

Maternal- Fetal Medicine COVID19

Outpatient Management Guidelines for Pregnant Women in Hawaii

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Modified from Thomas Jefferson University Division of Maternal Fetal Medicine (Philadelphia, PA; Version 2.0) and the University of Washington (Seattle. WA)

This document was prepared by Men-Jean Lee, MD on behalf of
The Division of Maternal-Fetal Medicine.
Email: mjlee3@hawaii.edu

These recommendations will be evolving quickly over time and may be superseded
by CDC, Hawaii DOH, and local Hospital polices.

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1. Objective

This document addresses the current COVID 19 pandemic. The goals the changes put forth here are two fold- First to reduce patient risk through healthcare exposure, understanding that health systems/healthcare providers may become the most common vector for transmission, and second to reduce the public health burden of COVID transmission throughout the general population.

2. General Guidelines

- Prevention of spread should be #1 priority
- Social distancing of at least 6 feet; if unfeasible, extended dividers, masks, other precautions
- Anything elective or not-urgent should be postponed
- Each patient should be called to decide on need for next visit and/or test
- Any visit that can be done by telehealth should be done that way; enroll all patients as feasible in mychart/telehealth
- Limit outpatient visits to no accompanying persons for any visit
- Symptomatic patients should be instructed to call their healthcare provider and best triaged via telephone in order to assess their need for inpatient support or supplemental testing; they in general should be presumed infected, and self-isolate for 14 days
- Drive-thru testing is available at various locations on Oahu and the neighbor islands. See appendices for locations and times. Testing requires a doctor's order which is in EPIC (CLH and DLS orders) and Hawaii Department of Health
- Symptomatic patients who nonetheless arrive to hospital or office should be managed as if they are COVID-19 positive; so immediately properly isolated in designated areas, with appropriate (e.g. N-95) mask on
- Designated separate areas should be created in each unit for suspected COVID-19 patients: e.g. a separate L&D unit; a separate office area; etc.
- Increase sanitization; Hand sanitizer available at front desk, throughout waiting area where sinks are not available. If a sink is available, hand washing with soap and water in between each patient is highly recommended. Wipe down seats, door knobs, keyboards, telephones, and countertop surfaces in waiting areas and all office work areas morning, lunch, and after hours
- Meetings should all be virtual/audio/video
- Keep some providers at home, as feasible with clinical duties. Examples: all medical students; fellows on research rotations; staff and providers with only administrative duties.
- Pregnancy alone in the setting of new-flu like symptoms with negative influenza is sufficient to warrant COVID-19 testing; test especially if additional risk factors (e.g. older, immunocompromised, advanced HIV, homeless, hemodialysis etc.).
- Practitioners should be leaders in their unit. COVID-19 leaders should be designated for each area (e.g. L&D, outpatient; ultrasound). Use this and other guidance (SMFM; ISUOG; etc), and adapt to your specific situation. **No guideline can cover every scenario.** Use this guidance and clinical judgement to avoid any contact as much as feasible.
- Please stay tuned as guidance will continue to change frequently.
- This document can be adapted for use by your hospital or clinic.

Helpful updates and guidance from our local hospital systems, Hawaii Department of Health, and the CDC:

- <https://governor.hawaii.gov/covid-19/>
- <https://www.hawaiipacifichealth.org/coronavirus>
- <https://www.queens.org/covid19/home>
- <https://health.hawaii.gov/news/covid-19-updates/>
- <https://health.hawaii.gov/docd/advisories/novel-coronavirus-2019/>
- <https://health.hawaii.gov/docd/for-healthcare-providers/news-updates/>

Public - starting places for basic info, general what-to-do's.

- Hawaii <https://hawaiiicovid19.com/>
- CDC <https://www.cdc.gov/coronavirus/2019-ncov/index.html>
- UW <https://www.washington.edu/coronavirus/>

COVID updates (daily # cases, situation report)

- HDOH <https://health.hawaii.gov/docd/advisories/novel-coronavirus-2019/>
- CDC https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fsummary.html

<https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>

- WHO <https://www.who.int/emergencies/diseases/novel-coronavirus-2019>

Health care professionals - starting place for clinical Q's, protocols, etc.

