

COVID-19 Virtual Monitoring Program

-----CVMP-----

Support for COVID-19 Patients and Families
through
Monitoring, Education, and Counseling
in Coordination with the
Patient's Personal Physicians

**HAWAI'I
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HEALTH**

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Pre-Test

1. 67 year old office worker with low grade fever, fatigue and subjective shortness of breath. Just tested and PCR results positive for COVID-19. You are calling the patient to inform of test results.

Which of the following patient instructions are the optimal next steps in managing this patient?

- a. Proceed to ED for evaluation and possible admission
- b. Quarantine and call if any problem
- c. Quarantine and enroll in home monitoring program
- d. Proceed to REC for evaluation.
- e. Inform patient's PCP.

Pre-Test

2. Which of the following are true statements?

- a. Patients with COVID-19 and moderate symptoms can be safely monitored and managed at home
- b. More than 80% of patients with COVID-19 do not require hospitalization
- c. Patients with COVID-19 using oxygen must be admitted to inpatient facility
- d. Patients being monitored at home can be stratified based on risk factors and symptom progression
- e. A, B and D
- f. All of the above

Pre-Test

3. My confidence level in being able to monitor and manage patients with COVID-19 and mild to moderate symptoms is:
- a. High
 - b. Moderate
 - c. Low
 - d. Low with expectation of being better!

Hawaii COVID-19 Data: Trends

This dashboard displays state and county trends for new and cumulative cases, recoveries, hospitalizations, and deaths. The "Trend for" drop-down menu can be used to switch between indicators.

Trend for: Active Cases

State Trends & 7-day Averages

**Bars represent daily values and line represents 7-day averages*



Trajectory will continue for at least the next 7 days, and longer if public health measures are not effective.

Hospitalization Rate assumptions vary from 1% to 20%; (we assume 10% at HHP).

ICU admission rate assumptions vary from 2% to 8%, (we assume 3%)

Every hospital bed, ER visit, and Respiratory Evaluation Clinic visit is a precious and limited resource.

The CVMP strives to assure optimum care of the COVID-19 patient at home, minimizing unnecessary in-person visits to health care facilities.

COVID-19 Virtual Monitoring Program

Facilitates home recovery from COVID-19 through:

- Education and Support
 - Help patients understand their diagnosis, what to watch for, and how to access care appropriately.
- Clinical monitoring
 - Care Companion online app, use of Thermometer, Pulse Oximeter, Blood Pressure cuff. How to keep accurate records.
 - Telehealth visits by phone or video.
 - My Chart enrollment if possible.
- Treatment
 - COVID-19 (e.g. mild hypoxemia, symptoms).
 - Pre-existing illness (e.g. hypertension, diabetes).
 - Concurrent illness (e.g. UTI, otitis media).
 - Social, nutritional, financial, and psychological complications of illness. (Help connect with appropriate resources).

CVMP Mission and Objectives

- Support COVID-19 patients and families to facilitate successful recovery from illness.
- Enroll Positive and Presumed Positive COVID-19 patients into the COVID-19 Virtual Monitoring Program via MyChart in EPIC.
- Provide ongoing daily clinical monitoring for 14 days, or longer if needed.
- Provide early intervention for symptom management and detection of clinical deterioration.
- Ensure proper documentation in patient's chart.
- Improve coordination of care across multiple providers and settings.
- Encourage home monitoring of symptoms by patient prior to contacting appropriate medical staff and receiving care in a hospital setting.

If COVID-19 test was ordered by PCP:

This is what is supposed to happen:

- PCP receives notification from clinical lab.
- PCP notifies patient of positive result.
- PCP completes PUI (Person Under Investigation) form and faxes to HDOH (Hawaii Department of Health).
- PCP documents in Epic that patient has been notified, PUI form completed and faxed to DOH.
- PCP enrolls patient into MyChart home monitoring program or provide daily symptom calls if unable to enroll in MyChart

If COVID-19 test was not ordered by a PCP

(i.e. Urgent care or ED):

And the patient already has a PCP:

- CVMP verifies that the ordering provider has contacted patient and has completed the PUI Form.
- CVMP will notify PCP via inbasket that their patient has tested positive for COVID-19
- PCP enrolls patient into MyChart home monitoring program or provide daily symptom calls if unable to enroll in MyChart

Patient Under Investigation (PUI) Form

v20200727b



Human Infection with 2019 Novel Coronavirus Case Report Form

Fax completed form to:
DOH Disease Investigation Branch
(808) 586-4595

Patient first name: _____ Patient last name: _____ Date of birth (MM/DD/YYYY): ____/____/____
Address: _____ Phone: _____ Email: _____

Interviewer Information

Name of interviewer: Last: _____ First: _____ Telephone: _____ Email: _____
Affiliation/Organization: _____
Patient's Healthcare Provider (if different): _____ Telephone: _____ Email: _____

SARS-CoV-2 Testing (approved by FDA or other designated authority)

Test	Pos	Neg	Indet.	Pend.	Not Done	Specimen collection date
Molecular amplification test (RT-PCR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Serologic test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____

Symptoms present during course of illness:
☐ Symptomatic ☐ Asymptomatic ☐ Unknown
If case was symptomatic:
Onset date (MM/DD/YYYY): ____/____/____
☐ Unknown symptom onset date

Hospitalization, ICU, and Death Information

Was the patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, admission date: ____/____/____ discharge date: ____/____/____ Did the patient die as a result of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, date of death (MM/DD/YYYY): ____/____/____ <input type="checkbox"/> Unknown date	Was the patient admitted to an intensive care unit (ICU)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, admission date: ____/____/____ discharge date: ____/____/____
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Case Demographics

