Post Acute Transitions During Covid 19 Pandemic

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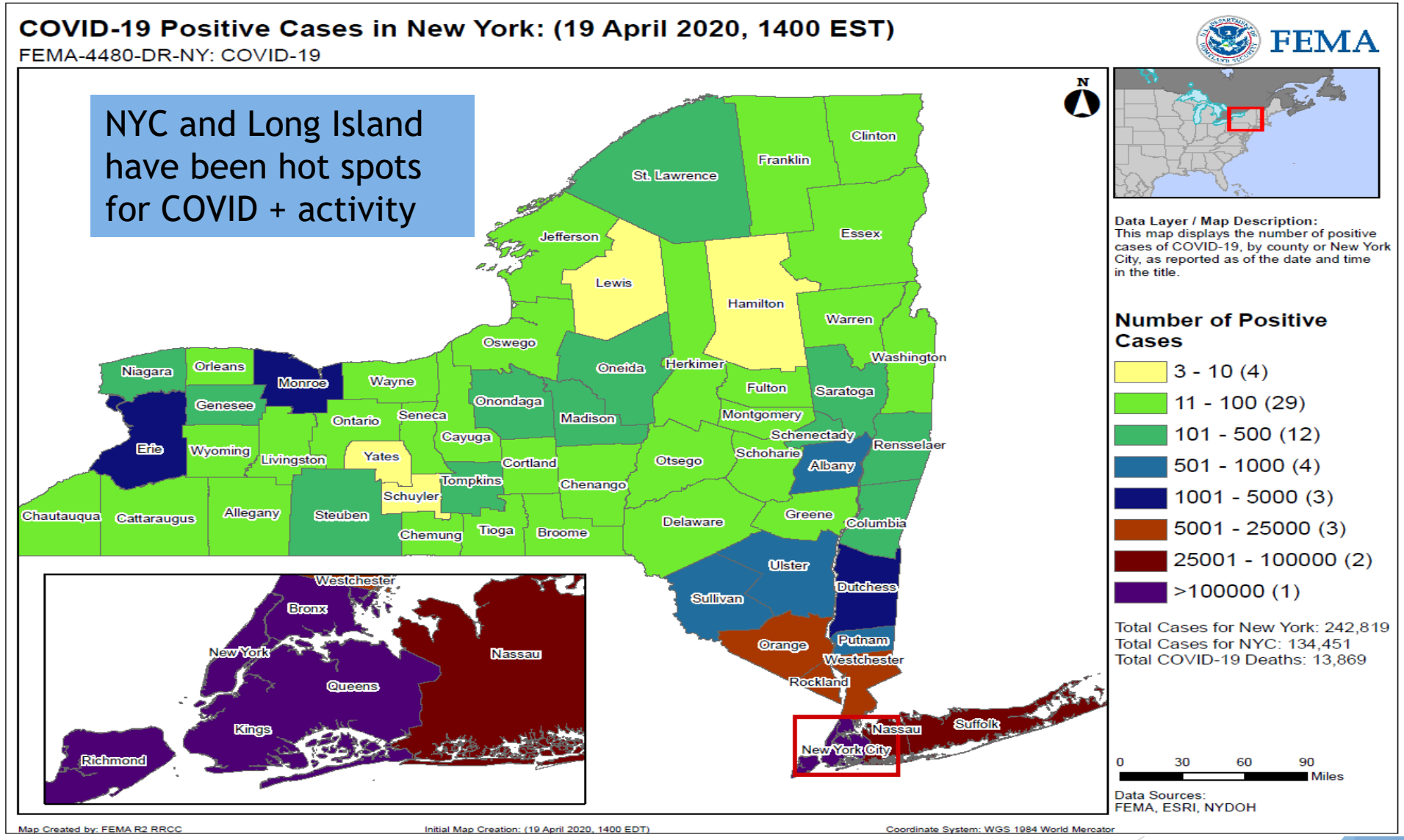
