Coronavirus Disease 2019 (COVID-19) Strategy for Outpatient Clinics and Practices
NYP ACN and Medical Groups, WCM PO, Columbia Doctors
Version 3/5/20

The algorithms below were created to address the current outbreak of COVID-19 that was first reported in China in December 2019. The purpose of these algorithms is to reinforce practices that should be followed at all times (e.g., screening all patients for symptoms of communicable disease and implementing basic infection prevention practices) and to provide recommendations specific to the COVID-19 outbreak.
Please note that screening criteria (e.g., specific locations of travel) may change over time.

Scenario 1: ALL patients presenting to practices/clinic

1. Upon arrival, **screen all patients for fever, cough,** and rash.
2. If patient has none of these symptoms, proceed with routine registration process.
3. **If patient acknowledges fever, cough, and/or rash**, provide patient (and anyone accompanying the patient) with a **surgical mask** and instruct them to perform **hand hygiene**.
    a. As per routine protocol, if patient acknowledges fever and rash, relocate patient to single room with door closed as soon as possible. [Note: This is intended to identify and prevent transmission of measles, chickenpox, and other infectious diseases that cause fever and rash. Fever and rash without respiratory symptoms is NOT suggestive of COVID-19.]
4. If patient acknowledges **fever or cough or shortness of breath**, ask if patient had **international travel OR exposure to someone who had confirmed or suspected COVID-19** within preceding 2-3 weeks.
    a. If no international travel or exposure, proceed with usual protocol (i.e., attempt to keep patient separated from other patients by 3-6 feet, prioritize placement in a single room.)
    b. **If travel to mainland China, Iran, Italy, Japan, South Korea OR exposure to someone with confirmed or suspected COVID-19 within 2-3 weeks from symptom onset** , relocate patient (and anyone accompanying the patient) to an exam room, close the door, and notify clinical staff. [Note: If a negative pressure room is available, this room should be used.] If an exam room is not immediately available, keep patient separated from other patients by at least 3-6 feet.
        i. Clinicians entering room should use EITHER of the following options for personal protective equipment (PPE) :
            1. **N95 respirator, gown and gloves, and surgical mask with a fluid shield. The fluid shield is worn for eye protection and is worn over the N95 respirator (double mask).** Healthcare personnel (HCP) must be fit tested to wear the N95 respirator. **OR**
            2. **Surgical mask with fluid shield (eye protection), gown and gloves.**

        Note: **The patient must wear a surgical mask for entire duration of office visit with either approach.** A face shield is not necessary for the patient. Both PPE options are acceptable based on the World Health Organization's assessment that COVID-19 is transmitted through droplets and contact and NOT transmitted

through the airborne route[1], as well as the CDC risk assessment of HCP exposure to COVID-19.[2]

ii. **Clinician obtains additional information** from patient: signs and symptoms and dates of onset of signs and symptoms, travel history (dates, locations), and history of any exposure to ill persons who are confirmed or suspected to have COVID-19.

iii. **Clinician contacts IP&C and local Department of Health** for guidance regarding further patient evaluation. Possible outcomes based on this guidance might include:
   1. Determination that patient does not require further consideration of COVID-19 (i.e., resume routine care) **OR**
   2. Request to collect samples (e.g., nasopharyngeal and oropharyngeal swab, sputum, serum) for COVID-19 testing with discharge home under self-quarantine **OR**
   3. Referral to ED for further evaluation and care

iv. Upon discharge of a patient with suspected COVID-19:
   1. The exam room should remain closed to other patients for one hour (30 minutes is acceptable if the patient was in a negative pressure room with ≥12 air changes per hour)
   2. Surface cleaning/disinfection should be performed with a disinfectant with an EPA-approved emerging viral pathogens claim or claim against human coronaviruses.

[1] https://apps.who.int/iris/bitstream/handle/10665/331215/WHO-2019-nCov-IPCPPE_use-2020.1-eng.pdf

[2] https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

See next page for Scenario 2: All Patients Calling to Schedule an Appointment

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Scenario 2: ALL patients calling to schedule an appointment

1. Ask if patient has had, within the past 14 days, either **(1) travel to/from mainland China, Iran, Italy, Japan or South Korea OR (2) exposure to someone with confirmed or suspected COVID-19.**
2. If patient answers "no," proceed with routine scheduling procedures.
3. If patient answers **"yes," refer patient call to a clinician** who will obtain details about travel (e.g., dates, locations) and exposures and determine the reason for visit request.
    a. If patient's appointment **request is for fever, cough, or shortness of breath**:
        i. If clinical illness does not warrant urgent in-person evaluation (e.g., mild symptoms):
            1. Clinician will collect details about symptoms and signs (including dates of onset), travel history (including specific locations and dates of travel), and any known contact with ill persons who are confirmed or suspected to have COVID-19.
            2. Clinician will contact IP&C and local Department of Health for guidance regarding further evaluation and management.
        ii. If clinical illness warrants urgent in-person evaluation:
            1. Clinician will refer patient to closest Emergency Department.
            2. Clinician will instruct patient to wear surgical mask if possible, alert ED staff immediately upon arrival, and avoid public transportation.
            3. Clinician will notify receiving ED of patient's anticipated arrival, symptoms, and travel history and concern for COVID-19.
    b. If patient **does NOT have fever, cough, or shortness of breath,** clinician will assess the urgency of visit.
        i. **If visit is non-urgent**, visit will be scheduled for >14 days after return from or after last exposure. Patient will be instructed to call back if they develop symptoms (fever, cough, shortness of breath) prior to the scheduled appointment.
        ii. **If visit cannot be deferred** until >14 days after return from affected area or after last exposure, visit will be scheduled. Patient will be instructed to call back if they develop symptoms (fever, cough, shortness of breath) prior to the scheduled appointment, at which time a clinician will reassess patient as noted in 3 above.

For more information about basic screening practices, refer to

NYP ACN Communicable Disease Screening Algorithm

For questions, contact the Department of Infection Prevention & Control at your site:
NYP-AH: 212-932-5219

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