Several decades ago, the introduction of the prospective payment system by diagnosis-related groups created a tremendous incentive for hospitals to shorten length of stay. Suddenly, there was a new person rounding with each inpatient team, paid for by hospital administration. These were “discharge planners,” and their job was to get physicians thinking about how to discharge a patient expeditiously even as they were writing admission orders. Rapidly, US hospitals pivoted to focus on short, procedure-heavy service provision, in contrast to many other countries, in which hospitals continue to offer a more leisurely process of patient evaluation or convalescence, leading to the unsurprising finding that a couple of extra days in the hospital is an effective strategy for minimizing rehospitalization.

The acceleration of hospital discharge processes led to the early release of millions of persons annually who were far from recovered from their illness or surgery and needed varying intensities and types of post-acute care. For US nursing homes, these post-hospital transfers created a potential financial windfall, because Medicare reimbursement rates were, and continue to be, more profitable than Medicaid rates. As a result, foci of post-acute care blossomed in the nursing home industry. Facilities vied with each other for favorable status, implementing strategies ranging from sending nurses to make pre-discharge hospital visits to gifting holiday baskets to hospital discharge planners, all of which aimed to demonstrate that nursing homes provided safe, high-quality care that was expeditious to obtain and easy to arrange.

These changes were not, however, without problems. Post-acute patients have very different needs than long-term stay residents; so, blending the 2 populations made it challenging to optimally serve either. Furthermore, the closer nursing homes were tied to hospitals, and particularly to patients who cycled in and out of acute care, the more they accumulated hospital-related complications, the most notable being resident colonization with antimicrobial-resistant pathogens.

An additional unintended consequence has been to accentuate disparities in care. This has occurred because nursing homes with high proportions of post-acute, primarily Medicare, patients tended to have more resources and operating margin, resulting in the quality of care in largely Medicaid facilities being lower.

Even as they increasingly embraced post-acute care, nursing homes have begun to see an erosion in their grip on the post-acute care market. One factor has been the rapid increase in provision of post-acute services in private homes and other non-nursing home settings, which has been supported by data indicating that outcomes are equivalent and costs lower. A related force has been a strong and steady push from funders and regulators in favor of home and community-based services, which has gradually eroded the share of federal dollars going to nursing home care. And the final, perhaps most inexorable force, has been public opinion of nursing homes as dangerous, unfriendly places; an opinion that was reinforced by the impression, developed early in the COVID-19 pandemic, that nursing homes were “death traps.”

This effort by nursing homes to capture a shrinking market for post-acute services has been part of an overall pattern of the industry’s decline. As a case in point, the average number of Medicare admissions per nursing home bed increased by 40% between 2001 and 2017, but the same time frame saw an overall decline in nursing home profitability, as evidenced by sagging occupancy rates and an increasing number of annual facility closures, such that by 2018 more than half of the country’s nursing homes were reported to be operating at a loss.

In addition, post-acute admissions tended to be concentrated in a subgroup of homes, leading to increased disparities in resources and quality of care between “have” and “have not” facilities, which led to further concern about the quality not only of the industry but of the regulatory system.
These trends, which were already established by early 2020, took a drastic turn for the worse during the COVID-19 pandemic. In the initial phases of the epidemic, hospitals stopped performing elective procedures, such as joint replacements, and consequently the number of persons needing post-acute care plummeted. Concomitantly, patients and families, frightened by the stories of nursing home deaths and of lockdowns separating residents from their loved ones, were more reluctant than ever to enter a nursing home after a hospitalization. Thus, between January 2019 and October 2020, the percentage of hospital discharges to nursing homes declined from 19% to 14%, an overall reduction of 26%, with a concomitant decline in post-acute spending and, for nursing homes, revenue. Thus, one could say that the nursing home industry faces a perfect storm. Consumer confidence is at an all-time low, hospitals are increasingly looking for and finding alternatives, and Medicare revenues have declined. Census levels, already low pre-COVID, have dropped to the point that many homes are teetering on financial insolvency.

As it always the case when a crisis occurs, now is a good time to consider radical change. For the nursing home industry’s leadership and funding sources, one element of that discussion should be the role of the industry in post-acute service provision. A related question is whether it really makes sense to mix in the same building 2 very different populations: individuals who want rehabilitation so they can get home and individuals for whom the facility desires to create a home.

The right answer is by no means clear.

On the one hand, bringing a post-acute focus into a nursing home can help professionalize the industry by providing a greater presence of licensed and advance care nurses, physical therapists, occupational therapists, speech therapists, and physicians. Such professionals can provide training to staff, consult on long-term care residents, and participate in committee work and decision-making. In addition, under the current payment system, the extra revenue that comes with Medicare-funded post-acute patients should lead to improved quality of care.

On the other hand, the more a nursing home focuses on post-acute care, the harder it is to feel like home. Having both a robust rehabilitation department and space for long-term residents necessitates a large building, whereas, as the Green House model has demonstrated, smaller settings by their very essence feel more homelike while also providing excellent care. Furthermore, smaller homes have been associated with particularly high resident and family ratings of quality of life, particularly for persons with advanced dementia and severe physical disabilities, who are increasingly the clientele of long-term nursing home care.

Nursing homes are not going to disappear. There are too many people whose care needs are too intensive to be provided by home care or by settings, such as assisted living, where presence of a licensed nurse is considered optional. However, the low public opinion currently held of nursing homes, combined with declining occupancies and the advanced age of many buildings, all indicate that major change may need to occur.

In considering the future of nursing homes, an important issue to evaluate is whether one building should deliver both post-acute care and residential long-term care, or whether the 2 service types should be in different settings. As Robert Kane noted more than a decade ago, “It is hard to deliver one form well. It is much harder to combine (the two),” because the goals and skills required are quite different. COVID-19 and the gradual attrition of post-acute care to other settings has made these issues especially timely.

The issue embodies many questions. Here are a few: Should post-acute settings be entirely separate from long-term care settings, so that each can truly focus on its distinct mission? Should post-acute care and residential long-term care be licensed and managed entirely separately? Should post-hospital rehabilitation routinely be tied to inpatient hospital care, separate from but located close enough so as to share services such as infection control and rehabilitation? If separation occurs, what is the best way to deal with persons who must transition from post-acute to long-term care, or persons in long-term care who need short-term rehabilitation? Can long-term-care-only nursing homes provide adequate services from physical therapy, occupational therapy, and other professionals to maximally serve their patients, and if so, how? And, finally, perhaps the most critical question of all: How should nursing home finances be adjusted to eliminate the current practice of using Medicare to make up for deficiencies in Medicaid reimbursement?

These are not easy questions. What is clear, however, is that nursing homes must change, and that part of that change should include reexamination of the role and structure of post-acute care in these settings.

References


