APPENDIX A:

COVID COMMUNITY MANAGEMENT HANDBOOK

Revised 4/8/2020
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Part I: Overview and Definitions

Definition of suspected COVID:

All patients with suspected COVID are managed as suspected COVID, whether they are tested or not. Decisions about testing will be made independently based on current CHA criteria.

Patients will meet criteria for suspected COVID if they have any of the following:

- New fever
- New myalgias
- New cough
- New dyspnea, or dyspnea worsened from baseline
- New sore throat
- New rhinorrhea
- Anosmia
- New diarrhea

This is a non-exhaustive list of symptoms that are consistent with COVID, and many other presentations have been reported. In the case of other unexplained symptoms, COVID may be an appropriate differential diagnosis.

Initial triage:

Initial triage will be performed by the nurses in the COVID triage center.

All patients with suspected COVID will have a provider visit at 24 hours. Patients meeting low-risk criteria will be scheduled with their PCPs; patients meeting moderate- or high-risk criteria will be scheduled with the COVID Management Team. (See Appendix 1.)

Risk stratification:

Patients with symptoms of COVID will be triaged by COVID Triage Center nurses into three risk categories based on their comorbidities (and not based on their clinical presentation). Patients who present with dyspnea on presentation will be seen in Respiratory Clinic and their risk status will be determined both by co-morbidities and by clinical evaluation.

Risk categories:

- High risk: Age ≥ 65, immunosuppression (active cancer, solid organ transplant, immunosuppressive medications, HIV with CD4 ≤ 200), pulmonary disease (asthma, COPD, ILD, CF, bronchiectasis, etc.), Type 1 diabetes, heart failure, cirrhosis, ESRD on dialysis, sickle cell disease
- Moderate risk: Pregnancy, Type 2 diabetes, CAD, CKD, neurodevelopmental or neurological disease (prior stroke, spinal cord injury, ALS, multiple sclerosis, muscular dystrophy), morbid obesity, opioid use disorder on agonist therapy
- Low risk: All other symptomatic patients
Respiratory Clinic and Management providers have the option of changing patients’ risk status based on other factors pertaining to their risk for complicated disease or their risk of transmitting disease; such factors include but are not limited to: severity of respiratory symptoms, other medical comorbidities, social or personal factors that may decrease the patient’s ability to monitor symptoms and report them consistently.

**Risk-based management:**

![Risk-based management diagram]

Patients will be seen in Respiratory Clinic for new or worsening dyspnea and will have their risk status reevaluated.

**Low-risk patients:**

Patients at low risk for complications from COVID will be managed by their PCP’s or members of their PCP’s teams. Patients will be directed to call the Triage Center with new symptoms. At that time, patients may be upgraded to Moderate Risk depending on whether they have respiratory symptoms. See below:
Moderate-risk patients:

Moderate patients will be managed by the providers of the Moderate-Risk Team. At initial televisit at 24 hours, providers will do an initial assessment and determine whether the patient has been appropriately risk-stratified. After initial televisit at 24 hours, moderate-risk patients will be followed throughout their course. Patients will be managed until Day 7 at a minimum. If improved at Day 7, they will be discharged from COVID Management; if still symptomatic, they will be managed at a minimum until Day 10. (See Appendix 2.)

High-risk patients:

High-risk patients will be managed by the providers of the High-Risk Team. At initial televisit at 24 hours, providers will do an initial assessment and determine whether the patient has been appropriately risk-stratified. After initial televisit at 24 hours, high-risk patients will be followed throughout their course. Patients will be managed until Day 7 at a minimum. If improved at Day 7, they will be discharged from COVID Management; if still symptomatic, they will be managed at a minimum until Day 14. (See Appendix 3.)

Outreach team:

The outreach team, composed of a number of staff members, will be responsible for reaching out to patients to reinforce self-isolation and self-quarantine. Patients receiving this outreach who have concerning symptoms will be escalated to Moderate-Risk providers. (See Section 7 and Appendix 7.) Providers following up with patients will determine the appropriate outreach team group at the time of 24-hour follow up.

