

Guidelines for Transferring Patients from Hospitals to Long-Term Care Facilities During the COVID-19 Epidemic

During the COVID-19 epidemic, long-term care (LTC) and assisted living (AL) facilities have been reluctant to accept patients on transfer from hospitals due to concerns these patients may introduce COVID-19 into their facilities. The Long-Term Care Facilities Subcommittee of the Utah Governor’s COVID-19 Community Task Force has consulted with representatives of hospitals and the LTC and AL communities to establish best practices when transferring patients from acute care hospitals to LTC or AL facilities. 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 LTC or AL facilities is critical for the successful implementation of this guidance. Hospitalized patients should be assessed for respiratory illnesses and COVID-19 prior to discharge to LTC or AL facilities. Patients diagnosed with COVID-19 who require hospitalization can and should be discharged once clinically indicated. Meeting criteria for discontinuation of Transmission-based Precautions¹ is **NOT** a pre-requisite for discharge; however, clear communication between LTC or AL facilities and hospital discharge planners must occur to ensure the receiving facility is 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 Utah Hospital Association, the Utah Health Care Association and the Long-Term Care Facilities Subcommittee recommend hospitals utilize a standardized **Hospital to Post-Acute Care Facility Transfer COVID-19 Assessment** (see attached tool). Communicate this assessment for every patient being transferred to LTC or AL facilities.

The following are patient categories and general protocols for hospital discharges to LTC or AL facilities:

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

Inadvertently introducing an asymptomatic COVID-19 carrier into a previously COVID-19 negative LTC or AL facility poses a particular risk for outbreaks. **ALL** hospitalized patients, regardless of presence of COVID-19 symptoms, who enter LTC and AL facilities 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 to a LTC or AL facility with no change in the standard process. The receiving LTC or AL facility should place the patient in an individual room and use Standard Contact² and Droplet Precautions for 14 days. Facilities may consider adopting a process to perform PCR testing on these

individuals at days 5 and 7 after admission to capture asymptomatic carriers and discontinue Transmission-based Precautions¹ 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 a LTC or AL facility with no change in the standard process and with no need for the patient to be placed in quarantine or Transmission-based Precautions at the receiving facility.

*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 LTC or AL facilities, while recognizing the potential for a false negative test. The receiving LTC or AL facility should place the patient in an individual room and use Standard Contact² 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 immunocompromised⁸ 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

LTC or AL facilities can accept patients diagnosed with COVID-19 as long as the facility is able to care for the patient to the needed level of Transmission-based Precautions¹ to adequately protect healthcare workers. If available, COVID-19 positive patients should be transferred to a location dedicated to the care of COVID-19 residents, and the patient should stay there until deemed safe to return to their pre-COVID-19 living situation. Patients requiring AGPs³ 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 who are not severely immunocompromised with symptoms:

- Transmission-based Precautions¹ 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 72 hours.
- Transmission-based Precautions¹ 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 recovery*, defined as resolution of fever (<100.0°F) without the use of fever-reducing medications, **AND**
 - Symptoms (e.g., cough, shortness of breath) have improved, **AND**

- 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 Precautions¹ discontinued, no further restrictions are required.

Patients with [mild to moderate illness](#) or who are not severely immunocompromised and asymptomatic throughout their infection:

- Transmission-based Precautions¹ 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](#) or who are severely immunocompromised with symptoms:

- Transmission-based Precautions¹ 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.

Patients with [severe to critical illness](#) or who are severely immunocompromised and asymptomatic throughout their infection:

- Transmission-based Precautions¹ 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.

Patients that are 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 are through 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

¹Transmission-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. See https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID-19_PPE_illustrations-p.pdf.

²Standard 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).

³Airborne Precautions should be used for known or suspected COVID-19 patients being treated with aerosol generating procedures (AGPs) that require the use of N95 or higher-level respirators for adequate protection. Medical procedures often considered AGPs that may be performed under routine or emergency conditions in LTC or AL facilities include open suctioning of airways, sputum induction, non-invasive ventilation (e.g., BiPAP, CPAP), nebulizer administration, cardiopulmonary resuscitation, and endotracheal intubation. In addition to current PPE shortages, a vast majority of LTC and AL facilities 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 LTC or AL facilities.

