VCMC/SPH HOSPITALIST QUICK GUIDE FOR MANAGEMENT OF PATIENTS WITH COVID19 + INITIAL WORK-UP

FIRST STEPS: *use interpreter phone if English is not first language*

- At admission: Code Status/MOLST filled out and updated
- Attending to discuss realistic goals re. intubation and CPR
- Check baseline EKG

LAB WORK-UP:

See management guidelines and COVID-19 Checklist

At admission →	CBC with differential, CMP, CRP, LFT, CPK, LDH,procalcitonin, troponin if ICU, d-dimer, ferritin
Daily →	Discuss with attending daily If patient is in ICU add: troponin, CPK
Every other day →	LFT, CPK, troponin, CRP, LDH, d-dimer, ferritin If patient on propofol add: triglyceride
If clinically worse →	LFT, CPK, troponin, CRP, procalcitonin, LDH, ferritin, d-dimer, fibrinogen, PTT, INR

LAB RESULTS TO EXPECT: *potential marker of disease severity

Normal WBC	Elevated AST*/ALT*
Lymphopenia*	Elevated CRP*
Mild thrombocytopenia	Elevated LDH*
BMP with elevated Cr	Elevated d-dimer*
Normal procalcitonin	Elevated troponin*

RESPIRATORY CARE: http://hospitals.vchca.org/medical-staff-services for details. If @6L/min NC (goal SpO2 92 - 96% or PaO2 >75): -Consult anesthesiology: contingency plan re. intubation

-Call Respiratory Therapy: consider venturi /nonrebreather

-Consult ICU Triage

****if decompensation or rapid increase in FiO2 call anesthesiology STAT to intubate**

ISOLATION: Remember these basics <u>for covid + or rule-out</u> patients

- Contact (gown + gloves) +Droplet (mask + eye protection)
- If aerosolizing procedure or intubated patient use N95 mask
- Aerosolizing procedures in negative pressure room only
- Avoid <u>unnecessary</u> aerosolizing procedures e.g. nebulization (switch to inhalers), high flow nasal canula, non-invasive ventilation (CPAP, BiPAP)
- OK to continue chronic night-time non-invasive ventilation, switch to BWH mask + machine because less aerosol risk

CONSULTS to CALL: Up front consults or when to call

- INFECTIOUS DISEASE → on ALL patients (discuss therapies)
- ANESTHESIOLOGY → if @6L/min NC or rapidly increasing FiO2
- RESPIRATORY THERAPY → if requiring 6L/min NC O2
- ICU TRIAGE → @6L/min NC or if concern for clinical worsening
- CARDIOLOGY → if concern for new heart failure, ACS, VT/VF, or cardiogenic shock
- ONCOLOGY → call primary oncologist at time of admission

INITIAL MANAGEMENT CONSIDERATIONS:

CT chest:	NOT necessary for diagnosis, recommend minimizing use of CT given challenges with isolation and transport
Daily CXR:	NOT necessary unless it will change management plan
IV fluids:	<u>Conservative</u> fluid management is important to mitigate risk of progression of respiratory failure
Steroids:	Avoid using empirically, only use if other indication
Antibiotics:	Follow CAP guidelines for empiric antibitics based on patient risk factors, talk to ID consult about concerns
Code Blue:	For covid + or covid rule-out, tell page operator this is covid patient; use normal protocol for donning of PPE prior to entering room, even if this delays CPR.