TEXAS
Health and Human Services

Texas Health and Human Services Commission

Phil Wilson
Executive Commissioner

Health Facility Compliance Guidance Letter

Number: GL 20-2008
Title: Novel Coronavirus (COVID-19), Discharge Assessment Form for Patient Transfers from Hospitals to Long-term Care Facilities
Provider Types: General and Special Hospitals, Private Psychiatric Hospitals
Date Issued: March 21, 2020

1.0 Subject and Purpose

Due to the escalating situation of COVID-19, the Texas Health and Human Services Commission (HHSC) issues the Hospital to Post-Acute Care Facility Transfer COVID-19 Assessment form, to be used to safely discharge a patient from a licensed hospital to a long-term care facility and facilitate communication between hospitals and facilities regarding a patient's COVID-19 status.

This letter outlines provider responsibilities and expectations.

2.0 Policy Details & Provider Responsibilities

HHSC strongly urges a licensed hospital to utilize the Hospital to Post-Acute Care Facility Transfer COVID-19 Assessment form, to assess a patient discharging to a long-term care facility.

A hospital should document the use and distribution of the Hospital to Post-Acute Care Facility Transfer COVID-19 Assessment form, in the discharge notes or patient notes located in the patient's medical record.

3.0 Background/History

Given a licensed hospital's responsibility to safely discharge patients and the serious nature of COVID-19's threat to at-risk populations, long-term care facilities and hospitals need an effective way to efficiently communicate with one another regarding whether a patient being discharged from a hospital

was tested for or is in need of testing for COVID-19. HHSC therefore adopts the Hospital to Post-Acute Care Facility Transfer: COVID-19 Assessment form to improve communication between hospitals and long-term care facilities regarding a patient's COVID-19 status.

4.0 Resources

The Hospital to Post-Acute Care Facility Transfer: COVID-19 Assessment form (on page 3).

5.0 Contact Information

If you have any questions about this letter, please contact the Policy, Rules, and Training Section by email at: HCQ_PRT@hhsc.state.tx.us.

Hospital to Post-Acute Care Facility Transfer – COVID-19 Assessment

INSTRUCTIONS: All hospitalized patients should be assessed for COVID-19 prior to transfer to a post-acute care facility. This tool should be used to document an individual's medical status related to COVID-19 and to facilitate communication between the hospital and the receiving facility during patient transfers. This document must be signed-off by the physician, APRN, or PA who completes the clinical assessment. CHECK THE BOX FOR EACH OF THE CRITERIA APPROPRIATE TO THE PATIENT'S STATUS:

Primary reason the patient was admitted to the hospital? _____

Patient Name: _____

Transferring Facility: _____ **Accepting Facility:** _____

Has patient been laboratory tested for COVID-19?

☐ **YES, Test Performed for COVID-19**
Date of test _____
Expected Date of Results (if still pending) _____

☐ **NO, test not performed because patient did not meet the CDC testing criteria. May transfer.**

☐ **Travel/Exposure** In the past 14 days, has the patient been to any of the restricted travel areas, traveled internationally, traveled on a cruise ship, or exposed to a person who has been lab tested positive for COVID-19?
Dates of travel _____ Date(s) of exposure _____

☐ **Respiratory** Signs/symptoms of a respiratory illness (cough, fever>99.6, shortness of breath, sore throat).

☐ **Negative test**

If the patient was tested due to travel/exposure criteria, are they still in the 14 day post travel/exposure period where isolation is required?

☐ **YES** ☐ **NO/Not Applicable**

MAY NOT TRANSFER | **MAY TRANSFER**

☐ **Positive test**

Does patient meet criteria outlined in *CDC Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19?*

☐ **YES** ☐ **NO**

MAY NOT TRANSFER

If the patient was tested due to travel/exposure criteria, are they still in the 14 day post travel/exposure period where isolation is required?

☐ **YES** ☐ **NO**

MAY NOT TRANSFER | **MAY TRANSFER**

_____
Clinical Assessment Completed by (signature)

_____
Date/Time

_____
Reported to (name of facility staff)

_____
Date/Time

Notes:

TEXAS Health and Human Services

Form updated as of 3/20/20