⁴Mild 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.

⁵Moderate 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.

⁶Severe 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%.

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

⁸The 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.”

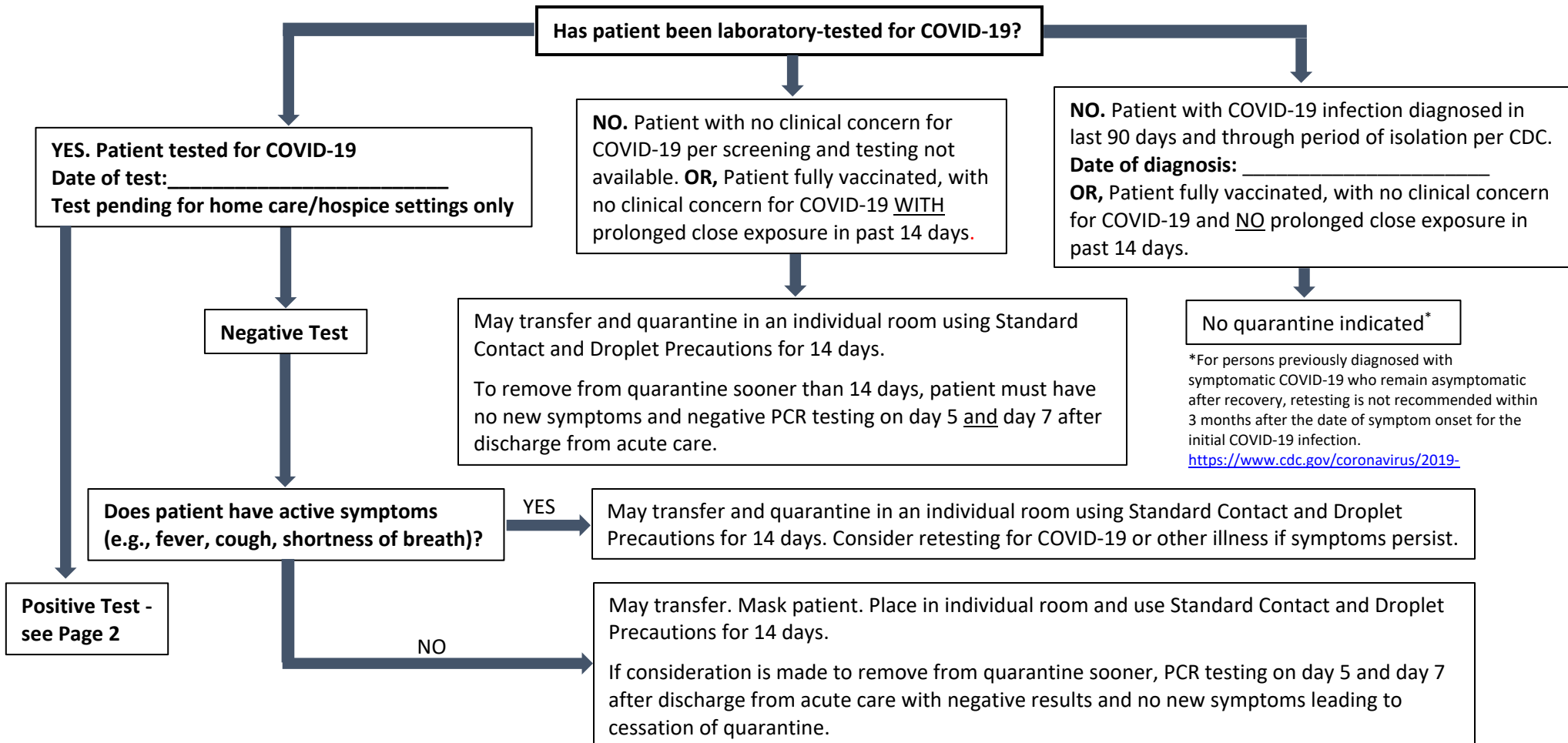
Assessment Form for COVID-19 Screening and Isolation Procedures on Transfer from Hospitals to Long-Term Care Facilities or Home with Home Care or Hospice

