Guidelines for Transferring Patients to Home with Home Care or Hospice Care During the COVID-19 Epidemic

The Long-Term Care Facilities Subcommittee of the Utah Governor's COVID-19 Community Task Force has consulted with representatives of long-term, assisted living and home care and hospice communities to establish best practices when transferring patients from acute care hospitals to home with home care or hospice needs. This guidance is consistent with the Centers for Disease Control and Prevention (CDC's) Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19.

Good communication between providers during the transition from the hospital to home with home care or hospice is critical for the successful implementation of this guidance. Hospitalized patients should be assessed for respiratory illnesses and COVID-19 prior to discharge to home with home care or hospice. Patients diagnosed with COVID-19 who require hospitalization can and should be discharged once clinically indicated. Meeting criteria for discontinuation of Transmission-Based Precautions[1] is **NOT** a pre-requisite for discharge; however, clear communication between home care or hospice caretakers and agencies and hospital discharge planners must occur to ensure the home caretakers are able to adhere to infection prevention and control recommendations as outlined in the CDC's Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings.

Building off processes developed across the country, the Long-Term Care Facilities Subcommittee recommend hospitals utilize a standardized **Hospital to Long-Term Care Facilities or Home with Home Care or Hospice COVID-19 Assessment** (see attached tool). Communicate this assessment for every patient being transferred who has been identified with home care or hospice needs as a face sheet and send at discharge to the referral agency.

The following are patient categories and general protocols for hospital discharges to home with home care or hospice needs:

Category 1 – Patients with no clinical concern for COVID-19

Inadvertently introducing an asymptomatic COVID-19 carrier into a previously COVID-19 negative home setting poses a risk for outbreaks. **ALL** hospitalized patients, regardless of presence of respiratory symptoms, who are discharged to home with home care or hospice services should be screened for COVID-19 through symptom screening and testing, if available.

- If the patient is unvaccinated or partially vaccinated, and has no clinical concern for COVID-19, the patient may be discharged with no change in the standard process. The receiving home care or hospice agency should recommend placement of the patient in an individual room and visiting home care or hospice staff shall use Standard Contact[2] and Droplet Precautions for 14 days. Agencies may consider adopting a process to perform PCR testing on these individuals at 5 and 7 days after they are discharged

from their acute care setting to capture asymptomatic carriage acquired in the hospital and discontinue Transmission-Based Precautions[1] if all tests remain negative.

- If the patient is fully vaccinated (at least 14 days since the COVID-19 vaccination series has been completed), has been screened and found to have no clinical concern for COVID-19, and had no prolonged close contact* with someone with SARS-CoV-2 infection in the prior 14 days, the patient may be discharged to home with home care or hospices services with no change in the standard process and with no need for the patient to be placed in quarantine or Transmission-based Precautions.

*Close contact means being within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period. See https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/appendix.html#contact.

Category 2 – Patients investigated for possible COVID-19, but with a negative test

If a patient has a negative COVID-19 test and meets usual clinical criteria for discharge, the patient is acceptable for discharge to home with home care or hospice, while recognizing the potential for a false negative test. The receiving agency should recommend the patient stay in an individual room and visiting staff shall use Standard Contact[2] and Droplet Precautions for 14 days. Patients requiring Aerosol-Generating Procedures (AGPs)[3] will require additional precautions.

Many patients with active symptoms, e.g., fever, cough, shortness of breath, may warrant retesting for COVID-19 if symptoms persist. Patients that have had severe or critical illness[6,7] or who are immunocompromised[8] may warrant a repeat PCR test 5 and 7 days from discharge to ensure no false negatives were missed and recategorized (see Category 4) if they are determined to be COVID-19 positive.

Category 3 – Patients under investigation for COVID-19, and test results are pending

Same guidance as Category 2.

Category 4 – Patients with positive COVID-19 testing

Home care or hospice staff can care for patients diagnosed with COVID-19 as long as they are able to care for the patient to the needed level of Transmission-based Precautions[1] to adequately protect the healthcare workers. Patients requiring AGPs[3] will require additional precautions, including staff use of appropriately fitted N95 masks or equivalent in areas of moderate to substantial community transmission**.**

Patients with mild to moderate illness[4,5] who are not severely immunocompromised and symptomatic:

- Transmission-based Precautions[1] are required for any patient who is <10 days from symptom onset, **AND** any patient with fever >100.0°F and/or symptoms, e.g., cough, shortness of breath, in the past 24 hours.
- Transmission-based Precautions[1] may be discontinued if a patient has met the criteria listed below:
    - At least 10 days have passed *since symptoms first appeared,* **AND**
    - At least 24 hours have passed *since last* fever without the use of fever-reducing medications, **AND**
    - Symptoms (e.g., cough, shortness of breath) have improved.
- Patients in this category should be restricted to a single room and wear a facemask during care until all symptoms resolve or 10 days after symptom onset, whichever is longer.

- If symptoms are resolved and Transmission-based Precautions[1] are discontinued, no further restrictions are required.

