CAMBRIDGE HEALTH ALLIANCE COVID TELEPHONIC MANAGEMENT HANDBOOK

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Part I: Overview and Definitions

Principles of COVID Community Management:

This comprehensive management strategy for outpatients with COVID, guided by our understanding of the clinical features and course of this illness, provides comprehensive medical care to patients with suspected or confirmed COVID while simultaneously decreasing unnecessary use of hospital resources and mitigating the risk of continued community transmission. As COVID disproportionately affects populations with social determinants of illness risk factors, a core population served by CHA, this strategy provides value-based care that allows maximization of resources for vulnerable patient communities.

The COVID Community Management program is embedded in CHA's broader approach to clinical care during the COVID pandemic and guided by the following principles:

1. To save as many lives as possible for our patients and for the surrounding communities.
2. To provide excellent, coordinated, and integrated clinical care to all patients throughout the system.
3. To use human resources, medical supplies, and personal protective equipment (PPE) efficiently and appropriately and to avoid unnecessary use of emergency departments and hospitals.

The Community Management program is based on a clinical approach to outpatient COVID characterized by the following principles:

1. At this time in the state of Massachusetts, COVID cannot be excluded on the basis of clinical signs or symptoms alone, and that, conversely, it is important to avoid cognitive anchoring on COVID and missing other important disease processes.
2. There are risk factors that predispose patients to severe disease, and these risk factors should be used to guide how closely a patient is followed.
3. There are known "turning points" in the disease process when patients are more likely to develop new severe signs or symptoms, if they progress to severe disease.
4. In the outpatient setting, the manifestation of severe disease is pulmonary involvement.

Definition of suspected COVID:

In areas of high COVID activity, patients with suspected COVID should be managed as suspected COVID, whether they are tested or not. Decisions about testing are made separately and are based on system and regional testing strategies.

In areas of high activity, patients meet criteria for suspected COVID if they have any of the following:

Table 1: Inclusionary criteria for symptoms of COVID

- 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, including, among other things, headache, urinary symptoms, and back pain.. In the case of other unexplained symptoms, for instance unexplained rash, COVID may be an appropriate differential diagnosis.

Initial triage:

Initial triage is performed in a dedicated COVID Triage Center. Patients are triaged based on 1) need for urgent in-person evaluation; 2) severity of COVID-like symptoms; 3) level of risk for the development of severe disease, based principally, on initial triage, on medical comorbidities; and 3) need for testing. (See Part II.) Patients also enter the CHA COVID continuum of care by referral from their PCP, or after emergency department or inpatient discharge.

Risk stratification:

With respect to COVID, “risk” can refer to (1) risk of acquiring COVID, (2) risk of spreading COVID, and (3) risk of complicated disease from COVID. Because patients calling with symptoms already have presumably acquired COVID in areas of high activity, the focus in Community Management is on risk of serious illness and on risk of spread.

For individual patients, the decision to refer a patient to Community Management is based on **symptoms**. Patients presenting initially with fever, cough, or shortness of breath (“Cardinal Symptoms”) are referred to Community Management, while those with other symptoms of COVID but none of the three cardinal symptoms are not actively followed by Community Management, but are advised to call back in the event of development of new symptoms. The subsequent risk stratification of a patient within Community Management is based on comorbidities predisposing to a higher risk of **serious complications**.

Decisions to move patients from Primary Care to Community Management, and across risk levels within Community Management, are made based on protocol and clinical judgment. Patients who originally present without Cardinal Symptoms are not actively community

managed, but are referred to Community Management in the event of the development of such symptoms.

Table 2: Management of COVID by symptoms and risk of complications

	Risk of Complications		
	High Risk	Moderate Risk	Low Risk
Community Management	Provider-led management		Outreach Team
Primary Care	Outreach Team		PCP follow up and anticipatory guidance

Patients with Cardinal Symptoms of COVID will be triaged by COVID Triage Center nurses into three risk categories based on their comorbidities. 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, in addition to other factors if appropriate.

