OUTPATIENT COVID-19 MANAGEMENT

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This document is a suggested approach/guideline for evaluating and managing COVID-19 outpatients.*

ALL patients from time of diagnosis or suspicion of COVID-19 disease should be medically triaged within 24 hours. Managing a patient can take various forms. Currently if a person is considered suspicious for COVID-19 (e.g. has symptoms) we recommend testing. Management should proceed as if the patient is positive, **including isolation until test results are known**.

Good data supporting a single outpatient management strategy is lacking. The frequency and type of outpatient follow up will depend on the patient's risk for developing severe disease. The OHA has recently published guidelines that will be updated regularly.

https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le2288J.pdf

Step 1
Assess Patient History and Risk Factors

1. **Time course: Is the patient < 10 days from symptom onset?**
   (Patients tend to get sickest around day 5-9 from onset of symptoms, with steep clinical decline often occurring within 8-24 hours)

2. **Risk factors: Does the patient have any of the following risk factors? [History]**
   - Age <1, or >65 years old
   - Chronic lung disease (asthma, COPD, chronic PE, pulmonary fibrosis, other), chronic tracheostomy
   - CAD or CHF
   - Diabetes (either non-insulin dependent or insulin dependent)
   - Immunocompromising meds (>20 mg of prednisone daily or greater, active chemotherapy, biologic medications) or condition, CD4<200
   - Hypertension
   - Obesity (BMI > 40)
   - ESRD
   - Sickle cell disease
   - End-stage liver disease (cirrhosis)
   - Neurologic disease (cerebral palsy, epilepsy, dementia)
   - Pregnancy
   - Current or former smoker

Labs/Imaging

Lab and imaging not necessary unless clinical indication.

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August 20, 2020

Step 2 - Assess Patient Symptoms and Clinical Trajectory

Symptom Severity	Mild	Moderate	Severe
PULM **How is your breathing?**	• New cough and no shortness of breath (SOB) • In patient with chronic cough, cough worse and no shortness of breath	• Cough with mild SOB • Aware of breathing but comfortable • Able to complete sentence without taking a breath mid-sentence • Able to climb a flight of stairs without losing breath • If at baseline has dyspnea with climbing stairs, worse from baseline	• SOB with one flight of stairs • Any chest pain • Unable to speak in full sentences • Pulse Ox < 93% (if able to measure)
FEVER **What is your temperature?**	• T <100.4 • OR no subjective fever	• T 100.4 – 103 responding to fever medicine • OR subjective fever	• >103 or >100.4 and not responsive to fever medicine • OR subjective fever unresponsive to fever medicine and/or confusion
GI **How is your intake of liquids? Are you having vomiting or diarrhea?**	• Mild vomiting/diarrhea • Able to drink liquids • Urinating every 4-6 hours	• Moderate vomiting or diarrhea • Decreased fluid intake (<50% usual) • Urinating at least 3 times daily, has tears	• Severe vomiting or diarrhea • Unable to keep fluids down • Decreased urine output to < 3x daily • Syncope or near syncope
NEURO **Are you (or your family member) more confused than usual?**	• Mentation normal/ at baseline	• Mentation is normal/ at baseline	• Mentation **not** at baseline: Confused, waxing and waning consciousness, not able to concentrate, hallucinating
MS **Have you had a change in your mobility or a fall?**	• Function is normal • able to perform ADLs without change in level of assistance	• Function is mildly reduced but able to manage daily function safely • Needs some increased assistance in performing ADLs from baseline	• Sustained a fall • Function severely reduced • Needs significantly increased assistance in performing ADLs from baseline

Clinical Trajectory

Are your symptoms better, worse, or the same as yesterday?

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August 20, 2020

Step 3 - Triage Patient to Either ED or Appropriate Follow-up

Symptoms and Clinical Trajectory	+ Risk Factors	No Risk Factors
Any severe symptom(s)	**Send to ED**	**Send to ED**
Moderate respiratory + worsening	**Send to ED**	**Send to ED or See in Clinic** vs. Follow-up in 1 Day
Moderate respiratory + stable	**See in Clinic** vs. Follow-up in 1 Day	Follow-up in 2 Days
Moderate respiratory + improving	Follow-up in 1 Day	Follow-up in 2 Days
Mild respiratory + worsening	**See in Clinic** vs. Follow-up in 1 Day	Follow-up in 2 Days
Mild respiratory + stable/improving	Follow-up in 2 Days or PRN*	Follow-up in 3 Days or PRN*
Moderate fever/GI symptoms/ mobility only	Follow-up in 2 Days	Follow-up in 3 Days
Mild fever/GI symptoms/ mobility only	Follow-up in 2 Days or PRN*	Follow-up in 3 Days or PRN*
No symptoms	Follow-up on Days 4, 7, and 10	Phone Follow-up Days 4, 7, and 10

Clinical worsening often occurs after the first week of illness. Be more conservative in follow-up if moderate symptoms present early in the course of disease.

