COVID-19 and Older Adults: What LTC and Community Clinicians Need to Know

Dr. Samir Sinha **MD, DPhil, FRCPC**
Director of Health Policy Research
National Institute on Ageing

Director of Geriatrics,
Sinai Health System and
University Health Network, Toronto

South Okanagan CME Webinar
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www.nia-ryerson.ca @RyersonNIA / @DrSamirSinha

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Faculty/Presenter Disclosure

- **Faculty: Samir K. Sinha, MD, DPhil, FRCPC, AGSF**

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Disclosure of Financial Support

- **This speaker has received an honorarium from the South Okanagan Similkameen Division of Family Practice**
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  - **NONE IDENTIFED**

Mitigating Potential Bias

- **Bias was mitigated by submitting slides for review by planning committee.**

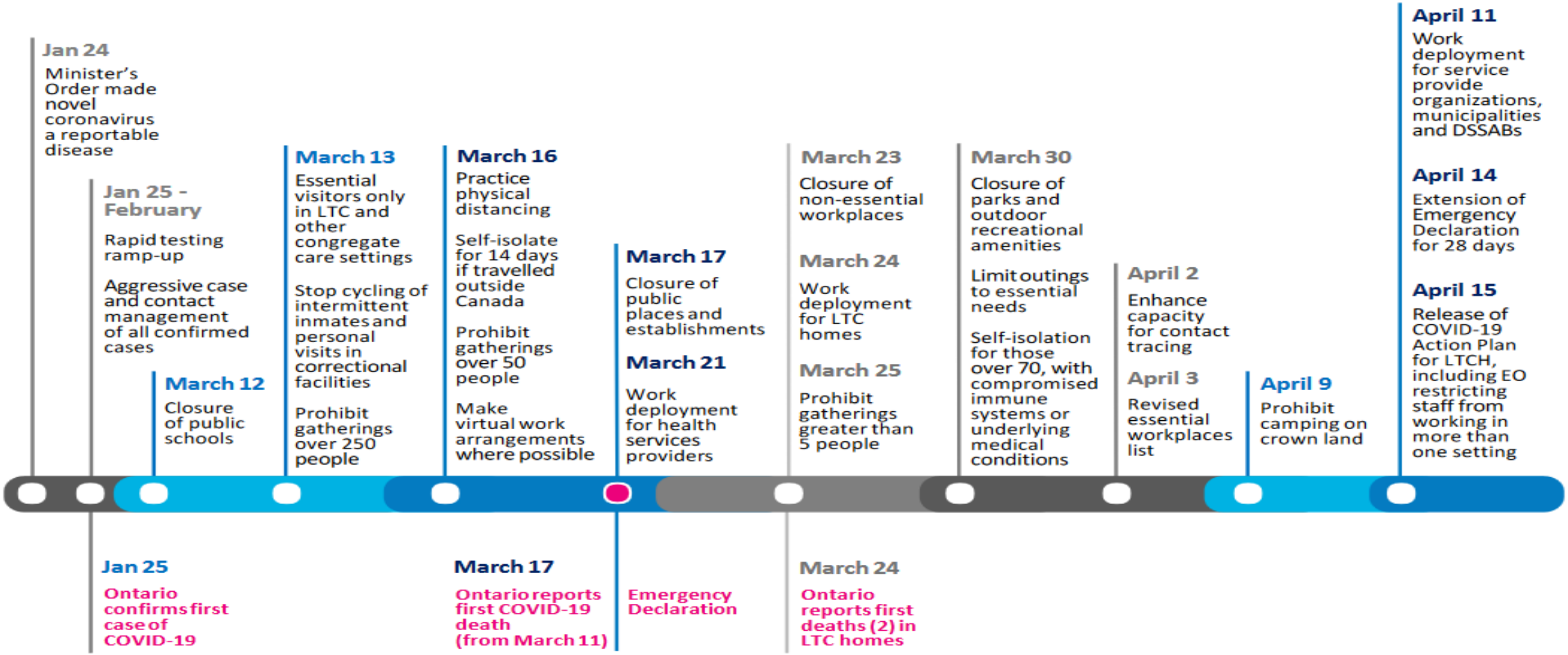
Learning Objectives

- Understand the epidemiology and way COVID-19 presents in older adults in community and residential care settings, and what the experience of other jurisdictions have taught us so far.
- Develop evidence-based approaches toward the prevention and management of COVID-19 in community and residential care settings that will help us all endure the life of this pandemic.
- Improve the attendee's confidence in discussing and managing some common geriatric and COVID-19 related concerns in their own practises in community and residential care settings.

COVID-19 Has a Predilection for the Old

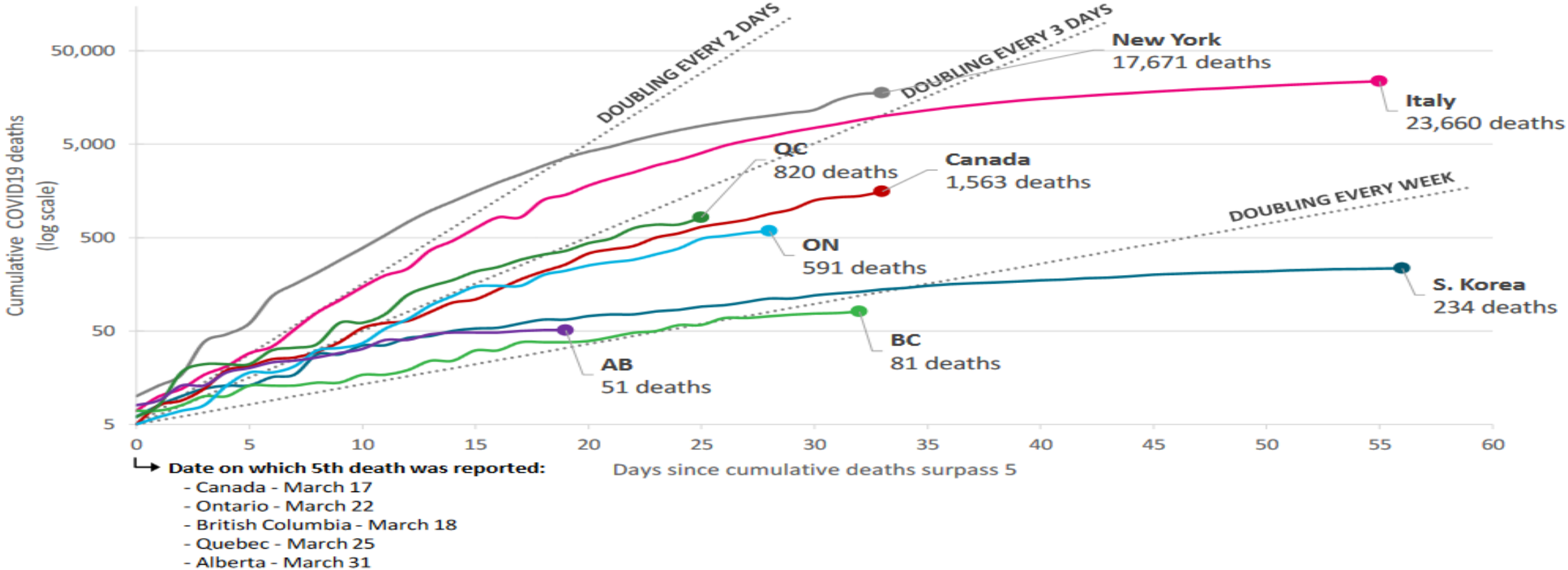
- Most Novel Viruses Affect those with Less Developed and Weakened Immune Systems: Young, Old and Chronically Ill
- CASE FATALITY RATES:
  - <18 = <1%
  - 18-59 = 1-2%
  - 60-69 = 3%
  - 79-79 = 8%
  - 89-89 = 15%
  - 90+ = 25%
  - LTC – 30-34%

