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SPECIAL COMMUNICATION

A Retrospective Quality Improvement Study to Describe Operational Management Strategies in an Inpatient Rehabilitation Facility During the COVID-19 Pandemic

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Abstract

The delivery of care in the inpatient rehabilitation setting was disrupted during the coronavirus disease 2019 (COVID-19) pandemic. As a 150-bed freestanding inpatient rehabilitation facility in the epicenter of the pandemic, Burke Rehabilitation Hospital was required to increase overall bed capacity for regional overflow needs and still maintain our mission to provide inpatient rehabilitation for patients with and without COVID-19. During the period between March and September 2020, Burke Rehabilitation Hospital treated over 300 rehabilitation patients who were COVID-19 positive and at one point had a census that was >50% COVID-19 positive. A model grounded in 5 priorities—communication, personal protective equipment, clinical service delivery, discharge planning, and patient/staff support—was implemented to reprioritize daily operations and ensure patient and staff safety while providing valuable rehabilitation services. The delivery of physical, occupational, speech, and recreational therapy services transformed, and a number of innovative clinical practices were developed. During the study period, 100% of our patients continued to be scheduled to receive therapy services. Patient length of stay values did increase during the pandemic (from 16.38d to 19.93d), and slightly more patients were discharged to home (68.7% compared with 68.3%). Despite modifications to rehabilitation care delivery, patients continued to make functional gains in the areas of self-care, mobility, and walking. Flexible leadership was pivotal in the development and implementation of new processes and procedures to meet the evolving needs of patients, staff, and the organization as a whole.

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Burke Rehabilitation Hospital is located in suburban New York and includes 10 outpatient clinics in addition to a freestanding 150-bed acute inpatient rehabilitation facility (IRF). Inpatient therapy services are provided to the adult population using a program model. Separate nursing and therapy spaces are used for each of the 5 programs: stroke, brain injury, neurologic/spinal cord, cardiopulmonary, and orthopedic/amputee. The Rehabilitation Services Division, comprising occupational, physical, speech, and recreational therapists, along with rehabilitation aids, works in collaboration with all members of the health care team (physicians, nurses, social workers, neuropsychologists, dieticians, respiratory therapists) to provide patient-centered care to enhance each patient’s quality of life and maximize functional recovery.

The IRF, located in the epicenter of the first wave of the pandemic in the United States, continuously maintained inpatient rehabilitation services for patients with and without COVID-19 while simultaneously increasing hospital bed size to 203 (50% increase over pre–COVID-19 average daily census) in compliance with a New York State Executive Order. The bed increase was achieved through the conversion of 3 therapy gyms into nursing units. During the period between March and September 2020, the hospital treated 343 rehabilitation patients positive for COVID-19, and at one point had a census that was >50% COVID-19 positive. The hospital’s emergency operations plan and incident command center were activated to manage all facets of the crisis. Key policies included those for communication, patient surge capacity, and infection control. The Rehabilitation Services leadership team (vice president and assistant vice president, directors, and supervisors) was tasked with maintaining the quality of care delivery and patient outcomes while concurrently managing staff and patient safety in the context of PPE shortages, infection control issues, a novel disease process, staffing issues, disruptions in the continuum of care, and regulatory changes.

The purpose of this study is to describe operational strategies utilized at Burke Rehabilitation Hospital during the first wave of the COVID-19 pandemic to answer the primary improvement question: What factors allowed for the delivery of interdisciplinary inpatient rehabilitation services during the COVID-19 pandemic? The secondary question is how did the COVID-19 pandemic influence patient outcomes in the inpatient rehabilitation setting?

Methods

This study met local criteria as a quality improvement project and did not need institutional review board review. The authors completed a retrospective review of processes and outcomes during the period between March 1 and September 30, 2020. This time frame represents the height of the first wave of COVID-19, because Burke’s first COVID-19 positive patient was identified on March 16, 2020. It is important to note that the Centers for Medicare and Medicaid Services (CMS) Intensity of Therapy Requirement (“3 hour rule”) was suspended on March 27, 2020; this waiver encouraged IRFs to “strive to provide typical IRF levels of care...” but allowed for deviations from the 3 hours of therapy per day/15 hour per week schedule requirement.

