VIEWPOINT

Postacute Care Preparedness for COVID-19
Thinking Ahead

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Audio and Supplemental content

National projections suggest that hospitals may be overwhelmed with patients with coronavirus disease 2019 (COVID-19) infection in the coming months. Appropriately, much attention has addressed the acute challenges in caring for this surge of critically ill patients. What has received less attention, however, is what happens as patients—most of whom will recover, even in the highest-risk groups—begin to do so. Many patients with COVID-19 will need postacute care to recuperate from their infection. However, postacute care facilities currently lack the capacity and capability to safely treat patients with COVID-19 as they transition from the hospital to other care settings or to their homes. In this Viewpoint, we present the scope of the problem and outline a series of steps that may be helpful as postacute care organizations prepare for the coming increase in patients with COVID-19.

Postacute care includes rehabilitation or palliative services that beneficiaries receive following a stay in an acute care hospital.[1] Depending on the patient's needs, treatment may include a stay in a facility, such as a skilled nursing facility, inpatient rehabilitation facility, or long-term care hospital, or care in the home via a home health agency. Although data are limited regarding the proportion of patients with COVID-19 in other countries who have needed some form of postacute care, historical data from Medicare suggest that more than 30% of patients hospitalized with sepsis, a condition with inpatient mortality similar to that associated with COVID-19,[2] require facility-based care and another 20% require home health care.[3]

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Postacute care is also a "pop-off valve" for hospital capacity, in that moving patients to a such a setting once they recover from the most acute phase of their illness could free up hospital beds. Medicare has already loosened restrictions on criteria for transfers by relaxing the 3-day rule,[4] which requires a Medicare beneficiary to spend 3 days in the hospital to qualify for the skilled nursing facility benefit. This will facilitate faster transfer for the least-sick patients.

Projections suggest a major surge in postacute care demand will occur following the hospital surge involving patients with COVID-19. Current skilled nursing facility supply varies nationwide (see the eFigure in the Supplement), and occupancy rates average 85%,[1] signaling that current capacity is inadequate for any surge. But the problems go beyond capacity alone. The discharge of patients with COVID-19 to skilled nursing facilities is complicated. The COVID-19 outbreak at Life Care Center in Kirkland, Washington, has already led to the death of 30 residents as of March 16, 2020, approximately one-quarter of its residents.[5] The Centers for Medicare & Medicaid Services has instituted a series of rules in an attempt to prevent further outbreaks from occurring in these facilities, including no-visitor policies and no group activities or communal dining. In this context, it is not safe in some cases for hospitals to transfer patients with COVID-19 into the mainstream skilled nursing facility population because some patients may still be able to transmit disease.

Where will patients who have begun to recover from COVID-19 receive postacute care? What steps can policy makers and health care organizations take to ensure safe and appropriate postacute care services in the coming weeks and month?

As an important first principle, all patients need to be tested for COVID-19 when they are being discharged to a postacute care setting regardless of whether they were being treated for COVID-19 at the hospital. No individual who has COVID-19 should be discharged to a mainstream postacute care setting except for those rare instances in which the facility can safely and effectively isolate the patient from other residents. There is still uncertainty around how long patients remain contagious after clinical recovery, so testing guidelines may need to be revised as additional information becomes available.

Consequently, specialized postacute care environments will need to be developed to treat patients who are recovering from COVID-19 and cannot receive care at existing facilities while still potentially contagious. These specialized environments could potentially take several forms. One approach would be to dedicate certain postacute care facilities in each market to be "centers of excellence" specializing in—and exclusively assuming—the care of patients recovering from COVID-19. Because these organizations would only care for these patients, the risk of infecting other patients could be minimized. Staff would need to receive appropriate safety equipment and training to provide this care safely. Certain types of facilities such as long-term care hospitals and hospital-based skilled nursing facilities may be well-suited to adopt this specialized role initially because of their existing infrastructure for infection control and their generally higher capacity to care for complex patients.

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In other local markets, temporary capacity will need to be built due to potential postacute care shortages. Rural hospitals, many of which have occupancy rates less than 50% and some of which have skilled nursing facility "swing bed" capacity, could be important sites to provide postacute care. New York Governor Andrew Cuomo proposed the idea of using the Army Corps of Engineers to retrofit unused buildings such as military bases and college dormitories as temporary hospitals. Similar approaches could be taken to establish temporary postacute care settings, which may be more appropriate for buildings in which the infrastructure is inadequate for hospital care but could plausibly meet the less intense needs of rehabilitative care.

Given the challenges with isolation in facility-based care, another important approach is treating patients who are recovering from COVID-19 in their homes when possible. Home health agencies are paid in 30-day episodes that typically consist of a mix of therapy, nursing, and home care aide visits. The current average level of care, however, will be insufficient to manage higher acuity patients with COVID-19 transitioning from the hospital. One potential solution is increased investment in hospital-at-home models,[6] which provide institutional-level services in the home.

Regardless of which of these approaches is taken (and likely all will be needed), staffing will be key. The postacute care sector already faces issues in identifying high-quality staff willing to work in these settings.[7] This issue will be magnified in the context of COVID-19. For this reason, the support of staff is essential. Staff must have the requisite training and personal protective equipment to treat patients recovering from COVID-19 safely. Staff will need to be tested regularly to ensure that they are not spreading the virus. And additional staff may need to be recruited to perform lower-skilled tasks that can be acquired relatively quickly, perhaps in part from industries that will experience major layoffs in the near term.

Another important staffing issue is the lack of access to physicians and physician extenders, who may be in short supply given the increase in demand. Telemedicine might be one approach to increase access in both facility and home care settings,[8] and in the context of COVID-19 has the added benefit of helping to prevent the spread of the disease by eliminating in-person contact. The recent announcement from Medicare indicating the provision of reimbursement for all telemedicine care, across video or voice platforms and with temporary Health Insurance Portability and Accountability Act (HIPAA) waivers,[9] is a crucial step toward making this feasible.

Policy makers should consider several temporary policies to support preparedness for COVID-19. All postacute care staff should be provided with paid sick leave. This will further encourage staff who are sick to stay home and not infect vulnerable patients. In terms of payment, an enhanced Medicare rate should be implemented for providing care for patients with COVID-19 across all postacute care settings. The treatment of these cases will mean added costs in terms of isolation, infection control, and staffing. Postacute care facilities and health care personnel should be incentivized to take on these cases and be given the resources to provide these patients with high-quality care. Medicare should also reimburse hospital-at-home models at parity with institutional hospital care to encourage adoption of this model.

The US has been playing catch-up in its COVID-19 response in terms of testing, social isolation, and hospital capacity. Making changes in postacute care delivery and policy today could help contribute to having adequate capacity and capability in the coming weeks and months.

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