



Guidance for Discharge from Hospitals

Updated: 5/19/20

This document has been created to provide guidance for the discharge of patients from the hospital during the COVID-19 pandemic.

Additional information is available at <http://coronavirus.delaware.gov>

Returning hospitalized residents to their nursing facility, assisted living facility, rest residential facility, or intermediate care facility for persons with intellectual disabilities, their home, remains a priority. For facility residents admitted to or seen at a hospital for COVID-19, the residents shall be allowed to return to the facility as long as the facility can follow the approved CDC recommendations for transmission-based precautions. If the residents must temporarily go to other facilities, such as an alternate care site, every effort must be made by the receiving and original facilities to transfer the residents back to their original facility as soon as possible, such as when transmission-based precautions can be discontinued if the original facility cannot effectively initiate these precautions prior.

A negative COVID-19 test shall not be required prior to a resident's return to a facility.

Newly admitted and readmitted residents to all nursing facilities, assisted living facilities, rest residential facilities, and intermediate care facilities for persons with intellectual disabilities not known to be positive for COVID-19 must be kept for 14 days on appropriate infection prevention precautions per CDC/DPH guidance while being observed every shift for signs and symptoms of COVID-19.

A resident transferred to, evaluated in, and discharged directly from an Emergency Department or ambulatory setting such as a dialysis center to return to the same post-acute facility shall not be considered a newly readmitted resident.

Patients with COVID-19 can be discharged from a healthcare facility whenever clinically indicated. Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge.

Facilities should reference CDC/DPH guidance regarding discontinuing transmission-based precautions and discharging hospitalized patients with COVID-19, available at (<https://coronavirus.delaware.gov/long-term-care-facilities/>).

Today's Date: _____

Form Completed by: _____ Contact Number: _____

COVID-19 Screen Prior to Discharge WITHOUT CONFIRMED OR SUSPECTED COVID-19:

Patient Name: _____ DOB: _____

Current Facility: _____ Destination Facility: _____

	At D/C	
Temperature		
SpO2		
Treated for fever in last 72 hours (Y/N)		
SIGNS AND SYMPTOM ASSESSMENT		
(Check YES if the patient has developed any NEW symptoms as listed below <u>in the last 48 hours</u> . Do not check if these are chronic symptoms.)		
<u>COMMON</u> Symptoms	YES	NO
Elevated body temperature >37.5°C (99.5°F)		
<u>NEW</u> Cough		
<u>NEW</u> Shortness of Breath, increased oxygen requirement or increased respiratory treatments		
<u>LESS</u> Common Signs and Symptoms	YES	NO
Confusion or Change in Mental Status		
Muscle Aches / Myalgias		
Headache		
Sore Throat		
Runny Nose / Rhinorrhea		
GI Symptoms (Diarrhea, Nausea and/or Vomiting)		
Loss of Taste and/or Smell		
Conjunctivitis		

If any of the above are marked "YES," default to Form LTC-B unless there is a strong indication that symptoms are from a non-COVID cause. **Attending physician must indicate reason why COVID is not suspected:** _____

Has any COVID-19 testing been completed during hospitalization?

COVID-19 testing has NOT been performed

COVID-19 testing has been performed (note: any patients with PENDING results must default to Form LTC-B)

Date: _____

Result: Positive Negative

Date: _____

Result: Positive Negative

This form must be completed for any patients WITHOUT confirmed or suspected COVID-19 prior to discharge/transfer to any post-acute care facility.

Today's Date: _____

Form Completed by: _____ Contact Number: _____

Patient Name: _____ DOB: _____

Current Facility: _____ Destination Facility: _____

COVID-19 Screen Prior to Discharge for Patients WITH Documented or Suspected COVID-19

Date of symptom onset: _____ Unable to determine

Date of first positive test: _____

Have symptoms of COVID-19 resolved? Yes No

If Yes, list first date of symptom resolution (defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath): _____

If not resolved, have symptoms of COVID-19 improved? Yes No

Patients stable for discharge can be accepted to PAC Facility as long as facility can provide Transmission-based precautions as per CDC/DPH Guidance.

Does patient require ongoing transmission-based precautions? Yes No

If NO, list date of discontinuation _____ and indicate strategy used:

Symptom-Based Strategy: (See DPH guidance regarding Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 to Long-Term Care or Assisted Living Facilities for full details)

- At least 7 days have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath)* and
- At least 10 days have passed since symptoms first appeared

*Facilities should consider extending the period of isolation beyond the symptom-based-strategy duration for discontinuation of Transmission-Based Precautions, on a case by case basis in consultation with the facility or private physician or state public health authorities. Given that hospitalized patients may have longer periods of SARS-CoV-2 RNA detection in a setting where they may have close contact with individuals at risk for severe disease, it is recommended that at least 7 days have passed since recovery prior to discontinuation of Transmission-Based Precautions.

