This document provides guidance on referring people who have recovered from COVID-19 and are experiencing ongoing symptoms, to multidisciplinary rehabilitation assessment and management.

The long tail of COVID-19

Research into COVID-19 in Italy and the UK found that over 80% of those who have recovered from COVID-19 continue to suffer from at least one symptom for a minimum of three months. This is echoed by interim results from unpublished data from ongoing Australian and UK studies.

These ongoing symptoms are now being referred to as ‘the long tail of COVID’. The most commonly reported symptoms are fatigue, dyspnoea, weakness and pain, although many with moderate and severe COVID-19 suffer from extra-pulmonary complications including renal failure, neuropathy and myopathy, and thromboembolism.

Further to those suffering ongoing effects of COVID-19, many other people who rely on regular face-to-face rehabilitation services in the community are suffering functional deterioration as a result of social isolation and/or lack of access to usual services, which may lead to falls, infections, poor wound healing, peripheral oedema, venous thromboembolism, mental health issues and carer strain.

COVID-19, primary care and rehabilitation

Published in October 2020, the Royal Australian College of General Practitioners’ document Caring for adult patients with post-COVID-19 conditions, provides guidance for the community management of post-COVID-19 illness.

Many ongoing symptoms of COVID-19 can be appropriately and effectively handled in community general practice (GP) and primary care. This includes a number of conditions that would respond to standard rehabilitation interventions that can be easily undertaken in the community setting, supervised by GPs using team care arrangements, mental health plans and regular coordination of allied health.

All rehabilitation interventions in general practice should be coordinated by the GP with regular coordination, case conferencing and a distinct, documented set of time-limited goals. There needs to be an admission case conference and a discharge case conference to define goals, assess goal achievement dates and completion of rehabilitation. Practice nurses may be able to assist in the coordination of these case conferences. It is assumed that all organic causes of the symptoms have been excluded and that the ongoing symptoms can be attributed to a prior COVID-19 diagnosis.
What is multidisciplinary rehabilitation?

Rehabilitation medicine can offer a range of community-based services for those recovering from COVID-19 requiring management from a number of disciplines of care, including medicine, allied health and nursing. This type of rehabilitation is particularly relevant for those with persistent symptoms, i.e. three months or more post COVID-19 diagnosis and/or extra-pulmonary complications.

Multidisciplinary rehabilitation teams are led by rehabilitation medicine physicians who coordinate a process of care by nurses, doctors and allied health therapists. Doctors in the team undertake medical liaison with treating clinical teams (neurology, psychiatry, respiratory physicians, etc.) as well as oversee ongoing management of other comorbidities if required.

Rehabilitation medicine can be delivered in the home, at an outpatient clinic or day facility, or via telerehabilitation. Telerehabilitation services can also be offered to people living with physical or intellectual disabilities, who depend on regular rehabilitation services such as exercise physiology, physiotherapy, speech pathology, cognitive rehabilitation or psychological treatments, to maintain a level of independence and optimal mobility, self-care, communication and/or cardiovascular and cognitive functioning.

Who to refer?

For people with symptoms who can be appropriately managed by a GP, it is reasonable for the practice nurse to take on a coordination role, provided the GP is present to ensure access to the relevant MBS claim code.

People with symptoms that are disabling or causing functional limitation may need referral to a rehabilitation physician for multidisciplinary rehabilitation. GP-coordinated rehabilitation may be appropriate as an interim measure while they are awaiting access to more comprehensive rehabilitation.

Referral to a rehabilitation physician or a multidisciplinary rehabilitation service in the public sector is appropriate when:

- GP-based rehabilitation programs are not meeting goals of care
- the GP determines the patient’s safety is at risk despite optimal therapy, e.g. recurrent falls at home
- it is not possible to coordinate two or more therapists using a goal-directed case conference system due to time constraints or a lack of resources
- patients are unable to afford the required number of community-based rehabilitation sessions and need access to publicly funded programs, such as a hospital-based pulmonary or other rehabilitation program
- the patient requests the continuation of existing service provision to rehabilitation hospital or centre based care that is already being attended
- there is a need for increased diversity and intensity of existing single discipline interventions by allied health practitioners
- patients with pulmonary symptoms are known to a pulmonary rehabilitation service, e.g. COPD.

It is appropriate to refer a person to a rehabilitation physician in the private sector if:

- the above referral criteria are met
- they have access to financial resources, such as private health insurance and workers compensation.
Rehabilitation prescription for general practice

The rehabilitation prescription is dependent on the achievement of specific rehabilitation goals.

