JHH and JHBMC | Discharge Guidelines for COVID Positive Patients Still on COVID Isolation

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Many, but not all, patients can be discharged while still on COVID isolation. This document provides guidance for the patient categories listed below. These guidelines may be updated frequently. Please refer to the Hospital Epidemiology and Infection Control (HEIC) website for the most recent version.

Patients Discharging to a Private Residence

Repeat inpatient or outpatient COVID testing is not needed for the majority of patients who are being discharged to a private residence; exception is certain immunocompromised patients who will or are likely to require an in-person visit to the hospital or clinic in the 30 days after symptom onset—see #3 below.

1. Patients who have a PCP with whom they can readily follow-up
   a. Instruct them to follow-up with their PCP (likely by phone or video) within 2-5 days.
   b. In the After Visit Summary, include the following documents:
      i. Krames Discharge Instructions: [link]
      ii. Krames COVID-19 What is Social Distancing and Self Quarantine?: [link]
   c. Most patients can discontinue self-isolation when ALL THREE of the following clinical criteria are met. (See below regarding severely immunocompromised patients who need to return in person for medical care.) We recommend including these three criteria in the After Visit Summary as well.
      i. At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications
      ii. Improvement in respiratory symptoms (e.g., cough, shortness of breath)
      iii. At least 7 days have passed since symptoms first appeared
   d. Please note that some patients eligible for discontinuing outpatient COVID isolation by the three criteria above may achieve these criteria while still an inpatient. If this is the case, they do not need any special isolation at the time of discharge (will not need the isolation and quarantine instructions in 1b.) and should simply return to the standard social distancing polices relevant to the general population when they leave the hospital.
   e. Suggest patients ask their PCP to discuss when they meet the three criteria in c. above.
   f. PCPs should be the ordering providers for home health needs (e.g. oxygen, durable medical equipment, nursing visits), and patients in established ambulatory substance abuse programs should plan to continue in those programs. (Please make every effort to work with case managers to ensure these links are confirmed prior to discharge).
   g. Provide the patient phone line number — xxx-xxx-xxxx — for the Hopkins COVID Ambulatory Response Team (CART) that patients can call if they are unable to connect with their PCP.
2. Patients who do NOT have a PCP with whom they can readily follow-up
   a. The discharging team should call the COVID Ambulatory Response Team (CART) scheduling number (xxx-xxx-xxxx; this is not a number for patients) to initiate CART follow-up.
   b. In the After Visit Summary, include the following documents:
      i. Krames Discharge Instructions: [Link]
      ii. Krames COVID-19 What is Social Distancing and Self Quarantine? [Link]
   c. Most patients can discontinue self-isolation when ALL THREE of the following clinical criteria are met. (See number 3 below regarding severely immunocompromised patients who need to return in person for medical care.) We recommend including these three criteria in the After Visit Summary as well.
      iv. At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications
      v. Improvement in respiratory symptoms (e.g., cough, shortness of breath)
      vi. At least 7 days have passed since symptoms first appeared
   d. Please note that some patients eligible for discontinuing outpatient COVID isolation by the three criteria above may achieve these criteria while still an inpatient. If this is the case, they do not need any special isolation at the time of discharge (will not need the isolation and quarantine instructions in 1b.) and should simply return to the standard social distancing polices relevant to the general population when they leave the hospital. Points e – h below will not apply in these cases.
   e. Instruct the patient that the CART will reach out to them for a video or telephone visit(s) with a provider within 2 days, who will evaluate symptoms and can discuss when they meet the three criteria above.
   f. Provide the patient with the CART patient phone number for questions, xxx-xxxx-xxxx
   g. FOR JHH ONLY:
      i. If the patient has home health needs (e.g. oxygen, durable medical equipment, nursing visits), ask your case manager to contact the After Care Clinic (xxx-xxx-xxxx or xxxx@xxx.xxx) where staff will serve as the ordering providers.
      ii. If the patient needs to start opioid replacement therapy, refer them for initial management by the After Care Clinic as outlined in the JHH COVID-19 Inpatient/Emergency Office Based Opioid Treatment Algorithm (see Appendix) and plan to provide a 7 day supply of buprenorphine as described therein.
   h. FOR BAYVIEW ONLY:
      i. If the patient has home health needs (e.g. oxygen, durable medical equipment, nursing visits), ask your case manager to contact xxxx via Staff Message with the patient’s information.
      ii. If the patient needs to start opioid replacement therapy, contact the BV301 practice triage nurse at x-xxxx or x-xxxx where xxxx or another provider can provide suboxone via telemedicine.

3. Severely immunocompromised patients expected to return for in-person hospital or clinic appointments, procedures, or tests
   Severely immunocompromised patients (e.g., solid organ transplant, active chemotherapy, bone marrow transplant, hematologic malignancy, inherited immunodeficiency, HIV with CD4 below 200) may shed COVID for longer periods of time. For patients with scheduled visits/procedures/tests that cannot be performed through
telemedicine or home care and that will occur within 30 days of symptom onset, patients should undergo the **test-based strategy as outpatients** (see criteria under “Patients Discharging to Institutional Settings” below). Their specialist and/or PCP should order the COVID tests with the CART staff who will schedule the outpatient test appointments. **If the COVID test remains positive**, COVID precautions are required. The visit(s) should be coordinated with HEIC. If repeat testing is not possible or has not been completed, COVID precautions for medical staff are required. Patients should present to the visit wearing a mask.