Respiratory Clinic:

The Respiratory Clinic serves to clinically evaluate patients presenting symptoms of COVID who may have 1) symptoms concerning for significant pulmonary complications, or other concerning symptoms, but who do not warrant immediate ED evaluation; 2) an unclear diagnosis, e.g. possible heart failure vs COVID. Patients with significant dyspnea or underlying asthma and COPD will be triaged to Respiratory Clinic during the initial call.
If a patient is triaged to Respiratory Clinic on the initial call, he or she will be risk-stratified by Respiratory Clinic staff based on existing risk stratification guidelines combined with clinical evaluation.

If a patient requires Respiratory Clinic evaluation during his or her course, Respiratory Clinic staff will re-evaluate the patient’s risk stratification and consider upgrading or downgrading the patient’s risk status based on clinical evaluation, social factors, and other new information.

**Result management:**

Results will be managed by the Moderate-Risk Team. Positive results of COVID Management Team patients will be communicated by the appropriate team (High- or Moderate-Risk provider following the patient) after review by the Moderate-Risk Team. Positive results will be communicated to low-risk patients by the Moderate-Risk team and the patient will be upgraded to the Moderate-Risk Team if still symptomatic. Negative results will be released to MyChart, if possible.

**Part II: Workflows**

**COVID Triage Center:**

Incoming calls to the Triage Center will be triaged by nurses in consultation with the on-site provider as necessary.

*Triage for new presentations:*

Patients calling for their first presentation of COVID will be assessed by nurses for need for Respiratory Clinic evaluation. If Respiratory Clinic evaluation is required, the patient will be scheduled for Respiratory Clinic. If the patient does not require evaluation, the patient will be scheduled for a follow-up televisit based on the patient’s initial risk stratification.

- Scheduling for Moderate- and High-Risk teams: COVID Community Management Front End Pool
- Scheduling for low-risk patients: home clinic front desk

04.10.2020
**Triage for re-evaluation:**

Patients calling back with worsening symptoms or questions will be re-triaged by nurses to determine whether they require Respiratory Clinic follow up. If they do not but are experiencing worsening symptoms, low-risk and moderate-risk patients will have televisits scheduled with the Moderate-Risk team, if necessary. High-Risk Team patients will be scheduled with the High-Risk Team.

**High-Risk Management Group:**

After initial televisit, providers in the High-Risk Management group will request Day 4 and 7 televisits at a minimum by sending a request to the COVID Community Management Front End pool.

**Moderate-Risk Management Group:**

After initial televisit, providers in the High-Risk Management group will request Day 4 and 7 televisits at a minimum by sending a request to the COVID Community Management Front End Pool.

**Patients who do not have CHA PCPs:**

Patients who do not have CHA PCPs but are discharged from the ED or hospital with a COVID test will be managed by the same teams that manage other outpatients with COVID or suspected COVID.

**WORKFLOW FOR HOSPITALISTS/ED COMMUNICATING THE EXISTENCE OF THESE PATIENTS -- PENDING**

Once those patients’ COVID has resolved, they will be offered the opportunity to establish with a CHA PCP. These patients can be scheduled by contacting the Union Square or Assembly Square front desks POOL NAMES.

**Patients who are pregnant**
Patients who are pregnant will be managed by Primary Care. However, if a patient is tested, the OB/Family Medicine team should be notified by sending a message to PRENATAL COVID TESTING AND RESULTS pool as it will change management during delivery.

**Use of the Problem List:**

All patients with suspected COVID, regardless of risk, will have **Suspected COVID** added to their Problem List and pinned to the top of the Problem List. Triage Center nurses will be responsible for creating the Suspected COVID problem and documenting within it the first day of symptoms. If patients are not seen in Respiratory Clinic, they will also document the initial risk category. The problem will be updated if a patient tests positive to **COVID Infection**.

