

Post-Acute and Specialty Care Settings: An Untapped Resource in Healthcare Emergency Management

Background

Post-acute care encompasses a range of services including home health, skilled nursing facilities, inpatient rehabilitation facilities, and long-term acute care hospitals, each with distinct operational characteristics (Massachusetts Health & Hospital Association [MHA], 2024). These settings possess unique features including specialized staffing models, varied patient mobility requirements, extended stay infrastructure, and rehabilitation-focused resources that differ substantially from acute care environments (Centers for Medicare & Medicaid Services, 2020).

Historically, emergency preparedness was rooted in efforts by hospitals to create disaster plans with trauma or mass casualty focus, beginning at the emergency department and ending at admission, discharge, or death of a patient (Kim, 2016). While emergency preparedness requirements have changed and expanded to additional provider types beyond the hospital context, complex response functions remain difficult to plan and execute (Kim, 2016).

During normal day-to-day operations, healthcare systems are tasked with overcoming significant operational challenges that are exacerbated during large-scale emergencies, such as capacity, staffing, and supply availability. Post-acute facilities, when intentionally and strategically integrated into systemic healthcare preparedness initiatives, provide a possible avenue to alleviate burdens and mitigate impacts. As a member of Mass General Brigham’s enterprise, Spaulding Rehabilitation has assumed an active role in supporting overall enterprise resiliency through strategic asset management and integrated preparedness programming.

Objectives

- Identify operational differences between post-acute and acute care settings that influence emergency preparedness approaches.
- Propose specialized planning frameworks that integrate post-acute and specialty care into comprehensive emergency management systems.
- Document field-tested strategies from Spaulding Rehabilitation's experience with Mass General Brigham.
- Demonstrate how post-acute settings can transition from passive recipients to active contributors in emergency response.

Methods

- This work synthesizes lessons learned from real-world emergency events and operational experiences at Spaulding Rehabilitation, a comprehensive post-acute and rehabilitation system within Mass General Brigham.
- Review of **emergency response activations** across Spaulding Rehabilitation inpatient locations.
 - After-action reports from **COVID-19 pandemic**, **Boston Marathon**, and other enterprise-wide emergencies, such as **CrowdStrike**.
 - Assessment of rehabilitation-specific **operational differences and challenges**.
 - Evaluation of **care coordination mechanisms** and transition of care patterns.
 - Assessment and adaptation of planning templates** and frameworks to address unique emergency preparedness requirements.

Findings

Operational characteristics of acute care settings was compared to those at Spaulding Rehabilitation. These comparisons are described in Table 1. Variations have prompted shifts in planning assumptions, resource allocation, and response goals, as outlined in Figure 1. These differences were leveraged during **COVID-19** (Boston Hope Field Hospital), the 2013 **Boston Marathon Bombing** (rehabilitation/traumatic surge capacity), **supply shortages** (e.g., Baxter IV Fluid shortage), and supporting communities through **temporary admissions** of medically vulnerable populations during extreme weather events.

