To the Editor: The severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) epidemic has been spreading in France since February 2020. Frail older people are at risk of worse outcomes, and community living raises fears of high mortality in nursing homes (NHs). In France, an official figure indicated more than 8,300 deaths in NHs up to April 26, 2020. In Brittany, in western France, there are 115 NHs within a 70-km 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. During the epidemic, NHs were 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, raising concerns about a decline in the quality of medical monitoring.

Against this backdrop of heightened tension, support for NHs and other residential care communities was rapidly deployed on the initiative of the Rennes University Hospital Geriatrics Department. Only one NH had residents with 2019 coronavirus disease (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 five geriatricians, four medical interns, six volunteer medical students, four nurses, and one 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 1-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 more than 140 participants each week.

A regional information platform 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 and 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 more than 300 calls a month on clinical or organizational matters, and it also provides reassurance regarding management of the epidemic. We did not open this hotline to the general public 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.

Because community laboratories were unable to perform real-time polymerase chain reaction testing at the start of the epidemic, a mobile sample collection team (Figure 1) was created on 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 ensued about 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 a longer term organization in place. This intern visited COVID-19 residents every day. He or she was overseen

DOI: 10.1111/jgs.16687
systematically by a geriatrician via daily teleconsultation and was in touch with the residents’ GPs. NHs without a coordinating physician because of recruiting difficulties could seek medical organization support from the association of nursing home coordinating physicians (AMCOOR). This association found volunteer coordinating physicians for onetime 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 twoperson team of a medical student and a student nurse.

In France, as in other countries, 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, in this health emergency we have seen the mobilization of a large number of stakeholders, despite the common fragmentations 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 because, unlike Kim et al, 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, implemented within a few days, and it 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.

Figure 1 Regional organization centered on nursing homes. Schematic representation of the regional organization centered on nursing homes that 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.

ACKNOWLEDGMENTS

We would like to thank all professionals, particularly AMCOOR’s volunteers and medical student volunteers.
In-Hospital Mortality Rates in Older Patients with COVID-19

To the Editor: A valid estimation of the in-hospital mortality (IHM) rate requires following a cohort of patients admitted to the hospital until all of them are discharged, either dead or alive. When a large proportion of the included patients is still hospitalized at the end of the follow-up, the calculated IHM rate is biased.

The term “IHM rate” in a recent article, published in the Journal, is not appropriate as the calculations by the authors were based on studies in which the patients still hospitalized at the end of the follow-up were either not reported or accounted for a large proportion of the included patients. First, the IHM rate of 49.6% computed in patients aged 60 years or older, hospitalized in Wuhan, China, is not valid, as the calculation was based on a selection of COVID-19 patients with the outcome (death or discharged alive) at the end of follow-up on March 5, 2020, whereas the patients in hospital were not reported. Second, a similar miscalculation was made regarding the IHM rate of 10.0% among the 1,474 COVID-19 inpatients aged 65 years or older in a selection of cases from 169 hospitals who were dead or discharged alive by March 28, 2020. Of note, this article has recently been retracted on June 4, 2020, because the data could not be validated by all the authors and a third-party auditor. Third, the IHM rates (from 15.8% in those aged 60–69 years to 52.3% in those aged ≥90 years) reported in that letter using the first New York case series also need to be interpreted with caution, as 57.7% of the included patients aged 60 years or older did not reach the vital outcome at the end of the follow-up on April 4, 2020. Miscalculation also occurred by mismatch between the numerator and the denominator of the IHM rate, as the former was the number of all COVID-19 deaths (in-hospital and out-of-hospital deaths) and the latter the number of all COVID-19 hospitalizations, using data provided by the New York City Health Department as of May 19, 2020.