CDC (gold standard): <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html>

UW (good protocols based on CDC): <https://covid-19.uwmedicine.org/Pages/default.aspx>

Health care professionals - what we know about COVID (some basic, some detailed)

- CDC (clinical guidance for management of patients with confirmed COVID).
 - This has the best "UpToDate" type description and is a good place to start. It's a couple of pages, read it all the way before clicking on links.
 - <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>
- CDC (health professionals Q&A) - easier layout, quick to read, but not as detailed.
 - <https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html>

3. Antenatal Visits

3.1 Obstetric Visit Timing for IN PERSON encounters

- Up to 20 weeks
 - Q 8 weeks in person visit (coincide with ultrasound, 12 wk dating/NT, 20wk anatomy/visit)
 - Avoid performing viability and dating US prior to 12 weeks unless patient is actively bleeding or an ectopic pregnancy is suspected or there is an obvious size-date discrepancy (schedule viability/dating scans at 12 weeks to limit unnecessary exposure or trips to the hospital)
- Gestational 28 to 34 weeks:
 - Q 4 week in person visits (schedule with NST and ultrasound to limit multiple encounters)
- Gestational age 36 weeks until delivery:
 - Weekly visits (but could check in with patient using telehealth and home BP monitoring)

3.2 TeleHealth

General Principles

Every patient on registration for any appointment needs to be enrolled in EPIC in order to access our Telehealth System. If your site does not have telehealth access, please contact a UHP OBGYN physician to register your patient for EPIC. If your patient does not have home internet access, you may refer your patient to the MI-Home (Midwifery-Integrated Home Visitation) Program (currently only available on Oahu). All efforts should be made to convert any follow up visit to a telehealth visit or home visit, anything that does not require an in-person examination should be performed via Telehealth. Reducing need for in-person evaluation is facilitated through provision of blood pressure cuffs to all pregnant patients. This includes follow up of diabetes, hypertension, nausea/vomiting, mood disorder, and all routine care (kick counts, anticipatory guidance, etc).

MFM Consultations

In general, MFM consultations can be done via telehealth as well through the UHP Kapiolani 801 office. In person consult scheduling should be reviewed with physician or NP prior to scheduling. All preconception consults should be done via telehealth or postponed for the next 30 days. Any consultation for a pregnant patient seen in the office by another provider in past 4 weeks can be telehealth.

Post Partum Visits

All post partum visits, especially the first 2-week postpartum visit should be via telehealth (or postponed until the 6-week postpartum time frame) unless there is an acute issue requiring in person evaluation (ie wound dehiscence). As a reminder, telehealth video capabilities may be used to physically see a wound as well and this may be done prior to having a patient come in.

4. Antenatal Testing Unit Policies and Procedures

General principles are offered below, antenatal surveillance should be tailored to individual patient/provider concerns and risk factors. Table 1 highlights indication specific recommendations. These changes are made with the understanding that coming for an office visit at this time incurs potentially significant both personal and public health risks such that risk/benefit of surveillance needs to be reevaluated and surveillance timing streamlined.

4.1 Scheduling of Obstetric Ultrasound

- Community Office ultrasound:
 - Use pelvic exams and LMP dating to determine EDD in the community offices.
 - Do not refer patients to formal ultrasound units for viability only; limit formal ultrasound referrals prior to 12 weeks to women with high suspicion for ectopic pregnancy or spontaneous abortion.
 - Schedule formal dating scans to be combined with NT scans at 12-14 weeks.
 - If a gestational sac is seen on office ultrasound with or without an embryo, recommend scheduling first formal ultrasound visit to 12-14 weeks.
- Dating ultrasound:
 - Combine dating/NT to one ultrasound based on LMP
 - For patients with unknown LMP or EGA>14 weeks may schedule as next available
- Anatomy ultrasound (20-24 weeks)
 - Attending review for any suboptimal anatomy, consider follow up views in 4-6 weeks rather than 1-2 weeks
 - Serial cervical lengths should be converted to a single cervical length screening at the time of the anatomy scan unless the patient is at risk for incompetent cervix.
 - Consider stopping serial CL after anatomy u/s if CL>35mm, prior PTB>34 weeks
 - BMI>40: schedule at 22 weeks
- Growth ultrasounds
 - All single third trimester growth at 32 weeks
 - Follow up placenta previa/low lying placenta at 34-36 weeks for a single visit
 - Begin serial growth at 32 weeks (not 24 weeks) with rare exception
 - Consider q 6 week rather than q4 week follow up for most patients

