Adult Foster Home Provider Alert

Policy updates, rule clarifications and announcements

Date: February 16, 2022

To: APD Adult Foster Home Providers

From: Safety, Oversight and Quality Unit

Topic: **Best practices for COVID-19 related admissions from hospitals to long-term care facilities (updated 02/11/2022)**

The Oregon Health Authority has updated guidance related to admissions from hospitals to Long Term Care Facilities (LTCFs). Please follow the link below to review the required guidance for long-term care facilities. Note that this document is also attached to this provider alert.

Best practices for COVID-19 related admissions from hospitals to long-term care facilities (*updated 02/11/2022*) (OHA 4075).

Please visit the OHA web site where partner resources are located:

COVID-19 Healthcare Partner Resources

If you have licensing questions, please contact your licensing team:

APD.AFHTeam@dhsoha.state.or.us

Oregon Department of Human Services website: www.oregon.gov/DHS/

APD means Aging and People with Disabilities. APD adult foster homes are licensed to care for adults who are older and adults with physical disabilities.

Oregon Health Authority
PUBLIC HEALTH DIVISION

Oregon Department of Human Services

Best practices for COVID-19 related admissions from hospitals to long-term care facilities

(Updated 2/11/2022)

Purpose

Ensuring hospital bed capacity for those who require acute care is an important component of the healthcare response to the COVID-19 pandemic. The ability to discharge hospitalized patients to an appropriate level of care is crucial to maintaining that capacity. Patients with suspected or confirmed COVID-19, who are still infectious and who no longer require hospital resources, can be discharged to settings equipped to provide appropriate care while maintaining the safety of staff and other residents.

Neither discontinuation of Transmission-Based Precautions nor negative COVID-19 test results are required prior to hospital discharge.

This document addresses discharge of people who are hospital inpatients to long-term care facilities (LTCF) as well as the timing for discontinuation of Transmission-Based Precautions. LTCFs include assisted living, residential care and nursing facilities, or other care settings (such as adult foster homes).

Key points

- LTCF residents evaluated in a hospital for symptoms unrelated to COVID-19 can return to their home facility without a negative COVID-19 test.
- Patients with COVID-19 who require Transmission-Based Precautions can be transferred to a LTCF as long as the facility has met infection prevention and control criteria for the care of COVID-19 patients, as outlined in Executive Orders issued by the Oregon Department of Human Services (ODHS) Office of Aging and People with Disabilities (APD).
- Patients who no longer require Transmission-Based Precautions can be discharged to a LTCF.

Discharge of patients or residents with no signs or symptoms of COVID-19

At this time, it is considered a best practice that LTCF residents who are evaluated in a hospital for symptoms **not** associated with COVID-19 infection **can be transferred or returned to their home facility without a negative COVID-19 test**. Requiring a negative test in this scenario:

- Is not recommended by either Oregon Health Authority (OHA) or the Centers for Disease Control and Prevention (CDC);
- Is of questionable benefit in preventing introduction of COVID-19 into LTCFs as it does not circumvent the need for an observation (quarantine) period for residents who are not up to date with all recommended COVID-19 vaccine doses. (CDC currently recommends either a 10-day observation period or 7-day observation period with negative test, if collected between days 5-7); and
- Results in unnecessary use of testing resources during a time when such resources are limited.

Hospitals are not required to perform COVID-19 testing on patients solely for discharge considerations. Testing is recommended if a patient develops new symptoms suggestive of COVID-19 or has a known exposure to COVID-19. The latter would include close contact (within 6 feet) for 15 or more minutes with an individual with confirmed COVID-19 within the past 14 days.

Discharge of patients or residents with confirmed COVID-19 who require Transmission-Based Precautions

Prospective or returning LTCF residents with COVID-19, who are being discharged from the hospital and have not yet met CDC criteria for discontinuation of Transmission-Based Precautions for COVID-19, can be transferred to a LTCF as long as the following criteria are met as outlined in APD Executive Orders:

- Facility is cohorting all confirmed and suspected COVID-19 cases, and has the ability to cohort any prospective or returning residents with confirmed COVID-19, and
- The facility has sufficient staff to meet the needs of the residents, and
- All infection control measures are implemented and strictly followed and monitored in accordance with OHA, CMS, and CDC guidelines, and
- When the facility has any COVID-19 positive residents, the facility has dedicated staff to care for residents with COVID-19.

If the facility cannot ensure all of the above criteria are met, they must consult with APD prior to admission or readmission. Facility must also consult with APD prior to admitting any COVID-19 positive resident into a building that does not already have COVID-19 positive resident cases.

Requirement

- Hospitals are required under OAR 333-019-0052 to provide advanced notice to a receiving LTCF for any transfer of a patient with confirmed or suspected COVID-19 who still requires Transmission-Based Precautions. Similarly, LTCFs that become aware that a person they are transferring to a hospital or another facility requires Transmission-Based Precautions are required to notify the receiving facility.

Best practice

- Though not required under OAR 333-019-0052, it is recommended that hospitals and LTCFs notify a receiving facility upon transfer of any patient/resident who is likely to have been exposed to COVID-19, either through known close contact with an infected person or due to residence or hospitalization in a facility during an active COVID-19 outbreak.
- It is also a best practice that discharge planners, under Transmission-Based Precautions for COVID-19, follow a tiered approach for discharge of LTCF residents with confirmed COVID-19 who do not have access to transitional sites or dedicated COVID-19 facilities. The order of preference of discharge is as follows:
    1. Transfer LTCF residents to a receiving facility with a separate area dedicated to COVID-19 patients, including dedicated staff and PPE.
    2. Transfer LTCF residents to a receiving facility that has private rooms with private bathrooms.

