COVID-19 Community of Practice for Ontario Family Physicians

January 21, 2021

Dr. Elaine Ma
Dr. Allison McGeer
Dr. Daniel Warshafsky

Responding to the Omicron surge

Family & Community Medicine
UNIVERSITY OF TORONTO

Ontario College of Family Physicians

Responding to the Omicron surge

Moderator: Dr. Tara Kiran

Fidani Chair, Improvement and Innovation
Department of Family and Community Medicine, University of Toronto

Panelists:

- Dr. Elaine Ma, Kingston, ON
- Dr. Allison McGeer, Toronto, ON
- Dr. Daniel Warshafsky, Toronto, ON

This one-credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada and the Ontario Chapter for up to 1 Mainpro+ credits.

The COVID-19 Community of Practice for Ontario Family Physician includes a series of planned webinars. Each session is worth 1 Mainpro+ credits, for up to a total of 26 credits.

Land Acknowledgement

We acknowledge that the lands on which we are hosting this meeting include the traditional territories of many nations.

The OCFP and DFCM recognize that the many injustices experienced by the Indigenous Peoples of what we now call Canada continue to affect their health and well-being. The OCFP and DFCM respect that Indigenous people have rich cultural and traditional practices that have been known to improve health outcomes.

I invite all of us to reflect on the territories you are calling in from as we commit ourselves to gaining knowledge; forging a new, culturally safe relationship; and contributing to reconciliation.

Mildly Ill Patients

Patients who do not require new or additional supplemental oxygen from their baseline status

Tier 1

Immunocompromised individuals[1] not expected to mount an adequate immune response to COVID-19 vaccination or SARS-CoV-2 infection due to their underlying conditions, regardless of vaccine status; OR Unvaccinated[2] individuals at highest risk of severe disease (only if also age ≥70 years, Indigenous and age ≥60 years, or age ≥60 years with one or more risk factors[3]). Older immunocompromised individuals are at higher risk, and should be prioritized for treatment in this tier.[4]

Tier 2

Unvaccinated[2] individuals at risk of severe disease (only if also age ≥60 years, Indigenous and age ≥50 years, or ≥50 years with one or more risk factors[3]).[4]

Tier 3

Vaccinated individuals at highest risk of severe disease (only if also age ≥70 years, Indigenous and age ≥60 years, or age ≥60 years with one or more risk factors[3]). Vaccinated individuals who are >6 months from their last dose of vaccine are at higher risk, and should be prioritized for treatment in this tier.[4]

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Vaccinated individuals at risk of severe disease (only if also age ≥60 years, Indigenous and age ≥50 years, or ≥50 years with one or more risk factors[3]). Vaccinated individuals who are >6 months from their last dose of vaccine are at higher risk, and should be prioritized for treatment in this tier.[4]

This guidance applies to mildly ill patients in any setting, including the community, hospital (including nosocomial cases), and congregate care settings.

● It is recommended that eligibility for outpatient therapies include patients who test positive for SARS-CoV-2 on either PCR or a healthcare-professional administered RAT or ID Now.

RISK LEVEL	RECOMMENDATIONS
HIGHER RISK OF SEVERE DISEASE Tier 1 Tier 2	● Sotrovimab 500 mg IV x 1 dose is recommended for these patients if they present within 7 days of symptom onset. • Previous SARS-CoV-2 infection and vaccination status do not need to be considered. Serologic testing is not recommended. • These individuals should have a reasonable expectation for 1-year survival prior to SARS-CoV-2 infection. • It is recommended that monoclonal antibody therapy be administered to non-hospitalized individuals across Ontario using a hybrid network that includes, but is not limited to, mobile integrated healthcare services, community paramedicine, and outpatient infusion clinics. *If sotrovimab is unavailable or contraindicated:* ▲ Remdesivir 200 mg IV on day 1, then 100 mg IV daily for 2 days may be considered for these patients if they present within 7 days of symptom onset and: (1) more effective therapeutic options (i.e. sotrovimab) are not available; and (2) intravenous administration is not a barrier. • These individuals should have a reasonable expectation for 1-year survival prior to SARS-CoV-2 infection. *If remdesivir is unavailable or contraindicated:* ▲ Fluvoxamine may be considered for patients with mild COVID-19 illness presenting within 7 days of symptom onset. The recommended starting dose is 50 mg PO daily, titrated up to 100 mg PO twice daily for a total of 15 days. Pharmacist consultation and outpatient provider follow-up is important to avoid any significant adverse drug interactions with fluvoxamine. This recommendation balances the very low certainty evidence of benefit for preventing hospitalization with the need for management options for mild illness with a reasonable safety profile during a surge in COVID-19 cases due to the Omicron variant. ▲ Budesonide 800 mcg inhaled twice daily for 14 days may be considered for these patients. This recommendation is based on very low certainty evidence of reduction in duration of symptoms, and the need for outpatient treatment options with a reasonable safety profile during an anticipated spike in COVID-19 cases due to the Omicron variant. Budesonide may have a role as an additional therapy in patients already on other therapies who have respiratory symptoms.
MODERATE RISK Tier 3 Tier 4	▲ Remdesivir 200 mg IV on day 1, then 100 mg IV daily for 2 days may be considered for these patients if they present within 7 days of symptom onset and intravenous administration is not a barrier. • These individuals should have a reasonable expectation for 1-year survival prior to SARS-CoV-2 infection. *If remdesivir is unavailable or contraindicated:* ▲ Fluvoxamine 50 mg PO daily titrated up to 100 mg PO twice daily for a total of 15 days may be considered for these patients if they present within 7 days of symptom onset. See fluvoxamine recommendation statement for higher risk mildly ill patients. ▲ Budesonide 800 mcg inhaled twice daily for 14 days may be considered for these patients. See budesonide recommendation statement for higher risk mildly ill patients. ■ Sotrovimab is not recommended for these patients. This recommendation is based on current limited supply of sotrovimab, and prioritizing its administration in patients at greatest risk of progressing to severe disease.
LOWER RISK *Any individual not included in tiers 1 to 4*	● Reassurance and information for self-monitoring of symptoms (including self-monitoring of oxygen saturation) are recommended. ■ Sotrovimab is not recommended for these patients. This recommendation is based on current limited supply of sotrovimab, and prioritizing its administration in patients at greatest risk of progressing to severe disease. ■ Remdesivir is not recommended for these patients. This recommendation is based on current limited supply of remdesivir, and prioritizing its administration in patients at greatest risk of progressing to severe disease (those who are moderately ill, followed by those who are mildly ill but at higher risk of progression). ■ Fluvoxamine is not recommended. ■ Budesonide is not recommended.

◆ There is currently insufficient evidence to make a recommendation around aspirin or anticoagulation for mildly ill patients.

■ The following therapies are not recommended in mildly ill patients: dexamethasone, tocilizumab, sarilumab, and baricitinib.

https://covid19-sciencetable.ca/sciencebrief/clinical-practice-guideline-summary-recommended-drugs-and-biologics-in-adult-patients-with-covid-19-version-8-0/

Changing the way we work

A community of practice for family physicians during COVID-19

At the conclusion of this series participants will be able to:

- Identify the current best practices for delivery of primary care within the context of COVID-19 and how to incorporate into practice.
- Describe point-of-care resources and tools available to guide decision making and plan of care.
- Connect with a community of family physicians to identify practical solutions for their primary care practice under current conditions.

Disclosure of Financial Support

This CPD program has received in-kind support from the Ontario College of Family Physicians and the Department of Family and Community Medicine, University of Toronto in the form of logistical and promotional support.

Potential for conflict(s) of interest:
N/A

Mitigating Potential Bias

- The Scientific Planning Committee has full control over the choice of topics/speakers.
- Content has been developed according to the standards and expectations of the Mainpro+ certification program.
- The program content was reviewed by a three-member national/scientific planning committee.

Planning Committee: Dr. Tara Kiran, Patricia O'Brien (DCFM), Susan Taylor (OCFP) and Mina Viscardi-Johnson (OCFP), Liz Muggah (OCFP)

Previous webinars & related resources:

https://www.dfcm.utoronto.ca/covid-19-community-practice/past-sessions

Dr. Elaine Ma– Panelist

Twitter: @DrElaineMa

Family Physician, Frontenac Doctors

Dr. Allison McGeer – Panelist

Infectious Disease Specialist, Mount Sinai Hospital

Dr. Dan Warshafsky– Panelist

Senior Medical Consultant at the Office of the Chief Medical Officer of Health

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Family Physician, North York Family Health Team and Vice President, Quality, Ontario Health

Dr. Liz Muggah – Co-Host

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OCFP President, Family Physician, Bruyère Family Health Team

Speaker Disclosure

- Faculty Name: **Dr. Elaine Ma**
- Relationships with financial sponsors:
  - Grants/Research Support: N.A
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians
  - Others: N/A

- Faculty Name: **Dr. Allison McGeer**
- Relationships with financial sponsors: Novavax, Medicago, Sanofi-Pasteur, GSK, Merck
  - Grants/Research Support: Sanofi-Pasteur, Pfizer
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Speaker Disclosure

- Faculty Name: **Dr. David Kaplan**
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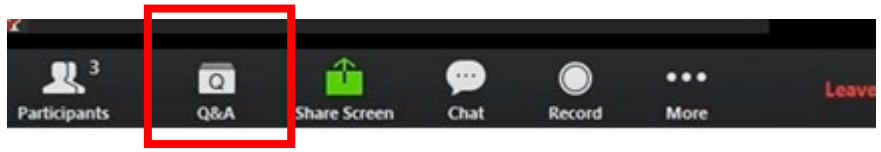
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians
  - Others: Ontario Health (employee)

- Faculty Name: **Dr. Liz Muggah**
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians
  - Others: N/A

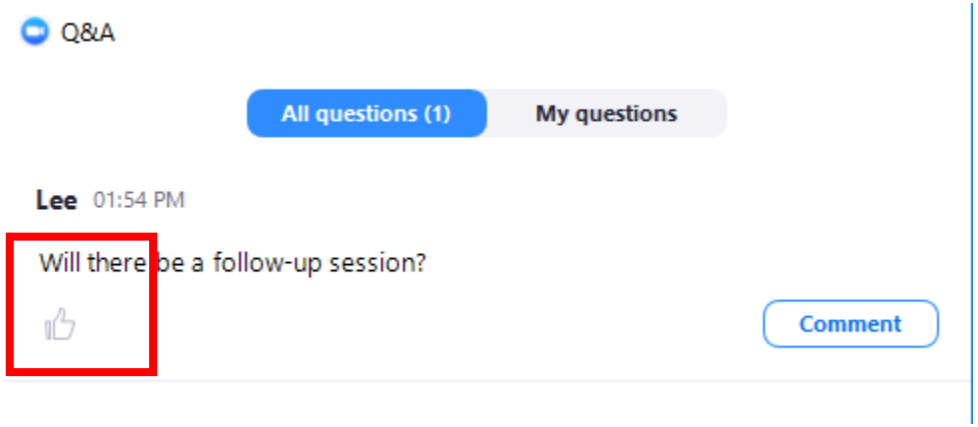
- Faculty Name: **Dr. Tara Kiran**
- Relationships with financial sponsors:
  - Grants/Research Support: St. Michael's Hospital, University of Toronto, Health Quality Ontario, Canadian Institute for Health Research, Toronto Central LHIN, Toronto Central Regional Cancer Program, Gilead Sciences Inc.
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians, Ontario Medical Association, Doctors of BC, Nova Scotia Health Authority, Osgoode Hall Law School, Centre for Quality Improvement and Patient Safety, Vancouver Physician Staff Association, University of Ottawa
  - Others: N/A

How to Participate

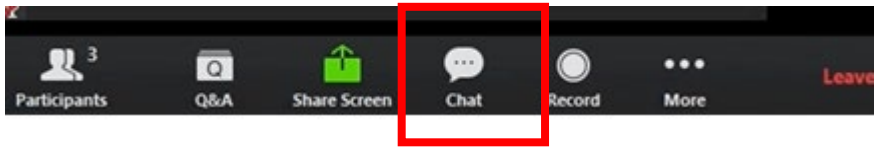
- All questions should be asked using the Q&A function at the bottom of your screen.



