COVID-19 Situation Summary

Situation and Background

A novel coronavirus infection (COVID-19), caused by the SARS-CoV-2 virus, was first reported in December 2019 in Wuhan, Hubei Province, China. The virus is similar but distinct from SARS and MERS. Initial cases were linked to an animal market but subsequent cases occurred through human-to-human spread.

In early 2020, widespread local transmission of COVID-19 occurred in China, followed by sustained local transmission in other countries across the world including the US. Currently, COVID-19 is considered a global pandemic.
Symptoms: Fever, chills, cough, dyspnea, malaise and fatigue, poor appetite. Some patients have sore throat, GI symptoms, headache, and/or loss of smell/taste. In children, cases of Pediatric Multi-system Inflammatory Syndrome temporally associated with COVID-19 (PMIS-C) have occurred. Symptoms of PMIS-C include persistent fever, inflammation (e.g. neutrophilia, elevated C-reactive protein, lymphopenia, etc.), evidence of single or multi-organ dysfunction (shock, cardiac, respiratory, renal, GI or neuro disorder), rash, conjunctivitis, mucocutaneous manifestations, and GI symptoms. This may include children meeting full or partial criteria for Kawasaki disease.

Incubation Period: The incubation period is 2-14 days, with an average of 5 days.

Transmission: Human-to-human spread through respiratory route and droplets (e.g. coughing, sneezing) and direct contact with respiratory secretions. Asymptomatic transmission and pre-symptomatic transmission can occur. Duration of infectious period varies by severity of illness, but appears to be highest in the first week of illness. The distance that viable infectious aerosols can travel, and the number of viral particles needed to cause infection is not known. The highest risk appears to be through prolonged close contact (within 6 feet) in enclosed spaces.

Severity of Disease: Approximately 80% of individuals infected with COVID-19 will have mild symptoms. The remaining 20% will require acute care in a medical setting, including 5% that will require ICU-level care. The elderly and those with chronic medical conditions have a higher likelihood of severe disease, but severe illness in young, healthy individuals also occurs. Children more rarely have severe disease including PMIS-C.

Treatment: Treatments of COVID-19 are evolving as we gain more clinical experience along with more published data. Results from the NIH ACTT1 trial show that those who received remdesivir had significantly shorter duration of hospitalization than those receiving placebo. Based on this observed
benefit, the FDA issued an Emergency Use Authorization (EUA) for remdesivir, and the federal government has distributed much of Gilead’s existing limited supply of remdesivir to hospitals across the US, including Montefiore. Trials are ongoing to use other experimental therapeutic options at Montefiore, as well. Remdesivir access pathways and other treatment protocols are available on the intranet and should be referenced for admitted patients.

Prevention: No approved vaccine currently exists for COVID-19. Diligent handwashing for at least 20 seconds with soap and water, or alcohol-based hand sanitizer can help prevent transmission. Social distancing strategies have been implemented nationwide and in New York to reduce the chance for transmission. For healthcare providers, use of proper personal protective equipment when indicated and isolation of suspected or confirmed cases also reduces the risk of transmission. For Montefiore associates, masks should be worn while at work unless alone with the door closed. Associates should also wear eye protection, in addition to the mask, if within 6 feet of patients. Droplet and standard precautions should be used at all times, even for patients not suspected of having COVID-19. CDC and NYS DOH Travel advisories should be followed. https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html

Risk of Exposure: At this time, there is sustained community transmission of COVID-19. Therefore, all staff and patients are at risk of exposure in the community.

Re-Infection, Mutation, and Immunity: There is limited data on re-infection. There are scattered reports of persons with COVID-19 disease who, during recovery, had a documented negative test and then on repeat test had another positive result. Most were asymptomatic at the time of the “new” positive test and did not transmit the virus to others, and it is likely that the prior negative result was due to a poor sample, or that the repeat positive test was due to low levels of non-viable virus after the initial infection. There are some persons who do not have antibody that we can detect in the blood after infection; the significance of this is unknown. There is one study of previously SARS-CoV-2 infected monkeys that showed protective antibodies and no re-infection after repeat challenge to SARS-CoV-2. It is not yet known if this will also be true for humans. In some persons, antibody levels appear to wane 2-3 months following index infection, but the clinical significance of this is unknown.

Assessment and Recommendations:

Sustained local transmission in New York is occurring. Screening in Montefiore emergency departments (ED) and outpatient practices has been implemented, including pre-procedure screening. Epic will be continuously updated to reflect documentation of this screening. Updated signs have been produced and distributed by Marketing.

Universal droplet precautions should be used for all patients and universal masking of all associates and patients (when possible) is required regardless of the patient’s COVID status. Associates should also wear eye protection when within 6 feet of any patient.

The situation is rapidly evolving, and all procedures and guidance are subject to change.
COVID-19 Person Under Investigation (PUI) Definition:

- Fever (measured or subjective), chills, rigors, cough, chest tightness, sore throat, malaise, myalgia, persistent headache, unexplained diarrhea, nausea/vomiting, anosmia, ageusia, shortness of breath with clinical suspicion based on clinical data and patient presentation
- Known COVID-19 PCR+ in the last 4 weeks and currently symptomatic, or with symptoms within the last 14 days
- Known exposure AND fever (measured or subjective), chills, rigors, cough, chest tightness, sore throat, malaise, myalgia, persistent headache, unexplained diarrhea, nausea/vomiting, anosmia, ageusia, shortness of breath in the 14 days following exposure OR other clinical suspicion
- Travel to or residence in a high-risk area AND fever (measured or subjective), chills, rigors, cough, chest tightness, sore throat, malaise, myalgia, persistent headache, unexplained diarrhea, nausea/vomiting, anosmia, ageusia, shortness of breath in the 14 days following travel OR other clinical suspicion

The objective is to **Identify, Isolate, and Inform.**

**Identify:**

Screen every patient in the ED, pre-procedural areas, and ambulatory practices per protocol. Ask all patients about history of known COVID19, travel to affected areas, contact with anyone who has or might have COVID-19, or symptoms. **All patients to be admitted must have a COVID test** to determine placement, and serology should be sent (but cannot yet be used for risk stratification).

Basic screening questions** are:

1. Have you been diagnosed with COVID-19 or had a positive test for COVID-19 in the last 4 weeks?
2. Have you been in contact with someone who has known or suspected COVID-19 in the last 14 days?
3. Have you had fever, chills, shaking, cough, sore throat, diarrhea, nausea, vomiting, muscle aches, persistent headache, loss of taste or smell, chest tightness, or shortness of breath in the last 14 days, or been in contact with someone with one of these symptoms?
4. Have you traveled internationally or domestically to an area with high COVID activity in the last 14 days?

