Northwestern Medicine®
Feinberg School of Medicine

Department of Medicine
Medical Grand Rounds Webinar: COVID-19 Updates
April 7, 2020
7:30 a.m. to 8:30 a.m.

Questions submitted by participants during webinar
The answers provided are relative to a specific point in time and are subject to change as the management and care for COVID-19 patients continues to evolve.

1. **Are there also investigations involving zinc?**
   Answer from Dr. Taiwo: At this time, we are not aware of any major studies looking at zinc

2. **There is a lot of interest in antibody tests. It is my understanding the recently approved test is not specific for covid-19. Is there any valid antibody test yet?**
   Answer from Dr. Taiwo: There is one FDA antibody test that is available today. There are several others available

3. **Is there difference between SIRS with non Corona Sepsis and COROAN sepsis-related SIRS?**
   Answer from Dr. Budinger: Great question and one we do not understand. These patients seem to have diffuse microvascular injury with evidence of tissue necrosis in the skeletal muscle, kidney in most patients and other organs (heart, brain, pancreas) in others. This microvascular dysfunction may drive some of the hypotension and requirement for pressors we see. Alternatively, or more likely in addition, we manage these patients with massive doses of sedatives and we keep their intravascular volume low to protect the lung.

4. **Are there thoughts on who will be staffing McCormick Place? Will it be Northwestern physicians?**
   Answer from Dr. Budinger: No. Plans have been put in place to exclude any staff working within a 50-mile radius of McCormick place. This includes all NM hospitals.
   Answer from Dr. O'Leary: In addition, we anticipate increasing volumes of patients at NMH in the coming weeks. We anticipate needing all the help we can get here at NMH. People interested volunteering can reach out to the Department for options on how to do so.

5. **Have we decided not to code sick patients to protect health care workers or is that theoretical at this time?**
   Answer from Dr. Budinger: This response was provided in part by Kathy Neely who has worked hard on this policy. Heretofore, the NM policy regarding resuscitation has been that a decision for "do not resuscitate" is to be arrived at consensually, that is, the patient or Legal Substitute Decision Maker (LSDM , that is, Health Care Power of Attorney, Surrogate, or Guardian) consents to the code status of DNR. The COVID 19 pandemic changes the paradigm of medical decision-making, and thus NM has provided new CPR guidance in this new context. It can be found in full in the Critical Care guidelines, section 4, on NMI. These updated guidelines align with those of academic medical centers in Chicagoland and nationwide, and are based on ethical crisis standards of care. Please refer to it for important details. In short, with regard to a COVID + patient who is dying despite maximal intensive support, and therefore is determined to have no reasonable chance of survival, the critical care physician will inform the LSDM that all that can be done has been done for this patient. CPR in this case is not beneficial and will not be performed. While we anticipate most LSDM will understand and

agree, some will not. If the LSDM protests the "no CPR" determination, and there is time, the attending will ask for a second opinion from an attending who does not know the patient. If the two attendings agree, the consent for the LSDM is not needed and a DNR order should be entered. A dot phrase for documentation is forthcoming. Consultation with NMH Medical Ethics is available. A reporter from The Washington Post misquoted Dr. Wunderink in stating this policy reflects a "Universal DNR" and misrepresented it to others in our field in her reporting. With NM media relations, I sent a letter clearly outlining our policy to the Washington Post signed by more than 40 Pulmonary Critical Care Division Directors from across the country and Dr. Vaughan. The Washington Post provided no response to the letter.

6. **Can you talk about any role for plaquenil in the VERY early stage of COVID - is there a trial that patients can be enrolled in if they want?**
   Answer from Dr. Linder: Not that I am aware of. To be clear, there is no safe and effective treatment for COVID-19. Outpatient treatment is symptomatic and supportive.

7. **I continue to be asked by recovered covid patients where they can donate plasma. do we have a way yet to collect their plasma?**
   Answer: 4/7/2020 daily email from Gary Noskin says:
   Q: Do we have plans to recruit patients who recovered from COVID-19 for plasma donations?
   A: Yes. We are hoping to identify such patients through the Ambulatory Monitoring Program.

