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Post-Acute Care Preparedness for COVID-19: Thinking Ahead

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National projections suggest that hospitals may be overwhelmed with patients with 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 post-acute care (PAC) to recuperate from their infection. However, PAC 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 to prepare PAC organizations for the coming spike in patients with COVID-19.

PAC 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 (SNF), inpatient rehabilitation facility (IRF), or long-term care hospital (LTCH), or care in the home via a home health agency (HHA). Although data are limited regarding the proportion of patients with COVID-19 in other countries that have needed some form of PAC, 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 PAC and another 20% require home health care.³

PAC is also a “pop-off valve” for hospital capacity, in that moving patients to a PAC setting once they are over the most acute phase of their illness could free up hospital beds. Medicare has already loosened restrictions on criteria for transfers to the PAC setting by relaxing the three-day rule,⁴ which requires a Medicare beneficiary to spend three days in the hospital to qualify for the SNF benefit. This will facilitate faster transfer to PAC for the least-sick patients.

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Projections suggest a major surge in PAC demand will occur following the hospital surge involving patients with COVID-19. Current SNF 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 SNFs 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 the residents at the SNF.⁵ CMS 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 SNF population, since some patients may still be able to transmit disease.

Where, then, will patients go who have begun to recover from COVID-19? What steps can policymakers and health care organizations take to ensure safe and appropriate PAC services in the coming weeks?

As an important first principle, all patients need to be tested for COVID-19 when they are being discharged to a PAC 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 PAC setting except in 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 PAC 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 PAC 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 in the PAC setting could be minimized. Staff would need to receive appropriate safety equipment and training to provide this care safely. Certain types of facilities such as LTCHs and hospital-based SNFs 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.

In other local markets, temporary capacity will need to be built due to potential PAC shortages. Rural hospitals, many of which have occupancy rates below 50% and some of which have SNF “swing bed” capacity, could be important sites to provide PAC 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 PAC 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 thirty-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 PAC 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 trained relatively quickly, perhaps in part from industries that will experience major layoffs in the near term.

Another important PAC staffing issue is the lack of access to physicians and advanced practice providers, who may be in short supply given the increase in demand. Telemedicine might be one approach to increase access in both facility and home PAC 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 HIPAA waivers,⁹ is a crucial step towards making this feasible.

Policymakers should consider several temporary policies to support PAC preparedness for COVID-19. All PAC 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 PAC payment, an enhanced Medicare rate should be implemented for providing care for patients with COVID-19 across all PAC settings. The treatment of these cases will mean added costs in terms of isolation, infection control, and staffing. PAC facilities and health care personnel should be incentivized to take on these cases and 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 regarding testing, physical distancing, and hospital capacity. Making changes in PAC delivery and policy today could help contribute to having adequate PAC capacity and capability in the coming weeks.

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