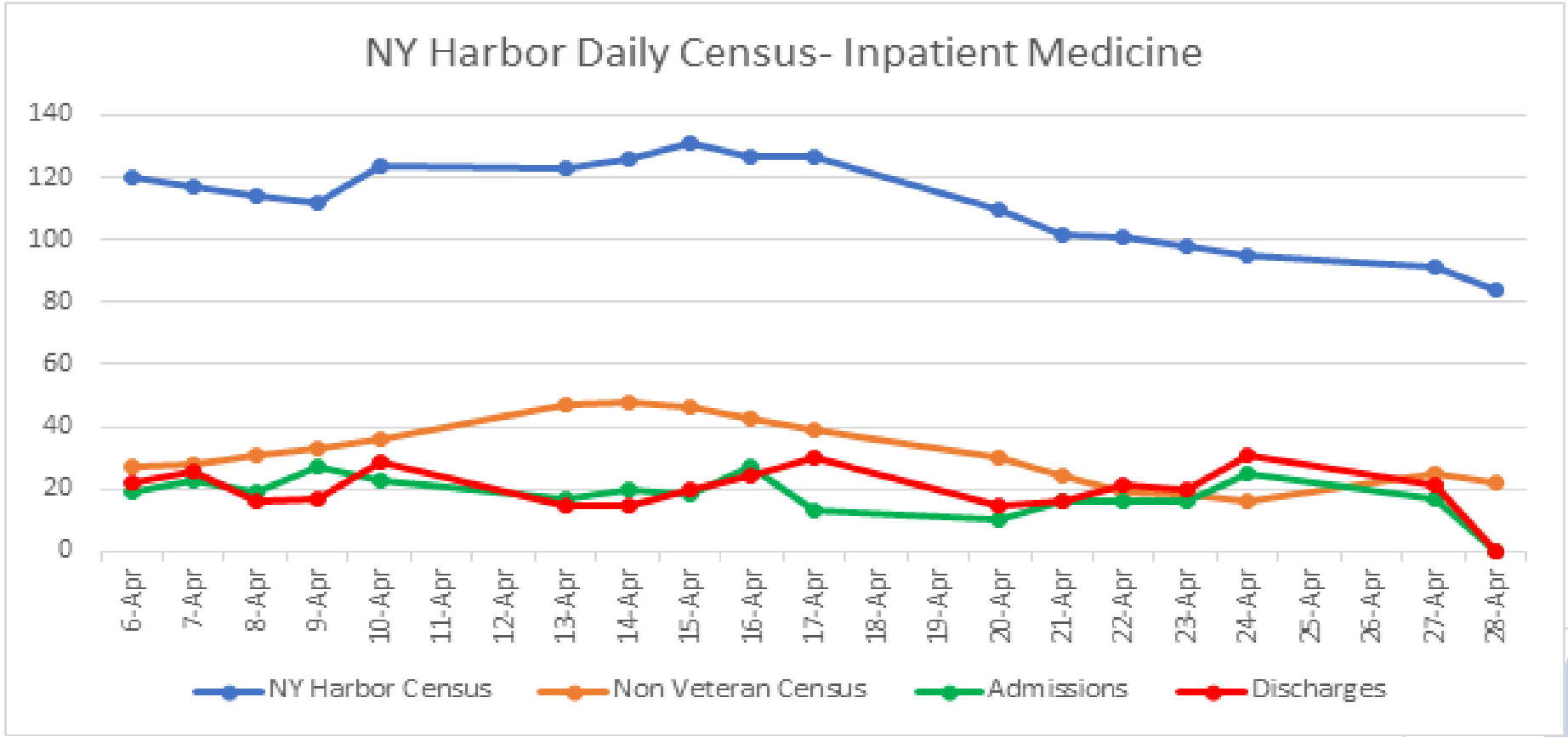
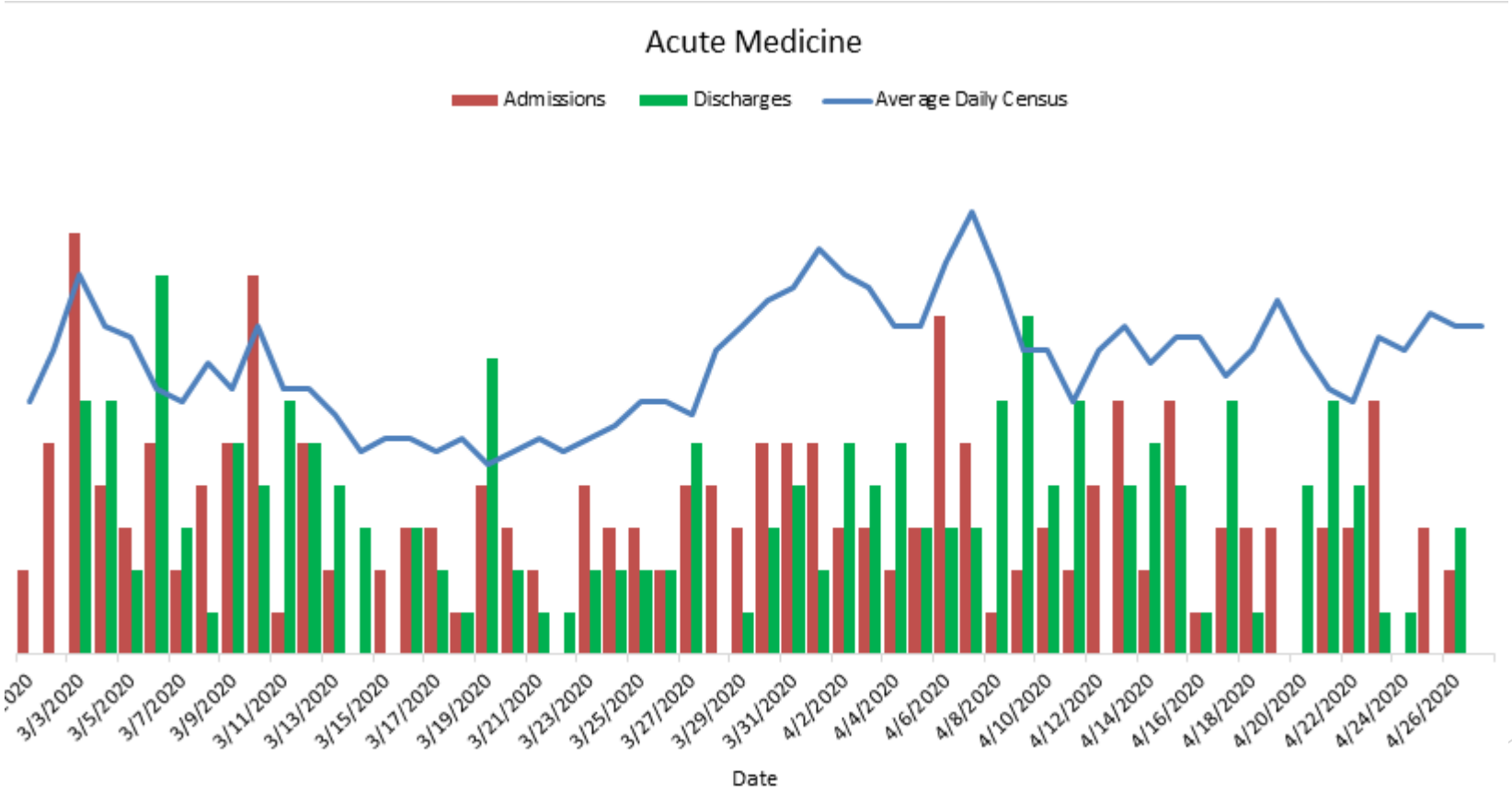
Pandemic Regional Impact



