

MOBILIZING A COVID-19 REHAB TEAM

ANDREW J. HAIG, M.D.

HAIG CONSULTING LLC

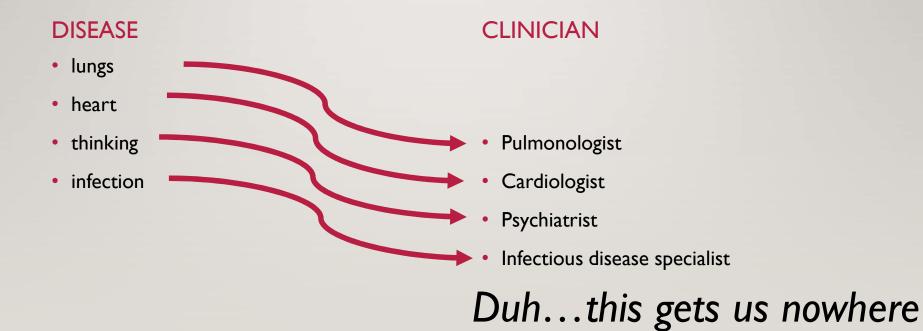
HAIG PHYSICAL MEDICINE PLC, MIDDLEBURY, VT

ANDYHAIG@UMICH.EDU

Other unpaid interests:

Professor Emeritus, University of Michigan President International Rehabilitation Forum Roles in ISPRM, AANEM, AAP

LONG COVID: MAPPING OUT THE DOCTORS



LONG COVID: MAPPING OUT THE NEED



THE WHOLE IS MORE DIFFICULT THAN THE PARTS

- Oh, by the way, she also…
 - Has all of these
 - Has only some of these
 - Has diabetes
 - Has pre-COVID depression
 - Had a stroke, too
 - Lost her husband
 - Is a pain in the butt
 - has a really physical job
 - Had her job eliminated or redesigned
 - Is afraid to return to work

How do you find out? How do you plan?

REHABILITATION TEAM ASSESSMENTS: AN IDEAL STATE

- Single-visit evaluation by appropriate experts
- Team meeting
- Interventions

THE VISIT

- · All medical, social information, patient goals gathered ahead of time
- Appropriate clinicians chosen for the evaluation
- ½ hour each. That's all.
 - ~15 minutes gathering traditional information
 - ~15 minutes getting specific and creative

THE TEAM MEETING

- Transdisciplinary teams require leadership and practice:
 - They know the protocol
 - They trust each other
 - They know each other's strengths and weaknesses
 - They strive to be creative, look for gaps in their expertise.
- Very structured meeting to allow brainstorming
- Preliminary report
 Action, goal, time frame, person responsible, contingencies.
- Review with patient, modify

WHAT ARE THE SPECTRUM OF INTERVENTIONS?

~2 recommendations/patient were physician driven ~2 recommendations/patient could not be traced to a profession

Transdisciplinary!

Table 3: Treatment Recommendations as a Result of Evaluation

Therapy (86)		Counseling (24)	
Physical	33	Psychological	10
Occupational	16	Financial	1
Speech	9	Family	4
Recreation	6	Vocational	7
Nursing (education)	9	Nutritional	2
Day rehabilitation	6		
Change current therapy	7		
Evaluation (17)		Equipment changes (46)	
Home	14	Prosthetics/orthotics	7
Job	1	Major equipment*	16
Driving	2	Assistive device	21
		Car modification	1
		Home modification	1
Medication changes (31)		Diagnostic (19)	
Spasticity	8	Laboratory	5
Bladder	1	X-rays	8 2
Depression	4	Obtain medical records	8
Pain	11	Other	2
Other	7		
Physician consultation (33)	Social (34)	
Physiatrist	12	Support group	13
Urologist	6	Community agencies	6
Primary care MD	3	Alternative placement	4
Psychiatrist	3 2 2 5	Alternative transportation	2
Oral surgeon	2	Alcohol treatment	2
Orthopedic surgeon	2	Adult day care	2
Other†	5	Other	3
Hospitalization (4)	:00;83.	Patient instruction (24)	9 12
Inpatient treatment	4	Medical	(
		Avocational	5
		Social	-
		Environmental change	7

^{*} Major equipment valued at over \$200, assistive devices valued under \$200.

[†] Single physician consults included cardiac surgeon, ear, nose, and throat specialist, obstetrician/gynecologist, ophthamologist, vascular surgeon.

INTERVENTIONS

- Share the report with everyone who may impact the person or plan
 - Patient, family, employer, clinicians (with consent)
- · Referrals directed by the team plan, but done by whomever is best
 - Local clinicians are often best
 - Often distant experts are only needed via telemedicine or a single visit.
 - Sometimes treatment requires ongoing coordination and authority
 - Sometimes treatment requires a team

THE QUICK PROGRAM AS A MODEL

- Wisconsin's ThedaCare, then University of Michigan
- Randomized controlled trial
 - Team vs. physiatrist alone
 - Twice as many recommendations
 - Better compliance, function, quality of life, satisfaction
 - So popular that insurers began sending from afar
 - Morphed into sub-speciality programs:

Spine Team Assessment (STA), and STA-Senior

UPPER assessment for arm disability

Pediatric Rehabilitation and Evaluation Team (PERT)

Haig et al., multiple articles

SO YOU DON'T HAVE A QUICK PROGRAM?

• Best: Build one!

Good: Consult a PM&R doctor

• Not so bad: Own the problem and share the big picture