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Cecilia Cofais, David Veillard, Celine Farges, Marion Baldeyrou, Pascal Jarno,  
Dominique Somme, Aline Corvol

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## COVID-19 epidemic: Regional organization centered on nursing homes

Cécilia Cofais, MD<sup>1</sup>, David Veillard, MD<sup>2</sup>, Céline Farges, MD<sup>3</sup>, Marion Baldeyrou, MD<sup>4</sup>, Pascal Jarno, MD<sup>2</sup>, Dominique Somme, MD, PhD<sup>1,5,6</sup>, and Aline Corvol, MD, PhD<sup>1,5,6</sup>.

<sup>1</sup>Service de Gériatrie. Centre Hospitalier Universitaire de Rennes, Rennes, France.

<sup>2</sup>Structure Régionale d'Appui, CAPPs Bretagne, Rennes, France.

<sup>3</sup>Service des Urgences, SAMU, SMUR. Centre Hospitalier Universitaire de Rennes, Rennes, France.

<sup>4</sup>Service de Maladies Infectieuses et réanimation médicale. Centre Hospitalier Universitaire de Rennes, Rennes, France.

<sup>5</sup>UFR Médecine, Université de Rennes 1, Rennes.

<sup>6</sup>UMR 6051, ARENES, CNRS/IEP, Rennes.

Corresponding Author:

Cécilia Cofais. Service de Gériatrie, Centre Hospitalier Universitaire de Rennes, Hôpital Pontchaillou, 2 rue Henri Le Guilloux, 35033 Rennes cedex 9, France.

Phone: +33 2 9 28 43 97. E-mail: [cecilia.cofais@chu-rennes.fr](mailto:cecilia.cofais@chu-rennes.fr)

Alternate Corresponding Author: Aline Corvol. E-mail: [aline.corvol@chu-rennes.fr](mailto:aline.corvol@chu-rennes.fr)

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Dear Editor,

The SARS-CoV-2 epidemic has been spreading in France since February 2020. Frail older people are at risk of worse outcomes (1) and community living raises fears of high mortality in nursing homes (NHs) (2). In France, an official figure indicated over 8500 deaths in NHs up to 26 April 2020 (3). In Brittany, western France, there are 115 NHs within a 70-kilometer radius of the Rennes University Hospital, which is the COVID reference hospital in the area and usually has no special link with these NHs. These public and private, not-for-profit and for-profit institutions each accommodate between 25 and 200 residents, who retain their general practitioners (GPs). Medical policy in these homes is overseen by a coordinating physician, who often works part time and does not usually prescribe treatment for the residents. Because of recruiting difficulties, one-third of the NHs in our area do not have a coordinating physician (4). During the epidemic, NHs felt hard pressed to implement recommended protection measures, especially for residents with challenging behavior. Early banning of family visits, imposed in France before general lockdown, and shortage of personal protective equipment added to their burden. Moreover, GPs were advised to limit their visits to NHs, which raised concerns about a decline in the quality of medical monitoring.

Against this backdrop of heightened tension, support for NHs and other residential care communities (5) was rapidly deployed on the initiative of the Rennes University Hospital Geriatrics Department. Only one NH had residents with COVID-19 infection when this organization was introduced. Overall, 17 NHs were affected during the epidemic. This support enabled access to medical expertise, the organized collection of nasopharyngeal swabs, and access to coordinated human and logistical support. This organization mobilized

up to 5 geriatricians, 4 medical interns, 6 volunteer medical students, 4 nurses, and 1 medical secretary. Because of a significant decline in activity in COVID-free departments, Rennes University Hospital was able to redeploy most of these professionals. Additional resources included a one-month contract for a geriatrician, paid by the hospital, and a weekend on-call system. The interaction between those involved was facilitated by an internet platform, weekly web conferences, and a hotline (Figure 1).

These weekly web conferences with NHs provide updated information on management of the epidemic and a forum for dialogue (30-minute expert presentation followed by a 1-hour question and answer session) with the area's stakeholders, such as Brittany's Center for Prevention of Healthcare-Associated Infections and Rennes University Hospital geriatricians, infectious diseases physicians, and virologists. NH managers, nursing supervisors, and coordinating physicians participate. Members of the regional ethics support team and user representatives also participate. Six web conferences were held between mid-March and the end of April, with over 140 participants each week.

A regional information platform (6) was set up to provide professionals with official documentation, expert up-to-date answers to frequently asked questions, practical videos, and contact information. To date, the platform lists 129 questions/answers. A form is available online for contacting an ethics support team.

In addition, a geriatric hotline operating 7 days a week was specifically created for NHs and allows direct interaction between a geriatrician and coordinating physicians or nurses. This hotline caters to a real need, with over 300 calls a month on clinical or organizational matters, and also provides reassurance regarding management of the epidemic. We did not open this hotline to the general public (7) because a national crisis hotline was already in

place. For complex cases, teleconsultation was available 5 days a week, with the possibility of a same-day consultation.

As community laboratories were unable to perform RT-PCR testing at the start of the epidemic, a mobile sample collection team (Figure 1) was created upon the initiative of the emergency call center (SAMU). A geriatrician checked the indication for each request and the mobile team was dispatched on the same day (250 samples a month). Virological data were forwarded to a geriatrician who informed the NH. If the results were negative, a discussion was proposed on whether or not to maintain isolation, depending on the clinical probability of infection. If the results were positive, close monitoring was started and direct admission to the hospital discussed. For NHs with insufficient medical resources, we offered the assistance of a medical intern (Figure 1), to allow them time to put in place a longer-term organization. This intern visited COVID-19 residents every day. He or she was systematically overseen by a geriatrician via daily teleconsultation and was in touch with the residents' GPs. NHs without a coordinating physician because of recruiting difficulties (5) could seek medical organization support from the association of nursing home coordinating physicians (AMCOOR). This association found volunteer coordinating physicians for one-time on-site help (Figure 1). Other local resources were mobilized, such as a mobile palliative care team and the home hospitalization team. The latter, if needed, could offer backup care by a two-person team comprising a medical student and a student nurse.

In France, as in other countries (8), the coronavirus pandemic has heightened the need for improved collaboration among healthcare organizations, regardless of status. Even though Brittany is one of the regions of France where the epidemic has claimed the fewest lives (9), in this health emergency we have seen the mobilization of a large number of stakeholders,

despite the common fragmentations (10) between social services and the healthcare sector, between GPs and hospital physicians, and between the public and private sectors. This mobilization was achieved by means of personalized communication emphasizing human ties, using phone calls and videoconferences. The absence of hierarchical relationships may have been a facilitator since, unlike Kim et al (8), we observed no fear of judgment in NH staff. This collaborative work, led by the Rennes University Hospital Geriatrics Department, is an example of efficient horizontal integration (10), implemented within a few days, and highlights the essential role of professional support services. Geriatricians have proved their leadership through their expertise for this vulnerable population. The challenge now is to perpetuate this collaboration.

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**Figure 1:** Regional organization centered on nursing homes. Schematic representation of the regional organization centered on nursing homes, which had access to logistical support, on-site medical support, off-site expertise and, the mobile team's management of samples. Communication was facilitated by a website, a hotline, and videoconferencing.



