Part 5: Recommendations

Clinical Frailty Scale in PAC

<table>
<thead>
<tr>
<th>Outcomes of 6-week inpatient rehabilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance</td>
</tr>
<tr>
<td>Functional exercise capacity</td>
</tr>
<tr>
<td>Strength</td>
</tr>
<tr>
<td>Mobility</td>
</tr>
<tr>
<td>Transfers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>T1</th>
<th>T2</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>BBS (0/100)</td>
<td>27 (22.3)</td>
<td>37 (13.3)</td>
<td>≤0.0001*</td>
</tr>
<tr>
<td>TUG (seconds)</td>
<td>59 (99)</td>
<td>40 (17.5)</td>
<td>≤0.0001*</td>
</tr>
<tr>
<td>6MWT (metres)</td>
<td>56 (55)</td>
<td>108 (70.5)</td>
<td>≤0.0001*</td>
</tr>
<tr>
<td>EQ-VAS (%)</td>
<td>61.25 (18.27)</td>
<td>72.5 (10.12)</td>
<td>≤0.0001*</td>
</tr>
<tr>
<td>BI (1/100)</td>
<td>57.66 (20.32)</td>
<td>76.41 (19.35)</td>
<td>≤0.0001*</td>
</tr>
<tr>
<td>CFS (7)</td>
<td>6.34 (0.48)</td>
<td>5.63 (0.66)</td>
<td>≤0.0001*</td>
</tr>
</tbody>
</table>

*Significant at the p<0.05 level.
T1 = Assessment on admission to rehabilitation service, T2 = Assessment following 6 weeks of rehabilitation.

Frailty Interventions in PAC

<table>
<thead>
<tr>
<th>Few studies evaluated interventions targeting frailty in PAC, with mixed results.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical therapy / exercise program</td>
</tr>
<tr>
<td>Resistance training</td>
</tr>
<tr>
<td>Functional walking or balance training</td>
</tr>
<tr>
<td>Deprescribing</td>
</tr>
</tbody>
</table>

Little evidence on nutritional supplementation and social support, which does not mean lack of benefit; further research is warranted.

Table II. Changes in outcome measures from initial to final assessment (n=32).

<table>
<thead>
<tr>
<th>Outcome measure</th>
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</tr>
</tbody>
</table>

Table I. Comparative Cost of Nurse’s Salary Compared With That of Other Diagnostic Instruments Used in Oncologic Workup

<table>
<thead>
<tr>
<th>Diagnostic Instrument</th>
<th>Cost (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse’s salary for 1 hour*</td>
<td>285</td>
</tr>
<tr>
<td>Complete blood count</td>
<td>13</td>
</tr>
<tr>
<td>Carcinoembryonic antigen</td>
<td>80</td>
</tr>
<tr>
<td>Chest x-ray</td>
<td>67</td>
</tr>
<tr>
<td>Bilateral screening mammography</td>
<td>321</td>
</tr>
<tr>
<td>Abdominal or chest CT scan</td>
<td>640</td>
</tr>
<tr>
<td>MRI pelvic</td>
<td>770</td>
</tr>
<tr>
<td>Liver biopsy</td>
<td>878</td>
</tr>
<tr>
<td>Whole-body PET/CT</td>
<td>1,788</td>
</tr>
<tr>
<td>Colonoscopy with biopsy</td>
<td>2,187</td>
</tr>
<tr>
<td>Breast cancer genomic testing (OncoHerit™)</td>
<td>3,410</td>
</tr>
<tr>
<td>Liquid biopsy (Guardant360®)</td>
<td>5,820</td>
</tr>
</tbody>
</table>

Address barriers to assessment in routine care

<table>
<thead>
<tr>
<th>Process</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening and assessment</td>
<td>• Time-related: lack of time, competing priority</td>
</tr>
<tr>
<td></td>
<td>• Clinic process: inadequate staffing, lack of standardized process</td>
</tr>
<tr>
<td></td>
<td>• Provider factors: reliance on patient or family report</td>
</tr>
<tr>
<td></td>
<td>• Patient factors: patient’s impairments preventing assessment</td>
</tr>
<tr>
<td>Documentation</td>
<td>• EHR: long reminders and complicated templates</td>
</tr>
<tr>
<td></td>
<td>• Connection to clinical use: limited utility of the obtained information</td>
</tr>
<tr>
<td>Use of information to improve care</td>
<td>• Connection to patient outcomes: lack of meaningful metrics</td>
</tr>
<tr>
<td></td>
<td>• Accessibility of data: lack of standardized data location in EHR</td>
</tr>
<tr>
<td></td>
<td>• Provider knowledge of referrals and services</td>
</tr>
</tbody>
</table>

Frailty assessment for transition of care

Frailty is a key concept for understanding health status, estimating prognosis, and delivering individualized care in older adults.