Pandemic Impact- New York Harbor



Pandemic Impact- Northport



COVID 19 Specific Challenges in Post Acute Transitions

- Limited in person contact with patients
- Traditional community resources (i.e. assistance with Medicaid, transportation, visiting companion services, APS, SW home visits) are less accessible
- Skilled Nursing Facilities are struggling with consistent staffing. Beds are available but staffing is down due to illness
- Discrepancies in viewpoints of homecare agencies on CDC vs. DOH guidance on accepting patients into homecare who are COVID+
- Many patients, including homeless lack ability to self isolate
- High volume of critically ill patients
- Illness has significant duration resulting in long acute hospital stays
- Patients may be intubated upon arrival and cannot locate next of kin or identify goals of care
- All of out traditional barriers (patients finances, resistance to discharge, family dynamics) still exist and often become heightened due to stress related to pandemic

Strong Practices and Innovations

- IDT rounds MUST go on- use of Skype to ensure interprofessional team members are as actively involved as they were when meeting in the same room every day
- Outreach made early on and continuously to local SNF in order to assess their staffing, creation of COVID “neighborhoods” and ability to assist in transitioning patients
- Outreach adult home and assisted living facilities to assess availability and policy related to COVID+ new and returning admissions
- Engage PT early on- movement may decrease need for rehab and help avoid further development of medical complications associated with deconditioning
- VISN call to discuss discharge planning daily- cases resources and ideas are shared between sites
- Partnership with recreation therapy to help Veteran’s face time with their families and engage in discharge planning conversations as needed
- Updating NOK with eligibility and completion of Goals of Care conversations by outpatient SW
- Collaborating with city agencies to identify isolation spaces for those who cannot
- NYH NIC coordinator- call with all contracts for skilled/non-skilled HHA to clarify discharge guidelines between CDC and DOH
- Use of rapid COVID testing to eliminate need to isolate as PUI, or facilitate timely discharge
- Additional HCHV beds

Discharge Template Facility Example

Current Facility	Last Name	First Name	DOB	Last 4	Medically Ready For Discharge?	Admission Source	From Another VA Facility?	COVID Status	Current Care Needs	Independent in ADLs?	Independent in IADLs?	Anticipated Long Term Disposition	Additional Notes
Northport	Doe	John	1/1/20	XXXX	Yes	Home	No	Positive	Quarantine	Yes	Yes	Home	
NY Harbor	Doe	Jane	1/1/20	XXXX	Yes	CLC	Bronx	Positive	Acute Reha	No	No	Skilled Nursing Facility	

Submitted by the facility daily and discussed via Skype call

Unmet Needs and/or Ongoing Challenges

- Transportation/funds
- Resources civilian cases/data sharing with outside hospitals
- Locations to self isolate for those who cannot
- Rapid testing early on
- Check in with treatment team members
- Updated next of kin information and advance directives/goals of care
- Evolving guidance on isolation practices