Date of birth (MM/DD/YYYY): ____/____/____ Age: _____ Age units (yr/mo/day): _____ State of residence: _____ County of residence: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown If female, currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown What is the patient's occupation? Industry: _____ Occupation: _____	Race (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander, specify: _____ <input type="checkbox"/> Japanese <input type="checkbox"/> Filipino <input type="checkbox"/> Chinese <input type="checkbox"/> Other Asian, specify: _____ <input type="checkbox"/> Black <input type="checkbox"/> Other, specify: _____	Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Unknown Primary Language: _____ Is a translator/interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify which language: _____
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Healthcare Worker Information

Is the patient a health care worker in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, what is their occupation (type of job)? <input type="checkbox"/> Physician <input type="checkbox"/> Respiratory therapist <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Nurse <input type="checkbox"/> Environmental services <input type="checkbox"/> Unknown	If yes, what is their job setting? <input type="checkbox"/> Hospital <input type="checkbox"/> Rehabilitation facility <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Long-term care facility <input type="checkbox"/> Nursing home/assisted living facility <input type="checkbox"/> Unknown
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Exposure Information

In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply): <input type="checkbox"/> Contact with a known COVID-19 case (probable or confirmed) If the patient had contact with a known COVID-19 case, what type of contact? <input type="checkbox"/> Household contact <input type="checkbox"/> Community-associated contact <input type="checkbox"/> Healthcare-associated contact (patient, visitor, or healthcare worker) <input type="checkbox"/> Travel <input type="checkbox"/> Interisland. Specify island(s): _____ <input type="checkbox"/> Mainland U.S. travel. Specify state(s): _____ <input type="checkbox"/> International travel. Specify country(s): _____ <input type="checkbox"/> Airport/Airplane <input type="checkbox"/> Cruise ship or vessel travel as passenger or crew member. Specify name of ship: _____ <input type="checkbox"/> Congregate settings <input type="checkbox"/> Workplace <input type="checkbox"/> Adult congregate living facility (nursing, assisted living, or long-term care facility) <input type="checkbox"/> School/university/childcare center <input type="checkbox"/> Correctional facility <input type="checkbox"/> Community event/mass gathering <input type="checkbox"/> Animal with confirmed or suspected COVID-19. Specify animal: _____ <input type="checkbox"/> Other exposures, specify: _____	Which would best describe where the patient was staying at the time of illness onset? <input type="checkbox"/> Traditional housing <input type="checkbox"/> House/single family home <input type="checkbox"/> Apartment <input type="checkbox"/> Healthcare/assisted living <input type="checkbox"/> Long term care facility <input type="checkbox"/> Nursing home/assisted living facility <input type="checkbox"/> Acute care inpatient facility <input type="checkbox"/> Rehabilitation facility <input type="checkbox"/> Other congregate/non-traditional housing <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Hotel/motel <input type="checkbox"/> Outside, in a car, or other location not meant for human habitation <input type="checkbox"/> Correctional facility <input type="checkbox"/> Mobile home <input type="checkbox"/> Group home <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____ Is this case part of an outbreak? <input type="checkbox"/> Yes, specify outbreak name: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Human Infection with 2019 Novel Coronavirus Case Report Form

Fax completed form to:
DOH Disease Investigation Branch
(808) 586-4595

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ____/____/____

Clinical course, symptoms, past medical history, and social history

Collected from (check all that apply): ☐ Patient interview ☐ Medical record review ☐ Other, specify: _____

Did the patient experience any of the following complications due to their illness? Did the patient develop pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Did the patient have acute respiratory distress syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Did the patient have an abnormal chest X-ray? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A, no chest X-ray done Did the patient have another diagnosis/etiology for their illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Did the patient have an abnormal EKG? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A, no EKG done Did the patient receive mechanical ventilation (MV)/intubation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, total days with MV (days): _____ Did the patient receive ECMO? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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If symptomatic, which of the following did the patient experience during their illness?			
Fever $\geq 100.4^{\circ}\text{F}$ (38°C)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Cough (new onset or worsening of chronic cough)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Subjective fever (felt feverish)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Shortness of breath (dyspnea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Difficulty breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Muscle aches (myalgia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Runny nose (rhinorrhea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Nausea or vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
New olfactory and taste disorder(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Diarrhea (≥ 3 loose stools/24hr period)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Other, specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		

Did the patient's symptoms resolve? <input type="checkbox"/> Yes, date of symptom resolution (MM/DD/YYYY): ____/____/____ <input type="checkbox"/> Symptoms resolved, unknown date <input type="checkbox"/> No, still symptomatic <input type="checkbox"/> Unknown if symptoms resolved

Did they have any underlying medical conditions and/or risk behaviors? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Diabetes Mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Disability (neurologic, neurodevelopmental, intellectual, physical, vision or hearing impairment)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If yes, specify: _____	
Severe obesity (BMI ≥ 40)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Psychological/psychiatric condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Cardiovascular disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If yes, specify: _____	
Chronic Renal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Other chronic diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chronic Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If yes, specify: _____	
Chronic Lung disease (asthma/emphysema/COPD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Other underlying condition or risk behavior, specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Immunosuppressive condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Autoimmune condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		

History of substance use			
Tobacco smoking	<input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> Never		
Vaping/E-cig	<input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> Never		
Alcohol use disorder	<input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> Never		
Other substances	<input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> Never		
Specify: _____			

Additional Comments or Notes

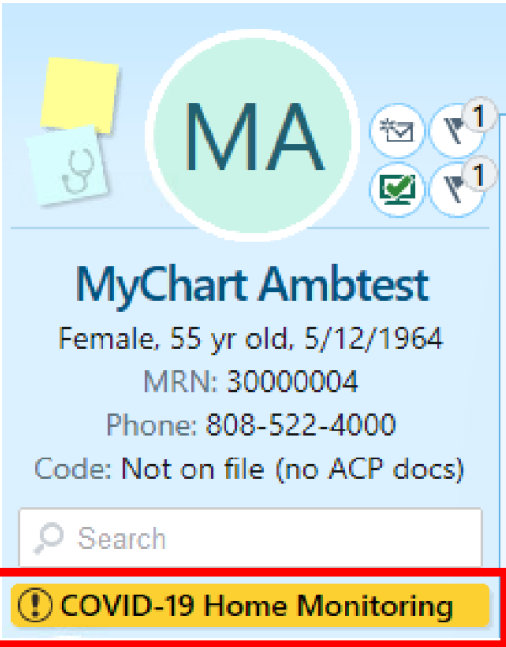
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How to Enroll a Patient into CVMP

Open a telephone encounter.

