Division of TennCare

MEMO

To: Medicaid Nursing Facilities
TennCare Health Plans

From: Patti Killingsworth, Assistant Commissioner and Chief of LTSS

CC: Jamie O'Neal, Assistant Deputy Chief, LTSS Policy, Programs, Contracts and Compliance

Date: **UPDATED** April 20, 2020

Subject: **COVID-19 Guidance Regarding Facility Admissions and MCO Notifications of Positive COVID-19 Cases, and Related Discharges or Transfers**

You have previously received the attached letter from Dr. Lisa Piercey, Commissioner of the Tennessee Department of Health regarding **important actions nursing facilities are expected to take in order to prevent and respond to COVID-19**. We encourage you to review and carefully follow the instructions in that memo, as these actions are critical to ensuring the health, safety and welfare of Tennesseans in your care, as well as your staff.

This memo addresses two additional issues pertaining to COVID-19: 1) admissions to your facility; and 2) required MCO notifications, including COVID-related discharges or transfers. It includes additional information regarding limited waivers of CMS requirements pertaining to the separation of COVID and non-COVID residents in the facility, and a link to additional information.

1. **Admissions to your facility**

Per CMS guidance (2nd attachment), "*Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present.*"

The CMS guidance further advises that *"A nursing home can accept a resident diagnosed with COVID-19 and still under Transmission-Based Precautions for COVID-19 as long as the facility can follow CDC guidance for Transmission-Based Precautions. If a nursing home cannot, it must wait until these precautions are discontinued."*

As you know, the ability to admit patients to nursing homes will be critical in order to ensure hospital capacity is available for those who are critically ill--especially during the coming days and weeks.

Facilities should remain mindful of admission, transfer, and discharge rights at 42 CFR § 483.15, which include permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. While in a typical scenario, the regulations provide that the person *"returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident…[r]equires the services provided by the facility; and*…[i]s eligible for Medicare skilled nursing facility services or Medicaid nursing facility services," CMS guidance provides alternative instruction in light of the current COVID-19 emergency: *"Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor, or returning to long-stay original room)."*

In addition, CMS has waived compliance with 42 CFR §483.10, §483.15, and §483.21 ***only*** to the extent to allow temporary transfers to separate facilities for the purpose of separating COVID and non-COVID patients. Guidance from CMS can be found here: https://www.cms.gov/files/document/covid-long-term-care-facilities.pdf, https://skillednursingnews.com/wp-content/uploads/sites/4/2020/03/QSO-20-14-NH-REVISED-3-13-2020_0.pdf. Please also find attached guidance developed by the AHCA to help facilities think about how best to provide services while minimizing risk of COVID-19 exposure or spread to other residents and staff.

2. **Required reporting of COVID-19 Related Discharges and Transfers**

Nursing facilities are contractually obligated to notify an MCO anytime a Medicaid eligible person is discharged or transferred from their facility (or when a member elects hospice). **These notifications are particularly critical during the COVID-19 emergency, as MCOs need to know where members are in order to ensure that appropriate services are in place.** This includes the ability to engage in timely hospital discharge planning or arranging in-home services if a resident is discharged home.

We recognize the tremendous challenges nursing facilities are facing. In an effort to simplify these required reporting processes should a COVID-19 event occur in your facility, MCOs have developed a streamlined reporting process specific to COVID-19 related discharges and transfers.

Within the first 24 hours from the discovery of a positive COVID-19 case in your facility (staff or resident(s), regardless of payer), **the facility should provide general notification to each MCO which has residents in your facility.** The notification will be made via email utilizing the contact list below and subject heading as follows: **COVID Report MM/DD/YY**:

- Amerigroup: TNCovid19notification@amerigroup.com
- BlueCare: COVID19REPORTING_LTSS@bcbst.com
- UnitedHealthCare: LTSSCMA@UHC.com

This notification should come ***after*** required notifications to the department of health, but within the first 24 hours after a COVID-19 case is confirmed and will not include any case-specific information.

