



Influenza Season During COVID-19: Guidance for Emergency Departments

This coming fall and winter, New York City (NYC)'s health care sector must be ready to serve a large number of New Yorkers who require medical attention for infectious respiratory diseases, including COVID-19, seasonal influenza (flu), respiratory syncytial virus (RSV), as well as rhinovirus and seasonal coronaviruses.

Hospital emergency departments (EDs) and other acute care settings can address this likely syndemic of respiratory disease by preparing their staff and facilities to separately triage patients with viral respiratory symptoms, use rapid point-of-care tests for flu and COVID-19, quickly discharge patients with mild illness, and provide remote follow-up care. This document provides several recommendations to prepare your facilities to effectively respond to a possible surge of patients with respiratory symptoms. The following is a summary of the information covered in this document:

Preparing your ED facility

- Communication
- Prepare satellite spaces with sneeze guards
- Infection control signs
- Stock up on personal protective equipment (PPE), extra vaccines and test kits
- Train your staff
- Crisis and surge planning

What to do during respiratory viruses transmission

- Infection control
- Patient flow and testing
- Patient admission

Ensuring equal access to care

Overview

This flu season will present a new challenge for EDs when evaluating and triaging patients with symptoms of influenza-like illness (ILI) given ongoing COVID-19 transmission. The exact timing and duration of flu seasons vary, but flu activity generally begins to increase in October and peaks between December and February. Activity can last as late as May. To prevent the spread of respiratory viruses, including the flu, COVID-19 and RSV, the NYC Department of Health and Mental Hygiene (NYC Health Department) recommends EDs develop a split triage system, with designated assessment and waiting areas for patients with symptoms suggestive of a viral respiratory infection (VRI) and those coming to the ED for other reasons. This may include a separate area outside of the ED or a specific area of the ED (or both) designated for the evaluation and treatment of those with symptoms of ILI or COVID-19-like illness (CLI) (such as fever, cough, sore throat and shortness of breath).

Ideally, hospitals will start this split triage process outside of the ED where patients would be screened for fever and respiratory symptoms. Patients who screen positive would be directed to an evaluation tent or other location near but outside the main ED or to a respiratory precaution area of the ED based on acuity of illness. There should be a concerted effort to assess patients with mild acuity illness quickly with rapid discharge and remote follow-up plans when possible. Rapid point-of-care testing for the flu and COVID-19 should be used when possible to screen and cohort patients based on their confirmed or suspected diagnoses.

This document outlines recommendations for hospitals, freestanding EDs and other acute care settings to prepare for a surge of patients during a syndemic of COVID-19 and the flu. These recommendations are intended for hospital planning leadership, including emergency management, ED, infection control and laboratory.

Preparation for Flu Season

Planning and Communications

- Hold meetings with internal staff (such as ED staff, leadership and social services) and external partners (such as emergency management and contractors for staffing and supplies) to incorporate lessons learned from the first wave of COVID-19.
- Update surge plans, including needed modifications to security protocols (such as visitor screening), infection control (such as staff screening), mortuary services and other identified priority areas.
- Form a crisis care committee to develop protocols to guide altered standards of care during times of scarce resources (see [Preparing for Crisis Care](#)).
- Identify alternate care spaces where patients could be triaged and assessed outside of the main ED. This could include tents, trailers or adjacent ambulatory clinics.
 - Develop and test operational protocols for these spaces and take into consideration some of the environmental risks associated with the spaces (such as the heat, cold and risk of flooding in tents).
 - Items to consider, including in these triage locations, can be found in [Surge Capacity Expansion Tool for Emergency Departments](#).

- Begin mobilizing additional resources and plan for potential shortages of PPE, medications, testing supplies, medical gasses and other equipment.
 - Consider expanding the list of hospital suppliers. A list of suggested PPE and medical suppliers can be found on the Health Department's [COVID-19 website](#).
 - When calculating supply needs, consider the increased demand required for a severe flu season along with COVID-19.
 - Consider planning for pulse oximeter supplies for distribution to patients at high-risk for severe COVID-19 who are discharged to home.
 - Plan for an increase in oxygen requirements during a surge of COVID-19 patients.
- Hold regular briefings with staff to update them on the [COVID-19 situation](#) and review current recommendations, plans and protocols.
- Promote 100% staff vaccination rate for seasonal flu. Encourage flu vaccination for all staff, unless contraindicated.
- Ensure widespread communication encouraging flu vaccination, including to patients being discharged. Begin patient communications early to promote flu vaccination and instruct on when to seek care, how to use telehealth options and what precautions to take during flu season.

