The RCA provided a webinar on *Rehab for Post COVID-19 Condition* on July 20 2021. Over 500 people attended. This document outlines the questions that were submitted during the session that could not be addressed during the webinar. The questions and answers are organized by speaker. The presentation and recording of the webinar are available here.

Responses to the questions have been provided by the following speakers:

Petra O'Connell, B.Sc., MHSA
Senior Provincial Director for the Neurosciences, Rehabilitation & Vision Strategic Clinical Network (NRV SCN) and Diabetes, Obesity & Nutrition Strategic Clinical Network (DON SCN), Alberta Health Services.

Sylvia Pearce, RN, MScN
Director for Post-Acute Care, The Ottawa Hospital.

Darlene Stafford, PT, BScPT
Manager of Program Development and Innovation for the Ontario Workers Network (OWN).

Q&A – Petra O'Connell

1. How are people being triaged into the Alberta Rehabilitation Pathway in terms of accessing care?

- We are working with our health care partners in acute care, long term care, primary care and community care settings to routinely build the screening and functional assessment tools into their teams' routine clinical practice whenever they encounter a patient with COVID. Depending on the results they are referred to the appropriate rehabilitation provider (virtual, group in-person or individual personalized care). The tools were developed for use by a wide variety of health care providers, including nurse, allied health, physicians.

- Individuals living in the community can also directly access services and resources available though our Rehabilitation Advice Line which is linked to our Health Link telephone network. They can also register for virtual information sessions offered by our provincial Alberta Healthy Living Program.

2. Has your material been translated to French?

- Yes, our primary Patient Self Care Resource is available online in multiple languages including French.

3. The gradations in the Symptom checklist questionnaire are quite broad. Has the research been done yet on the questionnaire to know that these are valid and measure meaningful change in function? (what is the level of change that is observed to be "meaningful") Is it important to also have objective measures of function to fully describe the impact of COVID on the individual's ability to function?

- The checklist is not intended to measure function. It is meant to serve as a comprehensive checklist to determine what symptoms people have. It is important to understand symptoms before we can measure function that is correlated with it. The checklist was derived from the UK

Yorkshire Tool. We still have a lot more to learn about this, so the first step is to understand the symptoms, and then eventually the functional assessment. Similar functional deficits could be caused by different symptoms - without understanding the symptoms and even diagnoses, we may be providing rehab treatments that may not be targeting the cause of the impairments and functional deficits. *(See also response from Sylvia Pearce to this question.)*

Q&A – Sylvia Pearce

1. The gradations in the Symptom checklist questionnaire are quite broad. Has the research been done yet on the questionnaire to know that these are valid and measure meaningful change in function? (what is the level of change that is observed to be "meaningful") Is it important to also have objective measures of function to fully describe the impact of COVID on the individual's ability to function?

   - The symptom checklist was borrowed from Alberta Health Services which was adapted from the UK C19-YRS telephone screening tool.* It is a quick tool to be used over the phone and not intended to be a valid outcome measure. The Nurse Practitioner uses the tool to screen patients to determine if additional investigations are required before starting the rehab program as well as used to collate information to provide a comprehensive pre-program assessment available in the patient's EMR. The interdisciplinary team and MD have the information available to them prior to their meeting with the patient.

   - For objective measures – patient receive pre-post (3-months) program questionnaires which include WHODAS 2.0; EQ 5D-5L; MFIS; GAD-7; PHQ-9; Sit to stand with Modified BORG.

   *https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-post-covid-response-framework-sum-appendices.pdf
   Adapted from: Sivan M, Halpin S, Gee J. Assessing long term rehabilitation needs in COVID-19 survivors using a telephonescreening tool (C19-YRS tool). ACNR. 2020; 19 (4): 14-7. doi: https://doi.org/10.47795/NELE5960 is used under CC BY 4.0

2. Is a positive PCR test required for the Ottawa program?

   - No, however clinical correlation is required – sequelae of post viral symptoms with no other clinical explanation (for current cohort of patients ID have ruled out any other cause).

3. Looking for how home based management could be integrated. COVID-19 Rehab Streams at TOH are 2 levels of Virtual program and one inpatient program.

   - As per Post-COVID-19 Functional Status Scale (PCFS): Grade 0-1 - web/app based self-management program with a health coach (3-month)(in development phase); Grade 2-3 - interdisciplinary group-based virtual rehabilitation program – 4-week – BOTH are done in the home

4. Virtual program offered by The Ottawa Hospital - how do you reach those that don't have access to technology?

- We are looking into offering a lending library with tablets and internet access.

5. In the Ottawa program, can patients in the group program repeat it if still needed or can only attend once?
   - At this point patients can only complete the program once due to the waitlist. The patients can graduate to web based/app platform with health coach if they require more support.

6. How many minutes/hours is each group session at the Ottawa Hospital?
   - Virtual interdisciplinary group program is q MWF from 10-1200 for 4-weeks.

7. In the rehab programs, is there a nutrition component for individuals with muscle wasting and deconditioning and likely malnutrition?
   - We recognized this as a gap in our program. Our Nutrition colleagues will now offer an education session and prepare an education module for the web/app based platform.

8. Is Therapeutic Recreation ever a consideration in rehab to support psychosocial goals, returning to leisure activities of interest and/or identifying adaptive strategies and or identifying new opportunities to support wellbeing and recovery?
   - While Therapeutic Recreation is not involved as a service, the interdisciplinary team of OT/PT/RT and Psychology work on these meaningful goals and strategies with patients.

9. I find it interesting that there has been no mention of SLP services during COVID-19 rehabilitation for cognitive-communication and dysphagia due to changes in respiratory status. Is there a plan to include this discipline in outpatient services and/or research?
   - While not part of the COVID-19 rehab team directly, patients can access these services through an ambulatory care consult. So far, our outpatients have not required the service – can certainly explore if more patients require this service. Inpatient COVID-19 rehab patients are seen as required.

Q&A – Darlene Stafford

1. How should individuals deal with private insurance companies who deny claims stating that the person's position is sedentary, although requires high cognitive functioning?
   - Objective testing is the most effective way of managing this situation, whether it be using a formalized cognitive battery or well-documented observations during treatment.

2. In my experience, WSIB programs are often prescriptive and with more rigidity in terms of return to work planning and implementation. How does this reconcile and compare with the "go slow" methodology discussed earlier on in this presentation? How much flexibility and individualization is built into the return to work planning?
   - Our experience with WSIB and the return to work process has been very positive. As rehabilitation of the patient with post COVID-19 condition is new territory for all of us, WSIB

included, collaborative discussion since the beginning of this program has resulted in a shared understanding of the most appropriate way to manage return to work. Evidence and patient experience have taught us that measured progression with respect to return is the most effective strategy.

- Individualization is a crucial concept in assessment, treatment, and development of return to work plans for these patients. Each patient can and does present vastly different from the next and this variability is also seen in their respective job demands and workplace environments. Return to work plans are individualized for the patient.

- Flexibility is built into the return to work plan. For patients that we see for treatment, functional testing is part of the treatment intake process; this comprehensive intake assessment facilitates the development of an effective return to work plan plus oversight as to how the patient is managing with the return to work process. If the patient is attending treatment in the community, a call to the community healthcare professional following assessment ensures an integrated approach to managing return to work. Collaborative meeting with Return to Work Specialists from WSIB is also a key component of developing an appropriate plan as it allows for exchange of information considering all factors; pre-accident job demands, availability of modified duties, proposed work restrictions, limitations, and accommodations, etc. The patient is part of this meeting. Creating a plan that is flexible and responsiveness to change is dependent upon effective communication.