

Outpatient care management following COVID-19 hospitalization

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ABSTRACT

COVID-19 survivors encounter issues that linger beyond hospitalization, and an increasing number of health care institutions are building multidisciplinary clinics to care for individuals with COVID-19 Post Acute

Sequelae (PASC). However, little is known about how COVID-19 patients are cared for after they leave the hospital. We aimed to describe post-discharge care delivery for PASC across a vast network of academic and community hospitals in the United States.

Key Words: *Acute lung injury.*

INTRODUCTION

The survey was carried out at hospitals that were members of the national heart, lung, and blood institute clinical trials network for the Prevention and Early Treatment of Acute Lung Injury (PETAL Network). The survey focused on the arrangement of outpatient follow-up for COVID-19 patients released from the hospital. The poll had 13 questions, most of which were closed-ended, with the possibility of further follow-up questions. In July 2021, electronic survey invitations were sent out, and the surveys were completed over the course of eight weeks. To describe hospitals, data from the 2019 American Hospital Association (AHM) annual survey database were used.

Of the 47 responding hospitals, 37 (79%) gave COVID-19-specific discharge advice to hospitalized patients—70% advised patients on reasons to return to the hospital, 66% on isolation measures, and 64% on reasons to call primary care. Only 26% of hospitals provided discharge information that identified possible symptoms or limitations from COVID-19 post-acute sequelae. At some capacity, post-discharge contact occurred in 30 hospitals (63%). The most popular ways of interaction were clinic visits (in-person or virtual 43%) and phone calls (38%).

Thirty-three hospitals (70%) have a post discharge outpatient clinic established exclusively for COVID-19 patients, with 20 starting before August 2020. Hospitals without PASC clinics were more likely to be smaller, for-profit facilities than hospitals with PASC clinics. Hospitals without PASC clinics were also more likely to be in a ZIP code with a median annual income of less than \$40,000 and to have a larger proportion of medicaid patients than hospitals with PASC clinics. This research, which used a broad network of hospitals across the United States, is the first large-scale, multicenter evaluation of COVID-19 care delivery following hospitalization.

Our findings show significant diversity in the spread of PASC symptoms or impairments, posthospital follow-up, and availability to PASC clinics across the country. Hospitals lacking PASC clinics were more likely to be smaller, for profit, and to service a larger number of medicaid patients, which might indicate a lack of resources at these facilities. It is crucial to note, however, that while this study provides one of the most comprehensive assessments of PASC treatment to date and covers a wide mix of academic, tertiary, and community hospitals, the survey was only conducted to institutions in the PETAL Network.

We found many critical areas where PASC care may be improved. First, despite the increased interest in interdisciplinary PASC treatment, the efficacy of these clinics is uncertain. Although interdisciplinary PASC clinics have the potential to eliminate care fragmentation, they may also encourage low-value care through superfluous testing or redirect resources away from proven benefits. It is still unclear what tests or assessments would be beneficial for people with PASC. It will be critical to investigate the impact of these clinics on patient outcomes and to determine which parts of PASC clinics, if any, may be useful. Second, there is a need to assess how PASC pathophysiology and therapy vary from those of other infections or severe diseases (eg: post-intensive care syndrome).

Third, if multidisciplinary post-COVID treatment is proved to be helpful, about one in three institutions did not have a PASC clinic, potentially limiting patient access. Finally, most institutions relied on physician referrals rather than systematic procedures to find patients for multidisciplinary PASC therapy. This may prevent some patients who might benefit from integrated PASC treatment from receiving it. For example, in the United States, COVID disproportionately affected black and hispanic persons, who may be less integrated within health care

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systems and less likely to obtain PASC care when referrals are not made systematically and are instead related to existing health care connections. Many health-care institutions in the United States built PASC clinics in response to the anticipated COVID-19 survivorship issue. Multidisciplinary PASC clinics may provide chances for care coordination, systematic PASC assessment, and the creation of an atmosphere conducive to iterative PASC knowledge gains. There are opportunities to leverage large networks of PASC clinics to establish-

1. Longitudinal observational studies to understand the epidemiology of PASC.
2. Clinical trials to study therapeutic interventions for PASC patients.
3. The effectiveness of multidisciplinary PASC care models.
4. Scalable care delivery models.
5. Collaborative quality improvement initiatives across PASC clinics.

Future research should seek to further understand the efficacy and equity of specialized, multidisciplinary treatment in enhancing long-term, patient-centered outcomes for COVID survivors.