

# Navigating Coronavirus Disease 2019 (Covid-19) in Physiatry: A CAN report for Inpatient Rehabilitation Facilities

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**Abstract:** We are facing a global pandemic in relation to coronavirus disease 2019 (Covid-19).

Emergency preparedness plans often do not consider issues specific to inpatient rehabilitation facilities.

The CAN model can be used to prepare for natural disasters, including the COVID-19 pandemic. This report was created to aid specialists in acute Inpatient Rehabilitation Facilities.

## Introduction

In December 2019, a severe acute respiratory syndrome coronavirus (SARS-CoV-2) infection causing coronavirus disease 2019 (Covid-19) emerged in Wuhan, China and has now rapidly spread throughout China and the world. The World Health Organization (WHO) has now declared coronavirus disease 2019 (Covid-19) a global pandemic and public health emergency<sup>1</sup>. A way to communicate vital information for incident action plans is via a CAN report. The CAN report stands for conditions, actions, needs. This report is often used with first responders and firefighters to help identify how they are doing, as well as

the conditions and support needed. This report was created to aid Physical Medicine and Rehabilitation specialists in acute Inpatient Rehabilitation Facilities (IRFs) to navigate patient care during this public health emergency.

## **CONDITIONS**

Patients who are in the acute inpatient rehabilitation unit are typically our most vulnerable populations. Inpatient rehabilitation facilities work with many patients greater than 60 years of age-almost all of whom have multiple comorbidities such as cardiac, respiratory or oncologic conditions. Due to the nature of treatment needs in an inpatient rehab setting, a high degree and frequency of physical contact is required for transfers/therapies in addition to daily nursing care needs. Additionally, most patients are treated in common areas due to equipment needs. It is not unusual to have over 40 people in the gym area at any given time. The current recommendation from the CDC is social distancing for those over age 60 and for patients with underlying conditions, which would be most of our patients.

## **Medicare Requirements unique to Acute Inpatient Rehab Facilities**<sup>2</sup>

- All patients must receive 3 hours of 1:1 therapy 5 days per week though this can be scheduled as 15 hours over 7 days if there is a medical reason.
- All patients must require intensive therapies in 2 of the following: Physical Therapy (PT), Occupational Therapy (OT), Speech and Language Pathology (SLP).
- Patients must have medical needs that cannot be met at a lower level of care and require a physician visit at least three times a week.
- The expectation is that patients will return home.

## ACTIONS

### **Limiting Spread**

- Monitor patients, physicians, and employees for fever or respiratory symptoms. Each hospital's HR department will have self-quarantine policies. Expect these policies to change.
- Limit OT and SLP to bedside therapy in patient rooms.
- Limit use of gym for PT only.
- Utilize hallways for walking including non-commonly trafficked parts of the hospital.
- Keep all patients at least 6 feet apart. It is not possible to keep therapists 6 feet from patients as all patients need hands-on care from PT and OT. Walking in hallways/outside for select higher functioning patients may reduce person/person contact.
- Cancel all non-required therapies: Therapeutic rehabilitation/music therapy/rehab psychology. There is the potential for continued services to patients using telecommunication technology- ie Skype.
- Make sure staff is aware of proper procedures for cleaning.
- Dedicated medical equipment should be used when caring for patients with known or suspected COVID-19.
- All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched

surfaces or objects are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed .<sup>3</sup>

- Permit staff who are able to do so to work from home. This could include rehabilitation liaisons, insurance coordinators, Prospective payment system (PPS) coordinators, care coordinators and social workers. Many of these workers are in small shared office space which would further increase risk of spread. At a minimum, consider having them on a rotating schedule. In the event that floor staffing needs become critical in acute care, many of these positions are filled with registered nurses (RNs) who could be used if needed, so keeping them healthy decreases burden on the health system and preserves their availability for later needs.
- Identify dedicated employees to care for Covid-19 patients and provide infection control training.
- Train superusers in personal protective equipment (PPE) to train nurses, certified nursing assistants, physicians, and therapists.
- Restrict visitors. Begin telling patients and families immediately that visitation may be restricted (in hours, time, and numbers) in the future so they will be prepared.
- Do not admit patients who are requiring droplet precautions at the time of admission.
- Have a plan in place for when therapies stop and when patients are no longer admitted.<sup>4</sup>
- Create a smart phrase to document in notes that it is a state of emergency and patients may not be receiving their 3-hours of Medicare-mandated therapy.

#### **Acute IRF changes to increase capacity at acute hospital**

- Discharge patients sooner than we typically would to free up beds.

