UPDATES ON COVID-19 PATIENT CARE MODEL AND CASE REPORTING

w.e.f. 13 Feb 2023

FREQUENTLY ASKED QUESTIONS (FAQs)

(Information Accurate as of 23 February 2023)

Reference: MOH Circular No. 04/2023: Updates on COVID-19 Patient Care Model and Case Reporting (9 February 2023) and MOH Circular 05/2023: COVID-19 Vaccination Updates: 2023 Recommendations for COVID-19 Booster Vaccination

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Overview

This set of FAQs references MOH Circular 04/2023*: Updates on COVID-19 Patient Care Model and Case Reporting dated 9 February 2023* and MOH Circular 05/2023: *COVID-19 Vaccination Updates: 2023 Recommendations for COVID-19 Booster Vaccination*.

From **13 February 2023**, Protocols 1-2-3 will be stood down and replaced by a general advisory. COVID-19 testing (ART and PCR) will continue to be Government-paid until 31 March 2023.

From **1 April 2023**, the additional subsidies previously provided will be scaled down accordingly and where applicable, financial support will revert to the S+3Ms (Subsidies, Medisave, Medishield and Medifund) healthcare financing frameworks.

Patient Care Model

1. Protocols 1-2-3 will no longer be used to manage COVID-19 patients and close contacts.
2. Doctors-in-charge[1] are required to oversee patients' care and management. They are to manage most COVID-19 patients, except the following:
    a. Clinically unstable patients should be referred to Emergency Departments (ED) if medically indicated.
    b. COVID-19 positive neonates less than 1 month old and with a fever (≥38°C), should be referred to the Children's Emergency for clinical assessment and be considered for admission to undergo inpatient investigation/management.

Patient Testing and Case Reporting [Updated]

3. SARS-CoV-2 testing will **not** be routinely required for every patient with acute respiratory infection (ARI) symptoms.
4. SARS-CoV-2 testing is **mandated** for the following patients:
    a. **Patients who are medically vulnerable and would benefit from early COVID-19 diagnosis and treatment** (i.e. paediatric (less than 12 years old), pregnant, geriatric (80 years old and above), dialysis-dependent and immunocompromised patients). If the ART is negative, an additional PCR test should be considered, especially if clinical suspicion is high, as the PCR is a more accurate test.
5. SARS-CoV-2 testing is **recommended** for the following patients:
    a. **Patients with travel history in the 7 days prior to the onset of ARI symptoms are recommended to be tested**. This contributes to MOH's continued surveillance of the global COVID-19 situation. Doctors do not need to specify travel history of these patients when submitting test results because MOH uses other government databases to do so.

[1] Doctor-in-charge refers to any registered medical practitioner who provides clinical care for a person with an undiagnosed health concern as well as continuity care for known medical conditions. This includes General Practitioners (GPs), Polyclinic doctors and Specialist doctors who are involved in patient care and management.

6. SARS-CoV-2 testing under **clinical discretion** may be considered for the following patients:
   a. Patients who are 60 to less than 80 years old.
   b. Patients who are not mandated for testing but fulfil the risk criteria detailed in Annex A of MOH Circular No. 04/2023 [see **Annex A** of GP FAQs].
   c. Patients who fulfil the prevailing criteria for OAV prescription [see **Annex B** of GP FAQs].
   d. Any other patients belonging to the groups listed in the "Advisory on Vulnerable Group" as referenced within the 9 Feb 2023 MTF Press Release "Singapore to Exit Acute Phase of Pandemic" [see **Annex C** of GP FAQs].

   Example of testing under clinical discretion: 50-year-old obese (BMI>30) patient with Diabetes Mellitus (DM), who presents on day 3 since onset of symptoms and is still symptomatic. This patient would fulfil the criteria for OAV prescription and can be tested for COVID-19 even though he/she does not fall in the category of patients who are mandated or recommended to be tested.

7. If testing is clinically indicated, the default testing of choice should be Antigen Rapid Test (ART). For healthcare provider-administered ARTs, healthcare providers should communicate the results to patients in alignment with other point of care testing.

8. COVID-19 tagging and submission of COVID-19 test results. Doctors-in-charge should continue to submit COVID-19 test results and tag COVID-19 positive patients using the following means:

   a. PRPP, iConnect.COVID and SRS users should submit COVID-19 test results and tag COVID-19 positive patients as per current practice.

   b. EMR users should submit COVID-19 test results via EMR and tag the patients through FormSG, using the embedded link in EMR or via https://go.gov.sg/submit-covid-tagging (see **Annex B** in the MOH Circular 04/2023 for details).

9. HealthHub. Doctors-in-charge should continue to submit ART results via PRPP/ iConnect.COVID/ SRS/ EMR, which will be reflected in HealthHub. PCR results will continue to be automatically reflected in HealthHub.

COVID-19 Recovery in the Community

10. COVID-19 positive patients who are mildly ill and/or patients with mild ARI symptoms should be advised to recover at home.

11. Doctors-in-charge are recommended to exercise their clinical judgement when issuing the duration of sick leave for COVID-19 positive patients and/or patients with ARI symptoms, and can adjust the duration as appropriate.

12. Doctors-in-charge can issue memos for patients who may require documentation of COVID-19 infection.

13. Commuting on public transport services, such as bus and MRT, is permitted. All COVID-19 positive patients and/or patients with ARI symptoms must remain masked regardless of transportation modality.

Healthcare Subsidies and Costs Involved for COVID-19 Treatment

13. From 1 April 2023, all patients will be required to pay for any COVID-19 testing (ARTs and PCRs), subject to prevailing subsidies.

14. Until further notice, COVID-19 oral anti-virals will remain fully subsidised for clinically eligible patients in ED and SOC settings of public hospitals (only for Singapore Citizens / Permanent Residents / Long-Term Pass Holders), polyclinics and PHPCs.

15. In addition, from 1 April 2023, non-designated Telemedicine (TM) providers[2] will no longer be able to claim for COVID-19 related TM services.

Key Operational Changes for PHPCs

The following key operational changes for PHPCs are listed in chronological order.

16. From 13 February 2023, Joint Testing and Vaccination Centres (JTVCs) will no longer accept swab referrals.

17. From 1 April 2023, the following will cease.
    a. Designated paediatric swab centres (Thomson Medical Centre and Raffles Hospital) providing Government-paid swabs.
    b. Provision of free ART kits to PHPCs.
    c. Current lab pairing arrangement for Government-paid COVID-19 PCR tests.

18. From 1 April 2023, the swabbing GP clinics may charge patients consultation fee on top of the swab fee for patients who are referred to them for swabs even if within 48 hours.

19. From 14 May 2023, provision of free PPEs to PHPCs will cease.

Vaccination Updates

20. The following groups are recommended to receive in 2023, one booster dose of COVID-19 vaccine at an interval of one year after their last booster dose1[3]:
    a. Ages 60 years and above,
    b. Medically vulnerable persons[4] or,
    c. Residents living in aged care facilities.

21. All persons aged 12 years and above may also do so if they choose to.

22. The updated bivalent vaccines are recommended for the above vaccination.

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[2] Non-designated Telemedicine (TM) providers refer to TM providers not designated by MOH (MOPC) for COVID-19 TM services.

[3] 1 Regardless of the number and composition (monovalent/bivalent) of previous booster doses.

[4] List of medical conditions who which persons are considered medically vulnerable to severe COVID-19 include: diabetes; heart conditions such as heart failure, ischemic heart disease, cardiomyopathy; chronic lung conditions, including severe asthma; chronic liver conditions, including cirrhosis; chronic kidney conditions, including dialysis; chronic neurologic conditions, including stroke; cancer on active treatment; blood conditions such as thalassemia and sickle cell anemia; immunodeficiencies, including HIV infection; obesity (BMI ≥ 30); genetic or metabolic conditions, including Down's syndrome and cystic fibrosis; persons on non-cancer immunosuppressive treatment and pregnancy (any trimester).

23. Children aged 5 to 11 years are recommended to achieve Minimum Protection (first booster Dose from around 5 months after last dose). For Children aged 6 months to 4 years, they are recommended to complete two doses of Moderna/SpikeVax or three doses of Pfizer-BioNTech/Comirnaty. Children are not recommended nor eligible for additional doses at this time.