COVID-19: Key Public Health Measures Timeline



Epidemic Curve: Cumulative COVID-19 deaths, number of days since the 5th death

By country, including the Canadian provinces of Ontario, Alberta, British Columbia and Quebec



Date on which 5th death was reported:

- Canada - March 17
- Ontario - March 22
- British Columbia - March 18
- Quebec - March 25
- Alberta - March 31

Data from: Dong, E., Du, H., & Gardner, L. (2020). An interactive web-based dashboard to track COVID-19 in real time. *The Lancet Infectious Diseases*, as of **April 19, 2020**.
Data compiled by Johns Hopkins University from the following sources: WHO, CDC, ECDC, NHC, DXY, 1point3acres, Worldometers.info, BNO, state and national government health department, and local media reports.

Ontario

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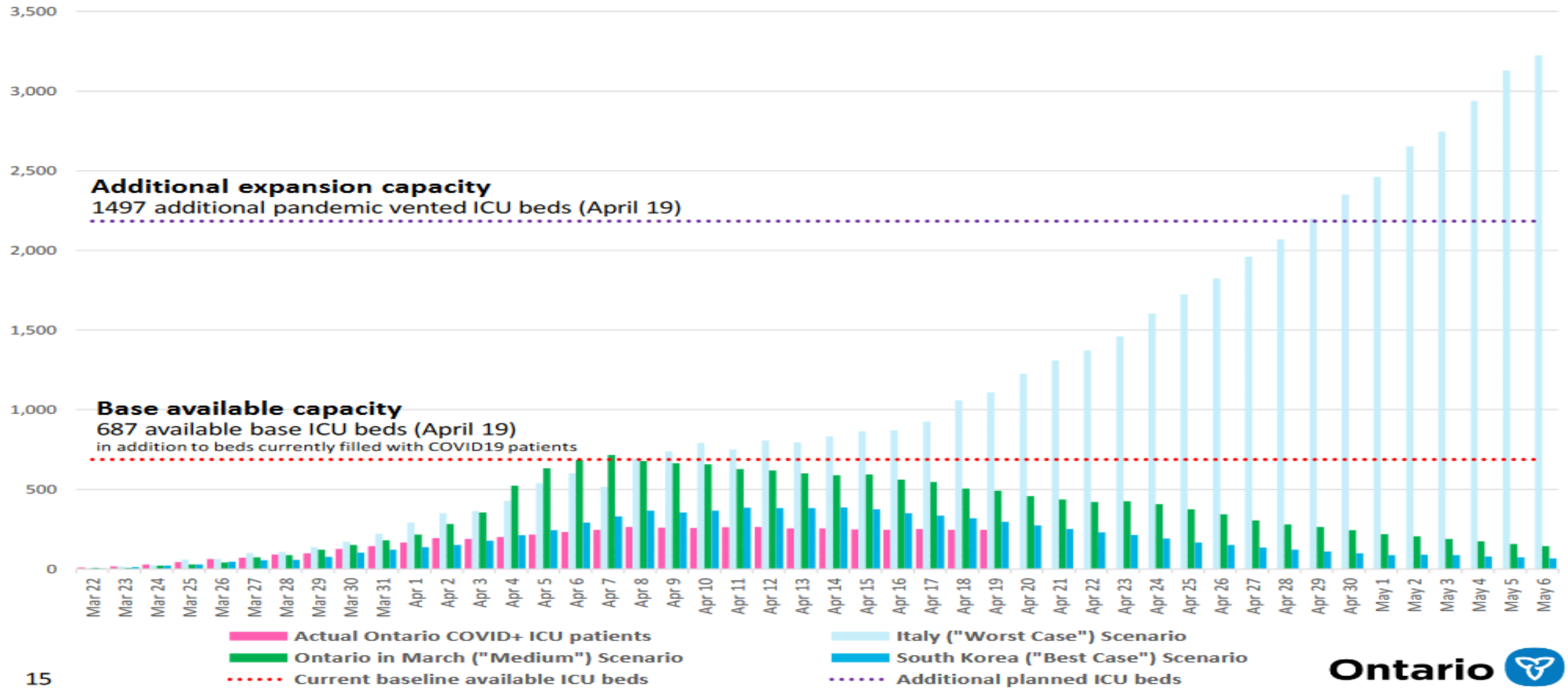
How are we doing so far?

COVID-19 patients in Ontario ICU beds each day vs. predicted ICU bed demands in 3 model scenarios