Any of the above should trigger immediate masking of the patient and anyone with them, and placement in isolation.

**These questions have been adapted for optimal workflow in specific healthcare settings in some cases.

Calls to 911 will be screened for symptoms and epidemiologic risk, and will notify EMS personnel responding to the call. EMS personnel will assess the patient wearing PPE, mask the patient, and inform the hospital on arrival and pre-notify when possible.
**MHS Adult ED/Inpatient/OB COVID-19 Screening Algorithm**

**Known COVID-19 Positive**

- **Known Exposure or Travel to High Risk Area for COVID-19 in last 14 days?**
  - **No:** Send SARS-CoV-2 nasopharyngeal PCR (ED/Inpatient standard protocol) if not done previously.
  - **Yes:** Consult ID for possible admission testing and instruct COVID-19 Isolation (CUI Isolation).

- **Known COVID-19 Patient, isolates:**
  - Stable for discharge home? **Yes:** Discharge with home isolation/investigations and call in 24h to follow-up.
  - **No:** Send SARS-CoV-2 nasopharyngeal PCR (standard protocol), isolate, and call in 24h to follow-up.

- **Cohort with another patient positive when possible, COVID-POSITIVE Isolation maintained until cleared by hospital epidemiology or ID, notify DHS/cluster or congragate setting**

**MHS Pediatric ED/Inpatient COVID-19 Screening Algorithm**

**Known COVID-19 Positive Test?**

- **Yes:** Send SARS-CoV-2 nasopharyngeal PCR (standard protocol), isolate, and call in 24h to follow-up.

- **No:** Single room when possible with cohort with another positive patient. Isolation maintained until cleared by hospital epidemiology or ID. Notify DHS/cluster or congragate setting.

**Isolation and Personal Protective Equipment (PPE) for Orange Pathway**

- Gowns/Contact/Touch/Standard with Eye protection recommended, and shower in private room with door closed. If safe to do so for cohort. 2 confirmed cases together. Air/gas generating procedure required or anticipated. Isolation/Contact/Standard with Eye protection recommended in negative pressure room.
- **Contact/Isolation:** Standard PPE (surgical mask with fluid shield, contact protection gown, gloves).
- **Aerosol generating procedure:** Standard PPE (surgical mask with fluid shield, contact protection gown, gloves).
- **Isolation: Standard PPE, surgical mask, face shield, contact protection gown, gloves.

**Isolation and Personal Protective Equipment (PPE) for Red Pathway**

- Gowns/Contact/Touch/Standard with Eye protection recommended, and shower in private room with door closed. If safe to do so for cohort. 2 confirmed cases together. Air/gas generating procedure required or anticipated. Isolation/Contact/Standard with Eye protection recommended in negative pressure room.
- **Contact/Isolation:** Standard PPE (surgical mask with fluid shield, contact protection gown, gloves).
- **Aerosol generating procedure:** Standard PPE (surgical mask with fluid shield, contact protection gown, gloves).
- **Isolation: Standard PPE, surgical mask, face shield, contact protection gown, gloves.

**Isolation and Personal Protective Equipment (PPE) for Orange and Red Pathways**

- Gowns/Contact/Touch/Standard with Eye protection recommended, and shower in private room with door closed. If safe to do so for cohort. 2 confirmed cases together. Air/gas generating procedure required or anticipated. Isolation/Contact/Standard with Eye protection recommended in negative pressure room. If available:
  - **Contact:** Standard PPE (surgical mask with fluid shield, contact protection gown, gloves).
  - **Aerosol generating procedure:** Standard PPE (surgical mask with fluid shield, contact protection gown, gloves).
  - **Isolation:** Standard PPE, surgical mask, face shield, contact protection gown, gloves.
  - **Aerosol generating procedure:** Standard PPE (surgical mask with fluid shield, contact protection gown, gloves).

**Known Exposure to COVID-19 within the last 30 days?**

- **Yes:** Discharge with home isolation/investigations and call in 24h to follow-up.
- **No:** Send SARS-CoV-2 nasopharyngeal PCR (standard protocol) prior to admit, alert from ID/infection control.

**Stable for discharge home?**

- **Yes:** Discharge with home isolation/investigations and call in 24h to follow-up.
- **No:** Send SARS-CoV-2 nasopharyngeal PCR (standard protocol) prior to admit, alert from ID/infection control.
## Montefiore Guide to COVID-19 Testing for Procedures

<table>
<thead>
<tr>
<th>Type of procedure</th>
<th>ELIGIBILITY SCREEN</th>
<th>PROCEDURE PLANNING</th>
<th>DAY OF PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent no delays</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
| Emergent few (<4) | If POS screen - consider CLI even if neg testing | Yes | 1. Intraoperative by anesthesia  
2. EXPEDITED order  
3. Hand deliver to lab  
4. Process with surgery – full PPE  
5. Recover in OR if test not back or if test positive or suspected/confirmed COVID disease |
| Elective          | Yes                |                |                  |

**Outpatient** – follow outpatient testing performed 2-3 days prior to procedure to ensure result available at the time of procedure

- Sars-Cov2 Viral test – deliver to lab by 2 pm for results same day. Testing MUST BE performed within 2-3 days prior to procedure to ensure result available at the time of procedure
  - POS – defer/reschedule
  - Neg – proceed

**NO TESTING REQUIRED ON DAY OF SURGERY UNLESS CLINICAL SUSPICION OF COVID**

**DAY OF PROCEDURE:**

1. Review PCR results from 2-3 days prior to surgery to confirm they are negative
2. If POS → recommend delaying and rescheduling procedure

* Patients who tested positive for COVID in the past 90 days or had clinical COVID and have now recovered (and are >14 days from positive result and onset of symptoms, afebrile for >72 hours and asymptomatic) – do not require repeat testing prior to procedure

**In rare cases where testing prior to procedure was not possible – perform expedited COVID NP testing and await results prior to initiating the procedure**

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Patients who tested POS in the last 14 days should remain on isolation, considered COVID POS for procedure purposes and procedure performed in COVID+ designated area.

