Publications 2020-2021 from Our division and Center Faculty

1. VanAalst R, **Gravenstein S**, Mor V, Mahmud S, Wilschut J, Postma M, Chit A. Comparative effectiveness of high dose versus adjuvanted influenza vaccine: A retrospective cohort study. Vaccine. 2020 Jan 10;38(2):372-379. doi: 10.1016/j.vaccine.2019.09.105. Epub 2019 Oct 9.PMID: 31606249

2. Gardner RL, Pelland K, Youssef R, Morphis B, Calandra K, Hollands L, **Gravenstein S**. Reducing Hospital Readmissions through a Skilled Nursing Facility Discharge Intervention: A Pragmatic Trial. J Am Med Dir Assoc. 2020 Apr;21(4):508-512. doi: 10.1016/j.jamda.2019.10.001. Epub 2019 Dec 5.PMID: 31812334

3. McConeghy KW, Huang SS, Miller LG, McKinnell JA, Shireman TI, Mor V, **Gravenstein S**. Hospital Influenza Admissions as a Harbinger for Nursing Home Influenza Cases. J Am Med Dir Assoc. 2020 Jan;21(1):121-126. doi: 10.1016/j.jamda.2019.06.025. Epub 2019 Aug 21. PMID: 31445924.

4. Moyo P, Zullo A, McConeghy K, Bosco E, van aalst R, Chit A, **Gravenstein S**. Risk Factors for Pneumonia and Influenza Hospitalizations in Long-Term Care Facility Residents: A Retrospective Cohort Study. BMC Geriatr. 2020 Feb 10;20(1):47. doi: 10.1186/s12877-020-1457-8.PMID: 32041538

5. Bardenheier BH, Lindley MC, Ball SW, de Perio MA, Laney S, **Gravenstein S**. Cluster Analysis: Vaccination Attitudes and Beliefs of Healthcare Personnel. Am J Health Behav. 2020 May 1;44(3):302-312. doi: 10.5993/AJHB.44.3.3.PMID: 32295678

6. Dosa D, Jump RL, LaPlante K, **Gravenstein S**. Long Term Care Facilities and the Coronavirus Epidemic: Practical Guidelines for a Population at Highest Risk. J Am Med Dir Assoc. 2020 May;21(5):569-571. doi: 10.1016/j.jamda.2020.03.004. Epub 2020 Mar 13.PMID: 32179000

7. Bosco E, Zullo AR, McConeghy KW, Moyo P, van Aalst R, Chit A, Mwenda KM, Panozzo CA, Mor V,**Gravenstein S**. Geographic Variation in Pneumonia and Influenza in Long-Term Care Facilities: A National Study. Clin Infect Dis. 2020 Jan 29:ciaa081. doi: 10.1093/cid/ciaa081. Online ahead of print.PMID: 31995171

8. Nanda A, Vura NVRK, **Gravenstein S**. COVID-19 in older adults. Aging Clin Exp Res. 2020 Jul;32(7):1199-1202. doi: 10.1007/s40520-020-01581-5. Epub 2020 May 10.PMID: 32390064

9. Saade E, **Gravenstein S**, Donskey CJ, Wilson B, Spiessens B, Abbanat D, Poolman J, dePalacios PI, Hermans P. Characterization of Escherichia coli isolates from post-transrectal ultrasound-guided prostate needle biopsy invasive urinary tract and

bloodstream infections. Vaccine. 2020 Jul 14;38(33):5100-5104. doi: 10.1016/j.vaccine.2020.06.024. Epub 2020 Jun 16.PMID: 32561123

10. Bonten, M, Johnson, J, van den Biggelaar, A, Leonidas, G, Geurtsen, J, Ibarra de Palacios, **Gravenstein S,** Verstraeten T, Hermans P, Poolman J. Epidemiology of Escherichia coli Bacteremia: A Systematic Literature Review, Clinical Infectious Diseases, ciaa210, May 14, 2020.

11. Silva JB, Bosco E, Quilliam DN, **Gravenstein S**, Zullo AR. Antiviral Chemoprophylaxis Use During Influenza Outbreaks in Rhode Island Long-Term Care Facilities. J Am Med Dir Assoc. 2020 Sep;21(9):1354-1356. doi: 10.1016/j.jamda.2020.05.020. Epub 2020 Jul 11. PMID: 32660853.