Frequently asked question (FAQ)

Patient Testing and Case Reporting in DORSCON Green

1. How do I determine if a patient needs a SARS-CoV-2 test? [Updated]

With high population vaccination coverage, most COVID-19 infections tend to be mild with uneventful recoveries.

a. SARS-CoV-2 testing will **not** be routinely required for every patient with acute respiratory infection (ARI) symptoms.

b. SARS-CoV-2 testing is **mandated** for the following patients:

Patients who are medically vulnerable and would benefit from early COVID-19 diagnosis and treatment (i.e. paediatric (less than 12 years old), pregnant, geriatric (80 years old and above), dialysis-dependent and immunocompromised patients). If the ART is negative, an additional PCR test should be considered, especially if clinical suspicion is high, as the PCR is a more accurate test.

These individuals will benefit from early COVID-19 treatment with OAVs, if suitable. These patients should also be considered for referral to receive free 24/7 ad hoc TM services.

c. SARS-CoV-2 testing is **recommended** for the following patients:

Patients with travel history in the 7 days prior to the onset of ARI symptoms are recommended to be tested. This contributes to MOH's continued surveillance of the global COVID-19 situation. Doctors do not need to specify travel history of these patients when submitting test results because MOH uses other government databases to do so.

d. SARS-CoV-2 testing under **clinical discretion** may be considered for the following patients:

i. Patients who are 60 to less than 80 years old.
ii. Patients who are not mandated for testing but fulfil the risk criteria detailed in Annex A of MOH Circular No. 04/2023 [see **Annex A** of GP FAQs].
iii. Patients who fulfil the prevailing criteria for OAV prescription [see **Annex B** of GP FAQs].
iv. Any other patients belonging to the groups listed in the "Advisory on Vulnerable Group" as referenced within the 9 Feb 2023 MTF Press Release "Singapore to Exit Acute Phase of Pandemic" [see **Annex C** of GP FAQs].

Example of testing under clinical discretion: 50-year-old obese (BMI>30) patient with Diabetes Mellitus (DM), who presents on day 3 since onset of symptoms and is still symptomatic. This patient would fulfil the criteria for OAV prescription and can be tested for COVID-19 even though he/she does not fall in the category of patients who are mandated or recommended to be tested.

If testing is clinically indicated, the default testing of choice should be the ART**.**

ARI Sentinel Surveillance would require a PCR test.

2. What is the 'ARI Sentinel Surveillance' programme about? Can my clinic sign up for it? [New]

The ARI sentinel surveillance programme is currently carried out at selected polyclinics to monitor prevalence and identify any changes in the circulating SARS-CoV-2 variants and other respiratory viruses in the community. A free-of-charge PCR test for COVID-19 and other common respiratory pathogens is offered to a random sampling of patients, and COVID-19 positive samples are sequenced to determine the underlying variant.

Some GP clinics are on a similar influenza-like illness (ILI) surveillance programme. MOH plans to progressively expand the ARI surveillance programme to include these GP clinics and include other clinics that are keen to join. Details will be shared once the ARI programme is opened up to GP clinics.

3. What does clinical discretion testing entail? [New]

General practitioners may still recommend patients for SARS-CoV-2 testing based on their own clinical judgement, whether the test is Government-paid.

The following group of patients who do not fall under the recommendations as outlined in MOH Circular 04/2023 Para 2 are explicitly identified for testing based on **clinical discretion** and would be eligible for Government-paid swabs from 13 February 2023 to 31 March 2023 (inclusive):

a. Patients who are 60 to less than 80 years old.
b. Patients who are not mandated for testing but fulfil the risk criteria detailed in Annex A of MOH Circular No. 04/2023 [see **Annex A** of GP FAQs].
c. Patients who fulfil the prevailing criteria for OAV prescription [see **Annex B** of GP FAQs].
d. Any other patients belonging to the groups listed in the "Advisory on Vulnerable Group" as referenced within the 9 Feb 2023 MTF Press Release "Singapore to Exit Acute Phase of Pandemic" [see **Annex C** of GP FAQs].

4. What is the cut-off age for paediatric/geriatric patients who are considered medically vulnerable? [Updated]

The cut-off age for paediatric patients is age less than 12 years old. However, MIS-C age criteria[5] extends up to 19 years old and below.

The cut-off age for geriatric patients is 80 years old and above. However, those who are 60 to less than 80 years old may be tested at clinical discretion.

[5] Kindly refer to Annex A-2 of MOH Circular No. 04/2023: Updates on COVID-19 Patient Care Model and Case Reporting dated 9 February 2023.

5. **For the purposes of COVID-19 testing criteria, is there any threshold for gestational age of pregnant patients?**

   All pregnant patients with ARI symptoms should be tested regardless of gestational age and if assessed that they would benefit from early COVID-19 diagnosis and treatment.

6. **Can I proceed to conduct a PCR swab (without ART) for patients who are assessed to be medically vulnerable, if they are agreeable to undergo a PCR swab?**

   ART swabs are sensitive for the current COVID-19 variant and less costly than a PCR swab. Hence, ART testing should remain the first-line test if COVID-19 is suspected. However, if patient is agreeable for a PCR swab, the doctor-in-charge can proceed to do the PCR swab alone without ART, taking into account the turnaround time for the test results.

7. **If a patient is symptomatic with recent travel history in the last 7 days and visits my clinic asking to be tested, should I provide ART/ PCR swab as requested? [Updated]**

   Patients with ARI symptoms and who had travelled overseas within the last 7 days are recommended to tested for COVID-19. This reporting contributes to MOH's continued surveillance of the global COVID-19 situation.

   The default test should be an ART. If a positive result is obtained, medical practitioners should submit the result via PRPP/ iConnect.COVID/ EMR/ SRS and tag the patient as "Case Reporting", if they are assessed not to be high/intermediate risk who require ad-hoc Telemedicine (TM) support. Doctors do not need to specify travel history of these patients when submitting test results because MOH uses other government databases to do so.

8. **What if my patient refuses a swab test?**

   a. **Medically vulnerable patients**

      Please advise the medically vulnerable patients to undergo a swab test for confirmation, and to be considered for early initiation of OAV if suitable. High/ intermediate risk patients may also benefit from the free 24/7 ad hoc TM support.

   b. **Patients with travel history (last 7 days) and have ARI symptoms**

      Please advise that MOH recommends that such patients undergo swab tests as results contribute to its continued surveillance of the global COVID-19 situation.

   For individuals who refuse to be swabbed despite the advice provided, doctors-in-charge should counsel patients on the indication of the test and document the reason for declining the test. Doctors-in-charge are recommended to exercise their clinical judgement in issuing the sick leave duration for COVID-19 positive patients and/or patients with ARI symptoms, and doctors can exercise clinical discretion in adjusting the duration as appropriate.

9. If my clinic does not provide ART, where should I refer my patients for the test?

We encourage all clinics to implement the provision of ARTs for patients who require a healthcare-administered ART swab.

Medically vulnerable patients with ARI symptoms and who would benefit from early COVID-19 diagnosis and treatment should be tested, while patients with recent travel history in the last 7 days and exhibit ARI symptoms are recommended to be tested. If testing is clinically indicated, the default choice should be the ART.

Clinics that need to refer patients for ART, please direct patients to a nearby SASH Clinic. Please do not refer patients to Polyclinics and Joint Testing and Vaccination Centres (JTVCs) as these referral workflows will cease from 13 February 2023.

10. Which brands of ART kits can be used on children aged from 3 months to less than 12 months old? [Updated]

The following three brands of ART kits can be used for children younger than 2 years old. However, they should be administered by healthcare workers.

- SD Biosensor Standard Q [New]
- Abbott PanBioTM COVID-19 Antigen Self-Test
- Acon Biotech Flowflex SARS-CoV-2 Antigen Rapid Test (Self-Testing)

11. Will the patients' ART/ PCR results continue to be reflected on Healthhub? Will SMS notifications be sent to them?

Doctors should submit all healthcare-administered ART results to PRPP / iConnect.COVID / SRS/ EMR (linked to FormSG), which will be reflected in HealthHub. PCR results will continue to be automatically reflected in HealthHub.