Most of the COVID-19 clinical studies so far published selected patients who had presented the vital outcome at a certain date, and compared dead patients with discharged alive ones. To the best of our knowledge, no clinical cohort of COVID-19 inpatients aged 65 years or older with a complete follow-up until hospital discharge has been published yet. However, some more valid estimations of COVID-19 IHM rates in older patients can be made. For example, in the Wuhan Pulmonary Hospital cohort, all the 179 patients admitted between December 25, 2019, and February 7, 2020, had completed their hospitalization as of March 24, 2020 (personal communication). Therefore, based on the 65 inpatients aged 65 years or older, of whom 17 died and 48 were discharged alive, we calculated an IHM rate of 26.2% in this age group. In a large Iranian cohort of 2,964 patients with 2.9% still hospitalized at the end of the follow-up on April 15, 2020, we could also calculate a more reliable IHM rate of 16.4% in the subgroup of 542 patients aged 70 years or older. Of note, we observed an IHM rate of 50.0% among the 90 patients aged 75 years or older (median age = 87 years) with COVID-19 confirmed by polymerase chain reaction between March 17 and April 17, 2020, in our Belgian university hospital, who were all followed up until death or discharge alive (unpublished data).

In conclusion, valid estimations of the COVID-19 IHM rate require clinical cohort studies with complete follow-up of all included inpatients until the occurrence of outcome (i.e., dead or discharged alive). As the length of stay can be long for COVID-19 patients, most clinical studies were ended before all patients completed their hospitalization. High-quality cohort studies are of utmost importance for understanding COVID-19. Further research is deeply needed to investigate the IHM rates and mortality predictors in the high-risk population of older patients with COVID-19.

Cédric Mahiat, MD and Christophe de Terwangne, MD Geriatric Medicine Division, Cliniques universitaires Saint-Luc, Brussels, Belgium

Séverine Henrard, PhD
Institute of Health and Society (IRSS), Université catholique de Louvain, Brussels, Belgium

See the Reply from Huang et al.
See the Reply from Sun et al.
DOI: 10.1111/jgs.16757

REFERENCES

1. Chen T, Dai Z, Mo P, et al. Clinical characteristics and outcomes of older patients with coronavirus disease 2019 (COVID-19) in Wuhan, China (2019): a single-centered, retrospective study. J Gerontol A Biol Sci Med Sci. 2020;glaa089. https://doi.org/10.1093/gerona/glaa089
2. Jones KM, Mantey J, Mills JP, Montoya A, Min L, Gibson K, Mody L. Research COVID–19 preparedness in Michigan nursing homes. J Am Geriatr Soc. 2020;68:937–939.
3. Gouvernement français. Information on coronavirus. https://www.gouvernement.fr/info-coronavirus Accessed April 27, 2020.
4. Bazin M, Muller M. Le personnel et les difficultés de recrutement dans les Ehpad. Ministère des solidarités et de la santé, numéro 1067. DREES. Juin 2018.
5. Coe NB, Van Houtven CH. Living arrangements of older adults and COVID-19 risk: it is not just nursing homes. J Am Geriatr Soc. 2020;68(7):1398–1399. doi:https://doi.org/10.1111/jgs.16529.
6. Genial.ly. COVID 19: Guide de gestion de l’épidémie à destination des établissements d’hébergement pour personnes âgées. https://view.genial.ly/5e7230ca5a13f909afc9178a/guide-covid-19-guide-pe. Accessed April 30, 2020.
7. Navarrete-Reyes AP, Avila-Funes JA. Staying in a burning house: perils of a hotline in the times of COVID-19. J Am Geriatr Soc. 2020;68(5):E10–E11.
8. Kim G, Wang M, Pan H, et al. A health system response to COVID–19 in long term care and post-acute care: a three-phase approach. J Am Geriatr Soc. 2020;68(8):1155–1161.
9. ARS Bretagne. Bulletin d’information n°14 COVID-19, vendredi 24 avril. https://www.bretagne.ars.sante.fr/system/files/2020-04/2020-04-24-bulletin%20d’information%20COVID-19.pdf. Accessed April 27, 2020.
10. Somme D. Integrated care in France: dream or reality? Int J Integr Care. 2014;14(1):e053.