Housekeeping Items

- Welcome to L.A. Care Provider Continuing Education (PCE) Program's Live Webinar!
- Webinar participants are muted upon entry and exit of webinar.
- Webinar is being recorded.
- ***Webinar attendance will be noted via log in. 2 Requirements: Please log in through a computer (instead of cell phone) to Join Webinar / Join Event and also call in by telephone by choosing the Call In Option with the call in number, access code and assigned unique attendee ID number. If your name does not appear on the WebEx Final Attendance and Activity Report (only as Caller User #) and no submission of online survey, no CME or CE certificate will be provided.***
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- The PowerPoint Presentation is allotted 60 minutes and last 30 minutes for Q&A session, total of 90-minute webinar, 1.50 CME credits for L.A. Care Providers and other Physicians, 1.50 CE credits for NPs, RNs, LCSWs, LMFTs, LPCCs, LEPs, and other healthcare professionals. Certificate of Attendance will be provided to webinar attendees without credentials.

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  https://www.lacare.org/providers/provider-central/provider-programs/classes-seminars

- Any questions about L.A. Care Health Plan's Provider Continuing Education (PCE) Program and our CME/CE activities, please email Leilanie Mercurio at lmercurio@lacare.org

Presenter's Bio

Nisha Viswanathan, MD, FACP

Dr. Nisha Viswanathan is an Assistant professor of medicine and Extensivist physician at UCLA Health. She attended University of Arkansas for medical school and completed her Internal Medicine residency at Mount Sinai Hospital in New York.

Dr. Viswanathan is currently co-Director of the COVID Ambulatory Monitoring Program and Director of the Long COVID program at UCLA.

Presenter's Bio

Sun Yoo, MD, MPH

Dr. Sun Yoo is the Section Chief of Extensivist Medicine in the Department of Medicine at UCLA, and the Medical Director of the Internal Medicine Practice at Ronald Reagan UCLA, and the Director of the COVID Ambulatory Monitoring Program. Dr. Yoo started the COVID Ambulatory Monitoring Program, a multidisciplinary group consisting of primary care doctors, subspecialists, nurses, social workers, and care coordinators, in April of 2020 to take care of COVID patients after hospital discharge and develop new pathways and protocols for the ambulatory care of COVID-19 patients.

Dr. Yoo obtained her medical degree and public health degree from Harvard Medical School, and the Harvard School of Public Health and her undergraduate degree from MIT, and completed her internal medicine residency and chief residency at UCLA.

Long COVID: Primer for the PCP

By: Nisha Viswanathan, MD, FACP

Sun Yoo, MD, MPH

July 14, 2022 Live Webinar via WebEx, 12:00 pm – 1:30 pm PST

Directly Provided CME/CE Activity by L.A. Care Health Plan

1.50 CME/CE Credits

Disclosures

The following CME planners and faculty do not have relevant financial relationships with ineligible companies:

- Leilanie Mercurio, L.A. Care PCE Program Manager, CME Planner
- Alex Li, MD, L.A. Care Deputy Chief Medical Officer, CME Planner
- Nisha Viswanathan, MD, FACP, CME Planner and Faculty
- Sun Yoo, MD, MPH, CME Planner and Faculty

Ineligible companies are companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Commercial support was not received for this CME/CE activity.

Learning Objectives

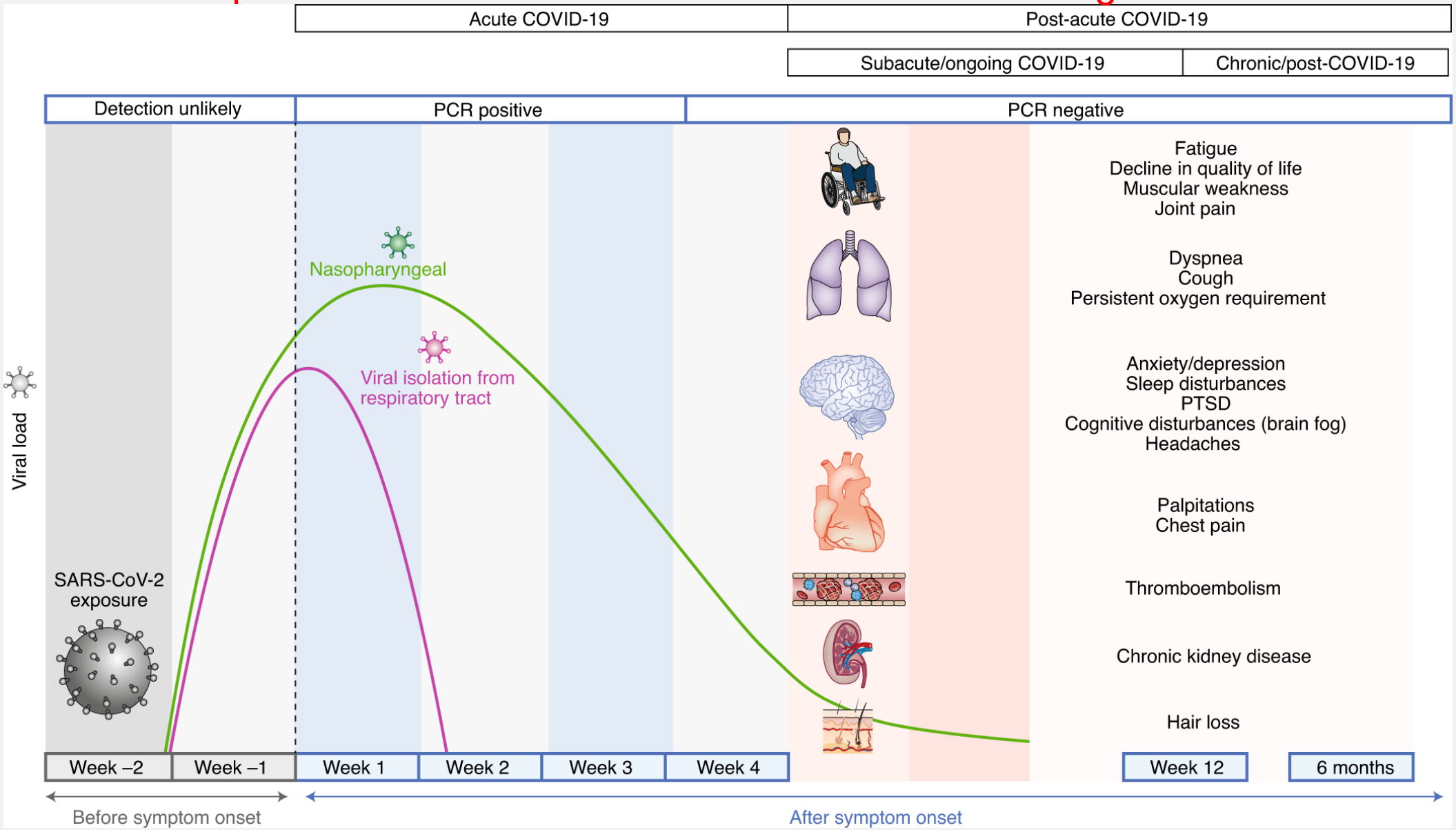
1) List three (3) commonly reported physical and three (3) psychologic/neurocog-nitive symptoms seen with Post-Acute Sequelae of SARS-CoV-2 (PASC).