Testing Capacity

- Plan for developing or expanding point-of-care testing capacity for COVID-19 and other respiratory viruses (such as the flu or RSV). Efforts should be made to ensure combined testing is available with rapid turnaround of the results.
- Work with your laboratory to develop testing algorithms and order sets. For example, some point-of-care tests with lower sensitivity may need to be combined with a confirmatory rt-PCR test.
- To ensure health equity, tests should be without cost to patients because they serve a dual purpose for public health and patient care.
- Ensure and confirm correct patient contact information (such as an accurate phone number, address and email address) is included in all COVID-testing orders. This is how contact tracers will reach the patient if they test positive.

Staff Training and Education

- Implement just-in-time screening and isolation training and drills for all clinical staff, registrars, security officers and others.
- Continue competency-based training on appropriate use of PPE, including safe donning and doffing procedures.
- Develop plans and processes for just-in-time respirator fit testing for staff who may be participating in care for patients with COVID-19 or when new respirators are introduced.
- Cross-train staff to ensure continuity of essential functions during staffing shortages.
- Ensure processes are in place to keep clinical staff updated on treatment protocols, infection control guidance and emerging best practices.

Infection Control Measures

Signage and screening

- Post clearly visible signs directing those with CLI or ILI to go to a designated triage area. Examples of signs can be found [here](#) and [here](#).
- Post signs instructing on good [respiratory](#) and [hand hygiene](#), and to stay at least 6 feet apart from others. Place staff outside the ED to perform an initial temperature and symptom screening in order to direct patients to appropriate areas.
- Ensure all patients and visitors, regardless of their symptoms, are wearing or are provided a face covering for source control. Universal source control helps reduce the risk of COVID-19 transmission by asymptomatic patients and staff.

Engineering controls for tents and ED spaces

- Use sneeze guards and other barriers to limit close face-to-face contact.
- Take measures to ensure appropriate physical distancing, such as spacing chairs 6 feet apart when possible or using barriers to separate patients. Evaluation stations should also be at least 6 feet apart and screens or curtains can be placed between stations for patient privacy. Consider use of floor markers in areas where lines may form.
- Consider utilizing a [walk-up testing booth](#) that allows health care workers to stand behind solid but transparent panels (such as polycarbonate) to collect samples for COVID-19.
- Explore options to improve indoor air quality in all shared spaces.
 - Optimize air-handling systems (such as ensuring appropriate directionality, filtration, exchange rate, proper installation and up-to-date maintenance).
 - Consider the addition of portable solutions (such as portable high-efficiency particulate air filtration units) to augment air quality in areas when permanent air-handling systems are not a feasible option.

Environmental Infection Control

- Consider use of dedicated medical equipment for patients with CLI or ILI. Appropriately disinfect equipment between use by different patients.
- Ensure environmental cleaning and disinfection procedures are followed consistently as instructed. Use [Environmental Protection Agency-registered products](#) appropriate for COVID-19.
- Ensure routine cleaning of surfaces, especially high-touch surfaces such as counters, tabletops, doorknobs, keyboards and tablets.

PPE for triage and CLI or ILI evaluation areas

- Staff performing initial symptom screenings and directing patients to triage stations who are not in [prolonged close contact](#) with patients should wear, at minimum, a mask and eye protection (face shield or goggles).
 - Gowns should be worn if there will be direct physical contact with symptomatic patients.