For patients who may require the doctor's memo for other purposes, doctors may separately issue such memos for the patients. Even though SMS notifications for ART results will continue to be sent to patients, doctors should communicate the test results to the patients.

12. Will clinics have to submit all ARI visits to PRPP or only for patients that will be tested for COVID-19?

Submission of ARI visit to PRPP is required **only** for patients who fulfil the prevailing criteria and are tested for COVID-19.

13. Do clinics still need to segregate high-risk patients?

Since 22 April 2022, safe distancing is no longer be required in all settings. However, clinics are encouraged to maintain safe distancing for febrile patients, where possible, given that these patients are symptomatic.

14. Am I still required to register non-ARI patients' visit onto PRPP?

With effect from 13 February 2023, clinics are only required to register patients who require a swab test onto PRPP. These include asymptomatic patients who request for a COVID-19 swab test (e.g., for travel purposes).

ARI/Fever/Swab reporting section is required only for cases that fulfil the prevailing criteria for COVID-19 swab test.

15. My patient is not high/intermediate risk but still requires a COVID-19 swab. What protocol should I select in PRPP?

You should select 'Case Reporting' Protocol. If the health protocol submitted is "NIL/NA/Others", it will create a record of the ART result for the patient in Healthhub but will not trigger any public health actions[6].

16. Am I required to report to MOH on deaths due to COVID-19?

Doctors-in-charge would no longer be required to notify MOH of deaths due to COVID-19. However, they should continue to notify I-FMD (Forensic Medicine Division), if the COVID-19 deceased is to be transferred for Post-Mortem under the Coroners Act or Infectious Diseases Act. Doctors-in-charge should ensure that the deceased's medical records contain documented evidence of infection (i.e., tested COVID-19 positive by PCR or healthcare provider administered ART) when documenting COVID-19 as cause of death or as a contributory factor.

17. What documentation should be given to the family of a COVID-19 deceased?

Doctors-in-charge should continue to provide a copy of the "***Memo by Medical Practitioner for Personnel Managing Deceased Persons with Suspected or Confirmed COVID-19***" to the family of COVID-19 deceased, without having to notify MOH. Refer to **Annex C** of MOH Circular 04/2023 for the updated memo. The family of the deceased should be informed to provide the memo to the engaged undertaker, to facilitate the safe handling and management of the deceased's remains.

[6] Public health and case management actions such as Telemedicine support is triggered only for patients whose Health Protocol was selected as "High/intermediate risk AND need 24/7 ad-hoc TM Support".

Patient Care Model

18. How should COVID-19 paediatric patients with Co-morbidities of Concern (COC) and/or Symptoms/Signs of Concern (SOC) be managed? [Updated]

Neonates less than 1 month old and running a fever (≥38°C) should be referred to the Children's Emergency (CE) for clinical assessment and be considered for admission to undergo inpatient investigations / management. Infants less than 3 months old should be evaluated for other relevant concomitant diagnoses.

Children with COC should be co-managed with their paediatrician[7], as they may be eligible for early initiation of therapeutics and are at risk of developing more severe illness. Doctors are to have a high index of suspicion for Multi-system Inflammatory Syndrome in Children (MIS-C) when managing patients below 19 years old.

Please be vigilant in monitoring for MIS-C. The following table shows the detailed criteria for MIS-C diagnosis[8]:

Criteria for case definition of MIS-C

- All 6 criteria must be fulfilled to meet case definition.
- All patients who fulfil MIS-C criteria or when there is high clinical suspicion of MIS-C, should be conveyed to hospital ED for further evaluation.

1) Age 0-19 years old
2) Persistent high fever (>38.5°C) for 3 or more days
3) Signs of multisystem involvement (at least 2 systems below)
    a. Cardiovascular (e.g., raised cardiac biomarkers, pericarditis, coronary abnormalities, ECG abnormalities)
    b. Hypotension or shock (e.g., light-headedness/dizziness)
    c. Gastrointestinal (e.g., diarrhoea, vomiting, abdominal pain)
    d. Mucocutaneous features (e.g., rash, conjunctivitis, mucositis/red, cracked lips and red tongue, swollen hands or feet)
    e. Neurological manifestations (e.g., headache, altered mental state, seizures)
    f. Haematological (e.g., lymphopenia, thrombocytopenia, coagulopathy)
    g. Respiratory (e.g., shortness of breath, tachypnoea)
    h. Renal (e.g., marks of acute renal injury)
4) Elevated markers of inflammation (e.g., CRP, ferritin, Procalcitonin, fibrinogen)
5) Other bacterial/viral causes are excluded AND
6) Evidence of current or recent COVID infection (e.g., PCR-positive, serology positive or antigen positive)

Notes for MIS-C:

- Always have a **high index of suspicion** for children **displaying high fever (>38.5°C) for 3 or more days at presentation and fulfilling 2 or more of the signs of multisystem involvement**, in **confirmed COVID-19 paediatric cases** and **paediatric cases who have recently recovered from COVID-19 infection (within 2 to 8 weeks prior to clinical presentation of MIS-C manifestations)**
- There is significant overlap in the presentations of MIS-C and Kawasaki. Even in the known diagnosis or clinical suspicion of Kawasaki, the recommendation is to still convey these patients to ED for review.

[7] Please refer to the FluGoWhere website. The clinics listed under **"Other Private Paediatrics Clinic (PPaedC) that provide consultation and COVID-19 testing"** section in FluGoWhere website is further divided into **"PPaedC Govt-Funded PCR swabs"** and **"PPaedC Non-Govt-Funded".**
"PPaedC Non-Govt-Funded" - these paediatricians may be contacted to co-manage COVID-19 positive paediatric patients and GPs have to contact the paediatricians via their listed phone numbers.

[8] Refer to MOH Circular No. 171/2021: Case Definition and Reporting of Multisystem Inflammatory Syndrome in Children (MIS-C) Associated with COVID-19

19. How should COVID-19 pregnant patients with Co-morbidities of Concern (COC) and/or Symptoms/Signs of Concern (SOC) be managed?

Pregnant patients with COC, regardless of gestational age, are suitable to recover at home with close monitoring and OAV (Paxlovid) usage if suitable. The management of pregnant patients should be done in consultation with the patient's regular specialist physician/obstetrician. In the event of deterioration, patients should be referred to the Emergency Department (ED) to receive the appropriate care.

20. How should COVID-19 adult (≥12yo) patients with Co-morbidities of Concern (COC) and/or Symptoms/Signs of Concern (SOC) be managed?

Adult patients who are clinically stable with COC are suitable to recover at home. Patients who are of high/intermediate risk should be closely monitored and are strongly encouraged to be considered for OAV (Paxlovid or Molnupiravir) usage if suitable and could be tagged for referral for free 24/7 ad hoc TM services, if required. In the event of deterioration or adverse events, patients should be referred to the Emergency Department (ED) to receive the appropriate care.

21. What should be done if my patient has co-morbidities that I feel require closer monitoring but are not included in the Risk Criteria?

Doctors-in-charge are to exercise own clinical judgement, and if the patient was deemed to require closer monitoring, the doctor can provide return advice and/or schedule follow up consultations as required. In addition, doctors may consider referring these patients for free ad-hoc telemedicine (TM) services for closer monitoring during the patient's recovery at home. For clinics using PRPP, please refer to the updated PRPP manual for details to refer such patients.

22. How should Primary Care Physicians assess one's eligibility for free 24/7 ad hoc Telemedicine (TM) services?

Doctors-in-charge may consider referring clinically stable *COVID-19 positive patients* [9] who are high/ intermediate risk for free 24/7 ad-hoc TM services to reduce ED attendance.

