Purpose	To provide guidance on evaluating and reporting persons under investigation (PUI) for coronavirus disease 2019 (COVID-2019) The CDC clinical criteria for a COVID-19 PUI have been developed based on what is known about MERS-CoV and SARS-CoV and are subject to change as additional information becomes available. Early reports suggest person –to-person transmission most commonly happens during close exposure to a person infected with COVID-19, primarily via respiratory droplets produced when the infected person coughs or sneezes. Airborne transmission from person to person over long distances is unlikely. Controlling exposures to occupational infections is a fundamental method of protecting HCP which include several layers of control; engineering, administrative and PPE. The latter is highly dependent on worker involvement and proper fit and correct and consistent use. Special care should be taken to ensure that respirators are reserved for situations where respiratory protection is most important such as performance of aerosol-generating procedures on suspected or confirmed COVID-19 patients or provisions of care to patients with other infections for which respiratory protection is strongly indicated (e.g., tuberculosis, measles, varicella).
Scope	NYC Health and Hospitals System
Requirements	Centers for Disease Control and Prevention (CDC) New York City Department of Health and Mental Hygiene (NYC DOHMH)
Policies	• Clinicians MUST take a travel history for <u>all</u> patients. • Whenever possible, designate entire patient care units (cohort) within the facility, with dedicated HCP to care for known or suspected COVID-10 patients **Please note, all guidance is subject to change as additional information becomes available.** **CDC recommendations regarding the use of PPE while caring for a known or suspected COVID-19 patient will be utilized until the WHO PPE recommendations are adopted by the CDC.**
Definitions	

Clinical and Epidemiological Case Definition	1. Fever[1] **or** signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) **<u>AND</u>**

Any person, including health care workers, who has had close contact[2] with a laboratory-confirmed[3,4] COVID-19 patient within 14 days of symptom onset

2. Fever[1] **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization
   AND
   A history of travel from affected geographic areas (see below) within 14 days of symptom onset

3. Fever[1] with severe acute lower respiratory illness (e.g., pneumonia, ARDS) requiring hospitalization[6] and without alternative explanatory diagnosis (e.g., influenza)[7]
   AND
   No source of exposure has been identified

Affected Geographic Areas with Widespread or Sustained Community Transmission*

***See Algorithm "Emergency Department & Inpatient Flow of Patients Presenting with Lower Respiratory Illness and Unknown Source of Exposure for COVID-19" for guidance on criteria #3.**

Last updated February 26, 2020

- China
- Iran
- Italy
- Japan
- South Korea

* The criteria are intended to serve as guidance for evaluation. In consultation with NYC DOHMH, patients should be evaluated on a case-by-case basis to determine the need for testing. Testing may be considered for deceased persons who would otherwise meet the PUI criteria.

[1]Fever may be subjective or confirmed

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

confirmation. Because of their often extensive and close contact with vulnerable patients in healthcare settings, even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potentially exposed healthcare personnel. Additional information is available 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 Coronavirus Disease 2019 (COVID-19).

[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 healthcare 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.

Additional information is available in 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 healthcare personnel exposed in healthcare 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. *Note: Patients with a mild clinical presentation may not initially require hospitalization. However, clinical signs and symptoms may worsen with progression to lower respiratory tract disease in the second week of illness; all patients should be monitored closely.* **Definition of Healthcare Personnel (HCP)** – For the purposes of this guidance, HCP refers to all persons, paid and unpaid, working in healthcare settings engaged in patient care activities, including: patient assessment for triage, entering examination rooms or patient rooms to provide care or clean and disinfect the environment, nutritionist, obtaining clinical specimens, handling soiled medical supplies or equipment, and coming in contact with potentially contaminated environmental surfaces. **Definition of Person Under Investigation (PUI)** – person who meets the case definition of a given infectious disease as designated by department of health
Process	**Infection Prevention and Control** 1. Identify: If a patient meets the above criteria for a suspected COVID-19 infection: • Immediately offer the patient a surgical mask, and alcohol based hand rub. • Encourage patient to practice respiratory hygiene and hand hygiene. • Immediately isolate the patient. See step 2. o If this is not possible, place patient as far away from others as possible. Identify a separate, well-ventilated space that allows waiting patients to be separated by 6 or more feet, with easy access to respiratory hygiene supplies. **Note:** Prioritize triage of patients with respiratory symptoms. 2. Isolate: Patient Placement • Immediately place patient into an airborne isolation room (AIIR), if available*. Once patient is in AIIR, mask can be removed from patient.