12. Rudolph JL, Halladay CW, Barber M, McConeghy K, Mor V, Nanda A, **Gravenstein S**. Temperature Variation in Nursing Home Residents Systematically Tested for SARS-CoV-2. Volume 21, Issue 7, July 2020, Pages 895-899.e1 https://www.jamda.com/article/S1525-8610(20)30513-2/fulltext

13. Canaday DH, **Gravenstein S**. On setting expectations for a SARS-CoV-2 Vaccine. Clin Infect Dis. 2020 Jun 4:ciaa726. doi: 10.1093/cid/ciaa726. Online ahead of print.PMID: 32497168

14. White EM, Kosar CM, Feifer RA, Blackman C, **Gravenstein S**, Ouslander J, Mor V. Variation in SARS-CoV-2 Prevalence in US Skilled Nursing Facilities. Available at https://onlinelibrary.wiley.com/doi/epdf/10.1111/jgs.16752 accessed 26 JUL 2020.

15. Schiltz NK, Dolansky MA, Warner DF, Stange KC, **Gravenstein S**, Koroukian SM. Impact of Instrumental Activities of Daily Living Limitations on Hospital Readmission: an Observational Study Using Machine Learning. J Gen Intern Med. 2020 Jul 29. doi: 10.1007/s11606-020-05982-0. Online ahead of print.

16. McConeghy KW, White E, Panagiotou OA, Santostefano C, Halladay C, Feifer RA, Blackman C, Rudolph JL, Mor V, **Gravenstein S**. Temperature Screening for SARS-CoV-2 in Nursing Homes: Evidence from Two National Cohorts. J Am Geriatr Soc. 2020 Oct 9:10.1111/jgs.16876. doi: 10.1111/jgs.16876. Epub ahead of print. PMID: 33034046; PMCID: PMC7675320.

17. Song S, Wilson BM, Bej T, **Gravenstein S**, Carter RR, Marek J, Jump RLP. Antibiotic Use Among Residents Receiving Skilled Nursing Care in 29 U.S. Nursing Homes. J Am Geriatr Soc. 2020 Oct 9. doi: 10.1111/jgs.16856. Epub ahead of print. PMID: 33037613.

18. White EM, Santostefano CM, Feifer RA, Kosar CM, Blackman C, **Gravenstein S**, Mor V. Asymptomatic and Presymptomatic Severe Acute Respiratory Syndrome Coronavirus 2

Infection Rates in a Multistate Sample of Skilled Nursing Facilities. JAMA Intern Med. 2020 Oct 19:e205664. doi: 10.1001/jamainternmed.2020.5664. Epub ahead of print. PMID: 33074318; PMCID: PMC7573793.

19. Bosco E, Zullo AR, McConeghy KW, Moyo P, van Aalst R, Chit A, Mwenda KM, Panozzo CA, Mor V, **Gravenstein S**. Geographic Variation in Pneumonia and Influenza in Long-Term Care Facilities: A National Study. Clin Infect Dis. 2020 Nov 5;71(8):e202-e205. doi: 10.1093/cid/ciaa081. PMID: 31995171; PMCID: PMC7643743.

20. Bardenheier BH, Zullo AR, Jutkowitz E, **Gravenstein S**. Characteristics of Repeated Influenza Vaccination Among Older U.S. Adults. Am J Prev Med. 2020 Nov;59(5):e179-e188. doi: 10.1016/j.amepre.2020.05.009. Epub 2020 Oct 2. PMID: 33012624.

21. Bardenheier BH, Baier RR, Silva JB, **Gravenstein S**, Moyo P, Bosco E, Ogarek J, van Aalst R, Chit A, Zullo AR. Persistence of Racial Inequities in Receipt of Influenza Vaccination among Nursing Home Residents in the United States. Clin Infect Dis. 2020 Sep 29:ciaa1484. doi: 10.1093/cid/ciaa1484. Epub ahead of print. PMID: 32990309.

22. Bonten M, Verstraeten T, **Gravenstein S**, Poolman J. Reply to Baird and Douglas. Clin Infect Dis. 2020 Aug 5:ciaa1106. doi: 10.1093/cid/ciaa1106. Epub ahead of print. PMID: 32756981.

23. McConeghy KW, Davidson HE, Canaday DH, Han L, Saade E, Mor V, **Gravenstein S**. Cluster-randomized trial of adjuvanted vs. non-adjuvanted trivalent influenza vaccine in 823 U.S. nursing homes. Clin Infect Dis. 2020 Sep 4:ciaa1233. doi: 10.1093/cid/ciaa1233. Epub ahead of print. PMID: 32882710.

