CORONA**VI**RUS **D**ISEASE 2019
(COVID-19)

Enhanced Acute Case Management & Ambulatory Care Management for Patients Discharged Post-COVID Critical Care

Trinity Health

Audience: Acute & Ambulatory Care Management, Medical Group Provider Services (MGPS), Clinically Integrated Network (CIN), Community Health & Well-Being (CHWB), Trinity Health at Home (THAH), non-Trinity Health Facilities & Agencies, Skilled Nursing Facilities (SNF), Post-Acute Community Provider (PAC)
Revision Date: 2/19/2024
Version: #4
COVID-19 Response Team Owner: Clinical and Operations
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What's Changed: Removed Obsolete Links and Updated Existing Links

Purpose:

The COVID-19 Enhanced Care Management for Patients Discharge Post-COVID Critical Care is to provide recommendations for transitional and longitudinal care for patients who have survived COVID-19 and have been ***discharged from hospital critical care***. The goal is to ensure each patient is safely transitioned to the next setting, to ensure necessary enhanced services are coordinated, and the patient's care is closely monitored during the post-critical phase of the coronavirus illness.

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Description of COVID-19 Patients and Post-Intensive Care Syndrome (PICS):

The clinical picture of COVID-19 patients has been evolving over the past several months. It is well known that the risk for serious disease and death in COVID-19 cases among persons in the United States increases with age. "Roughly 20% of symptomatic covid-19 patients require hospitalization and about 5% end up in the ICU" (Bernstein, 2020).

Approximately 25-30% of ICU survivors may develop a symptom related to post-intensive care syndrome (PICS) (Heydon, 2020). PICS is defined as survivors of critical care who experience new or worsening symptoms and/or impairments in physical, cognitive, or mental health that last beyond their critical illness and acute hospital admission. The impairments may persist for years and may be permanent, thereby impacting both the patient and their families (PICS-F). Patient caregivers and families are also at high risk for developing anxiety, depression, and post-traumatic stress disorders.

Risk Factors for PICS:

- Age
- Presence and duration of delirium
- Prolonged critical care, sedation, and mechanical ventilation
- Hypoxia and hypotension
- Acute respiratory distress and sepsis
- Blood glucose dysregulation
- Uncontrolled pain
- Pre-COVID mental and physical comorbidity

Long critical care length of stay, mechanical ventilation, prolonged sedation, immobilization, and delirium may contribute to a myriad of complications and impairment. Currently, within Trinity Health the average hospital stay for intensive COVID patients is approximately 22-25 days. The care provided during the prolonged hospital stay and the medications used for rescue and supportive care will influence the need for close monitoring post-critical care hospital stay. *PICS may impact any of our long stay intensive care patients and is not specific to COVID so it's important to recognize the symptoms.*

Symptoms of PICS may include:

Cognitive impairments	Behavioral Health	Physical Impairments
• Memory impairments	• Anxiety	• Dyspnea, impaired or reduced pulmonary function
• Attention, difficulty concentrating	• Depression	• Pain, dysphagia, voice impairments
• Visuo-spatial	• Post-traumatic stress disorder	• Sexual dysfunction
• Psychomotor		• Exercise intolerance, fatigue
• Impulsivity, impaired decision-making and planning		• Neurodegenerative complications, polyneuropathy/myopathy, paresis
		• Organ failure

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Acute Case Management and Ambulatory Care Management Post-Critical Care:

Inclusion Criteria	**Exclusion Criteria**
• Patients that have survived COVID and a critical care stay with discharge (Adult)	• Patient expires • Patient discharged home with hospice services

Acute Case Management Post-Critical Care:

The following checklist provides a guide for standardized assessment, planning, and facilitation in collaboration with interdisciplinary team including physicians, nursing, and all other clinical support services. Several considerations specific to post-critical care phase of COVID care are identified below in the four domains of integrated care management focusing on the medical, psychological, social, and health system (access to care).

Medical	Pulmonary	• Identify need for durable medical equipment including, but not limited to, supplemental oxygen, nebulizer, pulse oximetry
	GI/GU	• Educate on importance of how to monitor bowel regimen. • Identify and refer for dialysis if patient has continued acute kidney injury and/or how to monitor urinary output, if needed.
	Nutrition	• Collaborate with dietary and provide education on caloric intake, fluids, any dietary restrictions, and/or need for continued nutrition support
Psychological	Emotional Health & Pastoral Care Services	• Assess need for behavioral health and spiritual support for patient and family, due to the stress of prolonged hospitalization and/or social isolation during hospital stay
Social / Community Support	Home Health & Community Services	• All patients should be screened for social needs prior to discharge. Patients without a safe space to continue their recovery should work with acute care management team, CHWB Community Health Worker teams, and other available community-based resources to identify safe housing options and wraparound services to support this vulnerable population. • Assess home environment, support system, need for skilled home services, and/or community support services related to medical, behavioral, and social influencers of health. • Evaluate need for physical, occupational, and speech therapy services that may be required due to deconditioning, prolonged ventilation, and/or tracheotomy. • Identify need for monitoring including remote and/or in-person such as pulse oximetry, blood pressure, etc.
Follow -Up & Access	Discharge Planning	• Collaborate with acute interdisciplinary care team on rounds focusing on discharge planning • Evaluate need for palliative support