- Adopt a brief standardized assessment (e.g., Clinical Frailty Scale) for clear communication of prognosis and treatment plan.
  - Hospital: document frailty status prior to hospitalization
  - PAC: comprehensive frailty assessment from a multidisciplinary team

More research is needed on how frailty should be measured to enable individualized interventions to improve PAC outcomes.

- Avoid therapeutic nihilism (“frailty = no benefit from treatment”)

94- yo man with fall and fracture

- Fall, resulting in 4 rib fractures (concern for flail chest) and vertebral fracture
- PMH: multiple chronic conditions
- Prior to admission: use a rollator; ADLs independent; help with housekeeping
- Hospital course: pain control, tachycardia, fatigue, functional decline
- Discharged to rehab on hospital day #4

89- yo woman with pneumonia and AF

- Fell at home, unable to get up; pneumonia and new-onset AF with RVR
- PMH: multiple chronic conditions
- Prior to admission: live alone independently
- Hospital course: IV antibiotics, metoprolol and apixaban for AF, straight cath PRN for urinary retention, delirium
- Discharged to rehab on hospital day 12
### Managing frail patients across care spectrum

<table>
<thead>
<tr>
<th>Role</th>
<th>Clinical management</th>
<th>Hospital</th>
<th>Post-acute care</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prognostication</strong></td>
<td>Education about prognosis</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>(risk prediction)</td>
<td>Goals of care discussion</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td></td>
<td>Social worker/case manager</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td><strong>Risk stratification</strong></td>
<td>Prioritize chronic condition mgmt</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>(inform other disease management)</td>
<td>Relax disease target</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td></td>
<td>Medication reconciliation</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td></td>
<td>Deprescribing medications</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td></td>
<td>Minimize stressful interventions</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td><strong>Target of intervention</strong></td>
<td>Physical exercise</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>(improve frailty per se)</td>
<td>Nutritional supplementation</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
</tbody>
</table>

### Checklist for hospital and PAC providers

- **Hospital providers**
  - Review prognosis and goals of hospitalization
  - Medication reconciliation (to PAC)
  - Minimize stressful interventions
  - Early mobilization
  - Geriatric consultation for co-management

- **PAC providers**
  - Review prognosis and goals of PAC
  - Medication reconciliation (to community)
  - Modify chronic disease management (medication reduction, BP target, fatigue)
  - Physical therapy, nutritional supplementation
Pitfalls of Pills: ADEs & Transitions

Anita Vanka, MD, FHM, FACP
Kristen Knoph, PharmD, BCPS
Beth Israel Deaconess Medical Center
March 2020

Conflicts of Interest Disclosure

- We have no financial relationships with a commercial entity producing healthcare-related products and/or services.

How do we define Transitions in Care?

“Set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location”

Defining adverse drug events & their impact
Describe how ADEs relate to transitions in care
Describe the common errors of ADEs
List the common medications implicated in ADEs
Reflect on how we can prevent ADE through common case examples

Prevalence of Post-hospital Transitions

- Hospitalized Medicare beneficiaries
  - 73% -> HOME
  - 17% -> SNF or Acute Rehab
  - 10% -> Different hospital or within the same hospital

- Number of transfers within 30 days
  - 61% single transfer
  - 18% two transfer
  - 8.5% three transfers
  - 4.3% four or more transfers

Why is this important?

- Vulnerable time for patients
  - Shorter length of stay
  - Possible worsening of functional impairments
  - Discontinuities during their transitions
  - Changes in treatment regimen

One in five experienced an adverse event post discharge

- 50% used health services -> 24% readmitted

Adverse drug events were the most common type (66%)
- Antibiotics, steroids, CV drugs, analgesics, anticoagulants, AEDs

23% patients experienced an adverse event
- 21% AEs were preventable
- 17% AEs were ameliorable
- 17% AEs resulted in readmission
- 72% of AEs were due to medications

Adverse events among medical patients after discharge from hospital

One in five experienced an adverse event post discharge

- 50% used health services -> 24% readmitted

Adverse drug events were the most common type (66%)
- Antibiotics, steroids, CV drugs, analgesics, anticoagulants, AEDs

23% patients experienced an adverse event
- 21% AEs were preventable
- 17% AEs were ameliorable
- 17% AEs resulted in readmission
- 72% of AEs were due to medications
87% of ADEs associated with certain meds
Almost all cases associated with new med or dose change
Risk of ADE increased with number of medications prescribed

Number of meds per patient increased with each transition: (6.5 -> 10.7 -> 12.6)
Average of 7.5 medication changes per patient per transition
**Antipsychotics**

- Why is continuing an atypical antipsychotic medication on discharge an issue?
  - What are the consequences of long-term antipsychotic use?
- What can we do to prevent these ADEs?