24. Lally M, Tsoukas P, Halladay C, O'Neill E, **Gravenstein S**, Rudolph JL. Metformin Is Associated With Decreased 30-Day Mortality Among Nursing Home Residents Infected With SARS-CoV2. J Am Med Dir Assoc. 2020 Oct 26:S1525-8610(20)30924-5. doi: 10.1016/j.jamda.2020.10.031. Epub ahead of print. PMID: 33232684; PMCID: PMC7586924.

25. Panagiotou OA, Kosar CM, White EM, Bantis LE, Yang X, Santostefano CM, Feifer RA, Blackman C, Rudolph JL, **Gravenstein S**, Mor V. Risk Factors Associated With All-Cause 30-Day Mortality in Nursing Home Residents With COVID-19. JAMA Intern Med. 2021 Jan 4:e207968. doi: 10.1001/jamainternmed.2020.7968. Epub ahead of print. PMID: 33394006; PMCID: PMC7783593.

26. Damjanovska S, Smith C, Sayin I, Burant CJ, **Gravenstein S**, Canaday DH. Adjuvant effect of type I interferon induced by many but not all commercial influenza vaccines. Vaccine. 2021 Jan 29;39(5):786-789. doi: 10.1016/j.vaccine.2020.12.051. Epub 2020 Dec 31. PMID: 33390292.

27. **Gravenstein S**, McConeghy KW, Saade E, Davidson HE, Canaday DH, Han L, Rudolph J, Joyce N, Dahabreh IJ, Mor V. Adjuvanted influenza vaccine and influenza outbreaks in U.S. nursing homes: Results from a pragmatic cluster-randomized clinical trial. Clin Infect Dis. 2021 Jan 5:ciaa1916. doi: 10.1093/cid/ciaa1916. Epub ahead of print. PMID: 33400778.

28. White EM, Saade EA, Yang X, Canaday DH, Blackman C, Santostefano CM, Nanda A, Feifer RA, Mor V, Rudolph JL, **Gravenstein S**. SARS-CoV-2 antibody detection in skilled nursing facility residents. J Am Geriatr Soc. 2021 Feb 5. doi: 10.1111/jgs.17061. Epub ahead of print. PMID: 33544876.

29. Bardenheier BH, Wu WC, Zullo AR, **Gravenstein S**, Gregg EW. Progression to diabetes by baseline glycemic status among middle-aged and older adults in the United States, 2006-2014. Diabetes Res Clin Pract. 2021 Mar 1;174:108726. doi: 10.1016/j.diabres.2021.108726. Epub ahead of print. PMID: 33662490.

30. Kosar CM, White EM, Feifer RA, Blackman C, **Gravenstein S**, Panagiotou OA, McConeghy K, Mor V. COVID-19 Mortality Rates Among Nursing Home Residents Declined From March To November 2020. Health Aff (Millwood). 2021 Mar 11:101377hlthaff202002191. doi: 10.1377/hlthaff.2020.02191. Epub ahead of print. PMID: 33705204.

31. Bonten M, Johnson JR, van den Biggelaar AHJ, Georgalis L, Geurtsen J, de Palacios PI, **Gravenstein S**, Verstraeten T, Hermans P, Poolman JT. Epidemiology of Escherichia coli Bacteremia: A Systematic Literature Review. Clin Infect Dis. 2021 Apr 8;72(7):1211-1219. doi: 10.1093/cid/ciaa210. PMID: 32406495.

32. Riester MR, Bosco E, Bardenheier BH, Moyo P, Baier RR, Eliot M, Silva JB, **Gravenstein S**, van Aalst R, Chit A, Loiacono MM, Zullo AR. Decomposing Racial and Ethnic Disparities in Nursing Home Influenza Vaccination. J Am Med Dir Assoc. 2021 Apr 7:S1525-8610(21)00299-1. doi: 10.1016/j.jamda.2021.03.003. Epub ahead of print. PMID: 33838115.