ADULT (≥12 years old) Risk Criteria

- **High Risk – Suitable for recovery at home with close monitoring and strongly consider OAV if suitable (e.g. Paxlovid; note that Molnupiravir is only for those age > 18 years). For referral to A&E in event of deterioration.**
  - Prevailing Ineligible Criteria for Adults
    - Non-fully vaccinated 80 years old and above
  - Comorbidities of Concern
    - ESRF on dialysis with any other comorbidities of concern
    - High-risk immunocompromised
      - Daily corticosteroid therapy with dose ≥20mg (or ≥2mg/kg/day for patients <10kg) or prednisolone or equivalent for ≥14 days
      - Non-steroid immunosuppressants
      - Solid organ cancer on active chemotherapy OR with neutropenia
      - Haematological malignancies
      - Status post solid organ transplant
      - Status post haematopoietic stem cell <5 years ago OR on immunosuppressants
      - Combined primary immunodeficiency
      - HIV infection with CD4 count <200 cells/mm³ (or <15%) and not virologic suppressed
    - Chronic organ disease at high risk of deterioration e.g Decompensated Congestive Heart failure, Liver failure, COPD
- **Intermediate Risk – Can consider close monitoring and strongly consider OAV (either Paxlovid or Molnupiravir) if suitable.**
  - Obesity: (BMI >35 or Weight >100kg)
  - Poorly Controlled DM
  - Low-risk immunocompromised
  - ESRF on dialysis without any other comorbidities of concern

ADULT Symptoms/Signs of Concern

- **Symptoms**
  - Shortness of breath
  - Chest pain
  - Acute stroke symptoms
  - Chest palpitations
  - Symptoms suggestive of DVT
  - Severe headache not better with pain meds
  - Persistent diarrhea/vomiting/unable to take in fluids
  - Persistent Fever ≥ 3 days (≥38 degrees Celsius)
- **Signs**
  - Tachycardia >100
  - Tachypnoea >20
  - Hypotension <100mmHg
  - SPO2 ≤ 94%

*Doctor to exercise clinical judgement on whether to activate 995

PAEDS (<12 years old) Risk Criteria

- **High Risk – Suitable for recovery at home with caregiver and close monitoring. For referral to ED in event of deterioration. Strongly consider management with patient's regular paediatrician. May benefit from early treatment with IV remdesivir after discussion with paediatrician.**
  - Comorbidities of Concern
    - Bone marrow/Organ transplant on immunosuppressant
    - Active/current cancer on chemotherapy/treatment
    - Leukemia/lymphoma/other haematological malignancies
    - Disease or medications that suppress immune system
    - ESRF on dialysis
    - Poorly-controlled DM
    - Poorly-controlled HTN
    - Chronic/congenital respiratory conditions e.g. OSA, Chronic Lung Disease
    - Congenital heart/circulatory conditions
    - Neurodevelopmental conditions
    - Obesity (Refer to Table below)

Age group	At-risk BMI
9 - <12 YO	> 26
6 - <9YO	> 24
3 - <6YO	> 22
1 - <3YO	>20
3 months - <1YO	>20

PAEDS Symptoms/Signs of Concern

- **Symptoms**
  - Chest Pain
  - Shortness of Breath
  - Chest Palpitations
  - Drowsy/lethargic
  - High Fever >40°C
  - Prolonged Fever >38°C (continuously for 5 days or more)
  - Significant pain/discomfort anywhere
  - Headache worse than usual or not better with usual pain medications
  - Prolonged respiratory symptoms for 5 days or more
  - Persistent diarrhea/vomiting/abdominal pain and unable to take fluids (clinically unwell and fluid intake <50%)
  - Dehydrated - Poor urine output (<4 times/day)
  - Concerns of MIS-C/Kawasaki Disease
- **Signs**
  - SPO2 ≤ 94%
  - Tachycardia (Refer to table below)
  - Tachypnoea (Refer to table below)

AGE	HEART RATE		RESPIRATORY RATE	
	Minimum	Maximum	Minimum	Maximum
Birth – < 3 months	90	180	30	60
3 months – < 6 months	80	160	30	60
6 months – <1 year	80	140	25	45
1 year – < 6 years	75	130	20	30
6 years – < 10 years	70	110	16	24
10 years – < 15 years	60	90	14	20
15 years and above	60	90	12	16

*Doctor to exercise clinical judgement on whether to activate 995

[9] Healthcare provider-administered positive ART result will be sufficient for referral.

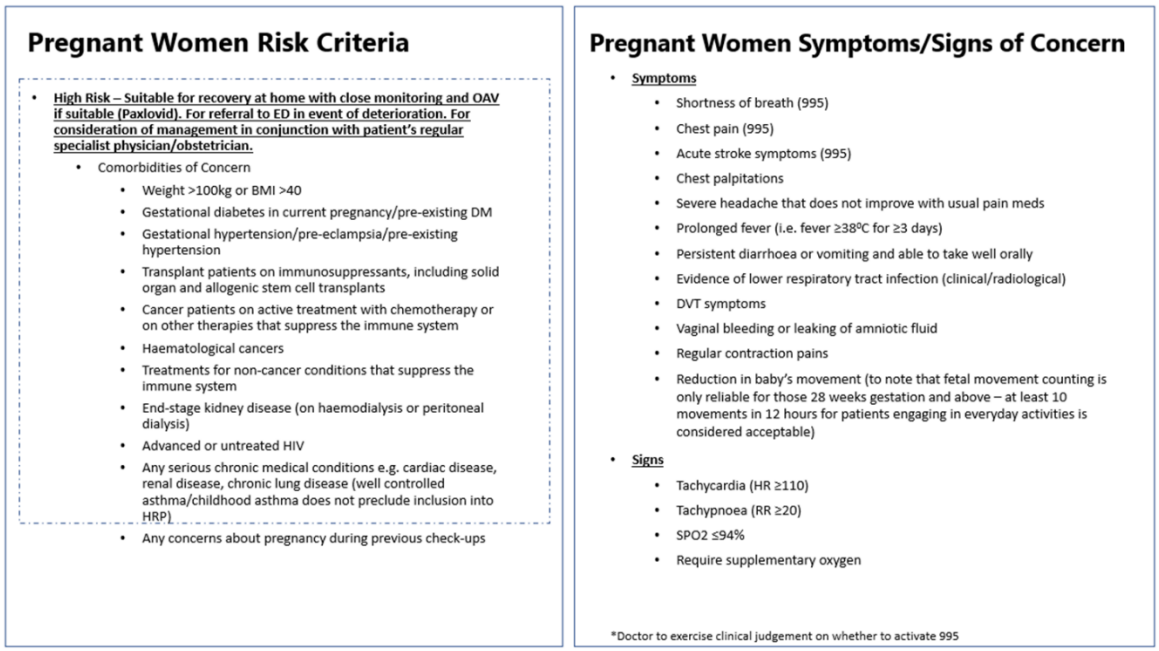


Figure 2. Risk Criteria for COVID-19-positive patients (Adults, Paediatrics, Pregnant)

The adult, paediatric and pregnant patients' risk criteria (Figure 2) list the co-morbidities which may negatively affect an individual's suitability to recover at home without additional medical assistance. It also highlights a list of symptoms/signs that may warrant urgent/emergent medical care.

Doctors-in-charge should exercise clinical judgement to decide if a patient should be conveyed to a hospital for further management. For emergencies, 995 should be activated for immediate conveyance to the nearest appropriate emergency department.

23. How do I refer "high/ intermediate risk patients who need 24/7 ad-hoc TM services" for the TM services?

Doctors-in-charge may refer patients as "High/ Intermediate Risk AND needs 24/7 ad-hoc TM support" through PRPP/ iConnect.COVID/ SRS/ EMR for submission of COVID-19 tagging and indicate the reasons for referral. This ad-hoc TM service will be free for a timebound period of 6 months till 13 Aug 2023.

24. For the group of patients tagged as high/intermediate risk requiring ad-hoc 24/7 telemedicine (TM) services, would they be assessed initially by a TM provider? [New]

Under DORSCON Green, there will **not** be an initial assessment by the TM provider to assess these tagged patients. If your patient is unwell, requiring an ad-hoc doctor consultation, he/she will have to contact a TM provider listed on a website accessible via the link provided in the SMS to seek medical advice.

Below is the SMS template that patients eligible for free TM support will receive from MOH.

