complicaciones que en unas condiciones de calidad asistencial no deberían producirse. Se hace también mención a una serie de grupos de pacientes a los que debe garantizarse el acceso al tratamiento rehabilitador durante todo el tiempo que dure la pandemia, en concreto: lesión de la médula espinal, quemados, intervenciones de cirugía mayor, ictus, infarto de miocardio, lesiones osteomusculares de gravedad (politraumatismos), traumatismo craneoencefálico, así como todo proceso cuya suspensión pueda acarrear una pérdida de función.

Los puntos tercero y cuarto engloban respectivamente una serie de recomendaciones para la administración sanitaria competente y para los gestores de salud incluidos quienes desarrollan actos de microgestión con base en lo expuesto en puntos previos.

En resumen, la rehabilitación no es un lujo del que se puede prescindir en épocas complicadas, sino una necesidad asistencial irrenunciable y un derecho de nuestros pacientes que debe ser garantizados sin que exista circunstancia o argumento en contra que lo justifique. No debemos permitir en una segunda oleada que la historia se repita.

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COVID 19 and the new challenges in health management: The pilot experience of the Internal Medicine Department of a Regional hospital

COVID 19 y los nuevos retos en gestión sanitaria: la experiencia piloto del Servicio de Medicina Interna de un hospital de primer nivel

Dear Editor,

A pandemic, any pandemic, always surpasses a healthcare system, any healthcare system. And ours was no exception. Following the well-known culture of safety[1] it is up to the wave crest to make a detailed analysis of the weaknesses and strengths that have been revealed during these arduous previous months and that have led to a paradigm shift in the way of understanding healthcare on a global level and particularly in our country. To do this, we would like to show the experience of a 141-bed regional hospital, located in an area with a low incidence of COVID-19 (south of the province of Lugo) and serving a population of 42,000 inhabitants. At the end of February and 15 days before the declaration of the state of alarm by the authorities, the first monographic meeting took place in our Internal Medicine Department to explain to the doctors how little was known about the disease at that time, everything illustrated with the first data from the Epidemic Alert Service and with scientific documentation from China[2] and France,[3] countries that had the most experience in the management of this disease. A week later, a multidisciplinary crisis cabinet was appointed that met daily to assess the current situation, made up of doctors from the Internal Medicine, Emergency, Anesthesia, Preventive Medicine Departments and members of the hospital management.

Differentiated circuits were created throughout the hospital, from the emergency room to the resuscitation area, not to mention the hospitalization area where we created a COVID and a Pre-COVID plant, with an availability in each of them of 14 double rooms. Multiple explanatory sessions were held at the center, mostly carried out by the Occupational Risk Prevention Service and Preventive Medicine, where they explained the epidemiology and transmission of the virus, as well as the necessary protection measures in each action and procedure protocol carried out in the hospital. They provided continuous training on the placement and removal of personal protective equipment in all areas of the hospital, as well as in the social and health centers to which we provide healthcare. A Contingency Plan was created in the Medical Area, consisting of 4 progressive phases according to the magnitude and impact of the disease in our territory and also proposed shift work for doctors if necessary. Finally, it was not necessary to go beyond phase 1 thanks to the population dispersion of our health area and probably also to the multidisciplinary care provided (in homes, social health centers and hospital) which will have to be evaluated in future

studies. Due to the average age of our population (more than 30% older than 65 years) and the high number of Social Health Centers in our small area (11), the Hospital Management together with our geriatrician, attached to the Internal Medicine Department, performed a work plan that consisted of close monitoring of the same through a daily telephone interview with the medical and nursing staff of said centers and scheduled and on-demand visits through the Home Hospitalization Unit. In addition, the social health centers were reinforced with nursing personnel and one of them also with medical personnel, with the intention of handling all positive COVID-19 cases without having to move them whenever their clinical situation allowed it. In mid-March, the first COVID-19 positive patient was admitted to our hospital and since April 15 we have not had positive cases that required admission, which has a much lower impact than in other Regional hospitals in our environment (being the entire Galician Community area of low incidence of the disease). This model of crisis management during the pandemic highlights the great importance of ''anticipating events'', working ''in a network'' between primary and hospital health care and the value of well-used telemedicine that allowed avoiding multiple hospital admissions from the centers social and healthcare, in addition to, through the TELEA monitoring program (Home Assistance Platform), carry out daily follow-up of patients from their homes, which is why we want to communicate this through this letter since we are convinced that teamwork and power anticipate the arrival of the virus, they have been very important to be one of the healthiest areas with the lowest lethality in Spain.

COVID-19 is here to stay. Although the fundamental pillars to prevent its expansion are hand washing and social distance, as long as there is no vaccine, community immunity or effective therapy,[4] perhaps in 1 or 2 months we will suffer another new outbreak of the disease, for which we will all be very more prepared without a doubt.

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A novel approach to combat COVID-19 – A risk stratification model with FAIR intervention

Nuevo enfoque para combatir la COVID-19: modelo de estratificación del riesgo utilizando la base de datos FAIR

Dear Editor,

It is observed that COVID climbs the disease ladder more lethally causing more severe illness with pronounced mortality when aided by the rungs of comorbidity, obesity and age.

A meta-analysis of 1527 patients revealed, the most prevalent comorbidities in COVID-19 were hypertension (17.1%) and cardio-cerebrovascular disease (16.4%) and diabetes mellitus (9.7%). Patients with DM or hypertension had a 2-fold risk, with cardio-cerebrovascular disease had a 3-fold risk of severe disease.[1] Age is an independent risk factor with reports conclusively indicating that age >65 years are at high risk and poor outcome with high mortality. Report from center for disease control (CDC) USA states that the percentage of COVID-19 patients with at least one comorbidity or risk factor was higher among those requiring ICU admission (78%) and those requiring hospitalization without ICU admission (71%) than among those who were not hospitalized (27%).[2]

Data from New York on COVID deaths reveal grave figures of 70.1% mortality in those above 75 years and comorbidities. Obesity alone and in association with other metabolic conditions is now a proven factor for higher mortality with COVID with odds ratio (OR) value approaching 3.68 in those with BMI > 25.[3]

The virus is ubiquitous in its tendency to infect but it discriminates in the way it selectively targets the susceptible group to a telling effect. A crude but compelling analogy is, we are wielding a butchers' knife instead of a scalpel against this menace. Some of the countermeasures initiated have been draconian causing severe disruption to the general population with collateral damage and burden on the health care systems. There are areas for huge improvement and for directing our future interventions to a more focused end. The strategy hinges on focusing on the '**C**omorbidity and **R**isk **S**tratified' (**CRS**) group.

Accurate health **database on comorbidities and age** in the community can be compiled and collated to analyze