**Patient Case**

- 74 y/o F history of COPD, tobacco use, AF, CKD, depression who presented to the ED with SOB and hypoxia requiring intubation and mechanical ventilation

  Admitted to the MICU for CAP

  Day 10: Transferred from ICU to the medicine floor and delirium was resolving

  ECHO-CT: Discussion about discontinuing quetiapine

  Day 7: Developed agitated ICU delirium and started on quetiapine 25 mg QHS

  Day 15: Quetiapine continued and prescribed at discharge

**Antipsychotics**

- Patients, especially the elderly, are at risk for developing delirium in the hospital
- Often started on antipsychotics (i.e., quetiapine, olanzapine, haloperidol) for treatment
- Many consequences of long-term antipsychotic use:
  - Due to potential long-term ADEs, the continued use of antipsychotics should be reevaluated

<table>
<thead>
<tr>
<th>Metabolic syndrome</th>
<th>Orthostasis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased falls risk</td>
<td>QTc prolongation</td>
</tr>
<tr>
<td>Urinary tract infections</td>
<td>Increased cost</td>
</tr>
<tr>
<td>Sedation</td>
<td>Increased risk of death in patients with dementia</td>
</tr>
</tbody>
</table>

84.2% of ICU survivors started on an antipsychotic had the medication continued on transfer from the ICU
28.6% received a prescription at hospital discharge
Patients who received a discharge prescription were more likely to be discharged to a location other than home (SNF, inpatient rehab)
Discharge Plans for Geriatric Inpatients with Delirium: A Plan to Stop Antipsychotics?

Kim C. Johnson, MD, Adelejo Echepojo, MD, Ramiro Madden-Fuentes, MD, Andrew J. Mezey, PharmD, Jane P. Gagliardi, MD, MHS, and Mamata Yenamandra, MBBS, MS

BACKGROUND: Studies show that geriatric patients with reversible conditions like delirium may continue on antipsychotic medications without clear indication after hospital discharge. We conducted this study to determine how often geriatric patients started antipsychotic drugs and to evaluate how many patients continued the antipsychotic at discharge.

PATIENTS: This study included 302 adult inpatients admitted to Beth Israel Deaconess Medical Center (BIDMC) from September 1, 2016, to August 31, 2017.

RESULTS: 30.2% of patients started an antipsychotic during their hospitalization. 12.4% of discharge summaries included instructions for discontinuation of the antipsychotic. 8% of patients in the ICU were started on an antipsychotic. 21% were continued on the new antipsychotic at discharge.

CONCLUSION: Discharge to a facility was identified a risk factor for continuation on discharge. Improper medication reconciliation at transitions of care was contributing to inappropriate continuation.

Antipsychotic utilization in the intensive care unit and in transitions of care


83% of patients in the ICU were started on an antipsychotic. 21% were continued on the new antipsychotic at discharge.

Identify improper medication reconciliation at transitions of care as contributing to inappropriate continuation.

Patient case

- 83 y/o F with history of chronically dislocated left THA presenting to BIDMC for removal of the left THA implant and girdlestone procedure
  - Discharge plan to take aspirin 81 mg BID for DVT prophylaxis and pantoprazole 40 mg daily for GI upset for 4 weeks after surgery
  - ECHO-CT conference
    - Discussed adding a stop date to pantoprazole order

Proton Pump Inhibitors (PPIs)

- Why is continuing PPIs on discharge an issue?
- What are the consequences of long-term PPI use?
- What can we do to prevent these ADEs?
Proton Pump Inhibitors (PPIs)

- PPIs are acid suppressive medications used to treat GI symptoms such as acid reflux and heartburn
- PPIs may be prescribed in the hospital for various reasons (stress ulcer prophylaxis, GI bleed) including continuing a patient’s home medications
- PPIs have been considered safe medications, but recent research has shown they are associated with several ADEs

<table>
<thead>
<tr>
<th>ADE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased fracture risk</td>
</tr>
<tr>
<td>C. difficile infection</td>
</tr>
<tr>
<td>Diarrhea</td>
</tr>
<tr>
<td>Pneumonia</td>
</tr>
<tr>
<td>Vitamin B12 deficiency</td>
</tr>
<tr>
<td>Hypomagnesemia</td>
</tr>
<tr>
<td>Rebound acid hypersecretion</td>
</tr>
<tr>
<td>Increased cost</td>
</tr>
</tbody>
</table>

68.8% were prescribed a PPI inappropriately at hospital discharge.