Table 3: Current risk criteria

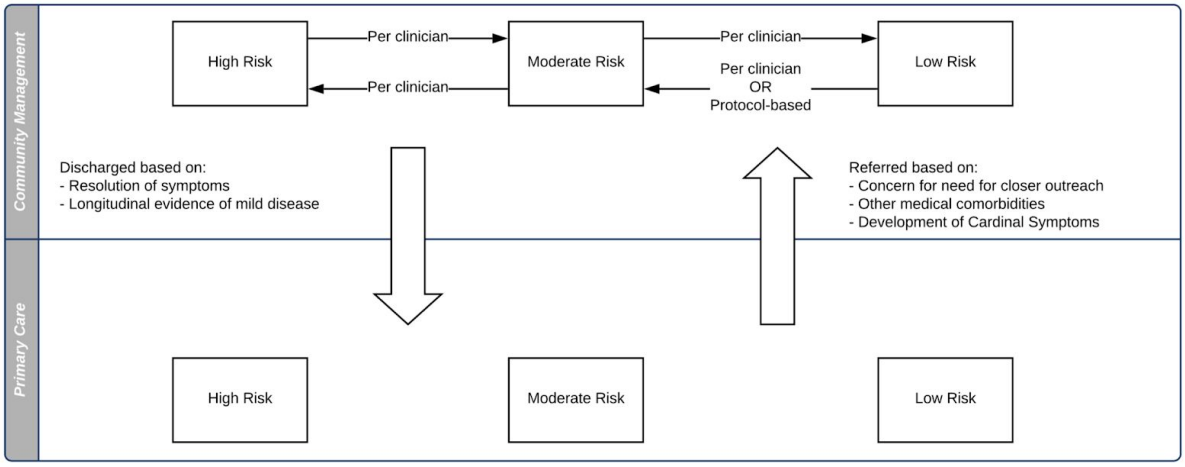
High Risk	Moderate Risk	Low Risk
• Adults ≥ 65 • Patients with current/active pulmonary disease (asthma, COPD, ILD, bronchiectasis, CF, OSA etc.) • Patients with heart disease (congenital heart disease, coronary artery disease, heart failure) • Diabetes • HTN • BMI ≥ 40	• Age < 1 year • CKD or ESRD • Cirrhosis • Neurodevelopmental or neurological disease (prior stroke, spinal cord injury, ALS, multiple sclerosis, muscular dystrophy), dementia/cognitive impairment • Pregnancy • Immunosuppressed patients (patients with active cancer, solid organ transplant, immunosuppressive medications, HIV) • Patients identifying as black or Hispanic/Latinx • Smoking	All other patients

Respiratory Clinic and Management providers, as well as PCPs, 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. PCPs, who often know the patient best, can also refer patients to Community Management if they feel coordinated outreach is appropriate for that patient. Finally, patients previously triaged who call back with new symptoms can be re-triaged to a different group based on new information.

Risk-based management:

Table 4: Risk-based approach to COVID



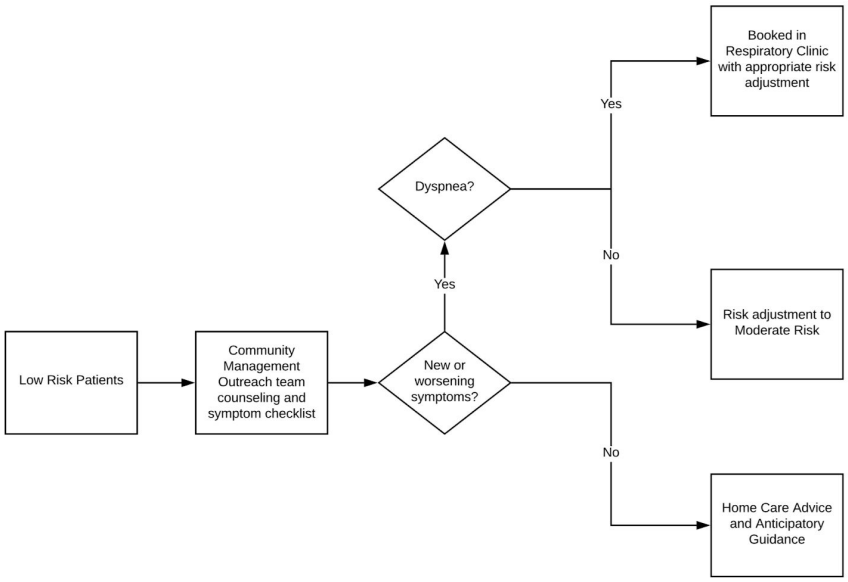
Patients without Cardinal Symptoms:

The understanding of the classical clinical course of COVID, including the development of respiratory symptoms at approximately Day 4-7, with a second potential turning point at days 9-12, drives the initial triage of patients with COVID-like symptoms. Patients without fever, cough, or shortness of breath are provided with Home Care Advice (see Appendix 5) and anticipatory guidance about the course of disease and reasons for seeking care. Any patient in this group who develops Cardinal Symptoms is re-triaged and referred to the appropriate Community Management group.