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Clinical Profile of COVID-Like Illness

<table>
<thead>
<tr>
<th>Major Features</th>
<th>Clinical Symptoms and Syndromes</th>
<th>Negative Infectious Workup for Other Pathogens</th>
<th>Imaging Consistent with Viral Pneumonitis</th>
<th>Laboratory Abnormalities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Fever/Chills/Rigors</td>
<td>• Blood culture</td>
<td>• CXR with bilateral infiltrates</td>
<td>• Leukopenia/lymphopenia</td>
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<td></td>
<td>• Cough</td>
<td>• Respiratory culture</td>
<td>• Pulmonary ultrasound with</td>
<td>• Thrombocytopenia</td>
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<td></td>
<td>• Sore Throat</td>
<td>• S. Pneumoniae &amp; Legionella</td>
<td>bilateral infiltrates</td>
<td>• Elevated PT</td>
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<td></td>
<td>• Chest Tightness</td>
<td>• Strong clinical suspicion for or</td>
<td>• CT with bilateral</td>
<td>• Elevated D-dimer</td>
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<td></td>
<td>• Shortness of breath</td>
<td>witnessed aspiration</td>
<td>ground glass opacities</td>
<td>• Elevated LDH</td>
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<tr>
<td></td>
<td>• Headache</td>
<td>• If done, Flu and/or RPP negative</td>
<td></td>
<td>• Elevated IL-6</td>
</tr>
<tr>
<td></td>
<td>• Myalgia/Fatigue</td>
<td>• Positive SARS-CoV-2 PCR or Antigen</td>
<td></td>
<td>• Elevated CRP</td>
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<td></td>
<td>• Unexplained Diarrhea</td>
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<td></td>
<td>• Nausea/Vomiting</td>
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<td>• New hypoxia or need for</td>
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<td>supplemental oxygen</td>
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<td>• Need for non-Invasive or</td>
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<td>invasive mechanical</td>
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<td>ventilation</td>
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<td></td>
<td>• Shock</td>
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<tr>
<td></td>
<td>• Cytokine storm</td>
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<tr>
<td></td>
<td>• PMHS-C in children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Chills</td>
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</tbody>
</table>

If a patient has or develops a COVID-like illness during ED stay or admission → convert to ORANGE:
1. Mask the patient
2. Isolate (droplet/contact/standard in a private room with door closed if safe to do so, OR airborne/contact/standard in a negative pressure room IF aerosol-generating procedure required*) with order in Epic and signs up for isolation
3. Infectious Diseases and Critical Care Consult (if unstable)

*Aerosol-generating procedures: BiPAP/CPAP, NFNC, Bag-Mask ventilation, nebulizer, intubation/extubation, ongoing ventilation with a device that does not have a closed circuit such as LTV (Servo ventilators are closed and are NOT considered aerosol generating), bronchoscopy, sputum induction, or open airway suctioning

Admission Guidelines for COVID-19

<table>
<thead>
<tr>
<th>&lt; 90%</th>
<th>91-94%</th>
<th>≥ 95%</th>
</tr>
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<tbody>
<tr>
<td>• Strongly consider admission in the setting of acute respiratory and IL syndromes regardless of co-morbidities. Order full/wa with in-house SARS-CoV2 test and contact/droplet isolation. Consider discharge for patients who are home O2-dependent or having a recurrent CHF exacerbation if no other symptoms of Covid-19 are present. Send in-house SARS-CoV2 test on all discharged patients and arrange a follow-up call within 24 hours.</td>
<td>• Consider admission for patients with acute respiratory and IL symptoms who are over 65 years old and/or with significant co-morbidities such as IBD, chronic lung, kidney or liver disease, active immune suppressive chemotherapy etc. Order full/wa with in-house SARS-CoV2 test and contact/droplet isolation. Consider admission for younger patients without chronic co-morbidities with persistent IL illness that cannot be corrected in ED over 18 hours or unable to care for 02/o2 home support. Very few patients should meet this criteria. Send SARS-CoV2 test on all discharged patients and arrange a follow-up call within 24 hours.</td>
<td>• IL symptoms do not require any testing or admission unless significant additional stressors such as known Covid and living in SNF, shelter or other uncontrolled congregate setting. O2 with mild pneumonia, by itself, does not require admission. Address other chief complaints (Neuro, GI, etc.) as required. Strongly consider outpatient management for patients who do not require prolonged telemetry/monitoring and have stable vital signs. Consider triage to ED in lieu of NA with follow up call within 24 hours. Children with PMHS-C should be admitted. Send SARS-CoV2 test on all discharged patients and arrange a follow-up call within 24 hours.</td>
</tr>
</tbody>
</table>

O2 Sats

v.3/10/2020
Isolate:

If a patient screens positive, tests positive, or there is clinical concern for potential COVID-19, the patient should be escorted to an isolation room or private room. **PLEASE ENSURE ALL PATIENTS ARE MASKED AT ALL TIMES WHEN TOLERATED**

Most patients can be placed in a private room with the door closed (if safe to do so) with droplet, contact, and standard precautions including eye protection unless the patient requires an aerosol-generating procedure. Intubated patients do not necessarily require negative pressure unless the ventilator does not have a closed circuit like LTV. NP or OP swab does not require negative pressure. Guidelines for respiratory therapy for COVID-19 suspect or confirmed cases should be followed. For aerosol generating procedures airborne, contact, and standard including eye protection should be used, and the patient should be placed in a negative pressure room if the procedure will be frequent or ongoing. Aerosol-generating procedures include: BiPAP, CPAP, HFNC, nebulizer treatments, bag-mask ventilation, bronchoscopy, active intubation/extubation, cardiopulmonary resuscitation, sputum induction, open airway suctioning, ongoing ventilation with a device that does not have a closed circuit such as LTV (Servo ventilators are closed and are NOT considered aerosol generating).

Associates who have direct patient care responsibilities for or who enter the rooms of suspected or confirmed COVID-19 patients may wear N95 masks (instead of surgical masks) if available, even if the patient is not on airborne isolation. It is recommended that safe PPE use and reuse guidelines (available on the intranet) are followed to safely protect the N95 for re-use and to prevent self-contamination or contamination of the mask inadvertently.
Inpatient COVID Testing, Isolation, and Placement

NP COVID PCR test is ordered
- COVID Symptoms +
- Screening (COVID Symptoms - and unrelated reason for presentation)

Special Pathogen Precautions
(Contact +Droplet, or Contact +Airborne if AGP)

Previously COVID POS result in MMC EMR?

< 14 days since last POSITIVE result
- COVID POS flag

> 14 days since last POSITIVE result
- +/ COVID POS flag (Exp at 30 d)

COVID PCR

Infection flag based on ordered lab
- COVID lab pending
- COVID labin process

Clinical suspicion for COVID?

