

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

Community transmission of SARS-CoV-2 in Minnesota has led to a rise in the number of COVID-19 cases 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. MDH recommends that patients with suspected or confirmed COVID-19 be discharged when clinically indicated. Neither discontinuation of Transmission-based Precautions nor negative COVID-19 test results is required prior to hospital discharge<sup>1</sup>.

This guidance addresses hospital inpatients' or congregate living settings residents' discharge to home or to congregate living settings, and 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. In light of COVID-19 testing limitations and shortages of personal protective equipment (PPE), all facilities providing health care should also address source control<sup>2</sup>, eye protection, and staff monitoring and exclusion policies<sup>3</sup>. This guidance is subject to change as diagnostic testing becomes more available and as more is learned about the duration of viral shedding.

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## 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- and time-based strategy<sup>1</sup>.
- Caregivers should be educated on care procedures and visitation restrictions in the home for confirmed or suspected COVID-19 patients<sup>4</sup>.
- Home care might be warranted to ensure complex patients are monitored, assessed, and treated by skilled nurses and therapists, regardless of their COVID-19 status.

## Discharge of an Inpatient or Resident to Congregate Living Setting that Provides Patient 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 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<sup>5</sup>.

- 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.
  - Transfer patients or residents to a receiving facility that has private rooms with private bathrooms or that has the ability to cohort<sup>6,7</sup> 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 as per CDC recommendations and symptoms have resolved, patients or residents can be discharged back to their facility of origin or receiving facility, regardless of the facility's ability to adhere to infection prevention and control recommendations for the care of COVID-19 patients. They can be placed into a regular room without Transmission-based Precautions and can be roomed with another resident.

### 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

or residents with COVID-19. Clear communication about the pending COVID-19 test must be provided to the receiving facility.

### **Patients or residents investigated for possible COVID-19 with a negative test:**

Patients or residents investigated for possible COVID-19 due to onset of concerning signs or symptoms or change in health status who have a negative COVID-19 test can be discharged from a hospital or congregate living to a receiving congregate setting.

- Providers should also consider evaluation of other potential causes of illness (e.g., influenza). When suspicion for COVID-19 remains high, repeat testing for COVID-19 might be indicated.
- Discharge planners should communicate clinical status, test results, and indication for continuation of Transmission-based Precautions to the receiving facility.
- The resident should be placed in a single-person room with private bathroom or in a separate admission/re-admission observation area, for monitoring of signs and symptoms of COVID-19. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after admission.
- All recommended PPE (face mask, eye protection, gloves, and gown) should be worn during care of residents under observation, when PPE supplies allow. At minimum, face mask and eye protection should be worn by staff during care. Cloth face coverings are not considered PPE.
- Receiving facilities should maintain a low threshold of suspicion for COVID-19 and consider testing immediately if a resident develops symptoms or any change in condition.
- If symptoms continue while in observation, the resident should be kept in observation under Transmission-based Precautions until 14 days after admission or in accordance with the symptom-based discontinuation strategy described below, whichever is longer.

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

At this time, patients or residents with no clinical concern (e.g., no presence of symptoms consistent with COVID-19), can be discharged from a hospital or congregate living setting to a receiving congregate living setting following normal procedures. However, they should be quarantined and observed for the development of symptoms.

- 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 symptoms suggestive of COVID-19.
- The resident should be placed in a single-person room with private bathroom or in a separate admission/re-admission observation area, for monitoring of signs and symptoms of COVID-19. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after admission.
- All recommended PPE (face mask, eye protection, gloves, and gown) should be worn during care of residents under observation, when PPE supplies allow. At minimum, face mask and eye protection should be worn by staff during care. Cloth face coverings are not considered PPE.

- Receiving facilities should maintain a low threshold of suspicion for COVID-19 and consider testing immediately if a resident develops symptoms or any change in condition.

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## 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 because, in a majority of cases, it 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- and time-based strategies:

#### 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

For patients who are not severely immunocompromised and who were asymptomatic throughout their infection, Transmission-based Precautions may be discontinued when 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 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

For severely immunocompromised patients who were asymptomatic throughout their infection, Transmission-based Precautions may be discontinued when at least 20 days have passed since the date of their first positive viral diagnostic test.