Low-risk patients:

Patients at low risk for complications from COVID but with Cardinal Symptoms and, conversely, patients at high risk for complications but with mild symptoms (e.g. isolated anosmia) are referred to the Community Management outreach pool for a one-time initial outreach by the MA team focused principally on self-isolation and self-quarantine counseling (see Part IV and Appendix V). At the time of this outreach call, patients are also administered a symptom checklist; if they have new or worsening symptoms, they are referred to the Triage Center, and upgraded to Moderate Risk.

Table 5: Low-risk algorithm



Moderate-risk patients:

Moderate patients are managed by the providers of the Moderate-Risk Team. At the initial televisit at 48 hours after initial triage phone call, providers perform an initial assessment and determine whether the patient has been appropriately risk-stratified. Patients are managed until Day 7 at a minimum. If improved at Day 7 and thought to be clinically stable and reliable for follow up, they are discharged from COVID Management; if still symptomatic, they will be managed at a minimum until Day 10. Patients can be “upgraded” from moderate risk to high risk based on additional factors as assessed by the risk manager. (See Appendix 2.)

High-risk patients:

High-risk patients will be managed by the providers of the High-Risk Team. At the initial televisit at 48 hours after initial triage phone call, providers will do an initial assessment and determine whether the patient has been appropriately risk-stratified. Patients are managed until Day 7 at a minimum. If improved at Day 7 and thought to be clinically stable and reliable for follow up, they are discharged from COVID Management; if still symptomatic, they will be managed at a minimum until Day 14. (See Appendix 3.)

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 are also triaged to Respiratory Clinic during the initial call.

If a patient is triaged to Respiratory Clinic on the initial call, he or she is 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 re-evaluates 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.

Testing and Results Management:

Testing is managed independently of symptoms and management of risk for severe disease. In the outpatient setting, as individual isolated negative test results should not be interpreted as absence of disease particularly in an area with high disease burden and a positive result does not change management, as there are no goal-directed therapies used in the outpatient setting, except in isolated cases (e.g. peripartum management). The CHA criteria for testing are based principally on conserving testing for patients at highest risk for severe disease and who might require hospitalization. Additionally, testing is available to patients at high risk for contracting and communicating disease, including health care workers (see Table 6).

Results are communicated by the Results Team, though results of patients enrolled in Community Management can also be communicated by the appropriate risk manager. The results communication call is an additional opportunity to provide guidance and counseling to patients about self-isolation and self-quarantine *regardless of the test result, given the test characteristics*. In the case of a positive result, patients are also counseled about clinical course and specifically anticipatory guidance related to development of pulmonary complications.

Table 6: Criteria for testing

1. Must have new fever, cough, or new or worsening shortness of breath **AND**
2. Be CHA patients **AND**
3. Be over the age of 18 **AND**
4. Must meet at least one of the following criteria (in any subgroup):
   a. Special populations:
      i. Health care workers including employees of group homes and nursing homes
      ii. First responders
      iii. People experiencing homelessness
   b. Risk factors for complications and hospitalization:
      i. Adults $\geq$ 65

ii. Patients with pulmonary disease (asthma, COPD, ILD, bronchiectasis, CF, etc.)
iii. Immunosuppressed patients (patients with active cancer, solid organ transplant, immunosuppressive medications, HIV)
iv. Patients with heart disease (congenital heart disease, coronary artery disease, heart failure)
v. Patients with diabetes, CKD or ESRD, HTN, or cirrhosis
vi. Patients with sickle cell disease
vii. Morbidly obese patients (BMI $\geq$ 40)
viii. Patients with neurodevelopmental or neurological disease (prior stroke, spinal cord injury, ALS, multiple sclerosis, muscular dystrophy)
ix. Patients with cognitive impairment or dementia
x. Pregnant women (note: pregnant women under age 18 should also be tested)

Use of the Problem List:

CHA uses the EPIC electronic medical record (EMR). We use the Problem List feature to log all information about the patient throughout the course of illness. On initial call, the Triage Center nurses create a “Suspected COVID” problem and input the initial risk assessment, first day of symptoms, and need for testing. At all subsequent “touches,” the Problem List is updated with new clinical information. (See Appendix 4.)