Can dic Special Pathogen Precautions, further management as per team

POS

\[\text{When can isolation be dic?}\]

- Isolation: Special Pathogen Precautions
- Infection flag: COVID POS Infection flag auto-activated (for 30 days)
- PPE: Mask, face shield, gown, gloves
- Cohorting: With COVID POS only

\[\text{Prolonged hospitalization or readmission}\]

\[\text{Disposition and Discharge planning}\]

DIC isolation in a pt hospitalized for > 14 days since last POS result (same admission or readmission)

- At least 14 days from first positive NP test
- Azithromycin for at least 72 hours
- Improved respiratory symptoms.
- Immunosuppressed patients - ALSO 2 neg NP PCR 24 hours apart

Negative result required for dic disposition and < 14 days since last POS result:

1. NP PCR testing as per dispo guidelines
2. COVID POS flag remains for 30 days - can be dic by Infection control
3. Isolation remains for 14 days from last POS

Retesting and Removal of isolation:
1. Repeat COVID NP PCR within 24 hours after admission to confirm negative
2. Can repeat NP PCR test, and if neg dic isolation if:
   - > 10 days from onset of symptoms,
   - clinically improving
   - > 72 hours of no fever without antipyretics

\[\text{COVID related INFECTION FLAG}\]

- COVID POS - active based on test results,
  Removed by Infection control only, autoexpires at 30 days
- COVID-Like illness - Activated by physician based on clinical assessment, active for 14 days
Montefiore Guide to COVID-19 Isolation and Infection Status

- Discontinue COVID-19 isolation precautions:
  - Immunocompetent + asymptomatic: 14 days after first positive SARS-CoV-2 PCR test
  - Immunocompromised with symptoms: 14 days after first positive SARS-CoV-2 PCR AND 72 hours after resolution of fever AND improving respiratory symptoms AND IPIC approval
  - Immunocompromised with symptoms: 14 days after first positive SARS-CoV-2 PCR AND 72 hours after resolution of fever AND improving respiratory symptoms AND 3 negative NP SARS-CoV-2 PCR 24 hours apart AND IPIC approval

- COVID-19 Isolation Flag will remain in place for 80 days from first positive NP swab (can only be removed by infection control physicians, may be removed earlier at the discretion or as deemed safe by IPIC).

- COVID-like illness (CUI) Flag will remain in place for 14 days from admission or onset of symptoms.

- Referring NP PCR – can be repeated at least 72 hours after last positive (all 3 negative results required – they should be performed 24 hours apart).

### Isolation and Infection Control

<table>
<thead>
<tr>
<th>SARS-CoV-2 PCR</th>
<th>Reason for testing</th>
<th>Isolation</th>
<th>Cohorting</th>
<th>Repeat testing if needed for discharge or disposition</th>
<th>Removal of isolation and infection flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>Symptoms</td>
<td>COVID-19 POS (Antigen/PCR at 14 days)</td>
<td>COVID-19 POS</td>
<td>&gt;= 10 days from symptoms onset</td>
<td>10 + days from symptoms onset of symptoms IMPROVING</td>
</tr>
<tr>
<td></td>
<td>Screening (otolaryngology or stool SARS-CoV-2 PCR)</td>
<td>As per infection control isolation guidelines</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Negative (obtain COVID-19 antibody testing)</td>
<td>Symptoms</td>
<td>COVID-like illness (CUI) (Antigen/PCR at 14 days)</td>
<td>CUI</td>
<td>Any consideration of cohorting with COVID-19 patient not to be discussed with Infusion Control</td>
<td>10 + days from symptoms onset of symptoms IMPROVING</td>
</tr>
<tr>
<td>Negative</td>
<td>Screening</td>
<td>None</td>
<td>As per infection control isolation guidelines</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Direct Admission or Transfers

- Non-admission or transfers (direct admission or transfer): COVID-19 test in progress or COVID-19 test pending
- Full Empiric Special Pathogens Contact and Droplet precautions
- Private room cannot cohorted while results are pending
- If PCR past 14 days – no need to retest
- Otherwise repeat testing on admission/transfer
- If not able to do preadmission testing and if is already admitted, while pending test result – current gown and full empiric Special Pathogens Contact and Droplet precautions
- As determined by symptoms and testing results

### Inpatient Isolation, Placement, and PPE

- Patient admitted with COVID or COVID-like illness
  - No aerosol generating procedure needed
  - Intermittent aerosol generating procedure needed
  - Frequent or continuous aerosol generating procedure needed

  **Contact + Droplet PPE:** Surgical mask or N95 with eye shield, gown and gloves
  **Airborne + Contact PPE:** 1655, face shield, gown and gloves

*Inpatient isolation guidelines (please also refer to COVID-19 Respiratory Guideline):*
  - System induction
  - Open outflowing of airways
  - BIPAP, CPAP (should be limited to only OSA or HFNC intubable)
  - HFNC
  - Nebulizer (Paw if possible, substitute MDI)
  - Bag-valve ventilation
  - Bronchoscopy
  - Carotidcavernous Resection
  - Active Intubation/Extrication
  - Ongoing ventilation with a device that does not have a closed circuit such as LTV
Procedures for positive COVID screen or suspected/confirmed COVID Patients

- **ED:**
  - Patient (and anyone accompanying them) is offered a surgical mask and escorted to a private room with the door closed or designated area.
  - No aerosol-generating procedure required: Providers should don either N95 or surgical mask, with eye protection (full face shield preferred), yellow gown, gloves in a private room with the door closed. Patients known to have confirmed COVID-19 could be cohorted in a room together with the door closed if necessary and if safe to do so.
  - If an aerosol-generating procedure is required (BiPAP/CPAP, NFNC, bag-mask ventilation, nebulizer, active intubation/extubation, cardiopulmonary resuscitation, ongoing mechanical ventilation via a ventilator without a closed circuit such as LTV’s, bronchoscopy, sputum induction, or open airway suctioning; please avoid these procedures when possible), providers should don N95 mask with face shield, yellow gown, gloves and the patient should be placed in a negative pressure room/area. Nasopharyngeal or oropharyngeal swab acquisition and mechanical ventilation alone do not require airborne isolation or N95 mask use.
  - Epic isolation orders and COVID flags should be entered and signs should be posted for isolation.
  - Perform a clinical assessment:
    - Define detailed travel history including any healthcare exposures
    - Determine if patient had close contact with a symptomatic traveler/case or someone with compatible symptoms
    - Define duration and timeline of specific symptoms
    - Assess severity of illness and any known prior testing
    - Assess risk factors for severe disease (elderly, immunocompromise, chronic cardiopulmonary disease, etc.)
- Assess patient’s living arrangement (private home vs. shelter, SNF, LTCF, etc.)
  - If patient potentially meets PUI criteria or clinical concern exists for COVID-19, SARS-CoV-2 testing should be ordered. Influenza is no longer prevalent, so influenza testing is not routinely recommended. If influenza testing is desired, it can be ordered separately but will be processed from the same swab that was sent for SARS-CoV-2; no need to send a separate specimen. RPP is not recommended routinely as part of the COVID-19 workup.
  - All patients who will be admitted to the hospital, regardless of concern for COVID-19, must have SARS-CoV-2 PCR sent to determine placement and isolation.
  - Patients with CONFIRMED COVID-19 can be cohorted in an area or room together.
  - Patients COVID-LIKE ILLNESS can be cohorted together if no readily available private rooms are available; in this case both patients must be on droplet and contact isolation and curtain should separate patients at all times. If the patients have discordant results, the exposed patient should remain on isolation if possible and a private room is preferred for the exposed patient, if available.
  - Patients with a clinical presentation concerning for COVID who have a negative test but no other definitive diagnosis should remain on isolation for COVID, as false negative tests can sometimes occur; err on the side of caution. COVID-like illness flag should be added in Epic.
  - Consider Infectious Diseases Consult if indicated, and a Critical Care Consult if unstable and ICU level care might be needed.