Burke Rehabilitation Hospital prioritized the ongoing provision of inpatient rehabilitation services from the outset of the pandemic, because it was anticipated that patients with both COVID-19 and non-COVID-19 diagnoses would continue to require this level of care. However, numerous operational changes had to be made quickly, and multiple ethical issues, including staff exposure risk, testing delays, and patient care expectations, had to be considered. Because there was no prior model to follow owing to the rare nature of the pandemic’s circumstances and a lack of evidence-based literature in February and March of 2020, multiple leadership brainstorming sessions were used to develop procedures to guide the IRF’s pandemic response within the Rehabilitation Services Division. To maintain inpatient rehabilitation services during the pandemic, the IRF developed processes that aligned with 5 operational priorities: (1) communication; (2) PPE; (3) clinical service delivery; (4) discharge planning; and (5) patient, family, and staff support.

Communication

Effective communication is essential to ensure the smooth operation of any organization. During a crisis such as a pandemic, prioritizing clear, concise, and effective communication is unequivocally the primary objective in maintaining the safety and well-being of patients and employees.

When COVID-19 cases were first reported in our geographic area, the facility quickly prepared for the potential surge. Division leadership immediately restructured our traditional communication structure to a revised formation considered to be effective in a crisis. This included developing backup communication systems. The final communication structure was formatted in an algorithmic-type diagram to allow for easy identification of role responsibility.

Daily huddles attended by division leadership were held to discuss any issues and questions, including, but not limited to, operations, safety, PPE management, and the provision of care as well as addressing the emotional well-being of our staff, including the effect on leaders as well. The huddles provided an effective medium to discuss, synthesize, and analyze the significant volume of information received on a continuous basis.

Within the rehabilitation division, an email distribution list that included all members, both clinical and nonclinical, was created. This “COVID-19 Update” email included information pertinent to maximizing safety and managing the rapidly changing environment. This was only sent by the vice president as updates occurred to minimize miscommunication and volume of emails. Communicating in real time was essential to achieving these goals.

A system was developed for asking questions and disseminating answers. A key to this included identifying team members who would serve as liaisons for a specific topic. The liaisons would present questions and funnel responses back to the vice president who would communicate out 1 message through the established division email. This proved highly effective as it created 1 line of communication, which reduced the chance of misinformation and confusion. An internal communication system for contact tracing and alerting our staff to a potential exposure was also developed.

Personal protective equipment

PPE created a unique set of challenges at the operational and clinical levels. PPE paradigms were developed based on Centers for
Disease Control and Prevention recommendations but were influenced by inventory levels. As in other health care organizations, guidelines changed frequently as new scientific evidence emerged and supplies were made available.

The designation of 2 rehabilitation leaders to PPE/infection control allowed for discrepancies in PPE use to be addressed and resolved. This allowed for a fluid set of PPE guidelines in a user-friendly table format that addressed the unique aspects of rehabilitation care delivery. From March until September of 2020, 5 versions of the PPE guidelines were released to the division (fig 1).

Prior to the pandemic, no staff in the Rehabilitation Division had been fit-tested for N95 masks, because the hospital did not previously treat patients requiring airborne precaution. When the guidelines switched from surgical masks with face shields to the use of N95 masks, the division needed to swiftly respond. To fit-test over 120 employees, all 5 directors were trained to be fit testers by the infection preventionist. Over a 5-day period, the program directors worked in teams, fit-testing team members during extended workday hours.

At the clinical level, PPE inventory levels did influence the delivery of therapy services. Efforts to conserve PPE included reduced total therapy hours, alternate therapy days, strict use of a primary therapist model, and PPE reuse as permitted. Although a hospital-wide reduction in therapy hours was instituted in accordance with the CMS waiver, all other PPE-conserving models were made at the individual patient level, based on each patient’s unique rehabilitation needs.