Each MCO with residents in your facility will then provide a roster of their members who are residents in your facility. Updates regarding any member(s) experiencing symptoms of illness, tested for COVID-19 (and results, when available), transferred to the hospital or another facility or location, or discharged to home or another location can then be provided via each MCO's provided spreadsheet, through an arranged call with MCO staff who will complete the updates, or by making medical information available to the MCO for completion of the updates. Facilities can select the method which best suits their needs, so long as the information is made available in a timely manner. Updates will continue until such time that the COVID-19 situation has fully stabilized such that no further COVID-19 testing, treatment, discharges or transfers are occurring.

This should help simplify required reporting for facilities when there are multiple impacted residents, while still meeting your contractual obligations and ensuring that MCOs have access to the information they need to fulfill care coordination responsibilities.

Thank for your continued vigilance and cooperation in helping to assure the health, safety, and welfare of residents during this challenging time.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
Andrew Johnson Tower, 5th Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

BILL LEE
Governor

LISA PIERCEY, MD, MBA, FAAP
Commissioner

March 28, 2020

Dear Health Care Facility:

The Tennessee Division of Health Licensure and Regulation and the Tennessee Department of Health (TDH) are committed to protecting the health, safety and welfare of the public. TDH is working closely with the Office of the Governor, additional state agencies, and the Centers for Disease Control (CDC) to ensure that facilities have the information and guidance they need to prevent the spread of COVID-19.

TDH recommends the following steps for long term care facilities:

1. **Keep COVID-19 from entering your facility:**
   - Ensure adequate supplies of PPE are on hand at all times.
   - Have in place an emergency response plan for meeting increased staffing needs.
   - Screen all staff for fever and respiratory symptoms before each shift; send ill staff home.
   - Restrict all visitors except for compassionate care situations (e.g., end of life). Restrict all volunteers and non-essential HCP, including consultant services (e.g., barber).
   - Cancel all field trips outside of the facility.
   - Have residents who must regularly leave the facility for medically necessary purposes (e.g., hemodialysis) wear a facemask (if possible) whenever they leave their room.

2. **Identify infections early:**
   - **Notify the local health department immediately for:**
     - **severe respiratory infection causing hospitalization or sudden death**,
     - **clusters (≥2 residents and/or HCP) of respiratory infection, or**
     - **individuals with known or suspected COVID-19 identified.**

     Local health departments can be found here: https://www.tn.gov/health/health-program-areas/localdepartments.html or at 615-741-7247.
   - **Discuss testing with TDH to ensure that any testing for COVID-19 is performed rapidly.** TDH's State Public Health Laboratory or partner laboratories can facilitate obtaining results as quickly as possible.
   - **Actively screen all residents at least daily for fever and respiratory symptoms; immediately isolate if symptomatic.**
     - Long-term care residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include: new or worsening malaise, new dizziness, diarrhea, or sore throat. Identification of these symptoms should prompt isolation and further evaluation.

3. **Prevent spread of COVID-19:**
   - Cancel all group activities and communal dining.
   - Enforce social distancing among residents.
   - **When COVID-19 is reported in the community, implement universal facemask use by all HCP (source control) when they enter the facility**.
     - If facemasks are in short supply, they should be prioritized for direct care personnel. All HCP should be reminded to practice social distancing when in break rooms or common areas.
   - **If COVID-19 is identified in the facility, restrict all residents to their room and have HCP wear all recommended PPE for all resident care**, regardless of the presence of symptoms. Refer to strategies for

optimizing PPE when shortages exist at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html.

- This approach is recommended to account for residents who are infected but not manifesting symptoms. Recent experience suggests that a substantial proportion of residents could have COVID-19 detected without reporting symptoms or before symptoms develop.
- When a case is identified, TDH can help inform decisions about testing asymptomatic residents on the unit or in the facility.

