

COVID Community Management Guidelines

The management of patients triaged as high- or moderate- risk is guided by the principles of 1) continuity, with attempts made to have the patient follow with the same provider throughout the clinical course; 2) a focus on management responsive to the classic clinical course of COVID, and notably turning points at days 4-7 and 9-12 of disease; 3) a focus on pulmonary involvement as the outpatient manifestation of progression to severe disease; and 4) the need to provide comprehensive care including seamless referral for in-person evaluation, if warranted, focus on anticipatory goals of care discussions, and referral to additional resources as needed.

Providers have initial televisits scheduled with patients either: 1) on Day 4 of symptoms; 2) if past Day 4 at the time of initial call, 48 hours after initial triage call; or 3) 24 hours after Respiratory Clinic evaluation. Follow up visits are based on a general framework of “touches” at a minimum at days 4, 7, and 10, but additional follow up is often much more frequent and deferred to the clinical judgment of the risk manager.

Initial phone contact:

During the phone call, the provider will reconfirm the following:

- Initial date of symptoms
- Medical comorbidities
- Living situation
- Household members and close contacts
- Understanding of self-isolation and self-quarantine

Assessment of symptoms:

On each call, pr will review all COVID symptoms with particular attention to dyspnea. Dyspnea and any signs of hypoperfusion are the most likely indications to require reevaluation in Respiratory Clinic and hospitalization.

Evaluation of dyspnea:

Evaluation of dyspnea focuses on:

1. Subjective assessment of breathing.
2. Objective assessment of breathing.
3. Roth score, if appropriate.

Table 10: Evaluation of dyspnea

Subjective evaluation of dyspnea:

- “How is your breathing today?”
- “Do you feel short of breath?”
- “Describe your breathing.”
- “What makes your breathing better or worse?”

- Do you feel short of breath:
 - Walking?
 - Walking up stairs?
 - Lying down?
 - Eating?
 - At rest?

- Is there anything that makes your breathing feel better?
 - Resting?
 - Lying on stomach?
 - Inhalers?

Objective evaluation of dyspnea:

Objective evaluation:

- Can the patient speak in complete sentences?
- Does the patient sound short of breath?

Assessment of respiratory capacity:

- “Where are you spending most of your time?” [in bed, in a chair, etc.]
- “Can you walk to the bathroom?”
- “Can you walk up a flight of stairs without stopping to catch your breath?”
- “Please walk across the room and speak to me as you walk.”

Change in respiratory function:

- “How far could you walk yesterday without stopping to take a breath?”
- “What did you do yesterday during the day? What did you do today?”

Use of the Roth score:

In patients with obvious moderate or severe dyspnea, or patients in whom there has been a change in respiratory status, the Roth score does not need to be performed; these patients should be evaluated in person. Patients with access to oximetry also do not require Roth score evaluation. In patients with an equivocal history or in whom there is no obvious respiratory component, the Roth score can help to elicit respiratory involvement that was not otherwise identified.

Table 11: Roth score

- Instructions:
 - *Patient instructions:* Take a breath in and count as fast as you can in your native language. Count until 30 or until you have to take a breath.
 - *Clinician:* Time # seconds to reach 30 or until the patient must take a breath. Also record maximum number reached.
- Interpretation:
 - If counting # < 10, suspect possible hypoxemia
 - If counting time < 7, suspect possible hypoxemia

Any patient with features of subjective or objective will be scheduled in Respiratory Clinic. For patients in whom the Roth test suggests SpO2 < 95%, patients will be referred to Respiratory Clinic.

Follow up:

Providers will determine follow up based on 1) patient’s clinical presentation, with particular attention paid to dyspnea; 2) medical comorbidities predisposing to severe course; 3) social factors; and 4) time in clinical course. If it becomes clear that the patient does not have COVID, the patient can be discharged from Community Management at any time.

All follow-up is done based on Day 1 of symptoms. Particular attention must be paid to days 5-8 and days 11-12, as these are known to be potential turning points in the disease. All patients will be followed for a minimum of 7 days with contact at days 4, 7, and 10 at minimum. If patient symptoms have **completely** resolved Day 7, they can be discharged from Community Management. Moderate-risk patients will otherwise be followed until Day 10, and high risk patients until Day 14; if there is no respiratory component, providers can choose to discontinue follow up at Day 10 or 14, respectively. (See appendices 2 and 3.)

Table 12: Follow up

Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
			***			*** STOP*			*** STOP**				STOP***

- *** These days are required provider "touches," as is the first day after the patient calls (may be Day 2 or some other day)
- * Stop only if symptoms resolved; if not, continue through Day 14
- ** Stop only if moderate-risk patient and symptoms resolved; if not, continue until symptoms resolved
- *** Stop if if symptoms resolved; if not, continue until symptoms resolved

If a patient is seen in Respiratory Clinic, a 24-hour televisit will be scheduled.

Management of co-infections and other medical issues:

Some patients with possible COVID may have evidence of a second progress, or may present with an unclear clinical picture (e.g. COVID vs heart failure, or COVID vs different infectious etiology). If a clinical evaluation may clarify the picture, for instance in the case of possible comorbid or independent bronchospastic disease exacerbation, the patient should be booked in Respiratory Clinic. It is acceptable to empirically treat suspected co-infections (e.g. PNA) or alternate diagnoses (e.g. Strep throat). All patients treated in this manner should still be presumed to have COVID. No treatment for infection risks worsening the clinical picture of COVID.

Risk group transitions:

Patients transition into Community Management if and when they develop Cardinal Symptoms of COVID. Patients are also transitioned to the moderate risk group from the low risk group if they have an initial outreach from the Outreach Team and subsequently call with worsening symptoms. Additionally, risk managers and respiratory clinic staff use clinical judgment to inform risk level transitions based on the following criteria, and clinical judgment:

- Advanced symptomatology warranting transition to high risk group for patients otherwise triaged to low or moderate risk
- Social or other factors necessitating frequent outreach
- Particularly severe comorbidities requiring risk group upgrade (e.g. uncontrolled diabetes requiring transition to high risk group) or, conversely, particularly mild comorbidities suggesting little clinical impact (e.g. diet-controlled diabetes)