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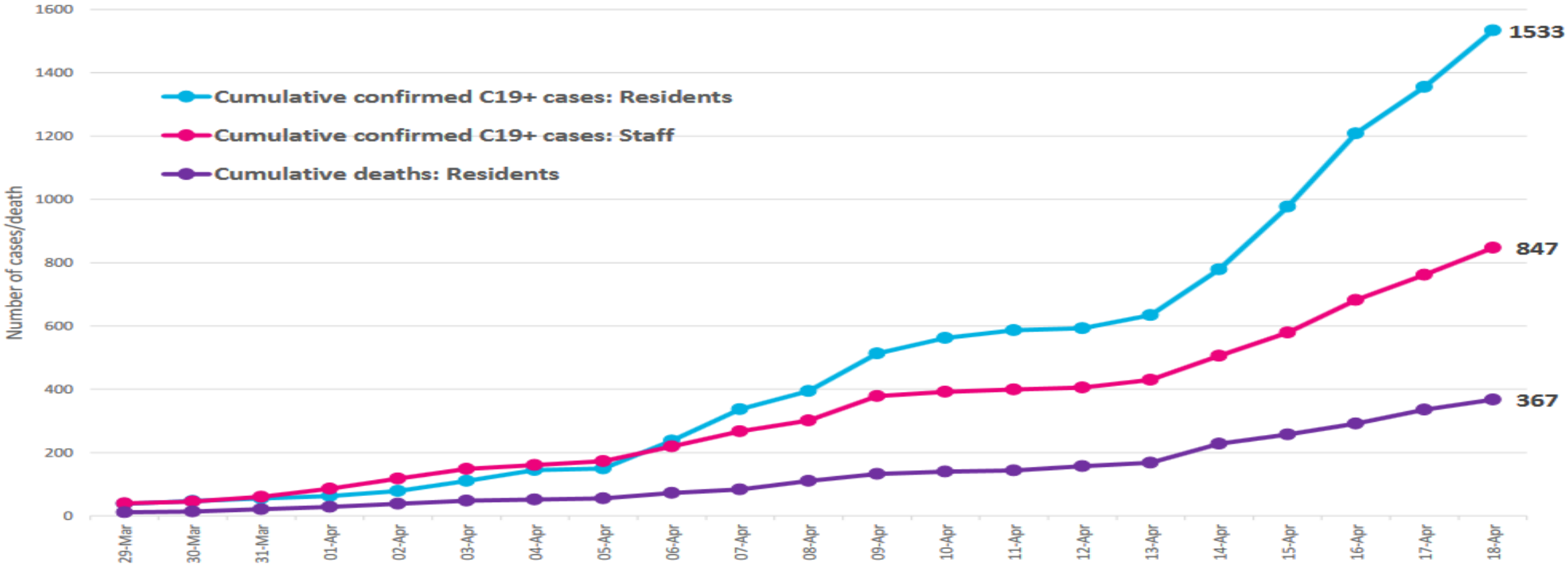
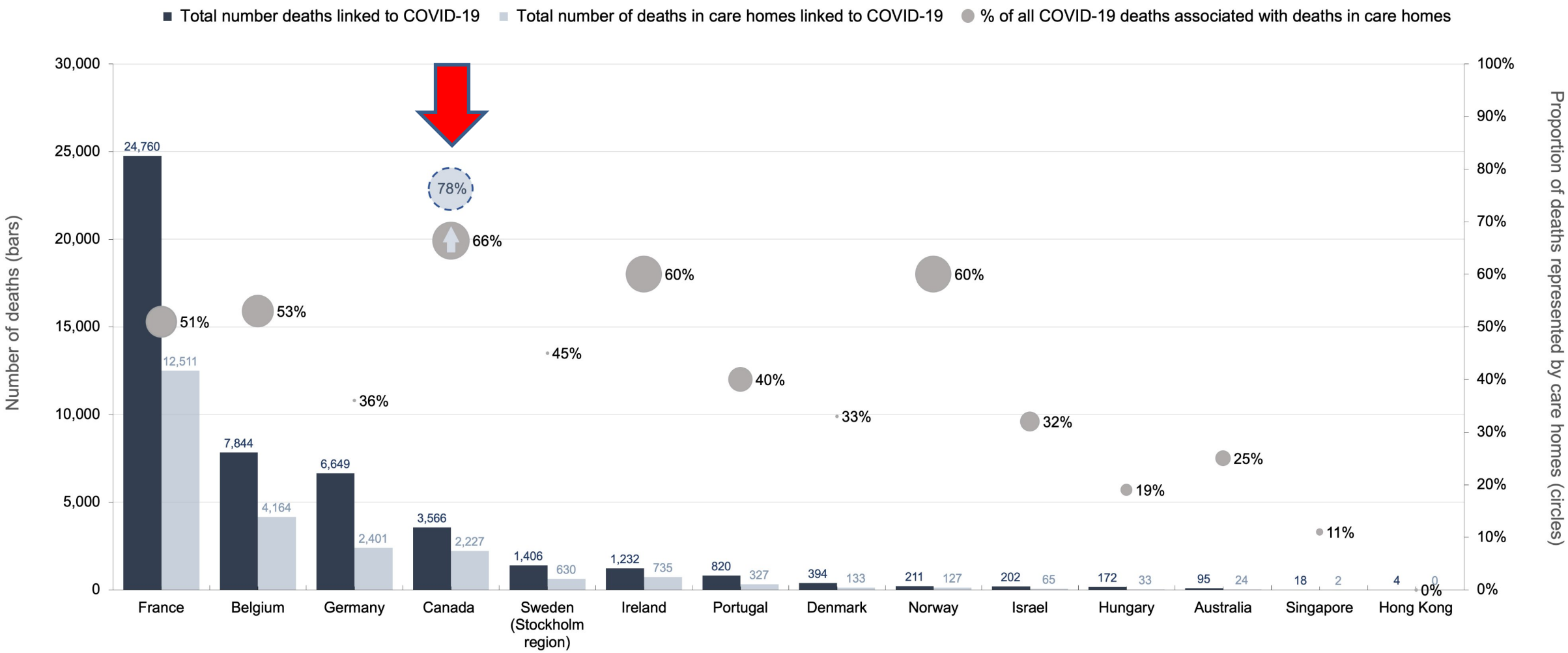
LTC Snapshot:
Cumulative resident COVID-19 cases, staff COVID-19 cases and resident deaths



Data source: LTC COVID-19 daily report via COVID-19 dashboard. All data current as of April 19.

Ontario

A National Tragedy and A Dubious Distinction



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Where Ontario's Outbreaks Live…

- Ontario's LTC Homes have faced 3x + 7.5x the number of influenzas, rhinoviruses, coronaviruses, combined outbreaks and other infections that Retirement Homes + Hospitals did between 2014-2019.