Table 1: Suggested timing/frequency of growth ultrasounds in pregnancy*

| Indication | Gestational Age | | | Frequency | | | Comments |
|--|-----------------|-----|-----|-----------|-----|-----|--|
| | 24w | 32w | 36w | Once | q4w | q6w | |
| Pregest DM | | | | | | | Once at 32 weeks |
| Chronic HTN on medications | | | | | | | Once at 32 weeks |
| Current preeclampsia/ghtn | | | | | X | | |
| Current IUGR | | | | | X | | |
| CKD | | | | | | | Once at 32 weeks |
| Multiples - Mono/Di | | | | | X | | |
| Multiples -Mono/Mono | | | | | X | | |
| Multiples -Di/Di | | | | | X | | |
| Lupus | | | | | | | Once at 32 weeks |
| Prior unexplained IUFD | | | | | | | Once at 32 weeks |
| Organ Transplant | | | | | | | Once at 32 weeks |
| Maternal Cardiac Disease | | | | | | | Individualize |
| Thyroid Disease | | | | | | | Once at 32 weeks |
| Abnormal placentation | | | | | | | Once at 34-36 weeks |
| 2 Abnormal analytes on Sequential Screen (no growth scan for 1 abnormal analyte) | | | | | | | Once at 32 weeks |
| Prior preterm birth due to PTL, PPROM | | | | | | | One TV cervical length at 20-week anatomy scan** |
| Prior mid-trimester loss or early preterm birth | | | | | | | One TV cervical length at 16-weeks and individualize |

4.2 Scheduling of Non Stress Tests

- Table 2 highlights our specific practice changes
- Twice weekly NST only for IUGR with abnormal Doppler
 - This means DM, preeclampsia/gestational hypertension, IUGR normal Doppler with weekly visit
 - If concurrent ultrasound visit, perform BPP and no NST
- In general, avoid initiating NSTs prior to 32 weeks
- For patients with gestational hypertension/preeclampsia: weekly visit in office with daily blood pressure checks at home. Weekly visit will include NST, blood pressure check and labwork drawn in the office
- Consider kick counts only for AMA or BMI>40 or other lower risk indication (see Table 2)
 - Discuss with patient/provider risk/benefit of coming to office

Table 2: Summary of common indications for antenatal surveillance and our adjusted NST recommendations in setting of COVID19 pandemic.

| INDICATION | GESTATIONAL AGE TO BEGIN | COMMENTS |
|------------------------------|--------------------------------|--|
| AMA | -- | Initiate kick counts at 28 weeks |
| CHOLESTASIS | 32 WEEKS | Twice a week NST |
| DECREASED FETAL MOVEMENT | | One time only NST |
| PREGESTATIONAL DIABETES | 32 WEEKS | Twice a week NST or weekly BPP |
| GDMA2 | 32 WEEKS | Twice a week NST or weekly BPP |
| CHRONIC HYPERTENSION ON MEDS | 32 WEEKS | Twice a week NST or weekly BPP |
| GESTATIONAL HYPERTENSION | DIAGNOSIS OR AT LEAST 32 WEEKS | Home BP monitoring with twice a week NST or weekly BPP |
| PREECLAMPSIA | DIAGNOSIS OR AT LEAST 32 WEEKS | Home BP monitoring twice a week NST or weekly BPP |
| IUGR WITH NORMAL DOPPLERS | DIAGNOSIS OR AT LEAST 32 WEEKS | Fetal kick counts |
| IUGR WITH ABNORMAL DOPPLERS | DIAGNOSIS OR AT LEAST 32 WEEKS | Twice a week NST or weekly BPP |
| SLE | 32 WEEKS | Twice a week NST or weekly BPP |
| FETAL ARRHYTHMIA | -- | If after 32 weeks, one time only NST and MFM consult with echo |
| DI-DI TWINS | -- | Not indicated |
| MO-DI TWINS | 32 WEEKS | Weekly BPP |
| OLIGOHYDRAMNIOS | DIAGNOSIS OR AT LEAST 32 WEEKS | Only if AFI \leq 5 and initiate twice a week NST |
| POLYHYDRAMNIOS | DIAGNOSIS OR AT LEAST 32 WEEKS | Only if AFI $>$ 30 and initiate weekly BPP or NST |
| SINGLE UMBILICAL ARTERY | 32 WEEKS | Weekly BPP or NST |
| POST-DATES | 40 WEEKS | Twice a week NST or weekly BPP |
| PRIOR IUFD | 32 WEEKS | Twice a week NST or weekly BPP |