Severely immunocompromised patients who do NOT need to return in-person within 30 days should follow the guidelines in 1c. above; however, it may be reasonable to continue home isolation for 14 days.

### Patients Experiencing Homelessness Who are Being Discharged to the Outpatient Setting

Note that patients who do have a home should return there. The services below cannot be used for people who have a home but wish to stay away for fear of transmitting COVID or other reasons

1. **Patients actively engaged in care at Baltimore Healthcare for the Homeless** (this can be determined by asking patients, but **must be confirmed by calling Healthcare for the Homeless** at xxx-xxx-xxxx, staffed M-F 8a – 4:30p).
   
   a. Ask your case manager to call the Baltimore Health Department to arrange housing (likely in a hotel) and transportation for a patient on COVID isolation.
   
   b. Ask your case manager to establish follow-up with Healthcare for the Homeless who will provide post-discharge care including any home care services and/or buprenorphine.
   
   c. If possible, reach out to the Healthcare for the Homeless provider to convey case details including when the patient may be projected to come off COVID isolation (see f. below)
   
   d. **If there is a delay** in housing or in confirming with Healthcare for the Homeless, or **if the patient is severely immunocompromised**, it may be best to complete the **test-based strategy, in conjunction with infection control, prior to discharge** (see section below for patients discharging to institutional settings).
   
   e. Note that which home health services are available in the hotel setting may vary by the hotel and by the patient (e.g. is the patient or his/her partner able to administer IV antibiotics, physical therapy, etc.). Plans will have to be individualized for each patient in discussions with case management and Healthcare for the Homeless.

   **f. In the After Visit Summary**, include
   
   i. The follow-up plan that has been worked out with Healthcare for the Homeless
   
   ii. The following documents

   

   3. The three criteria below (**non-test-based strategy**) that are generally used to discontinue COVID isolation

   a. At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications
   
   b. Improvement in respiratory symptoms (e.g., cough, shortness of breath)
   
   c. At least 7 days have passed since symptoms first appeared

2. **Patients not actively engaged in care** at Baltimore Healthcare for the Homeless.
a. Ask your case manager to call the **Baltimore Health Department** to arrange housing (likely in a hotel) and transportation for a patient on COVID isolation.

b. Ask your case manager to establish follow-up with **Johns Hopkins Homecare**, indicating that Johns Hopkins Homecare should visit the patient in the City-provided housing in order to complete a test-based strategy for discontinuing isolation under guidance from the COVID Ambulatory Response Team (CART).

c. **Initiate the test-based strategy** by obtaining the first nasopharyngeal swab as soon as fever has resolved for at least 24 hours off antipyretics and their respiratory symptoms have improved to the point discharge may soon be possible. The idea here is that they will plan to complete this strategy, i.e. get first-swab results and additional swab(s), after discharge. If discharge is held-up for any reason, they may, however, complete the strategy while an inpatient, alleviating any need for COVID-isolation-related follow-up.

d. **If the patient is severely immunocompromised**, the test-based strategy, in conjunction with infection control, should be completed prior to discharge; see section below for patients discharging to institutional settings).

e. The discharging team should call the **COVID Ambulatory Response Team (CART)** scheduling number (xxx-xxx-xxxx; this is not a number for patients) to initiate CART follow-up and indicate that it will be in conjunction with Johns Hopkins Homecare.

f. Instruct the patient that a Johns Hopkins Homecare nurse will likely visit them within 24 hours to continue the test-based strategy for discontinuing isolation.

g. Johns Hopkins Homecare will coordinate **home health needs** (e.g. oxygen, durable medical equipment). If an ordering provider is needed, see the processes (JHH-specific and JHBMC-specific) in the section for patients without a PCP who are discharging to a private residence.

h. It may be possible to initiate suboxone therapy. See the processes (JHH-specific and JHBMC-specific) in the section for patients without a PCP who are discharging to a private residence.

i. **In the AVS, include**
   
   i. Krames Discharge Instructions:  
   ii. Krames COVID-19 What is Social Distancing and Self Quarantine?:  
   iii. Criteria for the **test-based strategy** to remove COVID isolation:  
   1. Resolution of fever without the use of fever-reducing medications for at least 24 hours  
   2. Improvement in respiratory symptoms (e.g., cough, shortness of breath)  
   3. Negative results of COVID-19 tests from at least two consecutive nasopharyngeal swab specimens collected ≥ 24 hours apart (minimum of two negative specimens)

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**Patients Discharging to Institutional Settings**

Relevant patients include those who will be returning to long-term care and assisted living facilities, patients who originated from a private residence but need to discharge to a skilled nursing facility setting, and patients discharging to inpatient rehabilitation facilities, skilled nursing facilities for short-term needs (i.e. parenteral antibiotics), group homes, inpatient substance abuse centers, or other institutional settings.