- Press the thumbs up button to upvote another guests questions. Upvote a question if you want to ask a similar question or want to see a guest's question go to the top and catch the panels attention.



- Please use the chat box for networking purposes only.



What we will cover today

- The role of primary care in responding to the Omicron surge
- COVID Clinical Assessment Centres
- Omicron update: Where are we with cases, hospitalizations? Who is being hospitalized? How is it affecting kids? How long can it spread for and when can it best be picked up on testing? What is the effectiveness of 2 v 3 doses? When will teens get the vaccine? Is a booster important once you get Omicron?
- Paxlovid and how to access COVID therapeutics
- New testing and isolation guidance
- Update on where we are provincially with vaccine uptake

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Family Physician, Frontenac Doctors

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Infectious Disease Specialist, Mount Sinai Hospital

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Senior Medical Consultant at the Office of the Chief Medical Officer of Health

COVID-19 Clinical Assessment Centres and Primary Care

JANUARY 21, 2022

Ontario Health

Goals of the COVID-19 clinical assessment centre model

- Support improved patient outcomes and conserve needed capacity in emergency departments
- Provide patients with an expanded scope of clinical services related to COVID-19 assessment, appropriate testing, diagnosis, and disposition
- COVID-19 clinical assessment centres are not intended to replace:
  - Volumes in swabbing capacity currently provided by assessment centres. Rather, they are intended to augment the assessment centre model
  - Care being provided in primary care settings. Rather, primary care providers can consider directing patients with suspected or confirmed COVID-19 to these clinics if the patient needs to be examined in-person, but the provider is unable to safely see the person in their own clinic

Key Messages for Primary Care

- Primary care sector has been a key partner in Ontario's COVID response over the past two years and we deeply appreciate your efforts
- In response to Omicron, we are asking primary care to prioritize:
    1. Urgent/emergent care for their patients to avoid ED visits/admissions
    2. Supporting vaccination
    3. Remote monitoring for COVID patients
- COVID-19 clinical assessment centres are an additional resource available to primary care providers to help divert patients from emergency departments if they do not require emergency care.
- This resource is not meant to replace any existing pathways some regions have set up for providing this type of care

Four standard elements of a COVID-19 clinical assessment centre

Element	Description
1. Patient identification	Criteria are as follows: The COVID-19 clinical assessment centres are intended for patients with known or suspected COVID-19 with worsening symptoms/pattern of symptoms or advised by a health care professional that they require an assessment and diagnosis for their symptoms. This is because their symptoms cannot be safely self-monitored at home, but they are also not experiencing severe symptoms that would require emergency care. Patients who meet criteria are directed to the COVID-19 clinical assessment centre. Patients may be directed to the COVID-19 clinical assessment centre by: • Self/walk-in (walk-ins may be limited based on local context) • Telehealth • Primary care provider • Emergency department • Assessment centres that offer testing only Patients who are at higher risk of severe diseases (Tier 1 and Tier 2 based on COVID-19 Science Advisory Table) may be eligible for outpatient therapeutics (e.g., monoclonal antibodies, oral antiviral medication).

Four standard elements of a COVID-19 clinical assessment centre

Element	Description
2. Assessment and appropriate testing	Patients are assessed by an appropriate health professional (e.g., physician, nurse practitioner, registered nurse, registered practical nurse, paramedic). The assessment may include oxygen saturation, vital signs, and identifying relevant risk factors/comorbidities. Patients may be tested using a rapid test, if appropriate, and following the provincial testing guidance.
3. Diagnosis	Patients are diagnosed by an appropriate health professional (e.g., physician or nurse practitioner). The patient's disposition is determined by the assessment and diagnosis.
4. Disposition planning	Disposition planning will require clinical expertise and judgement. Depending on the patient's condition and risk of clinical deterioration, disposition options may include: • Home with self-monitoring, if appropriate • Home with remote care monitoring • Direct to emergency department for further investigation • Where possible, direct to inpatient COVID-19 unit • When/where available, direct to outpatient therapeutics

COVID-19 Clinical Assessment Centres

Inputs/referral sources

- Primary and community care
- Telehealth
- COVID-19 assessment centres (testing-only sites)
- Emergency department
- Self-referral (e.g., self-assessment tool)

Target Population for COVID-19 Clinical Assessment Centres:

- For people with suspected or confirmed COVID-19 who have worsening symptoms/pattern of symptoms or who need help monitoring their health
- See CEP for further guidance
- People with severe symptoms are directed to call 911 or go directly to an emergency department

Services provided at CACs

Clinical assessment, appropriate testing, and diagnosis

Disposition planning options:

- Home with self-monitoring, if applicable
- Home with remote care monitoring, if available in their region
- Direct to emergency department for further investigation
- Direct to in-patient COVID-19 unit, where possible
- Direct to or provide outpatient therapeutics, where available

Discharge/handover

Hand over to primary care* and home and community care

*For those without access to primary care provider, information provided about their follow-up options (e.g., Telehealth, nearest walk-in clinic, any other relevant supports)

Eligibility for COVID-19 therapeutics:

- The risk of disease and therapeutic recommendations are outlined by the clinical practice guidelines from the COVID-19 Science Advisory Table (Version 8)
- People who are at a higher risk of severe disease may be eligible for COVID-19 therapeutics, thus need to be assessed by an appropriate health care professional as soon as possible, ideally within 24 hours

Ontario Health

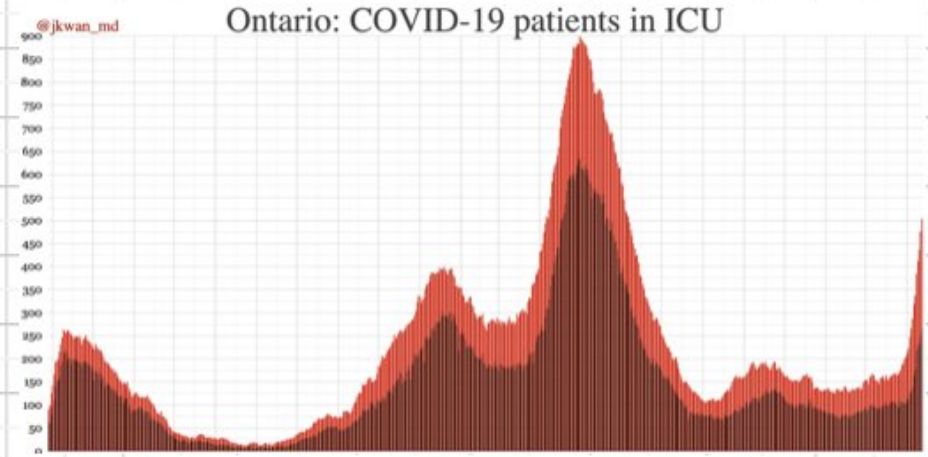
Primary care pathways

- Patients can be directed to the COVID-19 clinical assessment centres by a health care professional or may self-refer
- Patients who are assessed at the COVID-19 clinical assessment centres and are deemed eligible for COVID@Home may be referred to primary care based or other remote monitoring programs
- Ontario Health is exploring the possibilities for how primary care providers can order PCR tests for patients for the purpose of initiating COVID therapy

Ontario Health

For more info: https://tools.cep.health/tool/covid-19/#covid-19-clinical-assessment-centres-cacs-information-for-primary-care-providers

Ontario COVID-19: Daily cases vs. Total hospitalizations



Please see thread for additional graphs ⬇

(including vaccinations, ICU, tests)

Daily new cases

Total hospitalizations

15000
14000
13000
12000
11000
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0

7500
5000
2500
0

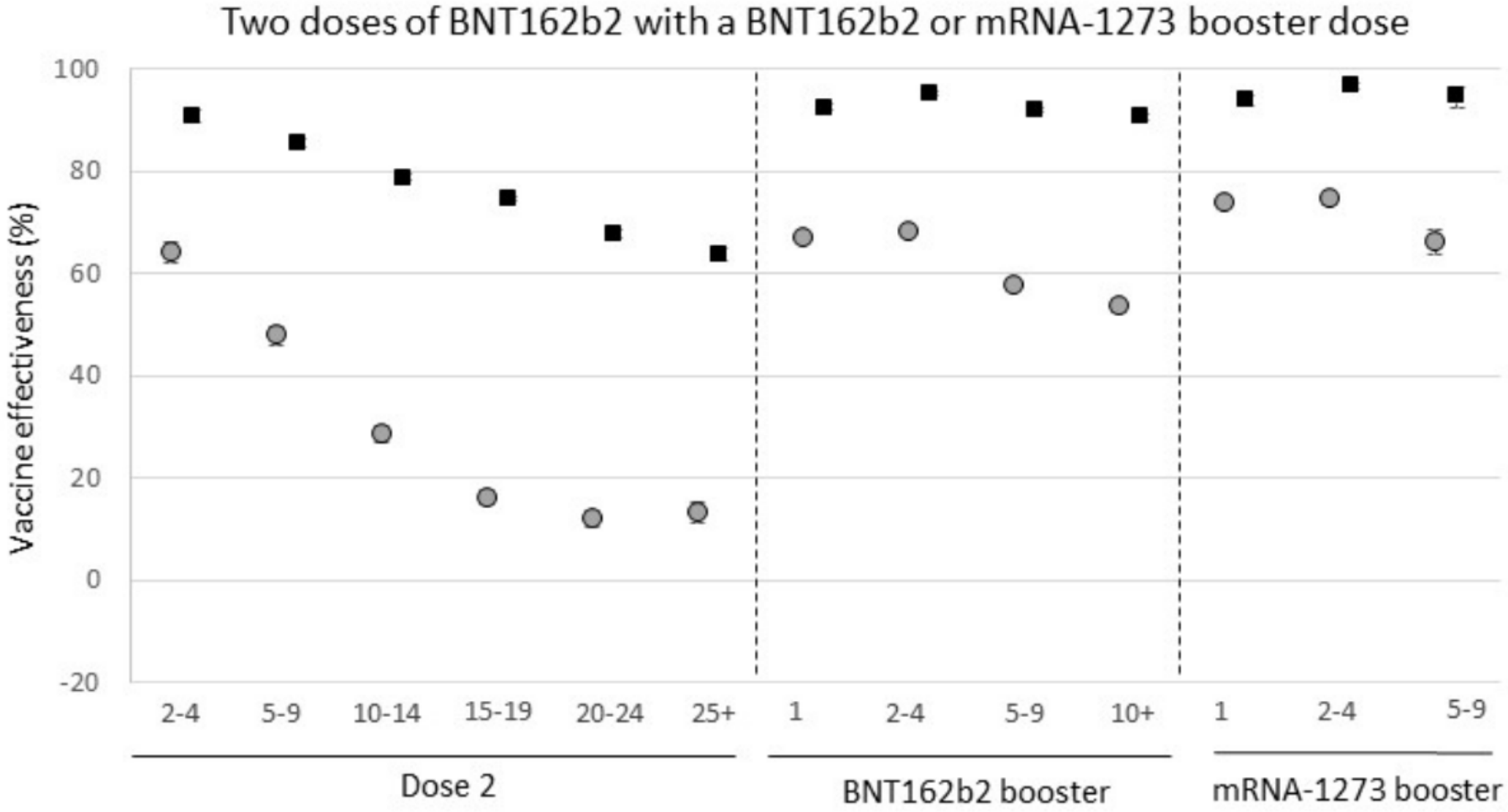
Aug 1
Sep 1
Oct 1
Nov 1
Dec 1
Jan 1
Feb 1
Mar 1
Apr 1
May 1
Jun 1
Jul 1
Aug 1
Sep 1
Oct 1
Nov 1
Dec 1
Jan 1