Note:

- Transfers of LTCF residents to facilities not meeting either of the above criteria need to be approved by APD.
- APD does not allow COVID-19 positive resident transfers into COVID-19 negative buildings unless approved by APD.

Discharge of patients or residents with confirmed 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 to an LTCF.** They can be placed into a regular room without Transmission-Based Precautions and can be roomed with another resident.

Residents who have recovered from COVID-19 do not need to be retested within 90 days of their onset of symptoms or first positive COVID test (whichever is earlier) unless they develop new symptoms of COVID-19. Alternative medical diagnoses should be considered.

Patients or residents with suspected COVID-19, with test results pending

A person with active symptoms suggestive of COVID-19 should not be transferred to a LTCF until test results are available, unless:

- There is urgent need to transfer the resident, such as a shortage of hospital beds resulting in an overload of patients awaiting hospital discharge, and
- The facility is experienced and able to care for residents with suspected COVID-19, and
- APD's licensing unit has approved the transfer.

The hospital must provide clear notification to the receiving facility about the pending COVID-19 test.

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

Prospective or returning LTCF 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, and are deemed to not have COVID-19 based on clinician assessment, may be discharged to a COVID-negative facility that is appropriately isolating and able to provide appropriate care while maintaining the safety of staff and other residents.

The following are considered best practices related to hospital discharges of patients or residents investigated for possible COVID-19 with a negative test:

- Healthcare professionals caring for a patient in the hospital or community setting should consider evaluation of other potential causes of illness (e.g., influenza). When suspicion for COVID-19 remains high, repeat testing for COVID-19 is

recommended. Note: Antigen tests are considered less sensitive than molecular (e.g., PCR, NAAT) testing. Negative antigen tests in symptomatic residents should be confirmed with molecular testing.

- Discharge planners should communicate clinical status, COVID-19 exposure, test results, and indication for continuation of Transmission-Based Precautions to the receiving facility.
- Appropriate duration of Transmission-Based Precautions should be implemented for the resident if an alternative infectious diagnosis (e.g., influenza) is suspected. In addition, a new admission/readmission observation period is still needed for residents who are not up to date with all recommended COVID-19 vaccine doses.
- Receiving facilities should consider re-testing for COVID-19 immediately if a resident develops additional COVID-compatible symptoms. If the test is positive for SARS-CoV-2, the start date for transmission-based precautions should be reset based on the onset date of the new COVID- compatible symptoms

Additional pathways for hospitals to navigate discharge to LTCFs

The following is information to assist hospitals in overcoming barriers to discharge to long-term care facilities.

APD offices and some Area Agencies on Aging (AAA) offices statewide provide eligibility assessments and case management services for individuals who receive Medicaid long-term services and supports. Staff in APD and AAA local offices are often the best contacts for resolving issues. Establishing and cultivating relationships between hospital staff and staff in APD/AAA offices is critical to the ongoing success of the discharge process to long-term care facilities. Ongoing meetings and case consultations have been shown to increase efficiencies, reduce frustrations and facilitate timely discharges.

In addition to working with APD/AAA offices, the following table provides examples of options for overcoming discharge barriers.

Issue	Mitigation
Individual does not choose to apply for Medicaid.	Work with the individual on options counseling and include family members if the individual approves their participation.
Individual needs a guardian.	Contact the local Guardianship Office (if applicable) or the Office of the Public Guardian. Engage with family members onfeasibility of pursuing guardianship.
Individual was assessed and determined not to meet criteria for Medicaid long-term care services and supports through APD.	Proceed with private-pay discharge practices and/or contact APD's Aging and Disability Resource Connection of Oregon (ADRC) at 1-855-ORE-ADRC to identify other resources.
The individual did not qualify for Medicaid services through APD, and the individual has a documented behavioral health diagnosis.	Contact the local Community Mental Health Program in the area where the individual resides.
The individual has an intellectual or developmental disability and needs or has been denied services.	Work with APD local offices to resolve. APD will also collaborate with ODHS Office of Development Disabilities Services in serving these Oregonians.
A placement has been identified, butthe provider requires an exceptionalrate to accept the individual.	Direct the provider to work with the consumer's case manager to submit an exception request. If it is not possible to reach the APD/AAA case manager in a timely fashion, escalate to local office management and/or reach to APD's Complex Case Consultation Team.

Issue	Mitigation
The individual is eligible for APD long-term care services and supports, but placement options have been exhausted and no discharge placement can be found.	Work through the APD/AAA local office. Inquire as to whether APD's Complex Case Consultation Team has been engaged. Escalate with local office supervisor if necessary.
Facility has implemented a more stringent admission requirement thanwhat is required under regulation.	Contact the APD licensing unit; if the care setting is an adult foster home, contact the local APD office.
Facility refuses to take consumer backafter ED visit.	Contact the APD licensing unit and provide name of facility, name of consumer, name of hospital and dates.
Facility refuses to take consumer backafter inpatient stay.	Inquire as to whether facility has complied with move-out notice requirements. Contact APD licensing for assistance.
Other issues not identified here.	Escalate to APD Director's Office forassistance.

Document accessibility: For individuals with disabilities or individuals who speak a language other than English, OHA and ODHS can provide information in alternate formats such as translations, large print, or braille. Contact the COVID-19 Response and Recovery Unit at 503-979-3377, 711 TTY or CRRU@dhsoha.state.or.us.