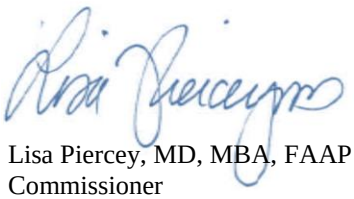
4. **Assess supply of personal protective equipment (PPE) and initiate measures to optimize current supply:**
   - Ensure adequate supplies of PPE. If you anticipate or are experiencing PPE shortages reach out to your state/local health department who can engage your local healthcare coalition.
   - Consider extended use of facemasks and eye protection or prioritization of gowns for certain resident care activities: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

5. **Identify and manage severe illness:**
   - Designate a location to cohort and care for residents with suspected or confirmed COVID-19, separate from other residents.
   - Monitor ill residents (including documentation of temperature and pulse oximetry) at least 3 times daily to quickly identify residents who require transfer to a higher level of care.

Extensive additional information and guidance can be found at: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html and https://www.tn.gov/health/cedep/ncov.html.

We will update this information as we learn more details from the Governor's Office, other state agencies and the CDC. We appreciate your commitment to protect the health, safety and welfare of Tennesseans.

Sincerely,



Lisa Piercey, MD, MBA, FAAP
Commissioner

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-14-NH

DATE: **March 13, 2020**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes ***(REVISED)***

Memorandum Summary

- ***CMS is committed*** to taking critical steps to ensure America's health care facilities and clinical laboratories are prepared to respond to the threat of the COVID-19.
- **Guidance for Infection Control and Prevention of COVID-19** - CMS is providing additional guidance to nursing homes to help them improve their infection control and prevention practices to prevent the transmission of COVID-19, *including revised guidance for visitation*.
- **Coordination with the Centers for Disease Control (CDC) and local public health departments** - We encourage all nursing homes to monitor the CDC website for information and resources and contact their local health department when needed (CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html).

Background

The Centers for Medicare & Medicaid Services (CMS) is responsible for ensuring the health and safety of nursing home residents by enforcing the standards required to help each resident attain or maintain their highest level of well-being. In light of the recent spread of COVID-19, we are providing additional guidance to nursing homes to help control and prevent the spread of the virus.

Guidance

Facility staff should regularly monitor the CDC website for information and resources (links below). They should contact their local health department if they have questions or suspect a resident of a nursing home has COVID-19. Per CDC, prompt detection, triage and isolation of potentially infectious residents are essential to prevent unnecessary exposures among residents, healthcare personnel, and visitors at the facility. Therefore, facilities should continue to be vigilant in identifying any possible infected individuals. Facilities should consider frequent

monitoring for potential symptoms of respiratory infection as needed throughout the day. Furthermore, we encourage facilities to take advantage of resources that have been made available by CDC and CMS to train and prepare staff to improve infection control and prevention practices. Lastly, facilities should maintain a person-centered approach to care. This includes communicating effectively with residents, resident representatives and/or their family, and understanding their individual needs and goals of care.

Facilities experiencing an increased number of respiratory illnesses (regardless of suspected etiology) among patients/residents or healthcare personnel should immediately contact their local or state health department for further guidance.

In addition to the overarching regulations and guidance, we're providing the following information about some specific areas related to COVID-19:

Guidance for Limiting the Transmission of COVID-19 for Nursing Homes

For ALL facilities nationwide:

*Facilities should **restrict** visitation of **all** visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation. In those cases, visitors will be limited to a specific room only. Facilities are expected to notify potential visitors to defer visitation until further notice (through signage, calls, letters, etc.). Note: If a state implements actions that exceed CMS requirements, such as a ban on all visitation through a governor's executive order, a facility would not be out of compliance with CMS' requirements. In this case, surveyors would still enter the facility, but not cite for noncompliance with visitation requirements.*

For individuals that enter in compassionate situations (e.g., end-of-life care), facilities should require visitors to perform hand hygiene and use Personal Protective Equipment (PPE), such as facemasks. Decisions about visitation during an end of life situation should be made on a case by case basis, which should include careful screening of the visitor (including clergy, bereavement counselors, etc.) for fever or respiratory symptoms. Those with symptoms of a respiratory infection (fever, cough, shortness of breath, or sore throat) should not be permitted to enter the facility at any time (even in end-of-life situations). Those visitors that are permitted, must wear a facemask while in the building and restrict their visit to the resident's room or other location designated by the facility. They should also be reminded to frequently perform hand hygiene.