Dear {Name}, {masked ID},

Your doctor has assessed that you may require close medical support while recovering from COVID-19 infection. Free 24-hour telemedicine support is available to you for 14 days from the date you tested positive per your doctor's record. The telemedicine service is available through go.gov.sg/telemedicineproviders.

If you experience mild flu-like symptoms, you are advised to stay at home until such symptoms improve or resolve. However, if you need to leave home, please wear a mask, avoid crowded places and minimise contact with vulnerable persons such as the elderly.

For any medical emergency, please call 995 immediately.

You may contact the 24-hour MOH hotline at 68744939 for any enquiry.

If you are an unintended recipient of this message, please delete and do not forward this SMS.

We wish you a speedy recovery.

25. Can the TM provider help to prescribe Oral Antivirals (OAVs) to "high/intermediate risk requiring ad-hoc 24/7 TM support" patients who were ART negative but PCR positive? My clinic may not have prescribed OAV while pending the PCR result, and the patient would no longer be at the clinic. [New]

While TM providers do prescribe OAVs, the referring clinic which provided the initial consultation is accountable for the care and management for the patient. This means that the referring clinic should convey the PCR result to the patient if needed and actively follow-up to ensure your patient is prescribed OAVs if clinically eligible.

If your clinic is not on the OAV programme, you should advise such patients to call for an ad-hoc consultation with the TM provider to assess their eligibility for OAV.

26. What is the current definition of *"fully vaccinated"*?

Fully vaccinated individuals are those who have completed their primary vaccination series and taken their 1st booster dose (minimum protection). Refer to MOH Circular No. 05/2023[10] for the latest recommendations for COVID-19 Vaccination. Otherwise, you may check https://www.moh.gov.sg/covid-19/vaccination to find out more about the vaccination definition.

[10] Refer to MOH Circular No. 05/2023: COVID-19 Vaccination Updates: 2023 Recommendations for COVID -19 Booster Vaccination

COVID-19 Recovery in the Community

27. Do I have to issue medical leave until the patient is ART-negative?

Doctors-in-charge are recommended to exercise their clinical judgement when issuing the duration of sick leave for COVID-19 positive patients and/or patients with ARI symptoms and can adjust the duration as appropriate. Patients should be advised to seek medical attention if their symptoms worsen or do not improve with time.

28. Does my patient need to isolate at home until they test negative for COVID-19? Must they test negative before they can return to work?

In DORSCON Green, there will no longer be a need to self-isolate at home for 7 days. There is no requirement to perform routine ART testing unless clinically indicated. Patients can return to work once they are well (asymptomatic). Patients who are symptomatic should be advised to recover at home.

Separately, you may refer to the FAQ from MOH website at https://ask.gov.sg/questions/840 which states that “You no longer need a negative test result to return to work. Please check with your organization/employer for specific requirements on showing your test results. If your employer insists on a negative test result, you can show your self-test ART result to your employer as proof of your recovery status.”

29. How should we advise patients with mild ARI and/or COVID-19 positive patients if they need to leave their homes to run errands?

Persons with mild ARI symptoms and/or COVID-19 positive patients who are mildly ill should be advised to recover at home with appropriate infection prevention control measures.

However, if they need to leave their homes while symptomatic, or if asymptomatic but test positive for COVID-19 please inform them to adopt the following precautions:

- Always wear a mask.
- Avoid crowded places, including hospitals and nursing homes.
- Avoid contact with vulnerable persons such as the elderly.

30. How should I provide return advice to my patient who is recovering at home?

Patients are advised to seek medical attention if their symptoms worsen or do not improve with time (visit a GP clinic or seek medical assistance via telemedicine consultation). For medical emergencies, please contact 995 for escalation to ED.

31. What should I do if my patient is unsuitable to recover at home?

For medical emergencies and clinically unstable patients, doctors can contact 995 for escalation to ED. Patients can choose self-conveyance to the EDs if they are clinically stable but require further care, such as oxygen supplementation. Patients may be subsequently decanted from Public Healthcare Institution (PHIs) to COVID-19 Treatment Facilities (CTFs) if they are assessed to be suitable for transfer to continue recovery in a CTF.

32. What are the options for COVID-19 positive persons living with vulnerable household members?

If there are vulnerable household members, such as 60 years old and above, these COVID-19 positive patients are advised to take preventive measures to mitigate infection spread. These measures include wearing a mask, cleaning the toilet after every use, and not sharing a room with other household members. These patients should consider alternative accommodation arrangements, other than their residence.

If patients express difficulty in arranging for alternative accommodation and require lodging, MOH may be able to assist patients on a case-by-case basis. Such patients are advised to contact the MOH hotline at 68744939.

33. Will MOH issue recovery memos to patients? If not, could clinics issue this document to patients?

Since 13 June 2022, MOH no longer issues recovery memos for patients. Doctors-in-charge should issue memos for patients who require documentation of COVID-19 infection. Alternatively, patients who are tagged could visit the website www.notarise.gov.sg/ to generate their notarised recovery certificates. www.notarise.gov.sg/ to generate their notarised recovery certificates.

Patients who are not tagged but require MOH recovery certificates may contact the 24-hourly manned MOH Home Recovery Buddy (HRB) hotline at 68744939 for assistance (in addition to their doctors' memos). This service is a timebound measure operating till 13 Aug 2023.

34. Are there any transportation restrictions for COVID-19 positive patients?

From 13 February 2023, commuting on public transport services, such as bus and MRT, is permitted for COVID-19 positive patients. For conveyance between places of residences (including nursing/MSF homes) and health care facilities (e.g. hospitals, Renal Dialysis Centres, clinics), as well as discharge from facilities, patients are to make their own transport arrangements.

All COVID-19 positive patients and/or patients with ARI symptoms should remain masked regardless of transportation modality. In the event of a medical emergency, SCDF should be activated by dialling '995'.

35. Are there any updated recommendations for close contacts of COVID-19 positive patients? [New]

There is no change in the recommendations for close contacts since the last update in MTF Press Release on 22 April 2022 [cessation of Health Risk Notice (HRN) for close contacts]. In general, close contacts should exercise social responsibility and monitor their health for development of symptoms.

Healthcare Subsidies and Costs Involved for COVID-19 Treatment in DORSCON Green

36. Will there be any costs involved for the tests and treatments provided to patients? Are there any subsidies available?

With effect from 1 April 2023, all patients will be required to pay for any COVID-19 swab tests (ART/PCR) performed. All patients, including Singapore Citizen / Permanent Resident / Long-Term Pass Holder (SC/PR/LTPH) patients regardless of vaccination status, will be charged for consultations, medications, as well as investigations utilised (such as ART, PCR) in relation to COVID-19 management, subject to the prevailing subsidies.

Patients who require a subsequent admission to a hospital or CTF may also tap on subsidies, MediShield Life and MediSave to help pay for their bills.

COVID-19 OAVs will remain fully subsidised for clinically eligible patients in ED and SOC settings of public hospitals*, polyclinics and PHPCs for the time being.

**Please note that fully subsidised OAVs will only be extended to SCs/PRs/LTPHs in ED and SOC settings of public hospitals.*

37. Can I claim swabs conducted for patients who visit my clinic for the sole purpose of getting a healthcare administered swab in order for their COVID-19 infection to be recorded in PRPP/HealthHub? [New]

No, clinics will not be able to make claims for these tests. Kindly advise your patient on the fees chargeable for the COVID-19 swab tests before administering them.

38. How should I charge my patients for COVID-19 swabs from 1 April 2023? [Updated]

Clinics can decide on the fees charged to patients for ART/PCR swabs. Where the patients are eligible CHAS/PG/MG cardholders, prevailing CHAS acute subsidies may apply.

39. Will there be any costs involved for patients admitted to the Community Isolation Facilities (CIFs)? Will there be any subsidies available?

With effect from 1 April 2023, the use of CIFs will be chargeable for all SC/PR/LTPH patients, regardless of vaccination status. As CIFs are not medical facilities, patients will not be able to tap on Government subsidies, MediShield Life and MediSave to help pay for these bills. However, SCs and PRs who are existing beneficiaries of government financial assistance schemes will continue to receive financial assistance.