2) Describe how you may be able to differentiate existing symptoms worsened by COVID-19 versus symptoms from Post-Acute Sequelae of SARS-CoV-2 (PASC).

3) Identify five (5) assessment tools or tests you could order in your initial workup of a patient fitting the clinical criteria and timeline for PASC for further evaluation.

4) Describe the recovery time expected in COVID-19 and when it is considered “Post COVID” or PASC (AKA Long COVID).

Acute COVID up to 4 weeks Post COVID > 4 weeks Long COVID ~ 12 weeks*



***No International consensus on Long COVID Definition to date**

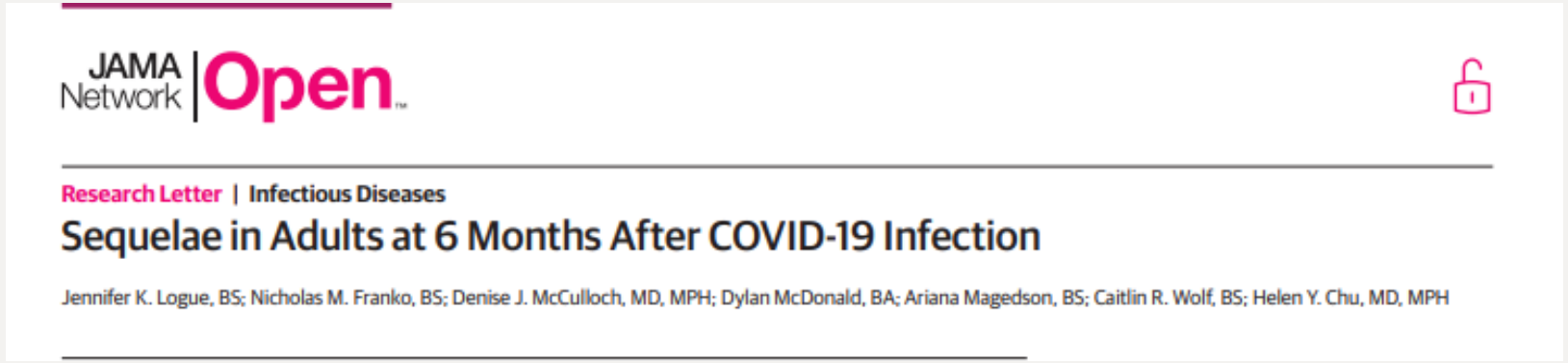
Nalbandian, A., *et al.* Post-acute COVID-19 syndrome. *Nat Med* **27,** 601–615 (2021).

What is Long COVID?

- Long COVID = Longhaul COVID = PASC = Post-COVID Syndrome
- No defined time interval to diagnosis: 4 weeks (NIH/CDC), 12 weeks (NICE), etc.
- Symptoms that persist after acute infection or develop in the first ~1-3 months after infection.
- Symptoms that begin later have an unclear association with this disorder and are evaluated on a case by case basis.

Who is developing Long COVID?

- Increasing Age
- Women > Men
- Requiring hospital assessment
- Asthma (Pre-existing)
- More than 5 symptoms in week 1 of illness