### Table: PPE Guidelines

| Patients on 1N, 1E, 1W, 2E, 2W (non-PUI, non-COVID positive) | Can same mask be used with multiple patients? | Mask/Shield storage | Can mask/shield be cleaned? | Additional PPE requirements |
|-------------------------------------------------------------|-----------------------------------------------|---------------------|-----------------------------|-----------------------------|
| N95 (must be fit tested) and Face shield | Yes | Plastic bag-keep unsealed or Paper bag | Yes for face shield. **Clean inside first, then outside.** Super Sani Cloth PDI (purple top) is preferred; approved alternates are alcohol wipes, Purell wipes, PDI Screen Cleaner | Gloves |

| Pt is PUI | N95 (must be fit tested) and Face shield | Yes | Plastic bag-keep unsealed or Paper bag | Yes for face shield. **Clean shield IMMEDIATELY after each patient use.** Clean inside first, then outside. Super Sani preferred; alternates are alcohol wipes, Purell wipes, PDI Screen Cleaner | Gown |

| Pt is COVID positive | N95 (must be fit tested) and Face shield | Yes | Plastic bag-keep unsealed or Paper bag | Yes for face shield. **Clean shield IMMEDIATELY after each patient use.** Clean inside first, then outside. Super Sani preferred; alternates are alcohol wipes, Purell wipes, PDI Screen Cleaner | Gown |

| Pt who is on droplet precaution, not related to COVID (i.e. Influenza) | N95 (must be fit tested) and Face shield | Yes | Plastic bag-keep unsealed or Paper bag | Yes for face shield. **Clean shield IMMEDIATELY after each patient use.** Clean inside first, then outside. Super Sani preferred; alternates are alcohol wipes, Purell wipes, PDI Screen Cleaner | Gown |

**Clinical service delivery**

At the start of this pandemic, COVID-19 was a completely novel disease process. As research was published, articles and online continuing education from professional organizations and other reputable sources were shared within the division. Daily medical leadership calls occurred, and relevant information was shared via the email process outlined. Therapy leadership developed patient education and home exercise packets for patients with COVID-19. Copies of exertional and dyspnea scales and other materials typically used on the cardiopulmonary program were provided to all staff. Updated procedures for room air trials, oxygen titration, and home oxygen ordering were developed. During the initial onset of the COVID-19 pandemic, all therapy-related aerosol-generating procedures were discontinued, including chest physical therapy, incentive spirometry, and respiratory muscle strength training devices. As the number of COVID-19–positive cases decreased in the hospital, policy changes only maintained restrictions on these interventions for COVID-19–positive patients.

At the onset of COVID-19, the first step to combating the virus’s spread from a therapy perspective was to discontinue group and concurrent sessions. All immunocompromised, persons under investigation for COVID-19 (PUI), and COVID-19 patient sessions were moved bedside. Additionally, a team of therapists was designated the “immunocompromised team” for transplant/immunocompromised patients; this group did not treat COVID-19–positive patients during the pandemic. Simultaneously, locations for

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Rehabilitation Services
PPE Guidelines
Effective Date: 4/13/2020

![Fig 1](example.png) Example of PPE guidelines presented to staff in table format.

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remaining patients’ therapy sessions were staggered between the gym vs bedside sessions to ensure social distancing in the gyms and reduce hallway traffic.

In early April, as the COVID-19 numbers rose rapidly, Burke Rehabilitation Hospital transitioned 3 of 5 therapy gyms into temporary nursing units to increase available beds per the governor’s mandate. Most of the hospital’s outpatient sites temporarily closed to patients. Many inpatient and outpatient therapy staff were redeployed to respond to the immediate needs of the hospital during this time. A large group of therapists transitioned to the role of “nursing assistant” assigned to all shifts, and others assisted in environmental, foodservice, central supply, social work, and new roles such as temperature screening and PPE distribution.

During this early March/April period, receiving the results of COVID-19 testing took several days, resulting in multiple days of isolation and use of full PPE for all PUIs. Although critical supplies of PPE were being acquired, decisions regarding the therapy scheduling of patients who were COVID-19 positive and PUI had to consider the preservation of PPE. Patients who were COVID-19 positive and PUI received a minimum of 1 hour a day of therapy to limit PPE use and reduce the risk of infection transmission until negative test results were received. These patients also had difficulty tolerating more than 1 hour of therapy due to the disease process resulting in poor endurance. Eventually, all therapy sessions for all patients were moved bedside to mitigate the risk of infection as COVID-19—positive admissions increased.