33. Davidson Canaday DH, Carias L, Oyebanji OA, Keresztesy D, Wilk D, Payne M, Aung H, Denis KS, Lam EC, Wilson B, Rowley CF, Berry SD, Cameron CM, Cameron MJ, Balazs AB, **Gravenstein S**, King CL. Reduced BNT162b2 mRNA vaccine response in SARS-CoV-2-naive nursing home residents. (medRxiv [Preprint]. 2021 Mar 22:2021.03.19.21253920. doi: 10.1101/2021.03.19.21253920. PMID: 33791727; PMCID: PMC8010759) AND *Clinical Infectious Diseases*, 2021;, ciab447, https://doi.org/10.1093/cid/ciab447

34. HE, Radlowski P, Han L, Shireman TI, Dembek C, Niu X, **Gravenstein S**. Clinical Characterization of Nursing Facility Residents With Chronic Obstructive Pulmonary

Disease. Sr Care Pharm. 2021 May 1;36(5):248-257. doi: 10.4140/TCP.n.2021.248. PMID: 33879286.

35. Mor V, Gutman R, Yang X, White EM, McConeghy KW, Feifer RA, Blackman CR, Kosar CM, Bardenheier BH, **Gravenstein S**. Short-term impact of nursing home SARS-CoV-2 vaccinations on new infections, hospitalizations, and deaths. J Am Geriatr Soc. 2021 Apr 16. doi: 10.1111/jgs.17176. Epub ahead of print. PMID: 33861873.

36.   Davidson HE, Radlowski P, Han L, Shireman TI, Dembek C, Niu X, **Gravenstein S**. Clinical Characterization of Nursing Facility Residents With Chronic Obstructive Pulmonary Disease. Sr Care Pharm. 2021 May 1;36(5):248-257. doi: 10.4140/TCP.n.2021.248. PMID: 33879286.

37. Madrigal C, Halladay CW, McConeghy K, Correa NA, Cersonsky TEK, Strauss D, **Gravenstein S**, Besdine RW, O'Toole TP, Rudolph JL. Derivation and Validation of a Predictive Algorithm for Long-Term Care Admission or Death. J Am Med Dir Assoc. 2021 May 10:S1525-8610(21)00387-X. doi: 10.1016/j.jamda.2021.03.034. Epub ahead of print. PMID: 33984291.

38. White EM, Yang X, Blackman C, Feifer RA, **Gravenstein S**, Mor V. Incident SARS-CoV-2 Infection among mRNA-Vaccinated and Unvaccinated Nursing Home Residents. N Engl J Med. 2021 May 19. doi: 10.1056/NEJMc2104849. Epub ahead of print. PMID: 34010526.

39. Silva JBB, Bosco E, Riester MR, McConeghy KW, Moyo P, van Aalst R, Bardenheier BH, **Gravenstein S**, Baier R, Loiacono MM, Chit A, Zullo AR. Geographic variation in influenza vaccination among U.S. nursing home residents: A national study. J Am Geriatr Soc. 2021 May 20. doi: 10.1111/jgs.17270. Epub ahead of print. PMID: 34013979.

40. Bardenheier B, **Gravenstein S**, Blackman C, Gutman R, Sarkar IN, Feifer RA, White EM, McConeghy K, Nanda A, Mor V. Adverse Events Following mRNA SARS-CoV-2 Vaccination among U.S. Nursing Home Residents. Vaccine. *In press*

Publication (chapters)

Geriatrics at Your Fingertips (GAYF) 2021 Coding in Geriatrics

Ham's Primary Care Geriatrics 7th ed Billing and Coding

Geriatric Medicine Fellows – AGS 2021 Virtual Annual Scientific Meeting

Ashna Rajan, MD

Does the use of a beta blocker cause a delay in testing for COVID-19?

A. Rajan,[2] F. Devone.[1] 1. Providence VA Medical Center, Providence, RI; 2. Brown University, Providence, RI.

Background: COronoVIrusDisease-19 (COVID-19)-related mortality in nursing home (NH) residents in the US is rising. Peak temperature (T) is used as a trigger to test for COVID-19 but as a single modality this lacks sensitivity. It is unknown whether exposure to BBs delays testing for COVID-19.

Methods: We retrospectively compared residents in 134 NHs screened for COVID 19 between March and August 2020 based on BBs use. We included residents receiving BBs at the time of COVID-19 testing and for at least 7 days (3 days prior to and 3 days after the test). We evaluated baseline characteristics, average baseline T and heart rate (HR) of the residents who tested positive for COVID-19 and the average difference to maximum HR (maxHR) and T (maxT). Baseline HR and T were the mean of 5 first values. We modeled measures (using pulse/temperature cutoffs) for triggering a COVID-19 test and compared the two groups to assess impact of the number of tests done on the days lost to diagnosis.