### Test-based strategy:

In some instances, a test-based strategy could be considered for discontinuing Transmission-based Precautions earlier than if the symptom-based strategy were used. However, many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some patients (e.g., those who are severely immunocompromised) in consultation with local infectious diseases experts 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  $\geq 24$  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  $\geq 24$  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 diagnosis of current 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.

**Considerations while operating under crisis standards of care**

In data described by CDC, an estimated 95% of severely or critically ill patients, including some with severe immunocompromise, no longer had replication-competent virus 15 days after onset of symptoms, and no patients had replication-competent virus more than 20 days after onset of symptoms<sup>8</sup>. Because of the risks for SARS-CoV-2 transmission and the number of patients in health care settings at risk for severe illness, a conservative approach was taken when assigning duration of Transmission-based Precautions. However, a majority of severely or critically ill patients no longer appear to be infectious 10 to 15 days after onset of symptoms. Facilities operating under crisis standards of care might choose to discontinue Transmission-based Precautions at 10 to 15 days, instead of 20 days, in order to maximize resources for those earlier in their clinical course who are at highest risk for being a source of transmission.

## Prolonged Shedding of SARS-CoV-2

Available data indicate that persons with mild to moderate COVID-19 remain infectious no longer than 10 days after symptom onset.<sup>8</sup> Persons with more severe to critical illness or severe immunocompromise likely remain infectious no longer than 20 days after symptom onset. Recovered persons can continue to shed detectable SARS-CoV-2 RNA in upper respiratory specimens for up to 3 months after illness onset, albeit at concentrations considerably lower than during illness, in ranges where replication-competent virus has not been reliably recovered and infectiousness is unlikely. The etiology of this persistently detectable SARS-CoV-2 RNA has yet to be determined. Studies have not found evidence that clinically recovered persons 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 these patients, so that persons who are by current evidence no longer infectious are not kept unnecessarily isolated and excluded from work or other responsibilities.

- 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. In addition, quarantine is not recommended in the event of close contact with an infected person.

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## Definitions

The following definitions are from [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) ([www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html](https://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 (SpO<sub>2</sub>) ≥94% on room air at sea level.

**Severe illness:** Individuals who have respiratory frequency >30 breaths per minute, SpO<sub>2</sub> <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 (PaO<sub>2</sub>/FiO<sub>2</sub>) <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, 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.

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## References

1. [CDC: Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings \(Interim Guidance\) \(www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html\)](http://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html)
2. [MDH: Interim Guidance on Facemasks as Source Control Measure \(www.health.state.mn.us/diseases/coronavirus/hcp/masksource.pdf\)](http://www.health.state.mn.us/diseases/coronavirus/hcp/masksource.pdf)
3. [MDH: COVID-19 Recommendations for Health Care Workers \(www.health.state.mn.us/diseases/coronavirus/hcp/hcwrecs.pdf\)](http://www.health.state.mn.us/diseases/coronavirus/hcp/hcwrecs.pdf)
4. [CDC: Caring for Someone Sick at Home \(www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/care-for-someone.html\)](http://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/care-for-someone.html)
5. [CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic \(www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html\)](http://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html)
6. [AHCA/HCAL: Cohorting Residents to Prevent the Spread of COVID-19 \(www.ahcancal.org/facility\\_operations/disaster\\_planning/Documents/Cohorting.pdf\)](http://www.ahcancal.org/facility_operations/disaster_planning/Documents/Cohorting.pdf)
7. [CMS: QSO-20-14-NH \(PDF\) \(www.cms.gov/files/document/qso-20-14-nh-revised.pdf\)](http://www.cms.gov/files/document/qso-20-14-nh-revised.pdf)
8. [CDC: Duration of Isolation and Precautions for Adults with COVID-19 \(www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html\)](http://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html)



Minnesota Department of Health | [health.mn.gov](http://health.mn.gov) | 651-201-5000  
625 Robert Street North PO Box 64975, St. Paul, MN 55164-0975

Contact [health.communications@state.mn.us](mailto:health.communications@state.mn.us) to request an alternate format.

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