Health **C**are **C**oalition

Acute Care to Post-Acute Care Transition Project

IMPROVEMENT PLAN

Healthcare Coalition Partners of Kansas, LLC

Revised: 11/18/2020

PROJECT OVERVIEW

Project Name	Acute Care to Post-Acute Care Transition Project			
Project Time Frame	**From:** 08/01/2020		**To:** 06/30/2021	
Project Primary Point of Contact	**Name**: Kerry G. McCue		**Agency**: Healthcare Coalition Partners of Kansas	
	Phone: (785) 623-8695		**Email**: kgmccue@outlook.com	
Project Area of Support	Biological, Medical Surge			
Funding Source	☐ EMPG	☒ HPP	☐ PHEP	☐ Other:
List the At-Risk populations accommodated in the Project:	Elderly, Medical Issues and/or Disabilities			

PROJECT SYNOPSIS

In early August of 2020, the Kansas Department of Health & Environment (KDHE) contracted with Healthcare Coalition Partners of Kansas (HCCP of Ks) to evaluate transitioning patients/residents from Acute Care facilities (hospitals in Kansas) to Post-Acute Care facilities (any setting in Kansas where a patient/resident would receive additional medical care after discharge from a hospital) and to make recommendations that could help resolve the identified difficulties. HCCP of Kansas defined the following plan of action to fulfill the project scope:

1. Immediate hiring of a contracted project-manager.

2. Engagement of Critical Project Partners.

These partners include:

- Kansas Department of Health and Environment (KDHE)
- Kansas Department for Aging and Disability Services (KDADS)
- Kansas Hospital Association (KHA)
- LeadingAge Kansas
- Kansas Healthcare Association
- Kansas Adult Care Executives
- Regional HCC Executive Committees and Regional Post-Acute Care Facilities (PAC Teams)

3. Creation and distribution of a survey to Acute Care, Public Health and Post-Acute Care to include the following questions:

    a. Acute Care: General questions identifying any current discharge issues or best practice in relation to Post-Acute Care residents.
    b. Post-Acute Care: Specific questions to identify barriers to housing COVID-19 residents, identification of their COVID-19 information source, identification of facilities that do accept COVID-19 residents and their best practices/policies, etc.
    c. Public Health: Questions regarding their experience with isolation/quarantine in Post-Acute Care settings and identification of facilities they are working with that could be used for this purpose and/or as a model.

4. Sorting and reporting of survey data to all 7 HCC Post- Acute Care (PAC) project teams. Members of these teams include the HCC Executive Committee members as well as Post-Acute Care representatives.

5. PAC Team facilitation to include the following tasks:

    a. Creation of a regional strategy to identify hospital discharge and Post-Acute Care barriers
    b. Implementation of the strategy.
    c. Creation of a regional team to serve as the point of contact for any questions regarding the project to resolve issues as they arise.

Upon completion of action step #4, the following core barrier was identified. Many of the Post-Acute Care (PAC) facilities do not believe they have access to correct, complete or consistent information regarding COVID-19 in order to feel comfortable opening their facilities to current or new residents who have been in an acute care setting. It appears that the lack of such comfort is causing a delay in patient discharge from the acute care setting.

Given this information, HCCP of KS commenced a series of 3 weekly (October 12, 2020 – October 30, 2020) meetings with the PAC teams throughout the HCC Regions. Discussions for these meetings were broken down into the three (3) key areas which were identified during the survey phase. These key areas included staffing, communication, and resources.

During the first week of discussion, the PAC teams appeared to naturally split into metropolitan and rural issues. However, as the weeks progressed, only one issue rose to the top which was different among the Regions. This issue is the idea of a Regional post-acute care transfer facility within the metropolitan regions. After further discussion, this center was supported as a project outside of this project scope as the staffing and resource shortages identified were too vast for the resources available within the PAC teams. Additional discussions and/or ideas which appear to be outside of this project scope were brought forth to HCCP of KS's State and Association partners as they do merit additional discussion. Our partners not only listened to this information, but they also assigned personnel to investigate each issue and are currently investigating the issues identified. These issues are included at the end of this report in the" Recommendations Outside of the Project Scope" section at the end of this report.

This project has focused on current barriers of transitioning patients/residents from acute care facilities to post-acute facilities. Proposed solutions to these barriers have been identified in this report. These proposed solutions were generated through conversations with the PAC teams and are supported by these teams to move forward. As stated above, the solutions are heavily focused on opening beds in the post-acute care settings. However, there appears to be a need for collaboration between the acute care facilities within the State and the post-acute care facilities. It is now up to the PAC teams to move forward with these proposed solutions within their Regions. As these teams move forward, HCCP of KS will continue to advocate to project partners for projects outside of this project scope, facilitate PAC team discussions and work with the PAC teams to implement recommendations identified in this document.