Part II: COVID Triage Center Guidelines

Patients calling for the first time about symptoms of COVID are preferentially evaluated by nurses in the COVID Triage Center. These nurses are supported by an administrative team and a dedicated Triage Center provider. Patients with preexisting COVID or suspected COVID are also preferentially triaged through the Triage Center. On these contacts, patients may be referred for in-person evaluation in Respiratory Clinic, or may have their risk status adjusted by clinicians or per protocol.

Initial call:

Patients calling the Triage Center for COVID-like symptoms for the first time will be evaluated for symptoms consistent with COVID, need for in-person evaluation, determination of the risk level for disease, and need for testing. As noted above, testing criteria are discussed elsewhere and do not, in the vast majority of cases, affect management. The following are components of the initial evaluation:

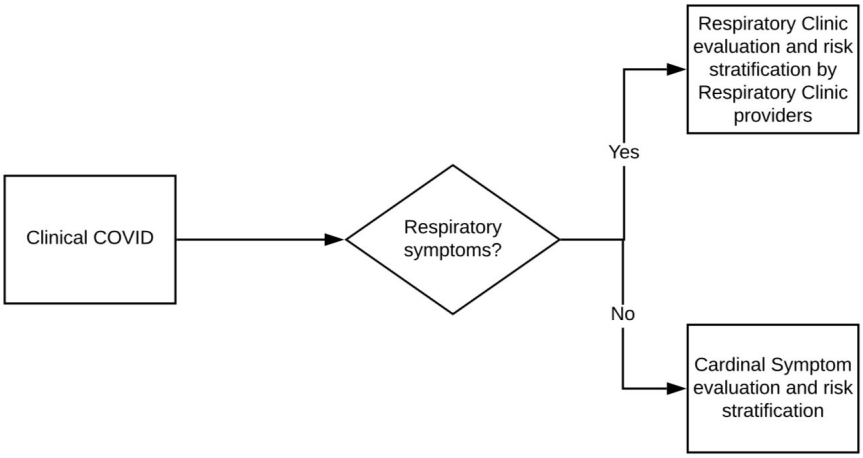
1. Does the patient have symptoms of clinical COVID (see Table 1)?
2. Does the patient have Cardinal Symptoms (fever/cough/SOB) of COVID requiring referral to Community Management?
3. What is the patient's risk level for complicated disease (see Table 3)?
4. Does the patient require in-person evaluation (Table 7)?
5. Does the patient require testing?

Table 7: Indications for in-person evaluation

1.	Does the patient have underlying heart failure or pulmonary disease and is the patient experiencing respiratory symptoms?
2.	Does the patient have fever or cough and underlying pulmonary disease (asthma, COPD, ILD, bronchiectasis, cystic fibrosis)?
3.	Does the patient have shortness of breath and is the patient on Day 4 or later of COVID symptoms?
4.	Is the patient using more O2 than at baseline or using inhalers more often without benefit?
5.	Does the patient have other symptoms necessitating in-person evaluation?

All patients not requiring urgent in-person evaluation are further triaged to determine risk level. All patients with Cardinal Symptoms are referred for Community Management based on attributed risk level, with moderate- and high-risk patients referred to the risk management providers and low-risk patients referred to the Outreach Team. Additionally, patients who are moderate- or high-risk for severe disease but without Cardinal Symptoms are referred to the Outreach program within Community Management for a minimum one-time outreach.