Requirements for these sets of patients vary depending on the receiving institution, and have been changing in recent weeks. The most important clinical guidance is to **work closely with your unit’s case manager** (and
physical/occupational therapists as relevant) starting early in the hospitalization to identify the likely destination and what the requirements will be.

1. Institutions that can accept patients who are still on COVID isolation (as identified by the case manager)
   a. This should include most patients who were previously residing in a long-term care or assisted living facility and will be returning to that facility and may include other facilities and patients on a case by case basis.
   b. Facilities will need to follow CDC Guidance for Transmission Based Precautions. Once the resident returns to the facility, the CDC guidance requires that the institution must use the test-based strategy to remove the COVID isolation precautions. It is reasonable to initiate this process and start sending repeat NP swabs while these patients are still hospitalized if they have 1) resolution of fever without the use of fever-reducing medications for at least 24 hours and 2) improvement in respiratory symptoms.

2. Institutions that CANNOT accept patients who are still on COVID isolation (as identified by the case manager)

Prior to discharge, the patient should fulfill the test-based strategy for removal of COVID precautions. ALL THREE of the following criteria must be met for removal of an inpatient from COVID precautions:

1. Resolution of fever without the use of fever-reducing medications for at least 24 hours
2. Improvement in respiratory symptoms (e.g., cough, shortness of breath)
3. Negative results of COVID-19 tests from at least two consecutive nasopharyngeal swab specimens collected ≥ 24 hours apart (minimum of two negative specimens)

Patients cannot be removed from COVID precautions without approval from infection control. If patients meet criteria for removal of COVID precautions but have persistent respiratory symptoms (e.g. lingering cough), infection control recommends they be placed in a private room in residential facilities. Facilities may have additional criteria that they will convey through case management.

Patients Who Will Attend Ambulatory Hemodialysis Centers

- As of 3/29/20, many COVID positive hemodialysis patients can receive outpatient dialysis in COVID-positive dialysis centers in the Baltimore area.
  o The inpatient nephrology team, together with the social workers, will arrange for slots in an appropriate COVID positive center and will ensure patients have transport arrangements from their homes to the dialysis center.
  o If there are anticipated delays, please discuss with nephrology and infection control whether to institute the test-based strategy (see above regarding patients discharging to institutional settings) to attempt to remove from COVID isolation prior to discharge. This may depend on the outpatient dialysis center’s guidelines for discontinuing COVID isolation, which may be different than our strategy.

- For patients that nephrology and social work determine cannot receive outpatient dialysis in a COVID-positive center (because live outside the Baltimore area or other reasons), discuss with nephrology and with infection control on a case by case basis whether they can transfer to a new center and/or what strategy is required to make them safe for their dialysis center.

- Depending on whether patients discharge to a private residence, to a city-sponsored housing facility (for persons experiencing homelessness), or to an institutional facility, the guidelines for their place of residence (see categories above) will still apply irrespective of their hemodialysis isolation status.
Appendix: Johns Hopkins Hospital after Care Clinic Algorithm for COVID Patients on Opioid Therapy

COVID-19 Inpatient/Emergency Office Based Opioid Treatment (OBOT) Algorithm

Prepared by The Johns Hopkins After Care Clinic. Updated 3/25/2020

1. **Verify** Is patient able to obtain an extended prescription for buprenorphine/methadone from their current program? 
   - Yes: Hand off to program  
   - No: Is the patient on methadone?  
     - No: Switch to Buprenorphine (see below)  
     - Yes: A DEA X-Waiver is required to prescribe Buprenorphine/Naloxone. If a provider is not X-waivered (and you do not have access to a waivered provider), please contact Dr. Wiesenfeld or CORUS or email the After Care Clinic at aftercare@jhu.edu.

2. **Obtain** (use patient's history if possible): 
   - Pain screen 
   - Use of naloxone
   - Admit to Pain Rehab, Treatment, or Screen
   - DRUG metabolism and use

3. **Obtain** (if possible): 
   - One-week supply of oxycodone
   - Include X-waiver in RX comments
   - Naloxone intranasal

4. **Counsel** Precipitated withdrawal
   - Naloxone

5. **Refer** to Pain Recovery Counselor, Discharge Abuse Consult Order

6. **Notify** ACC, OR Email ACC @ aftercare@jhu.edu

**HOME INDUCTION**

- Suboxone 4 mg SL #20
- Naloxone Intranasal

**Counsel** 

- Naloxone

**Refer** to Pain Recovery Counselor, Discharge Abuse Consult Order

**Provide Instructions**

- Day 1: Place 0-6mg Suboxone under the tongue, allow it to fully dissolve, and refrain from eating or drinking for at least 20 minutes.
- Wait 1-3 hours if the patient still feels unwell, take an additional 0-6mg Suboxone dose.
- Day 2: If patient required 0-6mg on day 1, on day 2 begin 2mg BID if the patient required BID on day 1, on day 2 begin BID (if needed).
- If follow up in 1 week

**Other Considerations**

- Pregnancy: Recommend methadone (over buprenorphine), based on insufficient data and animal studies.
- Liver Impairment: Avoid in Child Pugh >7, increase risk of W/O (naloxone).

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