@jkwan_md

Daily new cases (Left axis)

Total hospitalizations (Right axis)

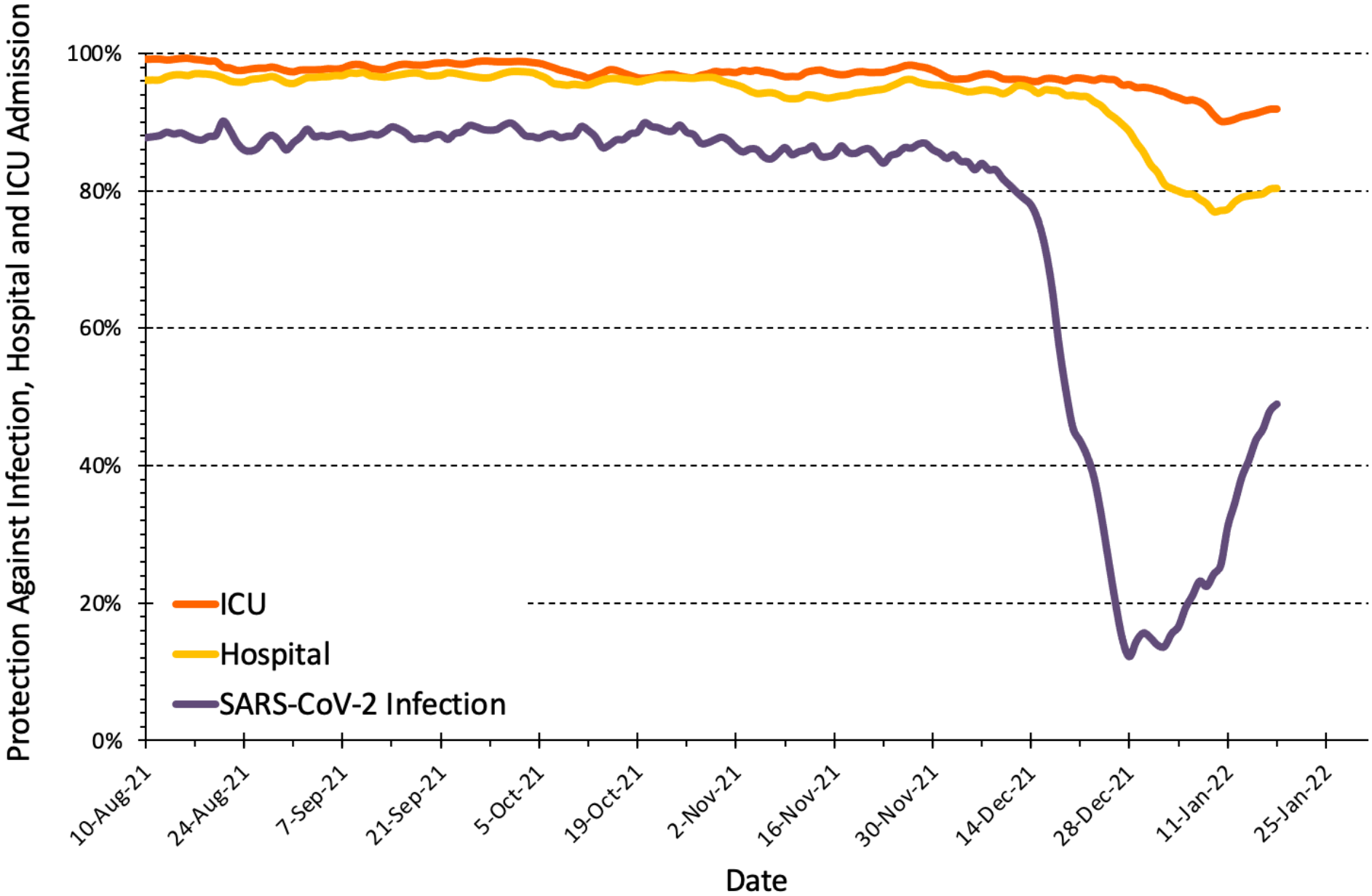
UK National Health Security technical briefing 34



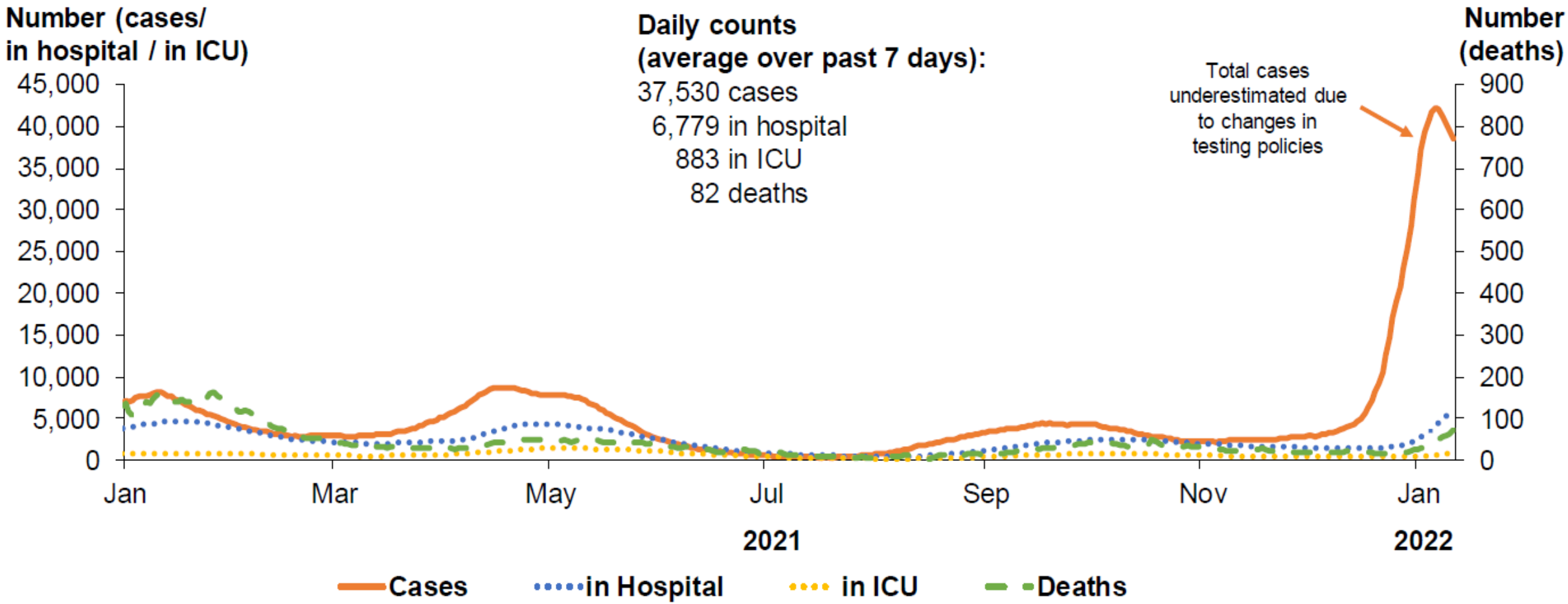
UK National Health Security technical briefing 34

Dose	Interval after dose (weeks)	OR v symptomatic disease	HR vs hospitalisation	VE vs hospitalisation
1	4+	0.74 (0.72-0.76)	0.57 (0.38-0.85)	58% (37-72)
2	2 to 24	0.81 (0.8-0.82)	0.45 (0.36-0.56)	64% (54-71)
2	25+	0.94 (0.92-0.95)	0.6 (0.49-0.74)	44% (30-54)
3	2 to 4	0.32 (0.31-0.33)	0.26 (0.19-0.35)	92% (89-94)
3	5 to 9	0.42 (0.41-0.43)	0.29 (0.23-0.37)	88% (84-91)
3	10+	0.5 (0.49-0.51)	0.34 (0.26-0.44)	83% (78-87)

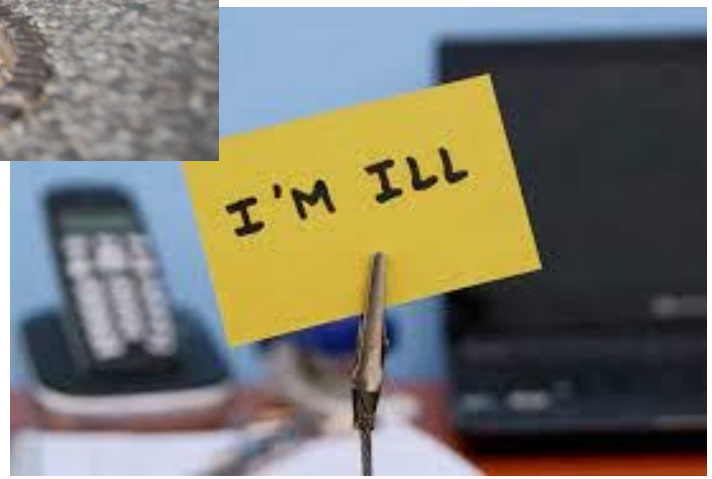
Protection Against Infection, Hospital and ICU Admission Associated With at Least 2 Vaccine Doses



Omicron disease activity has eclipsed all previous waves and is driving up severe illness trends despite being less severe than Delta

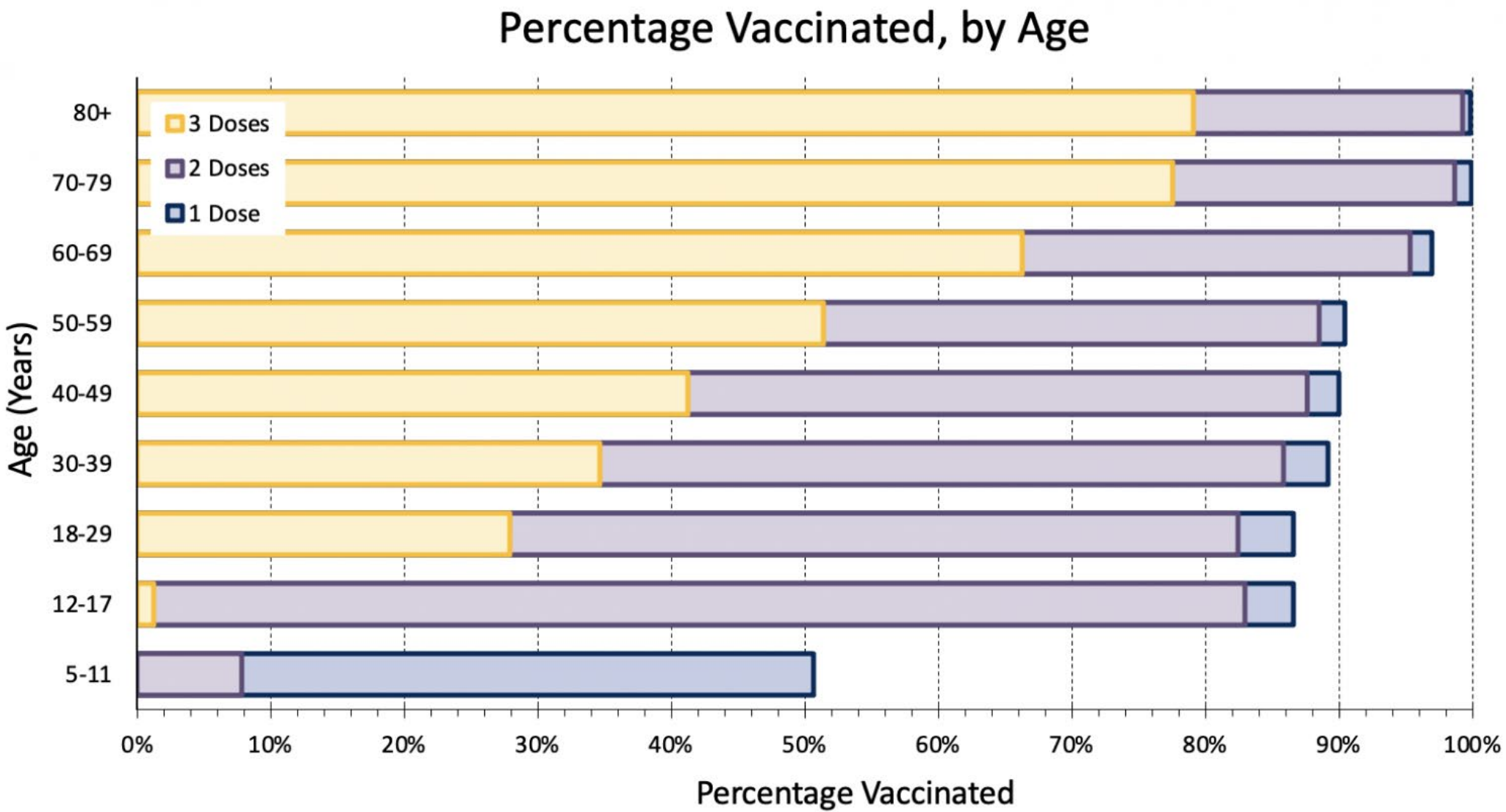


How do we know Omicron is plateauing?

