COVID-19
Community of Practice for
Ontario Family Physicians

Family & Community Medicine
UNIVERSITY OF TORONTO

Ontario College of
Family Physicians

Changing the Way We Work

Febraury 4, 2022: Responding to the Omicron surge – Part 2

Panelists: Dr. Rosemarie Lall, Dr. Edward Etchells, Dr. Zain Chagla
Co-hosts: Dr. Mekalai Kumanan, Dr. David Kaplan | Moderator: Dr. Tara Kiran

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Curated answers from CoP panelists and co-hosts to in-session questions posed by participants, based on current guidance and information available at the time.

COVID TREATMENTS | COVID CLINICAL ASSESSMENT CENTRES

- **Can you please post the ILI clinic list for Toronto?**

[COVID-19 Clinical Assessment Centres] https://tools.cep.health/tool/COVID-19/#COVID-19-clinical-assessment-centres-cacs-information-for-primary-care-providers

- **Will the monoclonal antibody clinic in Hamilton accept referrals for high-risk patients with clinical diagnosis or rapid test of COVID? It is impossible to get a PCR test appointment for patients.**

Yes – we will accept RAT. The Hamilton assessment clinic will accept everyone who is monoclonal-eligible, so not a problem there. As well, if patient meets criteria, can refer to the CAC (clinical assessment centre) at St. Joe's who can start the diagnostic workup and make the referral.

- **I heard that only one monoclonal Ab is effective against Omicron. Comments?**

Yes, only sotrovimab.

- **The sotrovimab referral form shared by OH on Monday was missing the COVID Treatment Clinic at Trillium Health Partners. Are there any other locations where mAb can be accessed that were not listed on the referral form?**

My understanding is that these are the sites. I will speak to accessing mAbs in Northern Ontario in my slides. [answered by Dr. David Kaplan]

- **Can you suggest options for patients who are already on SSRI (? switching to fluvoxamine) and budesonide is back ordered? Oftentimes, patients end up with prescriptions for antibiotics instead when the cough worsens…**

Thanks for your question. You can switch from existing SSRI or SNRI to fluvoxamine, but I would review this with a pharmacist, and it is probably not worth the trouble for most patients. It also depends on the dose on the SSRI/SNRI because you will run risk of serotonin syndrome.
I think the other inhaled steroids are acceptable if there is no budesonide.

- **Can you comment on Remdesivir vs Paxlovid vs monoclonal Ab for the high-risk patients?**

For tier 1/2 patients, sotrovimab is first consideration, Paxlovid is second consideration. There is very little remdesivir available even for the moderately ill patients and it is impractical (3 days of IV therapy)

- **How does information from the COVID clinical assessment centre get back to the primary care physician or NP? Will they receive a note re: any follow up required in the community?**

We send a consult note just like any other consult.

TESTING

- **When you mention that a healthcare-administered RAT is okay for treatment with antivirals, are there certain brands that are required or just the fact that we conducted it is enough?**

I am not aware of a specific brand requirement. The key is that it was administered and interpreted by the healthcare professional.

- **Should we still be doing rapid tests in office on our staff regularly at this point in time?**

Frequent, repeat rapid antigen testing can be used for asymptomatic staff to potentially identify cases that are pre-symptomatic or asymptomatic. RATs can be ordered through the provincial stockpile, and we understand supply has improved: https://ehealthontario.on.ca/en/for-healthcare-professionals/digital-health-services

- **Last session we learned that RAT has a 36% sensitivity for Omicron, and we can't trust negative results. Why are we still using this as a diagnostic tool?**

You are right; a negative RAT provides minimal information. RAT is very specific and very fast, so a positive test is useful. We do a RAT for tier 1/2 patients with fewer than 5 days of symptoms; if positive we have the diagnosis now and we can proceed with management more efficiently. If RAT negative, we send a PCR.

- **Please clarify – how are patients supposed to get PCR or RAT tests once ill? Do we order and send to a lab?? Will the ILI clinics do them? Can you go over practical logistics of what we should be doing or advising our patients to do please. Thank you.**

If a patient qualifies for PCR test, they can be referred to an ILI/COVID Clinical Assessment Clinic. Eligibility list can be found here: https://www.ontariofamilyphysicians.ca/tools-resources/COVID-19-resources/COVID-19-testing-antiviral-overview-2022-02-02.pdf

If a patient does not meet the eligibility criteria for PCR but has access to RATs, they may use this, recognizing the value of a positive test and the risk of false negatives.

