Thanks all for your participation in the 4/7/20 version of COVID in 20. Thanks especially to our colleagues in NYC for sharing their experience and wisdom with us.

We value your time, so we want to make sure to keep to the 20-minute timeframe. This will limit our ability to answer all questions on the call, so we did a few on the call, and here are the rest. Thank you to Drs Curt Dill, Reshma Patel and Glennon Park for being willing to answer these!

Have you guys started accepted Civilians to the VA?

- GP - 30 civilians in 3 campuses
- RP - NY Harbor accepted 50 patients to date, 17 ICU and others are med-surge25% pts slotted for med-surge bed have had to be upgraded to ICU status

Dr. Dill -- when you're talking "we" r/t shortages of equipment, are you talking just VA facility or NYC area as a whole?

- The city as a whole

Who has the protocol on discharging people home with oxygen/concentrator and pulse ox?

- When finalized, we will post the protocol on the EM CoP.

Did you do cephied test /quick turnaround covid test in ED itself or defer it to the floor

- CD - We just got Cepheid tests so we are not perfect. Since we have 4 tests a day now, I would recommend using them on patients where a negative result would change management such as if a patient with CHF can go to a non-Covid area or a positive test would change the immediate decision such as enroll in a clinical trial

If you tested in ED what criteria did you use?

- CD - Only patients for admission until testing availability is better. Plenty of false negatives, even in the surge of physicians who got sick in the early days. I think the test is fine, but the pathogen attacks in the lower pulmonary tissue so the RNA particles may not be in the nasopharynx in the way we are used to seeing for respiratory viruses

What is your current bed capacity in VA in NY?

- CD - We have beds, we need vents, staff and meds
- RP - Bed capacity is fluid, opening weekly based on available qualified nursing staffing which really has been a rate limiting factor in readily opening up units. Focus has been opening critical care beds as well and reconfiguring to negative pressure rooms

Where are your biggest staffing challenges?

- CD - Front line nursing with acute care chops
- RP - Shortage Front Line nursing and critical care/ICU training. EMS staffing also now becoming a shortage as many exposed and have become ill, testing offered to employee veterans

Are you using CPAP and anesthesia machines?

- CD - No CPAP yet. We have a brilliant anesthesia chief in the Bronx who mocked up the PACU to run a COVID Anesthesia machine ward. Need an anesthesiologist or CRNA in the room though. We have V60 Bipaps that we can convert to invasive ventilators

- RP - Not much CPAP at NY Harbor either. From what we have learned, it is very important to avoid intubation as long as possible. Patients who have trouble oxygenation on a non-rebreather mask, should first be tried on high flow. The Italians also use a lot of CPAP. We need to preserve our negative pressure rooms for these patients. They obviously need close monitoring, but I don't think we can limit this to the ICU. Our rooms are all taken by vented patients, although we try hard to keep our negative pressure rooms open. It also seems beneficial to prone or rotate (some have called this the pig roast approach) non-intubated patients with high oxygen requirements.

We've been struggling with how to cohort patients who have a negative test but have "classic" COVID presentations that we're concerned may be "false negatives". How are you handling cohorting for that type of patient?

- CD - Assume COVID. Understand it could be dicey cohorting someone with a negative test with other COVID patients. Likely several of you patients on Non-Covid area are asymptomatic positive though.

Do we know sensitivity of tests yet?

- CD – No
- RP – No do not know sensitivities but false negative rates high so if clinically COVID still treat as PUI

We are also doing Rapid COVID testing IF a Vet warrants emergent surgical intervention.

- CD - I think that's a good idea but beware the false negative.
- RP - I concur, in theory good practice but consider false negatives. Similarly, we have implemented similar practice in testing Rapid COVID for vulnerable psych patients who require admission

Have you guys had any issue with false negative testing? Are you able to speak to the clinical sensitivity/specificity of Abbott test?

- CD - I don't have the numbers, but it's a real entity. We also tested a bunch of asymptomatic patients on a CLC and 2/3 turned out positive.

Are you using regular criteria for ICU admission?

- CD - ICU chief makes the determination, usually pending respiratory failure. The hospitalists are doing some pretty good prone ventilation and support on the floor.
- RP - We are trying to come to more of a consensus between NY & BK campuses to establish guidelines for Threshold to admit to ICU but it is case by case. General overview is that the ICU & Hospitalists don't want to use strict O2 requirements solely to determine ICU admissions. NY doesn't use Venturi masks. Pt requiring a non-rebreather mask from 6+ L NC is the upper limit. Patients who have trouble oxygenation on a non-rebreather mask, should first be tried on high flow & idea is to keep the ICU well informed of any patients on a non-rebreather and high flow with borderline saturation

How is primary care staff functioning and delegation of functions?