- If an AIIR is not available, place suspected or confirmed COVID-19 patient in a single room with a dedicated bathroom, and door closed and instruct patient to keep surgical mask on. Place **Droplet + Contact + Eye Protection signage on the door.**
  - Airborne Infection Isolation Rooms (AIIRs) should be reserved for patients who will be undergoing aerosol-generating procedures. Facilities should monitor and document the proper negative-pressure function of these rooms.
- Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized.
- If no rooms are available, move patient as far away from others as possible, at minimum 6 feet, ensuring facemasks, tissue and alcohol-based hand rub is nearby.
- Limit patient movement. When not in AIIR or isolated (i.e. during transport) patient must wear surgical mask.
- Duration of isolation precautions: Until information is available regarding viral shedding after clinical improvement, discontinuation of isolation precautions should be determined on a case-by-case basis, in conjunction with local, state, and federal health authorities.

3. All personnel who enter the room should adhere to PPE recommended in CDC's interim infection control guidance for coronavirus disease:

   Prior to entering the patients room or healthcare area, don

   - N95 respirator or facemask if respirator not available
   - Goggles or disposable face-shield that covers the front and sides of face
   - Clean isolation Gown**
   - 1 pair of clean non-sterile gloves

- ***Note for facemask:** N95 respirators or respirators that offer a higher level of protection should be used instead of a facemask when performing or present for an aerosol-generating procedure. In particular, procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) should be performed cautiously and avoided if possible.
- If reusable respirators (e.g., powered air purifying respirators [PAPRs]) are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
- ****Note for Gown:** If there are shortages of gowns, they should be prioritized for:
  - aerosol-generating procedures

- care activities where splashes and sprays are anticipated
- high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP. Examples include:
    - dressing
    - bathing/showering
    - transferring
    - providing hygiene
    - changing linens
    - changing briefs or assisting with toileting
    - device care or use
    - wound care

4. Staff must utilize and refer to contents of facility specific Special Pathogens Cart. Visit the COVID-19 Intranet page for signage.
5. Staff must keep a log of all staff entering and exiting the patient room. Refer to contents of facility specific Special Pathogens Cart.
    - Only essential personnel with designated roles should evaluate patient and provide care to minimize transmission risk. Essential personnel can include: physician provider, assigned nurse environmental staff.
6. Evaluate patient and consider alternate diagnoses as clinically indicated.
7. Hand Hygiene: HCP should perform hand hygiene using alcohol-based hand sanitizer (ABHS) before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Hand hygiene in healthcare settings also can be performed by washing with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS. Healthcare facilities should ensure that hand hygiene supplies are readily available in every care location.

3. Inform: Immediately notify
    - Facility Infection Prevention and Control Department
    - Facility Leadership
    - When using the NYC Public Health lab-Call NYC DOHMH Provider Access Line to ascertain risk if patient meets case definition above: 866-NYCDOH1 (866 692-3641)

Standard Precautions

- Practice hand hygiene and respiratory hygiene.

- Routinely assess the risk of exposure to body substances or contaminated surfaces before any anticipated health-care activity.
- Ensure appropriate PPE is available at all times (gloves, gowns, respirators, **eye protection**).
- Routinely disinfect surfaces with a hospital approved disinfectant and according to manufacturer's recommendations.
- Take care to prevent sharps related injuries.

Contact Precautions

- Use single use disposable gloves and gown for all patient contact.
- Use dedicated equipment such as stethoscopes, disposable blood pressure cuffs, disposable thermometers, etc.