8. **For Dr. Linder - over the weekend, patients who tested positive at outside hospitals and were discharged lost their COVID flag that had been put in manually by IP. Has that been resolved?**
   Answer from Dr. Linder: There are 2 different flags: COVID and COVID Monitoring Program. You are probably referring to the COVID flag. That is managed by IP. To enroll patients in the Monitoring Program you can send .COVIDMONITORING to the COVID-19 NURSING POOL. They should be able to add back the COVID flag as well or at least be in touch with IP.

9. **Does anyone know when immunologic testing will be available?**
   Answer: 4/7/2020 daily email from Gary Noskin says:
   Q: Could we have an update on diagnostic testing for COVID-19, including test sensitivity of PCR? Is serologic testing coming soon?
   A: We have seen the sensitivity of nasopharyngeal PCR testing in the 70% to 85% range, but we do not yet have a timeline for serologic testing.

10. **What is the status of ambulatory testing?**
    Answer: 4/7/2020 Email from Gary Noskin): As you are aware, COVID-19 testing supplies are limited, and we have been working diligently to increase testing capacity, both in supplies and test processing. This includes investigating the implementation of the Abbott Alere rapid test across the health system. We have received Alere test kits, but the clinical validation of Alere has been challenging. At this time, we do not feel comfortable using Alere for all populations, but there may be an opportunity to use Alere in some capacity. We are partnering with our Emergency Departments to understand how to incorporate Alere as a preliminary test, where a patient can be tested on two testing platforms, Alere and another validated testing system (PCR or Cepheid). This will help us gather more data to better understand the Alere system.

    A workgroup has been created to monitor on-hand and incoming test supplies and testing capacity. Starting Wednesday, April 8, we will expand the scope of testing across the health system to include

the following patient populations: inpatient, ED admissions, symptomatic employees, surgical, and interventional services, which includes anesthesia and pregnant women who are delivering. We will continue to communicate updates as they become available.

11. **Jeff, can u share a list of signs/symptoms in the survey?**
    Answer from Dr. Linder: The "symptoms" – actually, not all are symptoms – are cough, shortness of breath, sore throat, muscle aches, trouble sleeping, lack of energy, feeling ill, fevers, diarrhea, stomach pain, overwhelmed (by my condition), worry that the infection will get worse, worry about spreading the infection.

12. **For physicians that are not on EPIC is there an email we can use to contact the outpatient team to get our COVID + patients enrolled?**
    Answer from Dr. Linder: For independent physicians, please use the Private MD Screening Request form to request patient monitoring.

13. **How many mechanical ventilators do you currently have available at Northwestern?**
    Answer from Dr. Budinger: This is a question that is in flux and depends on which vents you are counting and whether vents we have obtained are functional. The most up to date information is on the NMI website, which Michelle Prickett is working to keep as up to date as possible. Our current estimates are that we will have enough vents to meet our projected peak volume, but we will have to resort to older vents, vents for NIV and anesthesia machines to meet peak demand. Accordingly, we have already deployed those vents in our patients in order for staff and physicians to become familiar with them.

14. **Can you explain the projection that we will require 200 ICU beds? It seemed like this has been our projection for a few weeks but the date of peak keeps getting pushed to later. It appears our curve is flattening because the peak keeps getting pushed, so then why is the projected peak number of patients still the same?**
    Answer from Dr. Budinger: Good question. The projections are based on the assumptions in the model, which may or may not be valid. Personally, I am hopeful that we are bending the curve. If so, I will happily take a "mea culpa" for over planning. The good news is that there is increasing confidence that our projections might represent a worse rather than most likely case scenario.

15. **When will serologic testing be available?**
    Answer: 4/7/2020 daily email from Gary Noskin says:
    Q: Could we have an update on diagnostic testing for COVID-19, including test sensitivity of PCR? Is serologic testing coming soon?
    A: We have seen the sensitivity of nasopharyngeal PCR testing in the 70% to 85% range, but we do not yet have a timeline for serologic testing.

16. **It seems like the rise of covid patients at NM has been slower than expected. The predicted peak keeps being put further into the future, do we still think the peak will be 200 icu patients?**
    Answer: See answer to question #14

17. **Kevin, can u share discharge criteria?**
    Answer from Dr. O'Leary: Yes. O2 Sat >92% or at baseline. Improved fever curve. 7-10 days since symptoms onset. Safe quarantine plan.

18. **Are you retesting patients with an initial negative test, but with moderate to high suspicion for COVID-19 infection?**
Answer from Dr. Budinger: In the ICU we are confirming negative COVID testing by BAL in intubated patients with intermediate or high pretest clinical suspicion.

