MedStar Health

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COVID-19

Outpatient Treatment of COVID-19 – Pneumonia Evaluation and When to Transfer to the ED

Background: COVID-19 is a lower respiratory disease that results in presenting symptoms of fever, cough, and shortness of breath. The following guidance should be used by ambulatory providers in the evaluation and management of patients who present with these symptoms and for whom pneumonia or transfer to the emergency department (ED) are considered.

Clinical Guidance for Assessment of Severity of Illness in Patients Suspected or Confirmed to Have COVID-19:

- Follow the guidance below to determine the optimal care setting for management. Take into consideration underlying conditions, ability to self-monitor symptoms, and signs of moderate to severe illness.
- If patient is evaluated first via eVisit, Virtual Visit, or Virtual Check-In and there is concern for pneumonia, refer the patient to their PCP's office or closest Urgent Care or Emergency Department for in-person evaluation.

Low Risk Group (Mild Disease) From ED - Consider discharge	• Resting O2Sat > 94% and; • No desaturation with ambulation and; • RR < 20 and; • Clinically well appearing
Moderate Risk Group (Moderate Disease) From ED – Evaluate for Admission *Application of these suggested criteria should not override clinician gestalt for upfront ICU evaluation*	Resting hypoxemia or Ambulatory desaturation OR Any 2 of the following: • Confusion/AMS • Underlying conditions: DM, Immunosuppression, Severe Pulmonary Disease, CHF or Hypertension • RR > 25 • BP: SBP<90; DBP<60***(higher crystalloid needs)### • Age > 60

Evaluation and Management Recommendations for Moderate Risk Patients:

- Refer to the nearest Emergency Department.
- If the patient does not feel comfortable driving or being driven, or if you feel driving by personal car is unsafe, arrange for EMS transfer.

Evaluation Recommendations for Low Risk Patients:

- Patient can most likely be managed safely as an outpatient with self-monitoring of symptoms at home.
- If pneumonia is suspected, obtain a chest x-ray. If x-ray cannot be obtained (due to COVID-19 restrictions at radiology center), treat empirically with antibiotics per your clinical judgment.

  - Arrange follow-up within 48-72 hours and provide precautions for when patient should go to the ED.
- Follow the Testing Decision Guidance to determine whether COVID-19 testing should be performed. Consider testing if results will return within a timeframe that changes management (i.e. ordering radiology studies or prescribing medications).

Medication Management Recommendations for Low Risk Patients with Suspected or Confirmed Pneumonia (suspected or confirmed):

- **Hydroxychloroquine** is NOT currently recommended for outpatient treatment of COVID-19 with or without pneumonia.
- **Albuterol MDI** can be given for patients with history of reactive airway disease, COPD, asthma, or with wheezing on exam. AVOID nebulizers as this can increase spread of the virus.
- **Oral steroids** are NOT indicated for treatment of COVID-19, unless the patient is having a flare of underlying lung disease. Inhaled steroids should also be avoided unless the patient is already using this medication to treat an underlying lung disease.
- **NSAIDs** can be used for fever reduction and body aches but should not be recommended as a standalone treatment for COVID-19.
- **Antibiotics**: The below antibiotic regimens are recommended to treat pneumonia based on chest x-ray findings and COVID-19 status (c/w ATS/IDSA guidelines and Up to Date Guidelines from 10/2019):
  - PUI with interstitial markings on x-ray (no consolidation):
    - Age < 65 without co-morbidities: Azithromycin (500 mg on first day then 250 mg daily) or doxycycline (100 mg twice daily) for atypical pneumonia
    - Age > 65 or with co-morbidities: **consider adding** Augmentin (500 -125 mg TID, 875-125 mg BID or 2 grams-125 mg BID). Note for PCN-allergic patients use cefuroxime 500 mg BID; if history of anaphylaxis to PCN consider use of Azithromycin alone.
    - *For patients who test positive for COVID-19 or who are not tested and there is strong suspicion for COVID-19, can consider discontinuing or not prescribing antibiotics, as incidence of co-infection is low; use clinical judgment.*
  - PUI with focal consolidation on x-ray:
    - Age < 65 without co-morbidities: Amoxicillin (1 gm three times a day; for PCN-allergic patients use cefuroxime) **plus** azithromycin (500 mg on first day then 250 mg daily). Note if history of anaphylaxis to PCN use respiratory quinolone e.g. moxifloxacin 400 mg daily; if history of PCN allergy use cefuroxime 500 mg BID.
    - Age > 65 or with co-morbidities: Augmentin (500 -125 mg TID, 875-125 mg BID or 2 grams-125 mg BID) **plus** Azithromycin (500 mg on first day and 250 mg daily after). Note if history of anaphylaxis to PCN use respiratory quinolone e.g. moxifloxacin 400 mg daily; if history of PCN allergy use cefuroxime 500 mg BID.
  - With no abnormal findings on x-ray: supportive care
  - If x-ray is not available as outpatient: treat empirically using one of the above regimens, per your clinical judgment.