

General Management of Nonhospitalized Adults With Acute COVID-19

Last Updated: February 29, 2024

Summary Recommendations

- Management of nonhospitalized patients with acute COVID-19 should include providing supportive care, taking steps to reduce the risk of SARS-CoV-2 transmission (including isolating the patient), and advising patients on when to contact a health care provider and seek an in-person evaluation (**AIII**).
- Patients who are at high risk of progressing to severe COVID-19 may be eligible for pharmacologic therapy. See [Therapeutic Management of Nonhospitalized Adults With COVID-19](#) for specific recommendations.
- Patients with persistent or progressive dyspnea, especially those who have an oxygen saturation measured by pulse oximetry (SpO_2) $\leq 94\%$ on room air at sea level or have symptoms that suggest high acuity (e.g., chest pain or tightness, dizziness, confusion, other mental status changes), should be referred to a health care provider for an in-person evaluation (**AIII**).
- Clinicians should be aware that using pulse oximeters to measure oxygen saturation has important limitations. Therefore, SpO_2 results should be considered in the context of the patient's clinical condition. See [Clinical Spectrum of SARS-CoV-2 Infection](#) for more information.

Each recommendation in the Guidelines receives a rating for the strength of the recommendation (A, B, or C) and a rating for the evidence that supports it (I, IIa, IIb, or III). See [Guidelines Development](#) for more information.

This section of the Guidelines is intended to provide general information to health care providers who are caring for nonhospitalized adults with COVID-19. The COVID-19 Treatment Guidelines Panel's (the Panel) recommendations for pharmacologic management can be found in [Therapeutic Management of Nonhospitalized Adults With COVID-19](#).

This section focuses on the evaluation and management of:

- Adults with COVID-19 in an ambulatory care setting
- Adults with COVID-19 following discharge from the emergency department (ED)
- Adults with COVID-19 following inpatient discharge

Outpatient evaluation and management in each of these settings may include some or all of the following: in-person visits, telemedicine, remote monitoring, and home visits by nurses or other health care providers.

Data from studies in the United States show that certain racial and ethnic minorities experience higher rates of COVID-19, hospitalization, and death in relation to their share of the total U.S. population.¹⁻⁵ In addition, some studies have found that members of certain racial, ethnic, and socioeconomic groups were less likely to receive COVID-19 treatments.⁶⁻⁸ The underlying causes of these observed disparities may include inadequate insurance coverage, a lack of primary care providers, hesitancy about receiving treatment, barriers to telehealth visits, and transportation challenges. To reduce COVID-19 treatment disparities, providers must be aware of the problem and provide patient-centered care. The Panel recommends that health care providers, health care systems, and payers ensure equitable access to high-quality care and treatment for all patients, regardless of race, ethnic identity, or other minoritized identity or social status (**AIII**).

Managing Patients With COVID-19 in an Ambulatory Care Setting

Approximately 80% of patients with COVID-19 who are unvaccinated have mild illness that does not

require medical intervention or hospitalization,⁹ and the proportion is likely higher in patients who are up to date with COVID-19 vaccinations.^{10,11} Most patients with mild COVID-19 (defined as the absence of viral pneumonia and hypoxemia) can be managed in an ambulatory care setting or at home. Patients with moderate COVID-19 (e.g., those with viral pneumonia but without hypoxemia) or severe COVID-19 (e.g., those with dyspnea, hypoxemia, or lung infiltrates >50%) need in-person evaluation and close monitoring, as pulmonary disease can progress rapidly and require hospitalization.

When managing outpatients with COVID-19, clinicians should provide supportive care, take steps to reduce the risk of SARS-CoV-2 transmission as recommended by the Centers for Disease Control and Prevention,^{12,13} and advise patients on when to seek an in-person evaluation.¹⁴ Supportive care includes managing symptoms (as described below), ensuring that patients are receiving the proper nutrition, and being cognizant of the risks of social isolation, particularly for older adults.¹⁵ Health care providers should identify patients who are at high risk of progressing to severe COVID-19.¹⁶ These patients are candidates for antiviral therapy. See [Therapeutic Management of Nonhospitalized Adults With COVID-19](#) for more information.