40. Will there be any costs involved for patients admitted to COVID-19 Treatment Facilities (CTFs)? Will there be any subsidies available?

All SC/PR/LTPH patients, regardless of their age or vaccination status, will be required to pay for their CTF bills, but may tap on the regular healthcare financing framework (i.e., Government subsidies, MediShield Life and MediSave for SCs and PRs) to pay for their bills.

SCs and PRs who are existing beneficiaries of Government financial assistance schemes will continue to receive financial assistance for their COVID-19 bills.

41. With the changes in testing protocols from 13 February 2023 onwards, will MOH still fund ART/PCR testing done for patients between 13 February 2023 and 31 March 2023 (inclusive)? Which group of patients are eligible for Government-paid swabs from 13 February 2023 to 31 March 2023? [Updated]

Between 13 February 2023 and 31 March 2023, MOH will continue to fully subsidise any ART and PCRs done based on the mandatory, recommended and clinical discretion testing and patient management protocol during the period, as stipulated in the "Patient Testing and Case Reporting" section in this document.

a. SARS-CoV-2 testing is **mandated** for the following patients:

   Patients who are medically vulnerable and would benefit from early COVID-19 diagnosis and treatment (i.e. paediatric (less than 12 years old), pregnant, geriatric (80 years old and above), dialysis-dependent and immunocompromised patients). If the ART is negative, an additional PCR test should be considered, especially if clinical suspicion is high, as the PCR is a more accurate test.

   The cut-off age for geriatric patients is 80 years old and above. However, those who are 60 to less than 80 years old may be tested at clinical discretion.

b. SARS-CoV-2 testing is **recommended** for the following patients:

   Patients with travel history in the 7 days prior to the onset of ARI symptoms are recommended to be tested. This contributes to MOH's continued surveillance of the global COVID-19 situation. Doctors do not need to specify travel history of these patients when submitting test results because MOH uses other government databases to do so.

c. SARS-CoV-2 testing under **clinical discretion** may be considered for the following patients:
   i. Patients who are 60 to less than 80 years old.
   ii. Patients who are not mandated for testing but fulfil the risk criteria detailed in Annex A of MOH Circular No. 04/2023 [see **Annex A** of GP FAQs].
   iii. Patients who fulfil the prevailing criteria for OAV prescription [see **Annex B** of GP FAQs].
   iv. Any other patients belonging to the groups listed in the "Advisory on Vulnerable Group" as referenced within the 9 Feb 2023 MTF Press Release "Singapore to Exit Acute Phase of Pandemic" [see **Annex C** of GP FAQs].

Example of testing under clinical discretion: 50-year-old obese (BMI>30) patient with Diabetes Mellitus (DM), who presents on day 3 since onset of symptoms and is still symptomatic. This patient would fulfil the criteria for OAV prescription and can be tested for COVID-19 even though he/she does not fall in the category of patients who are mandated or recommended to be tested.

42. With the cessation of Government-funded COVID-19 swabs (ART/PCR) on 1 April 2023, by when must my clinic submit the claims for the Government-funded swabs on MHCP?

MOH will issue a finance circular which will provide more financing-specific instructions to address financing and claims-related issues subsequently.

Key Operational Changes for PHPCs

43. How should PHPCs obtain the Government-funded ART kits?

From 1 April 2023, the provision of Government-funded ART kits for PHPCs/SASH clinics will cease. Clinics may choose to procure ART kits at your own arrangements. PHPCs that require more time to procure ART kit supply may purchase from Zuellig Pharma while sourcing for alternate suppliers. More details will be shared on this arrangement in due time.

44. My clinic has balance free ART kits issued prior to 1 April 2023. Are we expected to return the unused ART kits? [Updated]

Clinics do not need to return the unused free ART kits that were issued to them prior to 1 April 2023 but are encouraged to use the balance free stock of ART kits on their patients as clinically indicated, including for non-funded purposes at the clinics' discretion.

45. What are the PCR lab arrangements when Government-funding ceases on 1 April 2023?

With effect from 1 April 2023, Government-funded PCR swabs and the current MOH-funded lab arrangements will cease. Clinics may choose to continue working with their previously paired labs. Alternatively, clinics are free to choose the lab they wish to engage for COVID-19 PCR testing service, depending on their operational considerations.

Labs would also be free to determine their price points for PCR testing for COVID-19. Healthcare providers may charge patients a reasonable fee for the PCR swabs used during consultation and diagnosis, and prevailing CHAS subsidies would apply for eligible patients.

46. My clinic does not provide ART/PCR swabs. Where can I refer my patients for COVID-19 swabs?

Clinics that do not provide COVID-19 swabs are strongly encouraged to start providing ART swabs minimally. If your patient has been assessed to require a swab test, kindly refer them to a nearby SASH Clinic. Kindly refer to the latest PRPP User Guide for referral steps.

JTVCs will no longer accept swab referrals from 13 February 2023 onwards.

47. My clinic does not provide COVID-19 swabs for paediatric patients. Where can I refer them for a swab test? [Updated]

Clinics may continue to refer children aged 12 years old and under to designated Paediatric swab centres (Thomson Medical Centre and Raffles Hospital) for Government-paid swabs until 31 March 2023. The swab referral workflow remains the same i.e. the referring doctor needs to submit the protocol tag and type of test required. The referring doctor will also retain the professional responsibility for their patient and for following up on the swab results of the patient.

Thereafter, Primary Care providers may refer their patients to the private paediatric clinics listing currently available on the FluGoWhere website (https://flu.gowhere.gov.sg). As the providers on the list are private paediatric clinics, these clinics may charge a consultation fee and swab fee for referred patients.

48. My clinic has received a COVID-19 swab referral. How do I charge that patient for the swab test?

Swab referrals will follow current workflow until 31 March 2023 (i.e. as long as eligible patient[11] present to the swabbing clinic within 48 hrs, patient should not be charged swab and consultation fee).

From 1 April 2023, swabbing clinics **may** charge patients consultation fee on top of the swab fee for patients who are referred to them for swabs even if within 48 hours. This will be aligned with other business-as-usual (BAU) workflows where patients would be expected to pay consultation fee, if seen by a doctor.

49. Will my clinic continue to receive free PPE in DORSCON Green?

With effect from 14 May 2023, free PPEs[12] to PHPCs will cease. Should you require further PPE supply beyond 14 May 2023, you may purchase from your own private channels or from Zuellig Pharma.

For PHPCs under the Oral Anti-Viral (OAV) scheme, the provision of free PPE will continue for the time-being to support PHPCs who are participating in COVID treatment for at-risk and infected patients until further notice. Should your clinic be interested to come onboard the OAV scheme, please contact your AIC account manager for more information.

[11] Patients who fall under the categories of mandated, recommended and clinical discretion testing outlined in FAQ 1.

[12] Free PPE includes: Gowns, face shields, gloves, surgical and N95 masks.

50. With the change in DORSCON level from Yellow to Green, is there any change to the PPE requirements?

There is no change to the PPE requirements since the last update on 27 September 2022. Kindly refer to MOH Circular No. 105/2022: Updated Guidance on Personal Protective Equipment (PPE) Use in General Practitioner (GP) and Community Paediatricians Clinics, or the latest prevailing MOH Circular.

COVID-19 Vaccination Updates

51. Can healthy, non-medically vulnerable, persons receive an additional booster?

All persons aged 12 and above may receive an additional booster around 12 months after their last dose, if they would like to do so. This is regardless of the number and composition (monovalent/bivalent) of previous booster doses received. It is recommended to receive the updated bivalent vaccines for vaccination.

52. With the current recommendation of receiving a booster dose 1 year after last dose, do clinics need to reject patients who already have vaccination bookings for their additional booster 5 months after their last vaccine dose?

Clinics need not reject patients who had already made vaccination bookings based on the previously recommended interval of 5 months. They can proceed to receive their additional booster dose.

From 13 February 2023, patients who arrange to receive the additional booster (such as walking into the vaccination site or making an appointment) should receive the additional booster dose 1 year after their last booster. Nevertheless, if the patient insists despite advice, it is allowable for clinics to provide additional booster doses at least 5 months after their last booster.