Airborne Precautions

- Place the patient in a single airborne isolation room (AIIR). Such rooms should have monitored negative air pressure in relation to corridor, with 6 to 12 air changes per hour (ACH), and exhaust air directly outside or have recirculated air filtered by a high efficiency particulate air (HEPA) filter. If an AIIR is unavailable, contact the health-care facility engineer to assist or use portable HEPA filters to augment the number of ACH.
- Use a fit-tested N95 respirator disposable mask (or PAPR/CAPR device if unable to fit test with N95 mask) when entering the room.
- Strict attention to airborne precautions is most essential when performing procedures that are more likely to generate small particle aerosols, such as intubation, bronchoscopy or sputum induction.

Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities (LTCF)

Prevent the introduction of respiratory germs ***INTO*** your facility

- Post signs at the entrance instructing visitors not to visit if they have symptoms of respiratory infection.
- Ensure sick leave policies allow employees to stay home if they have symptoms of respiratory infection.
- Assess residents symptoms of respiratory infection upon admission to the facility and implement appropriate infection prevention practices for incoming symptomatic residents.

Prevent the spread of respiratory germs ***WITHIN*** your facility

- Keep residents and employees informed.
  - Describe what actions the facility is taking to protect them, including answering their questions and explaining what they can do to protect themselves and their fellow residents.
- Monitor residents and employees for fever or respiratory symptoms.
  - Restrict residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a facemask (if tolerated).
  - In general, for care of residents with undiagnosed respiratory infection use Standard, Contact, and Droplet Precautions with eye protection unless suspected diagnosis requires Airborne Precautions (e.g., tuberculosis).
  - Healthcare personnel should monitor their local and state public health sources to understand COVID-19 activity in their community to help inform their evaluation of individuals with unknown respiratory illness. If there is transmission of COVID-19 in the community, in addition to implementing the precautions described above for residents with acute respiratory infection, facilities should also consult with public health authorities for additional guidance.
- Support hand and respiratory hygiene, as well as cough etiquette by residents, visitors, and employees.
  - Ensure employees clean their hands according to CDC guidelines, including before and after contact with residents, after contact with contaminated surfaces or equipment, and after removing personal protective equipment (PPE).
  - Put alcohol-based hand rub in every resident room (ideally both inside and outside of the room).
  - Make sure tissues are available and any sink is well-stocked with soap and paper towels for hand washing.
- Identify dedicated employees to care for COVID-19 patients and provide infection control training.
  - Guidance on implementing recommended infection prevention practices is available in CDC's free online course — The Nursing Home Infection Preventionist Training — which includes resources checklists for facilities and employees to use.
- Provide the right supplies to ensure easy and correct use of PPE.
  - Post Droplet + Contact + Eye Protection signage on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE.

- Make PPE, including facemasks, eye protection, gowns, and gloves, available immediately outside of the resident room.
- Position a trash can near the exit inside any resident room to make it easy for employees to discard PPE.

Prevent the spread of respiratory germs ***BETWEEN*** facilities

- Notify facilities prior to transferring a resident with an acute respiratory illness, including suspected or confirmed COVID-19, to a higher level of care.
- Report any possible COVID-19 illness in residents and employees:
  Facility Infection Prevention and Control Department
  When using the NYC Public Health Lab- Call NYC DOHMH Provider Access Line to ascertain risk if patient meets case definition above: 866-NYCDOH1 (866 692-3641)
  Facility Leadership

Visitor Restrictions

For Upcoming Appointments

- If you have cold or flu-like symptoms, please consult your doctor by phone.
- If you are symptom-free, your appointments will continue as planned, and we look forward to seeing you at NYC Health + Hospitals.

For Visitors and Caregivers

- Visitors must be 12+ years old or older
- Visitors will be screened for symptoms prior to entering patient areas. Sick visitors will be asked to leave.
- The number of visitors per patient will be limited; additional restrictions may be imposed based on the patient's clinical status. See below for details.