In general practice, there is access via Medicare to five sessions of allied health therapy and 20 sessions of psychological treatments per calendar year through various team care arrangements. For some patients, these sessions can be supplemented by private services where financial resources exist. This means that a limited rehabilitation course of treatment can be managed in general practice for patients suffering from functional decline due to symptoms associated with long COVID (weakness, fatigue, dyspnoea, pain etc.).

Goals need to be set at the beginning of the course of rehabilitation, and it is critical that reviews of functional goals are undertaken throughout the course of treatment and signed off as achieved at the end of the rehabilitation intervention.

This means undertaking regular case conferences with the allied health and nursing team, patients should also be included throughout the course of treatment. These case conferences are supported by MBS item numbers.

These case conferences are important because they review patient safety, the success or otherwise of the course of treatment and allow for changes in treatment goals or interventions. Without case conferences, the definition of multidisciplinary rehabilitation and the patient safety requirements associated with it are not achieved.

Included in this document is a sample of a case conference document for rehabilitation following functional decline associated with post-COVID-19 fatigue, a common symptom of long COVID. It forms part of the Health Pathways documentation.

Methodology

This document was developed by members of the Rehabilitation Community of Practice Executive Group in consultation with directors of rehabilitation services, rehabilitation physicians and other rehabilitation clinicians working in both the public and private sectors. Consultation with Dr Louise Delaney (Clinical Lead Advice and Support, Health Pathways Community) and colleagues from the HealthPathways Community and Royal Australian College of General Practitioners also informed the production of this document.

Document authors identified and reviewed relevant published research. Searches using Twitter were conducted between 10 September and 2 November using search terms ‘long covid’, ‘long tail of COVID’ and ‘primary care’.

The rationale for the communications and referral documents comes from five key sources:

- existing international guidelines on rehabilitation for those suffering from COVID-19
- research regarding early rehabilitation for a variety of conditions that cause temporary or permanent disability
- existing Agency for Clinical Innovation documents regarding models of care for rehabilitation
- limited evidence for early rehabilitation following COVID-19
- research on the ongoing symptoms following a diagnosis of COVID-19, commonly referred to as ‘the long tail of COVID’.
Appendix: Information required for rehabilitation referral

Patient information and clinical details that should be provided in the rehabilitation referral.

**Patient information**

- Patient details including name, contact details, date of birth
- Medicare and/or Department of Veteran Affairs number
- Whether an interpreter is required and the language
- If the patient is Aboriginal and Torres Strait Islander
- If the patient is an Australian resident
- Employment information, pre-pandemic, before illness and current status.

**COVID-19 illness information**

- Date of COVID-19 onset
- Swab dates
- Hospital admission dates (if relevant)
- ICU admission dates (if relevant).

**Current goals**

Below is a table that should be included in the patient file with some sample goals for one symptom (e.g., fatigue) and explanations in italics.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Goals</th>
<th>Metrics</th>
<th>Date achieved or abandoned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical/nursing</td>
<td>(e.g. for fatigue – medication review, minimise sedation)</td>
<td>Minimise benzodiazepines/antihistamines etc. during day</td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>(e.g. for fatigue – up to 30 min endurance exercise 3 times a week)</td>
<td>2 min walk test greater than 100m</td>
<td></td>
</tr>
<tr>
<td>Functional</td>
<td>(e.g. for fatigue – home visit focus on energy conservation)</td>
<td>Independent personal ADLs or cooking</td>
<td></td>
</tr>
<tr>
<td>Psychosocial</td>
<td>(e.g. for fatigue – CBT for depression/anxiety management)</td>
<td>Meditation session for 20 min, 2–3 times a week</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>(e.g. for fatigue – high energy/protein diet, increase iron in diet)</td>
<td>Albumin levels within normal range Monitoring of weight</td>
<td></td>
</tr>
</tbody>
</table>
Multidisciplinary rehabilitation communication and referral

COVID-19 Yorkshire Rehabilitation Screen

Covid 19 Yorkshire Rehab Screen (C19-YRS)

Patient name and NHS number:

Time and date of call:

Staff member making call:

We are getting in touch with people who have been discharged after having had a diagnosis of coronavirus disease (COVID-19). The purpose of this call is to find out if you are experiencing problems related to your recent illness with coronavirus. We will document this in your clinical notes. We will use this information to direct you to services you may need and inform the development of these services in the future.

This call will take around 15 minutes. If there is any topic you don’t want to talk about you can stop the conversation at any point. Do you agree to talk to me about this today? Yes ☐ No ☐

Opening questions:

Have you had any further medical problems or needed to go back to hospital since your discharge?

Re-admitted? Yes ☐ No ☐

Details:

Have you used any other health services since discharge (e.g. your GP)?