**The Problem List will serve as the main point of communication between all providers (Community Management and Respiratory Clinic, in addition to PCP) who may care for the patient.**

**Problem List:**

- Suspected COVID: Not tested, or tested but pending
- COVID infection: Confirmed positive (by testing)

Within the Overview section of the Problem List, providers will add information pertaining to COVID management so that it is easily accessible to all. Items that should be included in the problem list:

**Added at first contact (at triage or by Respiratory Clinic):**

- RISK CATEGORY (first line, updated if changed)
- First date of symptoms
- Whether the patient was tested

**Added by Moderate- or High-Risk manager:**

- Principal risk manager and team for high-risk patients
- Major risk factors for complicated disease (brief list)
- Risk factors for complicated course (social reasons, etc.)
- For moderate-risk patients:
  - Health care proxy
  - Other goals of care, if appropriate
- For high-risk patients:
  - Health care proxy
  - Code status
  - Other goals of care, if appropriate

**Added by all:**
All calls and Respiratory Clinic visits and any updates by date
Prescribed medications by date

All days refer to the first date of symptoms.

Example:

RISK CATEGORY: Moderate
First date of symptoms: 4/1/2020
Tested: Pending

Principal risk manager: Bonni Stahl, MD

Major risk factors: Diabetes

Health care proxy: Joe Smith, friend, XXX-XXX-XXXX

First contact: 4/2/2020
Day 3: 24-hour follow up, symptoms stable
Day 4: Day 4 follow up, stable
Day 6: Dyspnea, seen in Respiratory Clinic, O2 sat 96% RA
Day 7: 24-hour follow up, symptoms stable
Day 10: Day 10 call, symptoms resolved
Day 12: Discharged from Community Management
Part III: Management Guidelines for Community Management Providers

Providers will have a televisit scheduled with patients either: 1) 24 hours after initial COVID Triage Center contact OR 2) 24 hours after Respiratory Clinic evaluation.

Chart review:

Before contacting a patient, the provider will review the chart for any other comorbidities that may contribute to risk stratification. As an example, a patient stratified as moderate risk may be upgraded if there are significant comorbidities or social risk factors not identified by initial triage, or a patient deemed high risk may be downgraded in exceptional circumstances. These determinations will be made by the provider.

Initial phone contact:

All phone calls will use dedicated COVID Management SmartPhrases.

During the phone call, the provider will reconfirm the following:

- Initial date of symptoms
- Medical comorbidities
- Living situation
- Household members and close contacts
- Understanding of self-isolation and self-quarantine

Assessment of symptoms:

Providers will review all COVID symptoms with particular attention to dyspnea. Dyspnea and any signs of hypoperfusion are the most likely indications to require reevaluation in Respiratory Clinic and hospitalization. Specific questions will be incorporated into the SmartPhrases (see Appendix 5.)

Dyspnea:

Evaluation of dyspnea will focus on:

1. Subjective assessment of breathing.
2. Objective assessment of breathing based on specific questions.
3. Evaluation of delta of breathing status (changes).

Any patient with concerning features of dyspnea (e.g. has to stop in the middle of a sentence) will be scheduled in Respiratory Clinic.

All patients with subjective dyspnea or with underlying pulmonary disease will be administered the Roth test. If the Roth test suggests SpO2 < 95%, patients will be referred to Respiratory Clinic.

Volume status:

Questions about volume status are designed with the goal of assessing perfusion and will focus on fluid intake, urine output, and gastrointestinal symptoms.

Any patients with evidence of significant hypoperfusion will be seen in Respiratory Clinic.
Follow up:

Providers will determine follow up based on 1) patient’s clinical presentation, with particular attention paid to dyspnea; 2) medical comorbidities predisposing to severe course; 3) social factors; and 4) time in clinical course. If it becomes clear that the patient does not have COVID, the patient can be discharged from Community Management at any time.

All follow-up is done based on Day 1 of symptoms. Particular attention must be paid to days 5-8 and days 11-12, as these are known to be potential turning points in the disease. All patients will be followed for a minimum of 7 days with contact at days 4, 7, and 10 at minimum. If patient symptoms have completely resolved Day 7, they can be discharged from Community Management. Moderate-risk patients will otherwise be followed until Day 10, and high risk patients until Day 14; if there is no respiratory component, providers can choose to discontinue follow up at Day 10 or 14, respectively.

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
<th>Day 8</th>
<th>Day 9</th>
<th>Day 10</th>
<th>Day 11</th>
<th>Day 12</th>
<th>Day 13</th>
<th>Day 14</th>
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<td>**</td>
<td>STOP***</td>
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</tr>
</tbody>
</table>

*** These days are required provider “touches,” as is the first day after the patient calls (may be Day 2 or some other day)
* Stop only if symptoms resolved; if not, continue through Day 14
** Stop only if moderate-risk patient and symptoms resolved; if not, continue until symptoms resolved
*** Stop if if symptoms resolved; if not, continue until symptoms resolved

If a patient is seen in Respiratory Clinic, a 24-hour televisit will be scheduled.