The surge of patients who were COVID-19 positive at the hospital and the transition to 100% bedside treatments posed many challenges for therapists, including reduced work space, supervision and mentoring by leadership, patient treatment time, use of equipment and technology, and ability to provide caregiver training. Rehabilitation aides were used to assist with cleaning of equipment to preserve therapist treatment time. Any equipment brought into a patient’s room for therapy was small, cleanable, and ideally single use only. Staff needed to be creative in the room to mimic home situations in preparation for home discharges.

As the number of COVID-19—positive cases reduced over time in New York state, the option to bring COVID-19—negative patients outdoors as well as to trial stairs, the simulated car, and simulated tub/shower transfers in a common treatment space for discharge planning became a safe option. These decisions were made on a case-by-case basis under the guidance of therapy leadership. After a period without an increase in COVID-19 cases, the decision was made in consultation with the medical staff to resume a trial of therapy in the gyms. Significant procedures were developed to ensure that cleaning, physical distancing, and safe transportation would occur as gym sessions resumed. Eventually, all surge nursing units were transformed back into therapy gyms. Clinical supervisors again alternated scheduling sessions for patients who were COVID-19 negative in the gym vs bedside to maximize social distancing in the gym. Although therapy returned to the gym, all therapy initial evaluations remained bedside for observation of symptoms and test results. Once confirmed COVID-19 negative, patients received at least 1 therapy session in the gym with access to all pre-COVID-19 equipment and the rest remained bedside. At the end of the study period, all therapy remained a combination of bedside, gym, and office sessions.

Discharge planning

The COVID-19 pandemic affected many aspects of the discharge process at Burke. Access to discharge locations fluctuated based on changing regulations outlined by New York State Governor Andrew Cuomo. Initially skilled nursing facilities were able to accept patients who were COVID-19 positive, but that changed early on. Prior to the pandemic, the hospital discharged a portion of patients to skilled nursing facilities when they were not able to return home owing to medical needs, social supports, or functional status that would not allow for a safe home discharge. During the pandemic, only when a patient tested negative could they then be considered for skilled nursing facility discharge or discharge to communal environments in which they were unable to self-isolate. This change required some patients to remain at the hospital longer than usual. A strain on the discharge planning process occurred for those patients who continued to test positive for weeks. Home discharges were also affected by numerous challenges. Family members were fearful to have patients discharge to their home if they were still testing positive owing to concerns of viral spread. Some families were not physically well enough to care for the patient at discharge because the caregiver was sick with COVID-19.

Because of COVID-19, many services in the community were initially unavailable or restricted. Home care and home health aide services were limited throughout the pandemic. Important services, such as Meals on Wheels and transportation, were not able to be put in place. Once home, many patients were not able to make follow-up medical or therapy appointments due to outpatient facility closures or reduced hours. Limitations in access to follow-up care prolonged the discharge process for many patients.

Restrictions on visitors and family participation in care were put in place at all hospitals. Family training had to be completed using phone calls or video conferencing or, in certain instances, families came to the IRF and completed simulated training with staff members. Some patients received family training on the day of discharge when family members came to pick them up. Families often had not seen the patients for weeks or months due to visitor restrictions at all hospitals.

Patient, family, and staff support

The COVID-19 pandemic was emotionally challenging for patients due to the novelty of the virus and the isolation from human interaction due to visitor restrictions and PPE. Leadership worked to develop new initiatives to support patients and staff during this period. Owing to visitor restrictions, many patients had very few clothing items to wear. Burke Rehabilitation Hospital purchased large quantities of clothing, self-care items, and cell phone chargers. Not only did these items allow patients to feel more like themselves but patients also reported feeling very loved and cared for by the hospital. To provide more access to families, staff members used tablets to videoconference their loved ones. This provided relief to both the patients and the families, who often reported feeling helpless. Recreational therapy staff additionally called each patient upon admission and delivered in-room leisure resources to patients based on their interests. These included current magazines, word search and crossword books, anagrams, adult coloring books with colored pencils, puzzles, cards, adult dot to dot, craft supplies, movies, music, and a daily activity sheet. A virtual pet therapy program was also developed and initiated.

