COVID-19 Community of Practice for Ontario Family Physicians

January 7, 2021

Dr. Derelie Mangin
Dr. Janine McCready
Dr. Ullanda Niel
Dr. Daniel Warshafsky

Managing COVID-19 in the community

Family & Community Medicine
UNIVERSITY OF TORONTO

Ontario College of Family Physicians

Managing COVID-19 in the community

Moderator: Dr. Tara Kiran

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

Panelists:

- Dr. Derelie Mangin, Hamilton, ON
- Dr. Janine McCready, Toronto, ON
- Dr. Ullanda Niel, 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.

Prioritization Molecular[1] Testing for COVID-19 Infection

The following people are eligible for molecular testing (PCR or rapid molecular testing):

- Symptomatic[2] people who fall into one of the following groups:
  - Hospitalized patients
  - Patients seeking emergency medical care, at the discretion of the treating clinician
  - Patient-facing healthcare workers
  - Staff, volunteers, residents/inpatients, essential care providers, and visitors in hospitals and congregate living settings, including Long-Term Care, retirement homes, First Nation elder care lodges, group homes, shelters, hospices, temporary foreign worker settings, and correctional institutions
- Symptomatic outpatients for whom COVID-19 treatment is being considered
  - includes those 70 and older who have a risk factor including 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, or 50 and older if First Nations, Inuit, or Métis with any of those risk factors[3]
- Symptomatic people who are underhoused or homeless
- Symptomatic elementary and secondary students and education staff who have received a PCR self-collection kit through their school
- Symptomatic/asymptomatic people who are from First Nation, Inuit, and Métis communities and individuals travelling into these communities for work
- Symptomatic /asymptomatic people on admission/transfer to or from hospital or congregate living setting
- High risk contacts and asymptomatic/symptomatic people in the context of

https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/contact_mngmt/management_cases_contacts_omicron.pdf

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. Derelie Mangin– Panelist

Twitter: @DeeMangin

Family Physician, McMaster Family Health Team, Hamilton and provincial lead, COVID@home program

Dr. Janine McCready– Panelist

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Infectious Disease Physician, Michael Garron Hospital

Dr. Ullanda Niel– Panelist

Family Physician, Scarborough Center for Healthy Communities, member of the Drugs & Biologics Clinical Practice Guidelines Working Group of the Ontario COVID-19 Science Advisory Table

Dr. Dan Warshafsky– Panelist

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

Dr. David Kaplan – Co-Host

Twitter: @davidkaplanmd

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

Dr. Liz Muggah – Co-Host

Twitter: @OCFP_President

OCFP President, Family Physician, Bruyère Family Health Team

Speaker Disclosure

- Faculty Name: **Dr. Derelie Mangin**
- Relationships with financial sponsors:
  - Grants/Research Support: PI on grant from Co-RIG phase 1 (CCFP) on pathways for Extended Primary Care at home during COVID. Co-PI on grant from Co-RIG phase 1 Addressing the needs of vulnerable older adults during COVID.
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians
  - Others: Medical Lead, Centre for Effective Practice COVID Information Section

- Faculty Name: **Dr. Janine McCready**
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: N/A
  - Others: N/A

- Faculty Name: **Dr. Ullanda Niel**
- Relationships with financial sponsors:
  - Grants/Research Support: CIHR, Kids Brain Network
  - Speakers Bureau/Honoraria: N/A
  - Others: Scarborough Centre for Health Communities, Participation House, Surrey Place

- Faculty Name: **Dr. Daniel Warshafsky**
- Relationships with financial sponsors: N/A
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: N/A
  - Others: N/A

Speaker Disclosure

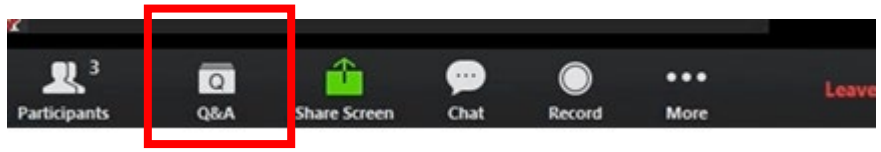
- Faculty Name: **Dr. David Kaplan**
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians
  - Others: Ontario Health (employee)