Yes ☐ No ☐

Details:

I’ll ask some questions about how you might have been affected since your illness. If there are other ways that you’ve been affected then there will be a chance to let me know these at the end.

1. Breathelessness

On a scale of 0-10, with 0 being not breathless at all, and 10 being extremely breathless, how breathless are you:

(a) At rest:

0-10: ______

(b) On dressing yourself:

0-10: ______

(c) On walking up a flight of stairs:

0-10: ______

2. Sleep

Have you had any difficulty getting to sleep? Yes ☐ No ☐

Details:

3. Depression

On a scale of 0-10, how severe is the depression you are experiencing?

Time and date of call:

Patient name and NHS number:

Details:

4. Cognitive-discomfort

On a scale of 0-10, how severe is the discomfort you are experiencing:

(a) At rest:

0-10: ______

(b) On dressing yourself:

0-10: ______

(c) On walking up a flight of stairs:

0-10: ______

5. Pain/

On a scale of 0-10, how severe is the pain you are experiencing?

(a) At rest:

0-10: ______

(b) On dressing yourself:

0-10: ______

(c) On walking up a flight of stairs:

0-10: ______

6. Mobility

On a 0-10 scale, how severe are any problems you have in walking about?

0 means I have no problems, 10 means I am completely unable to walk about.

Now:

0-10: ______

Pre-Covid:

0-10: ______

7. Fatigue

On a 0-10 scale, how severely do you think you are fatigued?

0 means I have no problems, 10 means I am completely unable to do my usual activities.

Now:

0-10: ______

Pre-Covid:

0-10: ______

8. Personal Care

On a 0-10 scale, how severe are any problems you have in personal cares such as washing and dressing yourself?

0 means I have no problems, 10 means I am completely unable to do my personal care.

Now:

0-10: ______

Pre-Covid:

0-10: ______

9. Continence

Have you developed any changes in the control of your bowel and bladder?

Yes ☐ No ☐

Details:

10. Usual Activities

On a 0-10 scale, how severe are any problems you have in doing your usual activities, such as being able to do your household role, leisure activities, work or study?

0 means I have no problems, 10 means I am completely unable to do my usual activities.

Now:

0-10: ______

Pre-Covid:

0-10: ______

11. Pain/discomfort

On a 0-10 scale, how severe is any pain or discomfort you have?

0 means I have no pain or discomfort, 10 means I have extremely severe pain.

Now:

0-10: ______

Pre-Covid:

0-10: ______

12. Cognition

Since your illness have you had new or worsened difficulties with:

• concentrating? Yes ☐ No ☐

• short term memory? Yes ☐ No ☐

13. Communication

Have you or your family noticed any changes in the way you communicate with people, such as making sense of things people say to you, putting thoughts into words, difficulty reading or having a conversation?

Yes ☐ No ☐

Details:

14. Anxiety

On a 0-10 scale, how severe is the anxiety you are experiencing?

0 means I am not anxious, 10 means I am extremely anxious.

Now:

0-10: ______

Pre-Covid:

0-10: ______

15. Depression

On a 0-10 scale, how severe is the depression you are experiencing?

0 means I am not depressed, 10 means I have extreme depression.

Now:

0-10: ______

Pre-Covid:

0-10: ______

16. PTSD screen

(a) Have you had any unwelcome memories of your illness or hospital admission whilst you were awake, so not counting dreams? Yes ☐ No ☐

If yes, how much do these memories bother you?

• mild ☐ moderate ☐ severe ☐ extreme ☐

(b) Have you had any unpleasant dreams about your illness or hospital admission?

Yes: ☐ No ☐

If yes, how much do these dreams bother you?

• mild ☐ moderate ☐ severe ☐ extreme ☐

(c) Have you tried to avoid thoughts or feelings about your illness or hospital admission?

Yes: ☐ No ☐

If yes, how much effort do you make to avoid these thoughts or feelings?

• mild ☐ moderate ☐ severe ☐ extreme ☐

(d) Are you currently having thoughts about harming yourself in any way? Yes ☐ No ☐

Details:

17. Global Perceived Health

How good or bad is your health overall? 10 means the best health you can imagine. 0 means the worst health you can imagine.

0-10: ______

18. Vocation

What is your employment situation and have your illness affected your ability to do your usual work?

Occupation: ______________________

Employment status now: ______________________

Employment status before Covid-19 Lockdown: ______________________

Employment status before you became ill: ______________________

19. Family/carer views

Do you think your family or carer would have anything to add from their perspective?

Details:

20. Other discussion (clinical notes):

Details:

Closing questions:

Are you experiencing any other new problems since your illness we haven’t mentioned?

Yes ☐ No ☐

Any other discussion (clinical notes):

Details:

Figure 1. The C19-YRS tool
References