- Outpatient: Patient (and anyone accompanying them) is offered a surgical mask, and patient is escorted to a private room with the door closed. Providers should don either N95 (or surgical mask if unavailable), with eye protection, yellow gown and gloves.
  - Perform a clinical assessment:
    - Define detailed history including any healthcare exposures and travel
    - Determine if patient had close contact with a symptomatic traveler/case or someone with compatible symptoms
    - Define duration and timeline of specific symptoms
    - Assess severity of illness
    - Assess risk factors for severe disease (elderly, immunocompromise, chronic cardiopulmonary disease, etc.)
    - Assess patient’s living arrangement (private home vs. shelter, SNF, LTCF, etc.)
  - If there is clinical concern for COVID-19, the patient should be referred to a designated ambulatory testing site through the PAC by calling 855-662-8160. The patient should be instructed to self-isolate until it has been 10 days from symptom onset, 72 hours without fever in the absence of antipyretics, and symptoms are significantly improving.
  - If patient potentially meets PUI criteria or clinical concern exists for COVID-19, and is not safe for home isolation, call ahead to ED and alert EMS to potential COVID prior to transfer to an acute care facility.
  - If pre-procedure ambulatory SARS-CoV-2 PCR is required, please follow the workflow outlined in the Ambulatory Guide to COVID-19 Testing available on the intranet.
Inpatient or main ED: If a patient develops fever or respiratory symptoms (or any other concerning symptoms/signs for COVID-19), and after appropriate evaluation the clinical profile is concerning for COVID-19, the patient should be treated as a possible PUI.

- Mask the patient, close the door, and post isolation signs
- No aerosol-generating procedure required: Providers should don either N95 or surgical mask, with eye protection (full face shield preferred), yellow gown, gloves in a private room with the door closed.
- If an aerosol-generating procedure is required (BiPAP/CPAP, NFNC, bag-mask ventilation, nebulizer, intubation/extubation, cardiopulmonary resuscitation, ongoing mechanical ventilation via a ventilator without a closed circuit such as LTV’s bronchoscopy, sputum induction, or open airway suctioning), providers should don N95 mask with face shield, yellow gown, gloves and the patient should be placed in a negative pressure room. Nasopharyngeal swab acquisition or mechanical ventilation alone do not require a negative pressure room or N95 mask.
- Epic isolation orders and COVID flag should be entered.
- Identify an available private or negative pressure room for transfer, preferably in a COVID+ designated area
- Patients with CONFIRMED COVID-19 can be cohorted in an area or room together
- Patients with COVID-LIKE ILLNESS can be cohorted in an area or room together
- Patients with COVID-LIKE ILLNESS can only be cohorted with confirmed COVID-19 patients if no readily available private rooms are available and clinical suspicion for COVID-19 is very high after discussion with Infection Prevention; in this case both patients must be on droplet or airborne and contact isolation and curtain should separate patients at all times. If the patients have discordant results, the exposed patient should remain on isolation if possible and a private room is preferred for the exposed patient, if available.
- Once receiving area is ready, the patient should be escorted/transported to the private or negative pressure room
- SARS-CoV-2 PCR testing should be sent as soon as possible. Influenza is no longer prevalent, so influenza testing is not routinely recommended. If influenza testing is desired, it can be ordered separately but will be processed from the same swab that was sent for SARS-CoV-2; no need to send a separate specimen. RPP is not recommended routinely as part of the COVID-19 workup.
- Patients with a clinical presentation concerning for COVID who have a negative test but no other definitive diagnosis should remain isolated, as false negative tests can sometimes occur; err on the side of caution. COVID-like illness flag should be added in Epic.
- Consider Infectious Diseases Consult if indicated, and a Critical Care Consult if unstable and ICU level care might be needed.
Suspicion or confirmation of COVID-19 should prompt a conversation with the care team, nurse manager, and any receiving services. If the patient is part of a cluster or from a congregate setting, DOH notification is required. Isolation orders and flags must be placed, and signs posted.

Respiratory Therapy Guidelines:

Please refer to Respiratory Therapy Guidelines for adults and pediatrics on the intranet, and the Surviving Sepsis Campaign: Guidelines on the Management of Critically Ill Adults with Coronavirus Disease 2019 (COVID-19).

Guideline for Respiratory Care of Mechanically Ventilated Suspected or Confirmed COVID Patients

1. A Resuscitator Bag and Mask must be at bedside and provided for transport in the event of self-extubation.

2. Ventilator will be set up with Aerogen nebulizer and inline suction ballard.

3. Ventilator circuit changes will be done PRN. Changing the ventilator circuit is considered an aerosol generating procedure. Respiratory Therapist must wear N95 Mask. Circuit change will be done for the following reasons: • If there is visible physical damage to the circuit causing interference with ventilation • If there is a circuit occlusion alarm that is unresolved after troubleshooting • RT must consult with Attending MD prior to changing the circuit

4. Inline suction ballard will be changed PRN. Changing the inline suction ballard is considered an aerosol generating procedure. Respiratory Therapist must wear N95 mask. Change of inline suction ballard will only be done if the ballard is non-functional.

5. Ventilator will be set up with Servo-guard HEPA Filter (or other approved HEPA filter) on expiratory limb prior to the expiratory cassette.
6. HEPA filter will be changed PRN. Changing the filter is considered an aerosol generating procedure. Respiratory Therapist must wear N95 mask. Change of filter will be done for the following reasons: • PIP is >15cmH2O and/or AutoPeep >10cmH2O above baseline for >30 minutes after patient has already been suctioned AND is not related to worsening lung compliance  
• Circuit Occlusion Alarm  
• RT must consult with Attending MD prior to changing the expiratory filter

7. During circuit changes, ballard changes, and filter changes, all healthcare workers in the patient room must wear N95 mask. The door to the patient room must be closed during all circuit changes, ballard changes, and filter changes.

8. Patients on mechanical ventilation via Servo ventilator will remain on the ventilator during transport. Patient will be accompanied by a Respiratory Therapist and personnel according to the Montefiore transport policy.

9. Every Servo ventilator has 2 batteries each lasting approximately 45 minutes.

10. Oxygen tank will be connected to high pressure hose – patient will be on 100% oxygen during transport. RT will determine how many tanks will be needed for transport.