- 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

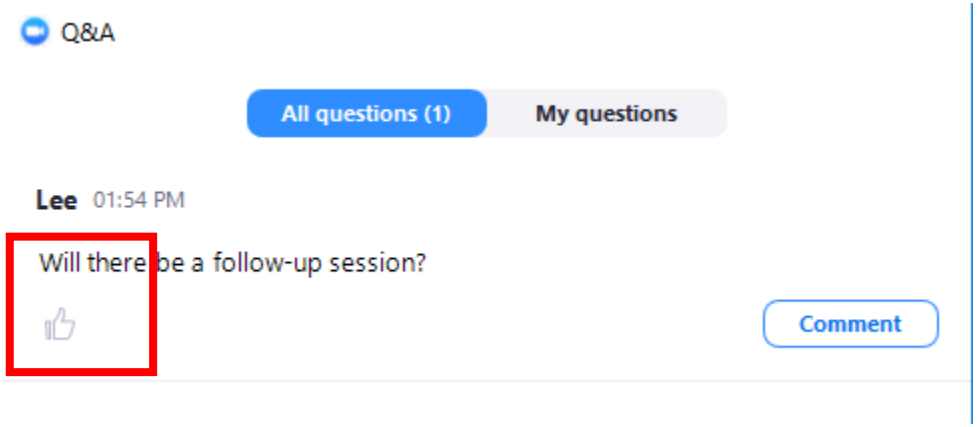
- Faculty Name: **Dr. Tara Kiran**
- Relationships with financial sponsors:
  - Grants/Research Support: St. Michael's Hospital, University of Toronto, Health Quality Ontario, Canadian Institute for Health Research, Toronto Central LHIN, Toronto Central Regional Cancer Program, Gilead Sciences Inc.
  - 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

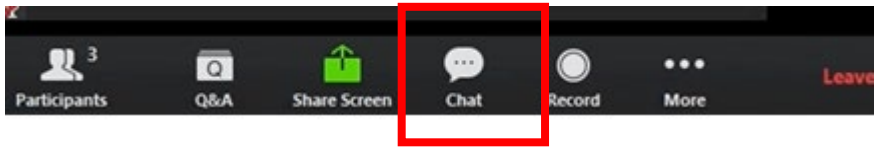
- All questions should be asked using the Q&A function at the bottom of your screen.



- 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.