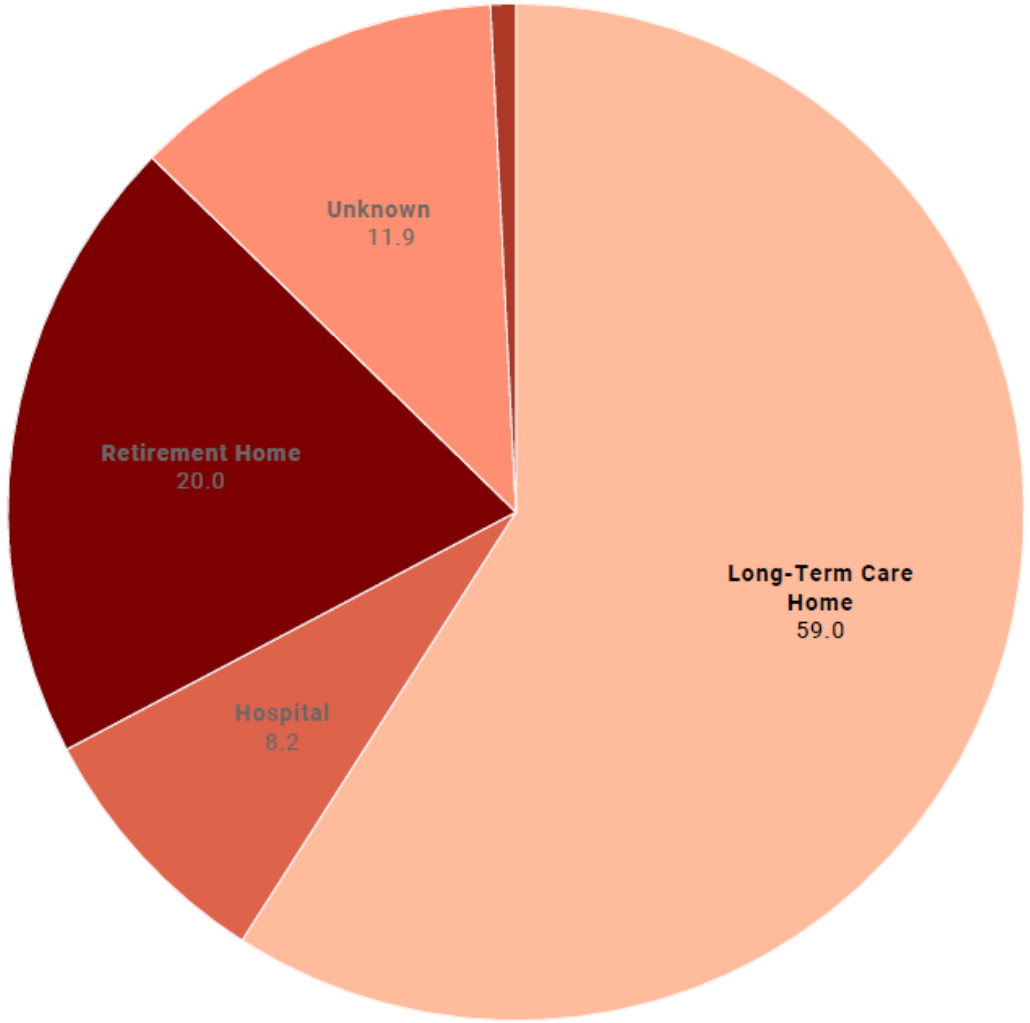

Chart: Victoria Gibson/iPolitics
Source: Public Health Ontario respiratory virus bulletins

COVID-19 is Anything but a Typical Virus

- Increasing Reports of its Ability to Present Atypically, Including Asymptomatically as well.
  - In LTC Settings 50-75% of Positive Cases on Widespread Testing for the CDC were in either Asymptomatic or Pre-Symptomatic Individuals.
  - COVID-19 ≠ INFLUENZA with a VACCINE and Effective Treatments
  - Restrict Non-Essential Visitors
  - Universal Masking
  - Test and Isolate Any Positive Contact
  - Ensure People Know HOW to Use PPE
  - Provide Excellent Supportive Care

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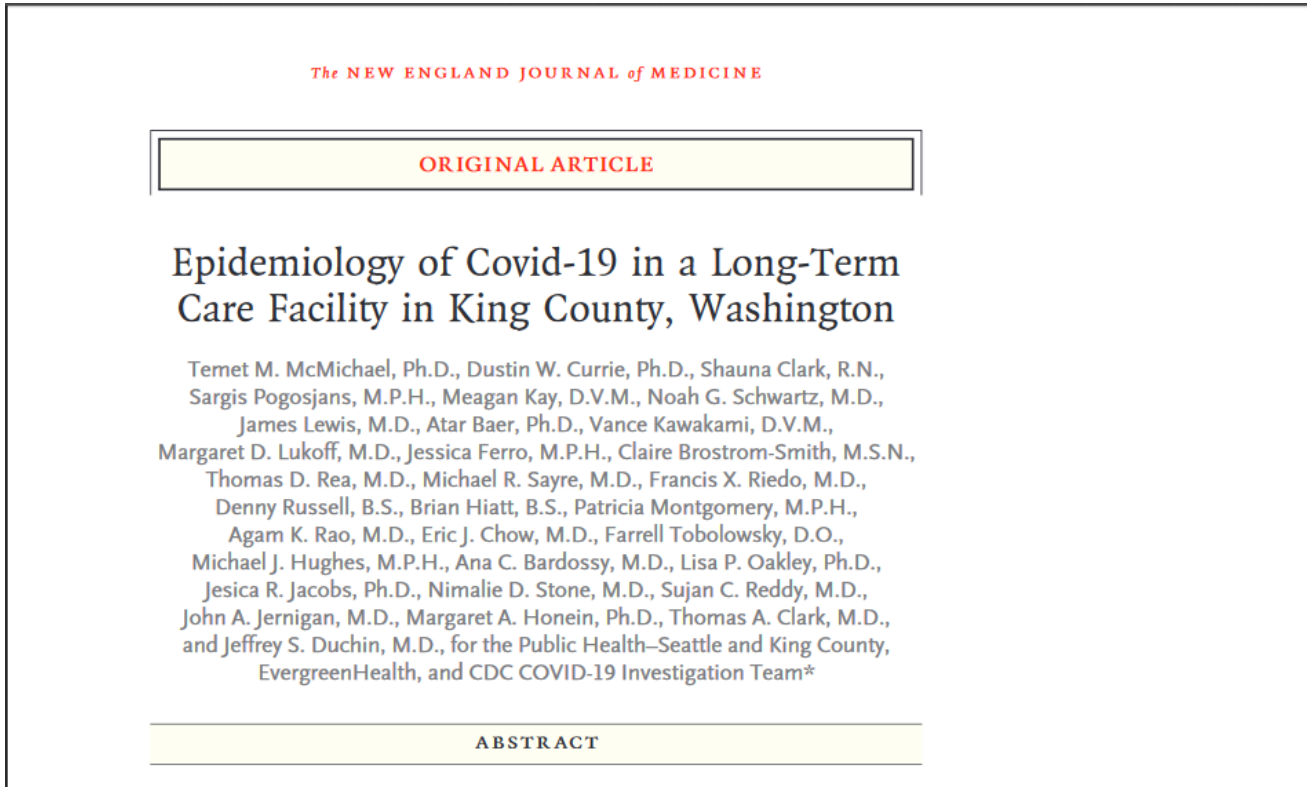

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ABSTRACT

Canada's Reponses Have Been Variable

- **Every province/territory has acted differently at different time points**
  - Stopping non-essential visits
  - Preventing staff to work in multiple settings
  - Masking all staff and visitors
  - Implementing infection prevention and control policies for COVID-19 and not influenza – including making more space to isolate residents during an outbreak
  - More flexible admission and discharge policies

https://www.nia-ryerson.ca/covid-19-long-term-care-resources

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NIA Review of Jurisdictional Responses 01-06-20

Jurisdiction	Restricting all Non-Essential Visits	Limiting Care Providers from Working in Multiple Care Settings	All Care Providers and Visitors Should be Wearing a Surgical Mask	Strong Infection Prevention and Control (IPAC) Policies	Flexible Admission and Discharge Policies
Federal PHAC Guidelines	R April 8th, 2020	R April 8th, 2020	R April 8th, 2020	R April 8th, 2020	
Alberta	✓ March 20thth, 2020	✓ Announced on April 10th, 2020 To be effective as of April 23rd, 2020	✓ Announced on April 10th, 2020 To be effective as of April 15th, 2020	✓ If there is a new confirmed outbreak, all residents and staff must be tested for COVID-19 April 28th, 2020	✓ Announced April 28th, 2020 The resident must "have a detailed plan of care and service applicable for an indeterminate length of time (up to or over one year)" and should include "back-up arrangements for contingences that may arise in the event of illness." They must also provide written consent that the room may be used by someone else while they are away.
British Columbia	✓ March 17th, 2020	✓ March 27th, 2020	✓ March 25th, 2020	✓ Testing if exhibiting mild and atypical symptoms April 10th, 2020	