ANALYSIS OF THE ACUTE CARE TO POST ACUTE CARE TRANSITION PROJECT	
Focus Issue One	Communication
Function/Task	Communication of consistent COVID-19 information, discharge planning coordination and infection control practices.
Objective	Identification and coordination of a communication model between disciplines which supports the common operating picture of COVID-19 patient discharge planning and care to transition patients/residents between acute and post-acute facilities in a timely and appropriate manner.
Areas of Improvement	PAC team discussions identified acute and post-acute facilities were utilizing and prioritizing different sources of COVID-19 information regarding patient discharge and care. In addition, some acute care visitor policies currently restrict post-acute care staff from entering the facility to perform in-person, pre-admission assessments of their residents.
Analysis/ Recommendations	To facilitate timely/appropriate patient placement and care the acute care and post-acute Care facilities should work together to identify a common patient transition model that incorporates the following: • Prioritization of a common communication source for Covid-19 care and discharge planning information. • Review of common communication sources to identify common infection control practices which may encourage pre-discharge, in per-son assessments of patients in an acute care setting by post-acute care staff.

Focus Issue Two	Communication
Function/Task	Identification and Reporting of a patient's COVID-19 status prior to acute care facility discharge.
Objective	Encourage development of Patient/Resident Covid-19 standards. The goal is to identify a standard which would provide knowledge of the patient's COVID-19 status prior to transition from an acute to post-acute care facility.
Areas of Improvement	PAC teams identified a need for post-acute care facilities to know a resident's COVID-19 status prior to admission. facilities.
Analysis/ Recommendations	Post-acute care facilities admit residents to different areas of their facilities based upon COVID-19 status. Currently, the post-acute care resident's COVID-19 status is determined through testing upon entering the post-acute care facility. At that point, the facility makes the decision as to which unit the resident should reside (COVID-19 positive unit, Isolation Unit, etc.) Determination of the patient's COVID-19 status prior to admission would allow for post-acute care facilities pro-actively plan for unit staffing and resources. • We encourage acute and post-acute care facilities to work together to determine a COVID-19 patient transition standard. An initial test at the acute-care facility could serve as notification to the post-acute care facility of probable staff and resource needs. It is understood the resident would be tested again upon arrival at the post-acute care facility to confirm the previous status.

Focus Issue Three	Resources
Function/Task	Reporting just-in-time acute care and post-acute care bed availability to provide real time information to physicians, discharge planners and others to facilitate patient/resident placement.
Objective	Facilitate timely patient/resident placement to alleviate avoidable days in acute care facilities.
Areas of Improvement	PAC teams identified the need for a common bed-availability system between disciplines.
Analysis/ Recommendations	Acute care and post-acute care facilities should have access and view rights into both an acute and post-acute care bed availability system/program in order to have coordinate patient placement with real-time data In such, the PAC teams recommend the completion of post-acute care facility data in EMResource. Recommended tasks are as follows: • Analyze the Long-Term Care (LTC) and Assisted Living (AL) template in EMResource for applicable facility information to be used for COVID-19 patient movement. • Identification and Contracting of an LTC/AL EMResource Administrator. • Creation and provision of training on implementation of the LTC and AL templates. • Creation and distribution training to acute care facility discharge staff and post-acute care facility intake staff regarding the available Hospital, LTC and AL information within EMResource.

Focus Issue Four	Resources, Staffing
Function/Task	Development of a Telehealth model to promote healthcare visits for residents in the post-acute care setting.
Objective	To relive pressure on the acute-care system by providing traditional acute-care facility services within the post-acute care facility.
Areas of Improvement	PAC teams identified the need for a review of telehealth services which are currently being utilized within post-acute care facilities. This goal of this review and potential new practices is to identify traditional acute-care services which can be offered in the post-acute care setting, reduce the amount of staff time and resources needed move patients between facilities and reduce potential resident COVID-19 exposure risks.
Analysis/ Recommendations	Using telehealth, many acute-care facilities in Kansas are now offering expanded services within the post-acute care setting. This practice is maximizing staffing levels within the facilities as well as keeping acute care beds open for patients who cannot be treated outside of the acute care walls. • Explore acute and post-acute care partnerships to deliver non-traditional healthcare services in the post-acute care setting.