Find the blue box in upper left.

Click yellow box
(soon to be re-labeled
COVID-19 Virtual Monitoring
Program)



The screenshot shows the MyChart Ambtest interface for a patient named MA. The patient's details include: Female, 55 yr old, 5/12/1964, MRN: 30000004, Phone: 808-522-4000, and Code: Not on file (no ACP docs). A search bar is located below the patient information. A yellow button labeled 'COVID-19 Home Monitoring' is highlighted with a red border. A blue arrow points to this button with the text 'Click here'.

PT OUTREACH ENCOUNTER Pt Outreach Contacts Reason for Call HM Summary

Routing Answer Qnrs **BestPractice** ▼ COVID-19 Monitoring


This will open up a Best Practice Alert (BPA) box with the CVMP order already selected for you. Click on Accept.

BestPractice Advisory - Ambtest, MyChart

Care Plan Suggestion (1)

ⓘ This patient has suspected or confirmed COVID-19. It is recommended to order the MyChart COVID-19 home monitoring program.

Last SARSCOV2: Not on file



 MyChart COVID-19 home monitoring program


Acknowledge Reason

You will be asked “is the patient willing to use a smartphone for remote monitoring via the MyChart app?” Respond yes or no.

NOTE: In order to receive the answers to the Questionnaire patient **MUST** use the app on their phone. It will **NOT** work on MyChart website.

MyChart COVID-19 home monitoring program


 Accept  Cancel


 Is the patient willing to use a smartphone for remote monitoring via the MyChart app?


Yes


No


This box will appear. Click on “Sign Orders”


 Dx Association


 Edit Multiple


 Interactions

Options ▾ 

 After Visit

MyChart COVID-19 home monitoring program
 ☒ Is the patient willing to use a smartphone for remote monitoring via the MyChart app? Yes

 STRAUB-PHARMACARE PHARMACY


 808-840-5640

☒ Approve All

☒ Refuse All

☐ Uncheck All

PEND


☒ SIGN ORDERS 

You may be presented with another BPA of “Temperature and oxygen monitoring.” Choose to Order and Accept.

BestPractice Advisory - Ambtest, MyChart




Care Plan Suggestion (1)


ⓘ Order the temperature and oxygen monitoring flowsheets.



 **Temperature and oxygen monitoring**



The following actions have been applied:

- ✓ Added: MyChart Care Companion for COVID-19

 Dx Association  Edit Multiple  Interactions Options ▾

 After Visit

Temperature and oxygen monitoring
  Normal, Expected: 4/15/2020, Expires: 4/15/2021

MyChart COVID-19 home monitoring program
  Is the patient willing to use a smartphone for remote monitoring via the MyChart app? Yes

Select a pharmacy

PEND

Click the box under “COVID-19” and then click Accept.

The screenshot shows a software window titled "Associate Diagnoses" with a close button (X) in the top right corner. The window has a light blue header area with the text "Ambtest, Bran". Below the header is a text input field labeled "Add diagnosis" with a green plus icon to its right. To the right of the input field, the text "COVID-19" is displayed diagonally above a small diamond icon. Below this is a list of two items, each with a red exclamation mark icon in a circle to its left and a checkbox to its right. The first item is "MyChart COVID-19 home monitoring progr..." and its checkbox is highlighted in blue. The second item is "Temperature and oxygen monitoring" and its checkbox is not highlighted. At the bottom of the window are two buttons: "Accept" with a green checkmark icon and "Cancel" with a red X icon.

Enter in the patient's PCP in the "For procedures" box and click Cosign Required. Accept.

 Nearby' option. Below the search box is a checkbox labeled 'Cosign required'. The 'Cosigners' section has a 'For procedures' label and an empty search box with a red error icon. At the bottom right are 'Accept' and 'Cancel' buttons."/>