Any patient with COVID symptoms should follow public health guidelines re: isolation, including those who cannot be tested.

TRAVEL NOTES

- **As we haven't been able to test patients with PCR who've had COVID, now when they travel and if PCR stays positive for weeks, even though they are over their illness; what should they bring with them to prove they are well and disease free?**

This is a big problem. Lots of advocacy at the federal level (I wrote about it here – https://www.theglobeandmail.com/opinion/article-canadas-current-travel-restrictions-dont-make-sense/). If people have a PCR or can obtain a PCR locally then that can help (exception), but it is a liability if people are travelling, and very hard to retrospectively confirm diagnosis. [answered by Dr. Zain Chagla]

[UPDATE: See OCFP President's Message, Feb. 4, 2022, with information on travel notes: https://www.ontariofamilyphysicians.ca/news-features/family-medicine-news/~240-Guidance-for-COVID-19-therapeutics-travel-notes-and-more]

- **RE: travel the problem is that patients can't get a PCR test at the time of infection so if they test positive for travel, they can't prove that it's post infection. Then they want a letter from us. How can I write a note saying my patient is post COVID-positive when I may be basing on clinical judgement, or they inform weeks after possible infection & now are PCR + for travel?**

I would approach this situation similarly to if you are providing guidance on when to end isolation – based on date of symptom-onset and guidance on duration for isolation (5 days for patients who are fully vaccinated, those under the age of 12, and not immunocompromised). You can outline the patient's symptom-onset date and end date for their isolation. Script to follow in OCFP President's Message today.

[ADDITIONAL INFORMATION:
- Section on travel notes in OCFP President's Message, Feb. 4, 2022: https://www.ontariofamilyphysicians.ca/news-features/family-medicine-news/~240-Guidance-for-COVID-19-therapeutics-travel-notes-and-more
- Guidance from the CMPA: https://www.cmpa-acpm.ca/en/covid19/testing-and-screening?utm_source=21Jan22EN-F&utm_medium=Email&utm_campaign=Ebulletin%22%20%5Cl%20%22providing-note-when-i-did-not-perform-test
- Note that patients may be charged a fee for travel letters – see OMA guidelines on "Charges for Uninsured Charges - Not Covered by OHIP"]

OTHER

- **Hospital & ICU statistics – are these patients admitted due to COVID infection or do they include patients admitted for other reasons with incidental + COVID tests?**

Both. The discrepancy is more at the hospital level with universal testing, less at the level of ICU where most are admitted because of COVID-19. Each hospital does it's reporting separately using its own mechanisms so there is a grain of salt.

- **Some patients are convinced that they have long COVID. Some date their infection back to 2020 again when access to testing was not available. Is there a way to assess these patients or determine whether or not they have COVID vs ab from vaccine? How are we**

to manage and diagnose suspected long COVID, are there diagnostic criteria at this time?

Ontario Health has a good resource here to help with assessment and management: https://www.ontariohealth.ca/sites/ontariohealth/files/2021-12/PostCOVIDConditionsClinicalGuidance_EN.pdf

[UPDATE: See also Hamilton Family Medicine's Assessment, Monitoring and Management of COVID, Tab 9: Long COVID – Management of Post-Acute COVID Symptoms: https://hfam.ca/clinical-pathways-and-evidence/covid/assessment-diagnosis-and-management-of-covid/]

- **Where to refer for long COVID syndrome diagnosis, management?**

Ontario Health has a reference document that provides guidance on assessment and management for patients with long COVID: https://www.ontariohealth.ca/sites/ontariohealth/files/2021-12/PostCOVIDConditionsClinicalGuidance_EN.pdf

[UPDATE: See also Hamilton Family Medicine's Assessment, Monitoring and Management of COVID, Tab 9: Long COVID – Management of Post-Acute COVID Symptoms: https://hfam.ca/clinical-pathways-and-evidence/covid/assessment-diagnosis-and-management-of-covid/]

- **Under Directive 2, are elective preventive care measures to be deprioritized at this time, such as routine pap? If so, is this changing very soon?**

