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Incidental Cases and Staff Shortages Make COVID's Next Act Tough for Hospitals

Unlike previous surges, large portions of patients with COVID are coming to the hospital for other reasons.

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The Cleveland Clinic in Weston, Florida, on January 11 was treating 80 COVID-19 patients — a tenfold increase since late December. Nearly half were admitted for other medical reasons.

The surge driven by the extremely infectious omicron variant helped push the South Florida hospital with 206 licensed beds to 250 patients. The rise in cases came as the hospital struggled with severe staff shortages while nurses and other caregivers were out with COVID.

The challenge is finding room to safely treat all the COVID patients while keeping staffers and the rest of patients safe, said Dr. Scott Ross, chief medical officer.

"It's not a PPE issue," he said, referring to personal protective equipment like masks, "nor an oxygen issue, nor a ventilator issue. It's a volume issue and making sure we have enough beds and caregivers for patients."

Nationally, COVID cases and hospitalizations are at their highest levels since the pandemic began. Yet, unlike previous COVID surges, large portions of the patients with COVID are coming to the hospital for other reasons. The infections are exacerbating some medical conditions and making it harder to reduce COVID's spread within hospital walls, especially as patients show up at earlier, more infectious stages of the disease.

Although the omicron variant generally produces milder cases, adding the sheer number of these "incidental" hospitalizations to COVID-caused hospitalizations could be a tipping point for a health care system that is reeling as the battle against the pandemic continues. Rising rates of COVID in the community also translate to rising rates among hospital staffers, causing them to call out sick in record numbers and further stress an overwhelmed system.

Officials and staff at 13 hospital systems around the country said that caring for infected patients who need other medical services is challenging and sometimes requires different protocols.

Dr. Robert Jansen, chief medical officer at Grady Health System in Atlanta, said the infection rate in his community was unprecedented. Grady Memorial Hospital went from 18 COVID patients on December 1 to 259 last week.

Roughly 80% to 90% of those patients either have COVID as their primary diagnosis or have a health condition — such as sickle cell disease or heart failure — that has been exacerbated by COVID, Jansen said.

Although fewer of their patients have developed pneumonia caused by COVID than during the major spikes early last year, Grady's leaders are grappling with high numbers of health care workers out with COVID. At one point last week, Jansen said, 100 nurses and as many as 50 other staff members were out.

In one of New Jersey's largest hospital systems, Atlantic Health System, where about half the COVID patients came in for other reasons, not all of those with incidental COVID can be shifted into the COVID wards, CEO Brian Gragnolati said. They need specialized services for their other conditions, so hospital staffers take special precautions, such as wearing higher-level PPE when treating COVID patients in places like a cardiac wing.

At Miami's Jackson Memorial Hospital, where about half the COVID patients are there primarily for other health reasons, all patients admitted for COVID — whether they have symptoms or not — are treated in a part of the hospital reserved for COVID patients, said Dr. Hany Atallah, chief medical officer.

Regardless of whether patients are admitted for or with COVID, the patients still tax the hospital's ability to operate, said Dr. Alex Garza, incident commander of the St. Louis Metropolitan Pandemic Task Force, a collaboration of the area's largest health care systems. He estimated that 80% to 90% of patients in the region's hospitals are there because of COVID.

In Weston, Florida, the Cleveland Clinic is also having a hard time discharging COVID patients to nursing homes or rehabilitation facilities because many places aren't able to handle more COVID patients, Ross said. The hospital is also having difficulty sending patients home, out of concern they would put those they live with at risk.

All this means there's a reason that hospitals are telling people to stay away from the ER unless it's truly an emergency, said Dr. Jeremy Faust, an emergency medicine physician at Brigham and Women's Hospital in Boston.

The sheer number of patients who are showing up and don't know they have COVID during this surge is frightening, Faust said. As more incidental cases pour into hospitals, they pose a greater risk to staffers and other hospital patients because they are typically at a more contagious stage of the disease — before symptoms begin, Faust said. In previous COVID waves, people were being hospitalized in the middle and later phases of the illness.

In Faust's analysis of federal data, Jan. 7 showed the second-highest number of "hospital onset" COVID cases since the pandemic began, behind only an October 2020 outlier, he said. But this data accounts for only people who were in the hospital for 14 days before testing positive for COVID, Faust said, so it's likely an undercount.

A KHN investigative series revealed multiple gaps in government oversight in holding hospitals accountable for high rates of COVID patients who didn't have the diagnosis when they were admitted, including that federal reporting systems don't publicly note COVID caught in individual hospitals.

"People in the hospital are vulnerable for many reasons," said Dr. Manoj Jain, an infectious disease specialist in Memphis, Tennessee. "All of their existing underlying illnesses with multiple medical conditions — all of that puts them at much greater risk."

The ER in particular is a potential danger zone amid the current crush of cases, Garza said. He recommended that patients wear high-quality masks, like a KN95, or an N95 respirator. According to The Washington Post, the Centers for Disease Control and Prevention is weighing whether to recommend that all Americans upgrade their masks during the omicron surge.

"It's physics and math," Garza said. "If you've got a lot of people concentrated in one area and a high viral load, the probability of you being exposed to something like that if you're not wearing adequate protection are much higher."

If patients can't tolerate an N95 for an entire day, Faust urges them to wear upgraded masks whenever they come into contact with hospital staffers, visitors or other patients.

Dr. Dallas Holladay, an emergency medicine physician for Oregon's Samaritan Health Services system, said that because of nursing shortages, more patients are being grouped together in hospital rooms. This raises their infection risk.

Dr. Abraar Karan, an infectious diseases fellow at Stanford, believes all health care workers should be mandated to wear N95s for every patient interaction, not just surgical masks, considering the rise in COVID-exposure risk.

But in the absence of higher-quality mask mandates for staffers, he recommended that patients ask that their providers wear an N95.

"Why should we be putting the onus on patients to protect themselves from health care workers when health care workers are not even going to be doing that?" he asked. "It's so backwards."

Some hospital workers may not know they are getting sick — and infectious. And even if they do know, in some states, including Rhode Island and California, health care workers who are asymptomatic can be called back to work because of staffing shortages.

Faust would like to see an upgrade of testing capacity for health care workers and other staff

members.

At Stanford, regular testing is encouraged, Karan said, and tests are readily available for staffers. But that’s an exception to the rule: Jain said some hospitals have resisted routine staff testing — both for the lab resource drain and the possible results.

“Hospitals don’t want to know,” he said. “We just don’t have the staff.”

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