



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

COVID-19 Outpatient Triage and Assessment Guidance

March 23, 2020 (replaces version dated March 16th, 2020)

This memo updates previous guidance shared on March 16th, 2020. It is intended to provide the latest information to all North Carolina outpatient facility types, including urgent care, primary care and other outpatient settings. Please read thoroughly as there are several updates, including:

- Changes in testing recommendations: **People with mild symptoms consistent with COVID-19 do NOT need testing and should be instructed to stay at home to recover.** Mild symptoms defined as fever and cough without shortness of breath, difficulty breathing, chest discomfort, altered thinking, cyanosis
- Steps for outpatient settings to assess and triage of suspected COVID-19 patients
- Updated categories of persons at higher risk for severe illness

North Carolina's response to COVID-19 will continue to rapidly evolve. The most up to date information and guidance can be found at <https://www.cdc.gov/coronavirus/2019-ncov/index.html> and <https://www.ncdhhs.gov/divisions/public-health/coronavirus-disease-2019-covid-19-response-north-carolina>.

Background:

The respiratory disease named "coronavirus disease 2019" (abbreviated "COVID-19"), caused by a novel coronavirus named "SARS-CoV-2", was declared a pandemic by the World Health Organization on March 11, 2020.

North Carolina now has laboratory confirmation of community transmission of COVID-19. Therefore, we are moving to a different phase of our response efforts and will be further increasing our population-based community mitigation strategies. The goal of mitigation is to decrease acceleration of spread of the virus among our population – especially for those who are at highest risk of clinical severity, and our health care workers – so fewer people need medical care at the same. In addition, we need to implement strategies to conserve supplies and capacity so our health care workers can care for people who need medical attention.

Why are recommending this change:

To decrease acceleration of spread in community and exposures in healthcare settings

1. People infected with SAR-COV-2 (virus causing the disease COVID-19) coming out to be tested may spread illness to others in the community, including those at higher risk of complications, and health care workers.
2. People who are not infected with SAR-COV-2 can become so when seeking testing, especially at health care sites.

To preserve resources

1. Personal Protective Equipment and supplies will be needed for outbreaks in high-risk settings (e.g. long-term care), to protect frontline workers (e.g. health care workers, first responders), and to care for people with more severe clinical symptoms.

No impact on management for most people

1. For those with mild symptoms, treatment is supportive and focused on symptom management.
2. A test will not change management.

Alternative surveillance tools can be used to track the spread of COVID-19

1. Tracking only lab-confirmed cases is not a reliable or accurate way to understand the pandemic.
2. We will use influenza flu surveillance tools, which are designed to track widespread respiratory illness.

How should an outpatient setting approach the assessment and triage of suspected COVID-19 patients?

Triage patients to meet demand

1. Use your telephone system to deliver messages to incoming callers about when to seek medical care at your facility and when to seek emergency care. Include messages such as “Please let us know if you have flu like illness or are having other respiratory symptoms,” so patients are prompted to share this information.
2. Maximize phone triage, visit prioritization, and telehealth visits to decrease demand on your systems and decrease potential exposure of patients in a health care setting.
 1. Identify essential and priority on-site appointments
 2. Consider converting non-essential on-site appointments, such as prescriptions refills or routine follow-up for chronic care to remote using telehealth services, such as telephone or video
 3. Decrease non urgent appointments to increase capacity for priority on-site appointments

Use telehealth for symptom assessment and management

1. Clinicians should encourage their patients to call if they have medical concerns before seeking care in-person. Clinicians should use, to the extent possible, telehealth/televideo and telephone triage to assess clinical status of patients with respiratory illnesses. Telehealth/televideo and telephone triage are critical tools to allow patients with mild symptoms to have safe access to appropriate assessment, clinical guidance and follow up, and self-care information, while preventing further spread of COVID-19 or exposing patients to COVID-19 in a medical setting. Telehealth is broadly being covered at parity for most patients with private insurance, Medicare and Medicaid and therefore should be used whenever clinically appropriate in lieu of face-to-face encounters.
2. Clinicians should use their judgment to determine if a patient has mild signs and symptoms compatible with COVID-19 (e.g., fever and cough) or more severe symptoms requiring in-person medical care (e.g. shortness of breath, difficulty breathing, chest discomfort, altered thinking, cyanosis).
3. **In general, patients who have mild symptoms consistent with COVID-19, do not need testing for COVID-19 and should be instructed to stay and recover at home.** This change in management strategy is consistent with [guidance](#) from the Centers for Disease Control and Prevention.
4. Patients should be counseled to call if they have worsening signs or symptoms of respiratory illness (e.g. increasing fever, shortness of breathing, breathing difficulty, chest discomfort, altered thinking, cyanosis).