Results: Of the 10,761 infected patients, 2,441 were on BBs. The average baseline T was found to be similar in both groups (36.5 degree celsius) while the HR was lower in the BB group (73.9 vs 75.8). The average of peak HRs were 91.03 (no BB) and 89.05 (on BB) while average of peak Ts were 37.29 and 37.23 respectively. The average maximum difference from baseline HR was found to be similar among the 2 groups. However, when hypothetical cutoffs (20/min. rise in HR and 0.4 degree celsius change from baseline) were used, there was an 8% and 11% increase in detection of cases in the BBs group, respectively.

Conclusions: BB use alone did not affect HR or T. If a threshold of 0.4 degree celsius or 20/min. rise in T and HR are respectively used, earlier detection of COVID-19 is possible. It is possible that the incidence of COVID-19 alters the mechanism of action of BBs, causing a sharp rise in T and HR aiding earlier detection. Further research needs to be pursued to determine if HR can be used as a measure for trigger testing in comparison to T in COVID-19 and other infectious diseases.

Marilyne Cadieux, DO

Temperature change following acetaminophen in nursing home residents with and without SARS-CoV-2 infection

M. Cadieux,[2] F. Devone,[1] C. Halladay,[1] K. McConeghy,[1] T. A. Bayer,[2] S. Elhamamsy,[2] A. Rajan,[2] M. Singh,[3] M. Sachar,[2] S. Gravenstein,[1] L. McNicoll,[2] A. Nanda,[2] S. Cizginer,[2] J. Rudolph,[1] L. Quach.[1] *1. Providence VA Medical Center, Providence, RI; 2. Geriatrics, Brown University Warren Alpert Medical School, Providence, RI; 3. Case Western Reserve University Department of Medicine, Cleveland, OH.*

Background: Acetaminophen (APAP) is known to decrease temperature (T). At this time, it is unknown whether APAP affects T differently among those with or without SARS-CoV2 infection (SARS). We aimed to compare temperatures in nursing home residents after APAP in the setting of SARS.

Methods: The study was done in the Veterans Administration nursing homes (NH). Our sample includes residents tested for SARS. We created a subset of patients who have a pair of Ts before and after APAP administration, where the change in T for each pair is defined as ΔT. We only included residents who received APAP as needed for fever or those who had a fever of at least 38°C prior to APAP administration. We used SARS- patients as a control group.

Results: Of 11709 NH residents assessed for SARS between March and September of 2020, 1109 were SARS+. Out of 577,994 vital readings collected, we created 1,355 pairs of Ts, which belong to 708 residents.

Conclusion: A similar reduction in T by 2.27% in SARS+ and by 1.79% in SARS- febrile residents follows APAP administration. This difference was not statistically significant. Therefore, APAP appears to have a similar antipyretic effect in the setting of SARS. A limitation from this study is that the time of T collection and of APAP administration may differ from the time of documentation in the EMR, adding to underlying variance of our assessment. Future studies could use devices measuring continuous T data to further analyse antipyretic trends.

Pre-APAP T	<37.2		37.2-37.5		37.5-38		>38	
SARS status	+	-	+	-	+	-	+	-
N	144	58	130	91	222	111	339	118
Mean ΔT (SD) %	1.55 (2.08)	1.79 (2.17)	-.08 (1.53)	-.29 (1.36)	-.048 (1.79)	-.064 (1.58)	-2.27 (2.36)	-1.79 (2.24)
P-value (95% CI)*	.51 (-.009,.004)		.52 (-.004,.005)		.50 (-.004,.007)		.06 (-.010,.0002)	

*Simple 2-sided z-tests on the mean % change in T

Approach to early detection of SARS-CoV2 in nursing homes

S. Elhamamsy,[1] A. Nanda,[1] F. Devone,[2] T. A. Bayer,[1] M. Cadieux,[1] A. Rajan,[1] C. Halladay,[2] K. McConeghy,[2] L. McNicoll,[1] M. Sachar,[1] S. Gravenstein.[1] *1. Geriatrics, Brown University, Providence, RI; 2. Providence VA Medical Center, Providence, RI.*

Background

Current nursing home (NH) guidelines for SARS-CoV2 screening using a temperature threshold such as 38°C. More than 70% of SAR-CoV-2 infected NH residents do not meet this criterion. A rate of rise of temperature and change from baseline temperature may improve sensitivity for earlier detection of COVID-19.

Methods

The study was done in the Veterans Administration NHs. SARS-CoV2 screening includes daily temperature checks. We calculated baseline temperatures by averaging the first 5 daily temperatures recorded before SARS-CoV2 was detected.