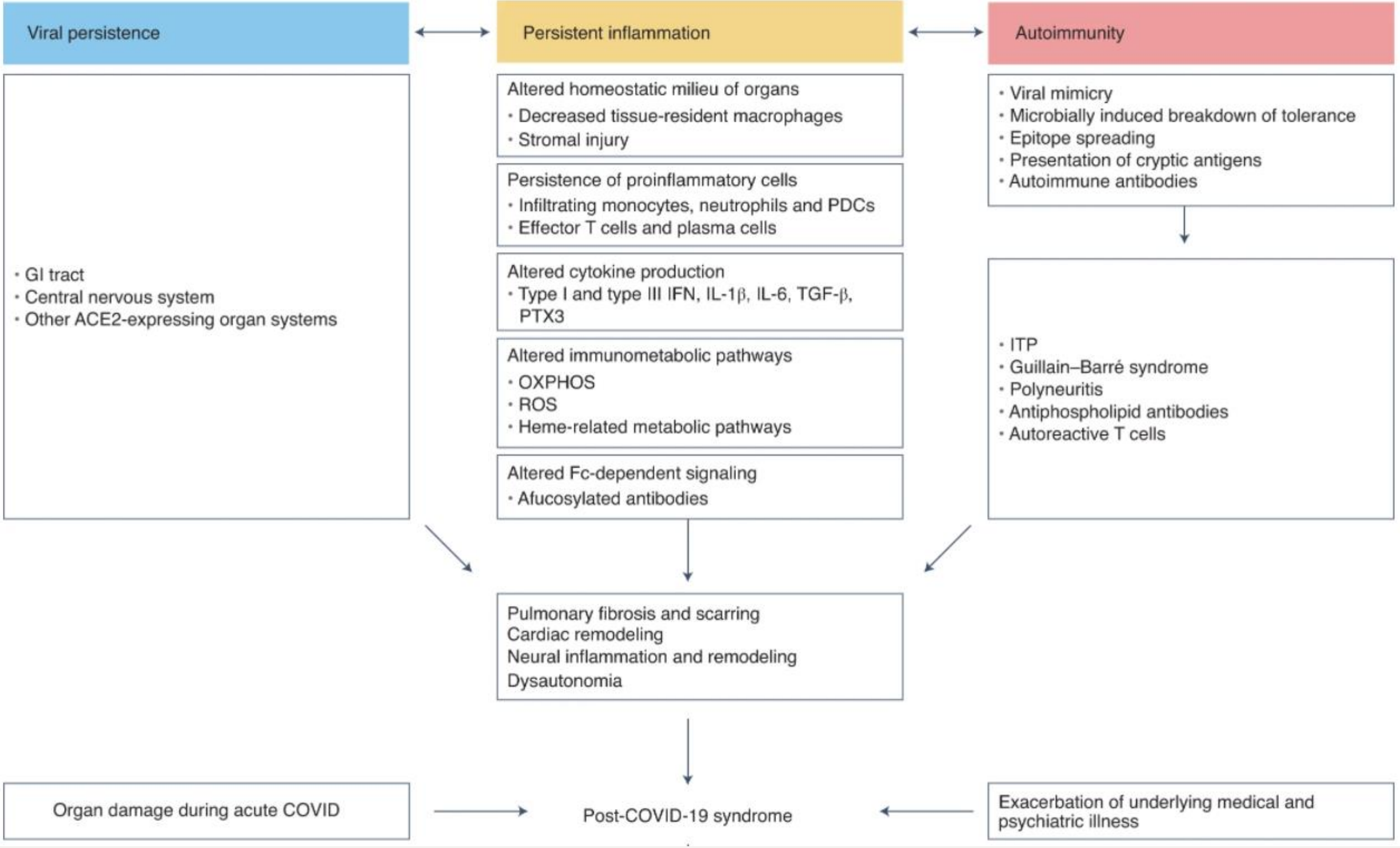


- Inpatients, Outpatients, Asymptomatic Individuals, and Controls
- Single study cohort (University of Washington)
- Small sample size (n=177)
- **30% reported persistent symptoms**
- Most commonly reported symptom was fatigue followed by anosmia
- 76.3% white,1.7% black, 4% LatinX

- Outpatients at Geneva University Hospitals
- Contacted at 30-45 days, again at 7-9 mos
- 629 participants completed baseline, 410 completed follow up at 7-9 months
- **39% reported residual symptoms.**
- Fatigue (20.7%) most common followed by anosmia (16.8%) and dyspnea (11.7%)

Pathophysiology

- Chronic inflammation
- System-specific damage during acute infection, including to the autonomic nervous system
- Viral reservoir
- Autoimmune or altered immunologic response
- Microthrombi, prothrombotic state and endothelial damage during acute infection
- Psychiatric/somatic overlay
- EBV reactivation
- All of the above?


Viral persistence
Persistent inflammation
Autoimmunity
Altered homeostatic milieu of organs
• Decreased tissue-resident macrophages
• Stromal injury
Persistence of proinflammatory cells
• Infiltrating monocytes, neutrophils and PDCs
• Effector T cells and plasma cells
Altered cytokine production
• Type I and type III IFN, IL-1β, IL-6, TGF-β, PTX3
Altered immunometabolic pathways
• OXPHOS
• ROS
• Heme-related metabolic pathways
Altered Fc-dependent signaling
• Afucosylated antibodies
• Viral mimicry
• Microbially induced breakdown of tolerance
• Epitope spreading
• Presentation of cryptic antigens
• Autoimmune antibodies
• GI tract
• Central nervous system
• Other ACE2-expressing organ systems
• ITP
• Guillain–Barré syndrome
• Polyneuritis
• Antiphospholipid antibodies
• Autoreactive T cells
Pulmonary fibrosis and scarring
Cardiac remodeling
Neural inflammation and remodeling
Dysautonomia
Organ damage during acute COVID
Post-COVID-19 syndrome
Exacerbation of underlying medical and psychiatric illness

First evaluation

- History of COVID illness
  - *Review acute symptoms, SpO2 requirements*
  - *Need for hospitalization or ICU-level care*
  - *Medications utilized in treatment of acute COVID*
- Review of medical and social history
  - *Diet and alcohol intake*
  - *Exercise*
  - *Life stressors (work, home life, etc.)*

Comprehensive Review of Symptoms

Fatigue:

Brain Fog:

Depression/Anxiety/PTSD:

Myalgias/Arthralgias:

Headache:

SOB/Cough/Wheezing:

CP:

Palpitations:

Lightheadedness:

Dizziness:

Nasal congestion/Rhinorrhea:

Anosmia/parosmia/dysgeusia:

Insomnia:

Rash:

Flushing/rashes:

Itching:

GI (nausea, abd pain, bloating, diarrhea, constipation):

GU (incontinence, difficulty with urination):

Neuropathy:

Temperature sensation/fluctuations:

Persistent fevers:

Hair loss:

Oral ulcers/dryness:

Ocular symptoms:

Other Sxs:

Evaluation and Treatment of Symptoms of Long COVID

Shortness of Breath

- **Initial work-up:**

  6-minute walk test evaluating both heart rate and oxygenation throughout

  Validated in COPD populations to evaluate airflow limitations[1]

  Utilize cones 30 meters apart to indicate distance to help evaluate exercise intolerance (normal 500m)