Exceptions to restrictions:

- *Health care workers: Facilities should follow CDC guidelines for restricting access to health care workers found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html. This also applies to other health care workers, such as hospice workers, EMS personnel, or dialysis technicians, that provide care to residents. They should be permitted to come into the facility as long as they meet the CDC guidelines for health care workers. Facilities should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html).*
- *Surveyors: CMS and state survey agencies are constantly evaluating their surveyors to ensure they don't pose a transmission risk when entering a facility. For example, surveyors may have been in a facility with COVID-19 cases in the previous 14 days, but because they were wearing PPE effectively per CDC guidelines, they pose a low risk to*

transmission in the next facility, and must be allowed to enter. However, there are circumstances under which surveyors should still not enter, such as if they have a fever.

Additional guidance:

1. *Cancel communal dining and all group activities, such as internal and external group activities.*
2. *Implement active screening of residents and staff for fever and respiratory symptoms.*
3. *Remind residents to practice social distancing and perform frequent hand hygiene.*
4. *Screen all staff at the beginning of their shift for fever and respiratory symptoms. Actively take their temperature and document absence of shortness of breath, new or change in cough, and sore throat. If they are ill, have them put on a facemask and self-isolate at home.*
5. *For individuals allowed in the facility (e.g., in end-of-life situations), provide instruction, before visitors enter the facility and residents' rooms, provide instruction on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the resident's room. Individuals with fevers, other symptoms of COVID-19, or unable to demonstrate proper use of infection control techniques should be restricted from entry. Facilities should communicate through multiple means to inform individuals and non-essential health care personnel of the visitation restrictions, such as through signage at entrances/exits, letters, emails, phone calls, and recorded messages for receiving calls.*
6. *Facilities should identify staff that work at multiple facilities (e.g., agency staff, regional or corporate staff, etc.) and actively screen and restrict them appropriately to ensure they do not place individuals in the facility at risk for COVID-19.*
7. *Facilities should review and revise how they interact vendors and receiving supplies, agency staff, EMS personnel and equipment, transportation providers (e.g., when taking residents to offsite appointments, etc.), and other non-health care providers (e.g., food delivery, etc.), and take necessary actions to prevent any potential transmission. For example, do not have supply vendors transport supplies inside the facility. Have them dropped off at a dedicated location (e.g., loading dock). Facilities can allow entry of these visitors if needed, as long as they are following the appropriate CDC guidelines for Transmission-Based Precautions.*
8. *In lieu of visits, facilities should consider:*
    a) *Offering alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.).*
    b) *Creating/increasing listserv communication to update families, such as advising to not visit.*
    c) *Assigning staff as primary contact to families for inbound calls, and conduct regular outbound calls to keep families up to date.*
    d) *Offering a phone line with a voice recording updated at set times (e.g., daily) with the facility's general operating status, such as when it is safe to resume visits.*
9. *When visitation is necessary or allowable (e.g., in end-of-life scenarios), facilities should make efforts to allow for safe visitation for residents and loved ones. For example:*
    a) *Suggest refraining from physical contact with residents and others while in the facility. For example, practice social distances with no hand-shaking or hugging, and remaining six feet apart.*
    b) *If possible (e.g., pending design of building), creating dedicated visiting areas (e.g., "clean rooms") near the entrance to the facility where residents can meet with*

visitors in a sanitized environment. Facilities should disinfect rooms after each resident-visitor meeting.

c) *Residents still have the right to access the Ombudsman program. Their access should be restricted per the guidance above (except in compassionate care situations), however, facilities may review this on a case by case basis. If in-person access is not available due to infection control concerns, facilities need to facilitate resident communication (by phone or other format) with the Ombudsman program or any other entity listed in 42 CFR § 483.10(f)(4)(i).*