4.3 Workflow

- Check-in:
 - Hospital Security:
 - Hospital Security Guards and screening staff are our first line of defense against the spread of COVID-19. They are pre-screening all guests entering the hospital and limiting access.
 - Receptionists:
 - Complete required COVID-19 screening – Screening should be completed for patient AND guests
 - Positive screens managed per office protocol
 - Mask required → Contact MFM provider (attending or fellow) to determine if ultrasound can be rescheduled
 - Notify patients that no guests will be allowed into the ultrasound exam room
 - “In order to protect other patients and staff during the COVID-19 outbreak, our current policy does not allow for guests in the ultrasound room.”
 - Patients who present with their children and no adult to watch them will be rescheduled.
 - If any patients or guests are upset about this rule, please notify the manager to come to speak with the patient. She will explain the purpose to the family.
 - Live in-person translators will temporarily be suspended during this crisis; Marti will be used for translation services until the COVID-19 outbreak is over.
 - Ideally the waiting room will be limited to less than 10 persons at all times to allow for social distancing.
 - Nursing and medical assistants:
 - Create daily list of required labs for anatomy scan visits:
 - Second part of sequential screen
 - MSAFP (for patients who have completed NIPT)
 - No genetics done (In order to offer quad screen, NIPT, etc.); MFM providers will counseling patients at the time of the NT scan.
 - Provide list to sonographers and MFM providers
 - Sonographers:
 - When bringing back a patient to the ultrasound unit, please remind patients of the new policy that no accompanying visitors are allowed to prevent COVID-19 transmission
 - If there are any issues, please notify the unit manager
 - For anatomy scans, please review the list of required labs and notify the patient to complete their labs before leaving
 - This is limited to second part of the sequential and MSAFP
 - If no genetic screening was done, the MFM provider will review the chart.
 - If there was documentation in the first trimester that screening and testing was declined, nothing needs to be done.

- If there was no documentation that screening/testing was declined, the provider will review options (i.e. quad screen, NIPT, genetic testing) directly with the patient

- Counseling

Patients with findings warranting face to face counseling before the patient leaves the office

- First trimester genetic screening in patients age 35 and older
- Any major anomaly
- Placenta accrete spectrum
- Vasa previa, placenta previa
- Short cervix
- New diagnosis of growth restriction
- Fetal echocardiograms in the setting of a known fetal anomaly
- No genetic screening or testing yet done
 - Excludes patients with documentation of declining screening or testing at their first trimester ultrasound or in prenatal notes
- Any patient who requests to speak with a provider regarding ultrasound or genetics
- Patients can be sent home on site without face-to-face counseling – Findings can be reviewed with MFM
 - Normal growth ultrasound
 - Normal NT scan in a patient who is not Advanced Maternal age and does not meet the criteria listed above.
- Patients being scanned remotely with any concerns should be reviewed with the MFM assigned to remote reads prior to her going home. The patient can be counseled over the telephone by the MFM.
 - Pali Momi
 - Wilox
 - Maui Community Clinic
 - Lanai Community Clinic

5. Visitor Policy for Obstetric Outpatient Office (Includes antenatal visit and antenatal testing unit)

5.1 General Policy

- All patients are suggested to bring ZERO family/friend/partner to their appointments
- All patients will be informed there is a maximum of 1 support person allowed in patient care area with them
- Patients are asked NOT to bring children 12 and under
- Visitor with symptoms at front desk check in WILL NOT be allowed in patient care areas and will be asked to return home.