Management of co-infections and other medical issues:

Some patients with possible COVID may have evidence of a second progress, or may present with an unclear clinical picture (e.g. COVID vs heart failure, or COVID vs different infectious etiology). If a clinical evaluation may clarify the picture, the patient should be booked in Respiratory Clinic.

Co-infections or other infections:

It is acceptable to empirically treat suspected co-infections (e.g. PNA) or alternate diagnoses (e.g. Strep throat). All patients treated in this manner should still be presumed to have COVID. No treatment for infection risks worsening the clinical picture of COVID.

Adults:

Adults with pulmonary disease or immunosuppression should be seen in Respiratory Clinic. Other
adults can be treated empirically over the phone per provider discretion.

- **Pneumonia:**
  - Amoxicillin/clavulanate 875/125mg PO BID x 5 days
  - PCN allergic:
    - Non-pregnant: Levofloxacin 750mg PO QD x 5 days
    - Pregnant (no PCN anaphylaxis): Cefpodoxime 200mg BID x 5 days
  - PNA in the setting of COPD (should be evaluated in Respiratory Clinic): Augmentin plus doxycycline 100mg PO BID x 5 days
- **Strep throat:** PCN 500mg BID x 10 days
- **Flu:** Oseltamivir 75mg BID x 5 days
- **Bacterial sinusitis:**
  - Symptomatic treatment
  - Augmentin 875/125mg BID x 10 days

**Children:**

*For children, particularly < 2 years or with comorbidities, if there is concern for secondary infection, the patient should be seen in Respiratory Clinic.*

- **CAP:**
  - Amoxicillin 90 mg/kg/d divided BID (max 3000g per day) x 10 days
  - If PCN allergy, over 5 years:
    - Not anaphylactic:
      - For children who can take pills: cefuroxime 500 mg BID
      - For children who need liquid meds: cefdinir 14 mg / Kg (max 600 mg / day) QD or divided BID
    - If PCN allergy, anaphylactic: azithromycin 10mg/kg/d for 1 dose then 5 mg/kg/d for 4 more days (max dose 500mg day 1)
- **Strep throat:** empiric amoxicillin 50 mg/kg once daily for 10 days
- **Influenza:**
  - < 15 kg: 3 mg / kg / day BID x 5 days (not recommended in infants < 2 weeks old)
  - ≥15 to 23 kg: Oral: 45 mg BID x 5 days
  - >23 to 40 kg: Oral: 60 mg BID x 5 days
  - >40 kg: Oral: 75 mg BID x 5 days

**Management of other medications:**

- **ACE/ARB:** Continue ACE/ARB unless other indication for discontinuing (e.g. concern for AKI or hypotension, in which case the patient should be seen).
- **NSAIDs:** NSAIDS are not contraindicated in COVID but Tylenol is preferred.
Immunomodulators: In the outpatient setting, there is no role for discontinuing these medications in the setting of COVID exclusively. If there is a question about a complicated patient (e.g. transplant), specialist consultation is advised.

COPD or asthma exacerbation:

Patients with concern for exacerbation of underlying pulmonary disease should be seen in Respiratory Clinic. Note that use of steroids in the outpatient setting is acceptable even in the setting of COVID.

COPD or asthma exacerbation:

- Adults:
  - Corticosteroids (PO or ICS -- 4x dose of baseline ICS)
  - For COPD: doxycycline 100mg PO BID x 5 days with food
  - It is preferred to use an MDI with spacer rather than a nebulizer as a nebulizer may aerosolize COVID
- Children:
  - Single-dose dexamethasone to be administered in clinic
  - If symptoms do not resolve, consider prednisone/prednisolone for further home management

CHF exacerbation or other cardiac pathology:

- No changes to clinical management

In many cases, management will be done in tandem with Respiratory Clinic. Guidelines for Respiratory Clinic can be found here: Adults; Children.