- Hand hygiene should be performed regularly, including before and after any direct patient contact.
- Physical barriers such as plexiglass can be used in lieu of eye protection.
- Staff performing clinical evaluations and testing should use, at minimum, droplet and contact precautions, such as wearing a mask, gown, gloves and eye protection (face shield or goggles).
 - Fit-tested N95 respirators are required when performing aerosol-generating procedures.
- If supplies are limited, staff should implement PPE conservation practices per facility guidelines including:
 - Extended use of facemasks, N95 respirators and eye protection
 - Disinfection and reuse of eye protection
 - Reuse of masks and N95 respirators should be considered
 - Use of elastomeric masks with P100 filters to reduce your need for N95 masks; cover the exhalation valve of elastomeric masks with a surgical mask to increase source control
- For more information on PPE in ambulatory or triage tent settings, see the Health Department's infection control guidance.

Patient Flow and Testing

Patient flow and triage at point of entry:

- Limit and monitor points of entry to the facility. If possible, utilize a separate point of entry to the ED for patients being evaluated for viral respiratory infections. Staff should be placed outside ED entrances, including emergency medical service ambulance arrivals, to direct patients to appropriate triage areas.
- Facilities should restrict accompanying companions in the evaluation areas.
- Patients arriving by ambulance should also be assessed and triaged to designated isolation areas as appropriate. See Appendix 2 for patient flow considerations.
- All patients should be masked during the triage process.

Patients who screen **negative** for CLI or ILI symptoms:

- Patients without fever or other viral respiratory symptoms should be directed to the non-respiratory precaution area within the ED.
 - Waiting areas should ensure people can remain 6 feet apart or use plexiglass to physically separate patients and companions to minimize risk of transmission from asymptomatic patients or staff.
 - All patients who live or work in areas with increased COVID-19 transmission should be tested, regardless of symptoms or a known contact. For more information current areas of concern, visit nyc.gov/COVIDZone.
 - If your laboratory capacity allows, consider testing all patients for COVID-19, or people at risk for severe COVID-19, regardless of symptoms to reduce the risk of asymptomatic transmission and support citywide Test & Trace Corp efforts.

Patients who screen **positive** for CLI or ILI symptoms:

- Screen patients for older age and comorbidities that indicate increased risk for severe COVID-19 illness. Patients should be assessed for respiratory distress for expedited movement to an appropriate care space, ideally an individual room or airborne infection isolation room if aerosol-generating procedures are anticipated (see Appendix 1).
- Patients with minor to moderate symptoms should be directed to a triage tent or another separate, well-ventilated space for further assessment.
 - Additional considerations for developing a triage surge space can be found in the “Patient Surge” section of the NYC Health Department’s Emergency Resources for Hospitals webpage.
- Patients with more severe symptoms that require a higher level of care can be directed to an area of the ED designated for the evaluation of patients with viral respiratory symptoms under appropriate precautions including contact, droplet and, if aerosol-generating procedures may be performed, airborne.
- When available, the NYC Health Department recommends the use of rapid respiratory virus diagnostics, including, at minimum, the flu and RSV viruses, and COVID-19 point-of-care testing for patients with symptoms of viral respiratory infections.
- Test patients for COVID-19 even if they test positive for another virus, as studies have found similar rates of COVID-19 in patients diagnosed with other respiratory viruses. An alternative etiology for a respiratory syndrome cannot be used to exclude COVID-19.
- Consider confirmatory rRT-PCR COVID-19 diagnostic testing for patients with a negative rapid COVID-19 test as the COVID-19 rapid test has been shown to be highly specific but not as sensitive and may miss some patients with lower viral shedding.
 - If a patient is found to be positive for another respiratory virus and has recovered from COVID-19 within the past 3 months, testing for COVID-19 is not recommended. If an alternative etiology is not found, then the person may warrant an evaluation for COVID-19 (see guidance from the Centers for Disease Control [CDC]).

Admissions

- Patients with a positive rapid COVID-19 test requiring further assessment or care should be admitted into COVID-19-designated units where patients may be cohorted, if necessary, according to hospital guidelines.
 - If a patient without respiratory symptoms needs to be admitted, the NYC Health Department recommends COVID-19 testing regardless of symptoms to ensure proper cohorting given the risk of asymptomatic and presymptomatic infections.
 - Patients with respiratory symptoms but pending COVID-19 test results should be kept in individual isolation until their test results are available. If individual isolation rooms are not available, patients should be cohorted based on similar symptoms and separated a minimum of 6 feet apart, ideally with physical structures between patients (such as curtains).
 - In the event such a patient requires an aerosol-generating procedure, they should be moved to an individual room (ideally an airborne infection isolation room) during the procedure.