Focus Issue Five	Resources
Function/Task	Provide common PPE training resources to acute, post-acute care and emergency medical services.
Objective	To promote similar knowledge and utilization PPE between acute, post-acute care and EMS. The goal is to provide consistent Infection Control Measures across the transition team.
Areas of Improvement	The various transition team disciplines receive infection control and PPE training from various resources. This leads to the potential of a variation in practice between the team members.
Analysis/ Recommendations	The potential risk of infection control practice variations could be reduced with common knowledge as well as standardized transition team protocols. To address this risk, the PAC team recommends: • Creation and distribution of an infection control training package to all transition team disciplines. • Identification and utilization of an electronic system for housing and maintaining the new training package. • Development of a of a Chain of Custody Form to document patient specific care and infection control protocols throughout the transition process.

Focus Issue Six	Communication
Function/Task	Identify a platform to promote sharing of COVID-19 Infection Control best practices.
Objective	Provide post-acute care facilities with a common platform to share best practices identified for Infection Control, PPE, Staffing and any other new practices which have been adapted in a successful manner in order to help care for patients during this pandemic.
Areas of Improvement	New adaptive best-practices for COVID-19 response measures in the acute-care setting are abundant. However, post-acute care facilities in Kansas do not have a way to share these practices with one another as they are created. A common best practice sharing platform is needed for the post-acute Care facilities.
Analysis/ Recommendations	Post-acute care facilities throughout the State are responding to new rules, regulations, and practices daily, all while managing patient care with critically short staffing levels. They simply do not have the time to research COVID-19 response and hospital transition best practices from their peers. To maximize their resources available, it is critical they receive access to innovative practices implemented from their peers. • An electronic platform will be identified, and access granted to interested post-acute Care facilities to facilitate this best practice sharing. This platform will always be open for input and review.

Recommendations Outside of the Project Scope

1. Recommendation:

   Creation and Distribution of common healthcare services and issues across all healthcare disciplines.

   Analysis:

   Although healthcare disciplines provide different types of care to various populations, they all have one thing in common. At the end of the day, they are all working in the same overall environment, which is healthcare. With this, many of the disciplines utilize the same service providers, are held to the same regulatory standards, help maintain common certifications for staff and apply for the same type of funding. In such, there are a variety of informational topics which are helpful to all. Examples of this include medical waste requirements, environmental decontamination products/services, available grants/funds, CPR training, etc. The PAC teams believe providers would benefit from sharing this information amongst each other.

2. Recommendation:

   Placement of Patients during a pandemic should be based upon facility capability as well as all resources needed to treat a patient.

   Analysis:

   Larger acute-care facilities in Kansas are currently at or reaching capacity while beds remain open in critical access hospitals and post-acute care facilities across Kansas. Healthcare partners may want to review the current transfer process and determine the full package of resources needed to care for patients. These resource considerations include bed availability, staff availability, staff capabilities, PPE, pharmaceutical availability and specialty care needs for a patients/resident's diagnosis. Once this information is gathered, healthcare partners could assess the type of patients which can be cared for at each type of facility and distribute/re-distribute patients based upon the full resources needed per patient within healthcare system.

3. Recommendation:

   Development and implementation of one (1) team to provide the post-acute Care industry with technical assistance.

   Analysis:

   Post-acute care facilities are currently seeking information regarding COVID-19 care through a variety of State departments currently. Calling around for information introduces an opportunity for variation in answers received and therefore, care provided. The PAC team believes the development of combined State-agency or an academic contracted "call-in technical assistance center" for the post-acute care industry would promote unified information and care. Additional benefits of this center would include promotion of questions asked within fear of regulatory penalties as well as promotion of best practice sharing.

4. Recommendation

Develop and Implement training for post-acute care facilities in Covid-19 onsite testing machine/kit functionality and purpose.

Analysis:

PAC team participants noted the delivery of COVID-19 testing machines and kits without adequate instruction as to how to utilize the machines and conduct the tests. Creation of this training would help reduce specimen collection variances.

5. Recommendation:

Develop and implement at least two (2) COVID-19 receiving/treatment facilities to treat COVID-19 positive patients or individuals who have been hospitalized and are in quarantine.

Analysis:

With the increasing numbers of COVID-19 cases in Kansas. Acute care facilities and some post-acute care facilities are quickly approaching capacity. Such a receiving/treatment facility would provide both disciplines a location to utilize for transition of COVID-19 positive patients/residents between acute and post-acute care. These facilities would relieve the current stress on the acute and post-acute care facilities.