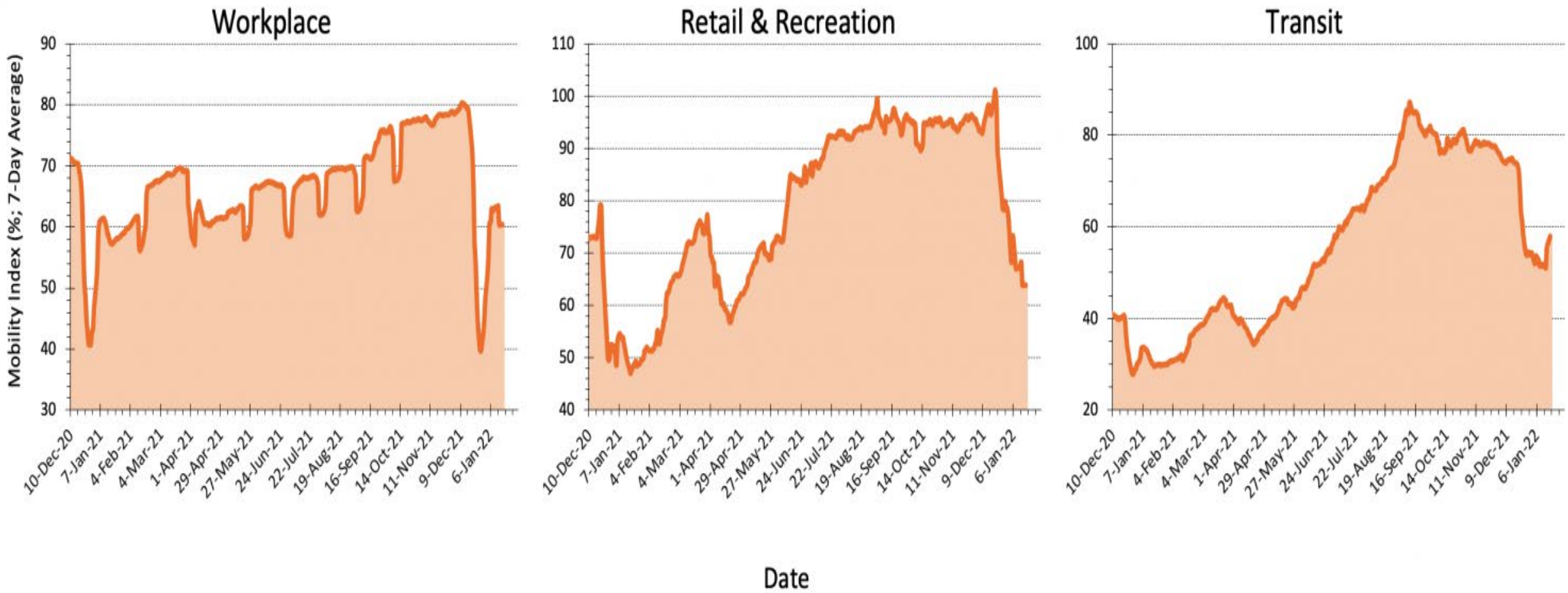


- Fewer new LTC outbreaks
  - Number of LTC staff cases flat
- Hospitalizations rising more slowly
- Staffing crisis easing
- TPH line list of outbreaks stable/decreasing

Vaccination rates in Ontario



Mobility indicators, high risk settings in Ontario

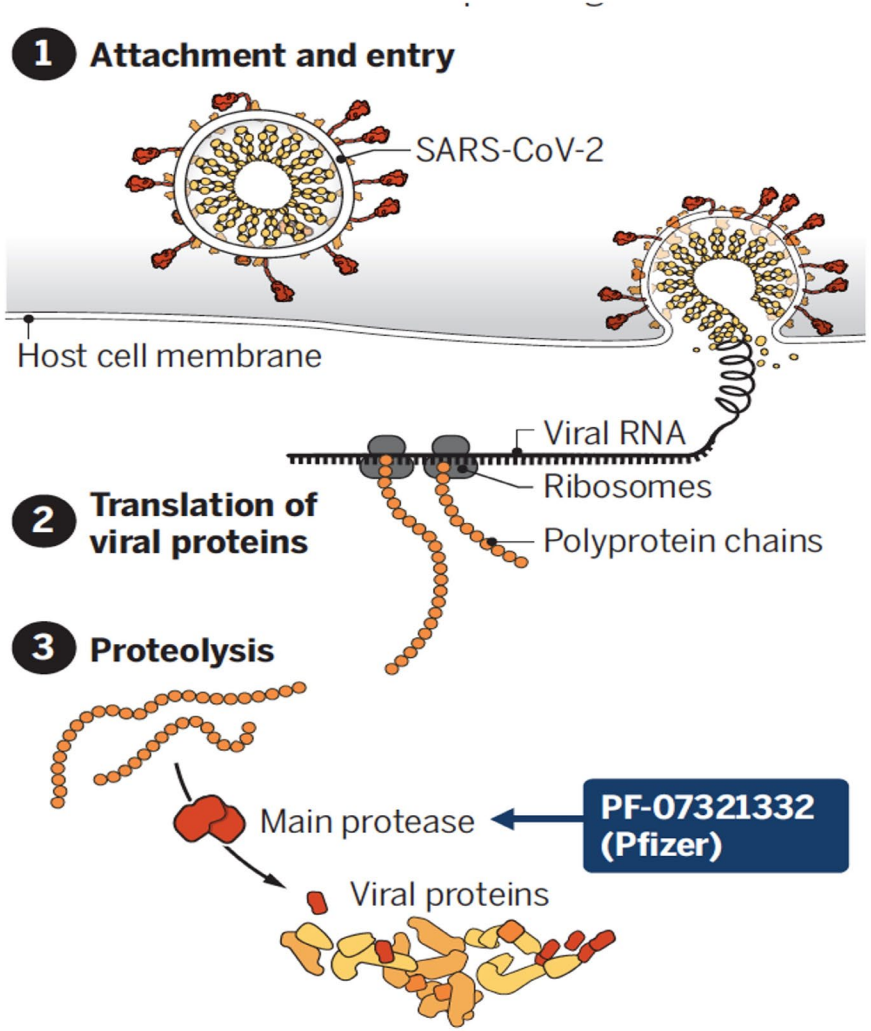


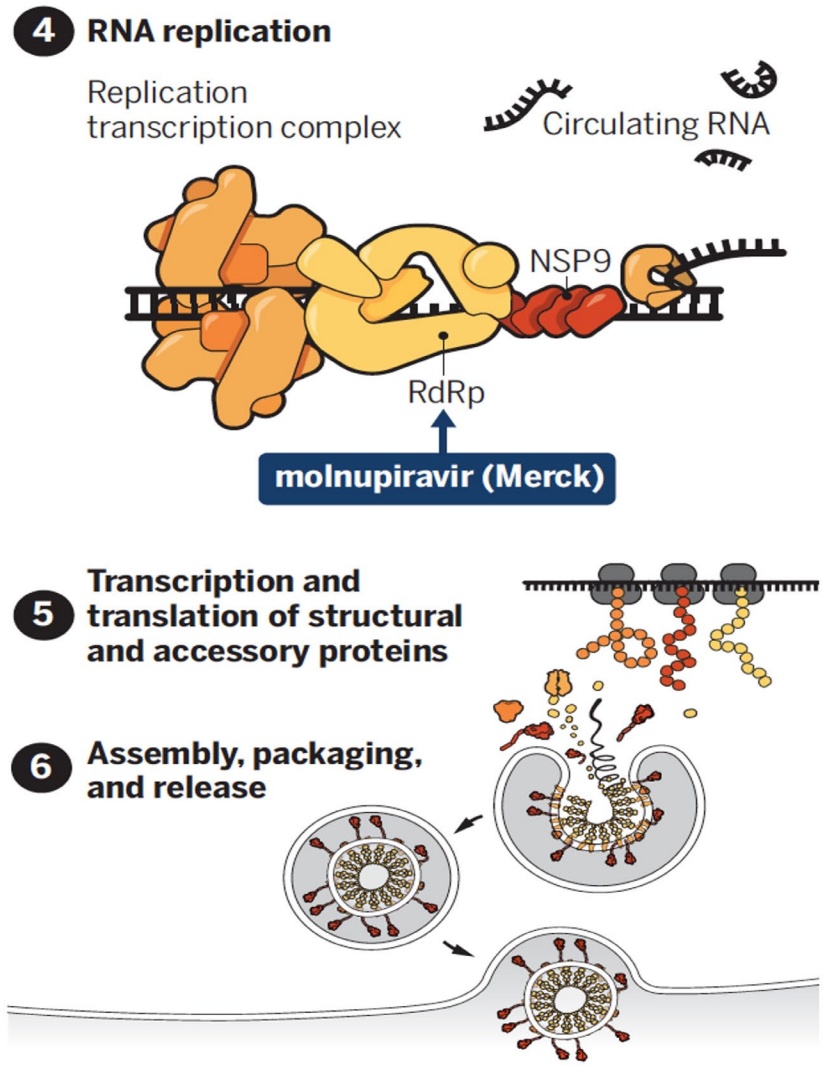
Sensitivity of RATs for Omicron

	Sensitivity (%)		
	Delta (n=34)	Omicron (n=36)	p[1]
Panbio	67.7	36.1	<.001
Standard Q	52.9	22.2	<.001
Sure Status	52.9	27.8	<.001
Onsite	64.7	47.2	<.001
Wondfo	76.5	75.0	.984
Tigsun	52.9	47.2	.634
Flowflex	91.2	88.9	.918

Bekliz https://www.medrxiv.org/content/10.1101/2021.12.18.21268018v2

Paxlovid


1 Attachment and entry
SARS-CoV-2
Host cell membrane
Viral RNA
Ribosomes
2 Translation of viral proteins
Polyprotein chains
3 Proteolysis
Main protease
PF-07321332 (Pfizer)
Viral proteins


4 RNA replication
Replication transcription complex
Circulating RNA
NSP9
RdRp
molnupiravir (Merck)
5 Transcription and translation of structural and accessory proteins
6 Assembly, packaging, and release

Paxlovid

Benefits

	Paxlovid	Placebo	P value
Treatment within 3 days of symptom onset	3/389 hospitalized No deaths	27/385 hospitalized 7 deaths	<.0001
Treatment within 5 days of symptom onset	6/607 hospitalized	41/612 hospitalized 10 deaths	<.0001

Challenges

- Early diagnosis and treatment
- Cannot crush pills
- Contraindicated if creatinine clearance <30ml/min or severe hepatic failure
- Drug interactions:
  - E.g. Quetiapine, lovastatin, simvastatin, warfarin, triazolam, trazodone….
- GI Side effects of ritonavir

