

Sunday, March 29, 2020

State Advisories re: Hospital Discharges and Admissions to Nursing Homes and Assisted Living Communities

As we anticipate the coming surge in COVID-19 cases in the United States, there is a clear need to balance the issues of patient safety, surge management, and conflicting guidelines and public policy around hospital-to-nursing home or hospital-to-assisted living community transfers. We are in extraordinary times, making highly complex decisions, often without adequate information and data.

We are deeply concerned with the recent New York State order, which states:

“No resident shall be denied re-admission or admission to the NH solely based on a confirmed or suspected diagnosis of COVID-19. NHs are prohibited from requiring a hospitalized resident who is determined medically stable to be tested for COVID-19 prior to admission or readmission.”

As organizations dedicated to preserving the safety of patients and residents in post-acute and long-term care settings including assisted living, we strongly object to this policy directive and approach to developing surge capacity. We are aware that other states may already be adopting a similar approach in order to free up hospital beds. This is a short-term and short-sighted solution that will only add to the surge in COVID-19 patients that require hospital care.

We understand the need for public health and elected officials to weigh the risks and benefits of their decisions. Without doubt, in the face of a significant surge in the number of people who need hospital care, difficult decisions must be made. However, a blanket order for every nursing home in the state to accept all admissions from hospitals is not sound policy.

Based on what we currently know about how this virus can spread in institutional settings, the hospitalizations and case fatality rate, this action by a state will put the many frail and older adults who reside in nursing homes at risk. The preliminary results from the first nursing home to have an outbreak of COVID-19 in King County Washington show a hospitalization rate of 57% for residents. The case fatality rate (CFR) for residents was 36% and 7% for staff. Subsequent published scientific studies from multiple countries, including recent U.S. data released by the Centers for Disease Control and Prevention (CDC), report the CFR to be in the 15-30% range for geriatric nursing home residents.

The question all state officials must consider is whether the risk of introducing a virus with an estimated 30% or higher mortality rate into a nursing home or assisted living community outweighs the risk of hospitals being overcrowded. Regrettably, this is a difficult decision that many officials will be facing now or in the near future. However, it is not a binary decision. Alternative settings for patients recovering from COVID-19 must be considered and implemented now, including large field hospitals, dormitories, hotels, and shuttered nursing homes or hospitals.

Unfortunately, a decision to attempt to create more hospital bed capacity by sending patients to nursing homes indiscriminately may have the unintended effect of making the problem this is

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trying to solve worse. In New York, requiring all New York nursing homes state-wide to accept all patients regardless of their COVID-19 status, even from hospitals that are not at capacity, will likely cause many more hospitalizations, since elderly people over the age of 80 with chronic diseases are most at risk of hospitalizations – and they constitute the majority of nursing home residents today.

Decisions to transfer hospitalized patients to a nursing home are not at the sole directive of the hospitals or hospital physicians. Decisions to transfer patients to nursing homes are joint responsibilities, made collaboratively, since a new admission to a nursing home from a hospital can impact the health of all the other residents with dire, and indeed fatal, consequences. Factors that must be taken into consideration include:

- **Inadequate Supplies** – Supplies such as masks, gowns and face shields are critically low. Some nursing homes have exhausted their supply and are making their own PPE (without any guarantee of effectiveness). This makes caring for COVID-19 (+) residents unsafe and jeopardizes all patients in the nursing home.
- **Staffing in the Nursing Home** – Many nursing homes have staff absent with symptoms, self-quarantining, or at home due to child-care issues, since schools are closed and there are few alternative child-care options. Staffing agencies are being stretched thin and have limited ability to fill in gaps. Moreover, agency staff may increase risk as these staff may be working in numerous buildings.
- **Nursing Home Infection Control Capabilities** – Nursing home capability to provide high-quality infection control may be limited due to situational factors out of their control, such as competencies of remaining available staff; loss of physician and advance practice providers due to illness, quarantine, or surge needs at other institutions; recent leadership turnover; and instability and financial struggles related and unrelated to pandemic stressors.
- **Physical Structure** – The physical structure of the nursing home often complicates delivery of safe and effective healthcare. Many homes do not have private rooms, negative pressure rooms are all but absent in nursing homes, and older corridor designs may inadvertently decrease the ability to reliably monitor residents with acute, high-intensity medical and respiratory needs.

In assisted living residences and continuing care retirement communities, these factors and the challenges in managing COVID-19 (+) or COVID-19 exposed residents are even more significant. These communities are not healthcare facilities, and thus are not prepared or equipped to handle medically complex surge-related discharges.

We recommend a more strategic and collaborative approach statewide, similar to which has been taken in states such as Louisiana, Florida, Iowa, and Michigan. CDC data released after these states issued their guidance raises serious questions about not testing patients before discharge to nursing homes. The CDC's Morbidity and Mortality Weekly Report (MMWR) published on March 27* shows that 57% of residents in Washington nursing homes who tested positive for COVID-19 were asymptomatic for up to seven days before developing symptoms, and "have

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potential for substantial viral shedding” during that period. Therefore, assuming adequate test availability, we recommend:

- Hospital patients with active COVID-19 infection should not be admitted to nursing homes without a previous or current COVID-19 case. Hospital patients with COVID-19 (+) tests may be admitted to cohort with other residents who are already COVID-19 (+) OR onto nursing home wings or units that can be kept separate from the other residents. To the extent possible, staff – including medical practitioners – should not circulate between units.
- Transfer of hospitalized patients with active COVID-19 disease to nursing homes with known COVID-19 cases should only occur if the nursing home is adequately equipped to care for them, i.e., has the staff, medical providers, and PPE necessary to provide safe care. This decision must be the responsibility of the receiving nursing home, in collaboration with the medical director or designee. This decision is not the responsibility of the referring hospital or hospital physician.
- Hospitalized patients with COVID-19 symptoms but no test results available should be assumed to have COVID-19 and follow the steps above.
- Admission of hospitalized patients who have recovered from COVID-19 should be admitted to nursing homes in accordance with current CDC guidance.
- Hospitals with hospital-based transitional care units (TCU) should be considered first as alternative care sites and/or step-down units for patients with COVID-19 before sending these patients to nursing homes.
- Hospitals, nursing homes, and public health agencies should convene open discussions regarding the actions being taken at their institutions and barriers that exist, including the staffing and resources present at their institutions. Such discussions are likely to result in creative and more effective solutions tailored to the local healthcare system needs.

We urge states to work together with nursing homes/assisted living communities, hospitals, and public health authorities. States should take targeted action where hospitals are overwhelmed and move residents within a nursing home to create open wings or floors to accept admissions from hospitals. This will ensure hospital patients that are moved to a nursing home are kept separate from existing residents. States could also make plans, working with nursing homes, to assist with moving nursing home residents between nursing homes to create an empty nursing home that can accept new patients (e.g. a COVID (+) nursing home). Finally, **states should immediately develop and implement options for alternate care sites and staffing to accommodate this expected overflow.**

A blanket, one-size-fits-all approach statewide, which will include areas of the state that are not as severely impacted as others, will result in more people going to the hospital and more deaths than using a more strategic and collaborative approach that takes all of the above elements into consideration.

*<https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6913e1-H.pdf>