  Pulmonary function tests

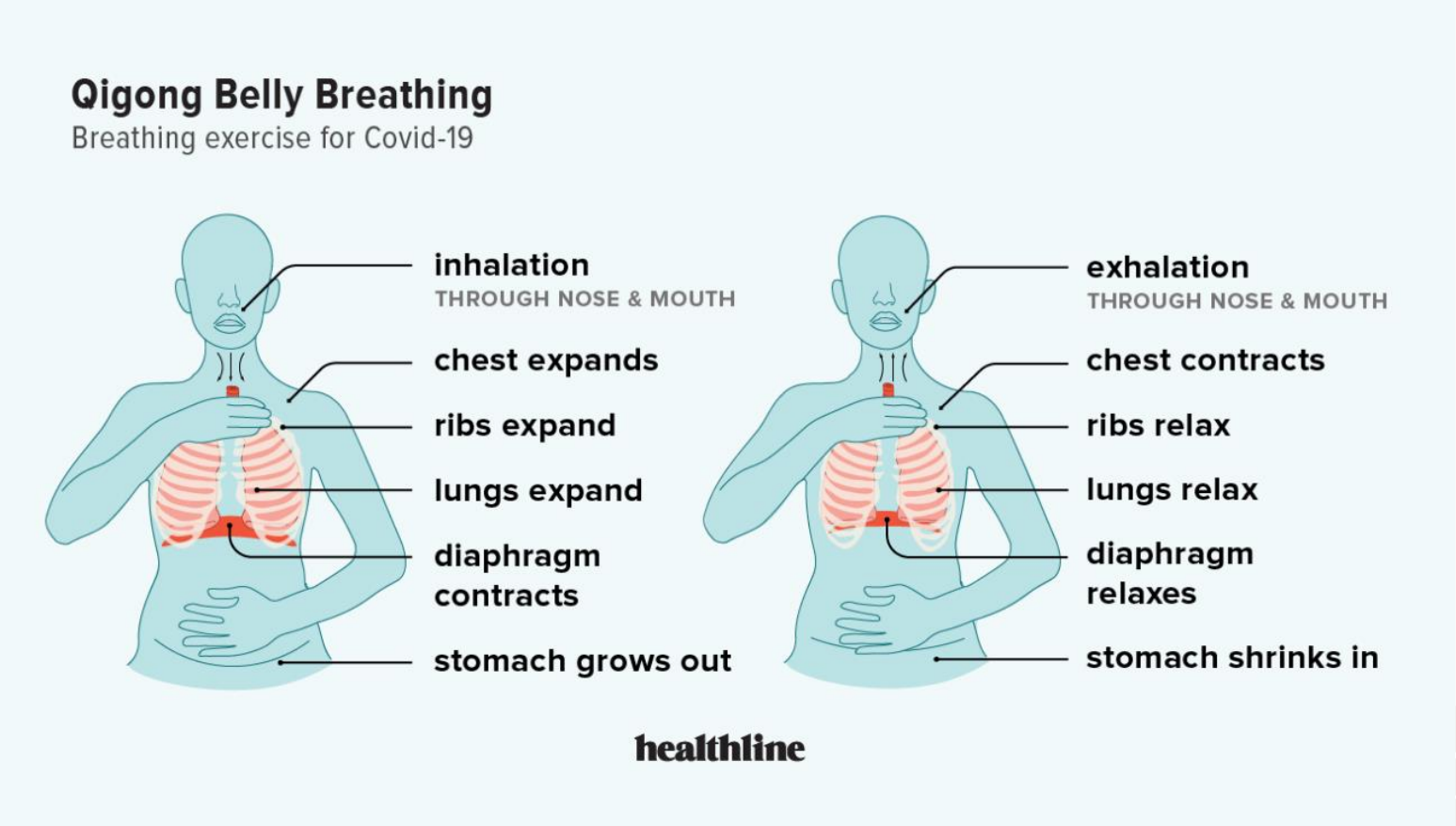
  Imaging: Chest Xray and/or CT scan (more severe initial illness)

  Assessments: Modified Medical Research Council Dyspnea Scale (mMRC)

Treatments for Shortness of Breath

- Empiric bronchodilators (only sometimes show improvement)[2]
- Qi Gong or STASIS breathing[3]
- Pulmonary Rehab[4]
- Biofeedback programs

Breathing Exercises



- Additional breathing exercises:
  - Yawn to a smile
  - Humming while exhaling
- LA Opera Program
- STASIS

  https://www.stasis.life/

Cardiac Management

- **Most common symptoms**: tachycardia, chest pain, palpitations, shortness of breath
- **Initial work-up:**

  Basic lab work: ESR, CRP, Troponin

  EKG in clinic

  If normal, consider Holter or Ziopatch

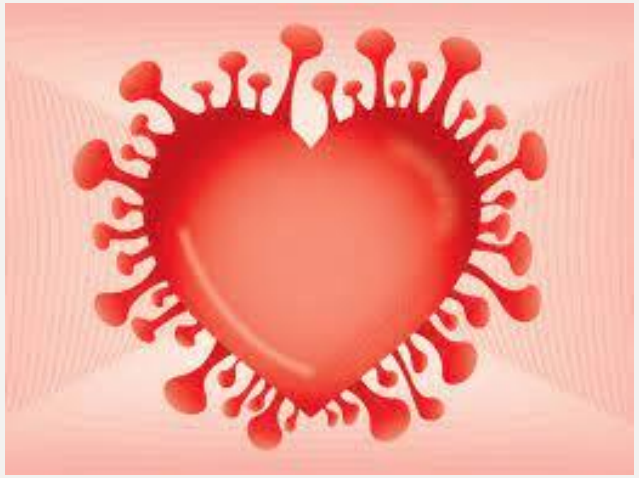
  TTE – post-COVID myocarditis[5] is always a consideration

