STAY SAFE MN

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

6/4/2021

Community transmission of SARS-CoV-2 in Minnesota continues to lead to COVID-19 illness and hospitalizations. Ensuring hospital bed capacity for individuals who require acute care is directly related to the ability to discharge COVID-19 patients to settings equipped to provide appropriate care while maintaining the safety of other vulnerable residents. Minnesota Department of Health (MDH) recommends that patients with suspected or confirmed COVID-19 be discharged when clinically indicated. Discontinuation of Transmission-Based Precautions nor negative COVID-19 test results are not required prior to hospital discharge.[1]

This guidance addresses discharging hospital inpatients or congregate living settings residents to home or congregate living settings. This guidance also addresses discontinuation of Transmission-Based Precautions in hospitals and congregate living settings. Congregate living settings include assisted living and skilled nursing facilities, or other congregate living settings that provide direct care. All facilities providing health care should address source control,[2] eye protection, and staff monitoring and exclusion policies.[3]

Discharge of an inpatient or resident to home

Patients or residents with confirmed or suspected COVID-19 can be discharged to home when it is clinically indicated. These recommendations are relevant when no additional health services are needed and when ongoing home health care (e.g., skilled nursing, physical therapy, occupational therapy, speech therapy, social work) is appropriate.

- Home isolation can be discontinued following a symptom-based strategy.[1]
- Caregivers should be educated on care procedures and visitation restrictions in the home for confirmed or suspected COVID-19 patients.[4]
- Home care might be warranted to ensure complex patients are monitored, assessed, and treated by health care workers (HCW), regardless of their COVID-19 status.

Discharge of an inpatient or resident to congregate living setting that provides health care

Patients or residents with confirmed or suspected COVID-19 who require Transmission-Based Precautions

Patients or residents with confirmed or suspected COVID-19 who require Transmission-Based Precautions for COVID-19 can be transferred to congregate living facilities if the facility follows the Centers for Disease Control and Prevention (CDC) infection prevention and control recommendations for the care of COVID-19 patients.[5]

- Hospital or congregate living facility discharge planners must provide advanced notice to the receiving congregate living facility for any transfer of a patient with confirmed or suspected COVID-19.
- Considering staffing challenges and inconsistently available PPE 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.
- Discharge planners should follow a tiered approach for patients or residents who are both symptomatic and under Transmission-Based Precautions and who do not have access to transitional sites or dedicated COVID-19 facilities.
  - Transfer patients or residents to a receiving facility with a separate unit dedicated to COVID-19 patients, including dedicated staff and PPE. **Only residents with confirmed SARS-CoV-2 should be placed in a designated COVID-19 unit.**
  - Transfer patients or residents to a receiving facility that has private rooms with private bathrooms or that can cohort[6,7] positive or suspect COVID-19 patients with dedicated staff and PPE.

Patients or residents with confirmed or suspected COVID-19 who do not require Transmission-Based Precautions

- If Transmission-Based Precautions have been discontinued, per CDC recommendations and symptoms have resolved, patients or residents can be discharged back to their home facility or receiving facility, regardless of the facility's ability to adhere to infection prevention and control recommendations for the care of COVID-19 patients.
- Patients or residents can be placed into a regular room without Transmission-Based Precautions and can be roomed with another resident.

Patients or residents with no clinical concern for COVID-19:

- In general, new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission.
  - Exceptions include residents within three months of a SARS-CoV-2 infection and fully vaccinated residents as described in CDC: Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination (www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html).
  - Facilities located in areas with minimal to no community transmission might elect to use a risk-based approach for determining which residents require quarantine upon admission. Decisions should be based on whether the resident had close contact with someone with SARS-CoV-2 infection while outside the facility and if there was consistent adherence to infection prevention and control practices in health care settings, during transportation, or in the community prior to admission.
- Hospitals are not required to perform COVID-19 testing on patients solely for discharge considerations unless they develop new symptoms suggestive of COVID-19.
- When available, residents should be placed in a single-person room with private bathroom or in a separate admission and re-admission observation area for monitoring symptoms of COVID-19. Residents can be transferred out of the observation area to the main facility if they don't have a fever or other COVID-19 symptoms for 14 days after admission.
- HCW should wear an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for residents with suspected or confirmed COVID-19.
  - HCW should implement CDC PPE optimization strategies when PPE are in short supply or unavailable.
  - Visit Optimizing Supply of PPE and Other Equipment during Shortages (www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/general-optimization-strategies.html) and Improve the Fit and Filtration of Your Mask to Reduce the Spread of COVID-19 (www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/mask-fit-and-filtration.html).
- Receiving facilities should maintain a low threshold of suspicion for COVID-19 and consider testing immediately if a resident develops COVID-19 symptoms or any change in condition.

