certificates

Death Certificates – Memo #9

Please note that death certificates must be completed within 48 hours of the death. Please see some recent questions and responses below related to death certificates and LTC.

I have not been onsite recently to assess my patient. Can I sign the death certificate?

Yes, you may sign the death certificate after reviewing the patient's chart.
If you require more than 48 hours to review the chart, you may write "interim" on part 1, line A for cause of death. Once you are able to review the chart, a replacement death certificate must be completed and sent.

What date do I list for the date of last visit if I have been using virtual visits for the past few months?

When completing a death certificate, you may list the date of the last virtual visit.

What do I list as the date of last visit if I am covering for a colleague and have never met the patient previously?

You may list the last date of visit by your colleague and the death certificate can be signed after you have reviewed the patient's chart.
Alternatively, you may list "intermin" as the cause of death (part I, line A) until the MRP can complete a death certificate. A replacement death certificate must be done.

If I suspect the patient died from COVID-19 but they were never tested or tested negative, what do I list as the cause of death?

If the patient was not tested and you suspect a COVID-19 respiratory infection as the cause of death, you may

a) call the coroner to review; they may consider post-mortem swabs
b) you may list "probable COVID-19" for line I, part A if you have a high index of suspicion