Mildly Ill Patients

Patients who do not require new or additional supplemental oxygen from their baseline status

Tier 1

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HIGHER RISK OF SEVERE DISEASE Tier 1 Tier 2	● Sotrovimab 500 mg IV x 1 dose is recommended for these patients if they present within 7 days of symptom onset. • Previous SARS-CoV-2 infection and vaccination status do not need to be considered. Serologic testing is not recommended. • These individuals should have a reasonable expectation for 1-year survival prior to SARS-CoV-2 infection. • It is recommended that monoclonal antibody therapy be administered to non-hospitalized individuals across Ontario using a hybrid network that includes, but is not limited to, mobile integrated healthcare services, community paramedicine, and outpatient infusion clinics. *If sotrovimab is unavailable or contraindicated:* ▲ Remdesivir 200 mg IV on day 1, then 100 mg IV daily for 2 days **may be considered** for these patients if they present within 7 days of symptom onset and: (1) more effective therapeutic options (i.e. sotrovimab) are not available; and (2) intravenous administration is not a barrier. • These individuals should have a reasonable expectation for 1-year survival prior to SARS-CoV-2 infection. *If remdesivir is unavailable or contraindicated:* ▲ Fluvoxamine **may be considered** for patients with mild COVID-19 illness presenting within 7 days of symptom onset. The recommended starting dose is 50 mg PO daily, titrated up to 100 mg PO twice daily for a total of 15 days. Pharmacist consultation and outpatient provider follow-up is important to avoid any significant adverse drug interactions with fluvoxamine. This recommendation balances the very low certainty evidence of benefit for preventing hospitalization with the need for management options for mild illness with a reasonable safety profile during a surge in COVID-19 cases due to the Omicron variant. ▲ Budesonide 800 mcg inhaled twice daily for 14 days **may be considered** for these patients. This recommendation is based on very low certainty evidence of reduction in duration of symptoms, and the need for outpatient treatment options with a reasonable safety profile during an anticipated spike in COVID-19 cases due to the Omicron variant. Budesonide may have a role as an additional therapy in patients already on other therapies who have respiratory symptoms.
MODERATE RISK Tier 3 Tier 4	▲ Remdesivir 200 mg IV on day 1, then 100 mg IV daily for 2 days **may be considered** for these patients if they present within 7 days of symptom onset and intravenous administration is not a barrier. • These individuals should have a reasonable expectation for 1-year survival prior to SARS-CoV-2 infection. *If remdesivir is unavailable or contraindicated:* ▲ Fluvoxamine 50 mg PO daily titrated up to 100 mg PO twice daily for a total of 15 days **may be considered** for these patients if they present within 7 days of symptom onset. See fluvoxamine recommendation statement for higher risk mildly ill patients. ▲ Budesonide 800 mcg inhaled twice daily for 14 days **may be considered** for these patients. See budesonide recommendation statement for higher risk mildly ill patients. ■ Sotrovimab is **not recommended** for these patients. This recommendation is based on current limited supply of sotrovimab, and prioritizing its administration in patients at greatest risk of progressing to severe disease.
LOWER RISK *Any individual not included in tiers 1 to 4*	● Reassurance and information for self-monitoring of symptoms (including self-monitoring of oxygen saturation) are recommended. ■ Sotrovimab is **not recommended** for these patients. This recommendation is based on current limited supply of sotrovimab, and prioritizing its administration in patients at greatest risk of progressing to severe disease. ■ Remdesivir is **not recommended** for these patients. This recommendation is based on current limited supply of remdesivir, and prioritizing its administration in patients at greatest risk of progressing to severe disease (those who are moderately ill, followed by those who are mildly ill but at higher risk of progression). ■ Fluvoxamine is **not recommended**. ■ Budesonide is **not recommended**.

◆ There is currently **insufficient evidence** to make a recommendation around aspirin or anticoagulation for mildly ill patients.

■ The following therapies are **not recommended** in mildly ill patients: dexamethasone, tocilizumab, sarilumab, and baricitinib.

1. Examples of immunocompromised or immunosuppressed individuals include individuals with active treatment for solid tumor and hematologic malignancies, receipt of solid-organ transplant and taking immunosuppressive therapy, receipt of chimeric antigen receptor (CAR)-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy), moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome, common variable immunodeficiency, Good's syndrome, hyper IgE syndrome), advanced or untreated HIV infection, active treatment with high-dose corticosteroids (i.e., ≥20 mg prednisone or equivalent per day when administered for ≥2 weeks), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis factor (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory. For individuals who are immunosuppressed or receiving immunosuppressants, their condition is considered both an underlying risk factor AND a marker of insufficient ability to mount an immune response to SARS-CoV-2. These individuals should have a reasonable expectation for 1-year survival prior to SARS-CoV-2 infection.
2. Unvaccinated is defined as individuals who have received one or zero doses of a COVID-19 vaccine.
3. Risk factors include obesity (BMI ≥30), dialysis or stage 5 kidney disease (eGFR <15 mL/min/1.73 m²), diabetes, cerebral palsy, intellectual disability of any severity, sickle cell disease, receiving active cancer treatment, solid organ or stem cell transplant recipients. If patients have, in the opinion of a physician, other important risk factors for disease progression beyond this list that merit the use of specific drugs or therapeutics, these should be clearly documented at the time of administration.
4. Although pregnancy is a risk factor for severe COVID-19, the absolute risk for this population remains low due to the young age and lack of comorbidities of most pregnant individuals. Considerations for the use of specific COVID-19 therapeutics should therefore be made on a case-by-case basis.

https://covid19-sciencetable.ca/sciencebrief/clinical-practice-guideline-summary-recommended-drugs-and-biologics-in-adult-patients-with-covid-19-version-8-0/

January 12, 2022

Fluvoxamine

What Prescribers and Pharmacists Need to Know

SCIENCE TABLE

UNIVERSITY OF WATERLOO | SCHOOL OF PHARMACY

Why is fluvoxamine used to treat COVID-19?

The consequences of COVID-19 that lead to poor outcomes, including hospitalization, invasive ventilation, and death, are in large part due to inflammation.

Fluvoxamine is an SSRI (selective serotonin reuptake inhibitor) typically used to treat depression and anxiety. It affects the sigma-1 receptor that controls inflammation and may reduce inflammation in COVID-19. Fluvoxamine is more anti-inflammatory than other SSRIs (i.e., this is not expected to be a class effect).

Fluvoxamine should not replace outpatient therapies with a higher likelihood of effect, such as sotrivomab and remdesivir. If patients are eligible for and can access these agents, they should be used preferentially.

What is the benefit of fluvoxamine for COVID-19?

Two studies (STOP-COVID 1[1] and the TOGETHER[2] trials) have shown a benefit from treatment with fluvoxamine in adult outpatients with PCR-proven COVID-19 who were less than 7 days from onset of symptoms. The studies suggest **fluvoxamine may reduce ER visit length, hospitalization, and disease progression.**

Research on fluvoxamine was done before widespread immunization and before the Delta and Omicron variants were circulating. However, with the anticipated impact of surging Omicron cases on the healthcare system, the Ontario Science Advisory Table has made a conditional recommendation for the use of fluvoxamine in patients with COVID-19 who are not on supplemental oxygen.[3]

What are other recommended outpatient treatments for COVID-19?

Sotrivomab

Anti-SARS-CoV-2 neutralizing monoclonal antibodies such as sotrivomab have been shown to benefit patients without immunity to COVID-19 (vaccine or disease-induced) who are within 7 days of symptom onset.[4] The evidence of benefit for sotrivomab in patients with COVID-19 not on supplemental oxygen is more certain than the evidence for fluvoxamine.

Remdesivir

Remdesivir is a direct-acting antiviral agent that has been shown to reduce the risk of COVID-19-related hospitalization and death in patients who are within 7 days of symptom onset and have risk factors for disease progression.[5] Remdesivir impacts outcomes that are likely more important to more patients than fluvoxamine (e.g., shorter time to recovery).

Budesonide

The inhaled corticosteroid budesonide has been shown to shorten duration of symptoms for high risk outpatients with COVID-19.[6] It has not been shown to reduce the risk of hospitalization or other serious outcomes.

How do I dose fluvoxamine for treatment of COVID-19?

1. Start with 50 mg PO once daily, preferably at bedtime.
2. If the drug is well tolerated, increase the dose to 100 mg PO BID on day 2.
   If the drug is less well tolerated, consider a dose of 50 mg PO BID on day 2, and increase the dose to 100 mg PO BID on day 3.
3. If the patient was on another SSRI/SNRI* before switching to fluvoxamine, and they were at or near the maximum dose, increase the dose to 150 mg PO BID.
   *Selective serotonin reuptake inhibitor / serotonin-norepinephrine reuptake inhibitor
4. Continue therapy for a total of 10 to 15 days.

Fluvoxamine has many drug interactions.
Refer to page 2 ⟶

https://covid19-sciencetable.ca/sciencebrief/fluvoxamine-what-prescribers-and-pharmacists-need-to-know/

Who is Eligible for COVID-19 PCR Testing?

Symptomatic people who are:	•staff, volunteers, residents/ inpatients, visitors in highest-risk settings (hospitals, including complex continuing care facilities and paramedic services; congregate living settings, including LTC, shelters, hospices, correctional facilities) •patient-facing healthcare workers •**household members of workers in highest risk settings *NEW*** •**first responders, including fire, police and paramedics *NEW*** •**Pregnant *NEW*** •**temporary foreign workers in congregate living settings *NEW*** •underhoused or homeless •living or working in First Nations, Inuit or Métis communities •elementary and secondary students and education staff (if given PCR kit through school) •seeking emergency medical care (at clinician's discretion) •directed to be tested by Public Health
Symptomatic outpatients for whom COVID-19 treatment is being considered, including:	•immunocompromised individuals not expected to mount an adequate immune response to vaccination or infection •not fully vaccinated individuals at highest risk of severe disease (age ≥ 70; Indigenous persons who are ≥ 60; individuals ≥ 60 who have a risk factor)

Ministry of Health: COVID-19 Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge (Version 2.0 – January 13, 2022) (Pages 3-4)

Case and Contact Management

Isolation periods for COVID cases (someone with COVID symptoms OR someone with a positive COVID test) :

Isolation Period	Population
5 days after the date of specimen collection or symptom onset (whichever is earlier)	• Fully vaccinated individuals • Children under the age of 12
10 days after the date of specimen collection or symptom onset (whichever is earlier)	• Individuals 12+ who are not fully vaccinated • Immunocompromised • Hospitalized for COVID-19 related illness
20 days after the date of specimen collection or symptom onset (whichever is earlier)	• Severe illness[6] (requiring ICU level of care) • Severe immune compromise[7]

•Day 0 is the day symptoms began OR the day of a positive test in someone who did not have symptoms.

•Exit isolation after Day 5/10/20 IF symptoms have been improving for at least 24 hours (48 hours for vomiting/diarrhea) AND no fever for at least 24 hours

Ministry of Health: COVID-19 Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge (Version 2.0 – January 13, 2022 – page 13

Case and Contact Management

20-day isolation period: What is “severe immunocompromise”?

- Individuals on these medications: high-dose prednisone; B-cell depleting therapies
- These conditions:
  - ✓ Individuals receiving active treatment (e.g., chemotherapy, targeted therapies, immunotherapy) for solid tumour or hematologic malignancies
  - ✓ Recipients of solid-organ transplant and taking immunosuppressive therapy
  - ✓ Recipients of chimeric antigen receptor (CAR)-T-cell therapy or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy)
  - ✓ Individuals with severe primary immunodeficiency
  - ✓ Individuals with stage 3 or advanced untreated HIV infection and those with acquired immunodeficiency syndrome
  - ✓ Individuals receiving active treatment with the following categories of immunosuppressive therapies: anti-B cell therapies (monoclonal antibodies targeting CD19, CD20 and CD22), high-dose systemic corticosteroids (refer to the Canadian Immunization Guide), alkylating agents, antimetabolites, or tumor-necrosis factor (TNF) inhibitors and other biologic agents that are significantly immunosuppressive

From MOH COVID-19 Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge (Jan.13, 2022): ***severe immune compromise*** *include cancer chemotherapy, untreated HIV infection with CD4 T lymphocyte count <200, combined primary immunodeficiency disorder, taking prednisone >20 mg/day (or equivalent) for more than 14 days and taking other immune suppressive medications*

Case and Contact Management

- A **close contact** is anyone who lives with a case AND anyone who spent a total of 15 minutes within 2 meters of someone who could spread COVID (unless everyone was wearing masks).
  - In general, the infectious period starts 48 hours prior to symptoms and extends up to 10 days from symptom onset (or before and after a positive test in someone without symptoms).