Discontinuation of Transmission-Based Precautions in hospitals and congregate living facilities

Except for rare situations, a test-based strategy is no longer recommended to determine when to discontinue Transmission-Based Precautions. In a majority of cases, a test-based strategy results in prolonged isolation of patients who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious. The decision to discontinue Transmission-Based Precautions for patients with confirmed SARS-CoV-2 infection should be made using a symptom-based strategy.

Symptom-based strategy

Patients with mild to moderate illness who are not severely immunocompromised:

- 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 who were asymptomatic throughout their infection and are *not* severely immunocompromised:

- 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:

- At least 20 days have passed since symptoms first appeared, OR
- At least 20 days have passed since the date of their first positive viral diagnostic test, 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.

Consultation with an expert in infectious disease can help determine the isolation period for those who are immunocompromised.

Test-based strategy

In some instances, a test-based strategy could be considered for discontinuing Transmission-Based Precautions. However, many individuals will have prolonged viral shedding, limiting the utility of this approach. In consultation with local infectious diseases experts, a test-based strategy could also be considered for some patients (e.g., those who are severely immunocompromised) if concerns exist for the patient being infectious for more than 20 days.

The criteria for the test-based strategy are:

Patients who are symptomatic:

- Resolution of fever without the use of fever-reducing medications, AND
- Symptoms (e.g., cough, shortness of breath) have improved, AND
- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA.

Patients who are not symptomatic:

- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA.

Additional considerations

Discontinuation of empiric Transmission-Based Precautions for patients suspected of having SARS-CoV-2 infection

The decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of current SARS-CoV-2 infection for a patient with suspected SARS-CoV-2 infection can be made based upon having negative results from at least one respiratory specimen tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA.

- If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-based Precautions and performing a second test for SARS-CoV-2 RNA.
- If a patient suspected of having SARS-CoV-2 infection is never tested, the decision to discontinue Transmission-based Precautions can be made by using the symptom-based strategy.

Ultimately, clinical judgement and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions.

Prolonged shedding of SARS-CoV-2

Available data indicate that adults with mild to moderate COVID-19 remain infectious no longer than 10 days after symptom onset. Most adults with more severe to critical illness or severe immunocompromise likely remain infectious no longer than 20 days after symptom onset.

There have been several reports of people shedding replication-competent virus beyond 20 days due to severe immunocompromise. Recovered adults can continue to shed detectable but non-infectious SARS-CoV-2 RNA in upper respiratory specimens for up to three months after illness onset, albeit at concentrations considerably lower than during illness, in concentration ranges where replication-competent virus has not been reliably recovered and infectiousness is unlikely.

The circumstances that result in persistently detectable SARS-CoV-2 RNA have yet to be determined. Studies have not found evidence that clinically recovered adults with persistence of viral RNA have transmitted SARS-CoV-2 to others. These findings strengthen the justification for relying on a symptom-based rather than test-based strategy for ending isolation of most patients who are no longer infectious.

For more information, go to CDC: Interim Guidance on Ending Isolation and Precautions for Adults with COVID-19 (www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html).

Definitions

The following definitions are from CDC: Discontinuation of Transmission-Based Precautions and Disposition of Patients with SARS-CoV-2 in Healthcare Settings (www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html).

SARS-CoV-2 Illness Severity Criteria were adapted from the NIH COVID-19 Treatment Guidelines.

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.

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.

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%.

Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction. In pediatric patients, radiographic abnormalities are common and, for the most part, should not be used as the sole criteria to define COVID-19 illness category. Normal values for respiratory rate also vary with age in children, thus hypoxia should be the primary criterion to define severe illness, especially in younger children.

Severely Immunocompromised: For the purposes of this guidance, CDC used the following definition:

- Some conditions, such as being on chemotherapy for cancer, being within one year out from receiving a hematopoietic stem cell or solid organ transplant, 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.

References

1. CDC: Discontinuation of Transmission-Based Precautions and Disposition of Patients with SARS-CoV-2 in Healthcare Settings (www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html)
2. MDH: COVID-19 Recommendations for Health Care Workers (www.health.state.mn.us/diseases/coronavirus/hcp/hcwrecs.pdf)
3. CDC: Caring for Someone Sick at Home (www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/care-for-someone.html)

4. CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic (www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html)
5. AHCA/HCAL: Cohorting Residents to Prevent the Spread of COVID-19 (www.ahcancal.org/Survey-Regulatory-Legal/Emergency-Preparedness/Documents/COVID19/Cohorting.pdf)
6. CMS: QSO-20-14-NH (www.cms.gov/files/document/qso-20-14-nh-revised.pdf)
7. CDC: Interim Guidance on Ending Isolation and Precautions for Adults with COVID-19 (www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html)

Resources

- COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings (www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf)
- Principles for COVID-19 Cohorting in Long-term Care (www.health.state.mn.us/diseases/coronavirus/hcp/ltcipchohort.pdf)