Hospitals/Inpatient Locations

- One visitor per adult patient.
- Two visitors per pediatric patient are allowed in the pediatric units. Parents, guardians, or family care partners only.
- Two visitors per patient are allowed in the Neonatal Intensive Care Unit (NICU). Parents or support persons only.
- Two visitors are permitted for obstetric patients. Partners and grandparents only.

Emergency Departments (ED)

- Visitors are prohibited in adult ED patient areas. For patients requiring assistance, one visitor may be permitted.
- Only one visitor per pediatric patient is allowed in the pediatric ED. Parent or caregiver only.

Hospital-based Outpatient Care Clinics and Gotham Health Centers

- One person is allowed to accompany each patient to an appointment, unless an aide or assistant is required.
- Any visitor who is coughing or shows other signs of illness will be asked to leave.

**Exceptions will be always made for special circumstances.

Clinical Management and Treatment

- Continue medical evaluation and empiric treatment for other causes of respiratory infection as clinically indicated
- All patients with suspected COVID-19 infection 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.
  NOTE: Routine laboratory tests such as respiratory viral panels may include testing for coronavirus. Coronaviruses tested for using routine respiratory viral panels are common coronaviruses that indicate a common cold. This is NOT related COVID-19. The COVID-19 can only be tested for at designated public health laboratories or other laboratories approved for COVID-19 testing.
- No specific treatment for COVID-19 infection is currently available.
- Clinical management includes prompt implementation of recommended infection prevention and control measures and supportive management of complications, including advanced organ support if indicated. Corticosteroids should be avoided unless indicated for other reasons (for example, chronic obstructive pulmonary disease exacerbation or septic shock

because of the potential for prolonging viral replication as observed in MERS-CoV patients).

- Patients with a mild clinical presentation may not initially require hospitalization. However, clinical signs and symptoms may worsen with progression to lower respiratory tract disease in the second week of illness; all patients should be monitored closely. Possible risk factors for progressing to severe illness may include, but are not limited to, older age, and underlying chronic medical conditions such as lung disease, cancer, heart failure, cerebrovascular disease, renal disease, liver disease, diabetes, immunocompromising conditions, and pregnancy.
- The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis.
- Consult with NYC DOHMH Provider Access Line for case by case guidance on clinical management.
- Do not discharge patient before discussing management with DOHMH.

Collection & Transport of Clinical Specimens for Patient's Under Investigation

- Clinicians should immediately contact DOHMH Provider Access Line to receive instructions on collection and transport of clinical specimens for persons under investigation (PUIs).
- Consult NYC DOHMH Provider Access line for specimen pick up: 1-866-692-3641
- Specimen testing is now available at NYC DOHMH
- Testing for other respiratory pathogens should not delay specimen shipping to NYC public health labs or other approved laboratories
- If a PUI tests positive for another respiratory pathogen, after clinical evaluation and consultation with DOHMH, they may no longer be considered a PUI. This may evolve as more information becomes available on possible COVID-19 co-infections.
- **If approved by NYC DOHMH for testing of COVID-19 *collection of <u>three</u> specimen types, lower respiratory, upper respiratory and serum specimens for testing is recommended.***

The following upper respiratory specimens

• **Two** nasopharyngeal (NP) swabs that are in separate viral media collection tubes.

i. One NP swab for multiplex respiratory panel testing.

ii. One NP swab for COVID-19 testing
- **One** oropharyngeal (OP) swab 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. If an NP or OP swab cannot be obtained, instead collect two NP washes/aspirates or nasal aspirates.

A lower respiratory specimen as feasible for hospitalized patients
- 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 personal protective equipment as described above

One serum specimen
- Children and adults: Collect 1 tube (5-10 mL) of whole blood in a serum separator tube.
- Infant: A minimum of 1 mL of whole blood is needed for testing pediatric patients. If possible, collect 1 mL in a serum separator tube.
- NOTES FOR SERUM SPECIMENS:
    i. Serum separator tubes should be stored upright for at least 30 minutes, and then centrifuged at 1000–1300 relative centrifugal force (RCF) for 10 minutes before removing the serum and placing it in a separate sterile tube for shipping (such as a cryovial).