- The **isolation period for household close contacts** is the same length as the case's isolation period.
  - If a new household cases occurs, the isolation period **resets** for people who haven't had COVID during the current episode.
  - The isolation period for cases is NOT AFFECTED by new household cases during the current episode. Once a case has completed their isolation period, they can stop isolating, even if other members of the household are still isolating.

- For **non-household close contacts,** decisions about isolation and the length of isolation periods relate to **age, vaccination status/recent Omicron infection, and immune system function:**
  - Self-monitoring for 10 days: people over 12 who have had ≥2 vaccine doses AND who don't have immunocompromise
  - 5-day isolation: people under 12 who have not had 2 vaccine doses
  - 10-day isolation: people who have not had ≥ 2 vaccine doses/ an Omicron infection within 90 days OR people who have immunocompromise

- People working in **highest risk settings** must follow more strict guidance for return-to-work.

Ministry of Health: COVID-19 Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge (Version 2.0 – January 13, 2022

Isolation guidance for people with COVID-19 symptoms and people who have tested positive for COVID-19

[Jan 17, 2022]

If you have COVID-19 symptoms:

At least 1 of:
- ❑ Fever/chills
- ❑ Cough
- ❑ Shortness-of-breath
- ❑ Change in sense of taste or smell

OR

At least 2 of:
- ❑ Runny nose/ nasal congestion
- ❑ Headache
- ❑ Extreme tiredness
- ❑ Sore throat
- ❑ Muscle aches or joint pain
- ❑ Vomiting or diarrhea

Presume you have COVID-19 and:
- ❑ Self-isolate (stay home and stay apart from people you live with if possible).
- ❑ Anyone you live with must self-isolate UNLESS they have recently had COVID-19 and have finished their isolation. *Each person who gets COVID-19 can stop isolating once their isolation period is done, even if close contacts still need to isolate.*

Can you get tested for COVID-19?
(Polymerase chain reaction (PCR) test **OR**
2 rapid antigen tests (RATs) taken 24-to-48 hours apart)

NO

YES

Did you test positive for COVID-19?

NO

- ❑ Self-isolate until you have not had a fever in at least 24 hours AND your symptoms have been getting better for at least 24 hours (48 hours for vomiting or diarrhea).
- ❑ People you live with do not have to stay home unless they feel sick.

YES

If you had a positive COVID-19 rapid antigen test (RAT)

Have you had 2 or more doses of a COVID-19 vaccine **OR**
Are you younger than 12 years old?

YES

NO

- ❑ Self-isolate for **10 days** from when you started to feel sick (or had a positive test if you did not feel sick). **If you are severely immunocompromised, self-isolate for 20 days.** *The day you started to feel sick (or had a positive test) is Day 0.*
- ❑ You can stop isolating after Day 10 (or Day 20) as long as you have not had a fever for at least 24 hours AND your symptoms have been improving for 24 hours (48 hours if you had vomiting or diarrhea).
- ❑ Do not work, visit or volunteer in "highest-risk settings" or with people at high-risk **for 10 days (20 days if you are severely immunocompromised).**
- ❑ Follow workplace guidance to return-to-work.
- ❑ **Close contacts** must follow the 'Isolation guidance for people who are close contacts of COVID-19'.

Are you immunocompromised?
(includes people with specific health conditions or who take specific medications that affect the immune system e.g. DiGeorge syndrome, chemotherapy)

YES

NO

- ❑ Self-isolate for **at least 5 days** from when you started to feel sick (or had a positive test, if you did not feel sick). *The day you started to feel sick (or had a positive test) is Day 0.*
- ❑ **After Day 5**, you can stop isolating as long as you have not had a fever for at least 24 hours AND your symptoms have been improving for 24 hours (48 hours if you had vomiting or diarrhea).
- ❑ Do not work, visit or volunteer in "highest risk settings" or with people at high-risk **for 10 days.**
- ❑ Follow workplace guidance to return-to-work.
- ❑ **Close contacts** must follow the 'Isolation guidance for people who are close contacts of COVID-19'.

A close contact is *anyone who lives with you AND anyone who was less than 2 meters away from you for at least 15 minutes in total while you could spread COVID-19 (unless everyone was wearing a mask).*
Most people can spread COVID-19 *from 48 hours before and for up to 10 days after they started to feel sick (or had a positive test).*

Source: Ontario Ministry of Health. (2022 January 2022). COVID-19 Integrated testing & case, contact and outbreak management interim guidance: Omicron surge. Version 2.0

Iso for cases p. 1/2

Confused about COVID?

Family doctors answer your questions.

- How do I know if I have COVID?
- When should I call my doctor?
- Do I need a COVID PCR test?
- When should I use a Rapid Antigen Test?
- What do I do if I have been in close contact with someone who has COVID?
- How do I keep safe during Omicron?

ConfusedAboutCOVID.ca

Family & Community Medicine
UNIVERSITY OF TORONTO

Ontario College of
Family Physicians

"I'm not feeling well. How do I know if I have COVID? What should I do?"

COVID is spreading so fast that we have changed how we identify and respond to it.

Assume that you have COVID if you have:

ANY ONE of the following:	OR	**ANY TWO** of the following:
✓ Fever > 37.7° C and/or chills		✓ Runny or stuffed-up nose
✓ A cough that's new or worse than usual		✓ Headache
✓ Trouble breathing		✓ Extreme fatigue
✓ Trouble tasting or smelling		✓ Sore throat
		✓ Muscle aches/joint pain
		✓ Vomiting or diarrhea

Most people do not need a test.
For more information on testing, visit rebrand.ly/COVID-PCR-test.

If you have symptoms but they do not meet the definition of COVID, self-isolate until your symptoms are getting better for 24 hours (48 hours if you have vomiting or diarrhea).

If you have symptoms of COVID, self-isolate and have all members of your household self-isolate.

CONFUSED ABOUT COVID? FAMILY DOCTORS ANSWER YOUR QUESTIONS.

How long do you self-isolate for?

12 years and older and have **two or more vaccine doses**	**OR**	11 years or younger	SELF-ISOLATE FOR **5 DAYS**
12 years and older and have **0 or 1 vaccine dose**	**OR**	Weak immune system*	SELF-ISOLATE FOR **10 DAYS**
Very weak immune system**			SELF-ISOLATE FOR **20 DAYS**

* *Examples of individuals with weak immune systems include people undergoing dialysis, organ transplant recipients not on immunosuppressant medications, and people taking high dose steroids.*

** *Examples of individuals with VERY weak immune systems include people undergoing cancer treatment, those with advanced HIV and people taking high-dose steroids or monoclonal antibodies. Please speak to your physician if you have questions or are unsure if your immune system is considered "very weak".*

Your isolation period starts from the first day you noticed symptoms or, if showing no symptoms, from the day you took a test that confirmed COVID. That is day 0. You may stop isolating after day 5, 10 or 20 *if* you have not had a fever for at least 24 hours AND if you have been getting better for at least 24 hours (48 hours if you had vomiting or diarrhea).

What about the people I live with?

People you live with should isolate while you are isolating. If they are feeling well, they can stop isolating at the same time as you.

If possible, stay apart from people you live with to lower the chance of spreading COVID. This is especially important if someone you live with has a very weak immune system OR is over 12 years old and has not had at least two doses of a COVID vaccine.

If you have COVID and someone you live with starts to feel sick, they must restart their isolation. Their isolation will last for 5, 10, or 20 days, depending on their age, health and vaccination status. You do not need to go back into isolation if someone you live with gets COVID. To return to school or work, make sure you follow the guidelines in place there.

Updated: Jan. 18, 2022
For other questions, please visit ConfusedAboutCOVID.ca
Family & Community Medicine University of Toronto
Ontario College of Family Physicians

As a close contact, do I need to self-isolate? For how long?

You need to self-isolate immediately if:

01 You have symptoms of COVID.

For more information on what to do if you have symptoms of COVID, see rebrand.ly/Feeling-Unwell.

02 You live with the person who has COVID.

If you live with the person who has COVID, isolate while they are isolating. If someone else in your home starts to feel sick, you will need to keep isolating until their isolation period ends. If you start to feel sick or have a positive test, your isolation period restarts. For more information on what to do if you have symptoms of COVID, see rebrand.ly/Feeling-Unwell.

03 You don't live with the person who has COVID but you had fewer than 2 doses of a COVID vaccine OR you have a very weak immune system.

If you don't live with the person who has COVID and you are:

12 years or older and have 0 or 1 vaccine dose	**OR**	A person with a weak or very weak immune system*	SELF-ISOLATE FOR **10 DAYS**
11 years or younger and have 0 or 1 vaccine dose			SELF-ISOLATE FOR **5 DAYS**

Day 0 is the last day you had contact with the COVID-positive person. Find out the date of their first symptoms or when they took the test that came back positive. They can spread illness 48 hours prior to, and up to 10 days after, that time.

* *Examples of individuals with weak or very weak immune systems include people undergoing cancer treatments or dialysis, organ transplant recipients, those with advanced HIV and people taking high doses of steroids or other medications that en the immune system.*

Self-isolation means staying at home. If possible, the person with COVID should stay apart from others to lower the chance of spreading COVID-19. This is especially important if someone in the household has a very weak immune system OR is over 12 years old and has had fewer than two doses of a COVID vaccine.

Updated: Jan. 18, 2022
For other questions, please visit ConfusedAboutCOVID.ca.

Family & Community Medicine UNIVERSITY OF TORONTO

Ontario College of Family Physicians

I think I have COVID. When should I call my doctor?

Most people with COVID can manage at home. You should:

- ✓ Rest.
- ✓ Drink plenty of fluids.
- ✓ For fever, headaches, and muscle aches: use over-the-counter pain and fever medications. Acetaminophen (Tylenol) is the best choice if you can take it.
- ✓ For a cough: try a teaspoon of honey (except if you have diabetes or if it is for a child under 12 months) or turn on a humidifier.
- ✓ For a sore throat: try lozenges or gargle with warm salt water.
- ✓ For mild discomfort when breathing: keep the room cool, open the window, try relaxation exercises and shifting your position.

If you have COVID, you must self-isolate. If you need care, you should not hesitate to call your doctor. Find out more about self-isolation at https://bit.ly/3q4Eyxb.

Call your doctor for an appointment if:

01 You have a medical condition that needs attention.

COVID can worsen medical problems such as diabetes, asthma, heart disease, lung disease, high blood pressure or other long-term conditions. If you get COVID and have one of those health problems, your treatment might have to change. Call your doctor if you are unsure about how to manage these conditions while you have COVID.

If pregnant, your risk of more serious illness from COVID increases. Call your doctor for advice and follow-up.

02 You are over a certain age and/or have health problems. You may need treatment or extra monitoring for COVID.

Some people* are more likely than others to get seriously ill from COVID. If you are one of them, you should call your doctor to talk about possible treatments and extra monitoring. New treatments for COVID can reduce your risk of serious illness if taken within the first week of your symptoms starting.