Annex A

Risk criteria for COVID-19 positive patients (Adults)

ADULT (≥12 years old) Risk Criteria

- **High Risk – Suitable for recovery at home with close monitoring and strongly consider OAV if suitable (e.g. Paxlovid; note that Molnupiravir is only for those age > 18 years). For referral to A&E in event of deterioration.**
  - Prevailing Ineligible Criteria for Adults
    - Non-fully vaccinated 80 years old and above
  - Comorbidities of Concern
    - ESRF on dialysis with any other comorbidities of concern
    - High-risk immunocompromised
      - Daily corticosteroid therapy with dose ≥20mg (or ≥2mg/kg/day for patients <10kg) or prednisolone or equivalent for ≥14 days
      - Non-steroid immunosuppressants
      - Solid organ cancer on active chemotherapy OR with neutropenia
      - Haematological malignancies
      - Status post solid organ transplant
      - Status post haematopoietic stem cell <5 years ago OR on immunosuppressants
      - Combined primary immunodeficiency
      - HIV infection with CD4 count <200 cells/mm^3 (or <15%) and not virologic suppressed
    - Chronic organ disease at high risk of deterioration e.g Decompensated Congestive Heart failure, Liver failure, COPD
- **Intermediate Risk – Can consider close monitoring and strongly consider OAV (either Paxlovid or Molnupiravir) if suitable.**
  - Obesity: (BMI >35 or Weight >100kg)
  - Poorly Controlled DM
  - Low-risk immunocompromised
  - ESRF on dialysis without any other comorbidities of concern

ADULT Symptoms/Signs of Concern

- **Symptoms**
  - Shortness of breath
  - Chest pain
  - Acute stroke symptoms
  - Chest palpitations
  - Symptoms suggestive of DVT
  - Severe headache not better with pain meds
  - Persistent diarrhea/vomiting/unable to take in fluids
  - Persistent Fever ≥ 3 days (≥38 degrees Celsius)
- **Signs**
  - Tachycardia >100
  - Tachypnoea >20
  - Hypotension <100mmHg
  - SPO2 ≤ 94%

*Doctor to exercise clinical judgement on whether to activate 995

Reference: Annex A of MOH Circular No. 04/2023: Updates on COVID-19 Patient Care Model and Case Reporting (9 February 2023)

Risk criteria for COVID-19 positive patients (Paediatrics)

PAEDS (<12 years old) Risk Criteria

- **High Risk – Suitable for recovery at home with caregiver and close monitoring. For referral to ED in event of deterioration. Strongly consider management with patient's regular paediatrician. May benefit from early treatment with IV remdesivir after discussion with paediatrician.**
  - Comorbidities of Concern
    - Bone marrow/Organ transplant on immunosuppressant
    - Active/current cancer on chemotherapy/treatment
    - Leukemia/lymphoma/other haematological malignancies
    - Disease or medications that suppress immune system
    - ESRF on dialysis
    - Poorly-controlled DM
    - Poorly-controlled HTN
    - Chronic/congenital respiratory conditions e.g. OSA, Chronic Lung Disease
    - Congenital heart/circulatory conditions
    - Neurodevelopmental conditions
    - Obesity (Refer to Table below)

Age group	At-risk BMI
9 - <12 YO	> 26
6 - <9YO	> 24
3 - <6YO	> 22
1 - <3YO	>20
3 months - <1YO	>20

PAEDS Symptoms/Signs of Concern

- **Symptoms**
  - Chest Pain
  - Shortness of Breath
  - Chest Palpitations
  - Drowsy/lethargic
  - High Fever >40°C
  - Prolonged Fever >38°C (continuously for 5 days or more)
  - Significant pain/discomfort anywhere
  - Headache worse than usual or not better with usual pain medications
  - Prolonged respiratory symptoms for 5 days or more
  - Persistent diarrhea/vomiting/abdominal pain and unable to take fluids (clinically unwell and fluid intake <50%)
  - Dehydrated - Poor urine output (<4 times/day)
  - Concerns of MIS-C/Kawasaki Disease

- **Signs**
  - SPO2 ≤ 94%
  - Tachycardia (Refer to table below)
  - Tachypnoea (Refer to table below)

AGE	HEART RATE		RESPIRATORY RATE	
	Minimum	Maximum	Minimum	Maximum
Birth – < 3 months	90	180	30	60
3 months – < 6 months	80	160	30	60
6 months – <1 year	80	140	25	45
1 year – < 6 years	75	130	20	30
6 years – < 10 years	70	110	16	24
10 years – < 15 years	60	90	14	20
15 years and above	60	90	12	16

*Doctor to exercise clinical judgement on whether to activate 995

Reference: Annex A of MOH Circular No. 04/2023: Updates on COVID-19 Patient Care Model and Case Reporting (9 February 2023)

Risk criteria for COVID-19 positive patients (Pregnant)

Pregnant Women Risk Criteria

- **High Risk – Suitable for recovery at home with close monitoring and OAV if suitable (Paxlovid). For referral to ED in event of deterioration. For consideration of management in conjunction with patient's regular specialist physician/obstetrician.**
  - Comorbidities of Concern
    - Weight >100kg or BMI >40
    - Gestational diabetes in current pregnancy/pre-existing DM
    - Gestational hypertension/pre-eclampsia/pre-existing hypertension
    - Transplant patients on immunosuppressants, including solid organ and allogenic stem cell transplants
    - Cancer patients on active treatment with chemotherapy or on other therapies that suppress the immune system
    - Haematological cancers
    - Treatments for non-cancer conditions that suppress the immune system
    - End-stage kidney disease (on haemodialysis or peritoneal dialysis)
    - Advanced or untreated HIV
    - Any serious chronic medical conditions e.g. cardiac disease, renal disease, chronic lung disease (well controlled asthma/childhood asthma does not preclude inclusion into HRP)
  - Any concerns about pregnancy during previous check-ups

Pregnant Women Symptoms/Signs of Concern

- **Symptoms**
  - Shortness of breath (995)
  - Chest pain (995)
  - Acute stroke symptoms (995)
  - Chest palpitations
  - Severe headache that does not improve with usual pain meds
  - Prolonged fever (i.e. fever ≥38^{0}C for ≥3 days)
  - Persistent diarrhoea or vomiting and able to take well orally
  - Evidence of lower respiratory tract infection (clinical/radiological)
  - DVT symptoms
  - Vaginal bleeding or leaking of amniotic fluid
  - Regular contraction pains
  - Reduction in baby's movement (to note that fetal movement counting is only reliable for those 28 weeks gestation and above – at least 10 movements in 12 hours for patients engaging in everyday activities is considered acceptable)
- **Signs**
  - Tachycardia (HR ≥110)
  - Tachypnoea (RR ≥20)
  - SPO2 ≤94%
  - Require supplementary oxygen

*Doctor to exercise clinical judgement on whether to activate 995

Reference: Annex A of MOH Circular No. 04/2023: Updates on COVID-19 Patient Care Model and Case Reporting (9 February 2023)

Annex B
OAV Prescription Criteria as of 2 December 2022 (V6)

Ver 6/ 2Dec2022/ 11:00

SIMPLIFIED CHECKLIST FOR PRESCRIBING ORAL ANTIVIRALS (OAV) PAXLOVID & MOLNUPIRAVIR: ACUTE & COMM HOSP, ED, PRIMARY CARE, NURSING HOMES, CTF, & HRP

Patient must fulfil ALL the following BASE ELIGIBILITY criteria:

- ☐ Within 5 days of onset of symptoms (must be symptomatic)
- ☐ Test-confirmed COVID-19 (PCR or Antigen Test Positive)
- ☐ ≥18 years old [Adult patient] OR ≥12 years old AND weight 40 kg or more [Paediatric patient]
- ☐ Able to swallow whole tablets / capsules (i.e., not crushed/ broken)
- ☐ Does not have severe disease (e.g., hypoxic, SpO2 < 94%)

NB: OAVs should be considered regardless of vaccination status although the option of careful observation/reassessment without OAV therapy may be reasonable if patient is clinically well and up-to-date with vaccinations, immunocompetent, with no concern for pneumonia and CRP <20 mg/L (if available)

YES & treatment being considered

Patient must have 1 or more of the following RISK FACTORS for severe COVID*:

- ☐ Age (≥60 regardless of vaccine status)
- ☐ Active cancer
- ☐ BMI ≥25 kg/m2 (unvaccinated/not up-to-date with vaccinations)
- ☐ BMI ≥30 kg/m2 (vaccinated)
- ☐ Chronic Kidney Disease (CKD)
- ☐ Chronic obstructive lung disease (including asthma)
- ☐ Serious heart conditions (e.g., heart failure, coronary artery disease, cardiomyopathies)
- ☐ Diabetes mellitus
- ☐ Ongoing immunosuppressive condition/ treatment

* Patients with 1 or more of the above risk factors and who have clinical or radiographic evidence of pneumonia (if available) or a CRP ≥ 50 mg/L (if available) should be prioritised for treatment.

