For inpatient adult patients who are showing symptoms of COVID-19, please utilize the following workflow to determine the need for COVID-19 testing:

**Key Factors to Testing:**

- Testing capability & PPE is limited at this point.
- For any patient transition from ED to Inpatient, an intentional conversation must occur between providers regarding patient specific potential for COVID-19 testing.
- If you have questions, please contact Infection Prevention or Infectious Disease.

The following patients with COVID-19 symptoms should be testing for COVID-19:

**Those with fever or cough AND:**

- Patients hospitalized with severe lower respiratory illness
- Pregnant women in the 3rd trimester or in active labor
- Severely immunocompromised as defined by the below:
  - Active chemotherapy
  - Hematology malignancy with prolonged neutropenia
  - Primary immunodeficiency
  - History of bone marrow or solid organ transplant
  - Active treatment for GVHD
  - Daily prednisone or equivalent >2 mg/kg/day
  - TNF inhibitor
  - Age>65
- Health Care and Public Service Worker

**Severe Respiratory Isolation**

Precautions include the following:
- Gown
- Gloves
- Eye Protection
- Simple Isolation Mask

When using Severe Respiratory Isolation precautions, remember that the following procedures require the additional precautions:
- Nebulizers: N95 mask or PAPR
- CPAP, BiPAP, Home Vents, Act of Intubation/Extubation, HFNC: N95 + Negative Pressure if available.

**Is COVID-19 testing positive?**

- Yes
  - Consider ordering Film Array.
  - Treat alternative cause and adjust to isolation precautions for diagnosis per policy.
  - Transfer to alternate floor as able.
  - **If clinical concern for COVID-19 remains, please see guidelines for clinical diagnosis below.**

- No
  - Maintain Severe Respiratory Precautions.
  - Consider ordering Influenza A/B PCR & starting Tamiflu (if positive).
  - Provide therapeutic support.
  - Follow treatment guidelines.
  - If you have clinical questions, contact the “COVID-19 Provider Resource – Adults” in PerfectServe.
**Suspicion Criteria:** For patients admitted with respiratory symptoms + concern for COVID-19 disease **BUT** COVID-19 AND other viral testing is negative, please consider the following clinical presentation if maintaining a high clinical suspicion of COVID-19:

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>Intermediate Symptoms</th>
<th>Uncommon Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common Symptoms (&gt;75% prevalence)</td>
<td>Intermediate Symptoms (15-40% prevalence)</td>
<td>Uncommon Symptoms (&lt;5% prevalence)</td>
</tr>
<tr>
<td>Fever (&gt; or = to 38 degrees) present at any point during the admission</td>
<td>Myalgias</td>
<td>Nausea and Vomiting</td>
</tr>
<tr>
<td>Cough</td>
<td>Fatigue</td>
<td>Diarrhea</td>
</tr>
<tr>
<td></td>
<td>Sputum production</td>
<td>Hemoptyis</td>
</tr>
<tr>
<td></td>
<td>Shortness of breath on admission</td>
<td>Nasal Congestion</td>
</tr>
<tr>
<td></td>
<td>Septic Shock</td>
<td></td>
</tr>
</tbody>
</table>

**LABORATORY FINDINGS**

- **Absolute lymphopenia <1500 per mm3 (>80% prevalence)**
- Elevated LDH (40% prevalence)
- Elevated CRP (severe disease)
- Elevated D-dimer (severe disease)
- NORMAL WBC count + Procalcitonin

**IMAGING FINDINGS**

- Chest CT: Approximately 85% of all patients with COVID19 have abnormal Chest CT scan, findings include local or bilateral patchy shadowing, ground glass opacities
- CXR: Abnormal in patients with non-severe disease, sometimes consistent with multifocal PNA. In this patient population with negative testing, non-severe disease, and equivocal or negative chest XR, non-contrast CT chest should be considered.
- **Uncommon:** Pleural effusions and hilar adenopathy

**CLINICAL GUIDANCE:**

For patients with fever + cough + one or more of the above laboratory or imaging findings, maintain high suspicion of COVID-19. Keep patient in severe respiratory isolation and treat accordingly. Utilize positive or presumed positive COVID-19 discharge instructions upon discharge.

**Re-testing Criteria:** Please use the following criteria to determine if retesting for COVID-19 should be considered. Note that testing accuracy is dependent upon appropriate technique of specimen collection. Sputum specimens could be considered for retesting.

<table>
<thead>
<tr>
<th>Status</th>
<th>Retesting Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID POSITIVE Patients</td>
<td>NO retesting is indicated at this time. Infection Prevention should be consulted to determine if patient can be removed from severe respiratory isolation.</td>
</tr>
</tbody>
</table>
| COVID NEGATIVE Patients with significant Clinical Suspicion (see above for clinical presentation guidelines) | Retesting may be indicated with the following scenarios: 
  - **Respiratory Decline requiring increased Level of Care:** retesting may be considered to confirm etiology 
  - **End of Life Situations:** retesting may be considered for the purposes of preserving PPE and/or directing PPE use within family visitation 
  - **Length of Stay:** retesting may be considered for the purpose of preserving PPE within a longer length of stay  
    ▪ Infection Prevention should be consulted with these scenario |
Treatment considerations for patients positive or presumed to be COVID-19 positive (as identified above):

- **PPE**: follow severe respiratory isolation precautions (see sign on door), contact "Hot Zone Boss" as needed for coaching on PPE.

- **Caregiver Limitation**:
  - RNs and RTs should serve as primary care providers for direct patient care
  - Physicians, APPs, Residents should limit to 1-2 providers per shift
  - Phlebotomists and Rehab may provide essential direct patient care as needed
  - All other team members (care management, MSW, pharmacy, consulting services, clinical students) should refrain from direct patient care (entering the room). Consider use of virtual or phone communication for subspecialty consults and/or patient & family communication.

- **Consolidate “Batch” Care**:
  - Minimize labs and consults as much as possible
  - Group and “batch” interventions to minimize direct patient contact throughout shift

- **Patient placement**: placement should follow organizational protocols for cohorting until COVID-19 volumes surpass capacity of designated units
  - Hospital Supervisors may be contacted to help facilitate transfers between units as needed
  - Patients not being tested or treated for COVID-19 should be relocated as needed to create capacity within designated units

- **Visitor Movement**: Visitor restriction should continue as established. Visitors permitted on case by case basis. Approved visitors must limit movement to travel between the room and parking lot only. Visitors must wear a mask while en route.