

REVISED UN MODEL OF CARE (MOC)
CHECKLIST FOR UN DUTY STATIONS IN RESPONSE TO COVID-19 PANDEMIC
20 May 2022



The key elements of a MOC for UN health facilities tasked with responding to the COVID-19 pandemic include:

1. Contain spread of COVID-19 cases in duty stations

Follow [guidance](#) with the assistance of materials provided on how to:

- a. Manage, monitor, and isolate confirmed COVID-19 case(s), in coordination with local health authorities and following WHO and UN guidelines
- b. Assist staff and dependants to set up home care essential supplies
- c. Facilitate access to vaccination for staff and dependants
- d. Prepare screening and isolation ward
- e. Review reporting and monitoring SOPs for confirmed or suspected COVID-19 cases
- f. Trace, quarantine, and monitor contact cases in coordination with local health authorities and following WHO and UN guidelines

2. Provide access to COVID-19 testing

- a. Identify local source(s) of COVID-19 testing if available
- b. Define SOP to access COVID-19 testing locally if available
- c. If available, define the type of test - Rapid Antigen test (provider administered or self-test) vs PCR - and purpose of test: case confirmation, isolation, clearance for return to work, duty travel related. Serological tests (serosurveys) may also be conducted
- d. Define the protocol for COVID-19 testing used by UN HCW

3. Facilitate access to COVID-19 vaccines through the [UN vaccination programme](#) or national vaccination programs

4. Provide in-home care to the greatest extent possible that is clinically safe for patients, caregivers, and other household members:

- a. Review public health and social measures (PHSM) with staff and dependents: hand hygiene measures, cough etiquette, maintaining 1-2-meter social distancing, use of medical masks, airing of rooms, and cleaning of surfaces.
- b. Train staff and dependents in the use of thermometers, pulse oximeters and personal protective equipment (PPE), together with strict adherence to PHSM
- c. Consider active and passive surveillance / monitoring of patients at home as appropriate, and identify those at risk of requiring higher level of care to allow time for hospitalization and/or medevac
- d. Provide psychological support to staff and dependents under isolation or quarantine.

4. Provide access to step-up care as clinically indicated (on-site and by medevac) based on disease manifestation, individual risk profile, local resources/capacity (see attached matrix):

Noting the lifting of restrictions on air travel and border crossings, adequate treatment and medical evacuation capacity might still be limited in some duty stations independent of a patient's diagnosis (COVID-19 or other). UN health care providers should therefore plan accordingly and submit requests for evacuation early when there is a clinical indication the patient's condition will not be able to be managed locally.

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TRIAGE ALGORITHM for MOC based on:

- A. Symptoms and indicators of disease severity - mild, moderate, severe, critical
 - B. Risk category*¹
 - C. Disposition
 - i. Home with/without extra support (oxygen, pulse oximetry, etc...)
 - ii. Intermediate satellite holding unit to facilitate closer monitoring and rapid movement if needed to UN Level 1 facility
 - iii. UN Level 2 facility or higher level of care or Severe Acute Respiratory Infection (SARI) facility
5. Following this MOC, the current available information and the experience garnered in the past two years, it remains difficult to make predictions on a global level on the need for COVID-19 ICU beds per country, as it very much depends on current host country preparedness. It is therefore recommended that each UNCT regularly conducts Duty Station Health Risk Assessments with particular emphasis on the availability of multifunctional critical care beds, which cater also for other critical injuries other than COVID-19.

To note is that the First Line of Defense (FLOD) WG is available to assist the UNCTs in evaluating their care pathway to a COVID-19 capable treatment center.

6. COVID-19 MEDEVACS are managed through the [UN MEDEVAC Mechanism](#) composed of the network of country COVID-19 coordinators, the Medical Coordination Unit/MCU, and the Brindisi Air Ambulance Cell/BAAC.

When multiple patients are at a threshold status for medical evacuation, healthcare managers and providers will establish a priority list/triage for medevac based on clinical factors, such as onset of illness, trend of clinical status, risk factors, etc. There is the need to maintain regular communication with receiving hospitals when identified as well as the medical evacuation provider. Medical evacuation criteria include critical patient data on overall status, vital signs, oxygenation, ventilatory requirement, etc.

Depending on the local context, there should be consideration for the early movement of patients with mild illness and multiple risk factors.*¹

7. In trying to estimate the potential need for medical evacuation, healthcare managers should review the demographics of their population, looking specifically at age as well as the prevalence of risk factors, and the vaccination status. Individuals identified as “at risk” should be instructed to review the general prevention measures as well as their home confinement preparations and consider if possible, moving to a location with better access to intensive care facilities.