- For more detailed laboratory guidance, see NYC DOHMH PHL instructions for specimen collection here.
- Refrigerate all specimens at 2-8°C, transport on cold packs. 4. Carefully and accurately label each specimen container with the following:
    i. Patient first and last name
    ii. Patient date of birth
    iii. Date of collection
    iv. Specimen source (e.g., sputum, serum)

- Order the tests following your facility's usual process. Send the specimens to the on-site clinical laboratory if available for processing. 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.

Shipping

- Specimens from suspected COVID-19 cases must be packaged, shipped, and transported according to the current edition of the International Air Transport Association (IATA) Dangerous Goods Regulations.
- Consult NYC DOHMH Provider Access line for specimen pick up: 1-866-692-3641
- Specimens can now be tested at NYC DOHMH PHL

Environmental Infection Control

- Clean and disinfect the patient's care area using an EPA registered disinfectant for appropriate contact times and according to manufacturer's recommendations.
- Patient care area should always be clean and disinfected before and after any procedures.
- As there are no available EPA-registered products that have a label claim for COVID-19, products with label claims against human coronaviruses should be used according to label instructions.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.
- Staff entering the AIIR or patient room soon after a patient vacates the room should use respiratory protection. Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles. Apply a similar time period before entering the room without respiratory protection as used for pathogens spread by the airborne route (e.g., measles, tuberculosis). In addition, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.

System Monitoring/Surveillance & HICS Activation

1. Incident Notification
Sites must notify System Chief Medical Officer of any suspected or confirmed cases of COVID-19: 212-442-4739. Health system leadership will monitor the outbreak, and collaborate with public health agencies.

2. HICS Activation
As with all incidents that might stress clinical, operational and financial resources, H + H sites must consider activation of their Hospital Incident Command System (HICS), in conjunction with Central Office Emergency Management, to ensure seamless communication, coordination and collaboration with all internal and external partners.

Epidemiologic Risk Classification[1] for Asymptomatic Healthcare Personnel Following Exposure to Patients with Coronavirus Disease (COVID-19) Infection or their Secretions/Excretions in a Healthcare Setting, and their Associated Monitoring and Work Restriction Recommendations

HCP=healthcare personnel; PPE=personal protective equipment

[1] The distinction between the *high-* and *medium-risk* exposures in this document is somewhat artificial as they both place HCP at risk for developing infection and the recommendations for active monitoring and work restrictions are the same for these exposures. However, these risk categories were created to align with risk categories described in the Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease (COVID-19) Exposure in Travel-associated or Community Settings, which outlines criteria for quarantine and travel restrictions specific to high-risk exposures. Refer to that Interim Guidance for information about the movement, public activity and travel restrictions that apply to the HCP included here.

[2] For the purposes of this guidance 'unprotected' means not wearing any PPE over the specified body part. For example, unprotected eyes, nose and mouth mean HCP are not wearing eye protection and either facemask or respirator. While respirators confer a higher level of protection than facemasks, and are recommended when caring for patients with COVID-19, facemasks still confer some level of protection to HCP, which was factored into our assessment of risk.

Epidemiologic risk factors	Exposure category	Recommended Monitoring for COVID-19 *(until 14 days after last potential exposure)*	Work Restrictions for Asymptomatic HCP
A. HCP (with unprotected eyes, nose, or mouth)[2] who perform or are present in the room for a procedure likely to generate higher concentrations of respiratory secretions or aerosols (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction).	High	Active	Exclude from work for 14 days after last exposure
B. HCP who perform or are present in the room for a procedure likely to generate higher concentrations of respiratory secretions or aerosols (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction) and not using a gown and gloves. Note: If the HCP's eyes, nose, or mouth were also unprotected they would fall into the high-risk category above.	Medium	Active	Exclude from work for 14 days after last exposure