Admission for PUI

It is important to avoid ED visits and admissions for patients not requiring acute care, such as supplemental oxygen, intravenous medications, etc. If a patient at Montefiore is considered a PUI or there is clinical concern and requires admission, the patient will be admitted to an isolation or negative pressure room, or cohorting area. Decisions will be made on a case-by-case basis regarding which location is optimal for ED or inpatient care of a PUI, based on the patient’s condition and level of care required, need for aerosol generating procedures, and volume of admitted patients requiring private and negative pressure rooms. Particular units may be designated for cohorting. ICU beds are limited. As such, these beds will be reserved for patients requiring the highest level care, such as ECMO, CVVH, or hemodynamic instability or respiratory failure that cannot be managed elsewhere, as determined by Critical Care Medicine.

Home Care

Duration of home isolation:
• At least 10 days since symptom onset
• Respiratory symptoms are improving
• The patient has been afebrile for at least 72 hours without needing antipyretics (Tylenol, ibuprofen, etc.)
• Mask should be worn for 14 days from symptom onset

Please provide the patient with the Home Isolation Guidelines document available on the intranet if discharged.
Transport

The patient should be transported wearing a surgical mask. **Staff transporting a PUI should wipe down the bed, ensure the patient has clean linen, wear an N95 or surgical mask with eye protection and perform diligent hand hygiene.** Gloves are not required. Transport should be limited; any therapeutic or diagnostic procedures including Xray should be done in the patient’s room whenever possible. If procedures outside the patient’s room are required, advanced notification (receiving area, infection prevention, and EVS) and removal of other patients and extra staff from the area are required. Staff performing the procedure should wear recommended PPE. Radiology guidelines for COVID-19 are available on the intranet.

**Care of PUI and Confirmed Cases in Isolation**

Entry of staff into the room should be limited to essential functions only, and clinical staff should be dedicated to COVID-19 patients only when possible; however, as volume of patients increases this will likely not be sustainable. Isolation will continue until the patient is cleared by Infection Prevention. All Montefiore clinical staff are eligible to care for a PUI/confirmed patient with the exception of pregnant staff. Students should not care for these patients.

**Diagnostics**

Please note that the Respiratory Pathogen Panel used at Montefiore will **NOT** identify COVID-19. Furthermore, a patient who has a positive result for coronavirus on this panel should **NOT** be treated as a person under investigation nor should disposition planning be delayed or care altered due to such a result. Coronaviruses represent a large family of viruses, and are a common cause of upper respiratory infections/common cold in the community.

All specimens for suspected or confirmed COVID-19 patients must be clearly labeled as such for the protection of lab personnel using an Epic-generated COVID alert label (based on isolation status), an orange sticker, Alert sticker, and/or printed alert to be put in the bag. All specimens including blood and other specimens from these patients should be hand-delivered to the laboratory and a supervisor notified immediately. The pneumatic tube system should not be used for specimens from suspected or confirmed COVID-19 patients.

Montefiore Medical Center has in-house SARS-CoV-2 PCR testing available for ambulatory and hospitalized patients. This test can be ordered without approval from ID. Ambulatory patients should
undergo testing at designated testing sites rather than at the point of care for safety reasons and in the setting of PPE and test kit limitations. Appointments can be made for outpatient SARS-CoV-2 PCR through the PAC. ED and Inpatient testing can be done in the hospital setting. Both a nasopharyngeal swab and a separate oropharyngeal swab should be obtained and both swabs should be placed in one viral transport media tube. Do NOT waste an entire viral swab kit with transport media if there is only one swab; either another individually wrapped swab can be used, or the same swab can be used for OP collection then NP collection in the same patient. If the provider also orders an influenza swab (not routinely recommended due to low influenza activity at this time), the same specimen can be used for BOTH COVID and influenza; a separate swab is not necessary.

Instructions for collection of NP swab: Use a synthetic fiber swab with plastic shaft. Do not use calcium alginate swabs or swabs with wooden shafts. Leave swab in place for 2-3 seconds then rotate completely around for 10-15 seconds, and repeat in other naris. Place swab immediately in a sterile tube with 2-3 ml of viral transport media. Then perform a separate OP swab using a synthetic fiber shaft and place immediately in the tube with viral transport media. If unavailable, E-swabs can be substituted.

COLLECT BOTH NP AND OP
(Same process for inpatient or ambulatory collection)

PREP WORK:
Don N95 or surgical mask, eye protection, gowns, gloves
PLACE LABELS VERTICALLY FOR SCANNING, PLACE ORANGE DOT/LABEL ON SPECIMEN AND BAG
(do all this before entering room)

1. OBTAIN KIT WITH 2 SWABS IF POSSIBLE (ONE SKINNY ONE FAT)
2. STICK THE FAT ONE IN THE BASE OF THE THROAT AND OBTAIN A GOOD SPECIMEN
3. STICK THE SKINNY ONE IN THE DEEP NARES, HOLD FOR 3 SECONDS, THEN SWIRL AROUND FOR 15 SECONDS; REPEAT ON EACH SIDE (do this for adults and the best process for pediatrics)
4. IF KIT HAS ONLY 1 SWAB, FIRST STICK IN THE THROAT, THEN STICK THE SAME SWAB IN BILATERAL NARES AS ABOVE
PCR Testing Sensitivity and Serology: While true sensitivity and specificity of SARS-CoV2 PCR is not yet established, false negative NP/OP PCR results have been noted in patients with symptoms very consistent with COVID (persistent fevers, hypoxia, shortness of breath, pulmonary infiltrates, diarrhea, neutrophilia, lymphopenia, elevated inflammatory markers and acute phase reactants, etc.). Studies suggest maximal viral shedding and maximal RNA test sensitivity occurs in week 1 of illness, then steadily declines in week 2 and beyond, while antibodies are building up. Providers can consider, if COVID-19 is strongly suspected, sending a repeat NP/OP test 24-48 hours after original test if initially negative. BAL or deep tracheal specimens can be tested for SARS-CoV2 by send out labs.

The Department of Pathology has validated serologic testing which could be helpful in such patients to confirm prior diagnosis, however, this test has significant limitations (e.g. false positive and false negative results). Serologic testing (IgG) is available for ambulatory and hospitalized patients, and also to all associates by request to OHS. If an associate had symptoms of COVID-19 it is recommended to wait until ≥ 21 days after symptoms began to ensure sufficient time has passed to develop antibody. Please note that many non-FDA tests available have limited sensitivity and specificity, and thus conclusions cannot be drawn from these test results and serology will not be used to determine fitness for work. Please contact ID with any questions.