Older patients and those with chronic medical conditions, especially those who are not up to date with COVID-19 vaccinations, have a higher risk of hospitalization and death.¹⁷ However, SARS-CoV-2 infection may cause severe disease and death in patients of any age, even in the absence of risk factors. When managing older adults with COVID-19, factors such as cognitive impairment, frailty, the risk of falls, and polypharmacy should be considered. The decision to monitor a patient in the outpatient setting should be made on a case-by-case basis.

Clinical Considerations When Managing Patients in an Ambulatory Care Setting

Patients with SARS-CoV-2 infection may be asymptomatic or experience symptoms that are indistinguishable from other acute viral or bacterial infections (e.g., fever, cough, sore throat, malaise, muscle pain, headache, gastrointestinal symptoms). People who have symptoms compatible with COVID-19 should undergo diagnostic SARS-CoV-2 testing (see [Testing for SARS-CoV-2 Infection](#)). Considering other possible etiologies of symptoms is important, including other respiratory viral infections (e.g., influenza), community-acquired pneumonia, congestive heart failure, asthma or chronic obstructive pulmonary disease exacerbations, and streptococcal pharyngitis.

Although mild dyspnea is common, worsening dyspnea and severe chest pain or tightness suggest the development or progression of pulmonary involvement. In earlier studies of patients with COVID-19 who developed acute respiratory distress syndrome, progression occurred a median of 2.5 days after the onset of dyspnea.¹⁸⁻²⁰ Patients with persistent or progressive dyspnea, especially those who have an oxygen saturation measured by pulse oximetry (SpO_2) $\leq 94\%$ on room air at sea level or have symptoms that suggest high acuity (e.g., chest pain or tightness, dizziness, confusion, other mental status changes), should be referred to a health care provider for an in-person evaluation (**AIII**).

If an adult patient has access to a pulse oximeter at home, SpO_2 measurements can be used to help assess overall clinical status. Patients should be advised to use pulse oximeters on warm fingers rather than cold fingers for better accuracy. Patients should inform their health care providers if the value is repeatedly below 95% on room air at sea level. Pulse oximetry may not accurately detect hypoxemia, especially in patients who have dark skin pigmentation.^{21,22}

Not all commercially available pulse oximeters have been cleared by the Food and Drug Administration (FDA). SpO_2 readings obtained through non-FDA-cleared devices, such as over-the-counter sports oximeters or mobile phone applications, lack sufficient accuracy for clinical use.^{23,24} Abnormal readings on these devices should be confirmed with an FDA-cleared device or an arterial blood gas analysis.

Importantly, SpO₂ readings should only be interpreted within the context of a patient's entire clinical presentation (i.e., results should be disregarded if a patient is complaining of increasing dyspnea). See [Clinical Spectrum of SARS-CoV-2 Infection](#) for more information regarding the limitations of pulse oximetry.

Assessing the Need for In-Person Evaluation

When possible, patients with symptoms of COVID-19 may be triaged via telehealth visits to determine whether they require COVID-19–specific therapy and in-person care. Outpatient management may include the use of patient self-assessment tools. During the initial triage, clinic staff should determine which patients are eligible to receive supportive care at home and which patients warrant an in-person evaluation.²⁵

Patients with persistent or progressive dyspnea, especially those who have an SpO₂ ≤94% on room air at sea level or have symptoms that suggest high acuity (e.g., chest pain or tightness, dizziness, confusion, other mental status changes), should be evaluated by a health care provider (AIII).

Clinicians who use SpO₂ results to assess patients must be aware of the important limitations of pulse oximeters and conduct assessments in the context of a patient's clinical condition. See [Clinical Spectrum of SARS-CoV-2 Infection](#) for more information.

The criteria used to determine the appropriate clinical setting for an in-person evaluation may vary by location and institution. There should be a low threshold for in-person evaluation of older people and those with medical conditions associated with an increased risk of progressing to severe COVID-19. The individuals who perform the initial triage should use their clinical judgment to determine whether patients require ambulance transport.