10. *Advise visitors, and any individuals who entered the facility (e.g., hospice staff), to monitor for signs and symptoms of respiratory infection for at least 14 days after exiting the facility. If symptoms occur, advise them to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the individuals they were in contact with, and the locations within the facility they visited. Facilities should immediately screen the individuals of reported contact, and take all necessary actions based on findings.*

When should nursing homes consider transferring a resident with suspected or confirmed infection with COVID-19 to a hospital?

Nursing homes with residents suspected of having COVID-19 infection should contact their local health department. Residents infected with COVID-19 may vary in severity from lack of symptoms to mild or severe symptoms or fatality. Initially, symptoms may be mild and not require transfer to a hospital as long as the facility can follow the infection prevention and control practices recommended by CDC. Facilities without an airborne infection isolation room (AIIR) are not required to transfer the resident assuming: 1) the resident does not require a higher level of care and 2) the facility can adhere to the rest of the infection prevention and control practices recommended for caring for a resident with COVID-19.

Please check the following link regularly for critical updates, such as updates to guidance for using PPE: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html.

The resident may develop more severe symptoms and require transfer to a hospital for a higher level of care. Prior to transfer, emergency medical services and the receiving facility should be alerted to the resident's diagnosis, and precautions to be taken including placing a facemask on the resident during transfer. If the resident does not require hospitalization they can be discharged to home (in consultation with state or local public health authorities) if deemed medically and socially appropriate. Pending transfer or discharge, place a facemask on the resident and isolate him/her in a room with the door closed.

When should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital?

A nursing home can accept a resident diagnosed with COVID-19 and still under Transmission-Based Precautions for COVID-19 as long as the facility can follow CDC guidance for Transmission-Based Precautions. If a nursing home cannot, it must wait until these precautions are discontinued. CDC has released Interim Guidance for Discontinuing Transmission-Based Precautions or In-Home Isolation for Persons with Laboratory-confirmed COVID-19. Information on the duration of infectivity is limited, and the interim guidance has been

developed with available information from similar coronaviruses. CDC states that decisions to discontinue Transmission-based Precautions in hospitals will be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials. Discontinuation will be based on multiple factors (see current CDC guidance for further details).

Note: Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present. Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor, or returning to long-stay original room).

Other considerations for facilities:

- Review CDC guidance for Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html
- Increase the availability and accessibility of alcohol-based hand rubs (ABHRs), *reinforce strong hand-hygiene practices*, tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, resident check-ins, etc.
    - Ensure ABHR is accessible in all resident-care areas including inside and outside resident rooms.
- Increase signage for vigilant infection prevention, such as hand hygiene and cough etiquette.
- Properly clean, disinfect and limit sharing of medical equipment between residents and areas of the facility.
- Provide additional work supplies to avoid sharing (e.g., pens, pads) and disinfect workplace areas (nurse's stations, phones, internal radios, etc.).

Will nursing homes be cited for not having the appropriate supplies?

CMS is aware of that there is a scarcity of some supplies in certain areas of the country. State and Federal surveyors should not cite facilities for not having certain supplies (e.g., PPE such as gowns, N95 respirators, surgical masks and ABHR) if they are having difficulty obtaining these supplies for reasons outside of their control. However, we do expect facilities to take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of ABHR, we expect staff to practice effective hand washing with soap and water. Similarly, if there is a shortage of PPE (e.g., due to supplier(s) shortage which may be a regional or national issue), the facility should contact the local and state public health agency to notify them of the shortage, follow national guidelines for optimizing their current supply, or identify the next best option to care for residents. If a surveyor believes a facility should be cited for not having or providing the necessary supplies, the state agency should contact the CMS Branch Office.

What other resources are available for facilities to help improve infection control and prevention?