	C. HCP (with unprotected eyes, nose, or mouth)[2] who have prolonged close contact with a patient *who was not wearing a facemask.* Note: A respirator confers a higher level of protection than a facemask. However, they are group together in this scenario because (even if a respirator or facemask was worn) the eyes remain uCOVID-19ered while having prolonged close contact with a patient *who was not wearing a facemask*.	Medium	Active	Exclude from work for 14 days after last exposure
	D. HCP (with unprotected eye, nose, and mouth)[2] who have prolonged close contact with a patient *who was wearing a facemask.*	Medium	Active	Exclude from work for 14 days after last exposure
	E. HCP (not wearing gloves) who have direct contact with the secretions/excretions of a patient and the HCP failed to perform immediate hand hygiene Note: If the HCP performed hand hygiene immediately after contact, this would be considered low risk.	Medium	Active	Exclude from work for 14 days after last exposure
	F. HCP wearing a facemask or respirator only who have prolonged close contact with a patient *who was wearing a facemask*	Low	Self with delegated supervision	None

	Note: A respirator confers a higher level of protection than a facemask. However, they are grouped together in this scenario and classified as *low-risk* because the patient was wearing a facemask for source control.			
	G. HCP using all recommended PPE (i.e., a respirator, eye protection, gloves and a gown) while caring for or having contact with the secretions/excretions of a patient	Low	Self with delegated supervision	None
	H. HCP (not using all recommended PPE) who have brief interactions with a or patient regardless of whether patient was wearing a facemask (e.g., brief conversation at a triage desk; briefly entering a patient room but not having direct contact with the patient or their secretions/excretions; entering the patient room immediately after they have been discharged)	Low	Self with delegated supervision	None
	I. HCP who walk by a patient or who have no direct contact with the patient or their secretions/excretions and no entry into the patient room	No identifiable risk	None	None
	Internal/External Communication			

	All internal and external communications related to the COVID-19 will be reviewed and issued by the System Chief Medical Officer. For questions, please view the additional resources below or write to us at COVID-19Readiness@nychhc.org
References	CDC-Interim Healthcare Infection Prevention and Control Recommendations for Patients Under Investigation for Novel Coronavirus https://www.cdc.gov/coronavirus/COVID-19/hcp/infection-control.html CDC- Interim Guidance for Healthcare Professionals https://www.cdc.gov/coronavirus/COVID-19/hcp/clinical-criteria.html CDC- Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation (PUIs) for Novel Coronavirus (COVID-19) https://www.cdc.gov/coronavirus/2019-COVID-19/lab/guidelines-clinical-specimens.html NYC DOHMH - https://www1.nyc.gov/assets/doh/downloads/pdf/imm/2019-COVID-19-provider-checklist.pdf

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Reviewed and Readopted Without Change

Signature	Title	Date
Removed from Service		
Reason:		
By	By	By

NYC HEALTH+ HOSPITALS

Emergency Department & Inpatient Flow of Patients Presenting with Lower Respiratory Illness and Unknown Source of Exposure for COVID-19

1. Patient presents with fever[1] AND/OR lower respiratory illness (e.g., cough, shortness of breath) requiring hospitalization without ANY epidemiologic risk

↓

2. Immediately provide patient with surgical mask

↓

Does patient require admission to ICU for severe pneumonia or ARDS? [2]

Yes →

* Admit into AIIR[3]
* Contact + Airborne + Eye Protection isolation
* Inform facility IPC, ID services, NYC DOHMH, and other healthcare facility staff as appropriate about the presence of a suspected patient for COVID-19.

No ↓

3. Place patient in private room with Contact + Droplet + Eye Protection.

↓

4. All patients should be tested, as clinically appropriate, for common causes of pneumonia (e.g. sputum culture, urine legionella, respiratory viral panel). Alternative non-infectious diagnoses should also be considered.

↓

After 48hr, is patient clinically improving or have you identified an alternative etiology for pneumonia?

No → (to * Admit into AIIR[3])

Yes ↓

5. De-escalate isolation precautions and continue with routine clinical care as appropriate.

Footnotes:

[1]Fever may be subjective or confirmed

[2]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.

[3]If there are not enough AIIRs to care for patients with COVID-19, existing AIIRs should be prioritized for the care of patients who are symptomatic with severe illness (e.g., those requiring ventilator support).