DRAFT April 1

Planning strategies for admitting COVID 19 patients to MossRehab

As a consequence of pandemic COVID19, there will be a number of particularly post-critical care patients who will develop post-acute care (PAC) needs, including functional impairments (debility/physical deconditioning/myopathy/neuropathy, dysphagia, new low-perfusion ischemic morbidities, new CVAs, critical limb ischemia, etc.), with some degree of new/increased impaired independence, caregiver burden, medical/nursing needs, i.e. cardiomyopathy/HF, respiratory failure with DME/O2 support, etc.), and medical frailty.

Due to COVID19 patient surge/infection control measures/workforce depletion, there will be strained or otherwise unavailable PAC resources, including long-term acute hospitals (LTACHs), acute inpatient rehabilitation facilities (IRFs), skilled (SNF) and sub-acute facilities, as well as home health and outpatient services.

There will be an unknown, but probably proportion non-COVID-related med-surg patients, who will have significant PAC needs, who normally are served by the current PAC system, but will not be able to access PAC when needed.

Historical data from Medicare suggest that more than 30% of patients hospitalized with sepsis, a condition with inpatient mortality like that associated with COVID-19, require facility-based care. Post-acute care is also a “pop-off valve” for hospital capacity, in that moving patients to a such a setting once they recover from the most acute phase of their illness could free up hospital beds.

In such a scenario, simply discharging patients to home, despite significant ongoing functional impairments, e.g., debility, impaired independence, high caregiver burden, new medical/nursing needs, and increased medical frailty, will likely result in excess morbidity/mortality, as well as significant frequency of patient readmissions to acute care, most likely through busy ED system.

Previously immune-competent COVID19 patients likely cease shedding COVID19 virus about 7-10 days post-infection. At that time, they will have a very low risk of transmitting or becoming re-infected with 2019-COVID19. Treating these patients will be relatively safe for both patients, and clinical staff with adequate planning.

Ideally an important first principle would require all patients to be tested for COVID-19 when they are being discharged from acute care setting regardless of whether they were being treated forCOVID-19 at the acute care hospital. Discharge to a post-acute care setting should be to a facility that can safely and effectively isolate the patient as it is still uncertainty around how long patients remain contagious after clinical recovery. These guidelines will be revised as additional information becomes available.

Consequently, specialized rehabilitation care environments will need to be developed to treat patients who are recovering from COVID-19 while still potentially contagious.

One approach would be to develop dedicated "centers of excellence" specializing in—and assuming—the care of patients recovering from COVID-19. Staff would need to receive appropriate safety equipment and training to provide this care safely.

MossRehab is proposing the development of such a care unit.

Admission criteria to MossRehab COVID19 UNIT

- 7 days from diagnosis of COVID19
- at least 72 hrs. with no fever and on no fever reducing medication
- if using aerosol treatments should be in private room
- no need for suction
- oxygen need ≤5 L at rest
- no nursing home residents
- improving symptoms and in need of rehabilitation while also considering individual psychosocial needs such as home environment and impact on family members

Process for admission will include discussion with attending physiatrists working in unit

- Need for rehabilitation and ability to tolerate such
- Patient would be admitted to the designated rehab unit if transmission-based precautions are not required
- If transmission-based precaution still required or persistent symptoms including coughing, oxygen use or muscle aches, then

Patient will go to segregated unit (3W) with other active or confirmed cases in recovery

Patients will go to a single room

Patients will be treated by an assigned rehabilitation team with the least amount of rotating staff. If needed use longer shifts and assure staff safety by using appropriate PPE

All staff working on this unit will be checked for temperature and symptoms before and after each shift

All radiographic studies to be done using portable unit.

Every rapid response and code is treated as if patient is COVID-19 positive.

Staff will wear the following Airborne precautions items:
PPE must remain in place and be worn correctly for the duration of exposure to potentially contaminated areas.
PPE, particularly masks should not be adjusted during patient care.

- An N95 mask
- Fluid resistant long-sleeved gown
- Goggles/face shield
- Gloves
- Hair should be tied back out of the face and eyes
- Shoes that are impermeable to liquids and can be wiped down. Use of shoe covers is not recommended

Staff should remove all personal items before entering clinical areas and donning PPE. This includes earrings, watches, lanyards, mobile phones, pagers, pens etc.
Use dedicated stethoscopes and pens within isolation areas.
It is recommended that all PPE donning and doffing are supervised by an additional appropriately trained staff member.

All equipment will be kept in the unit and fully cleaned before moved, X-ray equipment to be cleaned before returning to other use.

If aerosol treatment is provided will close door, use portable filter and use PPE

Patients will have temperature measured q/shift, close monitoring for respiratory symptoms and O2 needs

Patients may use humidified supplemental oxygen through a face mask

Meals will be served if appropriate in all disposable containers including the tray and consumed in the patient room.

No visitors allowed

Laundry if needed will be performed on site and if needed in biodegradable wash bag

Any clothing sent home should go in similar bag inside a plastic bag and handle with gloves

Patients can be discharged from the healthcare facility whenever clinically indicated.

Upon discharged to home:

- Isolation should be maintained at home if the patient returns home before discontinuation of Transmission-Based Precautions. The decision to send the patient home should be made in consultation with the patient's clinical care team and local or

state public health departments. It should include considerations of the home's suitability for and patient's ability to adhere to home isolation recommendations, all rehabilitation equipment will be cleaned before sending home

- Patient and family education on how to continue home isolation as needed and implementation of home exercise program.
- If discharged to a long-term care or assisted living facility they will need 2 negative tests AND
- Transmission-Based Precautions have been discontinued, but the patient has persistent symptoms from COVID19 (e.g., persistent cough), they should be placed in a single room, be restricted to their room,
- Transmission-Based Precautions have been discontinued and the patient's symptoms have resolved, they do not require further restrictions, based upon their history of COVID-19.

Acute care transfers of -COVID19 patients:

- In case of acute care transfer need of patients if in stable enough condition transfer to medicine unit.

- If unstable can go to the ED ensuring that staff is aware of the status of these patients so they are ready