# Community Partners

- **Should I transfer my resident with COVID-19 to the hospital?**

  This depends on several factors, including the burden of disease in your community, the burden of disease in your building, the ability to provide supportive care for your residents and on the resident's goals of care. Goals of care should be readdressed with the residents and their families when there is a COVID-19 outbreak in the facility. For residents with mild illness, we recommend a treatment-in-place. For those with moderate to severe symptoms, consider hospital transfer if that is part of their goals of care.

- **Should I transfer my resident with a respiratory viral illness to the hospital in order to help reduce the spread of disease?**

  We recommend transferring residents based on their medical needs, not as a means to reduce the spread of infection.

- **We have a resident who needs to be transferred to acute care for suspected COVID19. The hospital has resources to care for the individual and has accepted them. How do we approach this?**

  Transferring a resident with suspected or confirmed COVID-19 to the hospital requires consultation and communication with the local/state health department, receiving institution, and EMS services.

  While making the arrangements for transfer, the individual will still require care from staff, who should continue to use standard, contact, droplet precautions and eye protection as described above. Keep the door to the resident's room closed as much as possible. Pull curtains and limit the number of staff going in and out of the room and the unit.

  Alert the transport crew of the concern for COVID-19 so they can be prepared with their own respiratory protection. The hospital should be aware and have plans to minimize the risk of transmission once the individual arrives at the building.

  During the physical transfer of the resident into a gurney for transport, personnel should continue to wear gloves, gown, and a face shield or facemask with goggles. The resident should have a facemask if tolerated. Once the individual is on the gurney, with clean sheets and blankets, staff should remove their PPE and gloves and perform thorough hand hygiene.

Source: AMDA

- **We have not yet had any COVID-19 positive staff or residents in our building. The hospital has asked us to accept a COVID-19 positive patient. I'm not sure what to do.**

  AMDA's Resolution on COVID-19, dated March 19, 2020, states that a COVID-19 naïve facility should not accept an admission with clinical or lab evidence of active disease. Instead, care of these patients should be provided in alternate care sites and specialized COVID-19 facilities.

  The CDC has guidance for discontinuing transmission based precautions. These recommendations state that if 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. That guidance favors a test-based strategy for discontinuing transmission-based precautions for individuals being discharged to long-term care settings.

  We agree with this in principle and also have grave concerns about the potential for introducing COVID-19 into a building that has managed to remain COVID-19 naïve. The potential risk to other residents is severe.

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

  As per the recent AMDA Resolution on COVID-19, a COVID 19 naïve nursing facility should not accept a COVID 19 patient who is considered a transmission risk. As per CMS guidance, "If a nursing home cannot effectively implement transmission based precautions, it must wait until the resident does not require these precautions."

  The CDC has guidance for discontinuing transmission based precautions. These recommendations state that if 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. That guidance favors a test-based strategy for discontinuing transmission-based precautions for individuals who are discharged to long-term care settings.

  Ideally, nursing homes will 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 a short-term rehab floor or returning to a long-stay original room).

- **What about our medical providers? They work at multiple nursing homes and have outpatient practices.**

Source: AMDA

Encourage and support the use of telehealth so clinicians can avoid bringing COVID-19 into buildings or exposing themselves. If clinicians are providing outpatient care in addition to nursing home rounding, we recommend asking clinicians to visit the building first thing in the morning rather than at the end of the day. Also, if staffing permits, have clinicians limit their visits to one building. If this is not possible, then ask clinicians to only visit one building each day. The rationale for rounding in the morning is that the clinicians will have had overnight to know if they are starting to feel ill and can self-quarantine if needed.

Clinicians should also practice universal masking and gloving while seeing residents. Clinicians should clean their stethoscopes between use. They should wear gowns (not lab coats) when seeing patients.

Source: AMDA