NIA LTC COVID-19 Tracker Data as of 01-06-20

Canadian Jurisdiction	Total Number of Cases	Total Number of Deaths	Date Source Last Updated	Total Number of Homes	Total Number of Homes Affected	% of Homes Affected	Total Number of Resident Cases	Total Number of Staff Cases	% Staff + Resident Cases out of Total Cases	Total Number of Resident Deaths	Total Number of Staff Deaths	% Staff + Resident Deaths out of Total Deaths	Resident Case Fatality Rate %
Quebec	46141	3865	2020-05-22	2215	334	15.08	6624*	6079*	27.5	3118	2	80.7	47.1
Ontario	25995	2112	2020-05-22	1396	387	27.72	5953	2899	34.1	1680	6	79.8	28.2
Alberta	6800	134	2020-05-22	350	50	14.29	528	268	11.7	98	1	73.9	18.6
British Columbia	2507	155	2020-05-22	392	43	10.97	329	208	21.4	101	0	65.2	30.7
Nova Scotia	1048	58	2020-05-22	134	12	8.96	263	122	36.7	56	0	96.6	21.3
Saskatchewan	627	7	2020-05-22	402	2	0.50	3	4	1.1	2	0	28.6	66.7
Manitoba	292	7	2020-05-22	261	5	1.92	4	2	2.1	2	0	28.6	50.0
NL	260	3	2020-05-22	125	1	0.80	1	0	0.4	0	0	0	N/A
New Brunswick	121	0	2020-05-22	468	1	0.21	0	1	0.8	0	0	0	N/A
Prince Edward Island	27	0	2020-05-22	39	0	0.00	0	0	0	0	0	0	N/A
Yukon	11	0	2020-05-22	5	0	0.00	0	0	0	0	0	0	N/A
Northwest Territories	5	0	2020-05-22	9	0	0.00	0	0	0	0	0	0	N/A
Nunavut	0	0	2020-05-22	5	0	0.00	0	0	0	0	0	0	N/A
CANADA	83847	6341	2020-05-22	5801	835	14.39	13705	9583	27.77	5057	9	79.89	36.90

Source: NIA LTC COVID-19 Tracker Open Data Working Group https://ltc-covid19-tracker.ca/

*May14th

The Need for Good Data on COVID-19 in LTC Settings

- **You Can't Fight a Fire Blindfolded and You Can't Monitor What You Don't Measure**
  - In Early April, the NIA established its LTC COVID-19 Tracker Open Data Working Group
  - A team of staff and volunteers examines public health and ministry reports, media reports and information provided directly by homes to record reported cases and death amongst staff and residents of both nursing and retirement homes across Canada.
  - 5,801 homes and their corresponding Hospitals been identified with 1050 homes having reported at least one or more outbreaks to date.
  - The goal of the tracker is to strengthen front-line activities that can benefit those living and working across these settings

https://ltc-covid19-tracker.ca/

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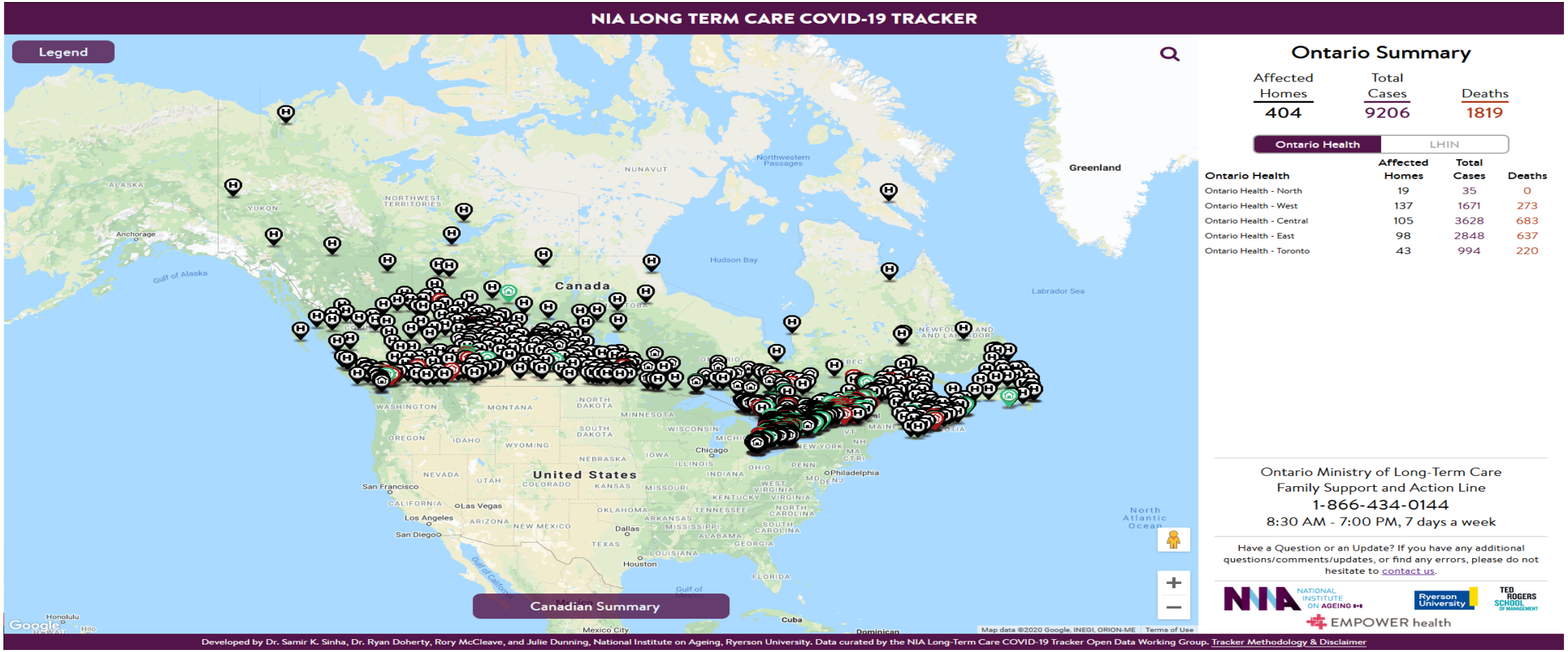
NIA Long-Term Care COVID-19 Tracker



