

Demonstrating the vital role of psychiatry throughout the health care continuum: Lessons learned from the impacts of the COVID-19 pandemic on skilled nursing facilities

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Editor's Note:

This article is one of a series published in the June 2021 issue of PM&R that collectively form a White Paper describing the vital role of Psychiatry throughout the healthcare continuum during the COVID crisis.

INTRODUCTION

On February 29, 2020, the Centers for Disease Control and Prevention (CDC) reported that the first patients in the United States hospitalized for coronavirus disease 2019 (COVID-19) were located in King County, Washington, in a single skilled nursing facility (SNF).¹ Investigation and contact tracing among the ~130 SNF residents and 170 health care personnel was initiated. There were 81 residents, 34 health care personnel, and 14 visitors who tested positive, and by March 27, 2020, there were 23 deaths.² Americans were given the news the COVID-19 pandemic had reached the United States through a nursing home near Seattle.

In New York State, COVID-19 was soon detected, and at least 6400 people died in SNFs and long-term care nursing facilities (NFs) by summer.³ Overburdened hospitals in New York lacked options for where to discharge patients with COVID-19. Unable to admit new patients because of capacity issues, acute care hospitals were instructed to discharge patients to SNFs. In late March 2020, NY SNFs were issued an administrative directive by Governor Andrew M. Cuomo. This order mandated SNFs to accept COVID-19 patients despite reports of inadequate personal protection equipment (PPE) and insufficient staff to provide care. The impetus was to free up hospitals for fresh waves of COVID-19 patients. Family members

and nursing home staff feared that sending those patients to nursing homes would create a dangerous environment that allowed the virus to quickly spread. The outcomes of this directive were controversial but clearly demonstrated the enormous role that SNFs and NFs play in the U.S. health care system. As these events unfolded, psychiatrists caring for patients in SNFs were instantly thrust into Ground Zero of the U.S. COVID-19 pandemic.

BACKGROUND

The role of SNFs in the health care continuum has grown. There are nearly 15,000 SNFs in the United States, accounting for over 1.6 million beds⁴ requiring physician care. During the first quarter of 2019, acute care hospitals discharged 21% of their patients to SNFs.⁵ When a patient requires ongoing care that precludes a home discharge but does not qualify for an inpatient rehabilitation facility (IRF) or long-term acute care hospital (LTACH), the patient is likely to be discharged to a SNF for a short rehabilitation course.

Historically, the therapy team led the rehabilitation aspect of care, and this care was overseen by the primary attending physician. This model strained under the shift to increased medical acuity and more complex rehabilitation needs. Increasing numbers of patients with rehabilitation needs, who traditionally would have received care in IRFs, are now receiving rehabilitation services in SNFs. These patients often have high

Disclosure: Dr Smith is a physician advisor for the AIM Specialty Panel and served on the AAPM&R Board of Governors (2016–2020).

medical acuity and complex rehabilitation conditions such as brain injuries, orthopedic polytrauma, and spinal cord injuries. The shift to caring for more complex rehabilitation patients created a need for expertise in managing the medical and rehabilitative needs of these complex patients.

Even prior to the COVID-19 pandemic, providing comprehensive rehabilitation services in SNFs was challenging. The increasing numbers of older adults with complex rehabilitation issues in SNFs rather than IRFs created a high demand for intense therapy. Simultaneously, managed care partners continued to have an expectation for shorter length of stays for geriatric patients who may not recover quickly. Older, sicker adults with complex rehabilitation issues often take longer to recover, but this is not accounted for in length of stay calculations. To be equipped to provide shorter and more intense rehabilitation, some facilities invested in refining both their facilities' environment and in their staff's training, but many facilities lacked the capital investment to invest in either. Another common SNF challenge is the historically high staff turnover that necessitates reliance on expensive external staffing agencies to meet nursing and rehabilitation therapy needs. Low per diem reimbursement has further challenged many facilities in their ability to meet their patients' needs in the context of increased operational costs.