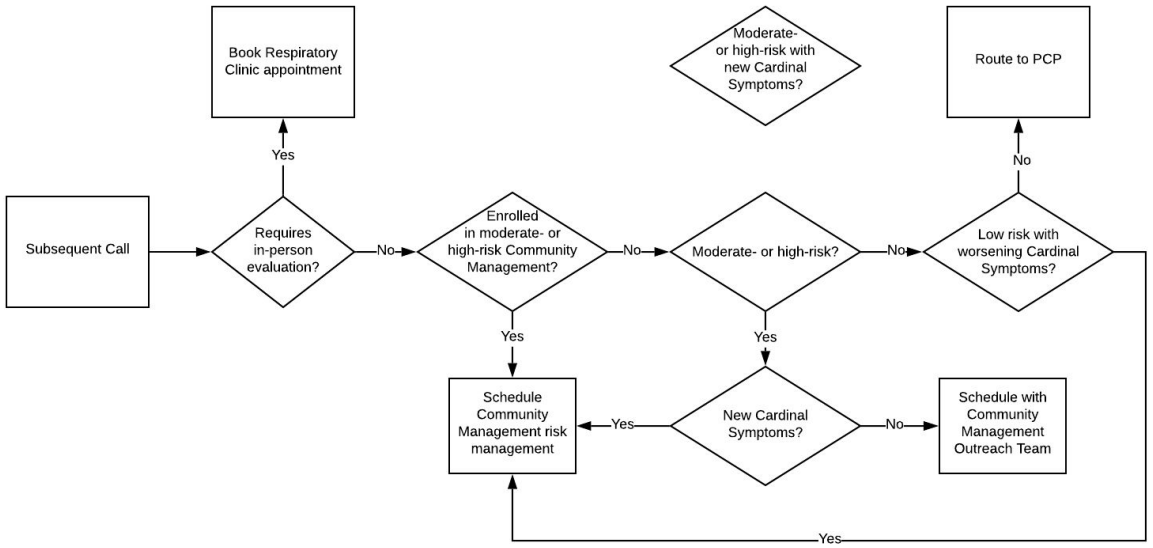
Table 8: Initial triage workflow



Subsequent calls:

Patients who call the Triage Center after an initial evaluation typically call because they are experiencing new or worsening symptoms. In this case, patients are re-evaluated for need for in person evaluation first. If in-person evaluation is not needed, those already enrolled in high- or moderate-risk community management are routed to the appropriate risk management team. Patients who previously did not have Cardinal symptoms are routed for enrollment in Community Management based on risk level. Moderate- and high-risk patients still without Cardinal Symptoms are re-referred to the Outreach Team. Finally, patients who were previously managed as low risk based on the presence of Cardinal Symptoms and a low risk profile are upgraded to moderate risk if they report persistent or worsening symptoms.

Table 9: Subsequent call workflow



Testing:

Decisions to refer to Community Management are based on the above criteria and are independent of CHA criteria for testing, though there is extensive overlap in the two groups. Criteria for testing are addressed in Table 6.

Part III: Management Guidelines for Community Management Providers

The management of patients triaged as high- or moderate- risk is guided by the principles of 1) continuity, with attempts made to have the patient follow with the same provider throughout the clinical course; 2) a focus on management responsive to the classic clinical course of COVID, and notably turning points at days 4-7 and 9-12 of disease; 3) a focus on pulmonary involvement as the outpatient manifestation of progression to severe disease; and 4) the need to provide comprehensive care including seamless referral for in-person evaluation, if warranted, focus on anticipatory goals of care discussions, and referral to additional resources as needed.

Providers have initial televisits scheduled with patients either: 1) on Day 4 of symptoms; 2) if past Day 4 at the time of initial call, 48 hours after initial triage call; or 3) 24 hours after Respiratory Clinic evaluation. Follow up visits are based on a general framework of “touches” at a minimum at days 4, 7, and 10, but additional follow up is often much more frequent and deferred to the clinical judgment of the risk manager.

Initial phone contact:

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:

On each call, pr 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.

Evaluation of dyspnea:

Evaluation of dyspnea focuses on:

1. Subjective assessment of breathing.
2. Objective assessment of breathing.
3. Roth score, if appropriate.

Table 10: Evaluation of dyspnea

Subjective evaluation of dyspnea:

- "How is your breathing today?"
- "Do you feel short of breath?"
- "Describe your breathing."
- "What makes your breathing better or worse?"

- Do you feel short of breath:
    - Walking?
    - Walking up stairs?
    - Lying down?
    - Eating?
    - At rest?