Test Based Strategy: (See DPH guidance regarding Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 to Long-Term Care or Assisted Living Facilities for full details)

- Resolution of fever without the use of fever-reducing medications and
- Improvement in respiratory symptoms (e.g., cough, shortness of breath), and
- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive specimens collected >24 hours apart (total of two negative specimens)

Where testing is not readily available, facilities should preferentially use the symptom-based strategy for discontinuation of Transmission-Based Precautions

Date: _____ Result: Positive Negative Pending

Date: _____ Result: Positive Negative Pending

This form must be completed for any patients with confirmed or suspected COVID-19 prior to discharge/transfer to any post-acute care facility.

Today's Date: _____

Form Completed by: _____ Contact Number: _____

Patient Name: _____ DOB: _____

Current Facility: _____ Destination Facility: _____

COVID-19 Screen Prior to Discharge from the Emergency Department

Does the patient have confirmed COVID or conditions suspicious for COVID, or is the patient a Person Under Investigation (PUI) for COVID?

Yes

No

Does the patient have any tests pending for COVID?

Yes

No

If you indicated "Yes" to either of the above, please refer to form 2020-LTC-B for COVID+ or Suspicious Patients.



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Services for Aging and Adults with Physical Disabilities

As part of the Delaware's Medical Surge System of Care during the COVID-19 emergency, Governor Bacon Health Center (GBHC) has been designated an Alternate Care Site (ACS) by the Delaware Department of Health and Social Services (DHSS) and the Delaware Emergency Management Agency (DEMA).

The purpose of an ACS is to provide a temporary facility that will support the return to the normal delivery of healthcare. An ACS will act as a field hospital with limited treatment capabilities for patients of all ages.

Patients will be referred to the GBHC ACS by a Delaware adult hospital upon discharge. A patient must meet the criteria set forth by DHSS and the referring care team should follow the transfer process.

Transfer Candidacy Guidelines

The GBHC ACS is designed for older individuals with some Activities of Daily Living (ADL) needs from any state of residence that are **MEDICALLY STABLE, DISCHARGED FROM ACUTE CARE, AND DO NOT REQUIRE 24-7 NURSING CARE**. Patients who require high-acuity care should be referred to other facilities.

The GBHC ACS is for patients who have tested **POSITIVE** for COVID-19.

Refer to the transfer guideline criteria below to determine GBHC ACS patient candidacy.

Ideal Patient Population:

- Discharged from adult hospital with plan in place for transitioning back to community
- Mobile
- Minimal Activities of Daily Living Needs
- Diagnoses
 - Geriatric patients awaiting placement/transition back to community (not on extensive adult meds)

Exclusion Criteria (Governor Bacon Health Center ACS **CANNOT** care for the following types of patients):

- Known or suspected cardiovascular disease requiring active monitoring and/or intervention
- Morbidly obese
 - BMI >40 or
 - BMI >35 with obesity-related conditions that require monitoring and/or intervention
- History of listed psychiatric disorders (not primarily related to hospitalization)
 - Schizophrenia being actively managed
 - Active suicidal ideation
 - Personality disorders
 - Uncontrolled mood disorders
 - Stable history of depression, anxiety, bipolar disorder should be acceptable
- High comorbidity
 - Multiple active comorbid illnesses requiring significant ambulatory care
 - Life expectancy less than 1 year
 - Multiple chronic medications
- Acute Gastroenteritis
- Ventilated patients
- Active neurologic disease

- CVA with residual neurologic deficits requiring significant assistance with ADLs
- Encephalopathy
- Uncontrolled Epilepsy
- Airborne and non-COVID MDRO isolation precautions

Transfer Process

Referring hospitals should contact State Health Operations Center (SHOC) on and after April 21st. Transfer requests will be reviewed for completeness and appropriateness between 8:00am and 4:30pm, Monday through Friday.