SNFs have a tremendous variability in metrics including cost, efficiency, and outcomes.⁶ To achieve best practices, the local, regional, and corporate entities set outcome targets for length of stay and functional recovery. The Centers for Medicare & Medicaid Services (CMS) and other regulatory agencies track all SNFs for metrics such as hospital readmissions, facility acquired infections, falls, and other measures included in the Five-Star Quality Rating System. SNFs are subject to fluctuating standards related to managed Medicare programs such as increased case management, new spectrum Alternative Payment Model systems, and increased collaboration with network partners. Because these entities assume a portion of risk within the system, their goal is to achieve "an efficient SNF stay" and be a preferred provider. To be a preferred provider for networks, SNFs need to demonstrate superior performance as compared to other facilities. Failure to be competitive in efficiency and quality metrics puts SNFs at risk for decreased referrals, lower census with consequent financial losses, and potential closures. A 2015–2019 national SNF/NF survey found that occupancy decreased ~2% and that ~550 facilities closed. Closures were not linked to poor quality; over 40% of the shuttered facilities had a 4- or 5-star rating.⁷ In most instances, closures were financially driven due to decreased census and Medicaid reimbursement that was inadequate to cover costs.

A new financial challenge arose in October 2019 when CMS initiated a new system for reimbursement that changed from the historic Resource Utilization Groups classification system (RUG IV) to the new Patient Driven Payment Model (PDPM). PDPM ended reimbursement determination based on minutes of therapy provided and shifts the focus to management of medical comorbidities. Physiatrists practicing in SNFs have had to adjust their practices to meet the new documentation requirements necessitated by this change in reimbursement models. Besides PDPM, multiple factors have caused the average length of stay in short-term SNFs rehabilitation to drop and census levels to decrease. The change has also resulted in staffing cuts of therapists. In a national survey, 43% of SNFs laid off therapy staff after PDPM began.⁸ There has been a far-reaching concern that although the previous system was perceived as bloated, the abrupt shift to the new system would lead to poor patient outcomes.

Physiatrists' historical roles in SNFs

The goal of physiatrists caring for patients in SNFs is to ensure the best functional outcomes possible. Physiatrists in SNFs typically function in one of several roles: "consultant," "admitting physician," "medical director," or "program director." There are three CMS defined roles and many other possible roles not strictly defined by the CMS. The "physician of record" (admitting physician), "treating physician," and "facility medical director" are roles defined by CMS and/or the state/local departments of public health. Physiatrists assuming the role of "program director" are typically involved in education, clinical support, team building, and development of rehabilitation specialty programs. For example, the role of "orthopedic program director" may be a leadership role for a SNF facility managing many orthopedic patients; such a role often is given to a physiatrist partnering with a surgical program. A post-acute network might also have a "program director" managing their census of patients and all the administrative duties associated with their system. In addition, some facilities have created "rehabilitation medical director" roles in which the physiatrist is formally contracted to oversee or assist with rehabilitation programs within the SNF.

Physiatrists are leaders in short-term IRFs because of their training and expertise in managing patients with complex rehabilitation needs. In addition to managing medical issues common to rehabilitation patients and overseeing rehabilitation plans of care, physiatrists lead interdisciplinary teams and assist with program development, educational programs, quality improvement, and administrative and regulatory issues. Because SNFs require additional support for growing rehabilitation populations, adding physiatrists to the SNF treatment team meets many of their needs.

The primary role of psychiatry is to optimize the rehabilitation plan of care, remove or reduce barriers to progress in rehabilitation, ensure ongoing medical stability for participation, and coordinate aspects of care needed at the time of discharge. This is done in conjunction with other physicians, the interdisciplinary team, patients, and families. There are numerous other secondary aspects of care involved. Each psychiatrist's practice and each facility's expectation will vary. The partnering physicians' reasons for consultation will also vary. Psychiatry duties are generally agreed upon with other stakeholders when working at any institution. Education and ongoing communication regarding the psychiatrist's role ensure synergy and optimal working relationships that improve patient care.

In addition to direct patient care, psychiatrists frequently assist the SNF interdisciplinary team including nursing, therapy, and administrative staff. Areas in which psychiatric involvement are helpful include staff education, program development, and assisting with implementation of administrative and regulatory issues such as the Patient Driven Payment Model (PDPM).