Plan of Action

Target dates are goals to reach for; they are **not set in stone and can be changed as needed. Please include an actual date**

Focus Area	Observation	Corrective Steps	Key Element • Resource • Communication • Staffing	Primary Responsible Agent	Agent Contact Information	Target Completion Date
One	PAC team discussions identified acute and post-acute facilities were utilizing and prioritizing different sources of COVID-19 information regarding patient discharge and care. In addition, some acute care visitor policies currently restrict post-acute care staff from entering the facility to perform in-person, pre-admission assessments of their residents.	To facilitate timely/appropriate patient placement and care the acute care and post-acute Care facilities should work together to identify a common patient transition model that incorporates the following: • Prioritization of a common communication source for Covid-19 care and discharge planning information. • Review of common communication sources to identify common infection control practices which may encourage pre-discharge, in per-son assessments of patients in an acute care setting by post-acute care staff.	☐ Resources ☒ Communication ☐ Staffing	Regional PAC	Respective HCC RRC	6/30/2021

Two	PAC teams identified a need for post-acute care facilities to know a resident's COVID-19 status prior to admission. facilities.	Post-acute care facilities admit residents to different areas of their facilities based upon COVID-19 status. Currently, the post-acute care resident's COVID-19 status is determined through testing upon entering the post-acute care facility. At that point, the facility makes the decision as to which unit the resident should reside (COVID-19 positive unit, Isolation Unit, etc.) Determination of the patient's COVID-19 status prior to admission would allow for post-acute care facilities pro-actively plan for unit staffing and resources • We encourage acute and post-acute care facilities to work together to determine a COVID-19 patient transition standard. An initial test at the acute-care facility could serve as notification to the post-acute care facility of probable staff and resource needs. It is understood the resident would be tested again upon arrival at the post-acute care facility to confirm the previous status.	☐ Resources ☒ Communication ☐ Staffing	Regional PAC	Respective HCC RRC	6/30/2021

	Three	Acute care and post-acute care facilities should have access and view rights into both an acute and post-acute care bed availability system/program in order to have coordinate patient placement with real-time data In such, the PAC teams recommend the completion of post-acute care facility data in EMResource. Recommended tasks are as follows: • Analyze the Long-Term Care (LTC) and Assisted Living (AL) template in EMResource for applicable facility information to be used for COVID-19 patient movement. • Identification and Contracting of an LTC/AL EMResource Administrator. • Creation and provision of training on implementation of the LTC and AL templates. • Creation and distribution training to acute care facility discharge staff and post-acute care facility intake staff regarding the available Hospital, LTC and AL information within EMResource.	☒ Resources ☐ Communication ☐ Staffing	Regional PAC	Respective HCC RRC	6/30/2021

Four	PAC teams identified the need for a review of telehealth services which are currently being utilized within post-acute care facilities. This goal of this review and potential new practices is to identify traditional acute-care services which can be offered in the post-acute care setting, reduce the amount of staff time and resources needed move patients between facilities and reduce potential resident COVID-19 exposure risks.	Using telehealth, many acute-care facilities in Kansas are now offering expanded services within the post-acute care setting. This practice is maximizing staffing levels within the facilities as well as keeping acute care beds open for patients who cannot be treated outside of the acute care walls. • Explore acute and post-acute care partnerships to deliver non-traditional healthcare services in the post-acute care setting.	☒ Resources ☐ Communication ☒ Staffing	HCC Clinical Advisors	Respective HCC RRC	6/30/2021

Five	The various transition team disciplines receive infection control and PPE training from various resources. This leads to the potential of a variation in practice between the team members.	The potential risk of infection control practice variations could be reduced with common knowledge as well as standardized transition team protocols. To address this risk, the PAC team recommends: • Creation and distribution of an infection control training package to all transition team disciplines. • Identification and utilization of an electronic system for housing and maintaining the new training package. • Development of a of a Chain of Custody Form to document patient specific care and infection control protocols throughout the transition process.	☒ Resources ☐ Communication ☐ Staffing	Regional PAC	Respective HCC RRC	6/30/2021

Six	New adaptive best-practices for COVID-19 response measures in the acute-care setting are abundant. However, post-acute care facilities in Kansas do not have a way to share these practices with one another as they are created. A common best practice sharing platform is needed for the post-acute Care facilities.	Post-acute care facilities throughout the State are responding to new rules, regulations, and practices daily, all while managing patient care with critically short staffing levels. They simply do not have the time to research COVID-19 response and hospital transition best practices from their peers. To maximize their resources available, it is critical they receive access to innovative practices implemented from their peers. • An electronic platform will be identified, and access granted to interested post-acute Care facilities to facilitate this best practice sharing. This platform will always be open for input and review.	☐ Resources ☒ Communication ☐ Staffing	Regional PAC	Respective HCC RRC	6/30/2021