¹ * Risk factors: age >60, underlying co-morbidities e.g., diabetes, obesity, cardiovascular and chronic lung disease, cancer, and immunocompromised individuals

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8. The proportion of persons who become infected with SARS-CoV-2 and remain asymptomatic remains to be better understood.
 - While evaluation for Omicron variant is ongoing, data² suggest a much higher rate of asymptomatic disease - as high as 73-90%, with lower risk for severe disease and death. Nevertheless, the higher levels of transmission for Omicron variant have resulted in significant increases in hospitalization and continue to pose overwhelming demands on health care systems in most countries, and may lead to significant morbidity, particularly in vulnerable populations.³
 - This compares to Delta variant where among patients that become symptomatic, most develop only mild (40%) or moderate (40%) disease, approximately 15% develop severe disease that requires oxygen support, and 5% have critical disease with complications.⁴
 - Available data⁵ continues to consistently demonstrate that non-vaccinated patients and those with risk factors are more likely to develop severe disease and require hospitalization.
9. Evidence is emerging with the recognition of [post COVID-19 condition \("long COVID-19"\)](#) which covers a wide spectrum of symptoms and signs. Associated risk factors for long COVID-19 include pre-COVID-19 mental / general health status, chronic lung disease, age, obesity, and being female. In this scenario, it is important to note that patients and dependents will require ongoing support and flexibility with working arrangements.

² Refer to [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(22\)00100-3/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)00100-3/fulltext), <https://www.nature.com/articles/s41577-022-00720-5/figures/1>

³ . Refer to [https://www.who.int/publications/m/item/enhancing-readiness-for-omicron-\(b.1.1.529\)-technical-brief-and-priority-actions-for-member-states](https://www.who.int/publications/m/item/enhancing-readiness-for-omicron-(b.1.1.529)-technical-brief-and-priority-actions-for-member-states)

⁴ Refer to Table 6.3, page 24 <https://www.who.int/publications/i/item/WHO-2019-nCoV-clinical-2021-2> for definitions).

⁵ Refer to <https://www.who.int/publications/i/item/WHO-2019-nCoV-clinical-2021-2>

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CLINICAL DECISION MATRIX FOR UN DUTY STATIONS IN EVALUATING AND TREATING ACUTE RESPIRATORY ILLNESS DURING COVID-19 PANDEMIC

Clinical severity category	Defining Symptoms	Defining Signs	UN recommended treatment centre	Threshold clinical signs to escalate to next	Needed level of equipment	Needed manpower, expertise	Disposition
Mild* (by WHO + CDC)	Upper respiratory tract symptoms, fever or chills, fatigue, cough, sore throat myalgias, headache, nausea or vomiting, diarrhea, anosmia, anorexia, congestion or runny nose, etc.	Temp over 37.5 - 38°C	Phone contact with COVID-19 Medical hotline or personal physician	Worsening symptoms: dyspnea, higher temp.	Supplies for self-isolation, paracetamol, thermometer, pulse oximeter, medical masks	Family care giver, access to provider via phone/ Telehealth	Maintain at home, monitor temp and O ₂ , close f/u if risk factors** If multiple pts, set priority list° for MEDEVAC
Moderate (by WHO + CDC)	Fever, cough, shortness of breath	Fever, labored breathing (Respirations 20-25/min) early pneumonia on CXR	Screening center isolated from clinic/hospital facility (Level 1)	Pulse ox SO<93 % at rest Respirations greater than 30/min at rest Worsening of comorbidities e.g. uncontrolled BP, BGL	PPE, isolation room or ward, Pulse oximeter, Vital sign equipment, access to CXR, lab services	Nursing staff with triage skills with physician back up	Isolation room or home with O ₂ , if risk factors**, test for COVID-19, plan early MEDEVAC to Level 2 or higher level of care
Severe (by WHO + CDC)	Fever, worsening SOB, severe fatigue, decreased mental acuity	CXR shows bilateral pneumonia, low lymphocyte count	Isolation ward of UN clinic/ hospital (Level 2), on oxygen (nasal cannula)	Severe respiratory distress with severe hypoxia refractory to oxygen therapy Pulse ox SO<90%	Oxygen, intravenous access, pulse oximeter monitoring, cardiac monitoring, resuscitation/intubation equipment, ventilator COVID-19 Test	Physician with RSI/ARDS treatment skills and nursing staff	Hospitalisation in Isolation unit. MEDEVAC should have been initiated to SARI treatment facility
Critical (by WHO + CDC)	Shortness of breath, obtundation, loss of consciousness	ARDS, sepsis and septic shock, severe hypoxia on oxygen, deteriorating vital signs, decrease renal function/output	ICU unit dedicated to COVID-19 cases SARI Treatment Center	Worsening hypoxia and deteriorating vital signs despite intubation and PEEP	Oxygen, Ventilator, ICU monitoring, cardiac defibrillator, all the above	ICU staff and resp therapist /technician	Patient should have reached advanced COVID-19 or SARI Treatment facility

* or asymptomatic, but with positive COVID-19 test

**Risk factors: age >60, underlying co-morbidities e.g. diabetes, obesity, cardiovascular and chronic lung disease, cancer and immunocompromised individuals.

°: Set Priority MEDEVAC list based on clinical factors: onset of illness, clinical status trend, risk factors, etc.

°°: timeline is meant to be a guide on when to expect changes in clinical status. Onset of symptoms as well as their worsening will vary between patients.

Local situation will influence decision on timely medevac request