Clinical duties of psychiatrists vary, but increasingly follow a "co-management" or "shared management" model, in conjunction with geriatricians, internists, or other facility physicians. "Co-management" is the shared responsibility, authority, and accountability for the care of a patient. Because both the medical and rehabilitation complexity of patients increases in both IRF and SNF levels of care, co-management is the new standard of care.

COVID-19 IMPACT

Safety concerns with high incidence of COVID

Resident density, "at risk" patients, and flaws in access to infection control systems made SNFs ideal for the spread of COVID-19. As early as April 23, 2020, COVID-19 killed 10,000 residents and staff in SNFs/NFs when there were 872,000 cases in the United States.^{9,10} These numbers were thought to be underestimates, as testing by nasal swabs was poorly tolerated by cognitively impaired patients and may have led to false-negative results.¹¹ Growing evidence showed that even with closer clinical monitoring, SNF/NF patients may not exhibit traditional COVID-19 symptoms; instead, these patients may exhibit atypical symptoms including confusion, anosmia, and dysgeusia.¹² This made screening patients more complicated.¹³ As the COVID-19 pandemic continued, the burden of providing care increased. By the end of 2020, more than 2900 health care workers died of COVID-19.¹⁴

Psychiatrists attending to patients in SNFs are at particular risk. Many SNF patients continue to exhibit acute

COVID-19 symptoms. Psychiatrists are not always provided PPE that is typically provided in an acute hospital setting. Although hospitals struggle at times to supply PPE, the challenge is far worse in SNFs. Patients with acute COVID-19 in SNFs are often complicated by cognitive deficits that make patient mask wearing, hand hygiene, and other safety strategies a challenge. Older patients are more likely to have delirium and may be combative or unable to follow commands. Assistance for patients that struggle to adhere to COVID-19 safety standards is limited. Staffing levels for nursing and therapy that are common at IRF and the acute hospital are lower in SNFs. Psychiatrists seeing patients in outpatient settings may defer visits when COVID-19 symptoms are acute. Patients less than 14 days from their diagnosis, who are actively febrile, coughing or hypoxic on supplemental oxygen are far more likely to be encountered in SNFs than in outpatient physician offices.

Safety concerns regarding the provision of therapy continue. Therapy gyms are frequently closed to prevent spread of infection, necessitating that therapy be provided in patient rooms. Subsequent space constraints and lack of access to necessary equipment or modalities limit the effectiveness of therapy sessions. Historically, staffing levels vary widely among different SNFs, making safe provision of care more challenging in facilities where lower staffing ratios stretch caregivers to provide more care in less time. In addition, high turnover of staff and reliance upon agency staffing adversely impact the proficiency and cohesiveness of the rehabilitation team.

With therapy restricted to within patient rooms, working on mobility goals or higher-level activities of daily living is challenging. Psychiatrists assisting with pain management may not have access to modalities that are traditionally relied upon. Physical distancing requirements restrict the observation of patients during therapy. The lack of face-to-face interactions and real time communication limits interdisciplinary collaboration. These limitations are barriers to developing an effective rehabilitation plan. All these issues make it difficult for psychiatrists to prescribe and oversee safe and optimal rehabilitation care for their patients.

Labeling psychiatrists as nonessential

To promote safety, some facilities restrict physician access to patients when COVID-19 rates are elevated. Many physicians, especially specialists, can be deemed "nonessential". According to internal AAPM&R polling among their members during a webinar conducted in 2020%, 25%–75% of psychiatrists were deemed "nonessential" and thus not allowed to enter SNFs. Some facilities also consider rehabilitation therapy services to be "nonessential," as compared to the management of general medical issues, causing some

patients to have delays or decreased services in therapy. Patients brought to SNFs, expecting to gradually experience a functional recovery in therapy, often find themselves isolated in their rooms and rarely seeing the therapists. Perhaps in an effort to keep staff safe, patients are only given treatment felt “essential,” but not optimal for functional recovery. Rehabilitation services are the cornerstone of post-acute care but are now relegated to a “non-essential” role as SNFs struggle to prevent further spread of COVID-19.