Providers

Authorizing Providers
For procedures

Enter in PCP

Enter in PCP name

Filter: ☐ Nearby

Cosigners
For procedures

☐ Cosign required

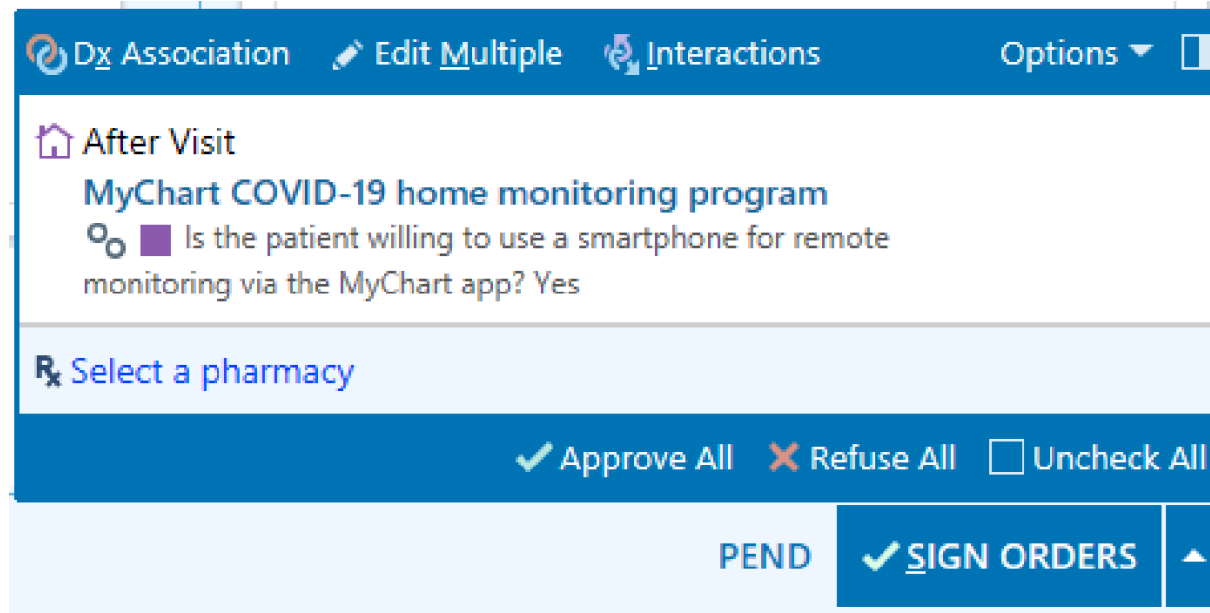
Accept Cancel

Orders will then go to the PCP's Epic In Basket to co-sign.

How to enroll a patient into Epic MyChart

If a COVID-19 patient is not already an active user of MyChart, Epic will detect this when you attempt to place CVMP order.


Send an Instant Activation for MyChart to the patient. Start by clicking the Sign Orders button in the box below:



The screenshot shows a software interface for patient enrollment. At the top is a blue header bar with icons and text for 'Dx Association', 'Edit Multiple', 'Interactions', and 'Options'. Below this is a white box titled 'After Visit' with a house icon. Inside this box is the heading 'MyChart COVID-19 home monitoring program' followed by a question: 'Is the patient willing to use a smartphone for remote monitoring via the MyChart app? Yes'. Below the question is a light blue bar with a pharmacy icon and the text 'Select a pharmacy'. At the bottom of the white box is a blue bar containing three options: 'Approve All' with a checkmark, 'Refuse All' with a red X, and 'Uncheck All' with an unchecked checkbox. Below the white box is a light blue bar with the word 'PEND' and a large blue button with a checkmark and the text 'SIGN ORDERS'.

When Epic detects MyChart Signup is needed, this BPA box will appear. Click MyChart Signup and Accept.

BestPractice Advisory - Zztest, Eric


Care Plan Suggestion (1) 

⚠ Use the link below to sign the patient up for MyChart.

[🔗 MyChart Signup](#)

The following actions have been applied: _____


✓ Assigned: MyChart COVID-19 Home Monitoring


 **Accept** **Cancel**


Click on either “Send Email” or “Send Text”


MyChart Signup


How would this patient like to receive MyChart signup information?


Send Email


Send Text

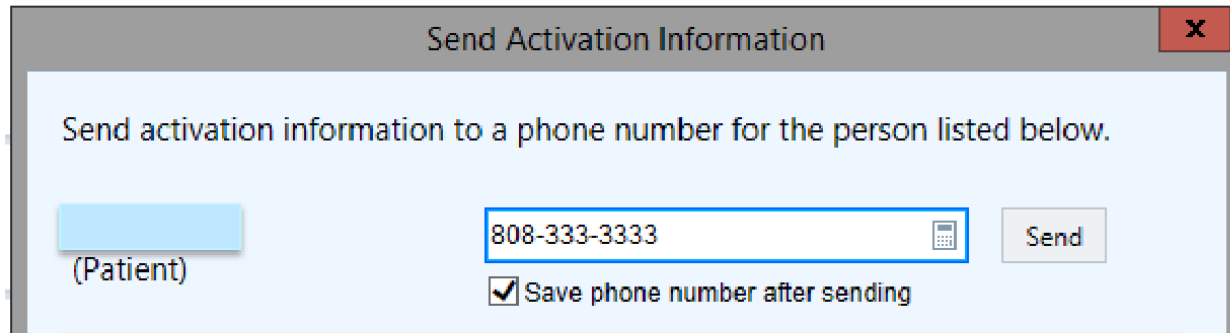

Print Letter


Ask Later


Patient Declined

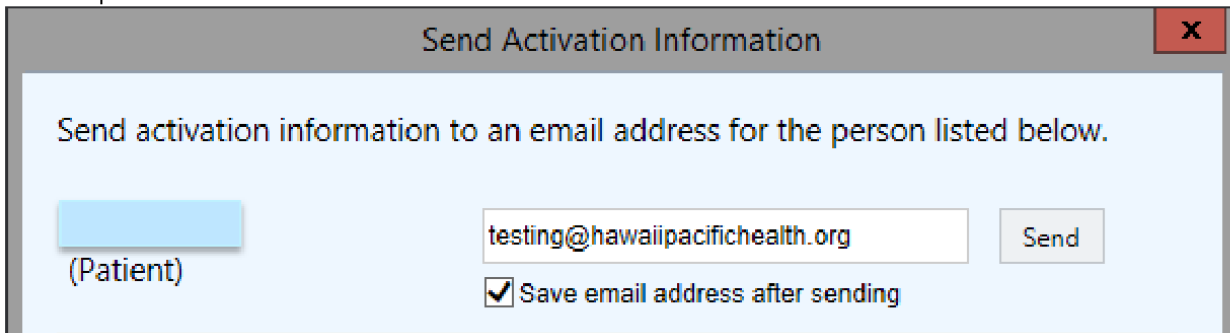
Confirm phone number and email with the patient.

