CRITICAL ACCESS HOSPITALS

Accepting COVID-19 Patient Transfers

Purpose: This resource is not intended to be an all-inclusive compilation of resources and information related to accepting acute transfers of COVID-19 positive or Persons Under Investigation (PUI) patients. The following is intended to help CAHs prepare to accept patients who were cared for in an acute facility who are a COVID-19 positive patient either confirmed through testing or clinical diagnosis.

For additional information on specific aspects of care, please contact:

- Finance-Andy Wheeler, awheeler@mhanet.com
- Clinical and Regulatory- Sarah Willson, swillson@mhanet.com
- Emergency Response-Keri Barclay, kbarclay@mhanet.com
- Supplies/PPE-Stacie Hollis, shollis@mhanet.com
- Testing-Terrie Bauer, tbauer@mhanet.com

CAHs play a vital role in combating the spread of COVID-19 through early recognition and response to sources of infection. The CAH will provide assessment and treatment through emergency services, potentially serve as alternate sites of care during surge and accept patients back into the community for ongoing care. CAHs have limited resources to begin their response including finances, staff, equipment and supplies. Rural hospitals typically have inherent challenges such as older and sicker patients, fewer physicians and support staff and older facilities and unreliable transportation. This added burden of staff falling ill presents an even greater challenge while treating patients and anticipating a surge. Early recognition that these limited resources quickly could be depleted and render the facility and community unable to appropriately combat the spread of the disease is critical.

Every CAH is held to the certification and licensure standards of the Centers for Medicare & Medicaid Services, EMTALA, Department of Health and Senior Services as well as accrediting organizations as applicable. CAHs are expected to meet the Conditions of Participation which includes emergency services, emergency preparedness planning and infection prevention and control. CAHs continuously must assess their capacity and capability taking into consideration best practice strategies for combating the spread of infection.

Preparation for COVID-19

- Healthcare Professional Preparedness Checklist For Transport and Arrival of Patients With Confirmed or Possible COVID-19
- Comprehensive Hospital Preparedness Checklist for COVID-19
- Strategies to Optimize the Supply of PPE and Equipment Operational Considerations

Hospitals likely will be asking to send patients to CAHs who are:

- recovering from a COVID-19 positive diagnosis and stay
- recovered from a COVID-19 positive diagnosis but need additional recovery care
- needing care for some other diagnosis and no COVID diagnosis

We do not know about reinfection rates or exactly how long a patient continues to shed the infection.

Patients with alternate diagnosis

The CAH cannot be assured the patient has not been exposed to COVID-19 during their previous hospital stay. The same is true for any patient who walks into the Emergency Department for a diagnosis not related to COVID and is hospitalized. The provider should screen the patient upon presentation/admission and continue to monitor during the hospitalization for purposes of early detection and implementation of appropriate infection control measures.

If the patient was diagnosed with flu or some other diagnosis, infection control measures appropriate to that diagnosis is recommended to be followed.

Patients who are considered “recovered” from COVID

The patient who is considered “recovered.”

Patients who are “recovering” from COVID

Patients who have tested positive for COVID and been hospitalized may need ongoing care that a CAH is asked to provide. The patient’s treatment status, days since diagnosis and symptom onset, current symptom status, PPE need and other factors will determine the level and type of care needed once transferred to the CAH. In addition, the CAH’s preparedness will be a factor as well. Internal factors that will influence the CAH’s ability to accept patients will include staffing, PPE supply, physical location and layout of patient care areas to name a few. These are the same considerations if a patient was a direct admit to the CAH who was suspected of having COVID.

CDC Discontinuation of Transmission Based Precautions

A patient’s physical readiness for discharge from the hospital may or may not coincide with recommended guidelines on the discontinuation of transmission-based precautions. The decision to discontinue Transmission-Based Precautions should be made using a test-based strategy or a non-test-based strategy (i.e., time-since-illness-onset and time-since-recovery strategy). Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge.