Patient Case

- 55 y/o F presented to BIDMC with abdominal wall cellulitis and drainage with concern for necrotizing fasciitis
  - Underwent multiple surgeries including wound vac placement
  - Discharged on large opioid requirement (50-60 mg oxycodone/day)
  - ECHO-CT: discussion about taper down opioid medications as tolerated and monitoring for bowel movements
Opiates and Sedatives

• What are some challenges managing patients on opiates and other sedatives (i.e. benzodiazepines) in transitions of care?

• What can we do to prevent these ADEs?

An estimated 20% of patients presenting to physician offices for non-cancer pain receive a prescription for opioid pain medication.

Although opioids are effective for pain control, they are associated with serious ADEs.

Older adults are more susceptible to ADEs.

Healthcare providers can ensure patients prescribed opioids and other sedatives are taking the lowest effective dose for the shortest duration possible.


<table>
<thead>
<tr>
<th>Respiratory suppression</th>
<th>Constipation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dizziness</td>
<td>Tolerance</td>
</tr>
<tr>
<td>Sedation</td>
<td>Physical dependence</td>
</tr>
<tr>
<td>Nausea/vomiting</td>
<td>Increased falls risk</td>
</tr>
</tbody>
</table>

Opiate Prescribing in Hospitalized Older Adults: Patterns and Outcomes

13% of patients received opiates prior to hospital admission and 5% received opioids while inpatient.

87% did not receive opiates prior to admission and 22% received opiates while inpatient.

Older adults with any opiate exposure was associated with poor outcomes, including longer hospital stay, and 30 day readmissions.

The Burden of Opioid-Related Adverse Drug Events on Hospitalized Previously Opioid-Free Surgical Patients

91% of opioid-naïve patients who had surgery received post-op opioids.

Of those, 9.1% had an opioid-related ADE.

Predictors of opioid-related ADEs included older age, disease severity, longer surgeries, and concurrent benzodiazepine use.
Pearls to Avoid Pitfalls

- Patients are at high risk of medication ADEs during transitions of care
  - Antipsychotics, proton pump inhibitors, and opioids
- Critical to be clear regarding end dates and/or taper instructions to the next provider
- Medication reconciliation at transitions of care can help to decrease overprescribing and medication-related ADEs

References


Following a Pandemic through Post-Acute Care

Zahir Kanjee, MD, MPH, FACP
Anita Vanka, MD, FHM, FACP
Beth Israel Deaconess Medical Center
August 2020

A teaching hospital of Harvard Medical School

Learning Objectives

1. Define the prevalence of COVID globally, nationally, and locally.
2. Recognize the societal level impact of the pandemic.
3. Describe common complications of COVID in hospitalized patients.
4. List the current recommendations for monitoring and management for patients who had COVID.
5. Reflect on how we can manage patients post discharge after being hospitalized for COVID.

COVID-19

- Novel coronavirus as cause of PNA identified in Wuhan -> rapid spread throughout China -> global spread
  - RNA virus, related to SARS and MERS virus
  - Entry mediated by ACE2 on host cells
- WHO designates this as COVID-19 in Feb 2020
- Virus causing COVID-19 known as SARS-CoV-2
- More than 19 million confirmed cases of COVID-19 globally
- WHO declares this a pandemic in March 2020

Conflict of Interest Disclosure

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COVID-19

- Transmission risk – incomplete understanding
  - Person-to-person: respiratory droplets (<6 feet), contaminated surfaces, airborne (unclear)
  - Viral shedding: prior to development of symptoms (2-3 days) is highest in early course of illness (within 7 days)
  - Can occur from asymptomatic individuals
  - Risk dependent on exposure type (closes and duration of the contact)
COVID-19

• Immunity
  - Natural, emerging data, magnitude & durability uncertain
  - Self-analogue, potential for durable T-cell immune response
  - HLA-dependent immune response?
  - Animal studies suggest some protection against reinfection in short term
  - More data needed to confirm protective value of current antibodies

• Protective immune response?
  - Animal studies suggest some protection against reinfection in short term
  - Lower levels or more rapid clearance of virus following challenge