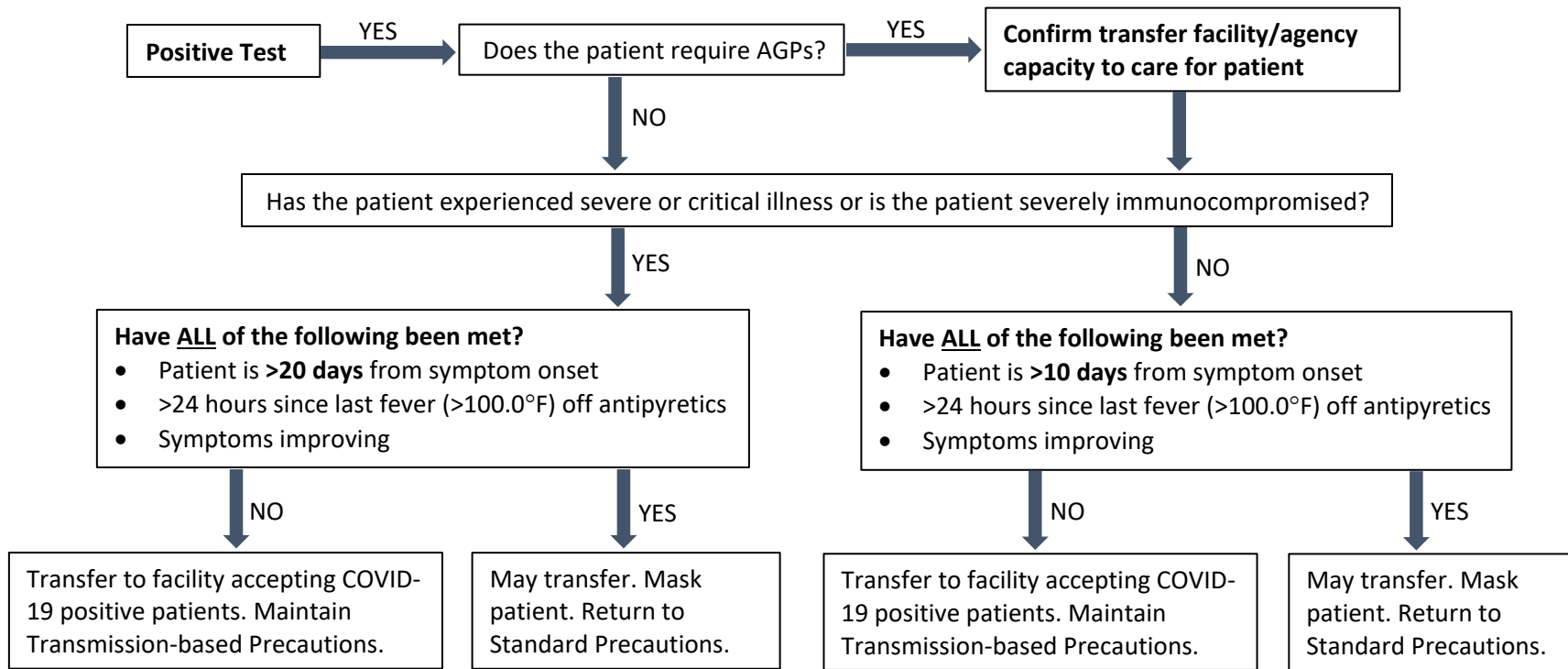
INSTRUCTIONS: All hospitalized patients who are discharged to Long-Term Care or home with home care or hospice services should be assessed for COVID-19 through symptom screening and/or testing, if available, prior to transfer. Patients who have been hospitalized for COVID-19 need to have appropriate 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: _____





Clinical Assessment completed by (signature)

Date/Time

Reported to (name of facility staff)

Date/Time