Recommendations for Assisted Living Residences and Hospitals Relative to Return from Hospitals for Assisted Living Residents Related to COVID-19

These recommendations were developed to assist Massachusetts hospital and assisted living staff in determining when to discharge patients to assisted living. It was reviewed and edited by stakeholders across the care continuum, including assisted living and hospital representatives. The Massachusetts Health and Hospital Association's Post-Acute Care Transitions and Emergency Preparedness Working Group was instrumental in the creation of the recommendations.

About assisted living

Transitions from hospital settings to assisted living occur both when an older adult needs consistent personal care that cannot be provided in their prior home and when assisted living residents that were hospitalized are ready to be discharged. Assisted living emphasizes aging with dignity and choice, while offering a high-quality lifestyle in a supportive, non-clinical environment. Most residents receive support with certain activities of basic daily living (ADLs), such as bathing, dressing, grooming, or mobility. Some of these individuals live in special memory care units that support those living with Alzheimer's disease or other dementias. Hospital case managers and prospective residents and family members can find certified assisted living residences by town or zip code at this link.

Determining if discharge to assisted living is appropriate

The Assisted Living Residence (ALR) is the resident's home, and the expectation is that he or she will return upon discharge if it is safe to do so. For residents of an Assisted Living Residence (ALR) who are planning to be discharged, the hospital and ALR should work together to ensure that the resident is capable of returning in a safe manner or whether alternate arrangements should be made to provide needed care for the resident until he/she is able to return safely. It is important to consider that assisted living residents gather for communal meals and group activities, and that the potential impact of discharge of an infectious resident on other residents be considered. Discharge planning should consider the different capabilities of the ALR to understand how and whether a resident's needs can be met before being discharged. Some ALRs have nursing staff available who are currently able to administer injections, oxygen management, and wound care, and some have nurses on staff 24 hours a day, and may be willing and able to accommodate patients discharged with more complex care needs. However, many ALRs do not offer these and other similar clinical services that may be necessary for individuals returning from the hospital and recovering from COVID-19 or other serious illness.

Return to ALR from a hospital for a resident whose infection status is COVID-19 positive

An ALR resident being discharged from the hospital and whose infection status is COVID-19 positive and is still under Transmission Based Precautions (as described by the CDC) can safely return to the ALR under the following conditions:

- The resident is able to adhere to the plan established by the ALR to reduce exposure and infection to other residents in the congregate setting.
- The resident is not in any immediate distress (next 24hrs) which would require continuous monitoring and is safe to reside in a private unit behind a closed door.
- The ALR has been sufficiently notified so they are prepared for the resident's return and any necessary changes to their care plan, including that necessary equipment and supplies have been received.
- The hospital has arranged or coordinated continued care by the patient's primary care physician including referrals for any home care services needed. The ALR is

advised of where the resident is in the Transmission-Based Precautions Interim Guidance from the CDC (fever, no fever without medication, whether there has been an improvement in symptoms for at least 10 days) including date of initial positive test. This will be the basis for the ALR to determine when the resident can discontinue isolation.
- The ALR receives any hospice or other instructions, including any physician orders for changes in medication upon discharge so the resident's service plan may be updated.

Consideration of alternative placements

If any of the following circumstances exist, the hospital, in partnership with the ALR, the patient's family, healthcare proxy and/or designated caregiver, shall seek to identify alternate care settings for a patient. These circumstances include:

- Resident has cognitive or other impairments that will preclude resident from following ALR plan to separate resident from other residents, placing other residents at risk of infection.
- Frequent monitoring of O2 and other skilled nursing needs are required, and such nursing services are not available either at the ALR or through contract with an agency.
- Patient has a new skilled nursing need or functional loss that requires rehab to return to pre-hospital level of functioning and stability that cannot be met at the ALR.

Where appropriate and available, the caregiving team shall work to identify dementia-friendly or memory care skilled nursing facilities for those with cognitive or other impairments. For those patients with skilled nursing care needs that cannot be provided at an ALR, the team shall identify skilled nursing facilities who can accept these patients until/if they are able to return to the ALR.

Discharge of residents that have not tested positive for COVID-19 back to ALR

- All efforts should be made by the hospital to vaccinate individuals against COVID-19 prior to discharge back to the ALR, if not previously vaccinated, consistent with DPH guidance.
- Residents not fully vaccinated against COVID-19 should voluntarily quarantine or refrain from participating in congregate dining and group activities upon return to the ALR for 10 days. Mandatory quarantine can only be issued by the Local Board of Health.
- Hospitals should follow the Standardized COVID-19 Testing Recommendations Prior to Hospital Discharge including 1 Polymerase Chain Reaction (PCR) test or any molecular test including nucleic acid amplification test (NAAT) to be administered to patient no more than 48 hours prior to discharge back to the ALR. Results of the test shall be shared with the ALR prior to discharge.
- The ALR should receive discharge instructions from the hospital, including any physician orders for changes in medication upon discharge so the resident's service plan may be updated.

If you have any questions, please contact us at Mass-ALA@mass-ala.org

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