5.2 Special Circumstances

- Antenatal Testing Unit (NST and Ultrasound): Given tight quarters in the antenatal testing unit, no visitors/support people allowed into NST room.
- Special Needs: Patients with special needs will be allowed to have their support person there to help per discretion of provider.
- Children: Because children are frequently vectors of transmission, children will not be allowed in antenatal testing unit. If a child under the age of 12 is brought to the office, patient will be asked to reschedule. It is strongly recommended that children not be brought to any outpatient office visit. The clinic staff will call all patients the day before to inform them of this new rule.
- Symptoms present: Patients may be asked to reschedule non-urgent care if they or support person are symptomatic

6. Trainees

- All students from any school (nursing, medicine, PA, sonography) will be asked to remain home
- Any observership students (whether in ultrasound or outpatient office) will be asked to remain home
- Limit in person oversight of outpatient visits (resident/fellow/attending all going into a room)
- Hawaii Residency Program OBGYN residents are on a modified shift schedule in order to minimize housestaff exposures, leaving half of the resident contingencies to be available to be called in for emergencies.
- Fellows have been placed on modified schedules to minimize exposure, and must be available to be called in for emergency coverage for in-patient services at the hospital.

7. Sanitization Measures

- Waiting Rooms:
 - Purell/sanitizer available throughout
 - Surgical masks for anyone symptomatic
 - Waiting area chairs/check in screen wiped down in morning, lunch, and after hours
 - Hand sanitizer or wipes available immediately next to check in screens, with sign to use prior to touching screen
- Check-In Desk
 - Purell available for both registrar and patient side of desk
 - Gloves for registrars to use
 - Position chairs/computer to maintain 4-6 feet distance between patient and registrar
 - Wipes at desk for registrar to wipe area frequently, and at least in morning, lunch, and after hours
- Patient Exam Rooms
 - Exam table, ultrasound machine, Doptone, chair, computer, door handle wiped down with a sanitizing wipe or spray after each patient visit
 - DESIGNATE PATIENT ROOMS FOR FLU/COVID SCREENING

8. Screening, Triage, and Evaluation for COVID 19

8.1 Phone Triage

SCREENING QUESTIONS

QUESTION 1: Do you have a fever and/or respiratory symptoms (cough, shortness of breath)?

AND

QUESTION 2: Have you traveled to **China, Iran, Italy, Japan and South Korea** within the last 14 days or had contact with any person returning from Mainland China or with a suspected or confirmed case of

1. Patient calls to schedule a visit, ask two Screening Questions.

Scenario #1 Patient answers "YES" to both questions:

- a. Direct patient remain at home. Based on their symptoms and travel history, an If they are not having trouble breathing, they can be directed to a local drive-thru COVID19 testing site.
- b. If they are having trouble breathing, have them call 911 for transportation to the hospital.

- Patient's Full Name
- DOB
- Travel locations
- Symptoms
- Phone contact information

Scenario #2 Patient answers "YES" to travel question only. They have NO symptoms of illness:

- a. Patient should be directed to stay at home for and self-quarantine for 14 days before an appointment is scheduled; if the reason for the appointment is non-urgent, recommend postponement of the appointment for 30 days.