Support of staff was an important component of the COVID-19 response. Hospital-wide initiatives included months of free food.
and snacks, sponsored by administration and community volunteers. At the division level, directors and supervisors monitored staff for signs of burnout and fatigue and encouraged staff to use available resources such as the Employee Assistance Program. Procedures such as creating periods of non-patient care time were used to give staff members time to decompress and allowed them opportunities to take a walk, get a snack, or simply rest during their workday. Mood-boosting activities like gym decorations, dance videos, and scrub cap design contests allowed for positive and safe interactions with colleagues. Daily division leadership huddles were used to identify staff related issues, including staffing needs, issues addressing their well-being, and outcomes of these initiatives.

Study of the intervention

Burke Rehabilitation Hospital used its outcome data to assess the effectiveness of care provided during this time and compared it to care provided prior to the pandemic. Outcome measures included percentage of patients who were scheduled to receive interdisciplinary rehabilitation therapy services for a minimum of 5 days per week, average length of stay, percentage of patients discharged to the community, and functional outcomes measured by Coding Section GG scores.8

The analysis included a mixed methods design using both qualitative and quantitative approaches. The qualitative approach involved real-time adjustment to safety measures, staffing needs, and attention to patient and staff well-being. The quantitative approach used the outcomes that are regularly collected in the IRF setting.

Results

Operational priorities

Figure 2 illustrates the timeline relationship between Burke’s COVID-19—positive patient census and key operational strategy changes.

![Fig 2 Depiction of key operational changes made during the study period.](www.archives-pmr.org)

Patient outcomes

Descriptive statistics were used to analyze patient outcomes. All data were obtained from eRehab and were analyzed using MS Excel.b

As previously noted, Burke Rehabilitation Hospital admitted its first patient positive for COVID-19 on March 16, 2020. For outcome analysis, the pandemic sample included patients who were discharged from the inpatient rehabilitation facility during the period April 1-September 30, 2020. Patients included in the nonpandemic sample were those who were discharged from the inpatient rehabilitation facility during the exact same time frame of the prior year (April 1-September 30, 2019).

The pandemic sample included 1440 patients with an average age of 67.1 years, and the nonpandemic sample included 1417 patients with an average age of 70.13 years. In the pandemic sample, the most common rehabilitation impairment category groups were stroke (32.8%), general rehabilitation/medicine (30.5%), and orthopedic (18.8%). In the nonpandemic sample, stroke was again the most common rehabilitation impairment category group (31.0%), but orthopedic (27.4%) was greater than general rehabilitation/medical (20.3%). The percentage of patients transferred to acute care during their inpatient rehabilitation stay was higher for the pandemic sample (15.53% of patients) than for the nonpandemic sample (12.56%).

Therapy was provided a minimum of 5 days per week for 100% of patients in the pandemic sample. The mean length of stay of the pandemic sample was higher (M=17.93 days) than the mean of the nonpandemic sample (M=16.38). A slightly higher percentage of patients were discharged to the community (with or without services) during the pandemic: 68.7% of patients in the pandemic sample were discharged to the community compared with 68.3% of patients in the nonpandemic sample.