Patients with mild to moderate illness who are not severely immunocompromised and asymptomatic throughout their infection:

- Transmission-based Precautions[1] may be discontinued if a patient has met the criteria listed below:
    - At least 10 days have passed since the date of their first positive viral diagnostic test.

Patients with severe to critical illness[6,7] or who are severely immunocompromised[8] with symptoms:

- Transmission-based Precautions[1] are required for any patient who is <20 days from symptom onset, **AND** any patient with fever >100.0°F and symptoms (e.g., cough, shortness of breath) in the past 24 hours, **AND** symptoms are improving.
- Transmission-based Precautions[1] may be discontinued if a patient has met the criteria listed below:
    - At least 20 days have passed *since symptoms first appeared,* **AND**
    - At least 24 hours have passed *since last* fever without the use of fever-reducing medications, **AND**
    - Symptoms (e.g., cough, shortness of breath) have improved.
    - Consider consultations with infectious disease experts.

Patients who are severely immunocompromised and asymptomatic throughout their infection:

- Transmission-based Precautions[1] may be discontinued if a patient has met the criteria listed below:
    - At least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.
    - Consider consultations with infectious disease experts.

Patients that have recovered from COVID-19 in the last 90 days

The last group of patients that may be transferred are those with a past diagnosis of COVID-19 who have completed their isolation period, are determined to be clear of illness, and are within 90 days of their initial diagnosis. These patients do not warrant a retest unless they develop significant symptoms. Retesting should be conducted with the consultation of infectious disease specialists or the Healthcare Associated Infections (HAI) program, Utah Department of Health.

Recommendations of the Long-Term Care Facility Subcommittee of the Utah Governor's COVID-19 Community Task Force.

Definitions

[1]Transmission-based Precautions should be used for all patients with known or suspected COVID-19 and include all the Standard Precautions plus the use of an N95 or higher-level respirator, when available. Cloth face coverings are NOT personal protection equipment (PPE) and should not be worn for the care of patients with known or suspected COVID-19. The use of N95 or higher-level respirators are only recommended for healthcare personnel who have been medically cleared, trained, and fit-tested, in the context of a facility's respiratory protection program. While respirators (instead of facemasks) are preferred, facemasks are generally an acceptable alternative except for patients requiring AGPs. See https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID-19_PPE_illustrations-p.pdf.

[2]Standard Contact Precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting. Elements of Standard Precautions recommended during the COVID-19 epidemic include masking the patient and placing in an individual room for source control, hand hygiene, and the use of PPE whenever there is an expectation of exposure to infectious material (gown, gloves, facemask, and eye protection).

[3]Airborne Precautions should be used for known or suspected COVID-19 patients being treated with aerosol generating procedures (AGPs) that require the use of fitted N95 or higher-level respirators, gloves, eye protection, and gowns. Medical procedures often considered AGPs that may be performed under routine or emergency conditions in home settings include open suctioning of airways, sputum induction, non-invasive ventilation (e.g., BiPAP, CPAP), nebulizer administration, cardiopulmonary resuscitation, tracheostomy patients with humidification, high flow nasal cannula use and endotracheal intubation. In addition to current PPE shortages, some home care settings have NOT fit-tested their healthcare personnel, and an abundance of caution should be used in determining whether it is appropriate to transfer patients with known or suspected COVID-19 who may require AGPs to properly trained agencies.

[4]Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

[5]Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

[6]Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.

[7]Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

[8]The studies used to inform this guidance did not clearly define “severely immunocompromised.” For the purposes of this guidance, CDC used the following definition:

“Some conditions, such as being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count <200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and inform decisions regarding the duration of Transmission-based Precautions.

Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of Transmission-based Precautions.

Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.”

Assessment Form for COVID-19 Screening and Isolation Procedures on Transfer from Hospitals to Long-Term Care Facilities or Home with Home Care or Hospice

INSTRUCTIONS: All hospitalized patients who are discharged to Long-Term Care or home with home care or hospice services should be assessed for COVID-19 through symptom screening and/or testing, if available, prior to transfer. Patients who have been hospitalized for COVID-19 need to have appropriate isolation timelines. This tool should be used to document an individual's medical status related to COVID-19 and sent with discharge orders as a face sheet to facilitate communication between the hospital and the receiving facility or agency during patient transfers. **This document must be signed-off by the physician, APRN, or PA or their designee who completes the clinical assessment.**

CHECK THE BOX FOR EACH OF THE CRITERIA APPROPRIATE TO THE PATIENT'S STATUS.

Patient Name:_____ **Vaccinated: Y / N** **Date Vaccine Series Complete/Mfr:**_____

Transferring Facility:_____ **Accepting Facility/Agency:** _____

Has patient been laboratory-tested for COVID-19?

YES. Patient tested for COVID-19
Date of test:_____
Test pending for home care/hospice settings only

Negative Test

Does patient have active symptoms (e.g., fever, cough, shortness of breath)?