- CD - Fine, those who know the wards are pulling shifts others are doing virtual care and managing patients away from the hospital.

- RP - Primary staff have been overwhelmingly receptive to needs of the ED and we have had many volunteers who have come forth to help ED/Walk in clinic do medical screenings either in person or via telephone or virtual visits for well patients who have questions on testing or who are asymptomatic but have had exposure.

Are the civilians at the VHA due to walk ins or transfer to support overcrowding from civilian EDs?

- CD - Transfers from a collapsing public hospital system

Are you offering any experimental treatment to patients?

- CD - Yes, several, all by experimental protocol

Now that the VA is accepting civilians, are civilians coming off the street to the VA for care, or does it have to be a civilian facility referral for a civilian to be seen?

- CD - The latter.

Are New York VA doctors getting deployed to field hospitals or civilian hospitals?

- CD - Lost some to the National Guard and other part-time providers with primary gigs at the University

What are your vital sign parameters that you utilize to triage someone to home vs hospitalization? Are you sending patients home directly from ER (without hospitalizing them) on home o2? If so, what O2 sat are you using? Basically, are you tailoring these parameters for COVID-19 vs using the same parameters you would have used to hospitalize someone in the past for a respiratory disease?

- CD - Can maintain Sat above 92 at rest → home

Have you used ECMO for any patient yet?

- CD - No, Beno Oppenheimer at NY Harbor SICU is looking into it. Need to be in a 1a with a lot of technical support

Advice on ED over boarding? Would a 'holding' area be helpful for those with a disposition from the ED?

- CD - I would consider moving the ED out into the ambulance bay if your ED is turning into a Surge ICU

Regarding help outside the VA, are you doing EMERGENCY credentialing? If so, what is the process (e.g., application), turnaround time re: approval, etc.?

- CD - You get a 2-week waiver on your home credentials. If longer your PSCB can do emergency credentialing

We had pulse ox in house already for other reasons, limited number

- CD - Check prosthetics, they can get them and concentrators

Any VA trial of Convalescent antibody use to treat COVID patients. I am only familiar with Mayo Clinic trial.

- CD - No, but would love to hear about it

Has the plaquanel/hydroclornique helped patients recover from COVID?

- CD - It's not magic, need to wait for the data

What testing or monitoring are you doing of your asymptomatic employees? Every morning on our way into the building, my CBOC is checking every employee's temperature with an oral probe. What is best practice?

- CD - That's fine, I would surgical mask anyone in 6 feet if you have community spread
- RP - Asymptomatic employees advised to self-monitor for fevers/symptoms and wear surgical mask.

Are we seeing a preference for certain RSI meds for these patients?

- RP - Succinylcholine in the ICU and ED. Most of the Covid 19 patients and PUI's are severely hypoxic when they require intubation leaving precious little pulmonary reserve, even with preintubation preoxygenation. These patients usually start to desaturate below 90% within 30 seconds of injection of meds for rapid sequence intubation (RSI). Only succinylcholine can give us intubation conditions within 30-60 seconds, as rocuronium will usually take 90-120 seconds and may result in more cardiac arrests. We have moved the malignant hyperthermia cart and have Ryanodex in pyxis. Anesthesia and/or most experienced provider intubating.

Are you using outpatient antivirals or hydroxychloroquine? Or inpatient only?

- CD - As you know the prescribing of hydroxychloroquine is investigational and VISN 2 quickly put up guardrails through the VISN pharmacy executive to regulate ad hoc prescribing by VA clinicians. To reserve stocks for potential inpatients VISN 2 also converted standard 90 prescriptions to 30-day prescriptions. My recommendation to the audience is to place hydroxychloroquine under ID control for outpatient prescriptions and develop investigational protocols for inpatient use.
- RP - At NY Harbor mainly for inpatients. An order set for COVID meds has been created under ER orders to facilitate initiation in the ED. Just to summarize, the COVID regimen that we have been using for inpatients is:
    - Hydroxychloroquine 400mg BID x 1 day, then 400mg daily (or 200mg BID) x 4 days (do not start if QTc>490)
    - Azithromycin 500mg x 1 day, then 250mg daily x 4 days
- In addition, for concerns of superimposed CAP:
    - Ceftriaxone 1g daily (or cefepime if patient has risk for MDRO infections)
    - Vancomycin (if patient has MRSA risk, check for colonization)