Patients recovering from COVID-19 remain isolated from their support systems and experience reduced, delayed or absent rehabilitation care. Patient often lack face-to-face access from a physiatrist who is expected to oversee their rehabilitation care. Physiatrists working in these environments are challenged with coordinating care remotely and sub-optimally providing counseling to patients and families via telephone. Despite being labeled as “nonessential,” the physiatrist is expected to stay abreast of constantly changing COVID-19 guidelines and provide quality care despite the enormous challenges created by the pandemic.

Even for physiatrists well trained in SNF care, not having direct access to SNFs is a significant barrier. Often administrators, facility medical directors, therapists, nursing, and other staff are not aware of how physiatrists benefit their patients and facilities. This lack of awareness results in far-reaching adverse consequences. When denied access to SNFs, physiatrists are unable to provide care to patients that could benefit from their expertise.

In addition, physiatrists are not routinely given the resources or authority to optimally assist with clinical or administrative functions that can benefit the patients, staff, and facility. These functions can include assisting with adjunct clinical duties, regulatory requirements, program development, team building, patient/family satisfaction, process improvement, quality programs, and other initiatives that could greatly benefit the treatment team, facility, and patients. Not being empowered to assist with these functions limits the effectiveness of the physiatrist.

Drawbacks with telemedicine when patients have cognitive and technological challenges

Providing care in SNFs is difficult when physiatrists are precluded from interfacing with patients in person due to COVID-19 quarantine. In addition to visualization, physiatrists rely upon hands-on assessment, making telemedicine challenging in SNFs. Cognitively impaired patients often have difficulty using technology, especially if there are hearing or visual deficits as are common with geriatric patients. Staffing shortages make it difficult to get help at the bedside to interface with

patients and assist physiatrists with telemedicine visits. SNFs often lack critical infrastructure such as functional broadband or adequate electronic devices for patients to use. These telemedicine issues can make it difficult to accomplish patient visits, family conferences or team conferences, and discharge planning becomes more difficult.

Transitioning patients from acute hospitalization or IRFs to SNFs

As the pandemic advanced, the medical community realized patients recovering from COVID-19 needed rehabilitation.¹⁵ Finding rehabilitation facilities for dense clusters of extremely ill patients who require isolation is a challenging public health problem. Despite the need to unburden the acute hospitals, the rehabilitation patient census in SNFs decreased 20% to 40%.¹⁶ Many facilities initially thought that they could not safely care for patients with COVID-19. Patients and families may refuse SNF placement as public opinion regarding SNF/NF is impacted due to isolation conditions and the perception of SNFs as hotbeds of COVID-19. In addition, some local regulations can require a SNF to halt admissions if any staff member tests positive for COVID-19.¹⁷

COVID-19 has overwhelmed most medical organizations. Physiatrists at acute care hospitals consulting to determine a patient’s needs for rehabilitation understand the importance of managing hospital throughput.¹⁸ Initially there were few systems in place that could rapidly increase resources to meet patient needs. Both the acuity of patient illness and the volumes of patients at this level strained numerous health care organizations. Because patients with COVID-19 require rehabilitation, and acute care hospitals are desperate to open up beds, the need for SNF care was urgent. Although SNF facilities were experiencing decreasing census, there were factors that limited their ability to accept large volumes of patients with COVID-19. Despite the need to transfer patients from acute care to SNF, staffing limitations and regulatory burdens limited access. Cases of COVID-19 that were acquired in SNFs often necessitated restrictions of admissions. This situation was exacerbated by the ongoing permanent closure of facilities. A survey of SNFs in August 2020 revealed that 1% of facilities would only stay open for a month or less and 40% could only sustain 1 to 6 months of operations without additional financial assistance.¹⁹

Historically, a model many perceive as optimal is when the severely debilitated medically complex patient who would otherwise be a traditional IRF patient comes to SNF to “warm up” for IRF. These patients arrive at SNFs deconditioned, unable to tolerate therapy, or with poor awareness of their surroundings. A

period of preparation in SNFs before IRFs (“staged rehab”) is helpful for a transition to a successful IRF stay. The goal for these patients is to be discharged to the community from IRF. Lack of access to SNFs precludes the option of staged rehabilitation. Instead, these patients must be discharged home and wait for outpatient rehabilitation, while further stretching the limit of available home health services and increasing the risk for adverse outcomes and readmissions.