YES

Does the patient have any of the following CONTRAINDICATIONS to Paxlovid?

- ☐ Significant drug-drug interactions that cannot be adjusted for
- ☐ GFR < 30mL/ min (no need Renal Function Test if patient has no known renal impairment)
  [Pls refer to next page on drug interactions with Paxlovid/ creatinine clearance]
- ☐ Severe hepatic impairment (Child-Pugh Class C)(Not recommended, insufficient data)

NO contraindications to Paxlovid

PAXLOVID should be considered as the 1st line (default) OAV treatment

Please remember to fill in the Data Returns Form

(HOSPITALS ONLY)

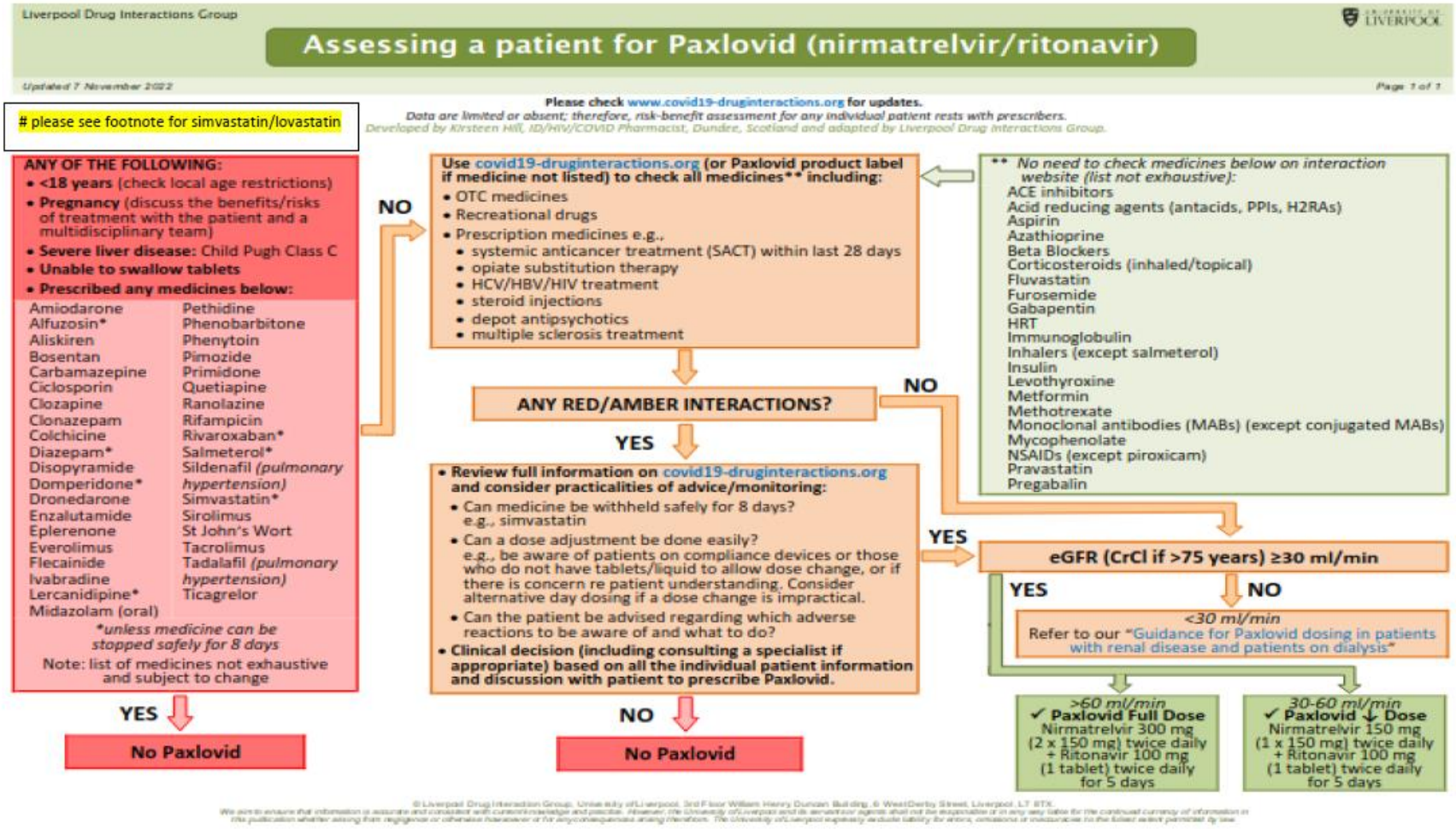
YES there are contraindications to Paxlovid

MOLNUPIRAVIR may be considered

NB: Patient must **not** be pregnant or breastfeeding, and must be ≥ 18 years old

This guidance does not replace sound clinical judgement & professional practice standards. Patient allergy & contraindications must be considered when prescribing these medications. Please refer to drug information sheets, consult patient's primary doctor, pharmacist, or drug interaction database for detailed prescribing guidance

DRUG INTERACTIONS WITH PAXLOVID



eGFR calculator: https://www.kidney.org/professionals/kdoqi/gfr_calculator; **# Note: simvastatin and lovastatin should be discontinued to at least 12 hours prior to starting Paxlovid, and do not restart simvastatin / lovastatin until after 5 days after completing Paxlovid (i.e. stop for a total of 10 days)**

Annex C

MINISTRY OF HEALTH
SINGAPORE

ADVISORY ON VULNERABLE GROUP

With better knowledge about COVID-19 infections, there has been further indication of groups who are at risk of poorer clinical outcomes in the event of a COVID-19 infection. Greater precautions should be taken for such individuals, in keeping with advisories applicable to the general population.

2. Such persons include:

a. Persons who are aged 60 and above[1];
b. Patients who are immunocompromised or have concurrent medical conditions such as obesity (e.g., adults with a BMI ≥30), hypertension, diabetes, chronic heart and lung diseases, kidney diseases on dialysis, hypercoagulable states, cancer, or patients on drugs that cause immunosuppression;
c. Pregnant women;
d. Persons with Down's syndrome.

3. Persons who are part of the groups identified above should take greater care to avoid exposure to COVID-19 infection, and should be encouraged to be vaccinated[2] against COVID-19 if they have no medical contraindications, so as to reduce their risk of severe disease if infected. They should pay special attention to MOH's health advisories, to observe a high level of personal hygiene with frequent hand washing with soap and water. They should also follow prevailing advisories and other infection prevention and control recommendations, e.g., use of masks, avoiding crowds and close contact with others who are unwell. We also advise them to continue to take medications for any underlying health conditions exactly as prescribed, go for regular vaccinations based on clinical indication, and to seek medical attention promptly if feeling unwell.

4. Employers and caregivers for at-risk persons/ groups should support them to follow the above advice.

MINISTRY OF HEALTH
9 FEBRUARY 2023

[1] While persons of age 60 and above are most susceptible to poorer clinical outcomes in the event of a COVID-19 infection, persons aged between 50-60 years old are also considered to be at higher risk of developing severe disease from COVID-19 infection, relative to younger age groups.
[2] As per the prevailing Expert Committee on COVID-19 Vaccination (EC19V) recommendations.

Reference: "Advisory on Vulnerable Group" as referenced within 9 February 2023 MTF Press Release "Singapore to Exit Acute Phase of Pandemic"