- Test-based strategy
  - 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 nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens) [1]. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

- Non-test-based strategy

- At least 3 days (72 hours) 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 7 days have passed *since symptoms first appeared*

A test-based strategy is preferred for discontinuation of transmission-based precautions for patients who are:

- Hospitalized
- Severely immunocompromised
- Being transferred to a long-term care or assisted living facility

If the CAH is accepting a COVID patient transfer **AND**

- Transmission-Based Precautions *still are required*, they should go to a facility with an ability to adhere to infection prevention and control recommendations for the care of COVID-19 patients. Preferably, the patient would be placed in a location designated to care for COVID-19 residents.
- Transmission-Based Precautions *have been discontinued,* but the patient has persistent symptoms from COVID-19 (e.g., persistent cough), they should be placed in a single room, be restricted to their room, and wear a facemask during care activities until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer.
- Transmission-Based Precautions *have been discontinued* and the patient's symptoms have resolved, they do not require further restrictions, based upon their history of COVID-19.

Additional Resources

- Hospital to Facility Transfer Form: In the same way an acute hospital would utilize the transfer form to communicate patient status to a long-term care or skilled nursing facility, the same form can be used to communicate about a transfer to a CAH.
  - Developed by Missouri Hospital Association, Missouri Healthcare Association, LeadingAge Missouri and Department of Health and Senior Services.
  - Transfer tool should be:
    - completed by the health care team with the signature of the provider overseeing care
    - provided to the facility as part of the inquiry for discharge placement
    - used regardless of COVID-19 diagnosis while in the hospital
    - provided to EMS

Has patient been laboratory tested for COVID-19?

COVID-19 Testing criteria for elderly/medically frail patients — Updated 3/23/2020
• Patients age 65 and older or patients with serious underlying medical conditions AND
• Patient presents with new onset fever 100.4 or greater AND cough OR other respiratory signs including shortness of breath

☐ **YES, Patient tested for COVID-19**
Date of test ____________________
What was the indication for testing?

☐ **NO,** Test NOT INDICATED per CDC criteria **OR, in patient with COVID diagnosis,** no fever for the last 72 hours without fever reducing medications and improvement in respiratory symptoms **AND** at least 7 days have passed since symptoms first appeared.
MAY TRANSFER

☐ **Travel/Exposure** In the past 14 days, has the patient been to any of the restricted travel areas, traveled internationally, traveled on a cruise ship, exposed to a person who has been lab tested positive for COVID-19, or is an immunocompromised person.

☐ **Respiratory** Signs/symptoms of a respiratory illness (cough, sneezing, fever>100.4, shortness of breath, sore throat).

☐ **Negative test**

☐ Patient greater than 14 days since travel/exposure → **MAY TRANSFER**

☐ Patient less than 14 days since travel/exposure → **TRANSFER TO FACILITY WITH APPROPRIATE STAFF, PPE AND SPACE**

☐ **Positive test**

Does patient meet criteria outlined in *CDC Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19*

☐ **YES** → **MAY TRANSFER**

☐ **NO** → **TRANSFER TO FACILITY WITH APPROPRIATE STAFF, PPE AND SPACE**

Clinical Assessment Completed by (signature)

- Visitor Screening: MHA put together guidance for hospitals on screening of staff, visitors and patients at points of entry. Managing visitor, patient and staff traffic is an important element of caring for and deciding to accept patient transfers.
  - Screening of Hospital Staff, Patients and Visitors
  - Recommendations for Hospital Visitor Restrictions
  - COVID-19 Screening Form
  - Daily COVID-19 Symptom Attestation Form
- CMS QSO 20-13-Hospitals-CAH: Infection Control Principles and Patient Placement in the hospital- This QSO provides valuable information from CMS on infection control considerations for hospital and CAH.
- CDC Return to Work Guidelines

Waivers

- Three-Day Qualifying Stay Waiver: CMS' waiver of the 3-day qualifying stay for skilled nursing facility payment has been clarified to also apply to CAH swing-bed status patients. This means CAH could potentially receive referrals for patients to enter swing-bed status earlier than the minimum 3-days. These patients may or may not have tested or have been clinically diagnosed positive for COVID-19.
- For a full listing of waivers being tracked by MHA, visit: https://www.mhanet.com/mhaimages/COVID-19/MHA%20Waiver%20Tracking.xlsx
- The following is a quick reference of CMS' CoP that have been waived and their congruency with state hospital licensure waivers.