[See more information below] The OCFP's "Balancing Demands" document outlines current priorities, which includes providing essential care and cancer screening, prioritizing high-risk patients: https://www.ontariofamilyphysicians.ca/tools-resources/COVID-19-resources/clinical-care-office-readiness/COVID-balancing-demands.pdf

Ontario Health provides further guidance on determining patient risk: https://www.cancercareontario.ca/sites/ccocancercare/files/assets/COVID-19TipSheet15-GuidanceForPrimaryCareProvidersResumingCancerScreening.pdf

[MORE INFORMATION:
  - Directive #2, reissued Feb. 1, 2022, currently applies to hospitals and Independent Health Facilities, does not apply to primary care.
  - For reference, Directive #2: https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/directives/directive_2.pdf]

- **Do they crash later even after improving?**

It is unusual to deteriorate from COVID after initial clinical improvement. However, complications such as PE or bacterial pneumonia are possible. Also sometimes other comorbidities get out of control (e.g. CHF) during the acute illness.

- **If people are still symptomatic after 5 days, should they continue to isolate? I think that message gets lost.**

If the patient qualifies for the 5-day isolation period (fully vaccinated, under the age of 12, not immunocompromised), then symptoms need to be improving for 24 hrs (48 if GI symptoms) and the patient should be fever-free prior to ending self-isolation.

- **Can one of you clarify the recommendation for receiving vaccination after COVID Infection? is it 30 days or anytime if not symptomatic?**

[See update below] Vaccination can be provided once the patient is past their isolation. However, 4-8 weeks post-infection for boosters may be ideal to maximize immunity. I believe that NACI will be issuing updated guidance imminently on this question.

[**UPDATE** – NACI recommendation, issued **Feb. 4**, is for fully vaccinated individuals who get infected with COVID to **wait three months before getting a booster,** stating a longer interval between infection and vaccination "may result in a better immune response as this allows time for this response to mature in breadth and strength, and for circulating antibodies to decrease, thus avoiding immune interference when the vaccine is administered." https://www.canada.ca/content/dam/phac-aspc/documents/services/immunization/national-advisory-committee-on-immunization-naci/naci-rapid-response-updated-guidance-covid-19-vaccination-timing-individuals-previously-infected-sars-cov-2.pdf]

- **What is HRM?**

HRM is Health Report Manager. It is the method by which you can get reports into your EMR electronically (i.e., not by fax). It is free of charge: https://www.ontariomd.ca/pages/health-report-manager.aspx

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These additional questions were answered live during the session. To view responses, please refer to the session recording.

- Any word on boosters for 12-18 age group?
- Any update on upcoming variants?
- Any update on Novavax vaccine? Are we looking at a 4th booster in the fall?
- I have patients calling requesting clearance letters from the US. What is recommended in this situation?
- Any information on vaccines for the under 5's? My grand daughter aged 3 now has COVID for the second time (from daycare)
- Vaccine clinics are currently empty, and CDC has recommended boosters for 12-17 years olds. There is currently a lot of COVID circulating among our teenagers. When are boosters coming for this age group?
- Any research on how long does the antibodies last after 3rd dose?
- Please provide some guidance regarding medical travel clearance requested notes.
- Will the monoclonal antibody clinic in Hamilton accept referrals for high-risk patients with clinical diagnosis or rapid test of COVID? It is impossible to get a PCR Test appointment for patients.
- What does the science say about the end of COVID? Is it coming soon, or will we forever be dealing with wave after wave of new and exciting variants?
- we also know that rapid tests can have as low as 20% pickup for Omicron so why is the message to the public, if rapid test is negative, you are ok to go to restaurants/party?
- What are the plans for telemedicine come September? Will a certain percentage be allowed by OHIP? My concern is that there will be a push back from patients who have gotten used to virtual visits especially for issues that can be dealt with virtually.

- For those that have had COVID and are travelling to US within 90 days of COVID, they need a note from MD stating they are clear to travel.
- More patients are asking for travel note after having COVID infection. Is there a template we can use?
- I think we need clarity on these ILI clinics. Some of my patients have attended and were told "you don't need to be here". The message I hear from this is that family doctors should be seeing potential COVID cases in our offices, instead of sending them to the ILI clinics. If our offices get COVID, we shut down and nobody gets care.
- If within the first 7 days and qualifies for treatment but when you speak to them their symptoms are improving, should you treat?