A system was needed to create new clinical pathways to safely discharge a patient from hospital, to rehab, and ultimately to the community. Coordinating with numerous independent SNF partners was a challenge due to lack of access, for both patients and psychiatrists. Building novel discharge protocols with remote partners in the middle of the pandemic was a burden for psychiatrists consulting on patients throughout the continuum of care.

Closure of SNFs

COVID-19 caused many SNFs to close, resulting in decreased SNF bed availability. These closures create tensions that psychiatrists performing acute care consults have to navigate. The lack of SNF beds decreases the discharge options for patients in acute care hospitals. Consulting psychiatrists face the dilemma of whether to advocate for extending the acute care hospitalization to obtain rehab services or to allow a medically stable but functionally impaired patient to discharge to a potentially unsafe home. Extending the acute care length of stay exacerbates throughput issues. Discharging debilitated patients prematurely increases the risk of injuries, medical complications, and hospital readmission. The lack of SNF beds also result in additional pressure being placed on psychiatrists practicing in IRFs to accept patients who do not meet criteria.

ADAPTIVE PROCESSES

During the pandemic, psychiatrists at SNFs must navigate facilities that struggle to meet the rehabilitation needs of patients. SNFs often require assistance in creating guidelines for the therapy of patients with COVID-19. Psychiatrists rapidly needed to become proficient in managing the unique combination of complex medical, rehabilitative, and social needs related to this patient population.

Patient and staff safety concerns

Psychiatrists collaborate with SNFs to create infection control standards and isolation protocols that allow for

rehabilitation to continue. Through information sharing among professional organizations such as the American Academy of Physical Medicine and Rehabilitation, the Society for Post-Acute and Long-Term Care Medicine, and the Gerontological Society of America (among many others such as the Centers for Disease Control and Prevention and numerous local health commissions), psychiatrists help SNFs to stay abreast of the evolving treatment and safety protocols for COVID-19. Psychiatrists work together with directors of therapy, directors of nursing, medical directors, facility administrators, and SNF Executive Leadership to develop and refine these protocols. Communicating safety protocols to patients and families is now part of the responsibility of psychiatry. Part of the safety programming includes new PPE stewardship standards. All medical settings were affected by the well-publicized shortage of PPE that remained a threat throughout 2020,²⁰ and SNFs were particularly at risk.²¹

Adapting to telehealth and working with SNF partners to ensure successful transition

Decreasing personnel traffic inside the SNFs is a keystone to reduce vectors of transmission. Due to SNFs limiting access to facilities, most psychiatrists have a change in workflow that includes a decrease in in-person visits, replacing those visits with telehealth technologies. On-site staff can assist patients with telehealth appointments with outside physicians, thereby limiting the need for patients to leave the facilities for outside appointments. To implement this approach, appropriate in-house electronics, functional connectivity, and staff availability to assist patients are necessary. Some psychiatrists now coordinate telehealth rounds with nursing or other staff. Other psychiatrists manage individual patient telehealth appointments during the patient’s in-room therapy sessions, when therapy staff is able to assist with electronic communication and provide valuable updates. In-house social work teams now are frequently tasked with assisting with face-to-face communication with patients, or via telephone with families.

Having psychiatrists leading the rehabilitation team remotely allows for the ongoing supervision of therapy services and treatment of issues common to post-acute care. Psychiatrists communicating with the patient, the nursing staff, and the therapy team could identify barriers to functional recovery and reduce them. Synthesizing the information from patients and nurses and integrating this information with functional information from therapy allows psychiatrists to provide specialized care. Telehealth facilitates continuing observation of therapy and evaluation of the patient both in room and in therapy. Remote interdisciplinary meetings allow for the continuing of the multi-disciplinary process of

rehabilitation. Telehealth allows the physiatrist to lead the entire team, while minimizing exposure.

