

ACUTE CARE COVID+ SITE: INTAKE CRITERIA FOR ADMISSION

Emergency Support Function (ESF)	#8 – Public Health & Medical	Effective	27 JULY 2020 / 1200 Hrs.
Relevant Section(s)	All Personnel	Next Review Date	JULY 2021

Purpose:

Establish guidance for the Acute Care ACS and sending Facilities to ensure a clear understanding of the capabilities of the ACS with the goal to balance patient care and healthcare worker safety.

Background

Health care facilities are experiencing significant impact from the impacts of COVID-19. Consequent to that capacity for care of patients who are acutely ill is exceeding capacity. In severe cases, hypoxemia with progression to respiratory failure is an unfortunate consequence. Evolving care strategies have been tested to include escalating requirements for oxygen. Intubation is avoided as outcomes have been predictably poor. The recovery of patients who have severe disease is prolonged at about 32 days in a monitored setting. Strategies to predict who may progress to severe illness was examined in a single study from March 2020 produced the CALL Score which uses a combination of Comorbidities, Age>60, Low Lymphocyte Count, and High LDH as predictive of poor outcome. Other measures found valuable were D-Dimer, Serum Ferritin, and Procalcitonin. There is an on-going study starting May 2020 thru ClinicalTrials.gov which will not be available until November 2020. Information thru phone calls with the Physician Director of ICU and ECMO Physician Director at Methodist Healthcare in San Antonio, both reporting frequent unpredictable deterioration.

Successful strategies without intubation include low flow nasal cannula, Oxymiser, High Flow Nasal Cannula, 15L NRM. High risk activities for this strategy include CPAP and especially BiPAP as this creates aerosols. A study by Whittle regards respiratory support showed HFNO as preferred to any NIPPV (CPAP or BiPAP) when available. Hand-held nebulization therapy outside a negative pressure environment presents a similar risk as does BiPAP or CPAP. MDI with a spacer has equivalent efficacy and is a safer equivalent treatment plan. As a strategy, some transport agencies disallow BiPAP given the high-risk nature. In the **Federal Healthcare Resilience Task Force (2020)**. **Alternate Care Site (ACS) Toolkit: Third Edition** BiPAP supplies are not included.

Efforts to avoid intubation, provide sufficient safety for healthcare workers, and decompress overwhelmed facilities must be balanced. Consequent to that, inclusion and exclusion criteria are set forth to balance all the concerns with patient safety foremost. Ventilators are not deployed in the ACS and pressor drips are not deployed (no arterial lines are used and there is no PICC service).

PROTOCOL

INCLUSION CRITERIA

- RT-PCR Test Positive
- Age ≥ 18
- Oxygen Sat $\geq 90\%$ on $\leq 10L$ NC
- Normal Blood Pressure or HTN
- Mental status at baseline

EXCLUSIONS

- Age < 18
- Suicidal/Homicidal/Violent
- New Altered Mental Status
- MAP < 65 or Requires Pressor/s to achieve MAP ≥ 65
- Behavioral/Disability Requiring 1:1 Sitter
- Wounds requiring Wound Vacs
- Requires aerosolizing Procedures (BiPAP/CPAP/Continuous Handheld Nebs)
- Alcohol Dependence with Possibility of Progression to Severe withdrawal
- No Patient with LVAD or Life Vest
- Hospice or palliative care patients with life expectancy < 14 days (Note: A physician-to-physician discussion must occur to accept any hospice or palliative care patient)
- O₂ Sat $< 90\%$ on $> 10L$
- Respiratory Rate > 30
- Requirement for continuous insulin drip
- Require Ongoing Remdesivir or Plasma from Recovered Persons
- Facility unable to send full course of Decadron (Dexamethasone) if a candidate
- Facility unable to provide ongoing DVT Prophylaxis via device or medication

TO QUALIFY FOR TRANSFER, PATIENTS:

- Must come from the inpatient setting
- Must have a documented positive COVID test by rtPCR testing
 - Persons Under Investigation (PUIs) pending test results cannot be accepted
- Must not meet any of the exclusion criteria described above

CALLER WILL ALSO BE ASKED THE FOLLOWING QUESTIONS AT THE TIME OF TRANSFER REQUEST:

- Patient Name
- Patient DOB/Age
- Is this a bariatric patient?
- Does the patient have mobility issues?
- How is the patient's oxygen requirement being met?
- Is the patient a diabetic on insulin?
- Is the patient in custody/currently incarcerated?
- Is the patient DNR/DNI?

INFORMATION TO BE PROVIDED BY HOSPITALS AT ON-SITE TRANSFER ACCEPTANCE

- Hospital is **required** to provide 4 days of medication (includes needles/syringes for insulin).
- Is Patient still in course of dexamethasone. If so, send remaining doses.
- Is patient on Remdesivir currently. If so will be excluded until course is complete.
- What DVT prophylaxis is used and how will continuation of dosing or device to be provided to ACS.
- Hospital is **required** to provide walker or cane if needed for mobility
- Hospital is **required** to provide the following paperwork:
 - Face-sheet
 - Discharge summary, Lab/Xray Report Summaries, ABG or Capnography not indicative of respiratory failure prior to transfer (CO₂>55)
 - Code status paperwork
- Please leave the hospital armband on the patient (do not cut it off)
- Hospitals may believe that the ACS doesn't have high flow capability because the exclusion criteria states, "Oxygen Sat \geq 90% on \leq 10L NC." To clarify, the patient needs to be Oxygen Sat \geq 90% on \leq 10L NC to be admitted to the ACS. But, once in the ACS, the ACS has the capability to provide high flow oxygen - "Oxygenation: 15L NRM, Oxymiser, Low Flow Nasal Canula (\leq 6L), High Flow Nasal Oxygen."
- Hospitals may believe that patients who have been treated with Remdesivir or Plasma cannot go to the ACS. To clarify, a patient that has completed Remdesivir or Plasma treatment can go to the ACS. However, the patient cannot receive Remdesivir or Plasma therapy at the ACS so they must complete this at the hospital prior to transfer.

Capabilities in ACS

Critical Care and Critical Care/EM Physicians, PAs, CRNAs

Critical Nurses, Paramedics, CNAs

On Site Pharmacist 24/7

Limited Onsite Lab with iSTAT, all other labs are sent out, no ability to care for DKA

Oxygenation: 15L NRM, Oxymiser, Low Flow Nasal Canula (\leq 6L), High Flow Nasal Oxygen

Central Monitoring with ACLS capability (no ventilator support)

Intubation capable but offsite transport of any patients who decompensate. Objective to move patient before need for intubation.

Not BiPAP/CPAP/Handheld Neb capable or emergent radiograph capable

Standardized Orders for Care of COVID Patients at entry

Patients on Handheld Nebs will be Converted to MDI Upon Arrival to ACS (There is no Negative Pressure Capability)