Figure 1: Phone triage per UHP Outpatient clinical practice guidelines

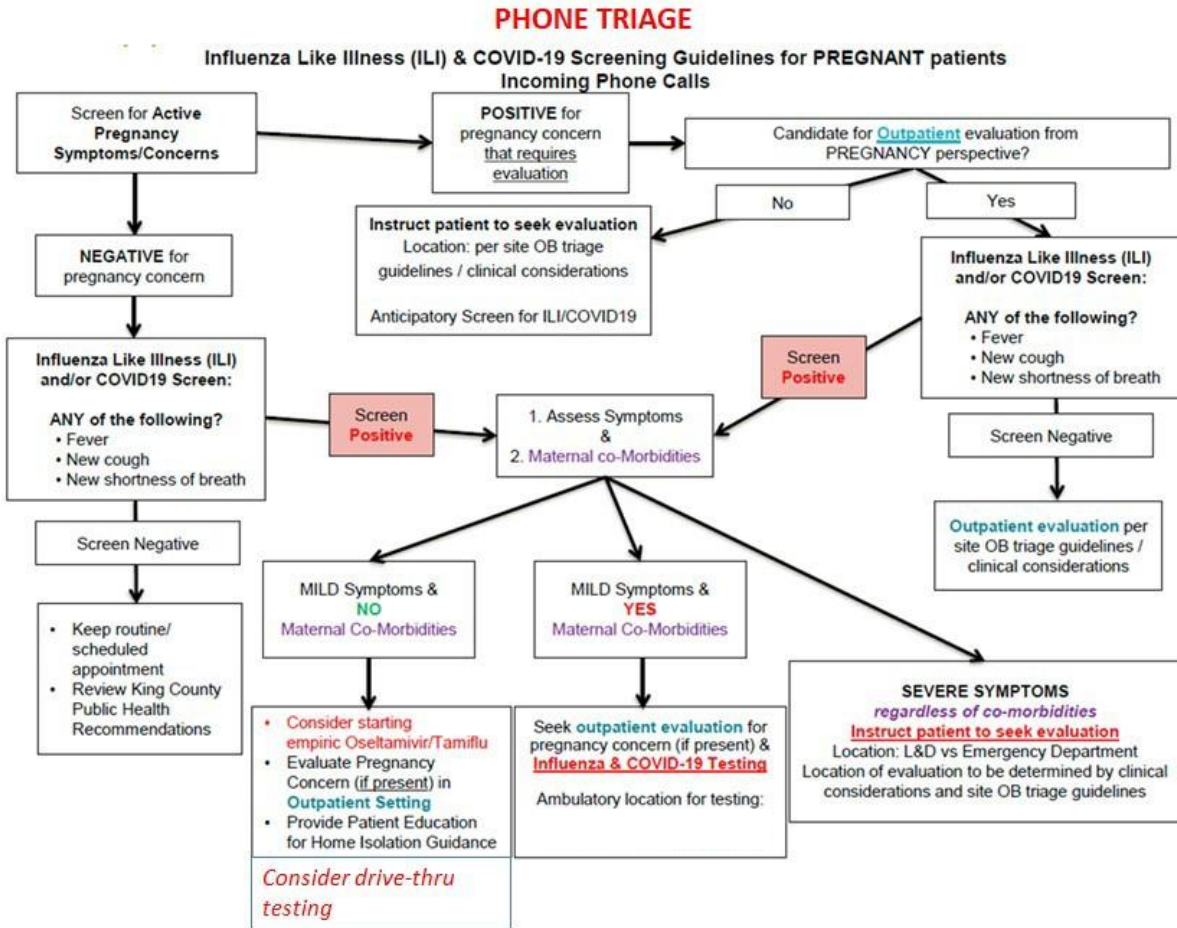


Figure 2: Suggested phone triage algorithm for obstetrics. Adapted from University of Washington

- Maternal comorbidities include:
 - Hypertension on medication
 - Insulin dependent diabetes
 - Immunocompromise/suppression (medically or due to medical condition as HIV)
 - BMI>40
 - Baseline cardiac or renal disease
 - Moderate to severe asthma
- Start Tamiflu as per ACOG guidelines regarding empiric Tamiflu in pregnancy
 - Fever >100.4 and any of the following: URI symptoms, myalgia, fatigue, head/body aches.
 - No fever but abrupt onset of symptoms suggestive of influenza, also proceed with Tamiflu
 - Treatment: oseltamivir 75mg BID x 5 days

8.2 Office Triage

SCREENING QUESTIONS

QUESTION 1: Do you have a fever and/or respiratory symptoms (cough, shortness of breath)?

AND

QUESTION 2: Have you traveled to **China, Iran, Italy, Japan and South Korea** within the last 14 days or had contact with any person returning from Mainland China or with a suspected or confirmed case of

Patient On-Site/In Physician Practice

Receptionist asks two screening questions.