Adjustments to clinical practice

Providing medical care at SNFs has changed dramatically due to COVID-19. To minimize cross-facility infections, physiatrists physically work at fewer facilities but maximize their value by adjusting the degree to which they assist the primary care team. Physiatrists assist with pandemic-related issues such as patient in-bed positioning programs, modified cognitive assessment programs, or other early intervention programs that overlap the acute recovery and rehabilitation realms. Physiatrists assist with the implementation of new policies relating to screening admissions, specific telehealth programs, and integration of other specific network service lines.

Understanding PPE protocols for different facilities is now a routine aspect of the physiatrist's job. Each facility has different access to PPE. When PPE is not provided to outside staff, the physiatrist must be prepared with their own PPE.

The COVID-19 pandemic created a need for broadened education. Staying current with COVID-19 recommendations is a critical part of the physiatrist's job. Therapy and nursing staff need guidance regarding clinical safety concerns during rehabilitation. There are more patient and family counseling sessions with emphasis on post-discharge functional adaptations.

Physiatrists have diversified their practice settings by seeking emergency privileges with partners in local SNFs to assist with PM&R consultations to facilitate discharge planning. Similarly, physiatrists have obtained emergency privileges with IRF and LTACH partners for on-call coverage or to meet growing patient needs.

FUTURE THREATS

The COVID-19 pandemic identified numerous real and potential threats involving SNFs that impact physiatrists and their patients. Capacity issues and limited resources occur in the context of increased patient debility and decreased facility access. These factors create challenges in meeting patient needs, stresses within facilities, and discharge planning dilemmas. There will undoubtedly be conflicts between the needs of patients and facilities. Physiatrists assist in the coordination of care throughout the rehabilitation continuum and are required to help reconcile these conflicts. Physiatrists are expert in decisions related to rehabilitation patient care and management of limited resources.

The pandemic highlights the relative lack of understanding related to the unique environment, function,

and patients residing in SNFs. Preparing physiatrists to be optimally equipped to practice throughout the rehabilitation care continuum is essential. All PM&R residency programs should adequately train physiatrists regarding the specific requirements of SNF care, including the clinical and regulatory processes and procedures of SNFs.

The level of debility and medical complexity prolongs the recovery curves in some patients infected with COVID-19. Despite this, SNFs feel pressure from managed care to decrease length of stay. Many patients with moderate to severe functional deficits or insufficient caregiver support are forced home prematurely. PDPM created financial incentives to minimize therapies and increases the risk of discharge at sub-optimal functional levels. Despite these challenges the physiatrist must ensure that patients receive appropriate and adequate rehabilitation care.

Furthermore, the number of patients with COVID limit many of the traditional options for improving outcomes after discharge from SNFs. Home health agencies struggle to meet the needs of patients debilitated by COVID-19; thus, home health care cannot be relied upon to be the safety net for preventing adverse outcomes. Likewise, physiatrists may have difficulty finding adequate outpatient therapy providers (physical, occupational, and speech/language) due to clinic closures and other capacity restrictions.

Post-SNF discharge options are more limited and may be premature. Physiatrists are frequently called upon to counsel patients and families who are concerned about discharge. Lack of face-to-face interactions with family members impedes relationships, making it harder to establish trust. These factors will increase the time requirements and complexity of caregiver education and counseling.

OPPORTUNITIES

In most SNFs, the physiatrist typically oversees the rehabilitation issues, whereas the primary care physician manages the primary medical issues. COVID-19 highlighted the need for trust and understanding between medical specialties. Each specialty is essential to the optimal care of the patient. Communication and clarity regarding each physician's role help physiatrists and other physicians work synergistically to provide efficient, high value patient care. Furthermore, the facility administration and staff must understand the role of the physiatrist and where physical medicine and rehabilitation expertise is best utilized. Mutual agreement regarding roles, responsibilities, and duties is critical in determining how each physician will function within a given SNF. In addition, strong working relationships improve outcomes, as well as decrease the risk of burnout and turnover of the treatment team. By working together and utilizing both the clinical and

administrative expertise of physiatrists, all the stakeholders benefit and thrive in the chaotic environment triggered by the COVID-19 pandemic or any other future widespread disaster.