CMS urges providers to take advantage of several resources that are available:

CDC Resources:

- Infection preventionist training: https://www.cdc.gov/longtermcare/index.html
- CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html
- CDC Updates: https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html
- CDC FAQ for COVID-19**:** https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html
- *Information on affected US locations: https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html*

CMS Resources:

- Guidance for use of Certain Industrial Respirators by Health Care Personnel: https://www.cms.gov/files/document/qso-20-17-all.pdf
- Long term care facility – Infection control self-assessment worksheet: https://qsep.cms.gov/data/252/A._NursingHome_InfectionControl_Worksheet11-8-19508.pdf
- Infection control toolkit for bedside licensed nurses and nurse aides ("Head to Toe Infection Prevention (H2T) Toolkit"): https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment
- Infection Control and Prevention regulations and guidance: 42 CFR 483.80, Appendix PP of the State Operations Manual. See F-tag 880: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf

Contact: Email DNH_TriageTeam@cms.hhs.gov

NOTE: The situation regarding COVID-19 is still evolving worldwide and can change rapidly. Stakeholders should be prepared for guidance from CMS and other agencies (e.g., CDC) to change. Please monitor the relevant sources regularly for updates.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/
David R. Wright

cc: Survey and Operations Group Management

AHCA/NCAL Guidance: Accepting Admissions from Hospitals During COVID-19 Pandemic

REVISED March 30, 2020

Purpose

The purpose of this document is to provide guidance to long term care facilities (SNFs and ALs) to determine when making decisions about accepting hospital discharges to LTC facilities. The decision-making and guidance are revised from March 20. The revisions are based on new evidence from CDC but may change as new data becomes available, the prevalence of COVID-19 varies in communities, hospital surge increases, or state officials issue additional orders. It is likely state public health officials may issue state or regional specific guidance that supersedes this guidance.

COVID-19 Epidemiology

The COVID-19 virus disproportionality impacts the elderly, with mortality increasing in every 10-year cohort to approximately 30% for those over the age of 80 and with chronic disease. It also appears to spread easily between people, particularly since younger people often have mild symptoms and can be infectious to others without symptoms. In addition, the incubation period is 2-14 days, which raises concerns that individuals admitted from the hospital maybe infected but asymptomatic as they are in their incubation period.

CDC data published in its Morbidity and Mortality Weekly Report (MMWR) on March 27, 2020, found that 57% of elderly patients without symptoms tested positive for COVID-19, who later went on to develop symptoms seven days later. When they tested positive, they shed virus at levels that likely made them infectious to others**.** Based on this data, **unless a person is tested for COVID-19 and negative before admitting them to your building, you should assume the person has COVID-19 regardless of their having or not having symptoms**.

Hospital Discharges to a LTC Facility

During the COVID-19 pandemic, the elderly will still have other medical problems that require hospitalization and post-acute care (e.g., strokes, CHF exacerbations, surgeries, etc.). The volume of some traditional post-acute admission has decreased as hospitals discontinuing most elective surgeries and elective admissions. However, hospitals expect to see a surge in admissions nationally related to COVID-19 as already seen in some U.S. cities. Hospitals will need more post-acute care beds to help with this surge. CMS has also waived the 3-day stay requirement for all discharges, regardless of COVID-19 status, to allow hospitals to more easily create new beds for the surge in COVID-19 admissions.

As such, LTC facilities will face the challenge as to which hospital discharges they can accept. The decision-making process will vary depending on the ability of the LTC facility to manage residents who are COVID-19 positive or suspected to have COVID-19.

We strongly urge LTC facilities to begin now creating separate wings, units or floors by moving current residents to handle admissions from the hospital and keep current resident separate, if possible. LTC facilities should also develop plans for consolidating residents between facilities to create "new" facilities to accept hospital discharges who may be COVID positive or negative or harboring the virus because testing is not available.