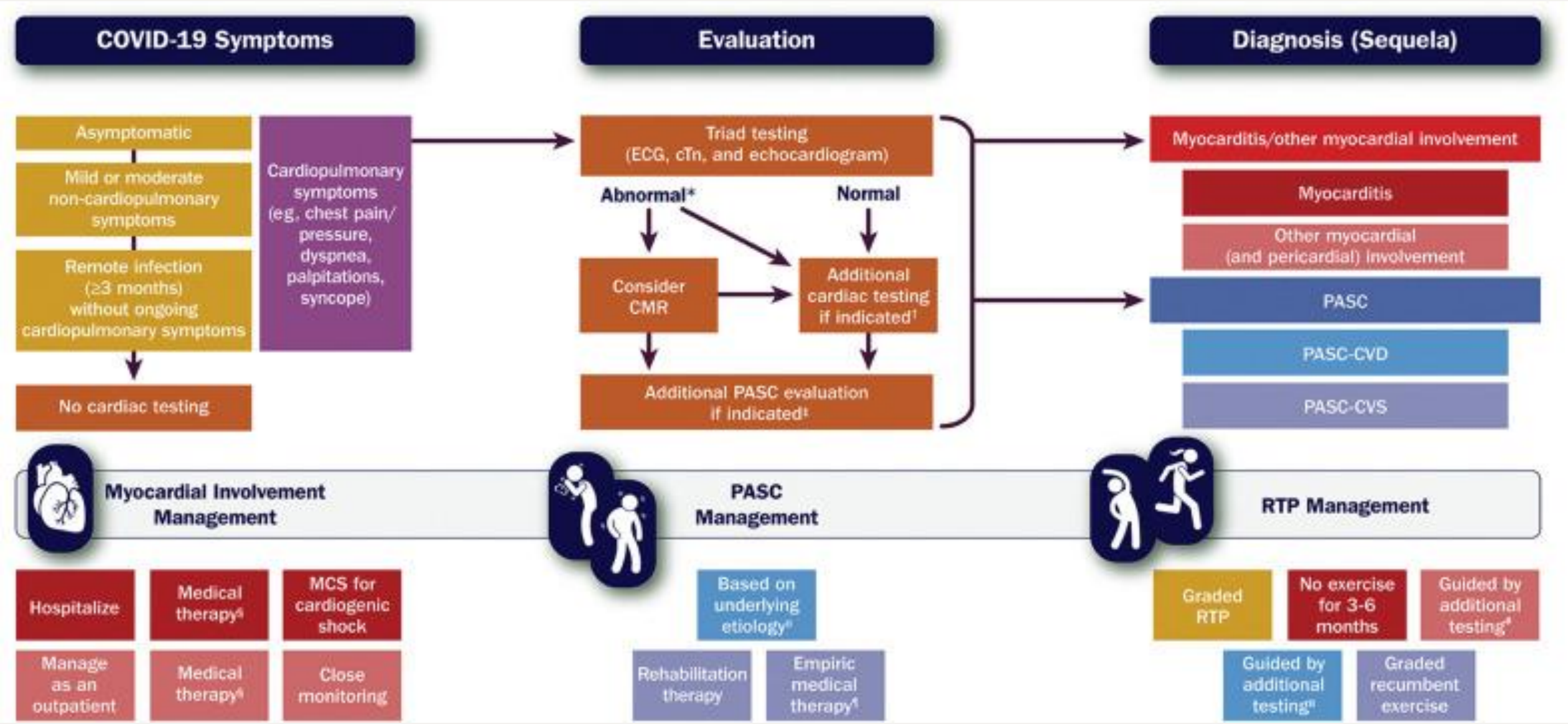
  If high suspicion, consider cardiac MRI and Cardiology involvement

  Stress Test

  CPET – to distinguish between cardiac and pulmonary involvement

  Evaluation for dysautonomia

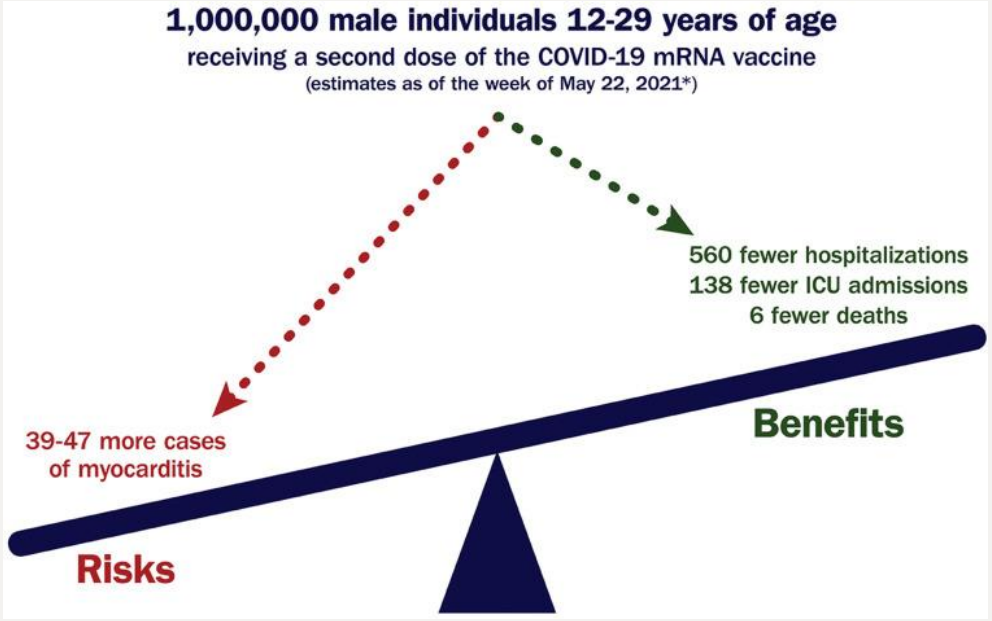




2022 ACC Expert Consensus Decision Pathway on Cardiovascular Sequelae of COVID-19 in Adults: Myocarditis and Other Myocardial Involvement, Post-Acute Sequelae of SARS-CoV-2 Infection, and Return to Play: A Report of the American College of Cardiology Solution Set Oversight Committee.

Post-vaccination Myocarditis

- Benefit of vaccination still outweighs risk per ACC guidelines
- CDC recommends 8 weeks between both doses of mRNA vaccines in males between 12 and 39 years of age[6]