Leaders of the rehabilitation team

The complexities of designing and coordinating medical and rehabilitation treatments is unique to physiatrists. The COVID-19 pandemic highlights the need for this level of expertise in SNFs. Physiatrists' "sweet spot" is leading interdisciplinary rehabilitation teams and integrating care with other medical specialists. Cultivating these strong working relationships benefits patients and improves outcomes. The physiatrist facilitates an atmosphere of support in which all members of the treatment team are respected and valued. This atmosphere promotes high job satisfaction and less burnout.

It is important to distinguish between rehabilitation services and rehabilitation medicine. The physiatric medical training and skillset is demonstrated during the COVID-19 pandemic. Patients present with a myriad of multi-system impairments. The ability to analyze physical, biomechanical, and cognitive deficits, and then effectively implement, coordinate, and monitor rehabilitation strategies is what distinguishes physiatrists from the rest of the therapy professionals.

Physiatrists support therapists, nurses, and staff in the SNFs by developing rehabilitation programs for patients with COVID-19 or other unique clinical conditions. There are many questions that intersect medical and rehabilitative care. For example: How soon after COVID-19 infection is it safe to begin muscle strengthening and cardiopulmonary exercises? What is the risk to medical professionals in performing a swallow evaluation on patients who are coughing with active COVID-19 infection? How effective are airborne precautions? Many physiatrists are expected to become leaders in COVID-19 safety and treatment protocols.

COVID-19 demonstrates that physiatrists play an important and unique role in times of widespread medical calamities.

Informing and advising C-suite (Chief executive officers)

During the pandemic, physiatrists demonstrate administrative and leadership skills beyond a purely clinical role. This necessitates working closely with medical directors and administrative leadership. During times of environmental stress that borders on chaos, physiatrists' expertise in integrating clinical knowledge and administrative skill is a critically important yet often underappreciated aspect of the physiatric acumen. SNFs benefit from the shared knowledge of physiatrists

regarding issues such as up to date recommendations related to PPE or capital purchases. Physiatrists also assist in novel protocol development and implementation that is effective for COVID-19 and other dramatic changes in SNFs. Physiatrists may also provide guidelines related to patient transfers from hospitals or strategies related to regulatory issues and reimbursement.

To benefit most from the contributions of physiatrists, many SNF C-suite professionals have recognized the benefit of creating a formal "Rehabilitation Medical Director" position. This position allows the SNF and physiatrist to define the physiatrists' role and responsibilities. In addition to working internally with the SNF administrators and leaders, the physiatrist can collaborate with external stakeholders to develop inter-facility relationships, protocols, and joint programs. When positioned as a rehabilitation medical director, the physiatrist has access to programmatic data and has the authority to engage the clinical staff in educational programs, process improvement, and team building. In addition, rehabilitation medical directors in SNFs work synergistically with the facility's medical director.

Offloading SNF medical director

The physiatrist can assist the SNF medical director with duties outside the comfort zone of other specialists, such as ordering durable medical equipment (DME), documenting face to face encounters for home health care, determining the next level of rehabilitation care such as outpatient rehabilitation versus home health, being a secondary signatory for processes such as determination of cognitive status, and other duties. By assisting with these critical tasks, physiatrists decrease the burdens of facility medical directors who in times of crises are likely overwhelmed with managing the complex medical issues and the volume of administrative tasks related to their role. The physiatrist can also serve as a backup physician if the facility medical director is not available and critical issues arise. For example, given the risks of COVID-19 infection in health care workers, having multiple levels of physician support is prudent.

Managing patient flow and throughput

Physiatrists provide medical services throughout the entire continuum of care. Consulting on patients in intensive care units and acute care, managing patients in IRFs, LTACHs, SNFs, and outpatient levels of care are all fundamental parts of psychiatry education and training. Because of this, physiatrists are experts in identifying the most appropriate level of care for individual patients. Proactively identifying the best disposition, despite challenging circumstances such as the COVID-19

pandemic, promotes efficiency, safety, and patient/family satisfaction.

