Q&A: April 18, 2020 Webinar

Physical Therapy Considerations of COVID-19 in the Post-Acute Setting

Introduction

1) **How do you triage patients who tested positive for COVID-19 because of associate exposure while they were admitted in your facility (e.g. SNF, LTACH)?**

   Pam Bartio: If a patient was tested due to exposure, found to be (+) but was not symptomatic that person is low priority for treating as they don't really need therapy if they aren't having any complications from the virus.

   Ken Miller: Melissa's intro slide on "disease presentation" may answer this question.

Triaging

2) **If a home health agency is accepting COVID patients, but does not have a designated COVID team (specific RN, OT, and PT), is it wrong if the PT does not tell their non-COVID patients that they just came from a home with a patient who is positive for it?**

   Ken: We need to follow HIPAA and it is not appropriate to tell patients any medical info from other patients.

3) **Many that are testing positive are experiencing other signs such as GI symptoms prior to the respiratory symptoms. Not sure if these questions are also being asked/considered in your screening process?**

   Ken: Other signs/symptoms are being reported - such as loss of smell. But officially, these other signs/symptoms are not part of the screening.

4) **Any concerns about taking oral temps if the clinician is wearing PPE, using a thermometer sleeve, and of course cleaning the thermometer appropriately?**

   Ken: Disposable thermometers; no touch thermometers; Tempa DOT or use patient's own thermometer (also telehealth equipment that may be left in the home).

5) **Absence of fever >3 days is a guide for when non-contagious...but many geriatric patients do not present w/temp -- so is that guideline a solid one for geriatrics?**

   Ken: Fever is only one sign and may not be present in older adults, but also masked by patients taking certain medications. Look at cluster of symptoms present. Recommend 14 days past symptoms.

   Pam: it's absence of any symptoms or 3 days for fever. So, if they never had fever, I would suggest a minimum of 14 days past initial symptom onset. We just don't have more concrete evidence at this time.

PPE

6) **Our home care agency is telling us to re-use disposable gowns. We are supposed to spray the gowns with Lysol - no guidance about how to do that without first spreading out gown and contaminating ourselves. Is there a gown shortage or do you see this as purely financial? Therapists are refusing to do this at risk of being fired.**

Pam: I have not experienced this yet but had heard about it. I would say you need to put it in a sealed bag when you first leave the house. Then have another to put on for the next pt. Later when you have time, you would spread them all out carefully and without shaking it and spray it down. I can't say Lysol is enough as I just don't know. I would advise PTs to look into that more and see if something else should be used. Then once it dries for the appropriate kill time, you could use it again. So, you can re-use them, but should have a couple to make it through the day.

7) **If seeing HH COVID19 positive patient, any considerations for waiting some time until symptoms are less acute?**

Pam: You can delay treatment if they don't need PT right then. Problem is many patients are D/C'ed home quickly to get them out of hospital, but they aren't independent yet.

8) **If treated as an airborne disease, shouldn't home PTs doing transfer training / close care be provided with N95 masks?**

Pam: Yes, use N95 if they are COVID 19 (+). If they aren't someone with COVID, the surgical mask is fine.

9) **Wearing gloves all the time in the community would actually give people a false sense of security. We should be teaching continuous hand hygiene instead.**

Pam: Yes, no one should be wearing gloves all the time.

10) **Is there any truth to the rumor that you can "cook" your mask in a 200-degree oven in order to sterilize it?**

Pam: I have heard a bunch of methods to sterilize it, but I can't condone any of them as I just don't have enough research on the specific techniques. So far, UV light sterilization is the most effective I've seen, but that isn't being considered the "go to" technique yet either since there isn't enough proof it's effective enough.

Rachel Botkin: 2009- Annals of Occupational Hygiene, research contrasted different methods for sterilizing N95 masks. Recommendations are heat in an oven for 30 minutes at 158 degrees F (70 degrees C) or UV light for 30 minutes. **Not recommended -** soaking in alcohol, cleaning with hydrogen peroxide, cleaning with bleach. Other recommendation is to steam the mask with hot vapor from boiling water.

11) **Our facility does not allow N95 for patient direct care that is not AGP.**

Pam: AGP is aerosol generating procedures. For a person that is COVID-19 (+), I hadn't heard of places restricting N95 with those pts to only during AGPs. Most facilities are saying that if the patient is COVID-19 (+) everyone wears N95 masks regardless of AGP or regular care. When patients are still being ruled in/out for COVID-19, that's when many facilities are limiting N95 to AGP only and not regular care. In that case, surgical mask only is used until the patient is ruled in for COVID-19 or if there is AGP care.

