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 establishment of two negative COVID-19 tests is required prior to hospital discharge.

This guidance addresses hospital discharge to home or congregate living settings, and discontinuation of Transmission-based Precautions in hospitals and congregate living settings. Congregate living settings include assisted living, long-term care and skilled nursing facilities, or other congregate living setting 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, eye protection, and staff monitoring and exclusion policies. This guidance is subject to change as diagnostic testing becomes more available, capacity changes of discharge facilities, and as more is learned about the 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.
- Caregivers should be educated on care procedures and visitation restrictions in the home for confirmed or suspected COVID-19 patients.

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

Patients with confirmed or suspected COVID-19 who require Transmission-based Precautions:

Patients 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.
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 staffing challenges and inconsistently available PPE in congregate 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.

Hospital discharge planners should follow a tiered approach for patients 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 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 positive or suspect COVID-19 patients with dedicated staff and PPE.

Patients 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 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. They can be placed into a regular room without transmission based precautions and can be roomed with another resident.
- If Transmission-based Precautions have been discontinued but the patient has continued symptoms, the patient 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.

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 a negative test:

Patients 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 to a congregate setting.

- Hospital 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.
- Hospital 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 (facemask, eye protection, gloves, and gown) should be worn during care of residents under observation, when PPE supplies allow. At minimum, facemask 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 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, 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 (facemask, eye protection, gloves, and gown) should be worn during care of residents under observation, when PPE supplies allow. At minimum, facemask 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.

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

Test-based strategy:

If testing capacity allows, RT-PCR testing can guide discontinuation of Transmission-based Precautions\(^1\) when there is:

- Resolution of fever without the use of fever-reducing medications AND
- Improvement in respiratory symptoms (e.g., cough, shortness of breath) AND
- Negative results from at least two consecutive nasopharyngeal or nasal swab specimens collected \(\geq 24\) hours apart (total of two negative specimens).

Prolonged detection of RNA by RT-PCR can occur without presence of live virus. For this reason, additional symptom- and time-based strategies can be used to guide discontinuation of Transmission-based Precautions.

Symptom- and time-based strategies:

These recommendations are based on available data regarding duration of viral shedding and will be revised as additional evidence becomes available.

**Immune-competent individuals with symptomatic confirmed or suspect COVID-19** should remain in Transmission-based Precautions until:

- At least 10 days have passed since symptom onset AND
- 3 days have passed since recovery, defined as fever resolution without fever-reducing medication and improvement in respiratory symptoms (e.g., cough, shortness of breath).

**Immune-competent individuals with confirmed COVID-19 who are asymptomatic** at the time of testing and remain asymptomatic during follow up, should remain in Transmission-based Precautions until at least 10 days have passed since the date of positive test.

**Patients 75 years of age and older, or those with persistent symptoms**, should remain in Transmission-based Precautions until:

- At least 14 days have passed since symptom onset AND
- 3 days have passed since recovery, defined as fever resolution without fever-reducing medication and improvement in respiratory symptoms (e.g., cough, shortness of breath).
Patients with immunocompromising conditions (e.g., medical treatment with immunosuppressive drugs, bone marrow or solid organ transplant recipients, inherited immunodeficiency, poorly controlled HIV) should remain in Transmission-based Precautions until:

- At least 21 days have passed since symptom onset AND
- 3 days have passed since recovery, defined as fever resolution without fever-reducing medication and improvement in respiratory symptoms (e.g., cough, shortness of breath).

**Prolonged Shedding of SARS-CoV-2**

Several studies and routine clinical testing have shown that some patients can shed SARS-CoV-2 virus for more than 30 days after symptom onset\(^8,9\). RT-PCR tests detect viral RNA but do not provide information about virus viability. Few studies are available to understand how persistently positive SARS-CoV-2 RT-PCR test results relate to infectiousness\(^10\). If using a test-based strategy to discontinue Transmission-based Precautions, facilities and providers should understand that patients or residents may have positive SARS-CoV-2 tests for an extended period of time. Consultation with a specialist in infectious diseases may be helpful in these circumstances.

Patients with persistently positive RT-PCR tests for SARS-CoV-2 can be discharged to facilities that have the necessary PPE and staffing to care for COVID-19 patients.

**References**

2. **MDH:** Interim Guidance on Facemasks as Source Control Measure (PDF) (www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf)
3. **MDH:** COVID-19 Recommendations for Health Care Workers (PDF) (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)
6. **AHCA/HCAL:** Cohorting Residents to Prevent the Spread of COVID-19 (www.ahcanal.org/facility_operations/disaster_planning/Documents/Cohorting.pdf)


Minnesota Department of Health
625 Robert St N
St. Paul, MN 55164
651-201-5414
www.health.state.mn.us

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