Scenario #1 Patient answers "YES" to both questions:

- Give patient a regular surgical mask. Mask any companions with the patient.
 - Place patient in an exam room immediately and close the door.
 - Make provider and MA aware.
- a. Before entering the exam room with the patient: Contact **your Unit Manager** to discuss next steps.
 - b. **Patient needs to be directed to the Drive-thru on Bingham for evaluation and testing.**
 - c. **If patient is in distress, the provider** will put on a fluid resistant gown, N95 respirator mask, eye protection and gloves to evaluate patient in room (if MA is present with provider, should also follow these PPE guidelines)
 - d. If patient is moderate to severely ill, they should be instructed by provider to go to the ED
 - e. Direct patient to TJUH Emergency Department for further evaluation and testing as needed. Remind patient to wear a mask upon entering the Emergency Department.
 - f. Infection Prevention staff will notify the Emergency Department of inbound patient requiring isolation.
 - g. Patient must wear surgical mask to the Emergency Department and upon entering the ED.

Scenario #2 Patient answers "YES" to travel question only. They have **NO** symptoms of illness:

- a. The patient will be masked and if her appointment is urgent, she will be assessed.
- b. If her appointment is non-urgent and routine, her visit should be postponed for 30 days.

Figure 3: UHP outpatient clinical practice general guidelines

A Hawaii PUI Form (COVID19) must be completed if the patient is having a COVID19 swab and faxed to HDOH at (808) 586-4595.

Forms are available for download at:

<https://health.hawaii.gov/docd/for-healthcare-providers/news-updates/>

For patients presenting in person who screen positive in office visit:

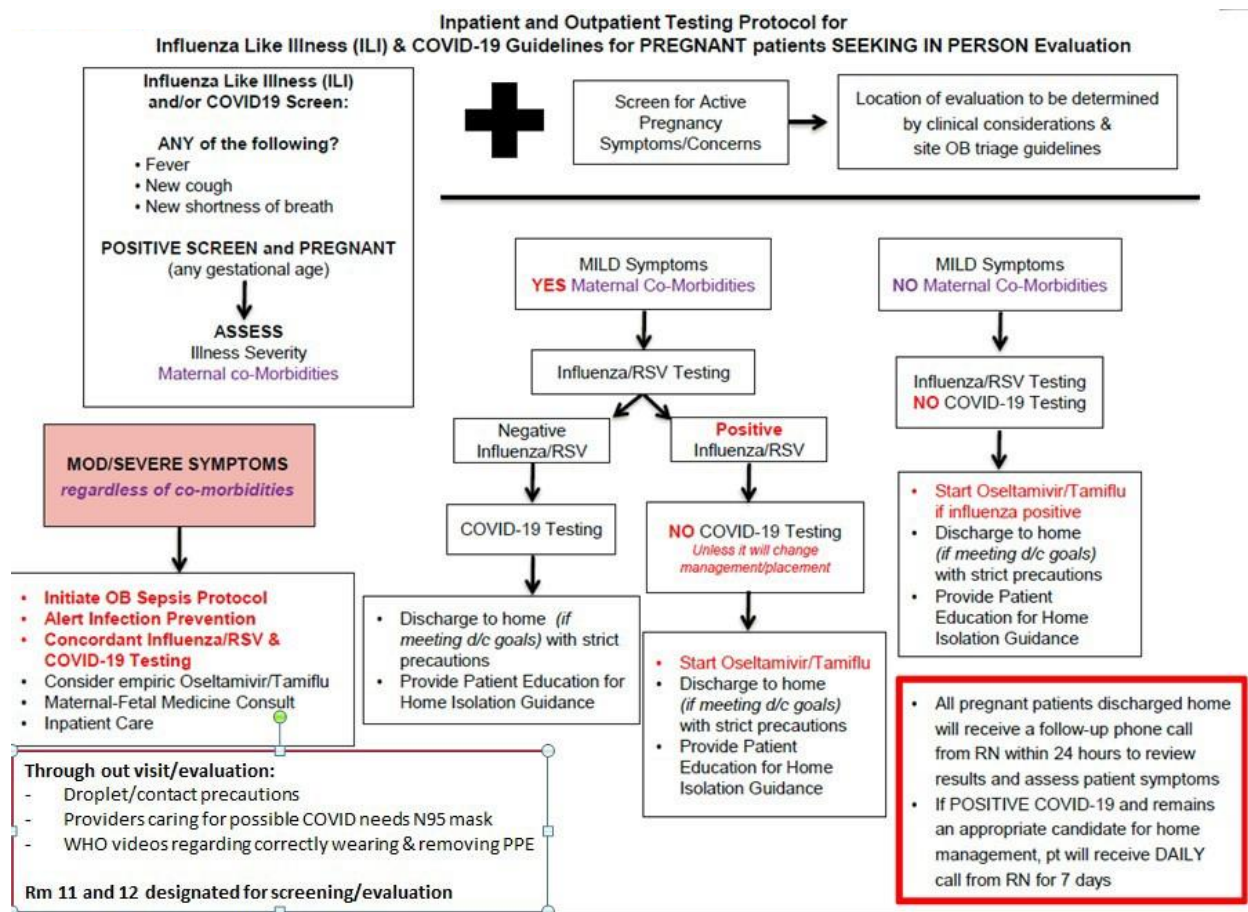


Figure 4: Flow diagram for triaging obstetric patients who present in person for care. Adapted from the University of Washington.

APPENDIX:**FAQs****(Adapted from Chien-Wen Tseng, MD, Department of Family Medicine)****Who should get tested. (all follow similar criteria).**

Most people who are sick do not need to be tested. There is no specific medicine to treat COVID-19, so whether someone tests positive or negative, it's still stay at home and monitor.

- Asymptomatic - don't test even if exposed - it can be false negative and uses up resources
- Symptomatic - consider test if
 - Hospitalized, work in LTC, health provider - possible also those in high contact travel industry, waste management, restaurant business, etc.
 - People at higher risk for severe respiratory infections (age 60+, chronic medical conditions - heart, diabetes, lung, etc., immunosuppression) - test sooner since progress faster from mild to severe
- HDOH - policy for Hawaii - from 3/20/2020 update, but can change.
 - <https://health.hawaii.gov/news/corona-virus/covid-19-daily-update-march-20-2020/>
- UW (testing criteria) - Nicely laid out, easy to use in clinic.
 - <https://covid-19.uwmedicine.org/Pages/default.aspx>

Preventing person-to-person transmission

- CDC <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html>

When persons with symptoms of COVID show up in your clinic

- CDC - This has it all. It's got detailed guidelines on how to minimize chance for exposure for staff. How to handle phone triage, and when patients come to clinic or show up in urgent care. A must read for anyone running a clinic.
 - <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html#minimize>
- UW: good protocol

Protocols on extended use of PPE

- CDC : <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html#minimize>

PPE

- CDC - <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirator-use-faq.html>
- UW (Sample collection - what to wear, how to do nasal swab - very good) <https://covid-19.uwmedicine.org/Pages/default.aspx>
- Lots of other helpful information on the UW website

Criteria for evaluating exposure

- General: <https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html>
- Health care professionals
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

Criteria for ending home isolation if known or suspected COVID + (or return back to work)

- General:
 - At least 7 days since onset of symptoms AND 3 days (72 hours) since recovery (no fever without meds, improvement in respiratory symptoms). If no symptoms initially, then 7 days from first COVID+ test. Can also do COVID neg x 2 taken 24 hours apart, but there's testing supply shortage and long turn-around times.
 - <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html>
- Health care professionals:
 - At least 7 days since onset of symptoms AND 3 days (72 hours) since recovery (no fever without meds, improvement in respiratory symptoms). If no symptoms initially, then 7 days from first COVID+ test. Can also do COVID neg x 2 taken 24 hours apart
 - After returning to work, wear facemask for at least 14 days after illness onset and longer as needed till symptoms have resolved (e.g cough). Adhere to hand hygiene, respiratory hygiene, cough etiquette (cover cough, tissue in trash)
 - If staffing shortage, then follow protocols in own institution.
 - <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html>
 - If flu positive, then manage per flu protocol
 - Always check with your own institution, which might have its own protocol