12) **Are you re-using N95 masks for different patients?**

Pam: Yes, almost all places are re-using masks between patients. They are all COVID-19 (+) patients so you aren't spreading the virus between patients. If they are not COVID-19 (+), you just use a surgical mask and those should be changed between patients.

13) **Our facility is recycling N95. They are then irradiated off-site and put back in use. Our facility also recommends providers refrain from wearing makeup to avoid soiling masks**.

Pam: Yes. Most infectious disease people recommend no make-up and no facial hair to get the best fit. Many agencies/facilities are sterilizing in some method and then returning masks to circulation for use.

14) **What is the recommendation if you do not have an N95 mask and are treating homecare patient COVID-19+? Only option is KN95 or surgical mask.**

Pam: N95 is recommended. However, if all you have is a KN95 mask, that may be all you can use. I would talk with administrators and infection control medical staff for the agency/facility for opinions. I'm just not an infection control expert so I can't say KN95 is completely appropriate.

15) **Does DOH have PPE supplies?**

Talia Pollok: This seems to be largely based on your home state. Some states (i.e. NY) are asking for PPE donations or vendors from which to purchase PPE. In comparison, the Louisiana DOH provides contact information for suppliers of PPE which can be contacted by local hospitals and businesses.

16) **I am in high COVID-19 region, and wondering if many agencies should be requiring all patients and family (esp within 6-feet contact) to wear face coverings during home care visits -- just as family are required in our state to do when then have to go to the grocery or pharmacy.**

Talia: I am not aware of any existing regulations which require face coverings during home visits. However, if wearing masks is a requirement in your state it seems reasonable to request families/patients wear a mask during a visit.

17) **Similarly, in light of viral shedding (though uncertain contagiousness) post days 14 --> 30, does it make sense to ask patients to continue wearing face cover until post 30 days?**

Talia: Absolutely. There's no evidence to say how long someone is contagious after recovery, so being conservative or cautious seems very reasonable.

<u>Oxygen</u>

18) **Regarding desaturation: Need to confirm with MD about titrating supplemental O2 to maintain appropriate SaO2?**

Morgan Johanson: If the order states a continuous flow rate versus saying the word "titrate" then you will need to consult the MD for the appropriate order. The recommendation is that you ask the MD to write the order, "titrate O2 to maintain SPO2 >/= a specific number."

19) **What about BP measures? The virus attaches to ACE2 cells so are we finding inappropriate BP responses to exercise? I believe I read that BP's are lower due to this.**

Morgan: BP can definitely be affected in patients, especially in patients who have had critical illness and been on stronger medications such as vasopressors. We should also be checking BP at rest and with activity with all our patients. Ellen HIllegass's lecture also contains a really nice breakdown on vitals. She discusses what is normal, what is abnormal and what to do if you are seeing abnormal vitals (not just BP but also HR and SpO2).

20) **Kindly share some good exercises to assist with breathing.**

Morgan: **Inspiratory holds** is when you ask the patient to take a deep breath and then hold their breath at the end of inhalation for 2-3 seconds. This can be repeated like any other exercise 5-10 times for example. You can

also **stack the breathing,** where you take smaller inhalations and combine it with holding your breath. For example, take a breath in & hold it for 2 sec, take another breath in, hold it for 2 sec, take another breath in and hold it for 2 sec, then you exhale all the air slowly. The important thing here, is that the patient doesn't exhale between inhalations or stacks. Paired breathing is when you combine inhalation with trunk extension, shoulder flexion/abduction/ER and upward gaze. Then you pair exhalation with trunk flexion, should adduction/extension/IR and downward gaze. This can be done as an exercise and repeated several times, or it can be incorporated into functional movement. For example, if the patient is reaching overhead, we would instruct them to inhale with the movement and if the patient is reaching down or bending down, we would instruct them to exhale with that movement.

21) **Slide says spo2 less than, not greater than.**

Morgan: Oops that is a typo, thanks for catching that! It is on slide number 47. It should say >/=.

Visits

22) **How do you make the determination about who was able to be "seen" by therapists via a telehealth vs. in-person visit?**

Chris Chimenti: Good question. It came down to which patients had caregivers/family in the home that could assist with the technology (i.e. connect with video and film the patient during a session), what interventions we planned to provide (if the patient needed a lot of hands on assist for bed mob, transfers, balance, amb then in-person was encouraged vs strength training progressions, self-ROM, ambulation for endurance, etc.). How chronic vs acute their situation was. For the post-hospitalization referrals, we completed a LACE readmission risk on each of them to support our decision for in person visits.