Guide for follow-up care after initial COVID19 assessment

(All patients told to call if symptoms worsen at any time; given handouts if possible, else verbal review and teach back)

At Home Symptom Assessment (nurse outreach call or telehealth visit)

	Clinical Assessment			Patient self-monitoring
Severity of Sx	Mild	Moderate	Severe	During every outreach, advise patient to call if
How is your breathing?	Cough and no shortness of breath (SOB) In patient with chronic cough, cough worse and no shortness of breath	Mild shortness of breath - aware of breathing but comfortable, Able to complete a sentence without stopping to breath, Able to climb a flight of stairs without losing breath; ---> *If normally out of breath climbing a flight of stairs, this is worse.*	Any need to take a breath mid-sentence, Short of breath with 1 Flight of stairs, Any chest pain; Pulse ox < 95% actual or decrease from baseline, Coughing blood. Using inhaler with no benefit	Increasing cough, shortness of breath or difficulty breathing; or chest pain; coughing blood
What is your temperature?	<100.4F	100.4F - 102.5F but responding to fever medicine	>102.5F or 100.4F - 102.5F and not responsive to antipyretics	Temp > 102.5F or unable to control with fever medicine
How is your intake of liquids?	Drinking liquids, urinating every 4-6 hours, has tears, vomiting or diarrhea mild or improving	Decreased fluid intake (<50% usual), urinating at least 3 times daily, has tears, moderate vomiting or diarrhea	Decreased urine output, dry mouth, lightheaded on standing, unable to keep fluids down	Worsening vomiting and diarrhea, dark urine, decrease urine output, dry mouth or dizziness
Any Confusion?	NO	NO	YES	Any confusion
Have you had a change in your mobility or a fall?	***Function:*** normal ***ADLs:*** performed without change in level of assistance from baseline	***Function:*** mildly reduced but managing safely ***ADLs:*** needs some increased assistance from baseline	***Function:*** severely reduced ***ADLs*** : Needs significantly increased assistance from baseline ***Fall*** - sustained	Struggling to manage daily tasks or have a fall
Initial Disposition based on highest severity	Monitor at home (see ***outreach frequency guide*** for interval)	**Evaluation in ILI/resp clinic (moderate resp symptoms)** Monitor at home (moderate fever or dehydration)	Send to ED or urgent physician evalutation	Any symptoms are worsening call, or if severe go to ED

Notes

1. Have a lower threshold for evaluation in patients with risk factors for severe disease.
2. Clincal judgment should be used to adjust disposition based on day of illness and overall course of illness (see outreach frequency guide)
3. Pay particular attention to how many days since the onset of symptoms; rapid clinical worsening most frequently occurs at days 5 to 12 or later.
4. Consider criteria for testing from DPH as well in your decision.
5. Any questions about symptom severity, should be run by a clinician urgently; if moderate v. severe unclear, this should be done in realtime. The clinician can then help facilitate communication with patient and ED.

WHEN GOING TO EMERGENCY DEPARTMENT (or other healthcare facility) –
a. patient should use PRIVATE transportation (not Uber/Lyft, MBTA) if stable, call 911 if not, AND
b. tell the first healthcare worker they see that they may have COVID19, AND
c. wear a mask if possible
Clinical Staff: Please call ED Access Nurse to alert of patient's impending arrival (insert local ED numbers)

Outreach Frequency Guide for follow up on COVID19 patients (known or suspected)

***Risk for severe disease*:** Based upon available information to date, those at high-risk for severe illness from COVID-19 include:
People 65 years and older
People who live in a nursing home or long-term care facility
People of all ages with underlying medical conditions, particularly if not well controlled, including
-- People with chronic lung disease or moderate to severe asthma
-- People who have serious heart conditions
-- People who are immunocompromised: Many conditions can cause a person to be immunocompromised, including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS (CD4<200), and prolonged use of corticosteroids and other immune weakening medications.
-- People with severe obesity (body mass index [BMI] of 40 or higher)
-- People with diabetes
-- People with chronic kidney disease undergoing dialysis
-- People with liver disease
-- Sickle cell disease*, age <1*, hypertension*, pregnancy*. (*Local ID consensus, not on CDC list)
CDC ref accessed 4/30/20 https://www.cdc.gov/coronavirus/2019-ncov/hcp/underlying-conditions.html (updated 4/6/20)

Use table below to determine follow up interval and action based on 1) Symptom Severity, 2) Clinical Course and 3) Risk for severe COVID disease