Consider use of patient self-assessment tools such as the on the CDC site:
https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html#

Guidance for environmental safety in a clinic where COVID-19 patients may be seen in person can be found under “Infection Control” here:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

*These are general guidelines, clinical judgement takes precedence.

Additional Considerations

- Try and get a pulse oximeter to anyone with significant risk factors
- In person evaluation can occur in a clinic (or Mercy Flights will do an assessment with you if in Jackson County).
- Home O2 is not appropriate for patient with new onset of dyspnea and hypoxia early in the onset of disease.
- CCO's may be able to assist in getting patient a smart phone for video visits and pulse oximeters.
- If patient is on an immunocompromising medication such as prednisone or a biologic consult the prescribing provider as to appropriate management.
- Optimize treatment of underlying conditions that put a person at increased risk of severity of disease.
- At this time dexamethasone and thromboprophylaxis etc. are recommended only for people sick enough to be hospitalized and not generally for outpatients.

Review how the patient can reach a provider after hours.

Discuss management of common symptoms: advise Tylenol, antitussives, fluids, good nutrition.

Advise use of CPAP, BiPAP and Neb treatments in a closed room without others present due to risk of aerosolization.

Especially for medically frail patients – make sure advanced directives in place, discuss if prefer to stay home with palliative care vs being admitted to hospital. Encourage them to discuss wishes with close family or caretakers.

Isolation and Housing

One of the most important things you can do is to isolate the patient from household members. The highest rate of transmission of COVID is between household members. This can be prevented. CDC language has phrases like 'if possible' stay in your own room or bathroom. Providers can help by saying it is **very important/imperative** to have your own bathroom and bedroom away from others.

- Is the patient capable of adhering to infection control and isolation precautions?
- Is there an available caregiver or support system?
- Does the patient have adequate access to food, medications etc. so that they can maintain isolation?
- Do they have any high-risk household members? Also, high risk folks living with a COVID + person can use Self Care Recovery Site (SSRS) for housing. Call the SSRS number at (541) 841-6776 to discuss options with an RN, or contact _____ .

Isolation and Housing continued

Although typical isolation is 10 days, for patients who have been hospitalized, that live in a congregate setting, or who are severely immunocompromised, the period of isolation is 20 days.

CDC has patient information on how to isolate at home. If there is doubt that patients are able to self-isolate but are independent enough to care for themselves, they may qualify for the County's SSRS program. More information is on the Jackson County COVID webpage for providers.

Meals on Wheels is a great option for food delivery.

Discontinuation of Isolation

Only the local health departments can clear someone from isolation.
Patients are provided a letter with the discontinuation date. It is not recommended to do testing. Check the CDC and OHA Investigative Guidelines **https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/COMMUNICABLEDISEASE/REPORTINGCOMMUNICABLEDISEASE/REPORTINGGUIDELINES/Documents/Novel-Coronavirus-2019.pdf** for current recommendations.

A negative test will not clear a patient from isolation (or quarantine) sooner so please do not waste scarce resources on repeat testing.

Jackson County Public Health . . . . . (541) 774-8209

Josephine County Public Health . . . . . (541) 618-4650 (Answering Service)

Curry County Public Health. . . . . (541) 247-3387

Oregon Health Authority . . . . . 211 (General Information)

Epilogue

In approximately 80% of patients, illness is mild and does not warrant medical intervention or hospitalization. Remote management via tele-medicine visits is encouraged in order to avoid the spread of disease and unnecessary PPE use.

Studies show that 35% of patients who had mild COVID disease after 2 weeks still had not returned to usual state of health. The most common persistent symptoms being cough, fatigue and loss of smell.

CDC links on isolation:
https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/isolation.html
https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/steps-when-sick.html

NIH Guidance on CoV-19 Management:
https://www.covid19treatmentguidelines.nih.gov/overview/management-of-covid-19/

References

1. Boston Medical Center. COVID-19 Screening and Assessment algorithm v 4 2020-05-27
2. UpToDate. Coronavirus disease 2019 (COVID-19): Outpatient evaluation and management in adults. 2020-07

Conceptual diagram of COVID-19 disease spectrum

https://www.jhltonline.org/article/S1053-2498(20)31473-X/fulltext#fig0001