In some settings where clinical evaluation is challenged by geography, home visits from a health care provider may be used to evaluate patients.²⁶ Patients who are homeless should be provided with housing where they can adequately self-isolate. All outpatients should receive instructions regarding self-care, isolation, and follow-up, and they should be advised to contact a health care provider or a local ED about any worsening symptoms.²⁷

Counseling Regarding the Need for Follow-Up

Clinicians should ensure that these patients receive adequate medical follow-up. The frequency and duration of follow-up will depend on the risk for severe disease, the severity of symptoms, and the patient's ability to self-report worsening symptoms. Health care providers should determine whether a patient has adequate transportation for clinic visits; whether they have access to a phone, computer, or tablet for telehealth visits; and whether they have regular access to food. The clinician should also confirm that the patient has a caregiver who can assist with daily activities if needed.

All patients and/or their family members or caregivers should be counseled about the warning symptoms that should prompt re-evaluation through a telehealth visit or an in-person evaluation in an ambulatory care setting or ED. These symptoms include new onset of dyspnea; worsening dyspnea (particularly if dyspnea occurs while resting or if it interferes with daily activities); dizziness; and mental status changes, such as confusion.

Managing Adults With COVID-19 Following Discharge From the Emergency Department

Clinicians who work in EDs should assess whether a patient requires hospital admission for the management of COVID-19 or whether the symptoms can be managed in the outpatient setting.

Treatment with an antiviral agent is recommended for outpatients with mild to moderate COVID-19 who are not on supplemental oxygen and are at high risk of clinical progression (see [Therapeutic Management of Nonhospitalized Adults With COVID-19](#)).

If a patient is not admitted to the hospital, the Panel **recommends against** the use of anticoagulants and antiplatelet therapy in the ED for the prevention of venous thromboembolism or arterial thrombosis, except in a clinical trial (**AIIfa**). This recommendation does not apply to patients with other indications for antithrombotic therapy. For more information, see [Antithrombotic Therapy in Patients With COVID-19](#). Patients should be encouraged to ambulate, and activity should be increased according to the patient's tolerance.

Managing Adults With COVID-19 Following Hospital Discharge

Most patients who are discharged from the hospital setting should have a follow-up visit with a health care provider soon after discharge. Whether an in-person or telehealth visit is most appropriate depends on the clinical and social situation. In some cases, adult patients are deemed to be stable for discharge from the inpatient setting while they still require supplemental oxygen. When possible, these individuals should receive oximetry monitoring and close follow-up through telehealth visits, visiting nurse services, or in-person clinic visits.

The Panel **recommends against** routinely continuing venous thromboembolism prophylaxis in patients with COVID-19 after hospital discharge unless they have another indication for anticoagulation (**AIIfa**). For more information, see [Antithrombotic Therapy in Patients With COVID-19](#). Patients should be encouraged to ambulate, and activity should be increased according to the patient's tolerance.

Considerations in Pregnant People

Managing pregnant outpatients with COVID-19 is similar to managing nonpregnant patients. Clinicians should offer supportive care and therapeutics as indicated, take steps to reduce the risk of SARS-CoV-2 transmission, and provide guidance on when to seek an in-person evaluation. Pregnant patients who have COVID-19 are at higher risk of severe disease, including a higher risk of death, intensive care unit admission, and mechanical ventilation, than nonpregnant people with COVID-19.^{28,29} Pregnant patients with COVID-19 also have an increased risk of poor obstetric and neonatal outcomes, and this risk may be even higher in people with comorbidities such as obesity, diabetes, hypertension, and lung disease.³⁰⁻³⁴ It is important for health care providers to thoroughly assess pregnant patients for potential risks of severe COVID-19 and offer antiviral therapy when indicated. Please see [Special Considerations During Pregnancy and After Delivery](#) for more information on managing pregnant patients with COVID-19.

In pregnant patients, SpO₂ should be maintained at ≥95% on room air at sea level; therefore, the threshold for monitoring pregnant patients in an inpatient setting may be lower than in nonpregnant patients. At this time, there are no changes to fetal monitoring recommendations in the outpatient setting, and fetal surveillance and management should be similar to the fetal surveillance and management used for pregnant patients with medical illness.^{35,36} However, these monitoring strategies can be discussed on a case-by-case basis with an obstetrician. Pregnant and lactating patients should be given the opportunity to participate in clinical trials of outpatients with COVID-19 to help inform decision making in this population.

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