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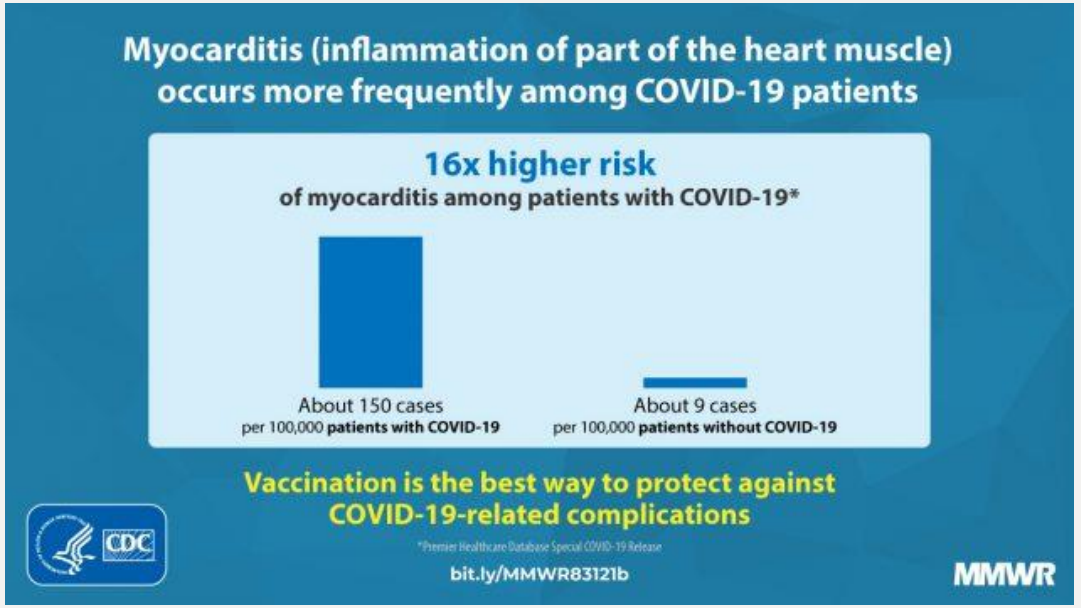


Myocarditis ACC treatment guidelines[5]

Cardiology involvement for guideline-directed medical therapy

Exercise abstinence for 3-6 months followed by graded exercise program (preferably cardiac rehab)

Dysautonomia

- **Recognizing dysautonomia: disorder of the autonomic nervous system (ANS) leading to failure of the sympathetic and parasympathetic parts of the ANS**

  Can affect heart rate, blood pressure, breathing, digestion, temperature, hormonal and bladder function, sexual function

- Four main types of dysautonomia

  Neurocardiogenic syncope – frequent fainting spells

  Postural Orthostatic Tachycardia Syndrome (POTS) – disruption of blood flow leading to syncope, chest pain, SOB and dizziness

  Multiple system atrophy – rare, mirrors Parkinson's disease

  Pure autonomic failure – orthostatic hypotension with chest pain, dizziness, fainting. Feel best when sitting or laying down.

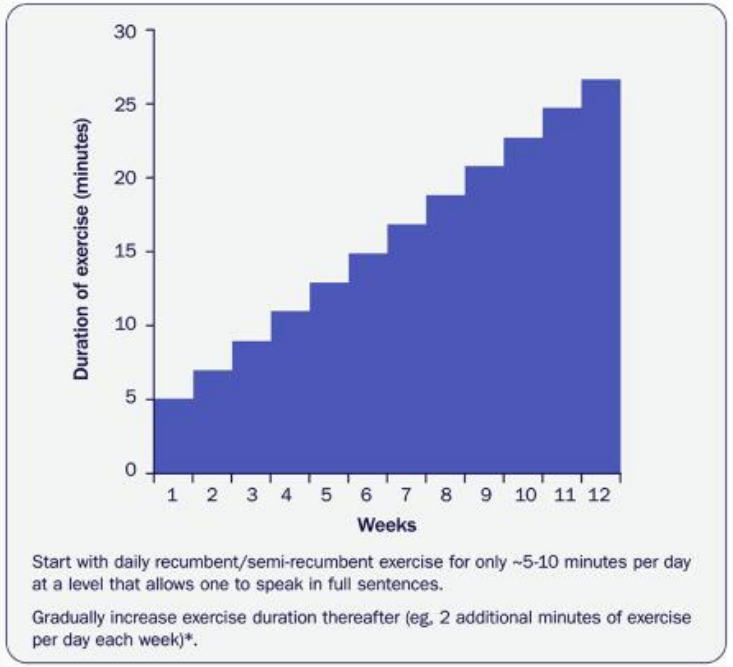
Evaluation for Dysautonomia

- **Assessments:** COMPASS-31
- **Orthostatics**
  - Obtain at 1,3,5,7, and 10 minutes (if possible) and can have patients lean on wall to prevent falls
- **Autonomic reflex screen**
  - Not as easily obtained everywhere
  - Need sudomotor testing to evaluate for small fiber neuropathy

Treatment of Dysautonomia

POTS/POTS-Like syndromes

- Graded exercise treatment (Levine protocol)[7]
  - https://www.dysautonomiainternational.org/pdf/CHOP_Modified_Dallas_POTS_Exercise_Program.pdf
  - Can provide this protocol for PT to utilize
  - ACC guidelines recommend starting with completely recumbent initially[5]
- Compression stalking/abdominal binders
- Increased salt intake (up to 4g daily) – can consider salt tabs
- Increase fluid intake (up to 8L daily)
- Can consider midodrine, fludro, BB depending on etiology
- Biofeedback[8]



A Note about Athletes[5]

Asymptomatic? Resume exercise training after 3 days of exercise abstinence during self-isolation.

Mild or moderate non-cardiopulmonary symptoms? May resume exercise training after their symptoms have resolved.

Remote infection (≥3 months) without ongoing symptoms? No additional testing.

Ongoing cardiopulmonary symptoms and/or those requiring hospitalization or after resumption of exercise? Additional testing.

Cardiac MRI is recommended if testing is abnormal or cardiopulmonary symptoms persist.

CMR not recommended to screen athletes who are asymptomatic

Repeat cardiac testing is not warranted in athletes with recurrent COVID-19 in the absence of cardiopulmonary symptoms.