Spectrum of infection

Mild
- No or mild pneumonia

Severe
- Dyspnea, hypoxemia, >50% lung involvement within 1-2 days

Critical
- Respiratory failure, shock, multiorgan dysfunction

Risk factors for Severity

Established
- Cardiovascular disease
- Type 1 DM
- COPD
- Cancer
- Chronic kidney disease
- Obesity
- Solid organ transplant state

Possible
- Tobacco use
- HTN
- Asthma (mod-severe)
- Cystic fibrosis
- Cerebrovascular disease
- Liver disease
- Pregnancy
- Pulmonary disease
- Immunocompromised state
- Type 2 DM

Greatest impact of COVID-19

• As of June 2020:
  - Nearly 22% and 34% of COVID-19 cases in the U.S. are in African American and Latinx communities
  - Mortality rate from COVID-19 is two-fold higher in African Americans compared to White persons
  - Native Americans disproportionately affected
    - 18% deaths in AZ (make up 5% of the state population)

Accessed via cdc.gov
Why these disparities?

Biomedical lens
- Increased prevalence of chronic disease (e.g., DM, HTN, CAD, obesity, CAD)
- Lower access to healthcare: uninsured, areas with lower quality/frequency of medical care

SDH lens
- Higher poverty rates in Native Americans, African Americans, LatinX
  - Frontline jobs, public transportation, essential workers, fewer options to work from home
- Living conditions
  - Higher housing density, more housing insecurity, scarcity of potable water, and more multigenerational households
- Knowledge gaps
  - Health literacy, LEP, justifiable mistrust of healthcare systems


AA is a 63yom w HTN, CAD, obesity who p/w 5d malaise/fever after his husband came down with COVID 19. In the last day, he has had worsening DOE. Vital signs in ED notable for HR 105, O2 sat 91% on 3L NC (83% on RA). CXR with bilateral infiltrates.

Which COVID complication are we most worried about here?

COVID in the Hospital: Disease Complications—pulmonary

He is admitted with severe COVID pneumonia. He requires oxygenation, avoidance of nebulized medications (why?), consolidation of medications and parsimonious diagnostic testing for infection control.

What medications are indicated at this point?

COVID in the Hospital: Case

AA is a 65yol w HTN, CAD, obesity who p/w 5d malaise/fever after his husband came down with COVID 19. In the last day, he has had worsening DOE. Vital signs in ED notable for HR 105, O2 sat 91% or 6L NC (83% on RA). O2H with bilateral infiltrates.

What complications are we most worried about here?
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COVID in the Hospital: Medical Management

- remdesivir
- dexamethasone
- T-AIP also
- no specific contraindication to NSAIDs or ACE/ARBs

He develops a VAP but eventually improves. Sedation is weaned and he is eventually extubated. Throughout hospitalization, team involves family remotely, implements aggressive PICS-supportive care, and enrolls him in a PICS prospective observational/supportive cohort study.

What other organ systems could COVID affect this hospitalization?

What complications of critical care treatment should we be worried about in the medium to long term?

AA's oxygenation is stable for a couple days, but then worsens abruptly, necessitating prolonged intubation and aggressive sedation/paralysis.

What other organ systems could COVID affect this hospitalization?
COVID in the Hospital: Complications—thrombosis

- Abnormal coagulation studies
- Prophylaxis (some get therapeutic dosing, maybe even on discharge)
- Treatment (maybe longer?)
- Abnormal locations

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Though there is no apparent thrombosis, he is started on aggressive prophylactic VTE ppx (enoxaparin 40mg BID).

What other COVID-associated organ damage should we watch for?

COVID in the Hospital: Complications—others

- Cardiac:
  - arrhythmias (fib/flutter, VT)
  - myocardial injury (myocarditis, hypoxic injury, stress, CAD, R heart strain, cytokines)
- AKI

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He receives very careful fluid resuscitation to resolve ATN. Troponin is non-specifically elevated, he is kept on telemetry without events.

He is discharged to post-acute care for aggressive rehabilitation.

What are the priorities now? How can we work together to improve AA’s outcomes?
Post-COVID Hospitalization

- Respiratory/dyspnea, deconditioning
- Post-intensive care syndrome (PICS)
  - Respiratory
  - Hemodynamic
  - Neurological
- Social (including isolation, financial)
- Delirium
- Infection control, including rationalizing medications and minimizing transfers

Learning Objectives

Define the prevalence of COVID globally, nationally, and locally
Recognize the societal level impact of the pandemic
Describe common complications of COVID in hospitalized patients
List the current recommendations for monitoring and management for patients who had COVID
Reflect on how we can manage patients post-discharge after being hospitalized for COVID

Questions?