



# General Management of Nonhospitalized Adults With Acute COVID-19

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## 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**).
- When possible, patients with symptoms of COVID-19 should be triaged via telehealth visits to determine whether they require COVID-19-specific therapy and in-person care (**AIII**).
- Patients who are at high risk of progression to severe COVID-19 may be eligible for pharmacologic therapy. See [Therapeutic Management of Nonhospitalized Adults With COVID-19](#) for specific recommendations.
- At a minimum, health care providers should use telehealth to closely follow patients with dyspnea, and in-person monitoring of these patients should be considered (**AIII**).
- Patients with persistent or progressive dyspnea, especially those who have an oxygen saturation measured by pulse oximetry ( $\text{SpO}_2$ )  $\leq 94\%$  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,  $\text{SpO}_2$  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.

## Introduction

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](#). The Panel recognizes that there are times during the COVID-19 pandemic when the distinction between outpatient and inpatient care may be less clear. Patients with COVID-19 may receive care outside traditional ambulatory care or hospital settings if there is a shortage of hospital beds, staff, or resources. In addition, asymptomatic SARS-CoV-2 infection or mild disease may be diagnosed during a patient's hospital admission for a non-COVID-19 condition. Health care providers should use their judgment when deciding whether the guidance offered in this section applies to individual patients.

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: telemedicine, remote monitoring, in-person visits, and home visits by nurses or other health care providers.

Data from the United States show that racial and ethnic minorities experience higher rates of COVID-19, hospitalization, and death.<sup>1-5</sup> In addition, inequitable receipt of COVID-19 treatments by race, ethnicity,

and socioeconomic status has been reported.<sup>6-8</sup> The underlying causes of these observed disparities may include barriers to telehealth visits, transportation challenges, inadequate insurance coverage, a lack of primary care providers, and hesitancy about receiving treatment. To reduce COVID-19 treatment disparities, providers must be aware of the problem and provide patient-centered care. All patient groups must have equal access to treatments, regardless of race, ethnicity, or other minoritized status.

## 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,<sup>9</sup> and the proportion is likely higher in patients who are vaccinated. 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 (those with viral pneumonia but without hypoxemia) or severe COVID-19 (those with dyspnea, hypoxemia, or lung infiltrates >50%) need in-person evaluation and close monitoring, as pulmonary disease can progress rapidly and require hospitalization.<sup>10</sup>

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 (CDC),<sup>11,12</sup> and advise patients on when to seek an in-person evaluation.<sup>13</sup> 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.<sup>14</sup> Health care providers should identify patients who are at high risk of progression to severe COVID-19. These patients may be candidates for antiviral therapy, including treatment with an anti-SARS-CoV-2 monoclonal antibody (mAb). See [Therapeutic Management of Nonhospitalized Adults With COVID-19](#) for more information.

Older patients and those with chronic medical conditions have a higher risk of hospitalization and death. However, SARS-CoV-2 infection may cause severe disease and death in patients of any age, even in the absence of risk factors. In the care of 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.

## Assessing the Need for In-Person Evaluation

When possible, patients with symptoms of COVID-19 should be triaged via telehealth visits to determine whether they require COVID-19-specific therapy and in-person care (**AIII**). 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.<sup>15</sup> Local emergency medical services, if called by the patient, may also be helpful when deciding whether an in-person evaluation is indicated.

At a minimum, health care providers should use telehealth to closely follow patients with dyspnea, and in-person monitoring of these patients should be considered (**AIII**). Patients with persistent or progressive dyspnea, especially those who have an oxygen saturation measured by pulse oximetry ( $\text{SpO}_2$ )  $\leq 94\%$  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 who use  $\text{SpO}_2$  results when assessing 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. It may also change over time as new data and treatment options emerge. There should be a low threshold for in-person evaluation of older people and those with medical conditions associated with an increased risk of progression to severe COVID-19. 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, health care provider home visits may be used to evaluate patients.<sup>16</sup> Patients who are homeless should be provided with housing where they can adequately self-isolate. Providers should be aware of the potential adverse effects of prolonged social isolation, including depression and anxiety.<sup>14</sup> 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 for any worsening symptoms.<sup>12</sup>