Part IV: Risk Group Transitions

If a patient meets a criterion for transitioning to a lower risk group, providers must use judgment to determine whether social or other factors suggest the patient should remain in the higher risk group.

Criteria for transition between Low- and Moderate-Risk management:

<table>
<thead>
<tr>
<th>Low Risk -&gt; Moderate Risk</th>
<th>Moderate Risk -&gt; Low Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Clinic appointment, if not otherwise assigned to High Risk</td>
<td>On first contact, if review of chart demonstrates:</td>
</tr>
<tr>
<td></td>
<td>- Absence of the original indication for moderate-risk placement</td>
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<tr>
<td></td>
<td>- Diet-controlled DM or controlled on one PO agent</td>
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<tr>
<td></td>
<td>- Mild neurodevelopmental or neuromuscular disease unlikely to be</td>
</tr>
<tr>
<td>Associated with respiratory problems</td>
<td>Other significant medical comorbidity not covered in risk guidelines</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>--------------------------------------------------------------------</td>
</tr>
<tr>
<td>Patient preference</td>
<td>PCP concern for social barriers to care and follow up</td>
</tr>
</tbody>
</table>

| Moderate Risk -> High Risk          | High Risk -> Moderate Risk                                         |
|-------------------------------------|--------------------------------------------------------------------|----------------------------------------|
| Other significant medical comorbidity not covered in risk guidelines | On first contact, if review of chart does not demonstrate previously identified risk factor and patient then meets criteria for Moderate Risk |
| Significant respiratory symptoms    | Absence of respiratory symptoms at Day 7                           |
| > 1 Respiratory Clinic re-evaluation |                                                                 |
| Concern for extensive social barriers to care and follow up |                                                                   |

| Low Risk -> High Risk               | High Risk -> Low Risk                                             |
|-------------------------------------|--------------------------------------------------------------------|----------------------------------------|
| Other significant medical comorbidity not covered in risk guidelines | On first contact, if review of chart does not demonstrate previously identified risk factor and patient then meets criteria for Low Risk |
| Significant respiratory symptoms    | Absence of respiratory symptoms at Day 7                           |
| > 1 Respiratory Clinic re-evaluation |                                                                 |
| Concern for extensive social barriers to care and follow up |                                                                   |
Part V: Management Guidelines for Home Clinics

We know that 80% of COVID infections are mild and do not require further intervention. For this reason, patients presenting with symptoms of COVID who are without dyspnea requiring Respiratory Clinic evaluation and who do not have medical comorbidities or complex social circumstances will not be followed by the COVID Management teams.

These patients will not be actively followed. However, if these patients develop concerning symptoms, they will call the COVID Triage Center and be re-triaged by COVID Triage Center nurses, with escalation to the appropriate Risk team if appropriate.

Patients calling with symptoms of COVID to the clinics should be instructed to call the COVID Triage Center.

Patients with mild COVID will be instructed to call the Triage Center for new respiratory symptoms, or with any other question. At that time, they will be re-triaged per COVID Triage Center policies and seen in the Respiratory Clinic if necessary.

Part VI: Triage Information for COVID Triage Center Nurses

When a patient calls in to the COVID Triage Center, nurses will:

1) Assess the patient for clinical COVID;
2) Assess whether the patient requires clinical evaluation;
3) Determine whether the patient meets criteria for testing;
4) Risk-stratify patients based on the risk categories below.

Patients who need to be seen in the ED or the Respiratory Clinic will be scheduled appropriately, but will not be risk-stratified until they are seen in person.

Risk categories:

- High risk: Age ≥ 65, immunosuppression (active cancer, solid organ transplant, immunosuppressive medications, HIV with CD4 ≤ 200), pulmonary disease (asthma, COPD, ILD, CF, bronchiectasis, etc.), Type 1 diabetes, heart failure, cirrhosis, ESRD on dialysis
- Moderate risk: Pregnancy, Type 2 diabetes, CAD, CKD, neurodevelopmental or neurological disease (prior stroke, spinal cord injury, ALS, muscular dystrophy), morbid obesity, opioid addiction on agonist therapy
- Low risk: All other symptomatic patients

Problem list creation:
For all patients who are not sent for in-person evaluation, nurses will add **Suspected COVID** to the Problem List, document the initial risk level, the first day of symptoms, and whether the patient was tested.

