Health Care Provider Management Checklist for Patients Suspected to Have Novel Coronavirus Infection (COVID-19)

This is interim guidance for the rapidly evolving COVID-19 outbreak.
For updates visit nyc.gov/health and search "COVID-19 providers"

1. Planning Checklist

The interim COVID-19 infection control guidance developed by the Centers for Disease Control and Prevention (CDC) recommends the use of standard, contact, and airborne precautions, including eye protection. To properly manage a patient suspected of or known to be infected with COVID-19, health care facilities should have staff who can use appropriate personal protective equipment (PPE). On site, there should also be at least one room where the patient can be isolated. Health care facilities that provide outpatient care are encouraged to plan in advance for these patients.

YES	NO	UNK	
☐	☐	☐	**Do you have at least one airborne infection isolation room (AIIR)?**
☐	☐	☐	**Do you have a room where you can isolate a patient with the door closed?**
☐	☐	☐	**Do you have staff who have been fit tested within the last year to wear an N-95 respirator?**
☐	☐	☐	**Do you have a plan in place to transport a patient to an emergency room or another health care facility?**

If you answered NO or UNKNOWN to any of the questions above, work with your administration and staff to develop a plan to appropriately manage patients suspected to have COVID-19.

2. IDENTIFY patients who may have febrile respiratory illness associated with COVID-19

This step is critical to minimizing potential exposures to staff and other patients

- ☐ Identify visitors with recent international travel to a COVID-19-affected geographic areas or exposure to a person with COVID-19 who have a fever, cough, or shortness of breath.
  - ☐ Encourage patients to call in advance of office visit. Screen callers requesting appointments by phone for travel and symptom history.
  - ☐ Place visible signage upon entry to the facility directing visitors with recent international travel and fever or respiratory symptoms to notify a staff member. Examples of triage posters in multiple languages can be found here.
- ☐ Place face masks on patients who present with fever or cough.
- ☐ **NOTE:** Persons seeking health care who are asymptomatic and had a possible exposure to COVID-19 (e.g., persons undergoing 14 day self-monitoring on return from mainland

China) can be managed using standard precautions and any other transmission based precautions for the condition for which they are being managed or evaluated.

3. ISOLATE and evaluate persons who report

- **Fever[1] or cough or shortness of breath**

  and

- **Recent international travel from COVID-19 affected geographic areas *or* had close contact with a laboratory confirmed COVID-19 patient within 14 days of illness onset**

Place the masked patient in an airborne infection isolation room (AIIR); if AIIR is not available, place in a private room with door closed.

- **IF YOU DO NOT HAVE AN AIIR OR PRIVATE ROOM**
  - **Have a pre-identified location where patients can be situated to minimize exposure to staff and other patients.**
  - **Use existing plans to arrange to have patients transported to an appropriate facility. Contact the transporter and receiving facility in advance and inform them of potential concern for COVID-19 to ensure awareness and permit adherence to appropriate infection control for COVID-19.**

☐ Restrict the number of personnel entering the room. All personnel who do enter the room should adhere to PPE recommended in CDC's interim infection control guidance:

- Standard precautions (gloves)
- Contact precautions (gown)
- Eye protection (goggles or face shield)
- Airborne precautions (e.g., N95 mask or Powered Air Purifying Respirator)
- Log of persons who cared for this patient.
- Once staff have donned appropriate PPE and the patient is in an AIIR, is it safe to remove the mask from the patient. However, if not in an AIIR, the patient should remain masked, as feasible, to contain secretions.

- **IF YOU <u>DO NOT</u> HAVE STAFF FIT TESTED FOR N95 RESPIRATORS OR OTHER PPE**
  - **Use existing plans to arrange to have the patient transported to an appropriate facility. Contact the transporter and receiving facility in advance and inform them of potential concern for COVID-19 to ensure awareness and permit adherence to appropriate infection control for COVID-19.**
- **IF YOU <u>HAVE</u> STAFF FIT TESTED FOR N95 RESPIRATORS OR OTHER PPE, CONTINUE WITH NEXT STEPS**

☐ Evaluate patient

☐ Consider alternative diagnoses as clinically indicated

☐ Ask the following questions about clinical illness and exposures in the 14 days prior to illness onset to determine if the patient has risk factors for COVID-19. The clinical and exposure history will be used to determine if the patient meets CDC's patient under investigation (PUI) criteria for COVID-19 testing.

Q1. Do they have **Fever[1] -OR- Signs/Symptoms** of lower respiratory illness (e.g., cough, shortness of breath)?

- IF YES – Did the person, including health care workers,[2] have close contact[3] with a laboratory-confirmed[4] COVID-19 patient within 14 days of symptom onset?

Q2. Do they have **Fever[1] -AND- Signs/Symptoms** of lower respiratory illness (e.g., cough, shortness of breath)?

- IF YES – Do they have a history of travel from affected geographic areas[5] within 14 days of symptom onset?

Q3. Do they have **Fever[1] AND Signs/Symptoms** of a lower respiratory illness requiring hospitalization[4] and without alternative explanatory diagnosis (e.g., influenza)[6]?

- IF YES– Is there no known source of exposure?

☐ If **YES** to Q1, Q2, or Q3, INFORM the NYC Health Department that you have a patient suspected to have COVID-19 and follow next steps of the checklist.

4. INFORM the NYC Health Department via the Provider Access Line (PAL) <u>866-692-3641</u> about any patient with suspected COVID-19.

☐ Collect all relevant patient details prior to calling PAL (See Appendix 1).

☐ Discuss case with the NYC Health Department to decide if COVID-19 testing is indicated.

☐ Create and maintain a list of all health care workers who had close contact with the patient from the moment the patient arrives until they leave the facility.