5. Patients in [high risk categories for clinical severity](#) (e.g., 65 year and older, chronic lung disease or moderate to severe asthma, heart disease, severe obesity BMI \geq 40, other underlying poorly controlled chronic health conditions such as diabetes, renal failure, liver disease, and immunocompromised) should have more frequent follow up to assess clinical status. Pregnant women should be monitored closely as they are known to be at risk with severe viral illness, however, to date data on COVID-19 has not shown increased risk. While children are generally at lower risk for severe illness, some studies indicate a higher risk among infants.
6. **Escalating medical care should occur if symptoms worsen.**
7. Patients who have mild symptoms consistent with COVID-19 should self-isolate for at least 7 days from symptom onset **and** \geq 72 hours after recovery (absence of fever without the use of fever-reducing medication and improvement in respiratory symptoms). Notably, patients with clinical COVID-19 infection do NOT need a negative COVID-19 test result to document recovery, if they meet the clinical criteria.
8. Household close contacts of a patients with mild symptoms who is self-isolating at home should self-monitor their temperature and symptoms of COVID-19, limit outside interaction as much as possible for 14 days, and self-isolate if they develop symptoms.

Use administrative, engineering, and personal protective equipment controls to increase safety of care for patients who do need medical attention

1. When scheduling non-urgent appointments for someone with respiratory illness, try and schedule at a time that may be less busy (e.g., beginning of the day or end of the day) and flag that the patients has flu-like symptoms, so they are identified ahead of time.
2. Post signs on the door of your practice instructing patients to alert practice staff if they have respiratory symptoms as soon as they arrive.
3. Have face masks readily available for patients with respiratory symptoms and have them put a mask on as soon as possible.
4. **Separate patients with respiratory symptoms, so they are not waiting among other patients seeking care.** If possible, identify a separate, well-ventilated space that allows waiting patients and visitors to be separated. Minimize time in waiting room.
5. Front desk and triage personnel should use physical barriers (such as windows) when possible or maintain spatial distance of 6 ft from patient with respiratory illness. No specific personal protective equipment is required for these staff members.
6. Isolate the patient in a private room or a separate area as soon as possible.
7. Consider setting up areas of the clinic just for evaluation and testing of respiratory illness and a dedicated care team of lower risk providers.
8. If practices are part of a multi-site system, consider designating alternate evaluation and sample collection sites to reduce exposure for staff and patients seeking onsite care.
9. Wipe down surfaces with EPA registered disinfectant effective against coronaviruses.
10. Clinicians should consider routine use of face masks and gloves for all patient interactions, if supplies are sufficient. Clinicians should wear respiratory protection for interview and examination of patients with respiratory illnesses. Either surgical mask or N-95 respirator are appropriate.
11. If an aerosol-generating procedure is performed in a non-Airborne Infection Isolation Room (AIIR) for a patient with known or suspected COVID-19, leave the clinic room empty for 2 hours before next use. If there is a window, it can be opened to air out the room, decreasing the 2-hour time frame.

Testing of patients who do need medical attention

1. Testing to detect COVID-19 is available through commercial and health system labs and the North Carolina State Laboratory of Public Health (NCSLPH). Identify which lab you will send samples to and order the supplies needed for your lab of choice.
2. Clinicians should determine if COVID-19 testing is clinically indicated. Testing should **not** be done for asymptomatic persons. In general, patients with mild illness (defined above) do not need testing. Clinicians should use their clinical judgement on who needs to be tested and focus testing on higher risk patients and settings, including patients with more severe respiratory symptoms, patients for whom clinical management would be different if they were infected with COVID-19, patients in high-risk settings (e.g., congregate care settings, long term care), health care workers and first responders with direct patient contact.
3. For patients who have more significant symptoms and do need medical attention, clinicians are strongly encouraged to also consider and test for other causes of respiratory illness, including infections such as influenza.
4. Testing is available through the North Carolina State Laboratory of Public Health (NCSLPH with prior **approval** from either the local health department where the provider is located, or the State Epidemiologists on call (919-733-3419, available 24/7) prior to submitting a sample for testing for COVID-19. Patients must meet at least the following criteria for a Person Under Investigation (PUI) to be considered for testing at NCSLPH:
 - a. Fever¹ OR signs/symptoms of lower respiratory illness (e.g., cough, shortness of breath) in any person, including healthcare workers², who has had close contact³ with a laboratory-confirmed⁴ COVID-19 patient within 14 days of symptom onset.
 - b. Fever¹ AND signs/symptoms of lower respiratory illness (e.g., cough, shortness of breath) AND negative influenza test (rapid or PCR) and no other more likely diagnosis.
5. Commercial and health system-based laboratory testing is also now available. Prior authorization from the state is **not** required for commercial and health system laboratory testing.
6. Clinicians should use personal protective equipment for nasopharyngeal sample collection: Gown, Gloves, Facemask OR N-95 respirator* (*dependent on supply), Eye protection (e.g., goggles or face shield). [Click here or updated PPE guidance.](#)
7. Clinicians should use N-95s as respiratory protection for aerosol-generating procedures including (but are not limited to) nebulizer treatment, sputum induction, airway suctioning, endotracheal intubation, bronchoscopy, positive pressure ventilation (BiPAP, CPAP), and tracheostomy care. Aerosol-generating procedures should be conducted in a negative pressure (e.g., AIIR) if available.
8. If you have a sufficient supply of swabs, consider collecting rapid flu sample and COVID-19 sample at some time. If rapid flu is negative, COVID-19 sample can be sent without redonning personal protective equipment.
9. Clinicians should do sample collection and submission for COVID-19 as specified by the laboratory to where they will be sending samples.
10. For the State Laboratory of Public Health (more details at this [site](#))
 - a. Supplies needed are:
 - i. Synthetic fiber swabs with plastic or metal shafts. Do not use calcium alginate swabs or swabs with wooden shafts, as they may contain substances that inactivate some viruses and inhibit PCR testing.
 - ii. Any commercial viral transport media/universal transport media in sterile vial. Alternative transport [media](#) (e.g., saline) may be possible and are being evaluated.
 - b. Sample collection instructions include:
 - i. Only a nasopharyngeal swab should be collected.