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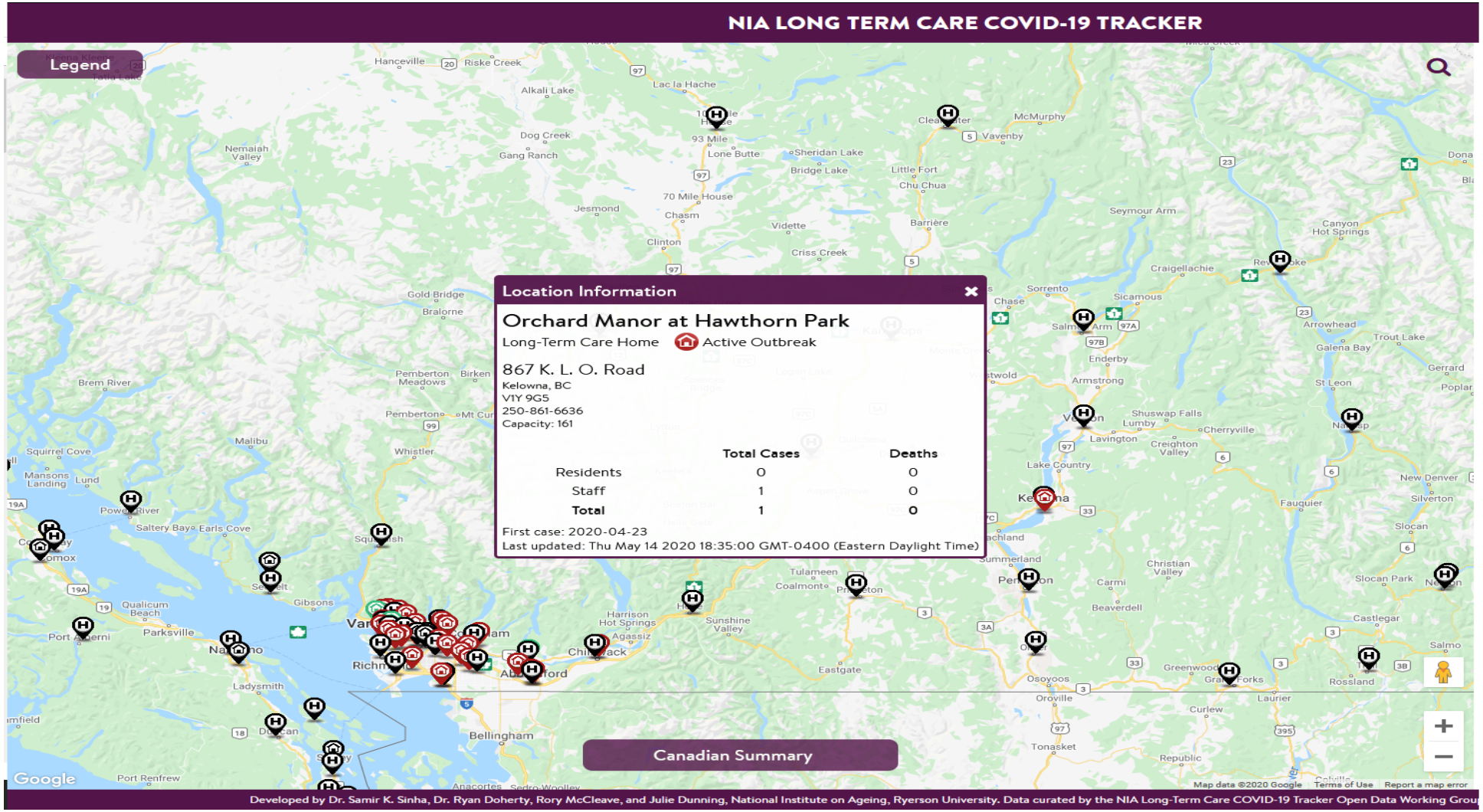

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Why Long-Term Care Matters

- **It is the LARGEST form of hands-on care that is NOT covered under the *Canada Health Act***.
- Coverage levels, qualifying criteria, and design standards vary significantly across provinces and territories.
- There is a growing value of these services to meet the *long-term care* needs of an ageing population effectively and sustainably.
- The current demand for long-term care services is already unprecedented and is only expected to grow as the population ages.
- The system has been challenged by longstanding systemic vulnerabilities when it comes to its health human resources and physical design and redevelopment approaches.

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My Lessons To Date

- **COVID-19 is here to stay for at least 18 months.**
- We need to do better to protect staff and residents as too many are still facing unnecessary outbreaks, illness and death.
- Actions have been encouraging, but we still need to do more, including considering how a lack of space can facilitate the spread of and our ability to control infectious outbreaks in LTC Settings
- We need to ensure we use what we have learnt as an opportunity to change Canada's long-term care system for the better once and for all.

COVID-19 Design Considerations…

1. **Physical Distancing Considerations**
2. **Easy to Clean Surfaces and Furniture**
3. **Smaller Footprints with Common Staff**
4. **Remembering that these Are First and Foremost Homes**

What's in Store for Long-Term Care?

- **We have yet to have a pandemic without a second wave.**
- As the first wave of LTC Outbreaks Resolve, do we have the right provincial regulations, policies and supports to limit future outbreaks from occurring
- Its Good to Ask Questions to Find Helpful Answers – is that through Inquiries, Commissions, or AG Investigations?
- A Conversation Needs to begin at the Provincial/Territorial Level to Determine how Should we approach the future provision of Long-Term Care in Canada

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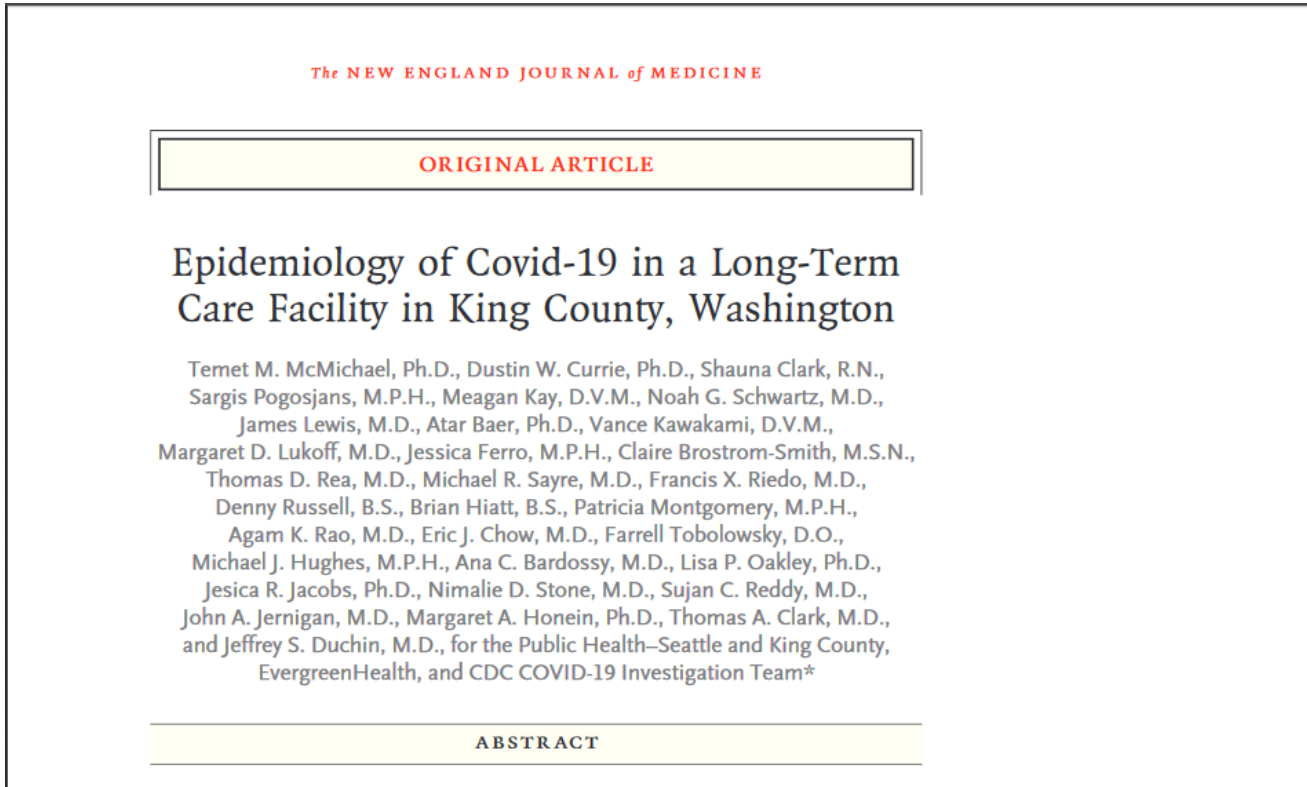