YES → May transfer and quarantine in an individual room using Standard Contact and Droplet Precautions for 14 days. Consider retesting for COVID-19 or other illness if symptoms persist.

NO → May transfer. Mask patient. Place in individual room and use Standard Contact and Droplet Precautions for 14 days, unless patient is fully vaccinated AND has had no prolonged close exposure in the past 14 days.

If consideration is made to remove from quarantine sooner, PCR testing on day 5 and day 7 after discharge from acute care with negative results and no new symptoms leading to cessation of quarantine.

Positive Test - see Page 2

NO. Patient with no clinical concern for COVID-19 per screening and testing not available. **OR,** Patient fully vaccinated, with no clinical concern for COVID-19 WITH prolonged close exposure in past 14 days.

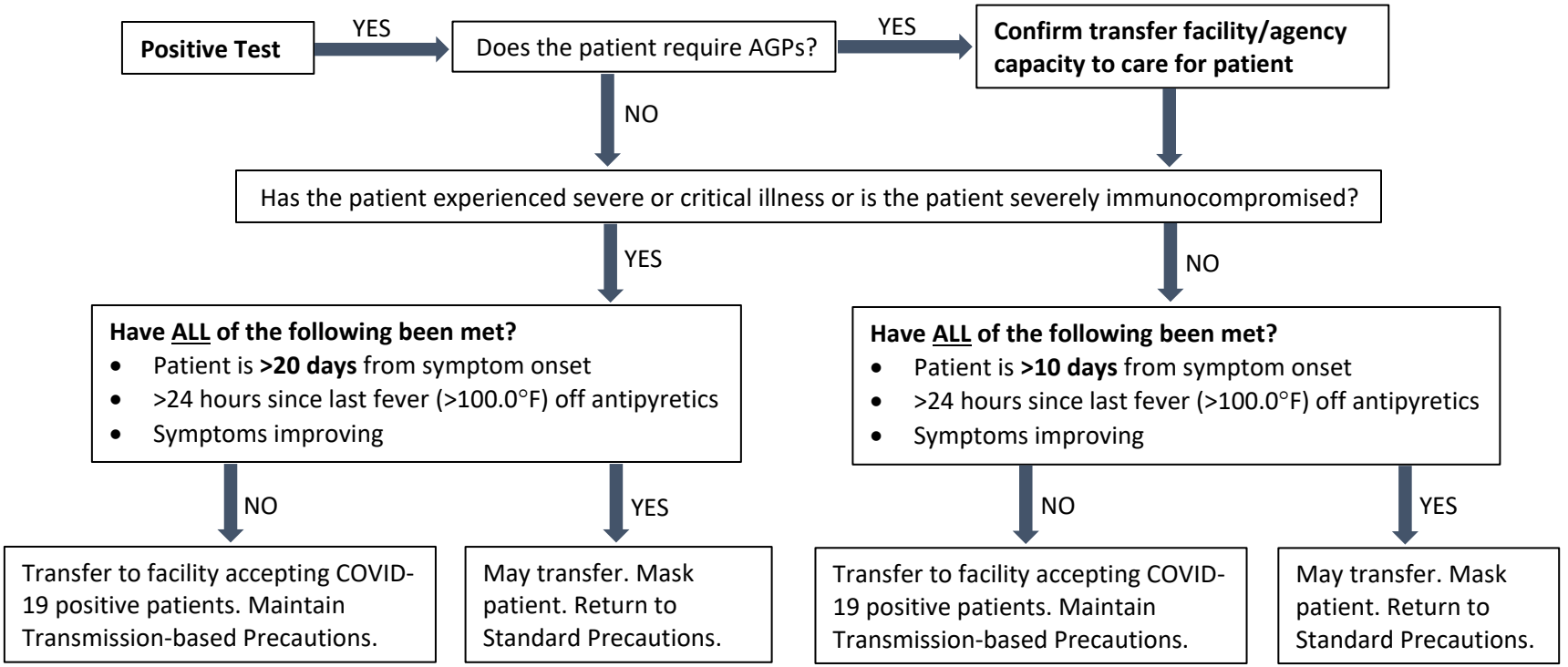
May transfer and quarantine in an individual room using Standard Contact and Droplet Precautions for 14 days.

To remove from quarantine sooner than 14 days, patient must have no new symptoms and negative PCR testing on day 5 and day 7 after discharge from acute care.

NO. Patient with COVID-19 infection diagnosed in last 90 days and through period of isolation per CDC.
Date of diagnosis: _____
OR, Patient fully vaccinated, with no clinical concern for COVID-19 and NO prolonged close exposure in past 14 days.

No quarantine indicated*

*For persons previously diagnosed with symptomatic COVID-19 who remain asymptomatic after recovery, retesting is not recommended within 3 months after the date of symptom onset for the initial COVID-19 infection. https://www.cdc.gov/coronavirus/2019-



Clinical Assessment completed by (signature)

Date/Time

Reported to (name of facility staff)

Date/Time

Last updated: 03/24/2021