Long COVID: The Pandemic’s Undocumented Long-Term Sequelae

By Christine Kilgore

Amidst a dearth of research on long COVID in post-acute and long-term care (PALTC), leaders and clinicians in the field have been taking note of worsening or new heart and lung problems, accelerated frailty and functional decline, prolonged delirium, unusual skin manifestations, and other symptoms and changes in individuals in skilled nursing facilities after SARS-CoV-2 infection.

Diane Sanders-Cepeda, DO, CMD, senior medical director for UnitedHealthcare (UHC) Retiree Solutions and a member of the AMDA – The Society for Post-Acute and Long-Term Care Medicine Board of Directors, is one of these leaders. Early in the pandemic, she noticed that patients and residents who survived COVID-19 were “not rehabbing as expected” and were not faring as well as would be expected after other acute illnesses.

Dr. Sanders-Cepeda began tracking published research about long COVID, social media discussions, and the experiences of her UHC members — and then speaking at state-level Society meetings and other forums about the importance of understanding post-acute sequelae of COVID (PASC), her favored term used to describe post-COVID conditions seen in PALTC.

“We need to have a high level of suspicion that post-acute sequelae of COVID can be occurring in our population; we need to be documenting it, and we need to be coding what we’re seeing as well as using the post-COVID}

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Behavioral Health Integration and Training — A Model to Extend the Reach of Psychiatry

By Lea Watson, MD, MPH

A majority (60% to 80%) of nursing home residents have one or more psychiatric diagnoses, including dementia (Med Care Res Rev 2010;67:627–656). And post-acute and long-term care (PALTC) residents take an astonishing number of psychoactive medications, most prescribed by nonpsychiatrists for a variety of indications (J Gerontol Soc Work 2012;55:444–461). Finding the best model to provide meaningful psychiatric services in PALTC, however, is a perennial struggle (Psychiatr Serv 2002;53:1390–1396). Psychiatric symptoms and requests for help to manage them with medications are widespread in the industry, yet practical solutions are seldom available due to the shortage of psychiatry-trained prescribers and the scarcity of geriatric psychiatrists working in the PALTC space.

The traditional model of sending patients out to limited community resources is fraught with barriers and prone to miscommunication, and still

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only touches a small minority of patients in need — often this option is available only in large urban areas. Although psychotherapists have found success in delivering on-site talk therapy, models of psychiatry prescribers coming into communities are harder to come by.

My observations over many years as a geriatric psychiatrist and consultant in this space are that we can only meet the need by systematically extending the reach of expertise, by training and empowering the primary care providers to address common psychiatric issues. Above all, we must provide care where people want it — and deserve to have it — in service of the whole person by eliminating the false dichotomy of “medical” and “psychiatric” care. Enter Behavioral Health Integration (BHI).

BHI is not a new concept. Fortunately, a model of BHI already exists in our outpatient primary care and has a strong evidence base for improving health outcomes and patient satisfaction because patients prefer being treated seamlessly in the primary care clinic, alongside their other medical appointments (JAMA 2002;288:2836–2845).

BHI is an endorsed model of care by the Centers for Medicare & Medicaid Services (see Medicare Learning Network, “Behavioral Health Integration Services,” CMS, 2022; https://go.cms.gov/304tkLl), which inspired us to try the model in nursing homes. The medical complexity of the population required creativity and flexibility. And, most importantly, it required several visionary large practices who were willing to partner in a novel model not driven by fee for service and who recognized the importance of access to psychiatric expertise.

The Key Components of BHI

The key components of BHI are systematic assessment and monitoring using validated measures, care navigation to support the treating (billing) practitioner, and oversight by a psychiatric consultant. By using a registry for all residents with psychiatric diagnoses, organized by designated care navigators (who can be clinical or nonclinical staff) and populated with objective measures such as the Patient Health Questionnaire (PHQ-9) and Brief Interview for Mental Status (BIMS), we can oversee a large population of patients systematically.

This population health approach includes regular review of data, with prompts to address changes in status and ongoing support (through the electronic health record and secure texting) to the primary care providers for prescribing guidance. Importantly, there were无缝 meetings with the entire team to discuss difficult cases and care plans. Patients can still be referred for specialty psychiatry care and other services.

Feasibility and Outcomes

The BHI program is like Chronic Care Management and can be billed as such for very prevalent, thus highly burdensome, chronic conditions that are under current case management.

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I find myself feeling a lot less hopeless and blue.

I do see headlines on my smartphone, and occasionally I read more about things I care about and might be able to act on. Obviously I can’t avoid some level of awareness when I use the internet. But I don’t need to see photos of children shot dead in a school or in the Ukraine for hours on end.

I don’t want more detail about how the Supreme Court is chipping away at the rights of Americans or other hypocritical politicians are spouting hateful lies. I am already sufficiently aware of the predictions that Miami will be under water in 15 years (and really — can San Diego be far behind?)

It’s been positively liberating to step away from the negativity.

How does this relate to our care setting, you might ask? Well, some of our patients who are facing serious or even terminal illness really want to know what’s going on with them — the laboratory values, the imaging results, the physical findings, and the prognosis; others most decidedly do not want to know such details. I read a study many years ago (that I’ve been unable to find, sadly) suggesting that patients who trust the process and do not request a lot of information about their condition actually do better clinically than those who want to micromanage.