## 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 studies of patients who developed acute respiratory distress syndrome, progression occurred a median of 2.5 days after the onset of dyspnea.<sup>17-19</sup> At a minimum, health care providers should use telehealth to closely follow patients with dyspnea, and in-person monitoring of these patients should be considered (**AIII**). Patients with persistent or progressive dyspnea, especially those who have an SpO<sub>2</sub> ≤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<sub>2</sub> 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.<sup>10,20,21</sup>

Not all commercially available pulse oximeters have been cleared by the Food and Drug Administration (FDA). SpO<sub>2</sub> readings obtained through non-FDA-cleared devices, such as over-the-counter sports oximeters or mobile phone applications, lack sufficient accuracy for clinical use.<sup>22,23</sup> Abnormal readings on these devices should be confirmed with an FDA-cleared device or an arterial blood gas analysis. Importantly, SpO<sub>2</sub> 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.

## Counseling Regarding the Need for Follow-Up

Health care providers should identify patients who are at high risk of disease progression. These patients may be candidates for antiviral therapy, including treatment with an anti-SARS-CoV-2 mAb (see [Therapeutic Management of Nonhospitalized Adults With COVID-19](#)). 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 access to a phone, computer, or tablet for telehealth; whether they have adequate transportation for clinic 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

There are no fixed criteria for admitting patients with COVID-19 to the hospital; criteria may vary by region and hospital facility. Patients with severe disease are typically admitted to the hospital. Rarely, a patient with severe disease may not be admitted due to a high prevalence of infection and limited hospital resources. In addition, patients who could receive appropriate care at home but are unable to be adequately managed in their usual residential setting are candidates for temporary shelter in supervised facilities, such as a COVID-19 alternative care facility.<sup>24</sup> For example, patients who are living in multigenerational households or are homeless may not be able to self-isolate and should be provided resources such as dedicated housing units or hotel rooms, when available. Unfortunately, dedicated residential care facilities for patients with COVID-19 are not widely available, and community-based solutions for self-care and isolation should be explored.

Treatment with an antiviral agent or anti-SARS-CoV-2 mAb is recommended for patients 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](#)).

In rare cases where institutional resources (e.g., inpatient beds, staff members) are scarce, it may be necessary to discharge an adult patient and provide an advanced level of home care, including supplemental oxygen (if indicated), pulse oximetry, and close follow-up. Although early discharge of patients with severe disease is not generally recommended by the Panel, it is recognized that these management strategies are sometimes necessary. In these situations, some institutions have provided frequent telemedicine follow-up visits for these patients or a hotline that allows patients to speak with a clinician when necessary. Home resources should be assessed before a patient is discharged from the ED. Outpatients should have a caregiver and access to a device suitable for telehealth. Patients and/or their family members or caregivers should be counseled about the warning symptoms that should prompt re-evaluation by a health care provider.

If a patient is not being admitted to the hospital, the Panel **recommends against** the use of anticoagulants and antiplatelet therapy in the ED for the prevention of venous thromboembolism (VTE) or arterial thrombosis, except in a clinical trial (**AIIa**). 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, although they still require supplemental oxygen. Special consideration may be given to continuing certain therapeutics (e.g., dexamethasone) in this setting. For more information, see [Therapeutic Management of Nonhospitalized Adults With COVID-19](#). 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 VTE prophylaxis after hospital discharge for patients with COVID-19 unless they have another indication or are participating in a clinical trial (AIII). 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 Pregnancy

Managing pregnant outpatients with COVID-19 is similar to managing nonpregnant patients (see [Special Considerations in Pregnancy](#)). 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. The American College of Obstetricians and Gynecologists (ACOG) has published recommendations on how to use telehealth for prenatal care and how to modify routine prenatal care when necessary to decrease the risk of SARS-CoV-2 transmission to patients, caregivers, and staff.<sup>25</sup>

In pregnant patients, SpO<sub>2</sub> should be maintained at 95% or above 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.<sup>26,27</sup> 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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