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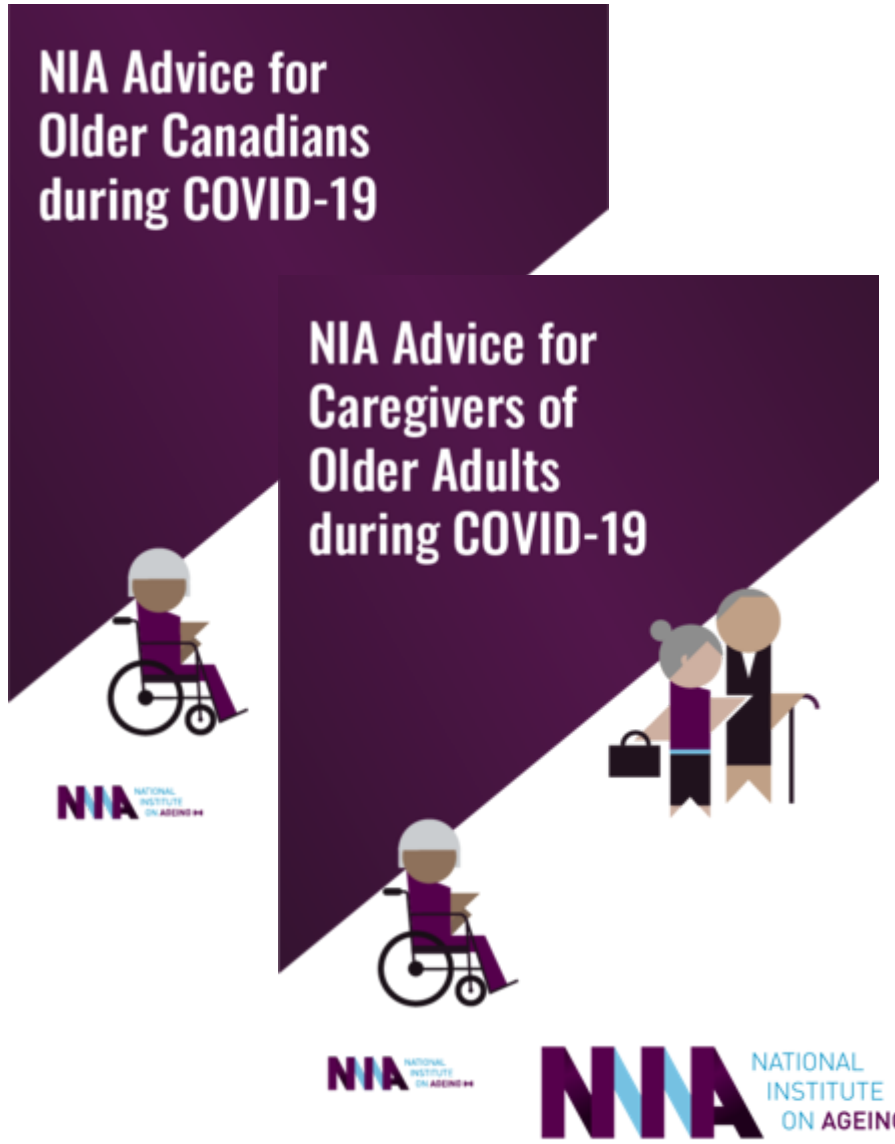
What About My Older Patients Not in LTC?

- **Continue to Provide Excellent Geriatric Care…**
  - **In A More Proactive and Virtual Way – ie Telephone or Video, Home BP Monitoring etc…**
  - **Be Mindful of How Fearful Older People Are – Too Scared to Exercise, Grocery Shop…**
  - **Ask About Social Isolation, Loneliness and Depression – Link to Available Services**
  - **Help Them Problem Solve Navigating What Matters Most to Them**
  - **Help Them Decide What is OK to Delay and What Needs to Be Done? Ie Glaucoma or Osteoporosis Injections**
- The Principles of Shared Decision Making that takes into account needs and preferences and risk tolerance is essential




Some Geriatric Pearls

Defining Memory Disorders

NORMAL AGE-RELATED MEMORY LOSS

1. Presence of subjective but no evidence of memory impairment associated with one or more cognitive domains

DIAGNOSTIC CRITERIA FOR MILD COGNITIVE IMPAIRMENT (MCI)

1. Presence of acquired memory impairment associated with one or more cognitive domains
2. Cognitive impairment dose **NOT** interfere with social/occupational function.

DIAGNOSTIC CRITERIA FOR DEMENTIA

1. Presence of acquired memory impairment associated with one or more cognitive domains
2. Cognitive impairment is severe enough to interfere with social/occupational function.

Reversible Dementias?

Rule Out Cognitive Impairment 2ndry to an underlying cause…

- Severe Anemia – Be Wary if Hgb < 100
- Cerebral Hypoperfusion (BP Don't Go too Low!!!)
- B12 Deficiency – Be Wary if B12 < 300
- Hypothyroidism
- Anticholinergics – Incontinence Medications