- This approach should also be utilized for patients with a high suspicion of COVID-19, negative COVID-19 test results and no other alternate diagnosis (such as the flu).

Discharge Recommendations

Patients without CLI or ILI symptoms

- Patients without CLI symptoms who don't need admission should be discharged home per usual protocol with instructions to practice physical distancing and good hand hygiene.
- Offer flu vaccination prior to discharge if indicated.
- Consider offering testing for COVID-19 to all patients if laboratory capacity allows, or to patients who may be at risk of severe COVID-19. For prioritization for testing, follow current public health recommendations. Ensure correct patient contact information is included in COVID-19 testing requisition orders to facilitate contact tracing efforts.

Mild to moderate CLI or ILI symptoms

- Provide prescription for oseltamivir as appropriate if the patient is diagnosed with the flu or is still on the differential and it was not ruled out during initial evaluation.
- If COVID-19 test results are pending, make sure patients know how to obtain their results. Instruct them to isolate until they receive the test results.
- **Patients less than 65 years of age without comorbidities** who have mild to moderate symptoms consistent with COVID-19 and live in a location where they can reasonably self-isolate during their illness should be allowed to return home with instructions regarding home isolation, contact tracing, and accessing care if symptoms worsen. See the CDC's home care guidance and the NYC Health Department's webpage.
 - Instructions should include guidance on length of isolation (at least 10 days from symptom onset, the prior 24 hours fever-free without the use of fever-reducing medications, and overall improvement in illness).
 - Advise them to call their health care provider if symptoms worsen to see if they need further evaluation. If they develop severe symptoms (such as difficulty breathing, constant pain or pressure in the chest, new confusion or inability to stay awake, or bluish lips or face), direct them to immediately go to the hospital or call **911** and alert the operator they have or may have COVID-19.
 - If they need to be seen at a health care facility while ill, instruct patients to wear a face covering. Advise them to notify staff again upon their arrival they have or may have COVID-19.
 - If a patient does not have a primary care provider, ensure they have an appropriate follow-up care plan or instruct them to call **311** or NYC Health + Hospitals' main contact center at **844-NYC-4NYC (844-692-4692)** to schedule a new patient appointment either by telehealth (phone or video) or in person.
- **Patients with mild to moderate illness who are considered at increased risk for severe disease** may be discharged home if stable after ensuring follow-up has been arranged (by telemedicine if possible, or an in-person appointment).
 - These patients may benefit from being discharged with a pulse oximeter and instructions on when to call their health care provider or return to the ED in case of worsening symptoms, including shortness of breath or lower oxygen saturation

levels. The [American College of Emergency Physicians](#) has included home self-monitoring pulse oximetry as part of a discharge plan from the ED.

- Ask the patient to follow up with their primary care provider. If staff resources are available, consider follow-up calls to check on the patient's condition and pulse oximetry to ensure the patient is improving.
- **Patients with symptoms consistent with COVID-19 who cannot isolate at home** (such as those who live in a group setting or cannot have a dedicated bedroom and bathroom for themselves) can be referred to the [NYC COVID-19 Hotel Program](#).
 - Call 212-361-5590 for housing options for patients already connected with the NYC Department of Homeless Services (DHS). Inform them of the need for patient isolation for possible mild to moderate COVID-19.
 - If the patient cannot safely self-isolate at home, including because the patient shares a room or a bathroom or lives with someone who is at high risk for severe COVID-19 illness, call the NYC COVID-19 Hotel Program at **844-692-4692** and inform them of the need for patient isolation for possible mild to moderate COVID-19.
 - Those that are discharged to a hotel who do not live in congregate settings should stay for the full isolation period (see above). For those living in congregate settings, the minimum period of isolation is 14 days from symptom onset.