- ii. To collect the nasopharyngeal specimen, place the swab into the nostril parallel to the palate until resistance is encountered. Leave the swab in place for a few seconds to absorb secretions. Slowly remove swab while rotating it. Place the tip into a vial of sterile viral transport medium. Aseptically cut off the applicator stick so that it does not protrude above the rim of the tube and cap. **LABEL THE VIAL: NP swab with 2 unique identifiers** (i.e. patient's name and date of birth) and date of collection.
 - iii. Store specimens at 2-8°C for up to 72 hours following collection. If longer storage is required, store at -70°C.
11. For sites that do not have capability to do sample collection at their site, contact healthcare networks in your area or your local health department to identify available sample collection sites in your areas. If you are unable to determine how to provide alternative sample collection sites for your patients, you may reach out to ncresponse@dhhs.nc.gov for assistance with identifying options.

Once a patient has a sample collected

1. Individuals will be considered a Person Under Investigation.
2. **Effective February 3, 2020, physicians and laboratories in North Carolina are required to immediately report when a patient is tested for SARS-CoV-2 infection.** Submit information on tested patients to local health department for the county of residence of the patient.
3. Providers should give the [Person Under Investigation Guidance \(Spanish\)](#) to all patients undergoing testing and ensure patients are aware that they are expected to stay in isolation until results are back and longer if they are positive.
4. Submitters will receive results and should inform patients of result. Isolation can be discontinued if the test is negative. If the test is positive, the patient should remain isolated until the following criteria are met:
 - o 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 7 days have passed *since symptoms first appeared*.
5. Further isolation may be done in coordination with the local health department.

Treatment

1. At this time, no vaccine for COVID-19 is available and no specific treatment for COVID-19 is approved by the FDA. NCDHHS does not recommend use of unproven pharmacologic agents at this time. Care is supportive.
2. Corticosteroids should be avoided unless indicated for other reasons (for example, chronic obstructive pulmonary disease exacerbation or septic shock).

Personal Protective Equipment

1. The state is aware of potential supply chain disruptions for personal protection equipment.
2. Use Strategies for Preservation and Management of Scarce Medical Resources.
 - [Strategies for Scarce Resource Situations](#) (March 13, 2020)
 - [NC Healthcare Supply Conservation Considerations](#) (Feb. 27, 2020)
 - [DOL Interim Guidance on COVID-19 Use of Filtering Facepiece Respirators After Their Expiration Date](#) (March 13, 2020)

3. The state is working on a plan to get some supplies of personal protective equipment to outpatient providers through local emergency management. We hope to have the ability to do this soon and will alert providers when it is in place. When available, you can contact your local emergency management through your local Health Care Preparedness Coalitions - <https://nhealthcarecoalitions.org/>, at the website of County emergency management - <https://www.ncdps.gov/Emergency-Management/EM-Community/Directories/Counties>, or call 2-1-1.

All primary care providers have a role to play in assessing patients with COVID-19 concerns. In general, most patients with mild illness do not need to be tested. If you are unable to perform assessments or collect specimens in your setting for patients for whom testing may be indicated, please work with your healthcare system or with your local health department ncresponse@dhhs.nc.gov to identify appropriate options. **Patients seeking medical care should NOT be referred to NC COVID-19 Call Center or the Communicable Disease Branch epidemiologist on-call line.** The Call Center line is intended to provide general information and the epidemiologist on-call line is intended for clinicians and local health departments needing consultation.

For more information

1. NCDPH coronavirus website: www.ncdhhs.gov/divisions/public-health/coronavirus-disease-2019-covid-19-response-north-carolina.
2. NC DHHS Guidance for all health care providers
<https://www.ncdhhs.gov/divisions/public-health/coronavirus-disease-2019-covid-19-response-north-carolina/covid-19-guidance#all-guidance-for-health-care-providers-and-local-health-departments>

<https://www.ncdhhs.gov/divisions/public-health/coronavirus-disease-2019-covid-19-response-north-carolina/health-care>
3. FDA website and [FAQ](#)
4. CDC website on health care facility preparedness <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/steps-to-prepare.html>.