HOMERuN Hospital Medicine ReEngineering Network

HOMERuN COVID-19 Collaborative Discharge Planning Focus Groups

May 12, 2021 Newsletter

The Hospital Medicine Reengineering Network (HOMERuN) is a national network of Hospital Medicine investigators at 12 academic medical centers (AMCs) and 50 affiliated sites. During the COVID-19 pandemic, HOMERuN leadership formed the "COVID-19 Collaborative" as a mechanism to share information and practices regarding pandemic responses across participating institutions.

The HOMERuN COVID-19 Collaborative held focus group discussions on discharge criteria and planning planning on March 12, 2021. Below are key themes identified in the discussions.

Organizers and Facilitators: Jeffrey Schnipper, Efren Manjarrez, Charlie Wray, Andrew Auerbach, Marisha Burden, Angela Keniston, Alan Kubey, Ifedayo Kuye, Clark Davis, Ryan Greysen

Evolving Discharge Planning Practices for Patients with COVID-19

"We had … a lot of dynamically changing guidelines and criteria at our institutions, with the big question becoming, 'How do you get that information to the key people when all of that is so chaotic?'"

- Home isolation after discharge

    - Federal and state/local guidance has changed over time (e.g., duration of isolation), and sites have had to change their policies to be consistent with that guidance
- Discharge to locations other than home
    - Different communities developed different solutions for caring for COVID-19 patients with homelessness, including field hospitals, hotels, and buildings run by religious and community organizations to care for patients during the period of isolation. This allowed for more options for these patients while they were in place
    - Skilled nursing facilities generally became more available over time, but availability has waxed and waned depending on the community
- Clinical criteria for discharge
    - Few sites have specific written guidelines
    - Decision-making has become more holistic (clinical gestalt) and trend-based (e.g., improvement in oxygen requirement), rather than meeting specific criteria at discharge
    - General guidelines include decreasing oxygen requirement, signs and symptoms improving, clinically stable
    - Clinicians have become more comfortable discharging patients earlier, e.g., still on oxygen, as long as they are otherwise clinically improving
    - Clinicians take symptom onset, comorbidities, and lab markers into account, but they are not the main drivers of when to discharge, unlike earlier in the pandemic
- Non-clinical criteria for discharge
    - Ability to discharge patients to home often depends on whether other people living there have already contracted COVID-19 (and thus were no longer susceptible). Families generally became more comfortable caring for loved ones with COVID-19 over time
    - As with all patients, social determinants of health, including home supports, often determine success of discharge
    - Some states and communities were able to contract with vendors for durable medical equipment (DME; e.g., home oxygen) for uninsured patients
    - Some sites used medical students and community health workers to provide continuity of care to underserved patients
- Post-COVID-19 clinics
    - These varied tremendously across sites. Some focused on patients with chronic symptoms (“long-haulers”), while others focused on patients with more acute and severe symptoms

Our next meeting will be May 21, 2021.

Successful Strategies

“We developed a more aggressive home monitoring program for COVID that’s now going to continue for non-COVID. It was a huge save for us. It allowed us to get patients out earlier and a lot more comfortably. We’ve had almost no readmissions.”

- Home Monitoring Programs

    - Many sites, but not all, have set up home monitoring programs to track patients after discharge
    - Technology at home varies, including thermometer, pulse oximeter, portable ultrasound
    - Many sites are using telemedicine to follow patients after discharge
    - Some sites used contracted home health nurses to follow patients after discharge
- Criteria for discharge
    - These programs do not always lead to earlier discharge, but they have allowed providers to feel much more comfortable discharging patients from the hospital

Challenges Faced

"Our comfort level increased and yet we don't really have any data to tell us if we were making the right decisions."

- Communicating changes to discharge plans
    - One challenge has been communicating information to clinicians as standards have changed; some sites use pathway-type systems such as Agile, integrated into the EHR
- Providing COVID-19 vaccines to inpatients
    - Programs still in their infancy
    - When present, generally provide vaccines to patients who were due for them (e.g., due for their second shot)
    - Concern that vaccine itself will cause symptoms, confusing the clinical picture
- Equity and efficacy in home monitoring programs
    - Concern that home monitoring programs, if limited to insured patients, could widen health care disparities
    - Capabilities of these programs could be overwhelmed by capacity during surges
    - Unclear if these programs have allowed for earlier discharge or just increased the comfort level of clinicians
    - Unclear if these programs have improved clinical outcomes
- Lack of data to guide discharge decisions
    - While clinicians' comfort level has increased, we still do not know what discharge criteria actually correlate with risk of readmission or post-discharge death

Key Takeaways

1. **Clinical gestalt reigns:** Clinicians have become more comfortable discharging patients earlier, based on general improvement. We still lack data on whether this is the right approach.
2. **Post-discharge monitoring sprang to life:** Many sites adopted these programs. The extent to which they changed timing of discharge, improved outcomes, or will continue post-pandemic remain to be seen.
3. **Communities stepped up:** State and local efforts were able to provide post-discharge options for many underserved patients, but these varied by location.
4. **Inpatient vaccination is a work in progress:** Determining eligibility and logistics remain the two major hurdles.

Relevant Resources

HOMERuN COVID-19 Knowledge Base: https://www.hospitalinnovate.org/covid19
SHM COVID-19 Resources for Hospitalists: https://www.hospitalmedicine.org/clinical-topics/coronavirus-disease-2019-covid-19-resources-for-hospitalists/
CDC Guidelines: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html
AHA Checklist for Discharging Patients with COVID-19: https://www.aha.org/system/files/media/file/2020/04/COVID-19-Checklist-for-Discharging-Patients-Checklist.pdf
Penn Medicine Center for Evidence-based Practice: COVID-19 Criteria for Discharging Patients from Inpatient Care: http://www.uphs.upenn.edu/cep/COVID/Inpatient%20discharge%20criteria%20update%20415.pdf
HOMERuN Discharge Planning Working Group Paper: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8034037/

Link to image: https://www.whitelotusclinic.ca/best-naturopath-toronto/

If you would like to receive an invitation to our upcoming calls, please reach out to Tiffany Lee (tiffany.lee@ucsf.edu).

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