DEPARTMENT OF HEALTH

Interim Guidance for Hospital Discharge to Home or Admission to Congregate Living Settings and Discontinuing Transmission-Based Precautions

GUIDANCE AS OF APRIL 8, 2020

Increased community transmission in Minnesota has led to a rise in the number of COVID-19 cases and hospitalizations. There is an urgent need to ensure hospital capacity for individuals who require acute care and also to ensure that discharges from hospitals are directed to settings that are equipped to provide appropriate care and ensure the safety of vulnerable adults already residing there. It is the recommendation of MDH that patients with suspected or confirmed COVID-19 can be discharged when clinically indicated and neither discontinuation of transmission-based precautions nor the establishment of two negative COVID-19 tests is required prior to hospital discharge[1].

The purpose of this guidance is to address hospital discharge to home or admission to congregate living settings and discontinuation of transmission-based precautions both within hospitals and congregate living settings. Congregate living settings include assisted living, long-term care or skilled nursing facilities or other congregate living setting that provide direct patient care. In light of testing and personal protective equipment shortages, all facilities providing patient care should also address source control[2] and staff monitoring and exclusion policies[3]. This guidance is subject to change as diagnostic testing becomes more available, capacity of discharge facilities changes, and as more is learned about duration of viral shedding.

Discharge of an Inpatient to Home

Patients with confirmed or suspected COVID-19 can be discharged to home when it is clinically indicated.

- Home isolation can be discontinued following a non-test-based approach.[1]
- Caregivers should be educated on care procedures and visitation restrictions in the home for confirmed or suspected COVID-19 patients[4].

Discharge of an Inpatient to Congregate Living Setting that Provides Patient Care

Patients with confirmed or suspected COVID-19

Patients with confirmed or suspected COVID-19 who still require transmission-based precautions for COVID-19 can be transferred to congregate living facilities as long as the facility can follow the infection prevention and control recommendations of the Centers for Disease Control and Prevention (CDC) for the care of COVID-19 patients[5].

- Hospital discharge planners must provide advanced notice to the congregate living facility for any transfer of a patient with confirmed or suspected COVID-19.
- Considering the inconsistent availability of PPE and staffing for in-congregating living facilities, transitional sites for post-acute care could be considered to allow hospital discharge and protection of vulnerable populations in congregate living facilities. Sites could include the following:

  - A temporary site that is staffed for the sole purpose of caring for patients with known or suspected COVID-19.
  - Post-acute care facilities that have moved patients to allow for use of dedicated buildings to accept patients with known or suspected COVID-19.
- For patients who are symptomatic and under transmission-based precautions who do not have access to transitional sites or dedicated COVID-19 facilities, hospital discharge planners should follow a tiered approach.
  - Transfer patients to a receiving facility with a separate unit dedicated to COVID-19 patients, including dedicated staff and PPE.
  - Transfer patients to a receiving facility that has private rooms with private bathrooms or that has the ability to cohort[6, 7] positive or suspect COVID-19 patients with dedicated staff and PPE.
- If transmission-based precautions have been discontinued (see below), patients with persistent symptoms should be placed in, and restricted to, a private room in the facility and wear a medical-grade facemask during care activities until symptoms are completely resolved or until 14 days after illness onset, whichever is longer.
- If transmission-based precautions have been discontinued (see below) and symptoms have resolved, patients can be discharged back to their facility of origin, regardless of the facility's ability to adhere to infection prevention and control recommendations for the care of COVID-19 patients and the patients' pending or completed test results.

Persons under investigation (PUI) for COVID-19, with test results pending

A PUI (someone who has symptoms suggestive of COVID-19) should not be transferred to a congregate living setting until test results are available, unless the facility is experienced and able to handle patients with COVID-19. Clear communication about the pending COVID-19 test must be provided to the receiving facility.

Patients investigated for possible COVID-19 with negative test

Patients investigated for possible COVID-19 with a negative COVID-19 test can be discharged from a hospital to a congregate setting.

- Prior to hospital discharge, hospital providers should consider influenza testing and evaluation for other respiratory pathogens, as appropriate.
- Hospital discharge planners should communicate test results and any indication for continuation of transmission-based precautions to the receiving facility.
- Residents should be admitted to a private room with private bathroom and monitored at least twice daily for 14 days to determine whether symptoms develop that could be consistent with COVID-19. Patients should stay isolated in the room for the 14-day period. The resident may be moved out of a private room if they remain asymptomatic after the 14-day period.

Patients with no clinical concern for COVID-19

At this time, patients with no clinical concern (e.g. no presence of symptoms consistent with COVID-19), can be discharged from a hospital to a congregate living setting following normal procedures. However,

patients should be quarantined and monitored for the development of symptoms. Recommendations are as follows:

- Congregate living settings should not require a negative COVID-19 test result as criteria for admission or re-admission of residents hospitalized with no clinical concern for COVID-19.
- Hospitals are not required to perform COVID-19 testing on patients solely for discharge considerations unless they develop new respiratory symptoms.
- Residents should be admitted to a private room with private bathroom and monitored at least twice daily for 14 days to determine whether symptoms develop that could be consistent with COVID-19. Patients should stay quarantined in the room for the 14-day period. The resident may be moved out of a private room if they remain asymptomatic after the 14-day period.
- Receiving facilities should maintain a low threshold of suspicion for COVID-19 disease and consider COVID-19 testing and implementation of transmission-based precautions immediately if a resident develops symptoms (see guidance below on confirmed or suspected COVID-19 patients).

Discontinuation of Transmission-Based Precautions in Hospitals or Congregate Living Facilities

Because of limited COVID-19 diagnostic testing supplies and potentially long delays between specimen collection and results, discontinuation of transmission-based precautions should be guided by clinical conditions using CDC's non-test-based strategy[1]. For immune-competent individuals with confirmed or suspected COVID-19, transmission-based precautions should be maintained until both of the following criteria are met:

- At least 7 days have passed since symptom onset AND
- 3 days have passed since recovery, which is defined as resolution of fever without fever-reducing medication and improvement in respiratory symptoms (e.g., cough, shortness of breath).

  Patients with persistent symptoms should be placed in, and restricted to, a private room in the discharge facility and wear a facemask during care activities until symptoms are completely resolved or until 14 days after illness onset, whichever is longer

- For patients 75 years of age and older, the period of isolation should be at least 14 days since symptom onset with 3 days of resolution of fever without fever-reducing medication and improvement in respiratory symptoms (e.g., cough, shortness of breath).
- For patients with immunocompromising conditions (e.g., medical treatment with immunosuppressive drugs, bone marrow or solid organ transplant recipients, inherited immunodeficiency, poorly controlled HIV), the period of isolation should be at least 21 days since symptom onset with 3 days of resolution of fever without fever-reducing medication and improvement in respiratory symptoms (e.g., cough, shortness of breath).

References

1. CDC: Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance): (https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html)

2. MDH: Interim Guidance on Facemasks as Source Control Measure: (https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf)
3. MDH: COVID-19 Recommendations for Health Care Workers: (https://www.health.state.mn.us/diseases/coronavirus/hcp/hcwrecs.pdf)
4. CDC: Caring for Someone at Home (https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/care-for-someone.html)
5. CDC: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html)
6. AHCA/HCAL: Cohorting Residents to Prevent the Spread of COVID-19 (https://www.ahcancal.org/facility_operations/disaster_planning/Documents/Cohorting.pdf)
7. CMS: QSO 20-14 (https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf)