Accepting New Patients During an Active Pandemic: Considerations for Both Transfers from Hospitals and Admissions from the Community

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Introduction and Welcome

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Meet Your Speakers

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Disclosures

Dr. Unroe is the CEO of Probari (www.probarisystems.com) a healthcare start-up founded to improve care in nursing homes through implementing the evidence-based OPTIMISTIC clinical care model.

Learning Objectives

1. Federal guidance on transfers from hospitals and admissions from the community to nursing homes
2. Guidance for managing admissions, readmissions, and transfers
3. Strategies to develop nursing home – hospital partnerships: the importance of a warm hand-off

General Guidance

- Nursing homes should admit any individuals they would normally admit, including individuals from hospitals with current or previous COVID cases

- A nursing home can admit residents with COVID-19 as long as the facility can follow Transmission-Based Precautions

- If the nursing home cannot safely accept a resident, they must work with their local health department to address barriers (e.g. obtain additional PPE, staff support)

General Guidance

- It is important to create a plan for managing admissions with an unknown COVID status (if coming from hospital or community)

Step-by-step guidance to admitting and readmitting residents: an overview

Admit

Place new admits or readmits with unknown COVID status in a single room

Monitor

Admitted residents should be monitored for 14 days. Test anyone who develops symptoms. Testing after the 14-day observation period may be considered.

Isolate

Limit contact with other residents

- Limit number of different staff interacting with resident

Cohort

- Place residents in areas with similar residents
- Create separate wings/units

Protect

- Follow Transmission-Based Precautions during the observation period

Testing

- Testing should not be required prior to transferring a resident from an acute-care facility to a nursing home
  - A single negative test during an exposure window does not rule out COVID-19
  - Assume residents may have been exposed and could go on to develop infection
- Older adults with COVID-19 may be asymptomatic or have atypical presentations
- Observation and maintenance of Transmission-Based Precautions is necessary for a full 14 days, even if a negative test was obtained upon admission

Monitoring

- Newly admitted or readmitted residents should be monitored for 14 days and cared for using appropriate PPE
  - Staff should wear N95 or higher-level respirator (or facemask if respirator is not available), eye protection, gloves, and gowns

- Monitor for: fever, respiratory symptoms, new or worsening malaise, headache, new dizziness, nausea, vomiting, diarrhea, loss of taste or smell
  - More than two temperatures >99.0° F might be a sign of fever in older adults
  - Include assessment of O_2 saturation via pulse oximetry
  - If symptoms develop, immediately test and promptly move to a dedicated COVID unit

- New positive cases should transfer to the COVID-care unit
  - Assess adherence to TBP during observation period and evaluate for potential staff/ resident exposures

Cohorting and Isolation

- Create a plan for cohorting admissions and readmissions whose COVID-19 status is unknown
  - Plan may include placing a resident in a single room or observation area
  - Keep admissions and readmissions separate from other residents

- Nursing homes could create wings/units/floors dedicated to admissions and readmissions; only if dedicated space already available for COVID-care unit
  - Move COVID positive resident to COVID unit

Cohorting and Isolation

- Residents can be transferred out of observation area/admissions unit if they have remained afebrile and without symptoms for 14 days after admission.
  - At this point testing may be conducted to increase certainty that the resident is not infected

- Limit staff working between units
  - Staff should only work on a single unit (COVID-19 unit, observation unit)
  - Staff should not move between units
  - Supplies (e.g. thermometers, oxygen, blood pressure cuffs) should remain on their dedicated unit

Staffing

- Facilities should assign at least one individual with infection control and prevention training to manage their COVID-19 response and prevention
  - Full time role in facilities with 100+ residents
  - Responsible for IPC policies, infection surveillance, adhering to recommended ICP practices, staff training

- The CDC has developed online training to orient individuals in this role, https://www.train.org/cdctrain/training_plan/3814

Engagement with Residents and Families

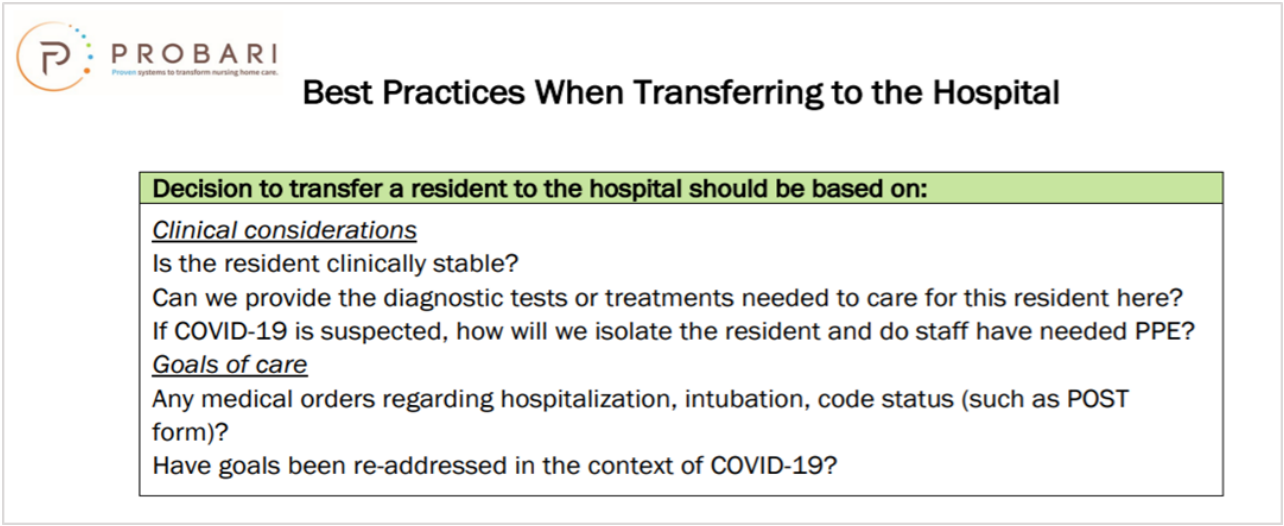
- Nursing home staff, residents, and families should:
  - Have an advance care planning conversation
  - Discuss the risks of hospitalization with COVID-19
  - Update advance care planning documentation
- Resources
  - https://www.vitaltalk.org/topics/covid-videos/
  - https://www.vitaltalk.org/guides/covid-19-communication-skills/

What can we say to residents and families?
"You know this virus is going around. Have you thought about what it means for you?"
"Not many older people who are sick enough to need a ventilator to breathe will survive. If you get a bad case, would you want to go to the hospital and potentially be treated in an ICU on a ventilator?"
"We will do our best to honor your preferences."

Engagement with Residents and Families

When do you hospitalize a resident?

- Confirmed goals of care are consistent with hospitalization
- Vitals become unstable despite interventions
- Urgent need for diagnostics and therapeutic



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Best Practices When Transferring to the Hospital

Decision to transfer a resident to the hospital should be based on:
Clinical considerations Is the resident clinically stable? Can we provide the diagnostic tests or treatments needed to care for this resident here? If COVID-19 is suspected, how will we isolate the resident and do staff have needed PPE? *Goals of care* Any medical orders regarding hospitalization, intubation, code status (such as POST form)? Have goals been re-addressed in the context of COVID-19?

https://www.optimistic-care.org/probari/covid-19-resources

Engagement with Residents and Families

- Involve resident and the resident's representative in transfer decisions
- Communicate transport plan to residents and their representatives, and provide them a contact person at the receiving facility
- Consider preferences for where the resident moves and when
- Plan for resident's return to their room

Partnering with Hospitals

- Older adults often arrive in the ED with upwards of 20 pages of documentation, and there is often critical information missing (e.g., reason for transfer, baseline cognitive status, and goals of care)
- If returned to the nursing home, details on the ED evaluation and treatment plan are often poorly communicated to the nursing home providers
- Terminology and expectations may vary based on setting

A Warm Hand-off

- A warm hand-off is recommended at each transition of care
- NH providers should consider “forward triage” for patient transitions of care
  - Assessing the resident’s level of acuity and where their care needs can most appropriately be met
  - A conversation with the ED physician who would otherwise be receiving the resident
- NH providers can directly share with ED providers any suspicion or confirmed testing that a resident has COVID-19, or any other reason for Transmission-Based Precautions. The presence of a current outbreak in the facility can also be shared
- NH providers should expect the same information when receiving a transfer back

A Warm Hand-off

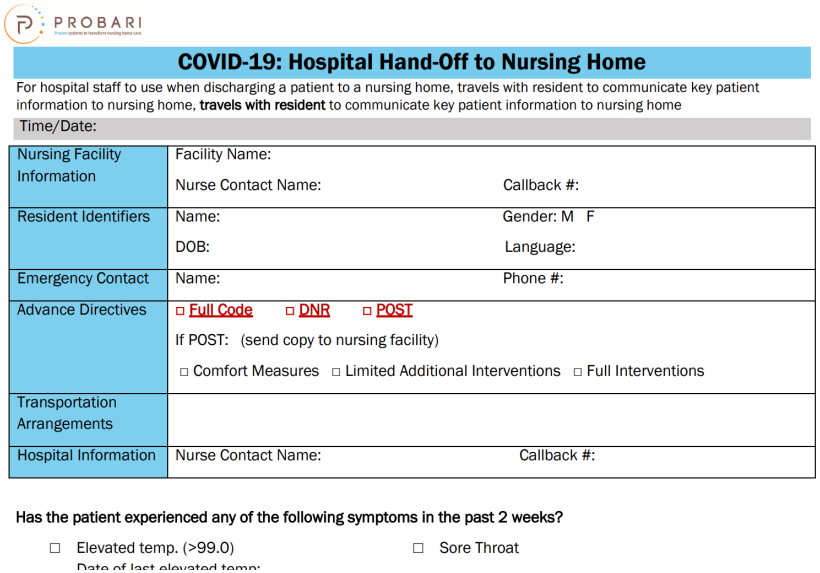
Nursing home and ED providers have two conversations:

1. Prior to the ED evaluation, they discuss the history of present illness, resident's medical history, baseline mental and functional status, goals of care, current hospital resources, and nursing home treatment (and isolation) capacity

2. After ED evaluation, they consider risks, benefits, and alternatives to construct a disposition and communicate with family members

Hand-off Tools and Transfer Projects

- **INTERACT** (Interventions to Reduce Acute Care Transfers)
- **BOOST** (Better Outcomes for Older Adults through Safe Transitions)
- **ProjectRED** (Re-Engineered Discharge)
- **OPTIMISTIC** (Optimizing Patient Transfers, Impacting Medical Quality, and Improving Symptoms: Transforming Institutional Care)



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COVID-19: Hospital Hand-Off to Nursing Home

For hospital staff to use when discharging a patient to a nursing home, travels with resident to communicate key patient information to nursing home, **travels with resident** to communicate key patient information to nursing home

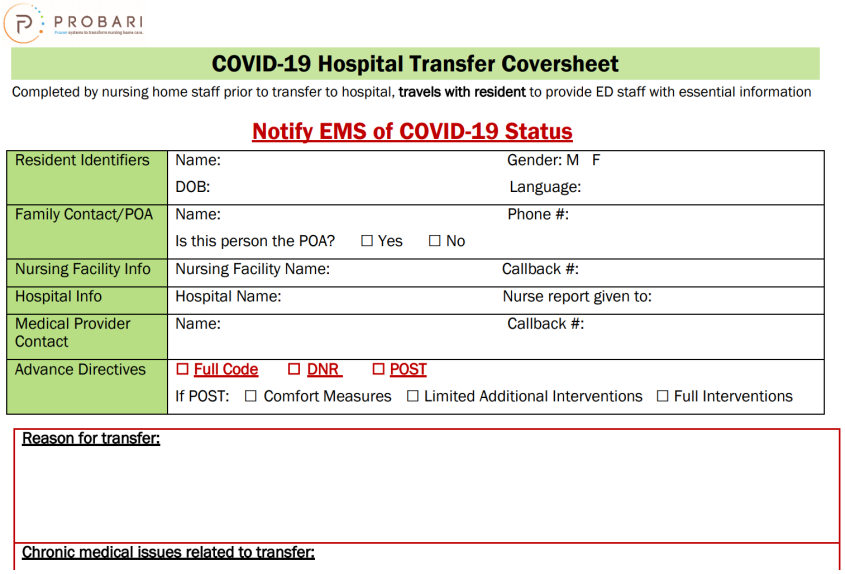
Time/Date:

Nursing Facility Information	Facility Name: Nurse Contact Name:	Callback #:
Resident Identifiers	Name: DOB:	Gender: M F Language:
Emergency Contact	Name:	Phone #:
Advance Directives	☐ Full Code ☐ DNR ☐ POST If POST: (send copy to nursing facility) ☐ Comfort Measures ☐ Limited Additional Interventions ☐ Full Interventions	
Transportation Arrangements		
Hospital Information	Nurse Contact Name:	Callback #:

Has the patient experienced any of the following symptoms in the past 2 weeks?

☐ Elevated temp. (>99.0) ☐ Sore Throat

Date of last elevated temp:



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COVID-19 Hospital Transfer Coversheet

Completed by nursing home staff prior to transfer to hospital, **travels with resident** to provide ED staff with essential information

Notify EMS of COVID-19 Status

Resident Identifiers	Name: DOB:	Gender: M F Language:
Family Contact/POA	Name: Is this person the POA? ☐ Yes ☐ No	Phone #:
Nursing Facility Info	Nursing Facility Name:	Callback #:
Hospital Info	Hospital Name:	Nurse report given to:
Medical Provider Contact	Name:	Callback #:
Advance Directives	☐ Full Code ☐ DNR ☐ POST If POST: ☐ Comfort Measures ☐ Limited Additional Interventions ☐ Full Interventions	

Reason for transfer:

Chronic medical issues related to transfer:

https://www.optimistic-care.org/probari/covid-19-resources/

Nursing Home – Hospital Partnership

- Be aware of local communication systems through:
  - Healthcare consortiums
  - Hospital systems
  - Local or statewide systems

Wait for it!

Receive attendance credit and **access your Certificate of Participation** by clicking the blue **Access Certificate** button at the very end of this training.

It may take a moment for the screen to appear. **Thank you for your patience.**

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