UMassMemorial Health Care

COVID-19 Clinical Care Council

Management of Hospitalized Persons Under Investigation for COVID-19

Version 10/23/20

Our understanding of the diagnosis and management of COVID-19 is evolving rapidly but is still incomplete. We continue to review and update our management protocols on a regular basis.

The current UMMHC infection control protocol for management of COVID-19 exceeds the CDC and WHO guidelines.

As we have an increasing number of patients hospitalized for concern of possible COVID-19 infection (also known as persons under investigation for COVID-19, PUI) we have found that there are a subset of patients who have a clinical illness that is worrisome for COVID-19 disease, but have had one, and occasionally two, negative COVID-19 PCR tests. No laboratory test is ever 100% accurate in making a diagnosis, and for certain infections such as pulmonary tuberculosis, we need to perform multiple tests to confirm a diagnosis. In addition, there are other conditions such as unstable angina that are diagnosed based on a clinical syndrome even in the absence of diagnostic testing. As COVID-19 PCR test can detect very low quantities of virus, in most patients a single negative test is enough to rule out COVID-19 infection; and patients with two negative tests are even less likely to have infection.

However, there remains a small group of individuals who have clinical findings highly worrisome for COVID-19 disease, and it is not always possible to exclude the possibility that these individuals actually have true infection with a low viral load in their upper airway. In this situation a formal ID consultation is recommended to assess these individuals. In addition, these individuals will continue to be managed using strict airborne/contact precautions. Given the likely low upper airway viral load, these individuals should be at lower risk of transmitting the virus to other individuals; and if the supply of negative pressure rooms is exhausted these patients would preferentially be transitioned to a standard private room.

Data from UMMHC in over 5000 symptomatic patients tested for COVID-19, showed repeat testing was triggered in 367 patients who initially tested negative. Of repeat tests performed within 3 days of initial test (including tracheal aspirates), only 4 (1.5%) returned positive on the second test. These 4 patients were thought to be early in disease and had a strong history suggesting exposure to a case. This supports the strategy outlined below.

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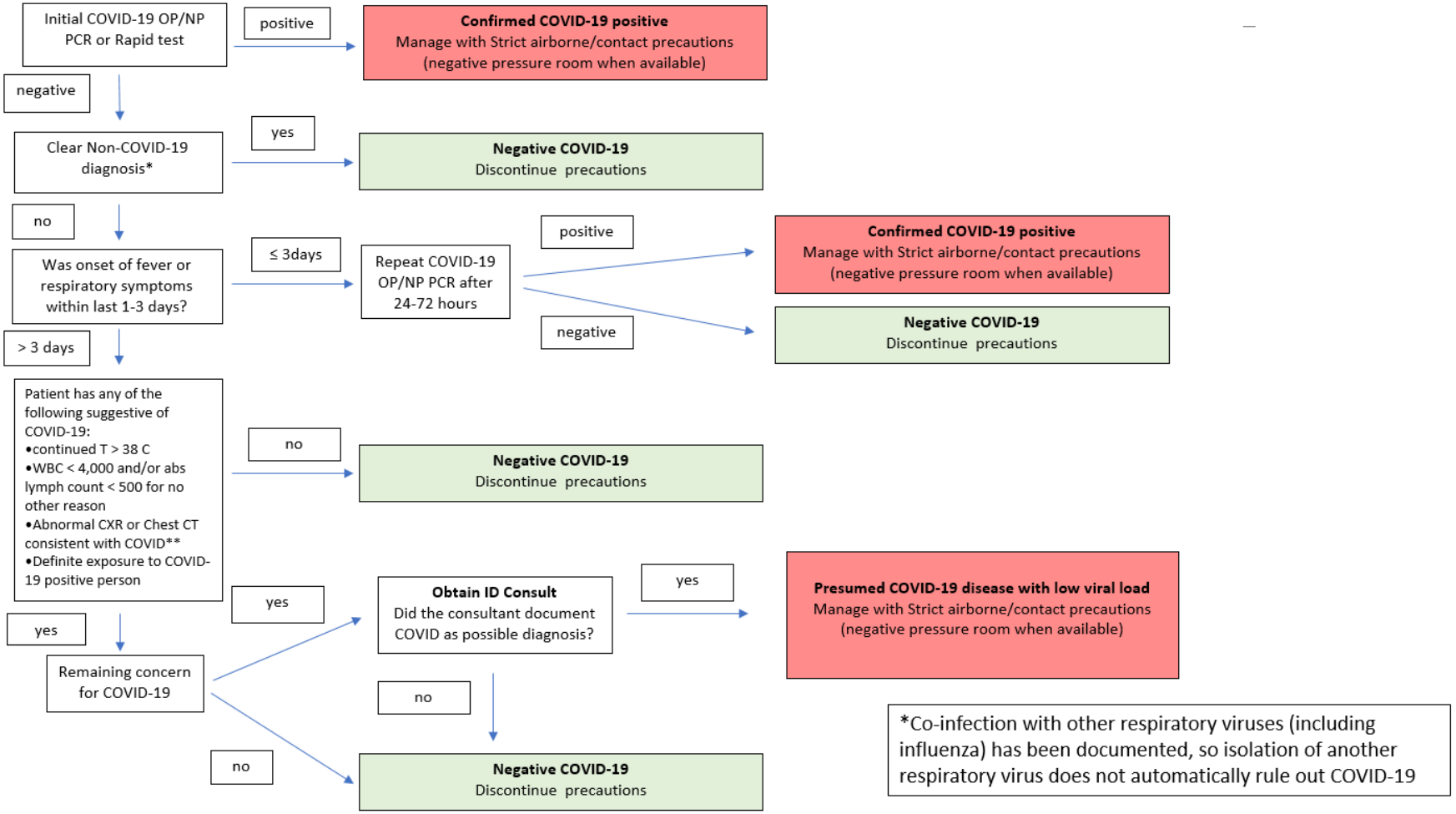

**characteristic findings include multifocal patchy or diffuse, often bilateral, infiltrates or ground glass opacities, sometimes located at periphery; later in disease can have opacification of both lungs as in ARDS

Modified: 10/23/20
Owner: Dr. Richard Ellison, Magdalena Slosar-Cheah

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Workflow for clearing isolation status

1. Primary team uses the flowchart for isolation management above and their clinical judgement to determine likelihood of COVID-19
2. To help overnight coverage, primary teams should communicate at shift handoff regarding what to do with isolation status once COVID-19 testing result comes back and record this in the primary team handoff
3. COVID-19 testing result comes back
4. Per the above algorithm, if:
    a. Isolation removed
        i. Primary team should write brief 1-2 sentence note stating intention to remove isolation
        ii. Page Infection Control (7305) to remove strict airborne isolation
        iii. Infection Control verifies note and removes isolation

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