Results

Of 11,050 VA NH residents tested, SARS-CoV-2 was identified in 1199 (11%). The average maximum temperature in those with SARS-CoV-2 (SARS+) was 38.1 compared with 37.3 in those without SARS-CoV-2 (SARS-) infection. Temperatures in SARS+ began rising 7 days before testing and remained elevated during the 14-day follow-up. Among SARS+ only 50% met the fever threshold of 38°C. Most SARS+ residents (91.55%) experienced 2 or more 0.4°C elevations above their baseline values. One cohort of SARS+ residents (4.23%) temperatures never deviated >0.4°C from baseline.

Temperature elevation >0.4°C from baseline identifies 89% of the SARS+ NH residents; persistent elevation improves detection to 95% of SARS+ residents.

Conclusions

A single screening criterion for temperature is inefficient or insensitive for detecting SARS-CoV-2 in nursing home residents. A patient-derived baseline temperature, persistent rise in temperature can increase sensitivity and lead to early detection of SARS-CoV2 infection in nursing home patients. These results indicate the value of incorporating temperature variation from baseline for early detection and containment of COVID-19.

Change of Temperature Definition	Cumulative Days Earlier Detected	Mean Days Earlier Detected	Measure-triggered COVID tests (Actual 94,849)	Number of COVID cases missed of 1199 detected
Persistent rise OR TMAX >37.2	1488	1.22	207,533	53 (4%)
Persistent rise OR TMAX >38	1468	1.24	206,887	58 (5%)
0.4 Change from Baseline	870	0.73	107,345	137 (11%)
TMAX >37.2	209	0.17	38,402	275 (23%)
TMAX >38	-253	-0.21	5,612	689 (57%)

Thomas Bayer, MD

Temperature-based Screening for SARS-CoV-2 in Nursing Home Residents with Dementia

T. Bayer,[1] F. Devone,[2] C. Halladay,[2] A. Rajan,[1] S. Elhamamsy,[1] M. Cadieux,[1] M. Singh,[3] M. Sachar,[1] K. McConeghy,[2] A. Nanda,[1] J. Rudolph,[2] S. Gravenstein.[2,1] *1. Brown University Warren Alpert Medical School, Providence, RI; 2. Providence VA Medical Center, Providence, RI; 3. Case Western Reserve University School of Medicine, Cleveland, OH.*

Background: Alzheimer Disease and related dementias (ADRD) may influence expression of temperature variation during viral illnesses due to degeneration of hypothalamic neurons influencing temperature homeostasis. Investigations of body temperature in nursing home (NH) residents have shown that testing for SARS-CoV-2 based on two or more temperature elevations of 0.5°C above baseline temperature (2TE) can improve detection. We compared the sensitivity and specificity of this strategy in NH residents with and without ADRD.

Methods: We retrospectively identified a cohort of individuals who resided in Veterans Administration operated NHs between March 1st, 2020 and August 5, 2020. We used ICD-10 codes from the prior 12 months to identify the patients diagnosed with ADRD. NH staff recorded vital signs including body temperature, and tested residents for SARS-CoV-2 for clinical and infection control purposes.

Results: Our cohort contained 9408 residents, 895 of whom had PCR-confirmed SARS-CoV-2 infection (see table). 2TE occurred in 2515 (44%) of the 5698 residents with ADRD, and in 1616 (44%) of the 3710 residents without ADRD. In residents with ADRD, 2TE had a sensitivity of 0.82 (95% CI 0.79 - 0.85) and a specificity of 0.61 (0.59 - 0.62). In residents without ADRD, 2TE had a sensitivity of 0.80 (0.75-0.85) and a specificity of 0.59 (0.58 - 0.61).

Conclusions: 2TE performed similarly in NH residents with and without ADRD. These results indicate body temperature elevations in residents with SARS-CoV-2 infection are similar with and without ADRD. We will further evaluate the utility of temperature-based selection for who should undergo SARS-CoV-2 testing in NH residents with ADRD using additional statistical techniques taking into account time to diagnosis and time to maximum temperature.

	N	ADRD<2*	ADRD≥2*	nonADRD<2*	nonADRD≥2*	ADRD	nonADRD
total	9408	3183	2512	2094	1616	5698	3710
SARS-CoV-2 +	895	110	512	55	218	622	273
SARS-CoV-2 -	8513	3073	2003	2039	1398	5076	3437

*number of temperature elevations 0.5 C above baseline