* You should call your doctor if:

- ✓ Your health condition/s or medications weaken your immune system. That includes, for example, people with:
  - » Ongoing cancer treatments
  - » Previous organ or stem-cell transplants
  - » Rare genetic disorders like DiGeorge Syndrome that attack your immune system
  - » Advanced or untreated HIV
  - » Medications that weaken the immune system, including antimetabolites like methotrexate, biologic drugs that often end in 'mab', or high-dose steroids (Prednisone 20mg or higher)
- ✓ You are over 60
- ✓ You are over 50 and if you belong to one of the following groups:
  - » You are indigenous OR
  - » You have had less than 2 doses of a COVID vaccine OR
  - » Your last dose of a COVID vaccine was more than 6 months ago OR
  - » You have diabetes, obesity, serious kidney problems, intellectual disability, cerebral palsy or sickle cell disease.

03 You really are not feeling well or are struggling to care for yourself at home.

Contact your family doctor's office and ask to speak with someone immediately if you are not managing well at home. That could include feeling:

- ✓ Light-headed and dehydrated (for example, ongoing diarrhea may lead adults to feel extremely thirsty and/or produce less and darker-colored urine than usual)
- ✓ So tired it is hard to care for yourself or getting short-of-breath just from doing your usual activities
- ✓ Like you are recovering then getting worse again - pay close attention if that happens 5 to 8 days after first showing signs of COVID
- ✓ At a loss because you cannot access food or other essential supports while self-isolating
- ✓ Struggling with your mental well-being and not managing well at home

You do not need to call your doctor to report a COVID test result or get a doctor's note for your employer — that should not be required. Employers are not legally permitted to require a medical note.

Call 911 if you:

- ✓ Are short of breath while resting or if you are finding it harder and harder to breathe
- ✓ Have chest pain
- ✓ Notice from your at-home pulse-oximeter that your oxygen level dropped 3% from usual over 24 hours, or is below 93% at any time

CONFUSED ABOUT COVID? FAMILY DOCTORS ANSWER YOUR QUESTIONS.

Caring for a child with COVID

Most children become only mildly ill when they get COVID. If they do, make sure they drink lots of fluids to stay hydrated.

Call your child's regular doctor if you have questions about supporting your child when sick with COVID.

Call 911 or go to the emergency department if your child:

- ✓ Is less than 3 months old and has a fever (temperature >37.5 degrees)
- ✓ Is over 3 months and has a fever that has lasted more than 4 days, or if they have a weak immune system
- ✓ Is not getting enough fluids, has ongoing diarrhea, or can't stop vomiting
- ✓ Is showing signs of dehydration — dry mouth or tongue, sunken eyes, peeing less than usual, and producing no tears when crying
- ✓ Is unusually sleepy, not behaving like themselves or interacting normally
- ✓ Is working hard to breathe
- ✓ Is causing you to worry that your child is seriously ill

If your child develops a new fever, body rash or other worrisome symptoms a few days or weeks AFTER they have recovered from COVID, please contact your doctor. These symptoms could signal a rare complication from COVID.

Call 2-1-1 for help with food, money and housing.

Connex Ontario can help you find mental health and addiction supports. Call 1-866-531-2600, text 247247, or visit connexontario.ca/en-ca/our-services.

More detailed information on managing at home including how to use a pulse oximeter: https://hfam.ca/wp-content/uploads/2021/05/Patient-Information-Long-Form-version-2021-05-19.pdf

CONFUSED ABOUT COVID? FAMILY DOCTORS ANSWER YOUR QUESTIONS.

Three doses of a COVID vaccine better protects you from getting and spreading the Omicron variant than two doses.

Everyone 18 years of age and older can get a third dose 3 months after their second dose. **Getting a 3rd dose is important for all adults.** It is especially important if you are:

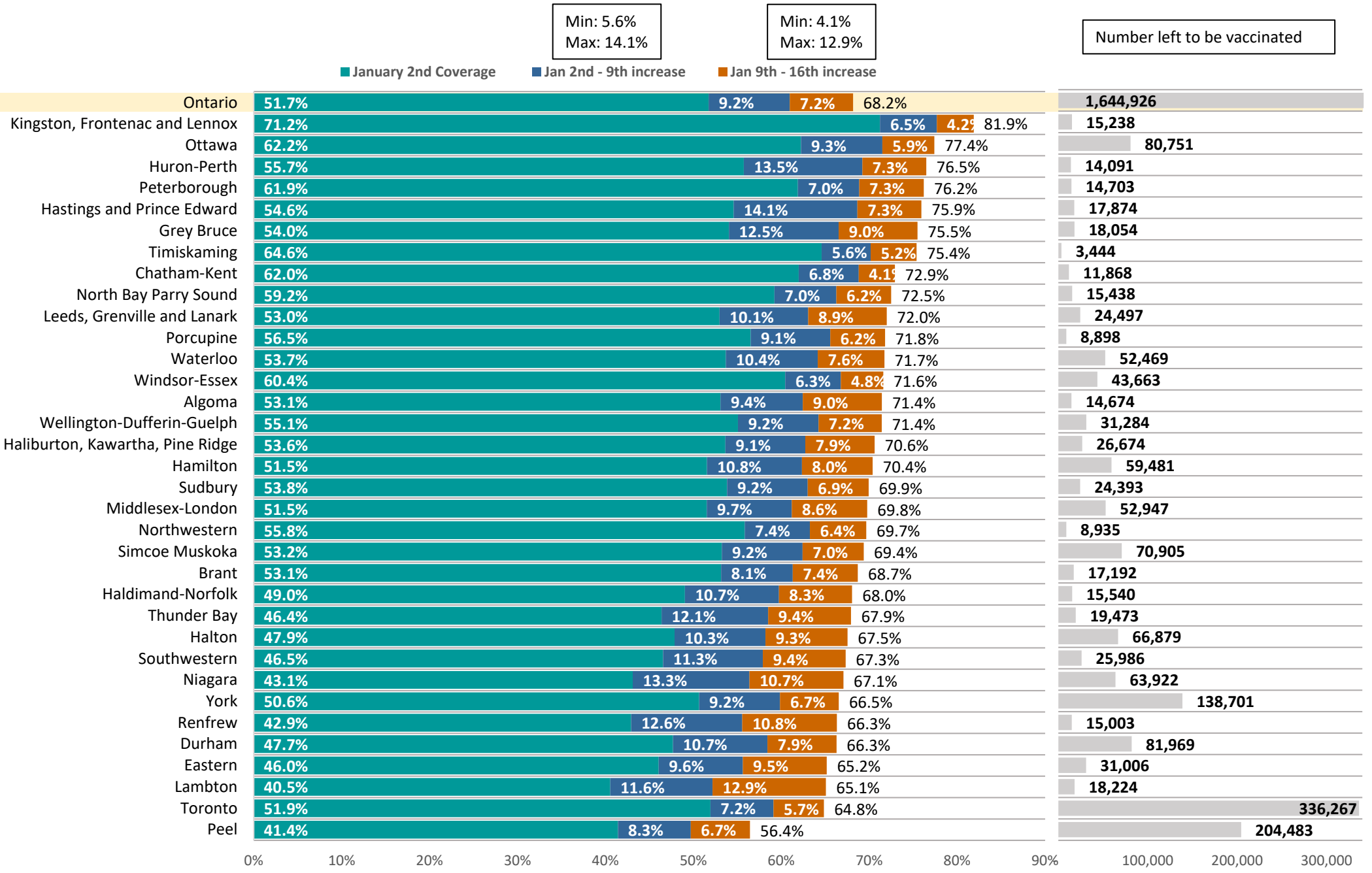
- ✓ Over 70
- ✓ At risk because of a very weak immune system
- ✓ Pregnant
- ✓ A recipients of two doses of the AstraZeneca or Covishield vaccines

People with a very weak immune systems are now eligible for a **4th COVID vaccine** 3 months after their 3rd dose. This includes people who:

- ✓ Receive dialysis
- ✓ Currently receive cancer treatments
- ✓ Previously had organ or stem-cell transplants
- ✓ Have a rare genetic disorder like DiGeorge Syndrome that impairs their immune system
- ✓ Have advanced or untreated HIV
- ✓ Take medications that weaken the immune system, including antimetabolites like methotrexate, biologic drugs that often end in 'mab', 'mib', or 'nib', and high-dose steroids (Prednisone 20mg or higher)

https://dfcm.utoronto.ca/confused-about-covid

Increase in Booster Coverage for those 50+ from January 2nd to 16th



Key Insights

- Overall coverage ranges from **81.9%** to **56.4%** with a provincial average of **68.2%**
- Week of Jan 3rd: Increase in coverage ranges from **14.1%** to **5.6%**
- Week of Jan 10th: Increase in coverage ranges from **12.9%** to **4.1%** the week of Jan 10th

Data Source(s): SAS VA Tool, COVax analytical file, extracted daily at 8:00 pm, CPAD, MOH. Note: analytical file has been processed for data quality checks and results may differ from the COVax live data system. Population Estimates 2020, Statistics Canada, CCM Cases Data, OLIS Testing File, CCSO ICU File

Summary of Third Dose Coverage by Characteristics

As of January 9th

Immunocompromised Populations

	Hematological Malignancy	Solid Organ Transplant	Hematopoietic Stem Cell Transplant	Other Immunocom-promising Conditions	Treatment Causing Immuno-suppression	Chronic Kidney Disease (with recent receipt of chronic dialysis)
Provincial Coverage (%)	**63.6%**	**63.3%**	**58.7%**	**37.8%**	**61.1%**	**66.4%**

Other Priority Populations

	Currently Pregnant	Newcomer	Recent Refugees	Recent Experience with Homelessness	Severe Mental Illness	Substance Use Disorder
Provincial Coverage (%)	**17.0%**	**9.5%**	**6.6%**	**8.9%**	**15.4%**	**11.9%**

Key Takeaways:

- Overall coverage for third doses in risk populations is **low provincially**

Patient information sheet

https://www.pcmch.on.ca/wp-content/uploads/2021/10/PCMCH-COVID-19-Vaccine-Pregnancy-Information-Sheet-2021Oct25_v4.pdf

Provincial Council for Maternal and Child Health
building a brighter future

Updated October 25, 2021 (Version 4)

This resource reflects the information available as of the date of issue. It is not intended to provide or take the place of medical advice, diagnosis or treatment. Talk to your healthcare provider if you have any questions about this resource.

I am pregnant or breastfeeding. Should I get the COVID-19 Vaccine?

Getting the COVID-19 vaccine as soon as possible is the safest choice.

Studies of hundreds of thousands of pregnant people who have received COVID-19 vaccines show it is safe and helps prevent COVID-19 and protect against severe illness. The information below will help you make an informed choice about whether to get the COVID-19 vaccine.

YOUR OPTIONS

Get a COVID-19 vaccine as soon as possible	Wait until your pregnancy and/or breastfeeding is complete

What are the risks related to COVID-19 in pregnancy?

COVID-19 infection is dangerous. It is more dangerous in pregnancy.

- Most pregnant people with COVID-19 will have mild symptoms and make a full recovery; however, 20-30% of pregnant people will develop moderate to severe COVID illness requiring hospitalization.
- If you are COVID positive and pregnant, your risk of hospitalization, intensive care unit admission and the need for life support is much greater than if you are COVID positive and not pregnant.
- Many people will have ongoing medical complications even after the COVID pneumonia has resolved.
- If you have any type of COVID infection in pregnancy, there is an impact on pregnancy outcomes: your risk of stillbirth, preterm birth, high blood pressure, caesarean delivery and low birth weight are significantly increased with a COVID infection in pregnancy.
- COVID infection in pregnancy increases your risk of medical complications and death.

What are the **benefits** of getting the COVID-19 vaccine?

The COVID-19 vaccines are highly effective in preventing infection and reducing spread.