Phone:



A screenshot of a web application dialog box titled "Send Activation Information" with a red close button (X) in the top right corner. The dialog has a light blue background and contains the text "Send activation information to a phone number for the person listed below." Below this text, there is a light blue button labeled "(Patient)". To the right of the button is a text input field containing the phone number "808-333-3333". To the right of the input field is a small icon of a telephone keypad. Below the input field is a checked checkbox with the label "Save phone number after sending". To the right of the checkbox is a grey "Send" button.

Email:

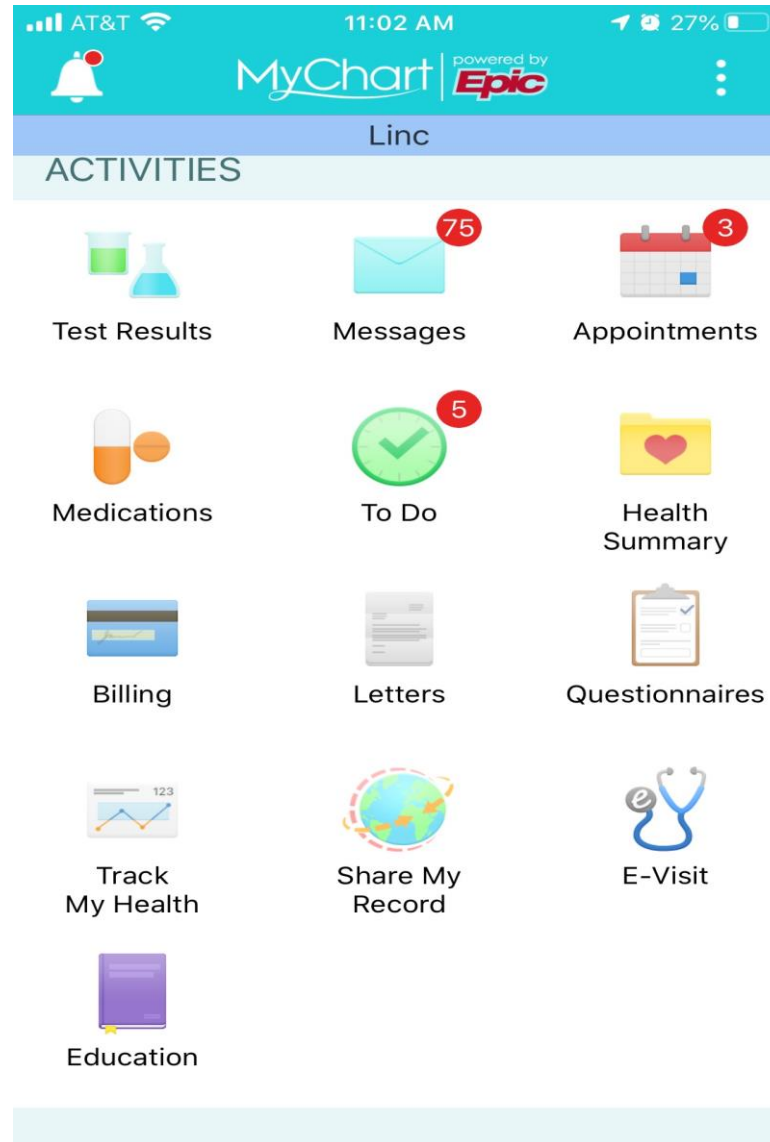


A screenshot of a web application dialog box titled "Send Activation Information" with a red close button (X) in the top right corner. The dialog has a light blue background and contains the text "Send activation information to an email address for the person listed below." Below this text, there is a light blue button labeled "(Patient)". To the right of the button is a text input field containing the email address "testing@hawaiiapacifichealth.org". Below the input field is a checked checkbox with the label "Save email address after sending". To the right of the checkbox is a grey "Send" button.

The patient will receive the MyChart activation immediately.

Instruct the patient to create a User ID and Password right away so that they may begin communicating with CVMP and their PCP.

MyChart Questionnaire-Patient view



MyChart Questionnaire-Patient view

The screenshot shows a mobile app interface for a patient questionnaire. At the top, the status bar displays the time 11:16, signal strength, Wi-Fi, and battery. The app header is teal with a back arrow, a profile icon labeled 'M', 'To Do', and 'Options'. Below the header is a progress indicator showing '0% complete' with a circular progress bar and the word 'Today'. The main content area lists five tasks, each with a sun icon and a time label: 'Enter Temperature Reading' (Morning), 'Enter Oxygen Saturation Reading' (Morning), 'COVID-19 Condition Monitoring' (Morning), 'COVID-19 Patient Instructions' (By End of Day), and 'Take steps to prevent the spread of COVID-19' (By End of Day). Each task has a brief instruction. At the bottom, there is a 'VIEW FUTURE TASKS' button with a clock icon. The bottom navigation bar has three icons: 'Tasks' (a checkmark with a red '5'), 'Progress' (a bar chart), and 'Changes' (a circular arrow).

11:16

< M To Do Options

0% complete
Today

Enter Temperature Reading
☀ Morning
If you have a thermometer, enter your highest temperature since last recording (in Fahrenheit).

Enter Oxygen Saturation Reading
☀ Morning
If you have a portable oxygen sensor, enter your lowest oxygen percentage since last recording.

COVID-19 Condition Monitoring
☀ Morning
Enter information about your condition




COVID-19 Patient Instructions
📅 By End of Day
Read about what to do if you are sick with Coronavirus (COVID-19).


Take steps to prevent the spread of COVID-19
📅 By End of Day

⌚ VIEW FUTURE TASKS

Tasks Progress Changes

MyChart Questionnaire-Patient view

11:34   

 Questionnaires Close

This is a non-production environment. If you are a patient, contact the system administrator immediately. [X]

For the questionnaire series **Symptom Check-in**

When did you first start experiencing symptoms related to COVID-19?