Transfers from LTC Facilities to the Hospital

A person with a positive test for COVID-19 or with fever or respiratory symptoms does not necessarily need to be hospitalized. They should be put in contact precautions and follow CDC guidance for COVID-19 positive or presumptive cases in long term care. If a resident requires IV fluids, oxygen and other treatments due to their respiratory symptoms, Medicare will allow you to switch the person over to Medicare Part A without a 3-day SNF stay.

Discussion with families and residents should occur about the risks of hospitalization with COVID-19 during this pandemic period. **We urge members to update residents advanced directives accordingly after having these discussions**.

Recommended Guidance for Admissions to LTC Facilities from the Hospital

The table below provides guidance on what to do with admission referrals whose COVID-19 status is positive, negative, or unknown. Patients should be tested for COVID before hospital discharge; if not tested, they should be assumed to be COVID positive based on CDC data showing the high proportion of COVID positive elderly who are asymptomatic. Accepting residents from the hospital is also contingent on the LTC facility having adequate staffing levels and PPE to manage COVID positive residents. If not possible, the LTC facility should stop accepting all admissions until the facility has staffing levels and PPE to manage residents, which may not be at typical levels, prior to this pandemic.

Table 1: Accepting Hospital Admission

The following are potential steps that can be taken to reduce the spread of COVID-19 in your LTC facility. These are referenced in the tables below.

1. Monitor for fever & respiratory symptoms.
2. Put in single room.
3. Place in contact precautions per CDC guidance based on new Strategies to optimize PPE supplies.
4. Limit contact with other residents as much as possible.
5. Limit the number of different staff interacting with a resident as much as possible and limit the number of times each staff enters a resident's room.
6. Cohort in rooms (and wings if possible) with similar residents (e.g. if COVID positive cohort with other COVID-19 positive residents or if unknown, cohort with other recent admissions from the hospital with similar status).
7. Create separate wing/unit or floor to accept patients. This may mean moving residents in facility to create a new unit/floor. Limit staff working between units as much as possible.

	Patient is tested & COVID-19 negative[1]	**Patient COVID Status unknown (asymptomatic)[2]**	**Patient tests positive for COVID-19 in hospital or with COVID symptoms**
No COVID-19 threat (Usual circumstance)	Not Applicable: At this time, assume COVID is in your area.	Not Applicable: At this time, assume COVID is in your area	Not Applicable: At this time, assume COVID is in your area
COVID-19 cases present <u>not</u> in the surrounding hospital catchment area	Not Applicable: At this time assume COVID is in your area	Not Applicable: At this time assume COVID is in your area	Not Applicable: At this time assume COVID is in your area.
COVID-19 cases present in the surrounding area or community of your hospital catchment area	Admit patient and • #1 per shift • #4 & #5 • #6 if possible	Do Not Admit unless #7 (then follow below)	Do Not Admit unless #7 (then follow below)
COVID-19 cases wide-spread in the surrounding area or community and hospitals are at or past capacity	Admit patient and • #1 per shift • #4 & #5 • #6 if possible	Admit patient only if • #7 if possible if not #2 or #6 AND • #1 per shift • #3, #4 and #5 AND Facility has adequate staffing levels and PPE to manage COVID positive residents	Admit patient only if • #7 if possible if not #2 or #6 AND • #1 per shift • #3, #4 and #5 AND Facility has adequate staffing levels and PPE to manage COVID positive residents

[1]This includes patients hospitalized with COVID who have recovered and now test negative on at least one most recent test at discharge.

[2]For hospital discharges with respiratory symptoms or fever, facilities should ask the hospital to perform a COVID-19 test and then base decisions on the test results. If COVID-19 negative they should be admitted and managed per usual care for respiratory symptoms adopting new CDC guidance for strategies to optimize PPE supplies. If testing is not available, then the facility should assume the person is COVID-19 positive. Additionally, patients with fever and respiratory symptoms should have a negative flu test.

NOTE: If the patient's condition and reason for admission requires transmission-based precautions other than related to COVID-19, the facility should follow those recommendations as best possible given the new CDC guidance for Strategies to optimize PPE supplies