EDITORIAL

Rehabilitation & Tele-Practice in Covid-19 Era

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Cite This Article as: Niazi IK. Rehabilitation & Tele-Practice in Covid-19 Era. JRCRS. 2020; 8(1):1-2

The most debated topic with no convergence of views globally is the COVID-19 pandemic and its impact on health care practice, policy, education, and research. Health professionals face challenges and resort to working from home while this novel infection defies all remedies known in the annals of medical science.

Rehabilitation healthcare professionals are grappling with recent varied clinical insights, emerging guidelines, and experiences, mutating as the virus itself with some following recognized health care principles, comprising of strategies like crisis preparation, resource conservation, substitution, adaption and rolling over of man and material.[1]

Italy was apparently the worst afflicted in terms of fatalities and flattening of the peak appears to be a source of solace. The frontline and what is termed as first responders comprised of varied professionals. The closer the proximity the more the probability increases of contracting this biological agent. Initially and as of today in many clinical settings across disperse regions protective gear is in short supply which is a high risk area for the healthcare personnel and a similar state exists for diagnostic equipment and ventilators. Attending to suspect or confirmed COVID-19 patients donning protective gear not meeting health safety requirements is unlikely to offer adequate protection. The downturn is that if Italy and France COVID-19 experiences are studied healthcare workers especially in the rehabilitation phase may experience considerably lower rates of infection and fatalities attributable to the lack of rehabilitative care as the high mortality toll, lack of beds, etc. did not permit rehabilitative care to take place at a corresponding pace.[2] It is an enigma whether Pakistan has issued notifications of COVID-19 as proscribed occupational diseases as that would entail adherence to stringent criteria for working in the healthcare sector.

The disease by itself is almost mocking as in some patients it may cause fatal pneumonia whereas others experience mild symptoms. No doubt the aged and elderly are at high risk and would subsequently require rehabilitative care for a longer duration to become functional, however, delivering rehabilitation services in a pre-COVID-19 manner is no longer pragmatic. The mental outlook of healthcare professionals as seen from the experience of China and Italy witnessed a withdrawal from clinical and hospital settings and a survey from Guangzhou revealed a very high prevalence of depression (51%), anxiety (45%), insomnia (36%) and symptoms of distress (73%).[3]

Post-COVID-19 rehabilitation will be complex and require specialized multidisciplinary, inter provincial, inter agency cooperation, and recourse to regular funding for clinical treatment in terms of human and material resources. The elderly and aged may be weaned from their ongoing rehabilitative treatment to divert resources to second or third waves of a pandemic. Rehabilitation models have to be developed on priority from the models that are being followed worldwide in this scourge of pandemic. There can be no single approach and depending upon co-morbidity factors standardized protocols may need to be individualized. Unfortunately, no significant rise in state funding is being witnessed in Pakistan. Lockdowns are pushing the ordinary citizen of Pakistan below the poverty line, and as nutrition is further

compromised the risk of lowering immune systems is grave. The frail and elderly are at the highest risk. The focus of the relevant policy makers should be primarily of healthcare rehabilitative research that is accessible through digital platforms rather than propriety basis.

Aggravating the pandemic and eventually disproportionately increasing the burden of the creaking health infrastructure in Pakistan it is a cause of concern that non-emergency rehabilitation programs have been deferred, which could have been shifted to remote digital applications so that rehabilitative care could have continued albeit limitations. To keep pace with the surge in rehabilitative care one option is to train and produce more rehabilitation healthcare professionals, requiring four to six years. The next generation of rehabilitation warriors will need to have a diverse skill set like telerehabilitation, as they may be encountering the aftermath of this pandemic. Till this desirable state of healthcare is achieved the slack can be taken up by significant investment in rehabilitative digital connectivity, rehabilitation telehealth being a viable alternative provided quality of service is maintained[4], achievable with education and training. Rehabilitative telehealth is an interactive digitally based communication between the patient and rehabilitation healthcare professional. Technologically phrasing there is an originating site supported by a secure mobile application and the patient can enter electronically through an electronic out care patient department (OPD) portal with a digital repository. However, in Pakistan with low digital literacy at the patient's level, internet connectivity issues, cognitive issues in elderly this might not be easy. Further, there cannot be any deviation from rehabilitation protocols or corner cutting. Hence clearly defined rehabilitation plans as well as telemedicine including virtual check-ins are essential.[5] Such a rehabilitation overview entails training and enhanced funding by state and philanthropy as well as the temporary loosening of national licensing criteria for rehabilitative telehealth practice. A cautious approach is initially recommended for ensuring the utmost care on the ethical front.

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