Equity Considerations

In NYC, COVID-19-related [morbidity and mortality](#) has disproportionately affected Black and Latino persons compared to White and Asian persons, and although we lack definitive data, low-income, undocumented, and indigenous New Yorkers may also be at increased risk of infection and severe disease, given well-documented health inequities in these groups. Flu vaccine coverage has also been historically low in some of the neighborhoods most impacted by COVID-19 (according to unpublished data by the Health Department). Emergency medicine providers can [help address these inequities](#) by:

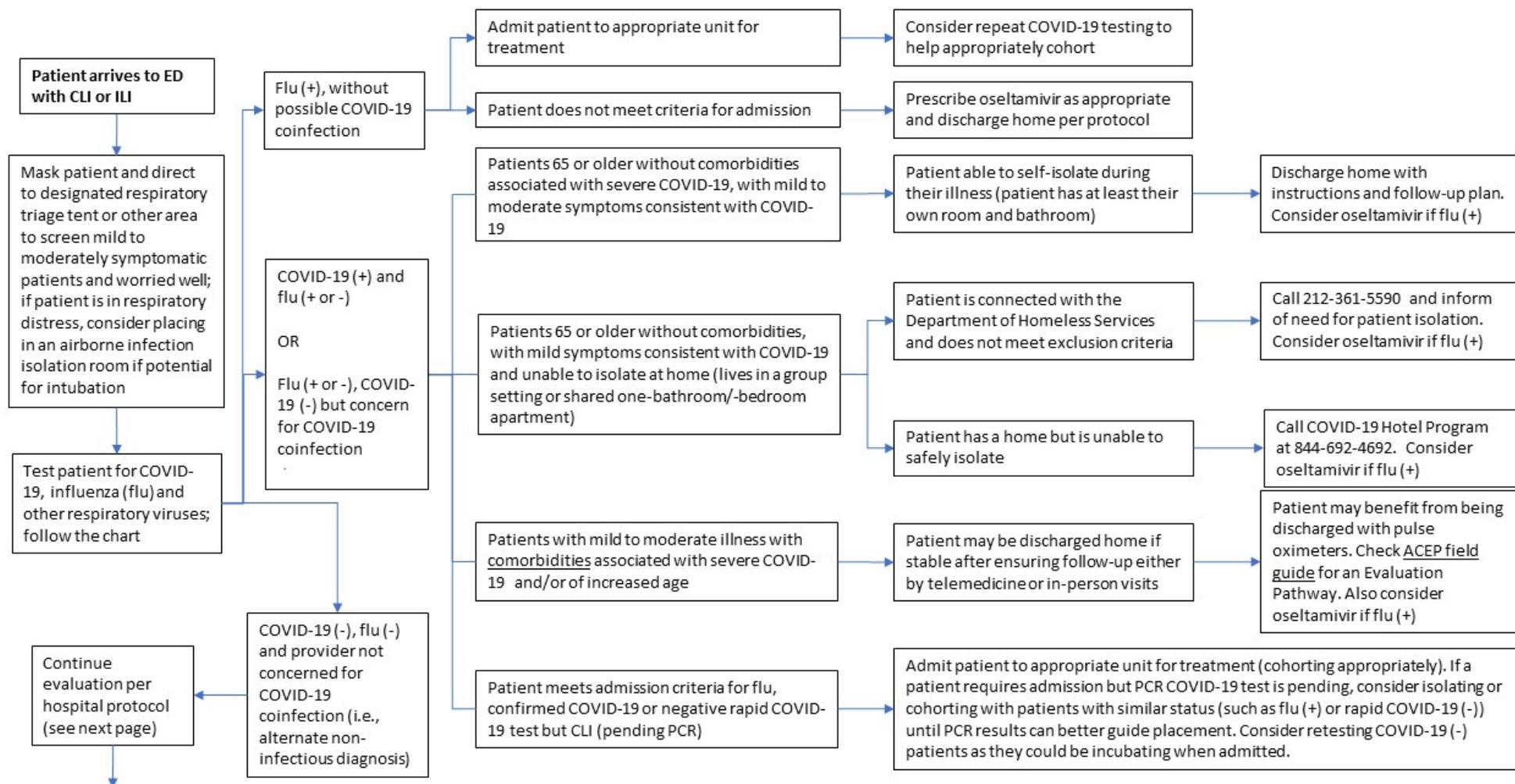
- Being alert for [patients most at risk](#) for severe COVID-19
- Proactively expanding health care access for vulnerable populations, including vaccinations and free respiratory virus testing
- Asking patients about their living conditions and ensuring that those who live in crowded dwellings can safely quarantine or isolate themselves
- Asking patients about their occupations
- At discharge, providing [comprehensive prevention education](#) to patients at occupational risk of exposure and informing them that people who miss work during quarantine or isolation may be eligible for New York State or Federal COVID-19 paid sick leave
 - Health Department Isolation or Quarantine Orders can be requested by calling 855-491-2667.
 - Information about New York State Paid Leave for COVID-19 can be accessed [here](#).
- Helping NYC identify and address health inequities by recording comprehensive demographic data in medical records and test requisitions, such as asking patients about their self-identified race, ethnicity and other demographic characteristics.