Symptom Severity	Clinical Course[1]	Risk factors present **High** *risk for severe COVID*	No Risk Factors **Low** *risk for severe COVID*
Severe (any)	--	ED[2]	ED[2]
Moderate (respiratory)	worsening	ED[2]	ILI or (ED or 1d FU)
	same	1d FU or ILI eval.	1-2d FU or ILI eval.
	improving	1-2d FU	1-2d FU
Moderate (fever/hydration)	--	1-2d FU	2d FU
Mild (respiratory)	worsening	1d FU or ILI eval.	1-2d FU or ILI eval.
	same	2d FU or graduate[3]	*None*[4] or (3d FU or graduate[5])
	improving	2d FU or graduate[3]	*None*[4] or (3d FU or graduate[5])
Mild (fever/hydration)	--	3d FU or graduate[3]	*None*[4] or (3d FU or graduate[5])
None	--	3d FU or graduate[3]	*None*[4] or (3d FU or graduate[5])

[1]Clinical judgment should be used to adjust interval based on day of illness and overall course of illness:
Day of illness 6-12 use caution consider shorter FU interval;
*****In elders severe illness may be atypical or appear mild; Monitor VERY closely - low threshold to bring in for evaluation**
-- **Improving** symptoms: could use longer end of FU interval.
-- **Unchanged** symptoms: patient might need FU visit or shorter FU interval
-- **Worsening** symptoms: shorten FU interval and consider evaluation ILI clinic or ED

[2]**next day call** to check if patient admitted, resume outreaches once discharged from ED, hospital or other facility

[3]Consider ***graduation*** from clinical FU calls in this group if
1) patient is beyond 14 days of illness **AND**
2) meets criteria to end isolation (see below)

[4]*None* : If no outreach follow up call planned, ask patient to call back when symptom free for at least 3 days or if symptoms worsen

[5]Consider ***graduation*** in this group if meets criteria to end isolation (see below)

CDC - Symptom-based strategy to end isolation

At least **3** days (72 hours) have passed since *recovery* *, defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **AND**,
At least **10** days have passed since symptoms first appeared"
https://www.cdc.gov/coronavirus/2019-ncov/community/strategy-discontinue-isolation.html (accessed 5/6/2020)

*Additional Clarification - Recovery means:
1) off fever-reducing medicines for at least >72h AND no fever during ANY of that time; AND
2) improvement in respiratory symptoms (meaning symptoms are resolved or in a person with chronic respiratory symptoms back to baseline)

Additional guidance for **Immunocompromised** persons:
1) Review CDC guidance -- https://www.cdc.gov/coronavirus/2019-ncov/hcp/ending-isolation.html
2) Also check in with local ID specialists on follow up

Summary of Criteria for Return to Usual Activities: *Graduation from FU Care Calls, Release from Isolation and Return to work*

Patient Charactieristics	Graduation from Clinical follow up	Release from Isolation	Return to work[1]
Suspected COVID19 not tested or test negative with symptoms	PCP site team (using guide above)	PCP releases using CDC guidelines symptom-based strategy (see above)	PCP works with patient's employer to clear for safe return to work
Test Positive COVID19	PCP site team (using guide above)	Local Board of Health (LBOH) **and only** LBOH can release patient from isolation to the community (patient may request a letter for documentation if they wish, but letter is not otherwise given)	Has Occupational/Employee Health: Occ Health must approve "return to work" and works with PCP as needed.
			Has **NO** Occupational/Employee Health: **after** release by LBOH (letter[2]) PCP works with patient's employer to clear for safe return to work

[1]Consideration for return to work should occur **AFTER** person is released by the LBOH

[2]If PCP needs confirmation of release by LBOH then ask the patient to send it to you, if they have not been given one they should call their LBOH and request it.

Exception : In some cases Occupational Health Departments may have authority to bring people back to work prior to LBOH ending isolation (e.g Health Care Workers when there is resource shortage). For example, Occupational Health Departments in the City of Boston have the authority to permit employees to return to work prior to BPHC releasing patient from isolation. Patient would still need to self-isolate from everyone during non-working hours until released by LBOH

Back up process:
If patient has not heard from BPHC/LBOH by 14 days after the test, ask them to notify PCP. (individual patients should not be told to call the LBOH)

PCP/CHC should contact the LBOH to check in regarding that patient and make sure that the patient is in the system and that the LBOH has the correct phone number. Please verify the city the patient lives in to make sure you call the correct LBOH

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