- Is there anything that makes your breathing feel better?
    - Resting?
    - Lying on stomach?
    - Inhalers?

Objective evaluation of dyspnea:

Objective evaluation:
- Can the patient speak in complete sentences?
- Does the patient sound short of breath?

Assessment of respiratory capacity:
- "Where are you spending most of your time?" [in bed, in a chair, etc.]
- "Can you walk to the bathroom?"
- "Can you walk up a flight of stairs without stopping to catch your breath?"
- "Please walk across the room and speak to me as you walk."

Change in respiratory function:
- "How far could you walk yesterday without stopping to take a breath?"
- "What did you do yesterday during the day? What did you do today?"

Use of the Roth score:

In patients with obvious moderate or severe dyspnea, or patients in whom there has been a change in respiratory status, the Roth score does not need to be performed; these patients should be evaluated in person. Patients with access to oximetry also do not require Roth score evaluation. In patients with an equivocal history or in whom there is no obvious respiratory component, the Roth score can help to elicit respiratory involvement that was not otherwise identified.

Table 11: Roth score

- Instructions:
  - *Patient instructions:* Take a breath in and count as fast as you can in your native language. Count until 30 or until you have to take a breath.
  - *Clinician:* Time # seconds to reach 30 or until the patient must take a breath. Also record maximum number reached.
- Interpretation:
  - If counting # < 10, suspect possible hypoxemia
  - If counting time < 7, suspect possible hypoxemia

Any patient with features of subjective or objective will be scheduled in Respiratory Clinic. For patients in whom the Roth test suggests SpO2 < 95%, patients will be referred to 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. (See appendices 2 and 3.)

Table 12: Follow up

Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
			***			*** STOP*			*** STOP**				STOP***

*** 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, for instance in the case of possible comorbid or independent bronchospastic disease exacerbation, the patient should be booked in Respiratory Clinic. 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.

Risk group transitions:

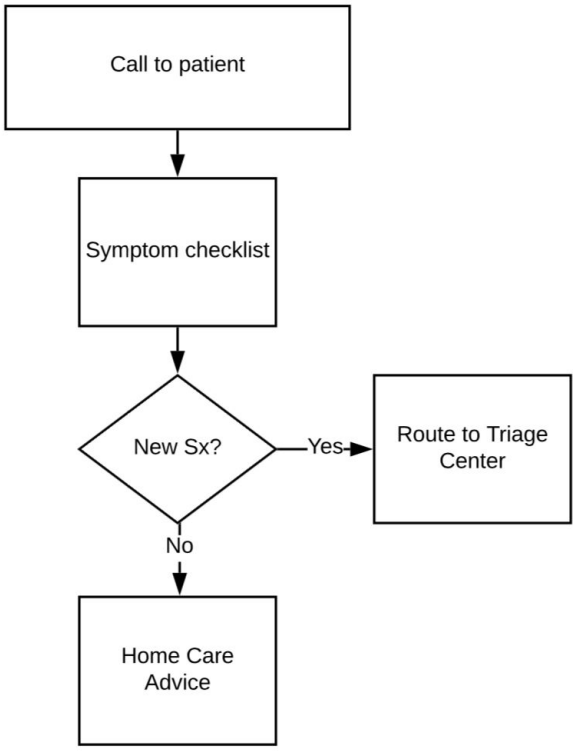
Patients transition into Community Management if and when they develop Cardinal Symptoms of COVID. Patients are also transitioned to the moderate risk group from the low risk group if they have an initial outreach from the Outreach Team and subsequently call with worsening symptoms. Additionally, risk managers and respiratory clinic staff use clinical judgment to inform risk level transitions based on the following criteria, and clinical judgment:

- Advanced symptomatology warranting transition to high risk group for patients otherwise triaged to low or moderate risk
- Social or other factors necessitating frequent outreach
- Particularly severe comorbidities requiring risk group upgrade (e.g. uncontrolled diabetes requiring transition to high risk group) or, conversely, particularly mild comorbidities suggesting little clinical impact (e.g. diet-controlled diabetes)

Part VII: Outreach Team Guidelines

Outreach Team members are responsible for reaching out to patients and reiterating advice about self-isolation and self-quarantine (see Appendix 5), as well as running the Symptom Checklist with patients. All patients who are low risk with Cardinal Symptoms or moderate- or high-risk without Cardinal Symptoms are referred to the outreach team. The outreach calls occur at 48 hours after initial triage. Any concerning findings on the Symptom Checklist are escalated back to the COVID Triage Center for re-triage. 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.