CMS Conditions of Participation Waivers In Congruence with State Hospital Licensing Regulations			
Complete MHA waiver guide		Allowed by State Waiver	Comment
CMS	Physical Environment: Suspend Physical Environment CoPs to allow for alternate care sites (testing and care)	✓	
CMS	Sterile Compounding: Allow face masks used during sterile compounding to be reused throughout a continuous work shift	✓	
CMS	Verbal Orders: Flexibility in the use of verbal orders related to verbal orders where read-back verification is required, but authentication may occur later than 48 hours	✓	
CMS	Medical Records: Suspend certain requirement relating to medical record department, content, retention and 30-day completion requirements	✓	
CMS	Patient Rights: Relaxation of timeframe to provide a copy of patient's medical record	✓	
CMS	Patient Rights: Suspend patient rights requirements relating to visitor policies and procedures and seclusion	✓	
CMS	CAH Status: Waives 25-bed limit and 96-hour average length of stay for CAHs	✓	
CMS	Care of Acute Care in Excluded Units: Allows hospitals to place acute care patients in excluded distinct part units if such beds are appropriate for acute care. IPPS hospitals should bill accordingly and document in the medical record that patient is there for capacity issues relating to emergency.	✓	

CMS	Care of Excluded IPU in Acute Care Units: Allows hospitals to relocate inpatients from excluded distinct part psychiatric unit to acute beds if beds and staff are appropriate for safe care. IPPS hospitals should bill for inpatient psychiatric services and document in the medical record that patient is in acute bed due to capacity or other exigent circumstances relating to emergency.	✓	
CMS	Care of Excluded IRU in Acute Care Units: Allows hospitals to relocate patients from excluded distinct part inpatient rehabilitation unit to acute beds if beds are appropriate for such patients and they continue to receive intensive rehab services. Hospitals should bill for rehab services under the IRF PPS and document in the medical record that patient is in acute bed due to capacity or other exigent circumstances relating to emergency. Also waives the 60 % rule for IRF's for patients admitted solely to respond to the emergency.	NA	
CMS	Long-Term Care Acute Hospitals: May exclude patients stays from the 25-day average LOS requirement for patients admitted and discharged to meet emergency demands	NA	
CMS	Inpatient Rehabilitation Facilities: May exclude from freestanding hospital or Distinct Part Unit the inpatient population for purposes of calculating applicable thresholds to receive payment as an IRF-60-Day Threshold	NA	
CMS	Occupational Mix Survey: Extending the deadline from July 1 to August 3. Hospitals should contact their MAC or CMS if they will have difficulty meeting the deadline.	NA	
CMS	Reporting Requirements: Waiver of reporting death in ICU in soft restraints unless directly causing death	✓	
CMS	Allows use of pre-printed and electronic standing orders and protocols for patient orders	✓	
CMS	Discharge Planning: Waives certain detailed requirements for post-acute care discharge	✓	
CMS	Physician Services: Waiver of requirement that Medicare patients be under care of a physician, so long as not inconsistent with state's emergency plan	✓	

CMS	Utilization Review: Suspends entire UR CoP, so long as not inconsistent with state’s emergency plan	✓	
CMS	Emergency Services: Waives requirement for written policies for evaluating emergencies at surge sites, so long as not inconsistent with state's emergency plan	✓	
CMS	Emergency Preparedness: Waives certain requirements for emergency preparedness plans and policies at surge sites and communication plans	✓	
CMS	QAPI: Suspends certain QAPI requirements related to scope, incorporation and priority setting for program activities and integration (hospitals part of health care system)	✓	
CMS	Nursing Services: Suspends nursing care plan requirements and requirement for policies and procedures for nurse presence at outpatient departments	✓	
CMS	Food and Dietetics: Suspends requirement to have current therapeutic diet manual approved by dietician and medical staff at surge sites	✓	
CMS	Patient Self Determination Act (Advanced Directives): Providing information on advanced directive policies	✓	
CMS	Anesthesia Services: Waives requirements for CRNA to be under physician supervision as determined by physician and CRNA	✓	
CMS	Respiratory Care Services: Waives certain policy and supervisory requirements related to personnel qualified to perform respiratory care procedures	✓	
CMS	CAH Personnel Qualifications: waives personnel qualifications for CNS, NP and PA	✓	
CMS	CAH Staff Licensure: Waives licensure, certification and registration requirements deferring to state law	✓	
CMS	3-day Rule for Swing Bed Status-required waiver of rule temporarily	NA	