* Are you feeling short of breath today?




* Are you having a cough today?


* Are you experiencing weakness today?

* How is your appetite compared to yesterday?

* Are you vomiting?

* Are you experiencing diarrhea?

11:33   

< To Do  Track My Health

Day Week Month Year


April 8 - April 14


Temperature

Tap to add readings

SPO2

Tap to add readings

 CONNECT TO HEALTH

 ADD READINGS

**HAWAII
PACIFIC
HEALTH**

**HAWAII
HEALTH
PARTNERS**





Best Practice Alert Message (BPA)

- Shortness of Breath - **New or Worse**
- Cough - **New or Worse**
- Vomiting - **Yes**
- Diarrhea - **New or Worse**
- Weakness - **New or Worse**
- Appetite compared to Yesterday - **Worse**
- If have thermometer, temperature **>100.3**
- O2 saturation - **<92% (13+) or <94% (0-12yrs)**

Best Practice Alert Message (BPA)-PCP view

Status	3 Subject	Msg Date	Msg Time	4 Patient
↑ New ?	COVID-19 Shortness of Breath or Vomiting Visit: 04/15/2020	04/15/2020 Pool?: X	3:50 PM	Ambtest, Andy
↑ Read ?	COVID-19 SPO2 < 92 Visit: 04/15/2020	04/15/2020 Pool?: X	3:50 PM	Ambtest, Andy
New ?	COVID-19 Temp > 100.3 F Visit: 04/15/2020	04/15/2020 Pool?: X	3:50 PM	Ambtest, Andy
↑ New ?	COVID-19 SPO2 < 92 Visit: 04/15/2020	04/15/2020 Pool?: X	1:06 PM	Ambtest, Ashley
↑ New ?	COVID-19 Shortness of Breath or Vomiting Visit: 04/15/2020	04/15/2020 Pool?: X	10:26 AM	Ambtest, Chris
↑ New ?	COVID-19 SPO2 < 92 Visit: 04/15/2020	04/15/2020 Pool?: X	10:25 AM	Ambtest, Chris
New ?	COVID-19 Symptom Questionnaire Not Done Visit: 04/15/2020	04/15/2020 Pool?: X	9:00 AM	Ambtest, Chris


←
Message
Help

Andy Ambtest

Male, 47 yr old, 7/17/1972
MRN: 30000862

PCP: None
Coverage: None


↑ COVID-19 SPO2 < 92
Received: Today

Mychart, User → P Covid-19 Outbreak Monitoring Pool

Suspected or confirmed COVID-19 patient recorded oxygen saturation less than 92 in MyChart.

Active

Date	User	Actions Taken	Triggers	Comment
04/15/20 1550	Mychart, User [EBMYCHART001]	Send In Basket Message	Patient- Entered Data	None

Telephone Encounter Documentation

SYMPTOM ASSESSMENT:

Date of Onset of symptoms: In the Past Day	Yes	Symptoms Improving	Symptoms Worsening	NO Symptoms	Comment
Fever >100.4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pulse 100-120	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Respiration Rate 20-24	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ambulatory SPO2 92-96%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dyspnea interfering with ADL's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Muscle Aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Loose Stools 3 or greater loose stools in a 24 hour period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urinating normally in a 24 hour period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tolerating food and liquids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nursing Assessment: - Appears ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Risk Tiers

	Tier 1 (Low Risk)	Tier 2 (Moderate Risk)	Tier 3 (High risk)
Patient Criteria	<ul style="list-style-type: none"> < 60 & Healthy 	<ul style="list-style-type: none"> 60-75 <60 with any of the following: DM, asthma, COPD, smoker, HTN, CKD, pregnant 	<ul style="list-style-type: none"> 75 and greater <75 with any of the following: CVD, ESRD, immuno-compromise, advanced COPD, cirrhosis, cancer, frailty or multiple morbid conditions
	and	or	or
Symptoms	<ul style="list-style-type: none"> Non-Specific, mild URI Sx or mild cough 	<ul style="list-style-type: none"> More pronounced URI Sx or cough Fever SOB 	<ul style="list-style-type: none"> Cough with pain, wheezing or shortness of breath lasting longer than 6 days; DOE, or chest tightness
	and	or	or
Data (if available)	<ul style="list-style-type: none"> Normal BP, RR, Pulse Ox and Pulse (mild tachycardia is normal if febrile) Normal Chest X-ray 	<ul style="list-style-type: none"> Significant leuko/lymphopenia Elevated CRP Pulse Ox <100% but >93% Pulse >100 	<ul style="list-style-type: none"> Hypoxemia (93% or less) Infiltrates on CXR or CT Chest
	and	or	or
Support System	<ul style="list-style-type: none"> Able to self-isolate Adequate Support 	<ul style="list-style-type: none"> Otherwise Tier 1 but <u>uncertain</u> support 	<ul style="list-style-type: none"> Otherwise lower tier, but <u>unstable</u> support system

Risk Tiers

	Tier 1 (Low Risk)	Tier 2 (Moderate Risk)	Tier 3 (High risk)
Clinical Course	<ol style="list-style-type: none"> 1. Tier 1 with stable or improving symptoms 2. <u>Previously Tier 2 patient</u> with improving symptoms over 6 days 	<ol style="list-style-type: none"> 1. Tier 2 with stable symptoms 2. <u>Previously Tier 1 patient</u> with symptoms not improving over 6 days 3. <u>Previously Tier 3 patient</u> with improving symptoms over 6 days 	<ol style="list-style-type: none"> 1. Tier 3 with stable symptoms 2. <u>Previously Tier 2 patient</u> with symptoms not improving over 6 days 3. <u>Previously Tier 1 patient</u> with worsening symptoms (clinical judgement.)
When to escalate to next Tier	<p>With worsening of any symptoms - or - symptoms not improving over 6 days</p>	<p>With worsening of respiratory symptoms, pleuritic pain, hemoptysis, Pulse Ox <93%, decreased urine output (<3 voids in 24 hours), decreased fluid intake (< 24 ounces of fluid in 24 hours), or signs of dehydration</p>	<p>With any worsening of symptoms:</p> <p>Contact: PCP, Urgent Care, or call 911</p>