	Discharge to home and/or housing alternative	• Educate patient/family on what to expect during COVID recovery
		  ○ Explain post-discharge services with patient and family
		  ○ Use teach-back to ensure understanding

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		• Refer for enhanced home care services with appropriate therapies and order necessary DME
		• Review discharge and or transfer instructions including medications.
		  ○ Provide instruction on timing of medications and what they are used for.
		  ○ Use "meds-to-beds," when available.
		• Ensure patient has a PCP and/or specialist for follow-up care and first visit has been scheduled 3-5 days from discharge collaborating with the patient/family.
		• Schedule follow up services including radiology / labs, when needed.

	Discharge to Skilled Nursing Facility, Long Term Acute Care, Acute Rehab	• Ensure handover communication use SBAR format, reference in the resource section. • Facilitate care conference with acute and SNF/PAC care team, physician(s), patient, family and/or caregiver, as needed • Ensure transfer information includes patient preferences, e.g., advance directives, durable power of attorney, etc.

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Ambulatory Care Management Post-Critical Care:

To ensure a safe transition home, the ambulatory care manager ensures the transition of care (TOC) outreach interaction occurs within 24-48 hours of discharge. The ambulatory care manager facilitates handover discussion, as needed, with acute care management team and/or post-acute facility case manager (SNF, IRB, LTAC).

Medical	Self-Management Education	• Educate the patient/family on the care management program • Re-assess home environment and/or housing alternative, safety, and caregiver/family support • Perform medication review and assessment. ○ Refer to ambulatory pharmacy resource, when needed. • Provide self-management and symptom education. • Provide education on COVID-19 health implications, after-effects, and keeping everyone "healthy at home" As a rule, patient will not need to quarantine at home if their hospital stay was greater than 14 days, and they were afebrile without fever-reducing medications for 72 hours prior to discharge.
Psychological	Emotional Health & Pastoral Care Services	• Assess need for behavioral health and spiritual support for patient and family, due to the stress of prolonged hospitalization and/or social isolation during hospital stay • Provide ongoing assessment for depression and anxiety using evidence-based tools such as the PHQ-9, GAD 7, etc. • Ensure patient education of services, understand affordability and willingness to seek behavioral health support
Social/Community Support	Patient Social Needs	• If not already completed during the patient's stay, screen for patient social needs using the standard tool available in TogetherCare or your local electronic medical record. • Where available, refer patients to RHM's Community Health Workers for connection to community resources and/ provide Community Resource Directory information.

Follow-Up & Access	Contacts & Supports	• Provide Care Management contact information and resources and how to reach triage line or practice for patient after-hour concerns
		• Confirm Home Health Care visit has been arranged and convey the importance of allowing the visit.
		  ○ Ensure enhanced home-based therapies to promote further recovery
		  ○ Evaluate need for palliative support
		• Ensure patient has on-going follow up appointments after initial post discharge appointment.
		• Appointments may also be needed with primary and specialty care providers
		• Coordinate transportation, as needed.
		• Complete a minimum of weekly calls for a minimum of 30 days

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Supporting Resources Links and Attachments:

This document outlines guidance on discontinuing isolation for discharge planning	COVID-19 Discontinuing Inpatient Isolation-Testing Method_Final
This document provides guidelines for Trinity Health Nursing Facilities regarding acceptance of recovering COVID-19 positive patients or Persons Under Investigation (PUI) in response to the pandemic are outlined below.	Placement of patients in a Skilled Facility
This document outlines Independent Assisted Living Admission requirements for returning to the community	Independent and Assisted Living – Admissions and Returns to the Community
This document outlines social needs screening questions and follow-up on positive screens.	Social Needs Screening Questions One-Pager_1-2024.pdf
These documents describe resources for addressing patient social needs.	Community Health Worker One-Pager_1-2024.pdf Community Resource Directory Overview_1-2024.pdf
Handover Process SBAR (From the Integrated Care Coordination System Toolkit - ICCS)	Handover Process SBAR.docx

Commented [MP1]: These links go to documents posted on Teams (set for "People in Trinity Health" to access. Is there a better place to host them?

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