**Part VII: Information for Outreach Team Members**

Outreach team members are responsible for reaching out to patients and reiterating advice about self-isolation and self-quarantine, as well as running the Symptom Checklist with patients. Any concerning findings on the Symptom Checklist would be reviewed by a Moderate-Risk Management Team provider, urgently if necessary.

This team will have a list of patients requiring check-ins and will call patients to reach out to them, with a focus on low-risk patients to ensure they are self-isolating appropriately. If the patient has any new or changing complaints, the patient will have a televisit by a Moderate-Risk Management Team provider; if the concern is urgent, the provider will be paged.

**Note:** Moderate- and High-Risk Providers can also request outreach from the outreach team for socially complex patients who need reinforcement of self-isolation and self-quarantine.

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**Low-risk patients:**

The check in will be conducted the second day from the day of initial triage.
“My name is X and I am calling from CHA to speak with [patient].” Is now a good time? ... I am reaching out to you because you called yesterday with symptoms of coronavirus. I would like to review some guidance with you and ask you about your symptoms. Is now a good time?”

1. Administer symptom checklist (Appendix 4.)
2. Review Home Care Advice (Appendix 5.)
3. Check-in requests for risk-managed patients:

A provider can request an additional check in for moderate- or high-risk patients requiring extra “touches” and reinforcement.

1. Administer symptom checklist (Appendix 4.)
2. Review Home Care Advice (Appendix 5.)

Use of symptom checklist:

If any symptom is new or worsening compared to prior days, the patient will be routed to the Triage Center.
Appendices

Appendix 1: Overview

Call to COVID Triage

Dyspnea or comorbidities requiring Respiratory Clinic assessment?

Yes

Schedule Respiratory Clinic appointment
Respiratory Clinic to risk-stratify based on criteria and in-person evaluation

No

Clinically COVID? (1)

Yes

Meets criteria for and desires testing?

Yes

Book Drive-Thru Testing

No

Determine risk status

High-risk comorbidities or wants to speak to a provider?

Yes

High

Book 24-hour follow-up with High-Risk provider

Low

No further action

No provider follow up

Moderate

Book 24-hour follow up with Moderate Risk provider

Appendix 2: Moderate-Risk Algorithm

04.10.2020
Appendix 3: High-Risk Algorithm

Moderate-Risk Patients

Televist with provider

Concern for high-risk overall clinical picture?  
Yes → Move to High-Risk Management

No

Worsening Sx?  
Yes → Schedule in Respiratory Clinic

No

Schedule follow up calls (minimum days 4, 7)

Symptomatic and not improving at Day 7?  
No → Schedule Day 10 follow up

Symptomatic and not improving at Day 10?  
Yes → Continue follow up until improved

No → Discharge from COVID management
Appendix 4: Symptom Checklist

Ask the patient:

1. Do you have any new symptoms?
2. Do you have any symptoms that are worsening?

If yes, see chart:

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call 617-665-1978 for warm handoff to a nurse</td>
<td>Transfer to 617-665-1977</td>
<td>Send staff message to SAM COVID RN POOL</td>
</tr>
<tr>
<td>● Shortness of breath</td>
<td>Any other symptom, including (but not limited to):</td>
<td>Any other question that you are unable to answer but that is not about a physical symptom</td>
</tr>
<tr>
<td>● Trouble breathing</td>
<td>● Fever</td>
<td></td>
</tr>
<tr>
<td>● Wheezing</td>
<td>● Cough</td>
<td></td>
</tr>
<tr>
<td>● Chest pain</td>
<td>● Runny nose</td>
<td></td>
</tr>
<tr>
<td>● Chest tightness</td>
<td>● Sore throat</td>
<td></td>
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<tr>
<td></td>
<td>● Diarrhea</td>
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<td></td>
<td>● Headache</td>
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</tbody>
</table>

Appendix 5: Home Care Advice

The following is a script for providing home care advice.

“Hello, my name is [NAME] and I am calling from Cambridge Health Alliance. I understand that you have not been feeling well and I am calling to see how you are doing and to make sure I answer any questions about what you need to be doing during this time. If there are any questions I can’t answer, I will make sure to connect you to someone who can. Is now a good time to speak with you?”