Symptom Monitoring & Management

- **Dyspnea (Shortness of Breath)**

- Note: Dyspnea reflects perception of increased work of breathing, not of oxygen levels. The patient may be short of breath with normal O2 sat. Conversely, they may feel fine with low O2 sats.
- Goal: Oxygen saturation >94 most of the time. At this O2 sat the patient may still feel dyspnea, but more oxygen will not make them healthier, safer, or more comfortable. Oxygen supplies are precious and should not be wasted.
- Patient instruction:
 - Monitor oxygen saturation at least twice a day when you are ambulating, more frequently if experiencing increased shortness of breath.
 - If on home oxygen, raise flow rate up to maximum of 3 litres to achieve Oxygen saturation goal. O2 may be turned up with activity and back down at rest.
- For patients who use inhalers, instruct them to use hand-held rather than desktop nebulizers.

Symptom Monitoring & Management

- Fever
 - Temperature >100.4
 - Monitor temperature three times a day and record along with blood pressure, O2 saturation pulse, and patient's symptoms.
 - Fevers up to 104.0 are not harmful and do not need to be treated. Temperature can be a valuable indicator of the patient's progress or deterioration. Reducing temp with Tylenol or NSAIDS does not necessarily make patients feel better. Always record when these meds are given in the log to help with interpretation of vital signs.
 - Pharmacological treatment
 - Tylenol 500mg up to 6 a day as needed for comfort.
 - Nonpharmacological treatment
 - Stay hydrated
 - Keep your environment cool
 - Dress in light clothes

Symptom Monitoring & Management

- Cough
 - Medication containing dextromethorphan can be of some help (Robitussin-DM and Mucinex DM).
 - Prescription medications such as benzonatate or those containing opiates like codeine can be more effective.

Home Isolation Guidelines

- Stay home except to get medical care.
- Separate yourself from others in your home.
 - Avoid sharing the same bedroom and restroom.
- Wear a facemask at all times unless completely alone.
- Cover your coughs and sneezes.
- Clean your hands often.
- Avoid sharing personal household items.
- Clean all “high-touch” surfaces daily.

When to seek medical attention

- Seek medical attention immediately if you have:
 - Trouble breathing
 - Persistent pain or pressure in the chest
 - New confusion
 - Inability to wake or stay awake
 - Bluish lips or face
- Call 911
 - Notify the operator that you or the person seeking medical care tested positive for COVID-19.



Blood Bank of Hawaii

Following are some guidelines to help you determine if you are eligible. **If you have questions about eligibility, please call our medical team at (808) 848-4745.**