19. **How accurate are these models expecting the surge? It has been a moving target. Do we have any hope that may be Chicago will be "spared" from disaster?**
Answer from Dr. O'Leary: Only time will tell how accurate the models will have been. The models err on the side of caution, which is appropriate. Simultaneously, policies to promote and ensure social distancing may be flattening the curve. We would much rather be over-prepared that under.

20. **What are the current recommended treatments for Covid-19 patients on home monitoring programs?**
Dr. Linder already responded to participant: Symptomatic treatments with acetaminophen, other cold/flu treatments, rest, fluids. No evidence for any outpatient therapeutic that is safe and effective.

21. **Some fellows have been credentialed as attendings in order to help with COVID volume, will they be paid as such if they are asked to work in this capacity?**
Answer: GME has established rules related to moonlighting pay rates for residents and fellows. Please contact Dr. O'Leary for more information.

22. **what are your feelings about using doxy.me?**
Answer from Dr. Liebovitz: We have a variety of video solutions approved for telemedicine at Northwestern Medicine including Doximity, Teams, FaceTime, WhatsApp, and Skype. Many others like doxy.me exist; please use only approved services.

23. **Are African American patients with COVID-19 surviving as well as others at NMH?**
Answer: Early reports from the CDC suggest that a higher percentage of deaths from COVID-19 are occurring among African-Americans. Further research is needed to confirm this finding and identify contributing factors.

24. **My question is either for Jeff (Linder) or Kevin (O'Leary). I want to be sure I am notified when my patients are discharged from the hospital after an COVID diagnosis and am happy to follow them to be sure they are well at home. Is there a special method to notify PCPs after our patients are discharged following a COVID episode?**
Answer from Dr. Linder: The usual notification applies. Discharged patients, if they were COVID+ are usually going to get included in the outpatient monitoring program, which is a complement to your care. We should be in touch with you if a) you haven't been in touch with them already that day and b) there is anything we feel that your knowledge of your patients will help.
Answer from Dr. O'Leary: Our expectation is that hospitalists contact PCPs during each patient's hospital stay and collaborate with PCPs on discharge plans. We will reinforce this expectation. Please let me know if this communication is not occurring.

25. **Question about surgical mask vs. N95 for universal masking given new concerning data that surgical masks are not sufficient protection**
Answer: The current CDC recommendations on NM recommendations for inpatients is to use N95 for ICU, AGP, or AIIR. Please refer to PPE guidelines on NMI. These are based on the most current IDPH and CDC guidelines and will be updated if these are revised.

26. **Charlie, just to clarify. A routine cardiac catheterization, we should be wearing N95 (assuming patient has not been tested for covid) - no symptoms.**
Answer from Dr. Davidson: The current recommendations on NMI developed by the guidelines committee is to treat the procedural areas like an OR. N95 are recommended for unknown, suspected or confirmed COVID patients.

27. **Although I am trying to keep my patients out of the ED as much as possible, there are a few times I need to send them to the ED for non-COVID reasons. They are understandably scared that they will be exposed to COVID if they go. What procedures are in our ED to attempt to minimize non-COVID patient's exposure to COVID in the ED?**
Answer from Dr. Sanjeev Malik: Each patient is treated with precautions. All patients are given a mask on arrival. Visitors are restricted to reduce exposures. Caregivers wear a mask, eye protection and gloves for all encounters. We also separate COVID type symptoms to selected areas of the department and separate care teams and as of now, we have each patient in a private room with a door. We are fortunate in that with the access to inpatient beds, there is 0 wait to be seen so no waiting room exposure and no boarding in the ED awaiting hospitalization.

28. **We seem very well prepared, I am sure there are many poorer hospitals in Chicago who are running out of PPE and ventilators. Might we share?**
Answer: NM is working hard to ensure that we have sufficient supplies and equipment to provide high quality care to the patients we expect in the coming weeks and to ensure that our healthcare professionals are safe in the course of providing that care.

29. **Are there any updates on when we will be able to test outpatients for COVID? What is the limiting reagent?**
Answer: 4/7/2020 Email from Gary Noskin:
Q: Are there any estimates on when we will be able to test outpatients with symptoms?
A: No. At this time, we have testing capacity only for employees and for patients who are ill enough to be hospitalized.