- Keep a running list of patients who are “almost ready” and have good caregiver support. These patients and families will be warned that they might need to go early (and quickly) in case of need for extra beds.
- Higher functioning patients will need to go home from acute care hospitals rather than inpatient rehabilitation to make more beds.
- Patients may not be able to be discharged to subacute rehabilitation if there is no proof that they have tested negative for COVID-19.
- Consider admitting patients while awaiting pre-authorization. Authorization can be initiated in acute care hospital and patients can be transferred. Peer to peer can be done by IRF staff. We could see a high rate of non-payment, so this would likely be a Tier III option.
- Consider co-mingling non-rehabilitation patients with rehab patients.
  - Will need to have adequate resources to manage these patients in a rehabilitation hospital setting, especially for those units that are not located within the walls of a hospital building.

### **Presumptive or known positive test**

If someone has a new diagnosis of influenza while in rehabilitation, they are placed on droplet precautions. Some IRFs place the patient on 1:1 nursing and completely stop therapies until the patient is transferred out. For many rehabilitation programs, if they have two patients who test positive for influenza, then everyone is placed on bedside therapies and they halt admissions.

- Be aware of testing protocols at your hospital. At this time, CDC is recommending testing under airborne precautions.
- Consider having dedicated staff to handle patients who are on droplet precautions.

- Consider having a dedicated wing or rooms for patients who are on droplet precautions.
- If PPE is limited, consider removing only gloves and gowns (if used) and perform hand hygiene between patients with the same diagnosis while continuing to wear the same eye protection and respirator or facemask. <sup>567</sup>
- Determine at what point you would halt admissions.
- These patients may not be able to return to the acute hospital. Clarify code status, as this may impact the decision to transfer back to acute hospital.
- Consider availability of Palliative Care support (possibly via telemedicine).
- Consider support available from Employee Assistance in case of patient deaths.

### **Staffing**

- Consider limiting census in preparation for decreased staffing on unit (ie quarantines, illnesses).
- Consider having therapists treat on a modified schedule (evening shift) to allow them to care for children who are out of school.
- Is there staff that can help in other areas?
  - Rehabilitation aides could help if there are shortages on CNAs
  - Consider having RNs and therapists who are administrative assist with patient care if needed. They may need to complete certain competencies to return to floor duties.
- Consider having outpatient attending physicians help cover units if staff is sick/quarantined.
- Consider having residents on outpatient/elective rotations be on back up for inpatient residents in case they are sick/ quarantined.
- Consider cancelling elective/non-essential outpatient clinic visits if it is a hospital-based clinic.

### **Management of Acutely Ill patients**

- Ensure that you have clear Code Status on all patients.
- Clarify what happens if you need to transfer someone to acute and there are no beds. Most units do not have the resources to manage acute strokes, myocardial infarctions, sepsis, etc. Can telemedicine be utilized to offer these acute consultations to triage patients?
- Know what resources and consultants are available to you, and what you will need.

### **Rehabilitation Care for Post-COVID-19 Patients**

Physicians are reporting that patients are requiring prolonged prone positioning during mechanical ventilation. From a rehabilitation perspective, we can expect to see posterior reversible encephalopathy syndrome and critical illness myopathy/neuropathy following acute respiratory distress syndrome (ARDS) and extracorporeal membrane oxygenation (ECMO). Patients will exhibit typical sequelae of neuromuscular illness along with plantar flexion contractures and wounds. These patients may have severe respiratory impairment and may not be able to tolerate intensive therapies.

### **Establish a Continuity Plan**

- Each facility will need to develop a succession plan in the event that key people become incapacitated.

## **NEEDS**

Consider your facility's needs in each of the following areas:

- Dining services
- Pharmacy
- Materials Management
- Expedited telehealth
- Remote telemetry
- PPE needs
- Palliative care resources
- Laundry Services

## **CMS Response to COVID-19<sup>8</sup>**

1. CMS is waiving requirements to allow to house acute care patients in excluded distinct part units
2. CMS is waiving requirements to allow acute care hospitals with excluded distinct units that in the event of an emergency need to relocate patient to an acute care bed, should continue to bill for inpatient rehabilitation services.
3. Waiver of the 60% rule

## **Conclusion:**

Hospital emergency preparedness frequently does not take into account issues specific to inpatient rehabilitation. The CAN model can be used to prepare for natural disasters, including the COVID-19 pandemic. Patient and staff safety have to be at the forefront of providing rehabilitation services to our community.



## References

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