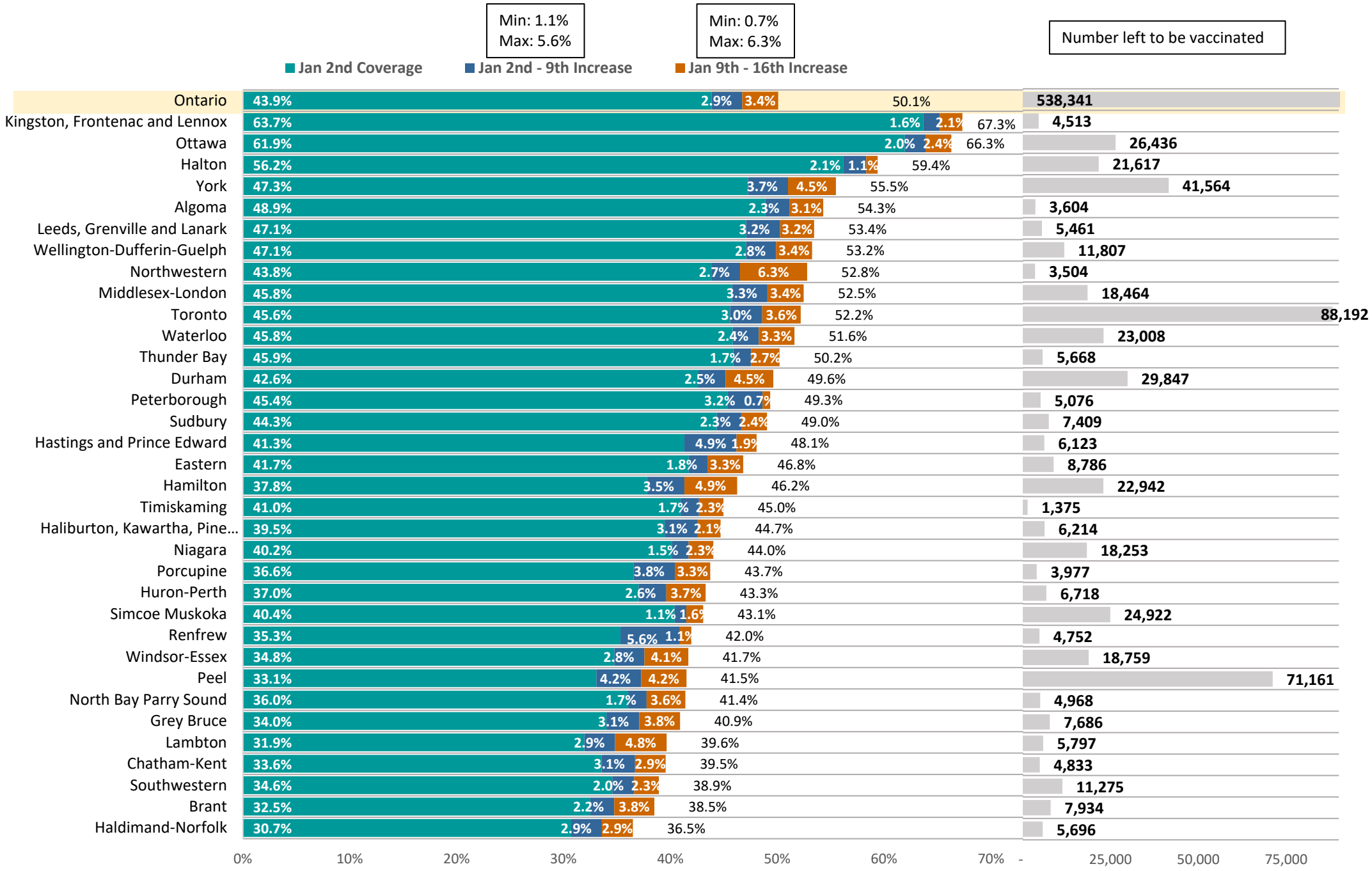
- The mRNA COVID vaccines are effective at reducing the risk of getting a COVID infection caused by any of the variants of the virus (e.g., Delta variant) in both pregnant and non-pregnant people.
  - Vaccination decreases the chance of having a symptomatic COVID infection, the severity of the COVID illness and the chance of being hospitalized because of COVID.
  - Vaccination decreases the spread of the virus within your family and in your community.

The mRNA COVID vaccines are safe in pregnancy.

- Several studies with large numbers of pregnant people have shown that vaccination immediately before and/or during pregnancy has no impact on pregnancy outcomes (i.e., no change in the rate of miscarriage, preterm birth, stillbirth, growth restriction, high blood pressure during pregnancy, medical complications of pregnancy or death).

Increase in 5 – 11 First Dose Coverage from January 2nd to 16th

DRAFT



Key Insights

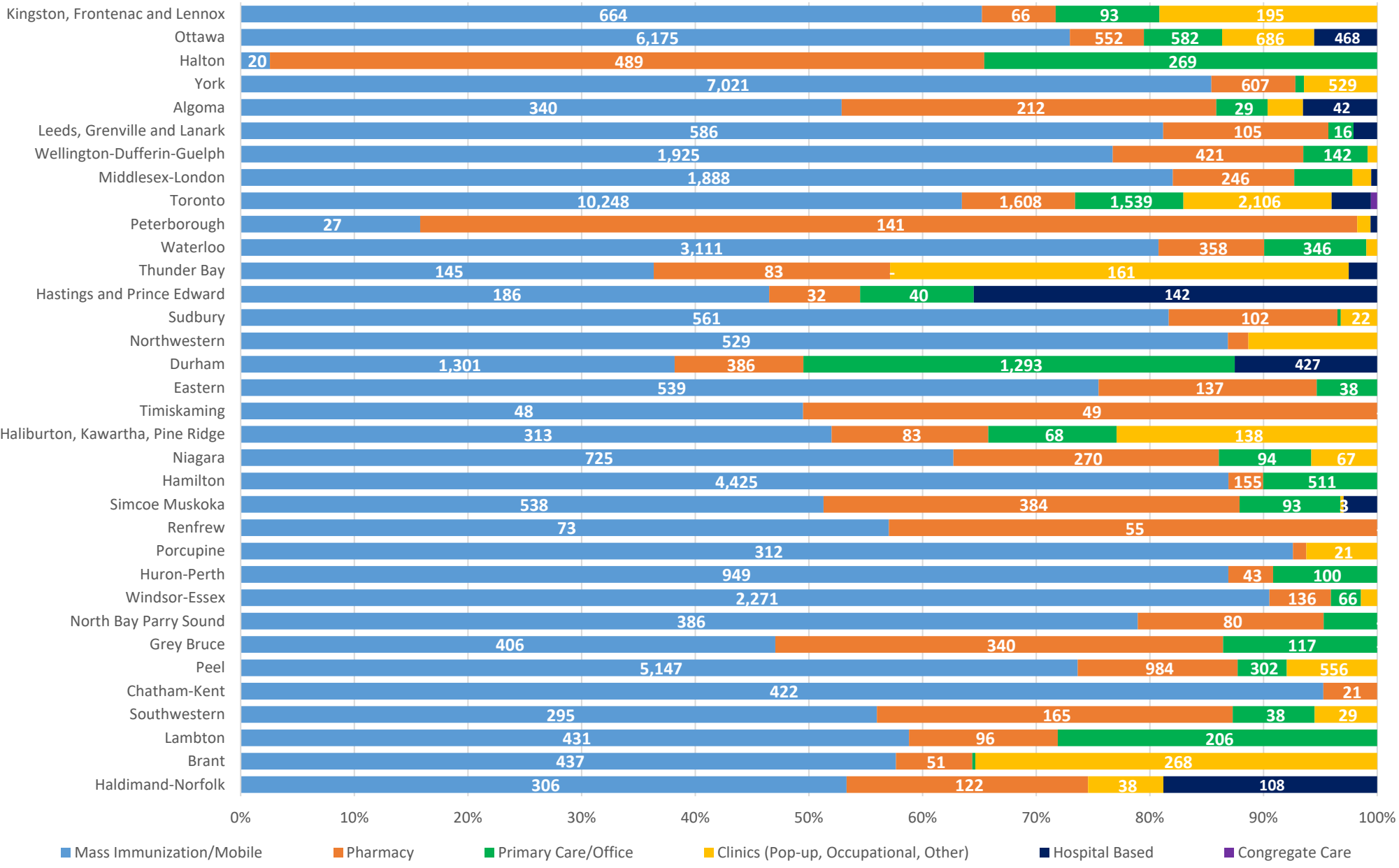
- Overall coverage ranges from **67.3%** to **36.5%** with a provincial average of **50.1%**
- Week of Jan 3rd: Increase in coverage ranges from **1.1%** to **5.6%**
- Week of Jan 10th: Increase in coverage ranges from **0.7%** to **6.3%** the week of Jan 10th

Data Source(s): SAS VA Tool, COVax analytical file, extracted daily at 8:00 pm, CPAD, MOH. Note: analytical file has been processed for data quality checks and results may differ from the COVax live data system. Population Estimates 2020, Statistics Canada, CCM Cases Data, OLIS Testing File, CCSO ICU File

Ontario

Children 5-11: Delivery Channels for Doses Administered in the Last Week (Jan 10th - 16th)

DRAFT



Key Insights

- Administration is primarily occurring in **MICs**

Data Source(s): SAS VA Tool, COVax analytical file, extracted daily at 8:00 pm, CPAD, MOH. Note: analytical file has been processed for data quality checks and results may differ from the COVax live data system. Population Estimates 2020, Statistics Canada, CCM Cases Data, OLIS Testing File, CCSO ICU File

Practising Well: Your Community of Practice

Upcoming sessions:

Working with patient social losses through the pandemic

January 26, 2022 (8:00 to 9:00am)

Drs. Larisa Eibisch, Jonny Grek and Lori Regenstreif

https://us02web.zoom.us/webinar/register/WN_9-CSL1KiQAG2gxMiFSH9EA

Navigating undifferentiated distress during the pandemic

February 23, 2022 (8:00 to 9:00am)

Drs. Chase McMurren, Michael Roberts and Joanna Shapiro

https://us02web.zoom.us/webinar/register/WN_XF-_NqDLQxWFTviavZkH1Q

Ontario College of Family Physicians

Practising Well
Teaching. Learning. Connecting.

Family & Community Medicine
UNIVERSITY OF TORONTO

Watch past Practising Well CoP sessions

https://www.ontariofamilyphysicians.ca/education/practising-well/practising-well-community-of-practice/past-sessions

Ontario College of Family Physicians

FMS 2022
FAMILY MEDICINE SUMMIT

Knowledge for the Now

January 28 and 29, 2022

I invite you to check out the full conference agenda and register today.

Here is a sample of the **presenters and timely topics** you'll find at FMS 2022.

- Drs. Angela Cheung and Ashley Verduyn with practical information on long COVID and **managing COVID-19's lingering effects on patients**
- Guidance to help **avoid the serious consequences of professional burnout**, from Drs. Marcia Kostenuik, Patricia Uniac, Chase Everett McMurren and Ajmal Razmy
- Drs. Louisa Marion-Bellemare, Julie Samson, Naheed Dosani and Alex Anawati on **social accountability and addictions care**, and innovative approaches to saving lives
- **Standing Up for Members** – an opening session introducing the OCFP's upcoming advocacy campaign
- **Powerful Purpose: Leaders for a Healthy Ontario** – a closing discussion with Drs. Jonny Grek, Nili Kaplan-Myrth, Onye Nnorom, and Sarah Newbery.

Register and learn more at **OCFPSummit.ca**

Questions?

Webinar recording and curated Q&A will be posted soon
https://www.dfcm.utoronto.ca/covid-19-community-practice/past-sessions

Our next Community of Practice: **Friday, February 4, 2022**

Contact us: *ocfpcme@ocfp.on.ca*

Visit: https://www.ontariofamilyphysicians.ca/tools-resources/covid-19-resources

This one-credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada and the Ontario Chapter for up to 1 Mainpro+ ®credits.

The COVID-19 Community of Practice for Ontario Family Physician includes a series of planned webinars. Each session is worth 1 Mainpro+®credits, for up to a total of 26 credits.

Post session survey will be emailed to you. Mainpro+ credits will be entered for you with the information you provided during registration.

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