5. COLLECT specimens for diagnostic testing AFTER discussing testing needs with the NYC Health Department. Only patients meeting the current CDC case definition for a person under investigation (PUI) for COVID-19 will be tested. Do not refer patients to another facility for diagnostic testing without first discussing with the NYC Health Department.

1. **If approved for testing, collect the following specimens as soon as possible from each PUI for testing by the NYC Health Department Public Health Laboratory (PHL) and CDC:**

☐ **Upper respiratory specimens (obtain only by staff wearing a fit-tested N95 Respirator)**

- **Two** nasopharyngeal (NP) swabs in separate viral transport media collection tubes
  i. One NP swab for multiplex respiratory panel testing
     Note: There is no cross-reactivity with routine coronaviruses.
  ii. One NP swab for COVID-19 testing
- **One** oropharyngeal (OP) swab in a viral transport media collection tube for COVID-19 testing
- **Notes for NP and OP Swabs:**
  i. Use synthetic fiber swabs with plastic shafts.
  ii. Do NOT use calcium alginate or cotton swabs or swabs with wooden shafts. Place each swab in a sterile tube with 2–3 mL of viral transport media.
  iii. Do NOT combine NP and OP swab specimens; keep swabs in separate viral transport media collection tubes.
  iv. If an NP or OP swab cannot be obtained, instead collect two NP washes/aspirates or nasal aspirates.

☐ **One lower respiratory specimen as feasible for hospitalized patients**

NOTE: Do not delay submission of NP or OP swabs for COVID-19 testing in order to collect a lower respiratory specimen

- Sputum sample: Have the patient rinse the mouth with water and then expectorate deep cough sputum directly into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container.
- Bronchoalveolar lavage or tracheal aspirate: Collect 2–3 mL in a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container.
- **Notes for Collection of Lower Respiratory Specimens:**
  i. Only one lower respiratory specimen is needed (either sputum, bronchiolar lavage, or tracheal aspirate).
  ii. These are aerosol generating procedures and should only be done in a negative pressure AIIR and with staff wearing appropriate PPE as described above.

2. For more detailed laboratory guidance, see PHL instructions for specimen collection here.

Carefully and accurately label each specimen container with the following:

- Patient first and last name
- Patient date of birth
- Date of collection
- Specimen source (e.g., sputum)

3. Order the tests following your facility's usual process. Send the specimens to the on-site clinical laboratory if available for processing. The laboratory will complete Laboratory Test Request Forms using the eOrder system or a paper request form. **One PHL form is required for *each specimen,* and the information on the form/eOrder form must EXACTLY match the information on the specimen label. Place one specimen in each specimen bag and place the form in the outer pocket of the specimen bag.** CDC submission forms will be completed by NYC Health Department PHL staff.

6. Transport of specimens to the NYC Health Department Public Health Laboratory

- ☐ Refrigerate all specimens at 2–8°C, until the NYC Health Department arranges pick up by courier transport on cold packs.
- ☐ **The NYC Health Department** will arrange for courier transport of specimens to PHL that have been approved by the **NYC Health Department. Specimens that arrive without prior approval or completed forms or that are not labelled properly will experience significant delays in testing or may be rejected.**

7. Continue medical evaluation and empiric treatment for other causes of respiratory infection as clinically indicated

- ☐ All patients with suspected COVID-19 should be tested for common causes of respiratory infection with a multiplex respiratory panel (including influenza) at your institution or at PHL, as above. Testing for other respiratory pathogens should not delay specimen collection for COVID-19 testing.

8. Review current confirmed COVID-19 patient management guidance

- ☐ CDC interim clinical guidance for management of patients confirmed with COVID-19 infection can be found on the CDC website.

9. Review patient management with the NYC Health Department before releasing the patient

- ☐ Continue patient isolation and infection control procedures as above until the patient is either discharged home or transferred to another facility.

10. Assess and monitor staff exposure risk using CDC health care worker monitoring guidance.

- ☐ CDC interim guidance for management of health care personnel with potential exposure in a health care setting to patients with COVID-19 can be found on the CDC website.

Visit the CDC and NYC Health Department websites regularly for COVID-19 updates.

Footnotes

[1]Fever may be subjective or confirmed

[2]For health care personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation

[3]Close contact is defined as—

a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a health care waiting area or room with a COVID-19 case

– or –

b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.

See CDC's updated Interim Infection Prevention and control Recommendations for Patients with Confirmed COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings.

Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to health care personnel exposed in health care settings as described in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with COVID-19.

[4]Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for COVID-19 patients in other countries.

[5]Affected areas are defined as geographic regions where sustained community transmission has been identified. Relevant affected areas will be defined as a country with at least a CDC Level 2 Travel Health Notice. See all COVID-19 Travel Health Notices.

[6]Category includes single or clusters of patients with severe acute lower respiratory illness (e.g., pneumonia, ARDS) of unknown etiology in which COVID-19 is being considered.

Appendix 1: Information Providers Need When Reporting a Suspected Case of COVID-19

Have the following information available when reporting persons who may have COVID-19:

- ☐ **Contact Information**
  - Provider
  - Patient contact information and demographics
- ☐ **Epidemiologic Risk**
  - Travel history
  - Exposure to someone suspected or confirmed to have COVID-19
- ☐ **Infection Prevention and Control**
  - If and when patient was placed in an AIIR or private room with a closed door
  - If and when PPE was used by personnel, including gloves, gowns, N95 respirators, and face shields or other eye protection
  - If and when a face mask was placed on the patient
  - If and when the patient was isolated
- ☐ **Clinical History**
  - Symptom onset date
  - Symptoms, including fever, cough and shortness of breath
  - Comorbidities
  - Previous encounters with health care system since illness onset
  - Clinical findings including measured temperature
  - Imaging tests and results