GOAL

To establish an interdisciplinary standardized approach to address the unique needs of COVID-19 survivors upon hospital discharge.

BACKGROUND

- The number of people with COVID-19 increases daily
- Approximately 20-30% of these patients currently require hospitalization, and about 5-12% will be treated in an intensive care unit (ICU).
- Severely ill in-patients commonly experience “Post-Hospital Syndrome” (or Post-Intensive Care Syndrome (PICS) for critical illness survivors).
- This syndrome includes markedly impaired strength/physical ability, worsened mood/anxiety/post-traumatic stress disorder, difficulties with thinking/memory, and increased use of healthcare resources.

ASSUMPTIONS

- Each Hospital will integrate site specific policy, resource and regulatory considerations to meet PACT clinical standards.
- Development of a PACT Service can be leveraged to establish a broader Post-Intensive Care Team (PICT) Service

CLINICAL STANDARDS

MINIMUM CARESTREAMS

- Physician Management
  - Pulmonary
  - Physiatry
- Outpatient Rehabilitation
  - Physical and Occupational Therapy
  - Speech Language Pathology
  - Psychology
- Home Care
  - Physical and Occupational Therapy
  - Speech Language Pathology
  - Nursing
  - Remote Patient Monitoring (RPM)

Specialty services: Develop a system and identify resources for targeted referrals to other subspecialties, including Psychiatry, Neurology, Cardiology, Infectious Disease, Dermatology, Nephrology, and Hematology as needed.

KEY WORKFLOW

- Coordinated Discharge Processes
  - Integration of PACT eligibility criteria into discharge workflow (Figure 1)
  - RPM referral if indicated (Figure 2)
  - Appointments to appropriate services in hand and MyChart enrollment.
- Clinic Evaluations and Synchrony
  - Utilization of harmonized evaluation templates for Pulmonary and PMR
  - Use of PACT core clinical outcomes set
  - PACT coordinated rounds (Pulmonary, PMR physician, Home Care team)
- Care Transitions
  - Establish system to transition patients from home care to outpatient rehabilitation
  - Effective communication with PCP.

FIGURE 1. PACT (POST-ACUTE COVID TEAM) CLINIC ELIGIBILITY FOR PATIENTS POST-HOSPITAL DISCHARGE

*If patient has an established pulmonologist, schedule follow-up with that pulmonologist instead of Pulmonary PACT.
*Outpatient rehabilitation services should not be delayed until Physiatry appointment if deemed appropriate at the time of discharge.
FIGURE 2. COVID AMBULATORY REMOTE PATIENT MONITORING (RPM)

*These are guidelines and should not replace use of clinical judgement, rather inform judicious use of this service.

CLINIC LEADERSHIP AND CONTACT

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