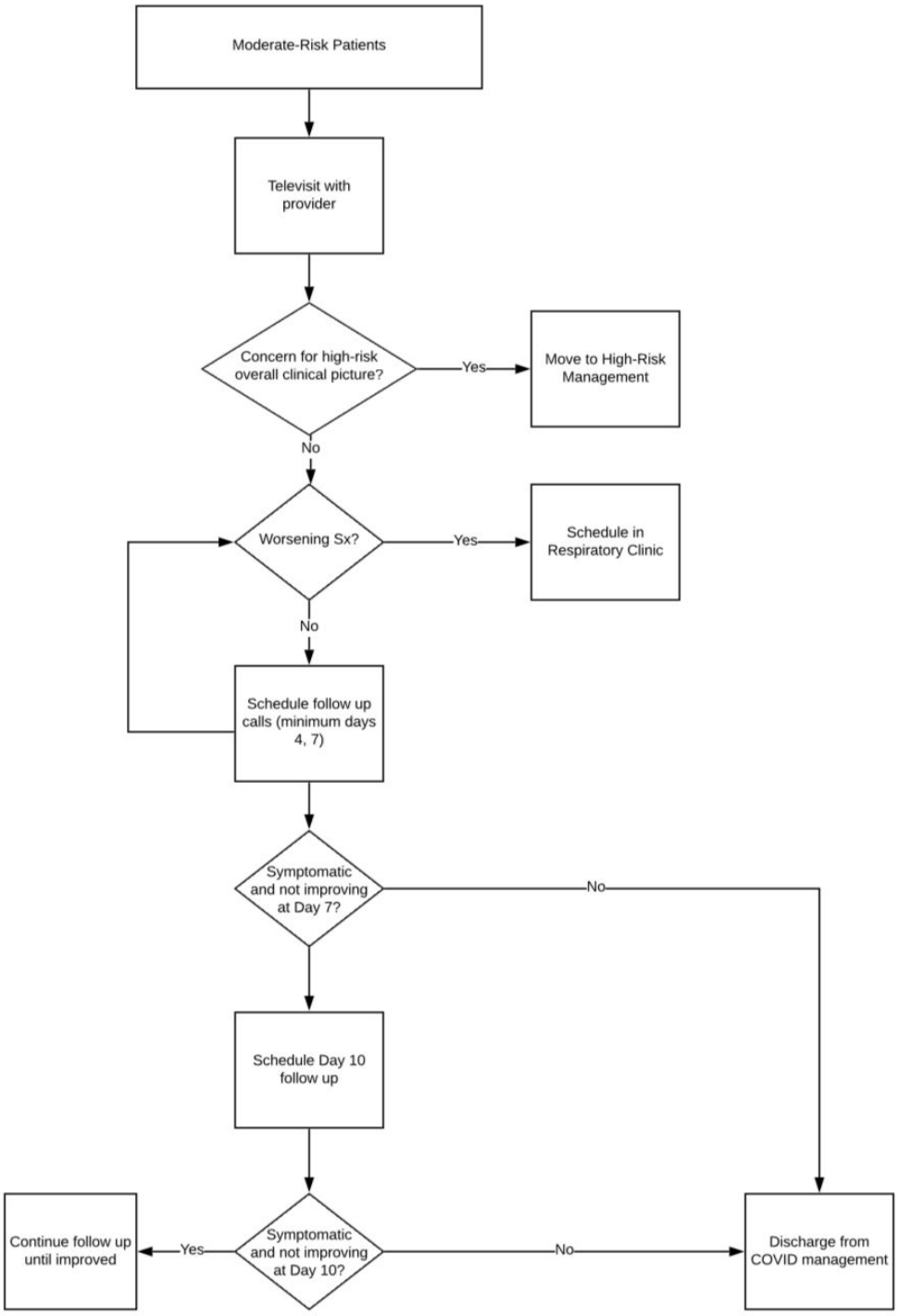
Table 13: Outreach Team Workflow



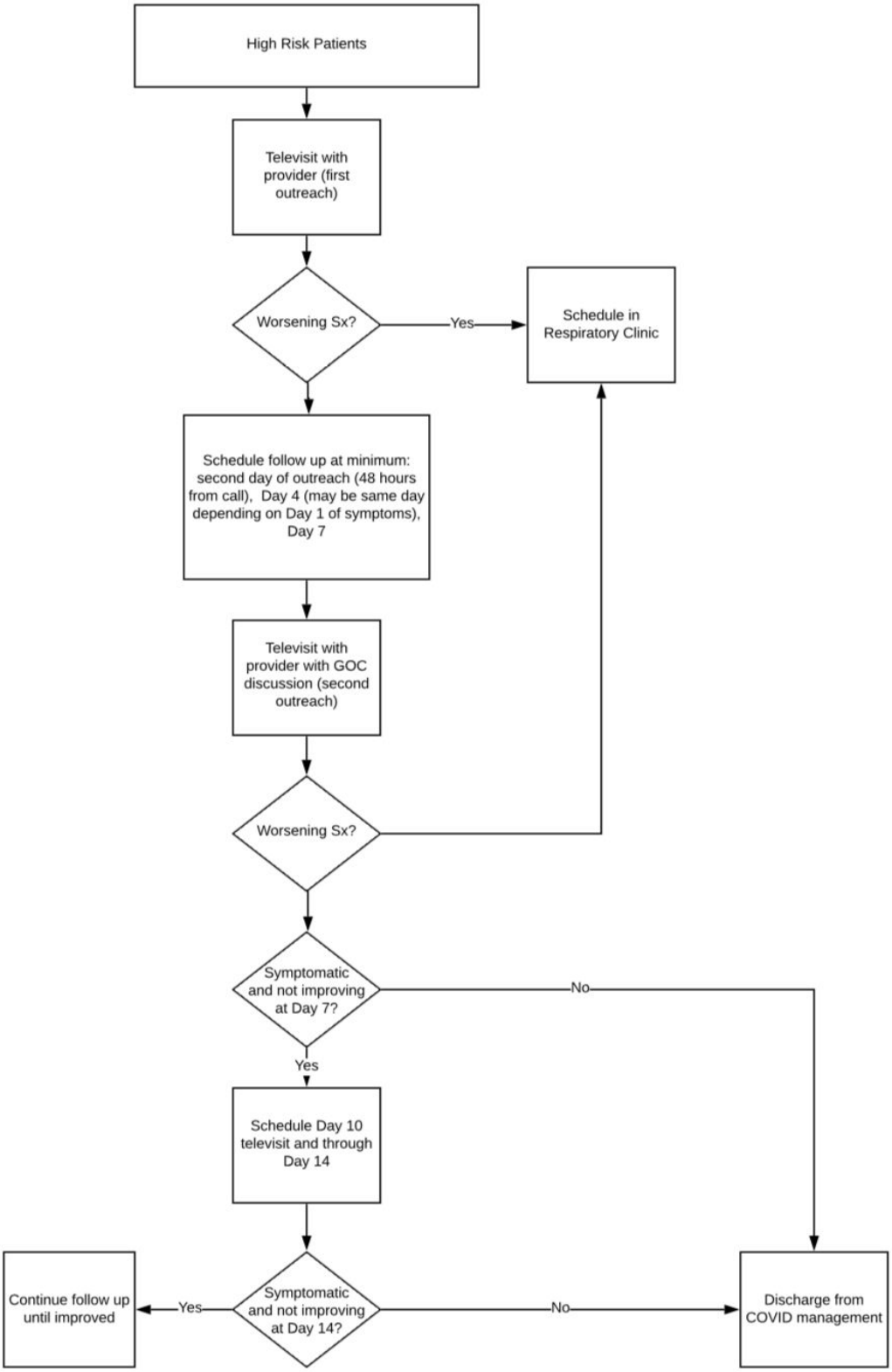
APPENDICES

Appendix 1: Overview

Appendix 2: Moderate-Risk Algorithm



Appendix 3: High-Risk Algorithm



Appendix 4:

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.

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:

Table 14: Problem List content

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**.

Table 15: Example Problem List

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

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, tabletops, 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].

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