Fatigue

- Vague and hard to quantify
- Consider assessments to track over time
    - WHO-DAS, Fatigue Assessment Scale
- Initial work-up:
    - Lab tests: CBC, CMP, TSH, CRP, ferritin, iron panel, HIV, Hepatitis B/C, Vitamin B12, ANA, other rheumatological work-up as indicated per history
    - STOP-BANG and evaluate for OSA
    - Ask about associated body aches/pains
    - PHQ-9/GAD-7 to evaluate for untreated depression/anxiety

Myalgic Encephalomyelitis (ME)/CFS

- Reduction in ability to engage in pre-illness activities that is accompanied by new onset fatigue >6 months (>3 months in PASC) and is not accounted for by another diagnosis
- Post-exertional malaise
- Unrefreshing sleep
- Cognitive impairment OR Orthostatic intolerance
- Must r/o sleep apnea and other contributing conditions

Treatment Options for Fatigue

- Alternative medicine can play a large role here
  - Fatigue-focused acupuncture
  - Anti-inflammatory diet
  - Supplements: ashwaganda, American ginseng, B Complex, magnesium for pain
- Concomitant presence of depression/anxiety often present
  - Sertraline is more activating than other antidepressants
  - If having associated body aches/pains, duloxetine is a better first line agent
  - One study on fluvoxamine in COVID, but high rate of GI upset and unclear benefit[9]
- Activating medications
  - Modafinil – 100mg BID under consideration as many patients may be struggling from Type 2 narcolepsy
  - Amphetamines – only if indicated with co-occurring concentration issues, although side effects have been noted to worsen fatigue
- Improving sleep quality
  - Consider melatonin, Valerian root
  - Some evidence for TCAs – nortriptyline is first line (can help with GI side effects as well)
  - Would avoid Ambien, Sonata

Role of Exercise in Fatigue

- Exercise therapy is controversial – many Long COVID patients note worsening fatigue with cardio-based exercise
- NICE (UK guidelines)[11] and CDC[12] recommend against graded exercise or cognitive behavioral therapy to discuss fear of exercise for management of fatigue (CBT for underlying psych conditions is appropriate)
- Adaptive pacing technique seems most helpful (PACE trial)[10]

Stay within the limits of activity that would cause worsening of symptoms, use internal cues and activity diaries, rest, switch types of exercise

Neurological Sequelae of Long COVID

Brain fog and cognitive impairment – most common and hardest to treat

Neuropathic pain and myalgias

Dizziness

Headaches

Sensorimotor deficits

Dysautonomia

Loss of taste and smell (Anosmia/Parosmia/Ageusia/Dysgeusia)

Initial work-up of Neurological Symptoms

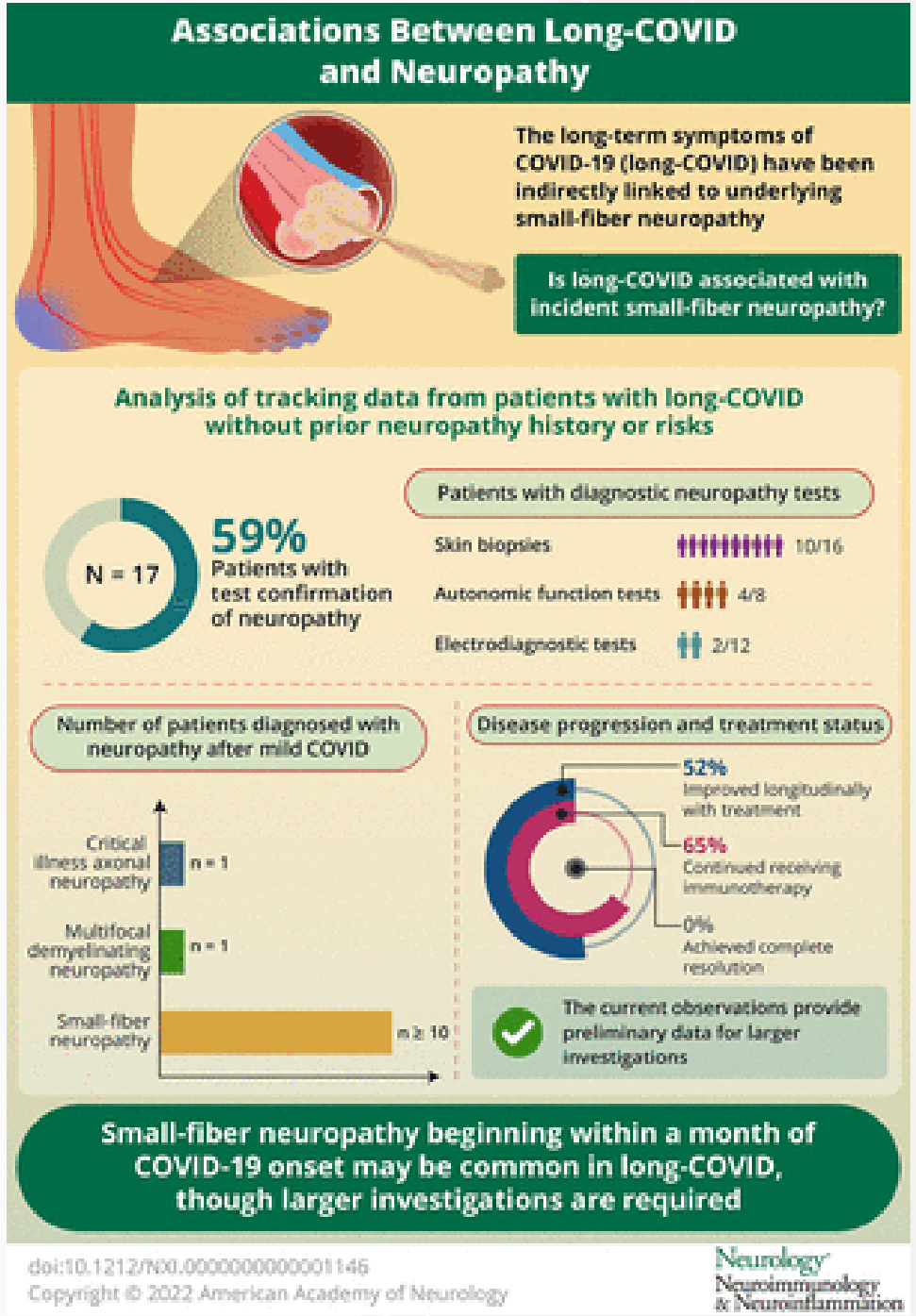
Lab tests: CMP, A1c, TSH, ANA, SSA/SSB, B12, MMA, SPEP, UPEP, immunofixation, Hep B, Hep C, HIV, sensory neuropathy panel (ANNA-1, etc), CK/aldolase if weakness and myalgias

Imaging: Brain MRI or MRI spine depending on symptoms

Assessments:

- MOCA/MMSE – hasn't been proven to be helpful given these were created for dementia evaluations
- Neurobehavioral Symptom Survey
- Wood Mental Fatigue Inventory