The inpatient rehabilitation facility uses Coding Section GG, self-care, mobility, and walk activities, to report patient functional outcomes, as per CMS requirements.5 Self-care activities include eating, oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, and footwear (7 total items). Mobility activities include rolling, sitting to lying, lying to sitting, sit to
stand, chair/bed to chair transfer, toilet transfer, and car transfer (7 items). Walk items include walking 10 feet, 50 feet with 2 turns, 150 feet, 10 feet on uneven surfaces, 1 step, 4 steps, 12 steps, and picking up an object (8 items). Scores range from 1 (dependent) to 6 (independent), based on the level of assistance a patient needs to complete the tasks. Activities that are not attempted (owing to safety or medical reasons, patient refusal, etc) are converted to a score of 1 as per CMS coding guidelines. Upon admission and discharge, average item scores are summed in these 3 domains, allowing for comparisons of GG scores. In this sample, the self-care change from admission to discharge was higher for the pandemic sample (13.06) than the nonpandemic sample (10.35). The mobility change admission to discharge was also higher for the pandemic sample (13.39) compared with the nonpandemic sample (12.22). Finally, the walk change admission to discharge was also higher for the pandemic sample (15.62) than for the nonpandemic sample (14.33).

Discussion
Burke Rehabilitation Hospital was able to maintain interdisciplinary inpatient rehabilitation therapy services to both COVID-19−positive and COVID-19−negative patients by implementing strategies that aligned with 5 operational priorities. The most important contextual factors were the CMS waiver, which allowed for modifications to therapy minutes, and leadership flexibility, which allowed for real-time updates in procedures as circumstances changed. A willingness to transform core elements of clinical practice allowed for provision of therapy services and also led to the development of new processes (creative bedside interventions; virtual or simulated caregiver training) that are sustainable and relevant during the COVID-19 pandemic and beyond.

Burke’s operational priorities, developed by leadership brainstorming sessions early in the pandemic, had both similarities and differences with literature published later in the pandemic. Key similarities included the needs for staff role flexibility, staff training, considerations of PPE supplies, enhanced cleaning, incorporation of technology, managing patient isolation, and employee wellness initiatives.1,4 Burke’s treatment model, which used a combination of separate treatment spaces and, at times, exclusive bedside sessions, also aligned with published recommendations.1,4 Burke Rehabilitation Hospital, however, did not follow the literature’s recommendations for admission of only patients who were COVID-19 negative or those no longer requiring isolation precautions.2,4 Owing to the IRF’s location in suburban New York, the admission of COVID-19−negative patients was simply not feasible, because there were large numbers of COVID-19−positive patients in the region who required rehabilitative care. In addition, it should be noted that though the cancellation of all “nonrequired” therapies (for example, therapeutic recreation) was recommended,2 the IRF did not follow this and continuously provided fully comprehensive rehabilitation therapies at all times during the study period.

At Burke Rehabilitation Hospital, the average length of stay increased during the pandemic. This outcome is likely attributable to downstream discharge disruptions that were prevalent during the study time frame, including inability of skilled nursing facilities or families to receive patients who were COVID-19 positive, sick family members at home, and limited home care and outpatient services. This required longer time in physical rehabilitation to increase functional independence, enabling patients to be safe at home. As a result, more pandemic sample patients were discharged to home. Patients who may have discharged to a skilled nursing facility prior to the pandemic (because of ongoing functional limitations and/or medical issues) requested home discharges to avoid virus exposure and visitor restrictions at another facility. Many family members, now working from home, were able to meet the needs of these patients and collaborated with the rehabilitation providers to ensure safe home discharges. Importantly, despite the expanded use of bedside treatment sessions (and, thus, less use of fully equipped dedicated therapy spaces) during the study period, patients continued to make functional gains in self-care and mobility domains. At discharge, patients had increased independence to complete tasks such as grooming, transfers, and ambulation, as measured by the GG scores.8

Although the findings of this quality analysis are limited to Burke Rehabilitation Hospital, a free-standing IRF within a larger health system, it is plausible that the strategies implemented during this crisis would generalize to other IRFs (either free-standing hospitals or single hospital units) that want to maintain comprehensive interdisciplinary therapy services under similar stressful circumstances. Leaders at other institutions are encouraged to maintain flexibility as they implement their emergency operations plan and prioritize communication, PPE, clinical and scheduling needs, discharge planning, and patient, family, and staff support to safely provide rehabilitation services during additional waves of COVID-19 or similar crisis scenarios.

Suppliers
a. eRehab; American Medical Rehabilitation Providers Association (AMRPA).

b. Microsoft Excel; Microsoft Corp.

Keywords
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