

**Milwaukee Alternate Care Facility (ACF)
At State Fair Park
Process and Protocol Guide
Overview of Alternate Care Facility Intake Request Process**

Wisconsin hospitals seeking to transfer patients to the Alternate Care Facility must meet the criteria for admission described below. The revised Alternate Care Facility (ACF) Admissions Form on **page 4-5** of this reference guide must be emailed, then verbally reviewed during the patient transfer request call, and finally discussed in a physician to physician discussion.

PRIOR TO INITIATING A TRANSFER REQUEST, PLEASE BE SURE THAT THE PATIENT IS WILLING TO RECEIVE CARE AT THE ACF. Much time and effort is lost if the admission review is carried out only to learn that the patient or family refuses the transfer.

To initiate the patient transfer assessment process, the hospital's Case Manager or designee will email the following:

- Revised ACF Admission Form (page 4-5)
- Current MAR

E Mail the completed Admission Form to: WIDLACFAdmissions@wisconsin.gov

Once this information is sent, please call the ACF Placement/Transport Coordinator by phone to advise the requested information has been sent: **414-374-6639**

Calls requesting patient transfer must be placed between 9:00 AM-5:00 PM. We encourage same day transfers, therefore please call as early in the day as possible.

The CMO or physician designee will personally review and approve all intake requests. The goal of the intake process is to assure safe care within the ACF, and admit those patients having the highest likelihood of successful discharge from the ACF to their pre-hospital environment. The nurse to patient ratios at the ACF is 1:6.

If the patient is accepted for admission, they **MUST** arrive at the ACF no later than 6:30pm.

If the patient transfer is approved by the ACF's Chief Medical Officer, the ACF will schedule ambulance transportation from the hospital to the ACF. The case manager or patient's nurse or designee will be notified as to the time the ambulance team will arrive.

The ACF reserves the right to refuse admission of a patient during the intake process if the ACF clinical assessment indicates an unacceptably high risk of clinical condition and transfer to the patient.

PLEASE NOTE: All patients are required to have an identified post-discharge primary care clinician and follow-up plan in place to be communicated to the ACF intake staff at the time of transfer request. The ACF will also need to have a contact at the transferring hospital to notify when the patient is being discharged from the hospital.

Please let patients and families know: For the health of friends and loved ones, as well as the safety of our patients, visitors will not be allowed at the ACF. The ACF is considered a Covid-19 positive environment.

Alternate Care Facility Inclusion Criteria

- From ED: 4-hour minimum stay, oxygen requirement of NC O2 6LPM or less to maintain pulse ox greater than 90%
- From Floor: oxygen requirement of Optiflow 50LPM/50% FiO2 or less to maintain pulse ox greater than 90%
- Confirmed COVID-19 positive
- Age 18 and over
- May require Remdesivir
- Patient weight limit up to 350 pounds.
- May require bronchodilator metered dose inhaler therapy
- Ambulatory and able to perform activities of daily living (ADLs) with limited (one person) assistance
- May require IV fluids for hydration and/or limited medications such as antibiotics
- Normal mental status evaluation
- Able to tolerate PO
- Patients have all needed home medical supplies or devices in hand (including diabetes monitoring, ostomy, self-catheterization, and ambulatory assistive devices) and can manage own care in their use during this stay
- Will be discharging back to an independent living situation and setting
- Transferring hospital/clinician provides list of home medications and schedule along with a minimum 3-day supply, and e-prescribes new medications or DME anticipated at discharge
- Clearly defined care management follow up strategy, with a Primary Care Clinician/Clinic identified to support the ongoing plan of care

- Any payor status (including uninsured)

Alternate Care Facility Exclusion Criteria

- COVID negative diagnosis
- Skilled nursing care, nursing home or assisted living residents
- Weight over 350 lbs/160kg
- Requirement of significant nursing care (e.g. more than one-person assist, assisted catheterization, complex wound care)
- CPAP or BiPAP (patients with SNA who require CPAP at night in the hospital are excluded)
- Requirement of dialysis
- CIWA score >8
- Acute mental health issues or drug/ alcohol addiction
- Pregnancy
- Incarcerated or in police custody
- Severely immunocompromised (as defined by discharge attending of record such that the patient is at high risk of decompensation with COVID-19; including pregnancy, neutropenia, diagnosis of AIDS or HIV-infected persons with severe immunosuppression defined as CD4 percent <15% or CD4 count <200 lymphocytes/mm³, primary immunodeficiency, patients who have received a bone marrow transplant until at least 12 months after finishing all immunosuppressive treatment, or longer in patients who have developed graft-versus-host disease; post-solid organ transplant on anything beyond a maintenance dose of immunosuppressive medications)
- On contact precautions for acute diarrheal illness
- Known active MRSA, C. Difficile, TB, active XDRO, MDRO, known Candida auris colonization or infection
- No concealed carry weapons allowed

Alternate Care Facility Admission Form

PLEASE EMAIL THIS FORM TO AND PATIENT'S MAR TO:

WIDLACFAdmissions@wisconsin.gov

**This form will be used during the Physician to Physician patient transfer request review
as well as included in the patient's record at the ACF.**

Please include the patient's MAR with the submission of this form.

Date/Time:

Hospital Requesting Transfer:

Hospital Address:

Patient Names:

Date of Birth:

Patient Phone Number:

Transferring Physician/APP:

Physician/APP Phone Number **(please include direct contact number):**

Name of Nurse/ Case Manager and Phone Number
for the Ambulance Company to Call to Coordinate
Patient's Transportation

Name and Contact Number of Family Member:

Assessment from Acute Care Site

Is patient consenting to ACF transfer? Yes/No

Is patient in the Emergency Department? Yes/No

Is this an inpatient? Yes/No

If yes, please indicate the patient's room number and hospital floor: _____

Vital Signs – BP _____ P _____ RR _____ Temp _____ SPO2 _____

Allergies_____

Oxygen requirement in past 24 hours (include with activity if known):

Date of onset of COVID symptoms_____Date of positive COVID test_____Date of admission_____

Brief clinical summary (including active medical problems):

Code Status_____

Patient weight_____

(Patient must weigh under 350 lbs/160 kg)

Is patient able to ambulate in the hospital? Yes/No

(Patient must be able to ambulate on own or with 1-person assist)

Does the patient require CPAP for SNA at night? Yes/No

(The ACF cannot take patients who require CPAP)

D-Dimer_____

CT PE (if D-Dimer positive)_____

(CT PE not required if D-Dimer negative OR patient is on adequate oral anticoagulation)

AST/ALT_____

GFR_____

INR (if on Coumadin)_____

List any significant lab abnormalities:

Patient on Remdesivir? Yes/No If Yes, date started_____

Please email current MAR with this form

Discharge Plan