Table 1. Operational Differences Between Acute and Post Acute Care Locations

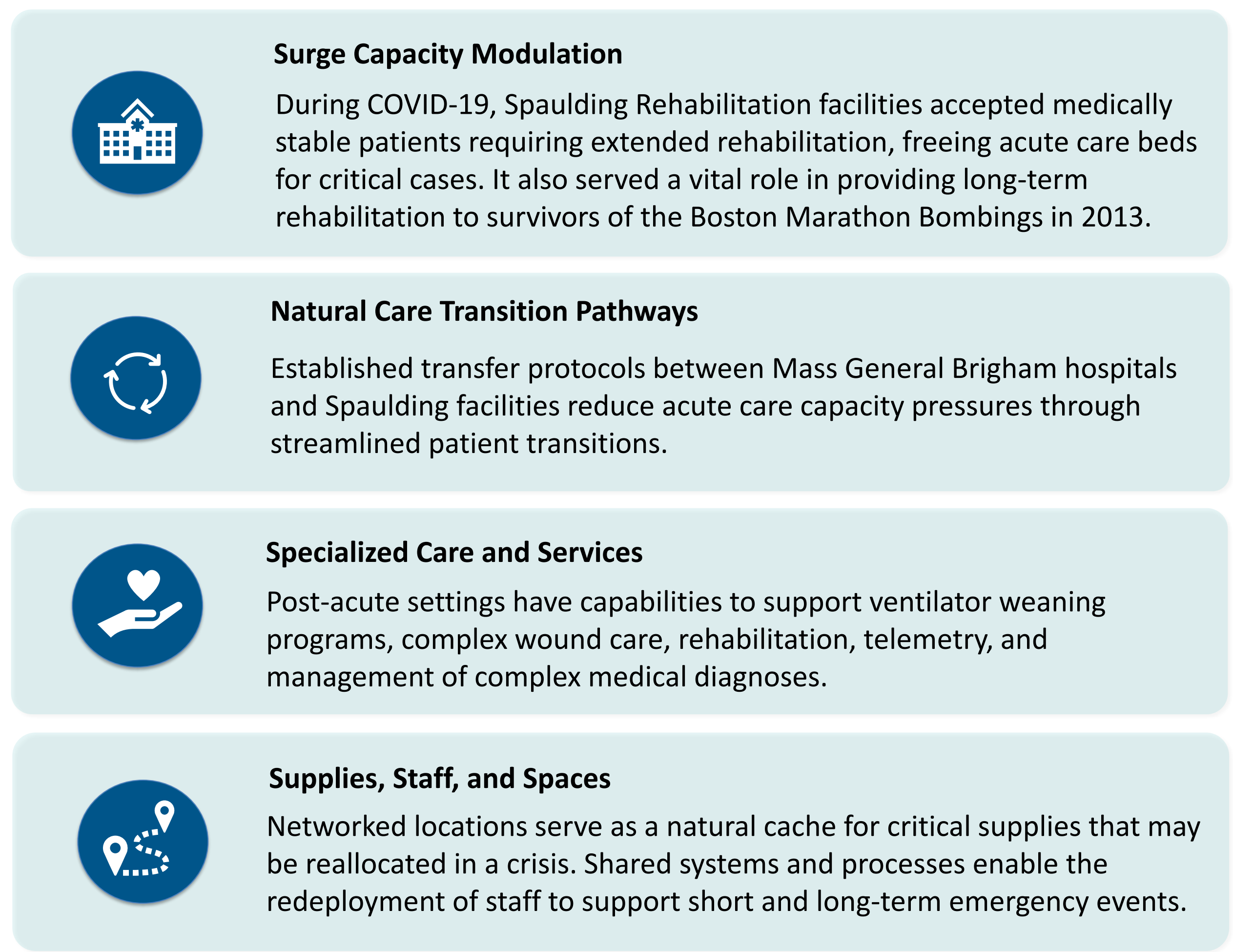
Attribute	Acute Hospital Setting	Post-Acute Care Settings
Primary Goal	Diagnosis, stabilization, and treatment of acute illness or injury (Mechanic, 2014).	Rehabilitation, recovery, and restoration of function; maintenance of chronic conditions (Medicare Payment Advisory Commission [MPAC], 2021).
Average Length of Stay	4-5 days (American Hospital Association, 2023)	IRF: 12-13 days, LTCH: 25-30 days; SNF: 28-100 days* (MPAC, 2023)
Patient Acuity	High acuity; medically unstable requiring intensive monitoring and intervention (Brock et al., 2013)	Medically stable but functionally impaired; lower acuity with rehabilitation potential (Gage et al., 2011)
Nursing Staffing Ratios & Physician Coverage	<ul style="list-style-type: none">Higher ratios: ICU 1:1-2; MedSurg 1:4-6 (Aiken et al., 2014)24/7 on-site physician presence; immediate response capability (Tenner et al., 2013)	<ul style="list-style-type: none">Lower ratios: IRF 1:6-8; SNF 1:8-15 (Bostick et al., 2006)Physician coverage is not 24/7 in all settings
Diagnostic Capabilities	24/7 comprehensive on-site diagnostic services (e.g., imaging, laboratories, specialty consultation) (Mechanic, 2014)	Limited on-site diagnostics; reliance on external facilities for advanced imaging and specialty testing (Teno et al., 2013)
Technology and Equipment	Advanced life support, surgical suites, intensive monitoring systems (Turner et al., 2013)	Rehab equipment, basic monitoring, limited advanced life support (Carter et al., 2011)
Discharge Planning	Begins at admission; focus on next level of care placement; brief timeframe (Brock et al., 2013)	Extended planning for community reintegration; focus on home safety, equipment, caregiver training (Buntin et al., 2010)

*IRF: Inpatient Rehabilitation Facility; LTCH: Long-Term Acute Care Hospital; SNF: Skilled Nursing Facility

Next Steps & Recommendations

- These findings have significant implications for the broader emergency management field. Healthcare coalitions, systems, state and local emergency managers, and all practitioners should consider the following:
- Critically Assess Emergency Preparedness Resources.** Evaluate resources and adapt them to reflect the unique patient and operational requirements during an emergency (e.g., mass casualty incidents, reunification, evacuation procedures, etc.).
 - Include Post-Acute Leadership in Planning.** Ensure post-acute care representatives participate in system-wide emergency activations and planning committees (Schultz & Koenig, 2006).
 - Invest in Emergency Preparedness Sustainability.** Dedicate staffing and resources to oversee and implement comprehensive emergency preparedness programming.
 - Develop Integrated Patient Placement Frameworks.** Create decision support tools that acknowledge post-acute capabilities (e.g., ventilator weaning, wound care, intensive rehabilitation, supply availability) during systemwide events.
 - Conduct Joint Training Exercises.** Routinely include post-acute facilities in health care system emergency exercises to align planning assumptions, understand capabilities, and encourage innovative strategies to address shared issues.

Figure 1. Strategic Capabilities of Post Acute Care Settings in Disasters



Sources: Levi et al., 2011; Spaulding Rehabilitation, 2025.

Conclusion

Integrating post-acute and specialty care settings into emergency planning and embracing their operational differences enables healthcare systems to develop more robust, flexible response mechanisms. Spaulding Rehabilitation, as part of the Mass General Brigham enterprise, exemplifies how post-acute care infrastructure can serve as a strategic force multiplier during emergencies.

The transformative potential lies not in treating post-acute settings as extensions of acute care, but in recognizing and operationalizing their distinctive capabilities within comprehensive emergency frameworks tailored to address capacity challenges and operational pressures across the entire healthcare continuum.

References



Please refer to the associated handout for a full list of references.