Appendix 1: List of High-Risk Aerosol-Generating Procedures

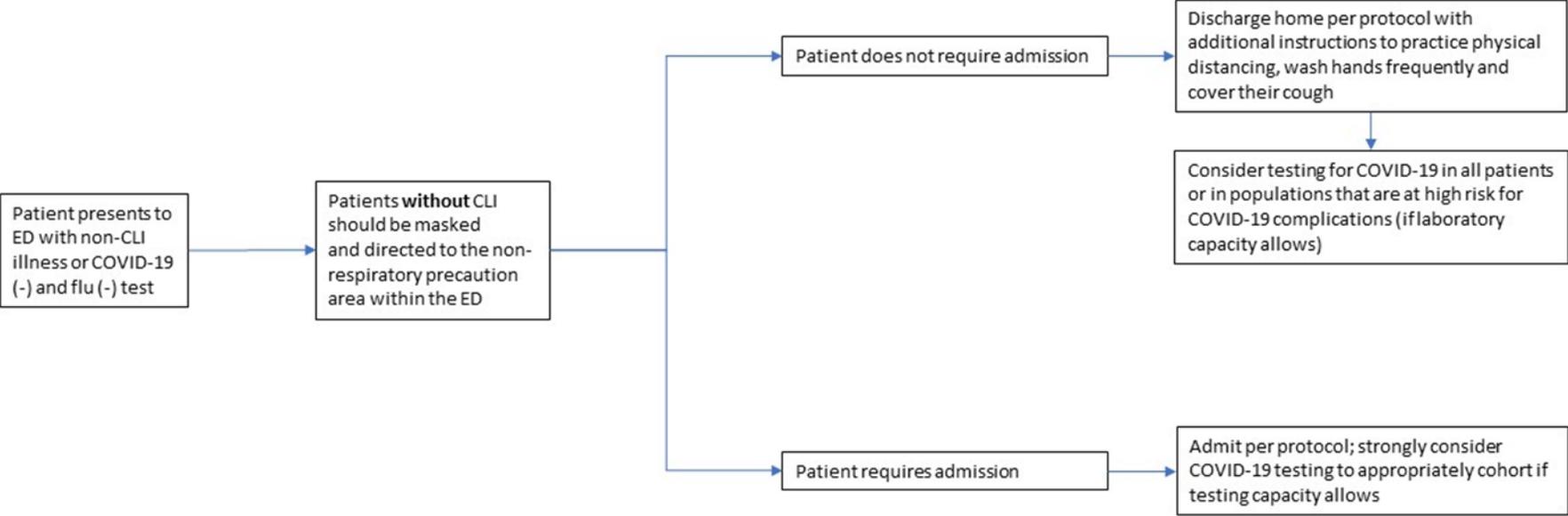
Aerosol Generating Procedures
<ul style="list-style-type: none">• Endotracheal intubation or extubation• Non-invasive ventilation (BIPAP or CPAP)• Manual ventilation before intubation• Open suctioning• Bronchoscopy• Nebulizer treatments• High-flow oxygen treatment• Sputum induction• Tracheotomy• Cardiopulmonary resuscitation

Appendix 2: Framework for Cohorting Patients With Confirmed or Possible COVID-19

Emergency Department (ED) Discharge Recommendations for COVID-19-Like Illness (CLI) and Influenza-Like Illness (ILI)



Emergency Department (ED) Discharge Recommendations for Non-COVID-19-Like Illness (non-CLI)



The NYC Health Department may change recommendations as the situation evolves. 10.14.20