- If yes, continue
- If no, ask patient when would be a good time to call back

“Because of the coronavirus epidemic, we are asking all patients with symptoms of coronavirus to stay home so that if they have coronavirus, we can help make sure that other people don’t catch it. Have you been able to stay home?”

- If yes, ask “Is it OK if I review with you what you should be doing at home?”
- If no, say “It is really important that you stay at home during the period when you might be contagious. Let me review what you to know.”
“Patients who might have coronavirus need to stay home for the entire time they might be contagious. This means that they should stay home for at least 7 days. They also need to stay home until they haven’t had a fever for 3 days, and until their other symptoms like cough are getting better. People with contagious symptoms, even if it’s not coronavirus, should not go to work, should not go to businesses like the grocery store or pharmacy, and should not take public transportation. What was your first day of symptoms?”

Based on the first day of symptoms, tell the patient: “So, the first day we would recommend leaving your house is [first day of symptoms + 7 days]. But, if you are still having fevers or other symptoms after 7 days, you will need to stay home longer. This is to make sure other people don’t get sick. It is also really important to not invite people over to your house.”

Next ask whether the patient lives alone. If the patient does live alone, skip to Symptom Check. If the patient lives with other people, continue:

“If anyone in your house has symptoms like yours or symptoms that you think might be coronavirus, please make sure that those people call their doctor.”

“It is really important that you separate yourself from other people in your house as much as possible, especially if they don’t already have symptoms or if they are older or have medical problems. This will decrease the risk that people in your house get sick. If you can, stay in a separate bedroom with the window open, and use a separate bathroom.”

“It is also really important to keep things clean. I want to go through a couple of things that everyone in your house, including you, should do:

- Wash hands frequently for at least 20 seconds with soap and water or alcohol-based sanitizer (soap and water preferred if hands visibly dirty).
- Cough or sneeze into a tissue, NOT your hand.
- Avoid touching your face/mouth/nose/eyes.
- Wear a facemask when sharing a room with other people.
- Do not share personal care items (brushes, etc.), kitchen items (dishes, cups, silverware), or linens (towels/bedding) with other household members; they should all be washed before reuse.
- Do not handle pets or other animals.
- Clean all “high-touch” surfaces every day (counters, table tops, doorknobs, bathroom fixtures like faucets, toilets, phones, bedside tables, lamps and lightswitches).”

“Next I want to talk about what the people in your house need to do to keep other people safe. Because they may have been exposed to coronavirus, they need to stay home so that other people don’t get sick. When people are exposed to something that may be coronavirus, we ask that they stay home for 14 days. This is because it can sometimes take up to 2 weeks for symptoms to appear. So, the people who live with you should stay home and not go to work or to places like the grocery store until [patient’s first day of symptoms + 14 days].”

04.10.2020
If the patient has any questions, review the points above.

### Appendix 6: SmartPhrases

<table>
<thead>
<tr>
<th>NAME</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>.COVIDCALL</td>
<td>For use by providers for first follow-up call</td>
</tr>
<tr>
<td>.COVIDCALLFU</td>
<td>For use by providers for subsequent follow-up calls</td>
</tr>
<tr>
<td>.COVIDPROBLEMLIST</td>
<td>For problem list Overview</td>
</tr>
<tr>
<td>.COVIDPROBLEMLIST2</td>
<td>For additional problem list information to be added by provider</td>
</tr>
<tr>
<td>.COVIDTRIAGE</td>
<td>For use by COVID Triage Center nurses for first call</td>
</tr>
<tr>
<td>.COVIDTRIAGEFU</td>
<td>For use by nurses for subsequent triage (patients with Suspected COVID already on Problem List)</td>
</tr>
<tr>
<td>.COVIDNEGMYCHART</td>
<td>Communication about negative results (in 4 languages)</td>
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<tr>
<td>.COVIDPOSMYCHART</td>
<td>Communication about positive results (in 4 languages)</td>
</tr>
<tr>
<td>.COVIDPOS</td>
<td>Telephone encounter documentation for positive results</td>
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<tr>
<td>.COVIDNEG</td>
<td>Telephone encounter documentation for negative results</td>
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