Isolated neuronal involvement? Consider EMG



Small Fiber Neuropathy

- **Symptoms** include pain and burning in extremities, electric "shocks", cramps, lightheadedness, orthostatic BP, excess sweating, GI issues, bladder control issues, skin discoloration
- Can begin within 1 month of COVID infection[12]
- **Treatment options[13]:**

  SNRIs, TCAs

  Neuropathic medications – Lyrica, gabapentin, lidocaine cream, capsaicin cream

  Opioids only if all else fails

  Aquatic PT

  Acupuncture or TENS unit

  Massage and heat/cold therapy

  Alpha-lipoic acid if EMG is negative

Brain Fog Management

- Screen for depression/anxiety and manage accordingly
- Evaluate for sleep disorders
- Neurocognitive evaluations can help determine degree of disability and ability to work
- Cognitive rehabilitation with speech therapy
- App based technology: Lumosity app
- Alternative medications: B Complex, Magnesium, Vitamin D

Loss of Taste and Smell

- Minimal role for ENT unfortunately
- Smell retraining (ABSCENT.org)

Can recommend smell retraining kits, or recommend daily mindful smelling of bright scented essential oils (4-5 max at a time)

Medications (low evidence): alpha lipoic acid, Vitamin A drops

Apps: NoseWell, Snif (mostly provide online communities for our patients)

Persistent congestion? Nasal rinses, BID antihistamines (2nd generation)

Depression/ Anxiety/PTSD Management

- Extremely common diagnoses in this population of patients
- **Sequential assessments**: PHQ-9, GAD-7, PTSD Symptom Scale, Impact of Event Scale
- Medication management is high in utility in this population
- Consider involvement of therapist early, would try to find trauma-informed therapist for those with PTSD
- Consider support groups: Body Politic, Survivor Corps, Long COVID Alliance, Long COVID Kids

Preventing Long COVID

- *Nature,* May 2022[14]

  "Compared to people with SARS-CoV-2 infection who were not previously vaccinated, patients with breakthrough infections exhibited lower risks of death and incident post-acute sequelae"

  mRNA vaccination proved to be the most successful.

Disability and Long COVID

Family and Medical Leave Act (FMLA)

- Provides up to 12 weeks of unpaid leave for patients to recuperate from COVID
- After initial infection, if patient continues to have symptoms, it would be advised to provide another month of leave for recuperation with a check-in point one month later to re-evaluate symptoms.
- If they persist, then it is appropriate to extend to cover full 12 weeks of leave time.
- *Documentation of initial symptoms are important to track symptoms. Assessments can also help evaluate degree of morbidity due to illness.*

Short-term disability

- Patients will often times ask you to complete this in addition to their FMLA if they need financial assistance
- Per HHS.org website:

  > *Long COVID can be a disability under Titles II (state and local government) and III (public accommodations) of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973 (Section 504), and Section 1557 of the Patient Protection and Affordable Care Act (Section 1557).*

- Must be a “physical or mental impairment” that “substantially limits one or more life activities”

Is Long COVID always a disability?

- No! This is why a comprehensive review of systems and sequential assessments can help guide treatment.
- If symptoms are improving or manageable, options to adjust work include:
    - Adjustments to work schedule (e.g. remote work)
    - Decreased work hours
    - More frequent breaks from work
    - Time off for flares in symptoms
    - Avoiding sleep-wake cycle disturbances (such as night shifts)
    - Additional time for testing (e.g. students)
    - Modifying existing work (e.g. minimize standing, etc.)

Federal Resources for Disability

- Office for Civil Rights of the Department of Health and Human Services (HHS): https://www.hhs.gov/civil-rights/for-providers/civil-rights-covid19/index.html.
- COVID-19 and the ADA: https://www.ada.gov/emerg_prep.html.
- Administration for Community Living's document, "How ACL's Disability and Aging Networks Can Help People with Long COVID," https://acl.gov/sites/default/files/COVID19/ACL_LongCOVID.pdf - PDF
- Equal Employment Opportunity Commission www.eeoc.gov/coronavirus.

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Clinical Resources

Clinical Guidance

1. Evaluating and Caring for Patients with Post-COVID Conditions: Interim Guidance. CDC. Updated June 14, 2021. https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/post-covid-index.html
2. COVID-19: Evaluation and management of adults following adult viral illness, UpToDate. July 2021.
3. NICE. Covid-19 rapid guideline: managing the long-term effects of covid19. https://www.nice.org.uk/guidance/ng188/chapter/4-Planning-care December 2020

Assessment Tools

1. https://www.healthmeasures.net/index.php
2. Academy of Physical Medicine & Rehabilitation's functional assessments: https://now.aapmr.org/functional-assessment/

ACP Managing Transitions of Care for Post-Acute COVID Patients

https://www.acponline.org/practice-resources/covid-19-practice-management-resources/covid-19-recovery-team-based-care-toolkitEXT

Thank you!

Nisha Viswanathan, MD, FACP

NViswanathan@mednet.ucla.edu

Frequently Asked Questions (FAQs)

1. What are the most commonly reported physical symptoms in Post-Acute Sequelae of SARS-CoV-2 (PASC) AKA Long COVID?

a. Fatigue, Dyspnea, Anosmia

b. Myalgias, Fever, Fatigue

c. Rash, Fatigue, Diarrhea

d. Dypsnea, Rash, Nausea

Answer: A

FAQs

2. Which of the following psychologic and neurocognitive symptoms can be seen in PASC?

a. Impaired memory

b. Poor concentration

c. Anxiety

d. Insomnia

e. All of the above

Answer: E

FAQs

3. Which of the following tool is **not** typically used as a screening tool for PASC?

a. Montreal Cognitive Assessment (MoCA)
b. 6 minute walk test
c. PET Scan
d. Patient Health Questionnaire-9 (PHQ-9)

Answer: C

FAQs

4. How long do symptoms need to persist for it to be considered “Post COVID” under current CDC guidance?

a. Greater than 10 days

b. Greater than 14 days

c. Greater than 4 weeks

d. Greater than 3 months

Answer: C

Q & A

L.A. Care PCE Program Friendly Reminders

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