



Anticoagulation FORUM

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Managing Anticoagulation During the COVID-19 Pandemic Frequently Asked Questions March 16, 2020

Below is a list of frequently asked questions (FAQs) related to the care of patients on chronic anticoagulation during the current COVID-19 pandemic caused by SARS-CoV-2 (coronavirus). Please closely follow all advisories from the Centers for Disease Control and Prevention www.cdc.gov and your local public health organizations.

Please refer to the AC Forum Anticoagulation Centers of Excellence Resource Center <https://acforum-excellence.org/Resource-Center/> for additional resources.

1) What can anticoagulation providers do to minimize exposure risk for our patients?

Each clinic should be developing processes for how to minimize person-to-person exposure risk for patients requiring INR lab tests. This might include reviewing screening protocols with any lab that your patients frequently visit to ensure that anyone with symptoms is appropriately isolated. This might also include re-assessing which patients can be managed by phone vs. in-person visits.

Given that the labs we routinely monitor in anticoagulated patients do not require fasting, advising patients to get their labs checked at lower-volume times of day may help avoid crowded waiting rooms.

Anticoagulation providers should encourage patients to avoid presenting to the emergency room for minor bleeding issues that can be addressed at home or with phone support from the clinic. These include minor cuts, bruises, and nosebleeds. The Michigan Anticoagulation Quality Improvement Initiative (MAQI2) has an online resource for patients on how best to manage many common bleeding issues at home: <https://anticoagulationtoolkit.org/patients>.

2) Are anticoagulated patients considered “high risk” for COVID-19?

Current advice from the CDC is that patients on chronic anticoagulant therapy are not considered high risk. Patients with other cardiac conditions (e.g., heart failure) are considered in the high-risk group.

3) Should I delay INR testing for my patients?

Stable patients should be offered extended INR testing and an interval of up to 12 weeks is appropriate. This approach is supported by a randomized, controlled trial and the CHEST guidelines published in 2012. Many institutions have employed this approach with no decline in TTR or increase in adverse events. Extending or delaying testing for unstable patients or out of range INR tests cannot be routinely recommended. Assessing risk/benefit is needed in patients with out of range INRs in order to individualize the approach - collaborating with patients will be critical.

4) Has COVID-19 been shown to impact the INR or other routine coagulation studies?

An early report from China has identified that patients with severe forms of COVID-19 may present with DIC (including prolonged PT/INR and elevated D-dimer) - <https://onlinelibrary.wiley.com/doi/epdf/10.1111/jth.14768>.

5) What do we need to consider for patients on chronic anticoagulation who may get a mild form of COVID-19 (the infection caused by coronavirus)?

As with any acute illness, the INR may be impacted. This is especially true if there is diminished dietary intake and/or diarrheal illness.

6) What strategies can be considered for patients who are unable to present to a clinic or lab for INR testing because they are currently in home quarantine?

Clinics need to be creative and incorporate other modalities to deliver care to patients during this unique time. One option is to utilize home health for either POC or phlebotomy INR draw. Another option is to investigate or establish a mobile health unit for INR testing. Many organizations have adopted this strategy for high risk patients. Results are reported to the responsible clinic and the patient is managed by phone or through secure messaging.

7) How can we incorporate telehealth visits into care of our patients?

Telehealth can be incorporated into your practice in a variety of ways. Patients can go to an outside lab, such as Lab Corp or Quest, and then have their warfarin managed via telephone or electronic messaging by your anticoagulation clinic staff. CPT code 93793 can be used for some anticoagulant virtual/phone management on warfarin. CPT code G2012 can be used for some DOAC virtual/phone management. Home testing is an additional option that can be utilized but may take several weeks to arrange (see below).

Be sure that you have contacted these outside labs to arrange for accounts to be set up specific to your clinic:

Labcorp - <https://www.labcorp.com/contact-labcorp-account-representative>

Quest - <https://www.questdiagnostics.com/home/physicians/>

8) Should we convert eligible warfarin patients to DOAC therapy? If so, should we be using the 30-day cards to help cover costs?

Converting patients from warfarin to DOAC is reasonable to minimize the need for frequent monitoring and clinic visits. However, patients must be good DOAC candidates and be amenable to switching. Several tools within the Centers of Excellence Resource Center (<https://acforum-excellence.org/Resource-Center/>) may assist in determining patients deemed appropriate for conversion to a DOAC.

As before COVID19, 30-day free DOAC supply cards should be used very judiciously. When deemed necessary, use must be supported by thorough and methodical transitions of care to ensure longitudinal access to anticoagulation therapy (especially after the initial 30-day period).

9) Should we be converting patients to home INR testing if they currently do not use home testing?

Home testing represents a great option to promote the continuation of INR testing in patients who are practicing social distancing. This will, however, take time to set up, there may be some financial implications, and training is involved. Additionally, patients have to be willing and able to perform home INR testing and insurance coverage must be verified before this can be implemented.

10) Is there any reason to be concerned that point-of-care INR tests (lab-based, clinic-based, or home-based) would be unreliable in the setting of COVID-19 infection?

At this time, there is no evidence to suggest that COVID-19 would impact POC INR test results any differently than other infections. Institutions should follow their current policies for checking out-of-range POC INR results with venipuncture INR lab tests.

11) What are some strategies that inpatient anticoagulation services should be considering to help manage hospitalized patients with COVID-19 and anticoagulation needs?

- Always consider DOACs as first line therapy for acute VTE and new onset NVAF patients that are seen in the hospital or emergency department
- Assess whether established warfarin patients with NVAF or VTE might be a good DOAC candidate and if so, consider switching during hospital admission

- Assess hospitalized VTE patients on warfarin (or any anticoagulant) for intended duration of therapy, and if course completed consider discontinuing anticoagulation

12) What are some strategies that health systems or clinics can consider to maximize the safety of their clinic staff during the COVID-19 pandemic?

For many clinics that operate phone-based anticoagulation management, they may consider if anticoagulation clinic staff can safely and effectively work from home. If a “work from home” environment is not possible, anticoagulation clinic staff should work closely with their management and infection control teams to identify strategies to minimize any exposure risk to patients and the staff.

Please note that this is a rapidly developing area. The local infection patterns, local supply of personal protective equipment, and local guidance must be considered. CDC current general infection control recommendations can be found on the coronavirus.gov website:

<https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>