<table>
<thead>
<tr>
<th>COVID Symptoms and/or Nasal PCR Result</th>
<th>COVID-19 IgG Antibody Result</th>
<th>Interpretation</th>
<th>Do I have protection from future COVID-19 infection?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>Positive</td>
<td>COVID-19 Infection occurred and antibodies against the virus are present in your blood</td>
<td>We don’t know yet</td>
</tr>
<tr>
<td>Positive</td>
<td>Negative</td>
<td>COVID-19 Infection occurred and antibodies against the virus are absent from your blood</td>
<td>We don’t know yet</td>
</tr>
<tr>
<td>Symptoms were present, but test was Negative or no test</td>
<td>Positive</td>
<td>COVID-19 Infection likely occurred</td>
<td>We don’t know yet</td>
</tr>
<tr>
<td>Symptoms were present, but test was Negative or no test</td>
<td>Negative</td>
<td>COVID-19 Infection either did not occur or occurred but wasn’t confirmed</td>
<td>We don’t know yet</td>
</tr>
<tr>
<td>No symptoms, no test or Negative test</td>
<td>Positive</td>
<td>COVID-19 Infection could have occurred, but cross reactivity with other seasonal coronaviruses is possible</td>
<td>We don’t know yet</td>
</tr>
<tr>
<td>No symptoms, no test or Negative Test</td>
<td>Negative</td>
<td>COVID-19 Infection likely did NOT occur</td>
<td>Likely no protection</td>
</tr>
</tbody>
</table>
Appropriate PPE Use and Conservation: N95 and other PPE supply chain is **extremely strained** by the demand in the setting of the current outbreak and disruptions in manufacturing; consequently, extraordinary efforts must be taken to reduce utilization and preserve supply so it is available when needed for the weeks to come as we respond to this pandemic:

- All associates should wear a surgical mask while working unless alone in a room with the door closed. N95 masks for patient-facing staff should be worn when caring for COVID patients or other patients on airborne isolation, and during any aerosol generating procedures or other procedures with potential for aerosol generation. Surgical masks can be worn at all other times. Eye protection should be worn during patient care activities when within 6 feet of patients.
- N95 masks are available at ambulatory facilities and should be used as above.
- N95 masks will be actively stocked on units and in procedural/OR areas, pharmacy, and the laboratory. Remaining stock will be secured in Central Supply, by specified unit leaders, and/or ADN’s. PPE requests should be requested from central supply directly during regular hours, and to the ADN off hours.
- N95 masks can be removed and re-used by the same provider for multiple uses for airborne isolation patients only OR for airborne and contact patients IF the N95 mask is completely covered by a barrier (such as a full face shield or hood) during use, unless/until integrity is compromised, or the mask becomes soiled/wet. Providers should avoid touching the mask with gloved/soiled hands. The provider should perform hand hygiene immediately prior to removing the mask. Masks should be stored in a paper bag with name on it between uses.
- N95 masks can be continuously worn for an extended period of time to care for multiple COVID patients, unless/until integrity is compromised, or the mask becomes soiled/wet. Providers should avoid touching the mask with gloved/soiled hands between patients and should not reuse the mask as above after removal if aerosol generating procedures were performed and there was incomplete coverage of the mask.
- Face Shields and goggles should be reused by the same provider on an ongoing basis if integrity is not compromised, and if carefully removed and disinfected by wiping with PDI purple top or gray top wipes between uses. Face shields and goggles should be stored and labelled in a clean, dry place, similar to N95 masks.
- Surgical masks without a fluid shield CAN in times of short supply be reused if not touched with unwashed hands, soiled, wet, or contaminated. Providers should leave the patient care areas if they need to remove the facemask. Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean sealable paper bag or breathable container labeled with the provider’s name. The facemask should be removed and discarded if soiled, damaged, or hard to breathe through. **The facemask should never be worn/stored under the chin.** If not touched with unwashed hands, soiled, wet, or contaminated, surgical masks can also be worn continuously for an extended period of time (i.e. a shift).
- N95 masks are for **ASSOCIATES ONLY** (never patients/visitors).
- Routine annual fit testing for existing associates has been suspended and replaced by just-in-time fit testing (available at designated locations of each hospital or upon request to IPC, EHS). Routine new associate fit testing will continue to occur. Associates with failed fit test should re-
attempt with a size small N95 instead of regular available on units, or by directly requesting from central supply at each campus. If the associate’s fit test fails with both sizes of the model, repeat fit testing with an alternative model.

- Seal check should be performed each time the N95 is used to ensure proper fit.
- Please avoid using thick skin barrier items or tissues over the bridge of the nose that interfere with seal; liquid skin protectant materials that do not cause eye irritation are acceptable if the seal can be maintained (please follow NPIAP guidance on the intranet).

**Environmental Cleaning:** Not considered Category A waste, no special cleaning procedures beyond normal terminal cleaning. Rooms where a patient ordered for airborne isolation due to aerosol generating procedures was located should be rested (time-based on air exchanges, up to 2h) prior to cleaning and the opening to further patient care; however, if another patient with COVID-19 infection will be moved into the area after, and all associates are wearing N95 masks, eye protection, gowns, and gloves, it is not necessary to rest the room prior to cleaning. If UV is available for terminal cleans and discharge cleaning, it should be used.

**Duration of Isolation:**

For patients going home, home isolation after discharge should continue until:

- At least 10 days since symptom onset
- Symptoms are improving
- The patient has been afebrile for at least 72 hours without needing antipyretics (Tylenol, ibuprofen, etc.)
- Mask should be worn for 14 days from symptom onset

Patients being discharged to a SNF must first have a negative SARS-CoV-2 PCR.
For patients still in the hospital, isolation should not be discontinued until approved by Infection Prevention and discontinuation criteria are met (as per the Montefiore Guide to COVID-19 Isolation and Infection Status).

Visitors: Please refer to the intranet for current visitation policy and restrictions. Visitors to high-risk units and vendors will be required to have regular SARS-CoV-2 PCR testing as per the policy.

All visitors will be screened for COVID-19 symptoms or exposure at entrances and will be asked to leave if they display symptoms, have an exposure in the last 14 days or have traveled to a high-risk area in the last 14 days and should thus be on home quarantine. All visitors should be encouraged to perform scrupulous hand hygiene, and are required to wear a surgical mask at all times (but never N95 mask), as well as other PPE when appropriate.