Only Things Proven to Prevent Progression of MCI Patients to a Dementia…

- Blood Pressure Control
- Regular Exercise

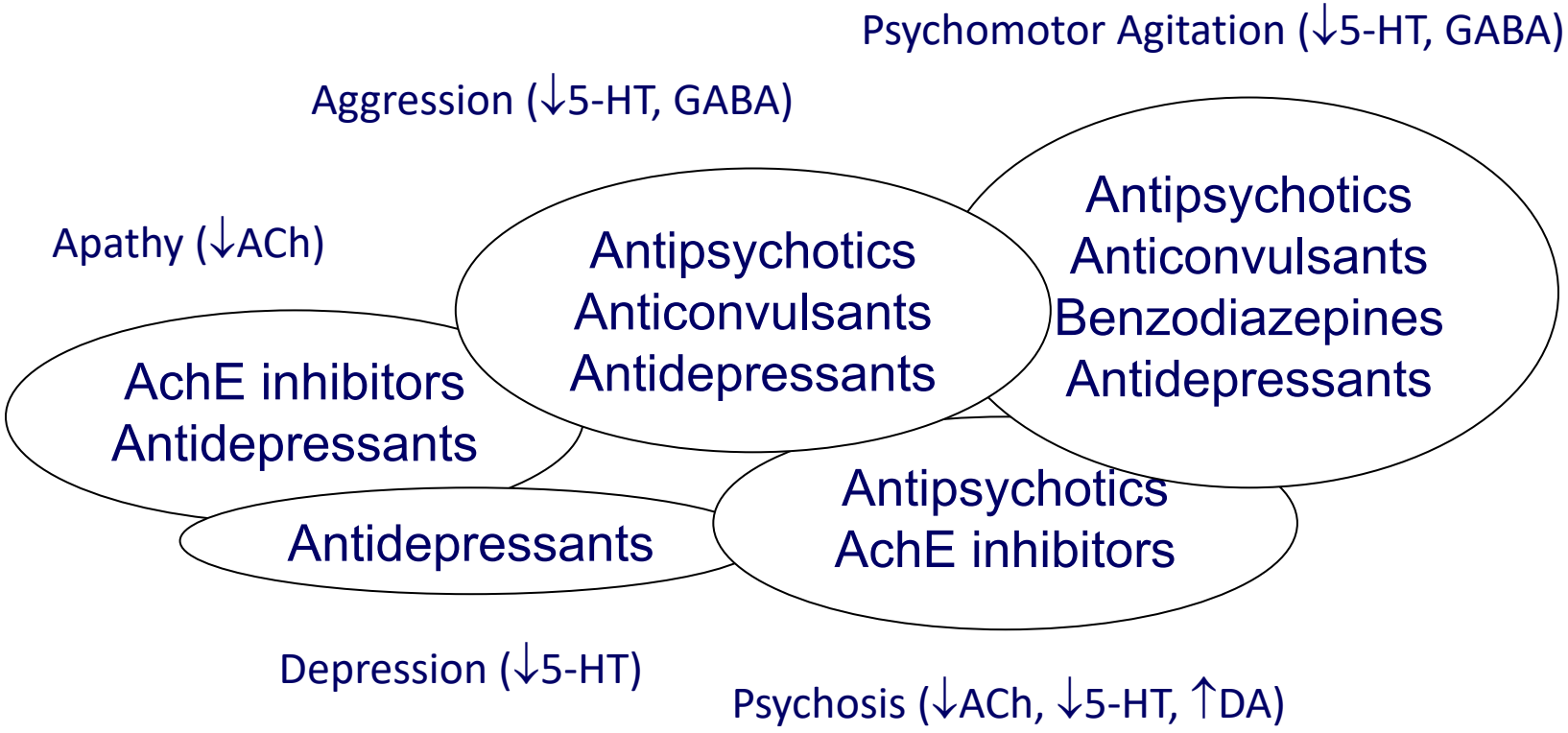
Dementia Management

BEHAVIOURAL AND PSYCHIATRIC SYMPTOMS

Symptoms Which Respond to Behavioural Approach	Symptoms Which MAY Respond to Pharmacological Intervention
Wandering	Depression
Pacing	Apathy
Repetitive Questioning	Paranoid and Delusional Ideation
Inappropriate Defecation/Urination	Hallucinations
Inappropriate Undressing	Aggression
Repetitive Vocalization	Sleep-Rhythm Disturbance
Hiding/Hoarding	Anxiety
Eating Unedibles	

Dementia Management

BEHAVIOURAL AND PSYCHIATRIC SYMPTOMS



BPSD Management

RISKS ASSOCIATED WITH ANTISPYCHOTICS

1. Death OR 1.7
2. Cerebrovascular Event OR 3.6
3. Extrapyramidal Symptoms OR 1.8
4. Somnolence OR 2.4
5. Falls OR 2.4

Tapering and discontinuation should be tried at least q 3months or whenever a new baseline is established.

BPSD Management

IF MEDICATING…START LOW AND GO SLOW

TYPICALS ARE FINE IN THE SHORT TERM

1. **Atypicals are no more effective than Typicals**
2. **If long-term use or high doses use Atypicals**
3. **Match Dosing with Timing of Symptoms!**
    1. ie qhs prn 0.5 mg Haldol or 12.5 mg Quetiapine **for night time agitation**
    2. **ie. bid standing** 0.5 mg Haldol or 12.5 mg Quetiapine for consistent agitation

Tapering and discontinuation should be tried at least q 3months or whenever a new baseline is established.

Falls Prevention

Falls Prevention Often Requires Multicomponent Interventions

Multidisciplinary, multifactorial, health/environment screening/intervention programs in the community (NNT = 8)

Risk Factor	Discipline	Intervention
postural hypotension	RN, RPh	non-pharmacologic, med changes
benzo/sedatives	RN, RPh	sleep hygiene, med changes
≥ 4 medications	MD, RN, RPh	med review and changes
unable to transfer	RN, PT, OT	gait aids, adaptive equipment
home hazards	OT	environmental assessment
gait impairment	PT	gait training, gait aids
balance impairment	PT	balance exercises
strength/ROM impairment	PT	resistance and ROM exercises

NEJM 1994;391:821-7.

Pain Management

Keeping it Simple

- Avoid Combination Tablets – ie T3s or Percocets (You never know what is working)
- Start with the Least Harmful Agent ie Tylenol Standing on a TID Basis – 2 Tablets TID of ES or Arthritis
- Add on a Narcotic if Needed ie Hydromorphone 1mg PO QID PRN and build up from there
- When titrating meds ask about actual effect and how long the effect lasts – this clues you in on whether to increase the dose or frequency or both.

Weight Loss: The Battle!

Strategies to Stem and Reverse Weight Loss

- Minimize Dietary Restrictions
- Meals on Wheels – Culturally Appropriate
- Maximize High Energy Foods
- Flavour Enhancers
- Small Meals More Often, Snacks etc.
- Encourage Eating their Favourite Foods – ie Ice Cream
- Eat in Company or with Assistance
- Supplements between Meals ie Ensure – but Wouldn't you rather eat Ice Cream?

Prescribing Tips

Keeping it Simple

- Once a Day Dosings whenever possible *(Bisoprolol vs Metoprolol)* and those most targeted to treat issue at hand.
- Putting all Prescribed Medications and Supplements whenever possible in Compliance Packaging.
- Horse Pills are for horses – ie use Elixers or more friendly forms of administration whenever possible – ie with Calcium or Pottasium Tablets.
- Re-Evaluate Medications that can linger and cause harm (PPIs, Antipsychotics, Iron etc.
- Avoid Combination Tablets when changes may likely be required – ie pain management

Vaccinations: Not Just for Kids

Essential Vaccinations

- Influenza – Annually
- Pneumovax – At least once after 65
- Tetanus – Every 10 Years
- Shingles (Zoster) – Once after age 65


Some Final Thoughts
DOLOMITE

Final Thoughts

- Without an end to COVID-19 Insight – Welcome to the New Normal in Geriatric Care.
- Much of what I have presented remains applied common sense.
- Each of these items can collectively transform the care you provide to your patients…

Thank You! Questions?

Samir K. Sinha MD, DPhil, FRCPC, AGSF
Director of Geriatrics,
Sinai Health System and the University Health Network, Toronto

Director of Health Policy Research, National Institute on Ageing

Associate Professor of Medicine, Family and Community Medicine
Health Policy, Management and Evaluation, University of Toronto

samir.sinha@sinaihealth.ca
@DrSamirSinha