When it becomes necessary to request a discharged patient be transferred to the Governor Bacon Health Center ACS, the referring provider should follow the outlined process:

- Complete the attached form and email to Faith Mwaura at SHOC: faith.mwaura@delaware.gov. Questions can be asked by calling 302-225-9691.
- Division of Aging and Adults with Physical Disabilities and SHOC staff members will review the submission form and connect with the requesting physician to discuss patient summary and requirements for treatment, including necessary medications.
 - If GBHC is unable to acquire the patient's medication, the transfer will not be accepted.
 - SHOC staff may require additional information beyond what's available on the forms to determine if the transfer is appropriate. That need will be appropriately communicated to the health system.
- If SHOC determines the transfer is appropriate and acceptable, SHOC staff will forward appropriate paperwork to the GBHC ACS case manager to identify a patient bed.
- Upon receipt of the approved form, the GBHC ACS case manager will contact the health system to arrange for transfer and inform the GBHC Administrator of the patient's arrival date and time.
- If the transfer is not accepted, SHOC staff will inform the health system.

Prior to the transfer, the requesting physician will be required to provide the patient's care summary, medication history, necessary care plans, and considerations for discharge.

The sending hospital will provide:

- 72 hours of patient's medications
- Care plan and transfer paperwork (including electronic backups) including any follow-up medical appointments
- Patient's essential belongings
 - Patients are limited to a cell phone, clothing for discharge, and religious/sacred items

After Transfer

Upon completion of the transfer, the discharged patient will become a short-term resident of GBHC ACS. The nurses at GBHC ACS will ensure that ADLs and nutrition needs are met for the individuals staying at GBHC ACS.

The DSAAPD Care Transitions team will check in daily with the person's originating facility and/or family members to determine a date to return home.

Contact Information

If you have questions about determining patient candidacy or the transfer process, please contact the State Health Operation Center:

Phone: (302) 225-9691

Email: faith.mwaura@delaware.gov

DEPARTMENT OF PUBLIC HEALTH REFERRAL FORM

CLIENT DEMOGRAPHICS:

INTAKE DATE	/ /	DATE TESTED	/ /
FIRST NAME		LAST NAME	
DATE OF BIRTH	/ /	SEX	<input type="checkbox"/> M <input type="checkbox"/> F
ADDRESS		COUNTY	<input type="checkbox"/> NEW CASTLE <input type="checkbox"/> KENT <input type="checkbox"/> SUSSEX
CITY	STATE	ZIP CODE	
Medicaid Recipient <input type="checkbox"/> Y <input type="checkbox"/> N	Medical Insurance <input type="checkbox"/> Y <input type="checkbox"/> N	CARRIER: MEMBER/GROUP #	
DATE OF SYMPTOM ONSET	/ /	COVID-19 SUSPECTED, NOT TESTED	<input type="checkbox"/> Y <input type="checkbox"/> N
		COVID-19 SUSPECTED, RESULT PENDING	<input type="checkbox"/> Y <input type="checkbox"/> N
		COVID-19 CONFIRMED, POSITIVE RESULT	<input type="checkbox"/> Y <input type="checkbox"/> N
RECOMMENDED LAST DAY OF ISOLATION:	/ /		
DISPOSITION	<input type="checkbox"/> HOSPITALIZED <input type="checkbox"/> AT HOME <input type="checkbox"/> OTHER: _____		

HEALTH NOTES/CONCERNS/UNDERLYING HEALTH CONDITIONS (INCLUDING MEDICATIONS):

CORONAVIRUS (COVID-19) RELATED EMERGENCY SERVICES INTAKE AND NEEDS:

HOUSEHOLD SIZE	# OF ADULTS: _____	# OF CHILDREN _____
SOURCES OF INCOME (CHECK BOX IF APPLICABLE)	Wages <input type="checkbox"/>	Pensions <input type="checkbox"/>
	TANF <input type="checkbox"/>	Unemployment comp. <input type="checkbox"/>
	SSI <input type="checkbox"/>	Workman's Comp <input type="checkbox"/>
	Social Security <input type="checkbox"/>	Utility Allowance <input type="checkbox"/>
	General Assistance <input type="checkbox"/>	Other _____ <input type="checkbox"/>