For patients experiencing long-term effects of COVID-19 and for other patients with complex medication conditions, there is an opportunity for physiatrists in SNFs to collaborate with other physiatrists, physicians, and facilities to help with throughput, getting individual patients to the best environment to meet their medical and rehabilitative needs and allow for a safe discharge. Prior to admission to SNFs, physiatrists can assist in managing patient flow and throughput by understanding the continuum of care from acute to IRF to SNF to home. This knowledge base is helpful in identifying patients who are appropriate for admission to SNFs. The physiatrist can assist in this function by performing consults in acute care facilities or collaborating with other consulting physiatrists in referral facilities. The physiatrist can assist the acute care facilities with complex discharge planning and the SNF Admissions Team by reviewing potential admissions to ensure that a SNF stay is appropriate and beneficial, thus assisting in obtaining payor authorization. The physiatrist can provide education and counseling to patients and families, helping to reassure them regarding the benefits and goals of a SNF stay. All these functions can facilitate an efficient transfer, shorten length of stay at the acute care hospital, and promote patient and family satisfaction. Establishing relationships between acute care facilities, inpatient rehabilitation facilities, and SNFs promotes synergy. Physiatrists can be the “glue” that cements these relationships, promoting collaboration and other network initiatives.

Become the go to “jack of all trades” provider that can integrate on many different levels

The COVID-19 pandemic created many needs that physiatrists are uniquely qualified to meet. In addition to the traditional role of physiatrists in identifying the optimal rehabilitation environment and planning for patients with functional compromise, physiatrists assist SNFs in improving satisfaction with services and patient outcomes in the context of limited resources and environmental challenges. They can assist SNFs with optimizing programs, improving employee morale, improving efficiencies, and helping facilities maintain financial viability by functioning optimally. All these activities are critical in ensuring that patients have access to high quality rehabilitation and medical care in SNFs. Because of physiatrists’ unique skills and involvement in every level of care, incorporating physiatry into SNFs and all levels of care improves facility throughput by identifying appropriate levels of post-acute care, helps to limit iatrogenic complications that increase length of stay, and helps achieve synergy

between different facilities. In addition to COVID-19 patients, this same approach is beneficial in other patient populations in SNFs including patients with complex medical conditions, neurological and orthopedic illnesses, or other medical conditions adversely impacting function. As rehabilitation team leaders, physiatrists are experts at optimizing the rehabilitation plan of care and providing innovative solutions to barriers that prevent progress in therapies. Furthermore, physiatrists are well trained in managing rehabilitation comorbidities, and specialize in managing pain, neurogenic bladder, neurogenic bowel, spasticity, dysphagia, and other issues commonly seen in patients receiving rehabilitation.

Patient and family education and counseling are other arenas in which physiatrists excel. Patients and their families, as well as referring physicians, will seek SNFs where a physiatrist is available to assist in the patient’s plan of care, particularly for patients with complex rehabilitation needs. Physiatrists can assist in developing educational programs for patients and families for use throughout the facility. In addition to COVID-19-specific issues, the physiatrist can provide education related to other complex clinical conditions in which nursing, therapists, and other staff need guidance. Rehabilitation teams look to the physiatrists for answers. Being a trusted resource, for both patients and staff, is a way that physiatrists demonstrate leadership of the rehabilitation team.

CONCLUSION

SNFs were ill-prepared for the enormous volume of fragile, medically complex, and infectious patients created by COVID-19. Waves of patients entered acute care hospitals with COVID-19. Many who left these facilities found themselves in desperate need of ongoing medical and rehabilitation care. Physicians working in SNFs witnessed catastrophic loss of life and function, necessitating adaptations in order to care for their patients and lead the multidisciplinary rehabilitation team. These desperate times created urgency for physiatrists to participate in and create many new processes that have benefitted facilities and patients. Physiatrists continue to evolve their practices as they learn to assist in new ways, to partner with colleagues through new avenues, and to advocate for safe patient care to a historic degree. In SNFs physiatrists work with fewer resources in the context of sicker and older patients. The degree of physiatry expertise needed is highest in these types of circumstances. SNFs have benefitted from having physiatry involved to assist during this pandemic. Most importantly, SNF patients have benefitted from physiatrists involvement in their rehabilitation care. The COVID-19 pandemic has demonstrated the importance of physiatry in SNFs and throughout the entire health care continuum in providing high value care.

Lessons learned from this experience will undoubtedly be helpful in establishing best practices for SNFs and to prepare for future health care crises.

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