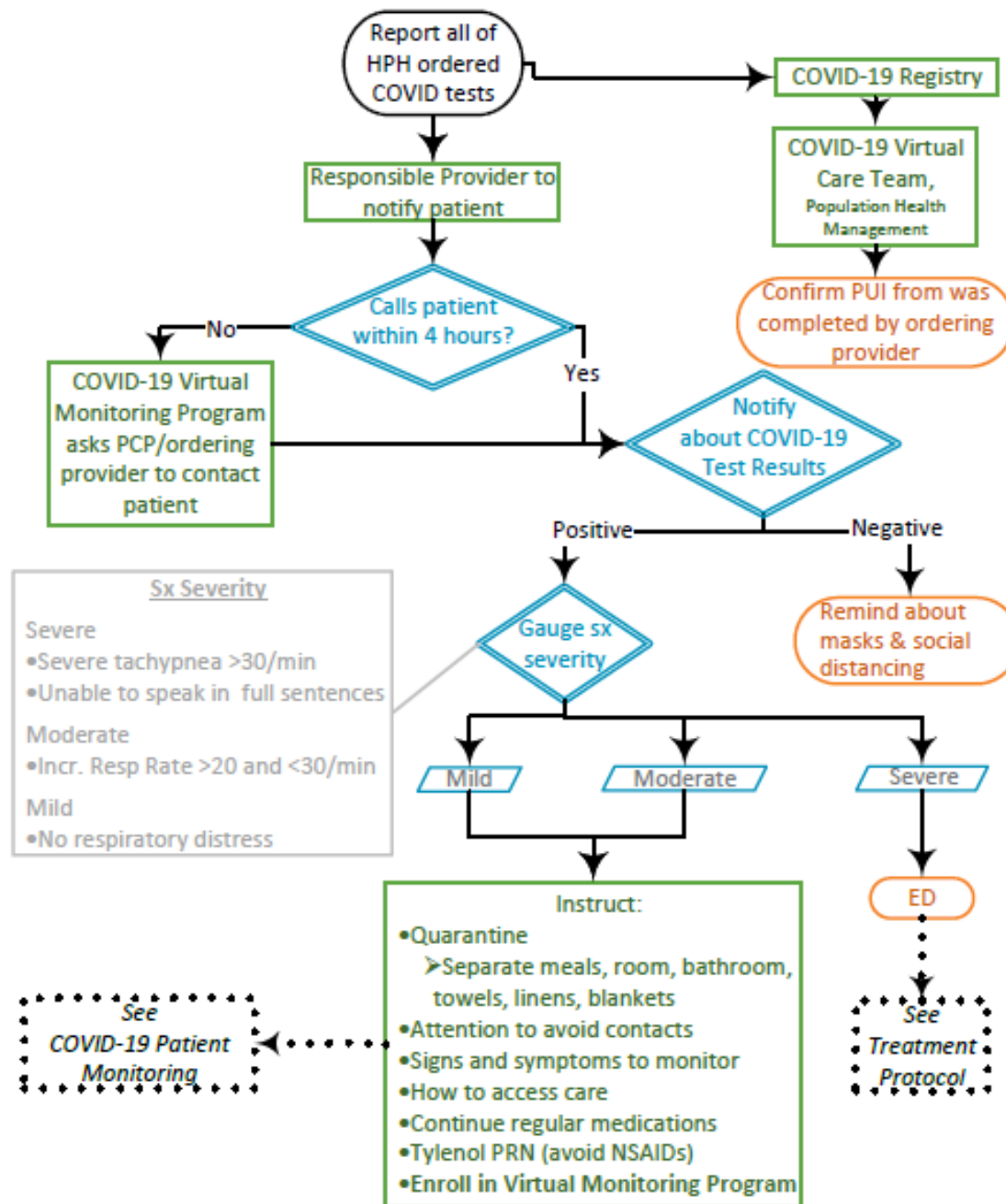
General Eligibility

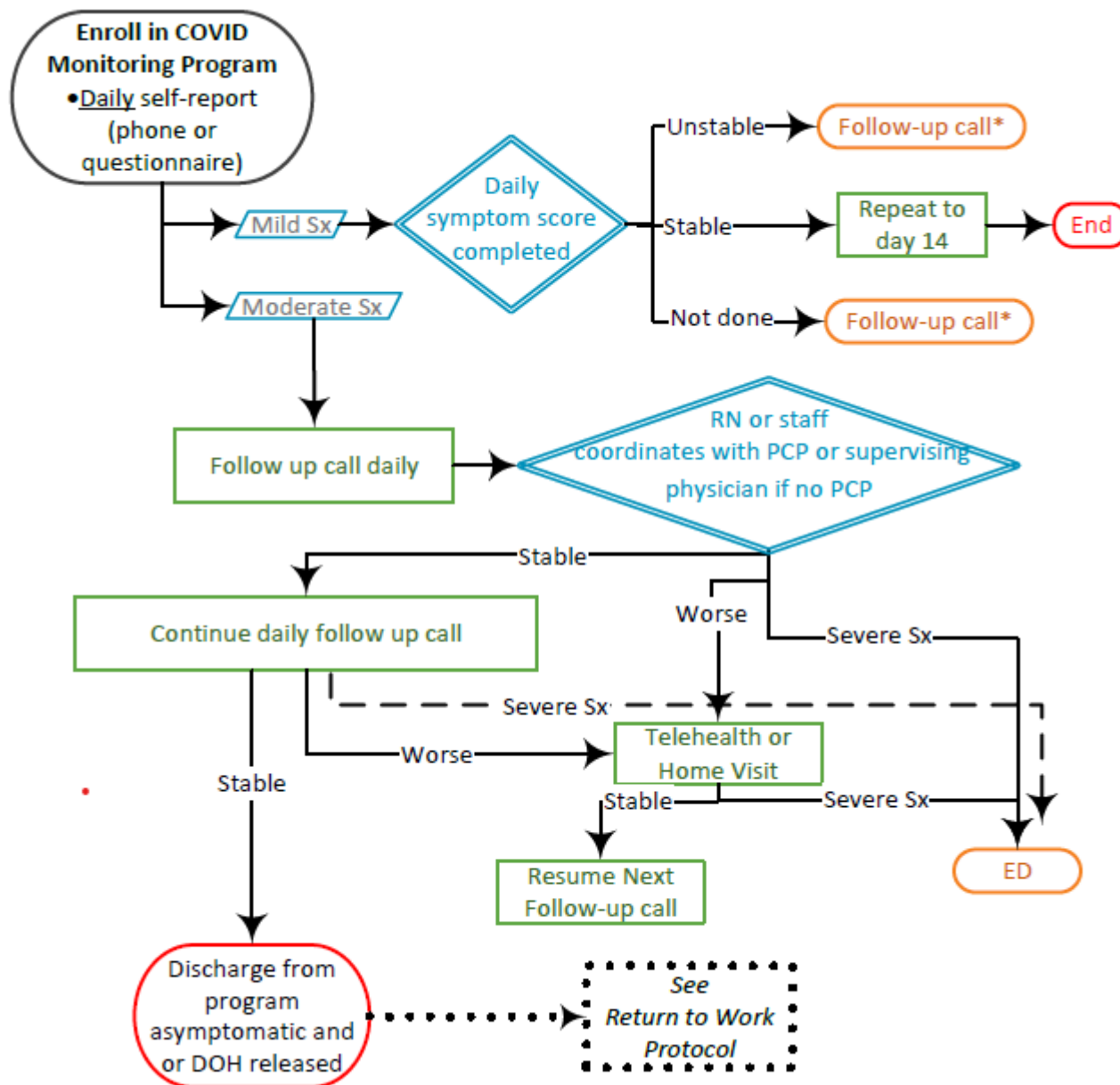
You are able to donate if you have:

- Diabetes
- Menstruation
- Surgery without transfusion

You are unable to donate if you have:

- AIDS or have ever engaged in high-risk activities including
 - Male to male sex in the past year
 - Intravenous drugs use
- Cold or flu
- Hepatitis B or C
- Pregnancy – 6 week wait
- Surgery with transfusion of blood or blood components – 1 year wait
- There are other guidelines for donating if you have Tattoos, Cancer, Heart conditions or Stroke, Lung conditions, Autoimmune disorders, Piercings/Brandings, if you've Traveled, if you are taking certain medications and received certain Vaccinations. Contact Blood Bank of Hawai'i for more information.





Thank you for your dedication to our patients and our community!

Please feel free to contact us for any questions:
info@hawaiihealthpartners.org

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