Post-Mortem Care

If a patient with suspected or confirmed COVID-19 expires, the following steps should be taken:

• If the patient lives or works in a congregate setting (nursing home, group home, dorm, shelter, etc), the primary clinical service should call the NY City DOH to report death of a COVID19 patient. The death of a healthcare worker who works at a hospital or nursing home should also prompt a call to the NY City DOH. NY Provider Access Line 866-692-3641

• If report to DOH is required, the primary clinical team should document in the chart that report was made to the NY City DOH and document the DOH case number

• Office of the medical examiner is no longer accepting COVID19 cases

• Associates who place the patient in a body bag and transfer the body to or from the bed in the hospital room or in the morgue should wear gown, gloves, and surgical mask with eye shield

• Advance notice should be given to the morgue that a deceased patient with COVID19 will be coming

• Transport guidelines should be followed during transport to the morgue, with the exception that surgical masks are not needed for the deceased patient or the transporter

• The entire body of the deceased patient should be fully covered by clean linen during transport

• Other post-mortem care should be dictated by pathology policy and procedure

Due to the COVID-19 pandemic and a shortage of Personal Protective Equipment (PPE):

The Montefiore Pathology Department cannot perform autopsies except under very limited conditions.

• Clinicians can no longer routinely offer autopsies to next of kin for every death.

• Only autopsies discussed with and approved by the autopsy attending pathologist (pager (917) 956-7007) will be performed.

• See the full policy on the intranet for more details.
Communication:

The intranet has an extensive FAQ section on the COVID-19 landing page. Please consult this page for all questions.

There is also a COVID-19 hotline (914-457-4136) or email COVID19@Montefiore.org for questions that cannot be answered by the intranet page.

All communication with Montefiore associates, the community, and the media regarding PUI or patients with confirmed COVID-19 should occur through Public Relations in coordination with Executive Leadership and Hospital Epidemiology in order to provide the most accurate information and promote safety and security for all. Montefiore’s public relations policy and HIPAA regulations must be followed at all times.

Employee Exposure and Illness:

Any employee who meets criteria for quarantine by a public health entity such as DOH or CDC must notify their supervisor and Occupational Health Service (including documentation of public health order) and will be furloughed for 14 days per human resources, including travel-related quarantine recommendations. Please see Montefiore’s Travel Policy on the intranet for details. Employees with a high-risk COVID-19 exposure at work or outside of work must also notify Occupational Health Services as soon as possible. ALL healthcare workers, regardless of whether they have had a known COVID-19 exposure, should self-monitor by taking their temperature twice daily and assessing for COVID-19 like illness (Fever >100.0F, muscle aches, severe fatigue, persistent or unusual headache, upper respiratory symptoms, sore throat, dry cough, shortness of breath, chest pressure, diarrhea, nausea, vomiting, chills or loss of smell/taste). Individual presentations can vary, and associates should call MMC OHS to discuss any symptoms of concern. If healthcare workers develop any signs or symptoms of a COVID-19 like illness, they should NOT report to work, and should notify their supervisor and OHS as soon as possible. If any signs or symptoms occur while working, healthcare workers should immediately leave the patient care area, inform their supervisor and OHS, and isolate themselves from other people.

In addition, by the Governor’s Executive Order, staff that work in adult care facilities must have weekly SARS-CoV-2 PCRs, to be arranged according to written plans issued by each facility. SNF personnel who test positive for COVID-19 but remain asymptomatic are not eligible to return to work for 14 days from the date of the first positive test. Symptomatic nursing home employees may not return to work until 14 days after the onset of symptoms, provided at least 3 days (72 hours) have passed since resolution of fever without the use of fever-reducing medications and respiratory symptoms are improving. A negative PCR test is not required before returning to work.

OHS can be contacted at: (718) 920-5406 for any Montefiore associate experiencing COVID-19 symptoms. After consultation with OHS, if indicated, testing can be arranged. Per the NY State Department of Health, associates with COVID-19 symptoms can return to work if symptoms are substantially improved, at least 10 days after onset of symptoms, and when fever is absent for 72 hours without fever reducing medications, whichever is longest, with the approval of OHS. Sick associates should contact OHS before coming back to work to confirm these parameters are met. Associates returning after a COVID-like illness or confirmed COVID-19 should wear a surgical mask at all times for 14 days from the onset of symptoms. In addition, for any associate requiring hospitalization for COVID19
related disease, OHS will require the associate to complete their recommended care as directed by their own physicians and the associate must have their physician provide a doctor’s note clearing the associate to return to work.

If an associate who is asymptomatic is tested for COVID-19 for any reason, and that test is positive, the associate must remain out of work for 10 days from the date of the test assuming symptoms do not develop within 10 days of testing. If symptoms do occur, the criteria above for symptomatic associates should be used to determine readiness to return to work.

OHS can also be contacted to schedule SARS-CoV-2 IgG antibody testing upon request. If the associate had known COVID-19 or a COVID-like illness, they should wait 21 days from the date of symptom onset prior to antibody testing to ensure sufficient time has passed for antibody formation.

**Employee Travel:**

Montefiore employees may not travel to any destination for business purposes at this time.

Employees are urged to follow CDC and DOH guidance regarding non-essential travel to high-risk areas. Employees choosing to travel for personal reasons will not be offered special pay if mandated to self-quarantine by CDC or DOH on return. Please refer to Montefiore’s Travel policy on the intranet for details.


**Important Contacts:**

Internal inquiries regarding COVID-19 should be directed to the intranet FAQ page, and to the associate’s supervisor and site leadership. If the question cannot be answered, 914-457-4136 or COVID19@Montefiore.org can be used to direct the inquiry to the appropriate department.

For all other questions regarding Infection Prevention issues, please contact your site-specific Infection Prevention Office and ask for the Infection Preventionist assigned to your unit/site. For Montefiore Medical Center, this information is available on the intranet on the Infection Prevention Department page. For after hours questions, ask the operator to page Infection Prevention on-call. For employees seeking information related to furlough or exposure, please call your local Occupational Health Services office. Contact information can be found in the intranet page for Occupational Health Services.

**Health Department Provider access lines:**

- NYC DOH 866-692-3641
- Westchester County DOH: 914-813-5000
- Rockland County DOH M-F 8am-5pm: 845-364-2997
- Rockland County DOH after hours/weekend: 845-364-8600
- Orange County DOH: 845-291-2330
- Dutchess County DOH: 845-486-3400
- Ulster County DOH: 845-340-3090
Additional Resources:

Information, workflow, protocols, and documents for COVID-19 are available on the Montefiore intranet, on the COVID-19 page. Montefiore’s external website also has community-oriented information.

The NYC DOH has many helpful and informative documents, tools, and guides for the general public and for providers and a hotline for questions:

NYC DOH COVID-19 Hotline 1-888-364-3065

https://www1.nyc.gov/site/doh/health/health-topics/coronavirus.page

The CDC has up-to-date information, comprehensive guidance, risk assessment, preparedness checklists, provider and laboratory guidance, travel information, and more:


The WHO also has comprehensive guidance and daily global situation summaries on COVID-19:

https://www.who.int/health-topics/coronavirus