Organization of acute patients' transfer to rehabilitation services during COVID-19 crisis.

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The current COVID-19 epidemic is influencing the Israeli Rehabilitation infrastructure and practice in many forms. At this point, in Israel we are mostly facing problems of epidemiologic restrictions - and not a large number of infected patients (although this has entered the stage of exponential growth). Our health system, including our specialty, is putting a lot of effort into preparing ourselves for worst case scenarios. A few changes have already taken place:

1. Almost all day-rehabilitation facilities are closed, mostly due to patients' refusal to come and expose themselves to infection.
2. Most of the acute patients, with a necessity for rehabilitation, prefer to go home and not to enter an in-patient multidisciplinary program.
3. Acute wards' staff and hospital administration are "pushing" patients from those departments to keep beds empty and ready for potential patients of COVID-19.
4. Outpatient and supportive structures are collapsing due to partial closure, epidemic restrictions and staff loss.

These considerations have made the decision about optimal transfer of the acute patient to the appropriate type of rehabilitation services much more challenging than previously. The number of options has decreased, the patients' preferences changed and the list of familiar caregivers lost its relevance. In our hospital, the Rehabilitation and Physical Medicine department doctors were always in charge of such decisions and we did it via daily rounds - with professional assessment of all referred patients in the “acute” departments. At present, we decided that it must be the task of one of the most experienced senior rehabilitation doctors to find an optimal destination for each patient in the shortest time. On the other hand, it is unsafe to expose such specialists to the various acute wards in the hospital.

The following regional schema was established:

- All requests were referred to the Senior PRM doctor (SR) by the electronic medical record (EMR) system.
- The Chief Rehabilitation Doctor of the Southern Regional Department was selected as the SR and is working remotely, without entering the hospital.
- The information used for decision making is the following: The acute staff (doctor, nurse, social worker, physiotherapist, occupational therapist or speech therapist when needed) documents the clinical findings in the chart.
- If this information is not sufficient one of the PRM residents goes and physically assesses the patient. (This is also minimized to prevent unnecessary exposure to the other departments).
- SR's decision is transferred the same day by the EMR to the acute department, the appropriate Health Fund for funding approval and to the appropriate Rehabilitation facility for admission planning.

Over the past 10 days, the results of this scheme seem positive, with high efficiency, effectiveness and level of satisfaction of all the pertinent parties. In addition to the standard cases, a few scenarios were created on an individual basis, as in these presented cases:

- For one oncological immunocompromised patient with severe deconditioning, an individual plan of reconditioning was built - with physiotherapist and PRM doctor backup in the oncology ward. Normally, this patient would be admitted to the rehabilitation department, however, given the current situation, this decision was made for the patient’s safety – as the oncology ward is more insulated from the outside.
- Two patients (one after a moderate stroke and one after avascular below knee amputation) were admitted to the in-patient rehabilitation due to the need for multidisciplinary assessment and treatment and the absence of day–rehabilitation institutions in the region. Normally, these patients would be transferred to day–rehabilitation departments.
- Two patients after mild stroke were assessed in the neurology department, trained there with a home exercise program, referred for a short physiotherapy course in the (still operating) outpatient clinic and discharged home. In regular times they would be transferred to day–rehabilitation departments for primary assessment and appropriate programs.

In our opinion this regional management scheme can be very helpful and safe during the COVID-19 crisis. As the situation fluctuates daily, if not hourly, all plans are in constant flux, but this demonstrates the approach to preserve the medical staff from exposure to infection as much as possible, while maintaining highest possible level of care and maximizing the number of patients we can treat.