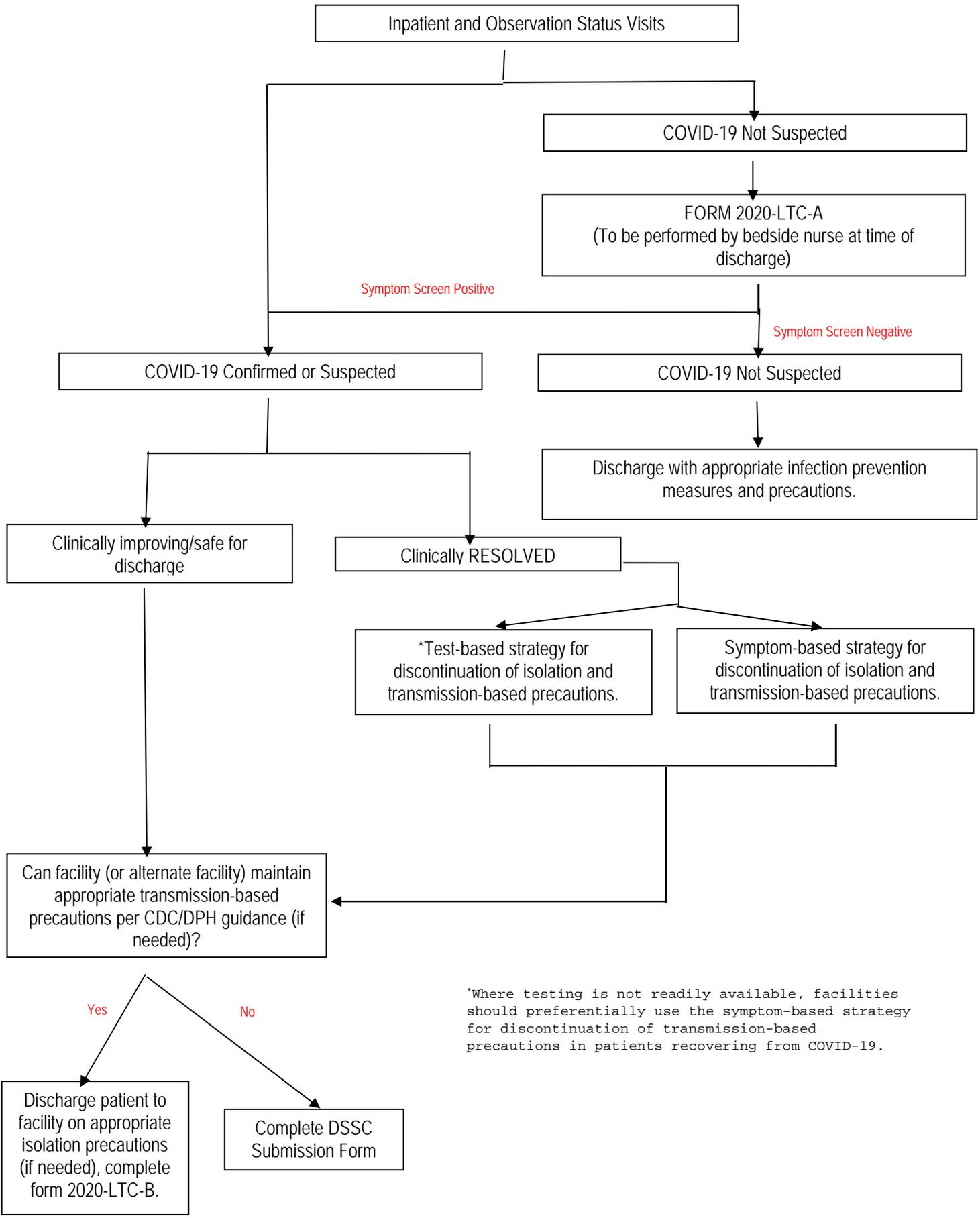
EMERGENCY SERVICE NEEDS	REQUESTED	COMMENTS
HOUSING/SHELTER	<input type="checkbox"/> Y <input type="checkbox"/> N	
GOVERNOR BACON ALTERNATIVE CARE SITE	<input type="checkbox"/> Y <input type="checkbox"/> N	
PERSONAL/HOUSEHOLD SUPPLIES	<input type="checkbox"/> Y <input type="checkbox"/> N	
FOOD AND NUTRITION ASSISTANCE	<input type="checkbox"/> Y <input type="checkbox"/> N	
RENT/MORTGAGE	<input type="checkbox"/> Y <input type="checkbox"/> N	
PRESCRIPTION/MEDICAL/DIABETES	<input type="checkbox"/> Y <input type="checkbox"/> N	
OTHER	<input type="checkbox"/> Y <input type="checkbox"/> N	

EMERGENCY CONTACT:

FIRST NAME		LAST NAME	
EMAIL		CONTACT #	
ADDRESS		COUNTY	<input type="checkbox"/> NEW CASTLE <input type="checkbox"/> KENT <input type="checkbox"/> SUSSEX
CITY		ZIP CODE	
STATE			

ACTIVITIES OF DAILY LIVING NEEDS (Please provide description)

ADDITIONAL CASE NOTES: (Please provide DPH):



*Where testing is not readily available, facilities should preferentially use the symptom-based strategy for discontinuation of transmission-based precautions in patients recovering from COVID-19.