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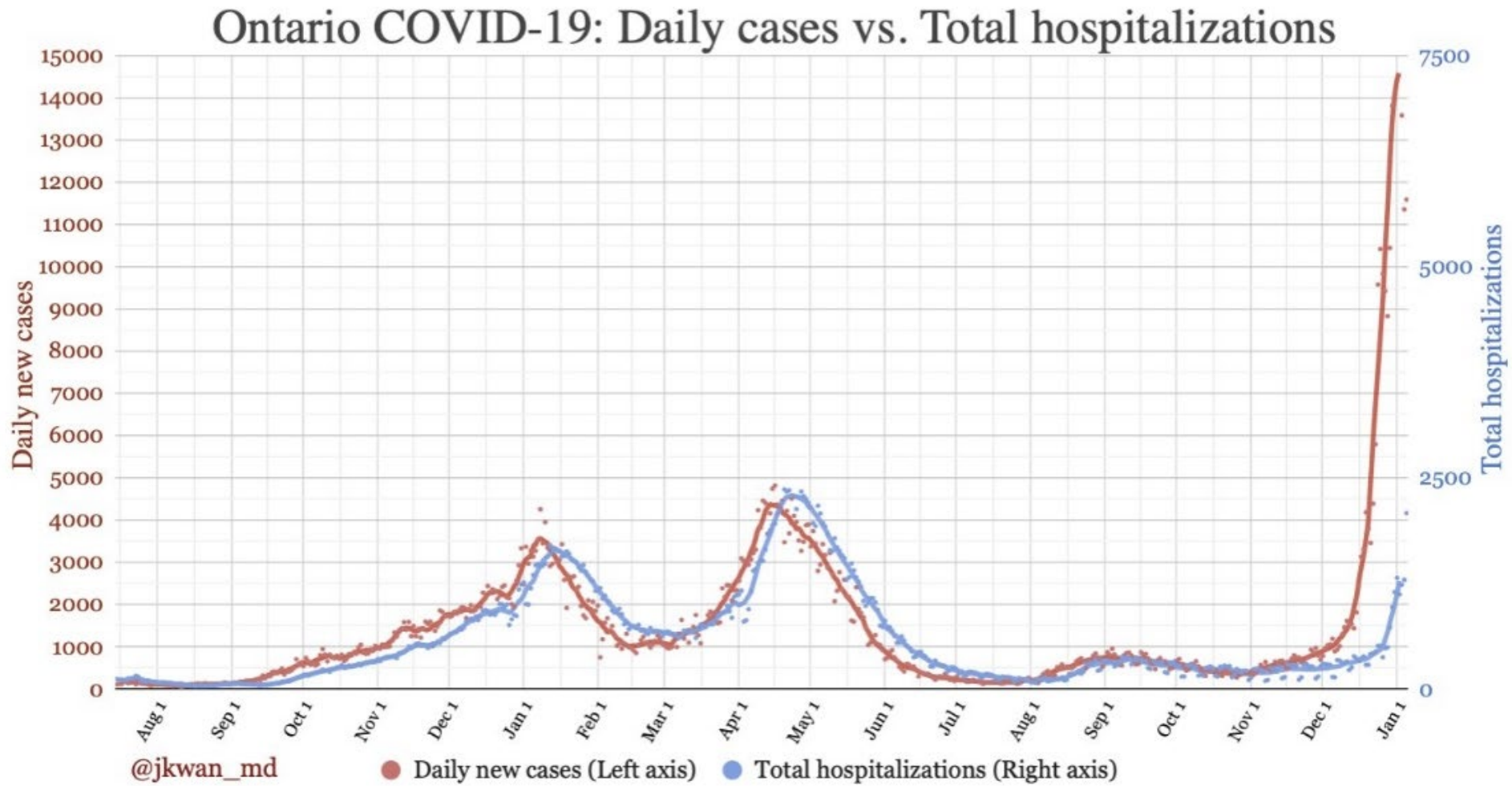
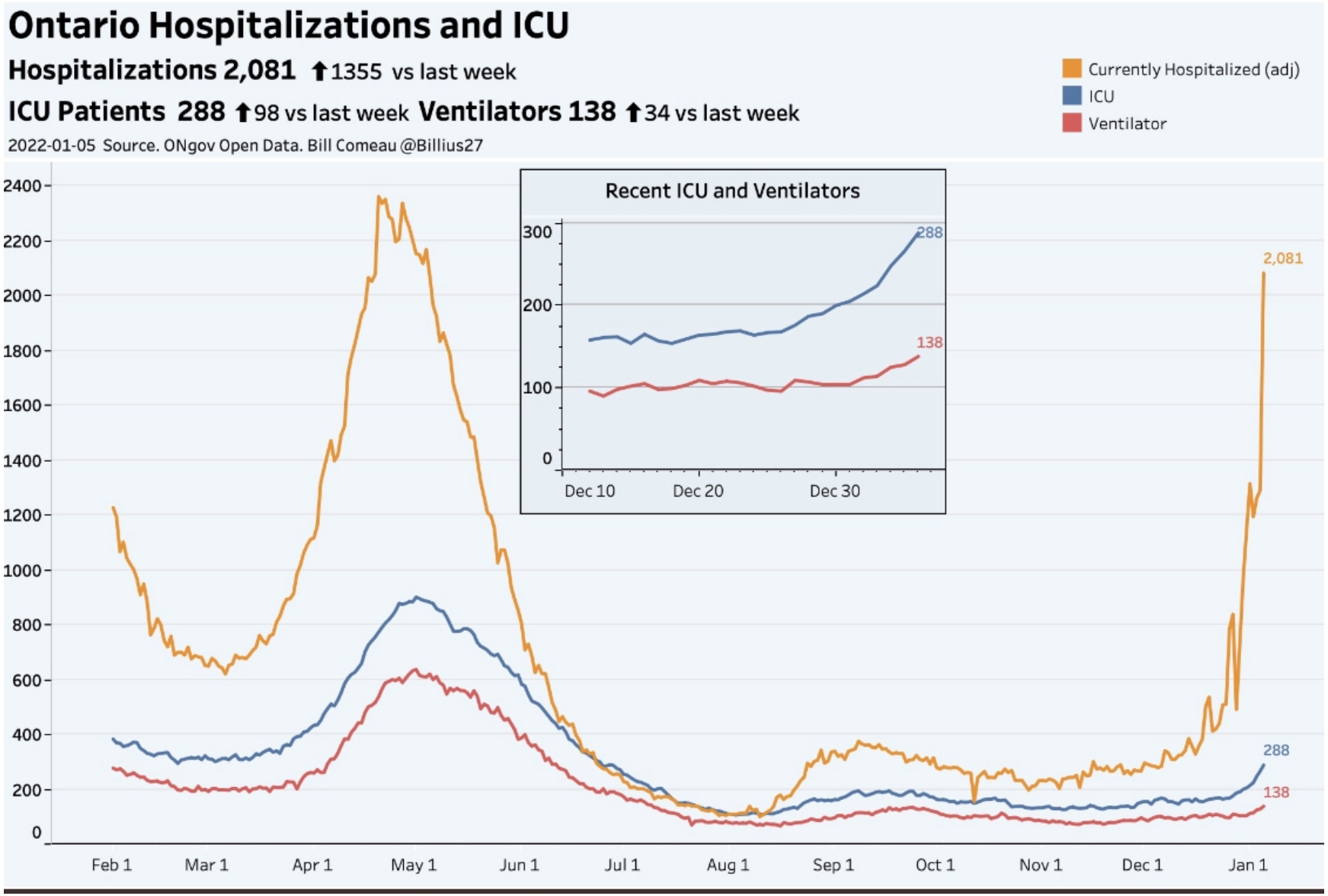
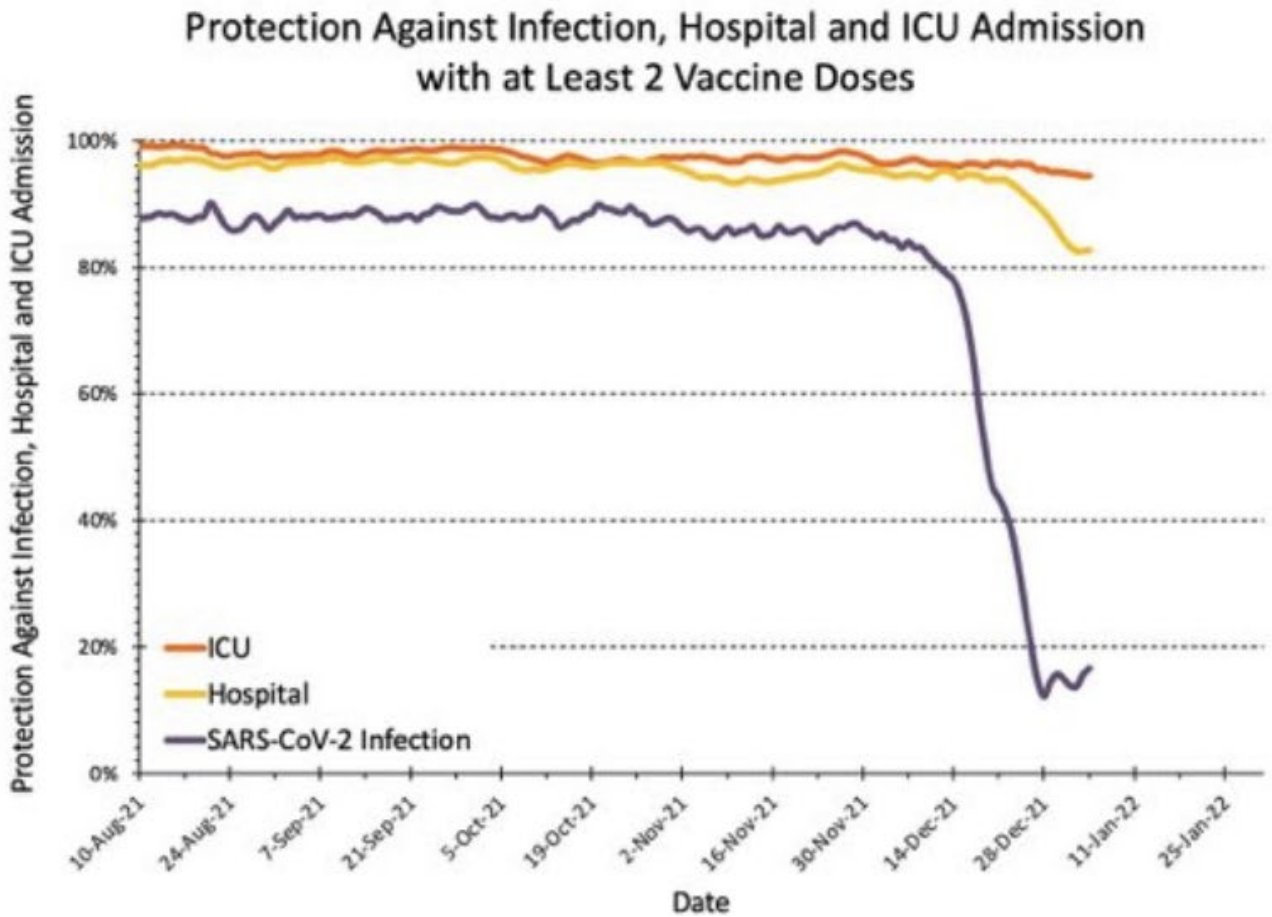

Ontario COVID-19: Daily cases vs. Total hospitalizations
Daily new cases
Total hospitalizations
15000
14000
13000
12000
11000
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
7500
5000
2500
0
Aug 1
Sep 1
Oct 1
Nov 1
Dec 1
Jan 1
Feb 1
Mar 1
Apr 1
May 1
Jun 1
Jul 1
Aug 1
Sep 1
Oct 1
Nov 1
Dec 1
Jan 1
@jkwan_md
Daily new cases (Left axis)
Total hospitalizations (Right axis)

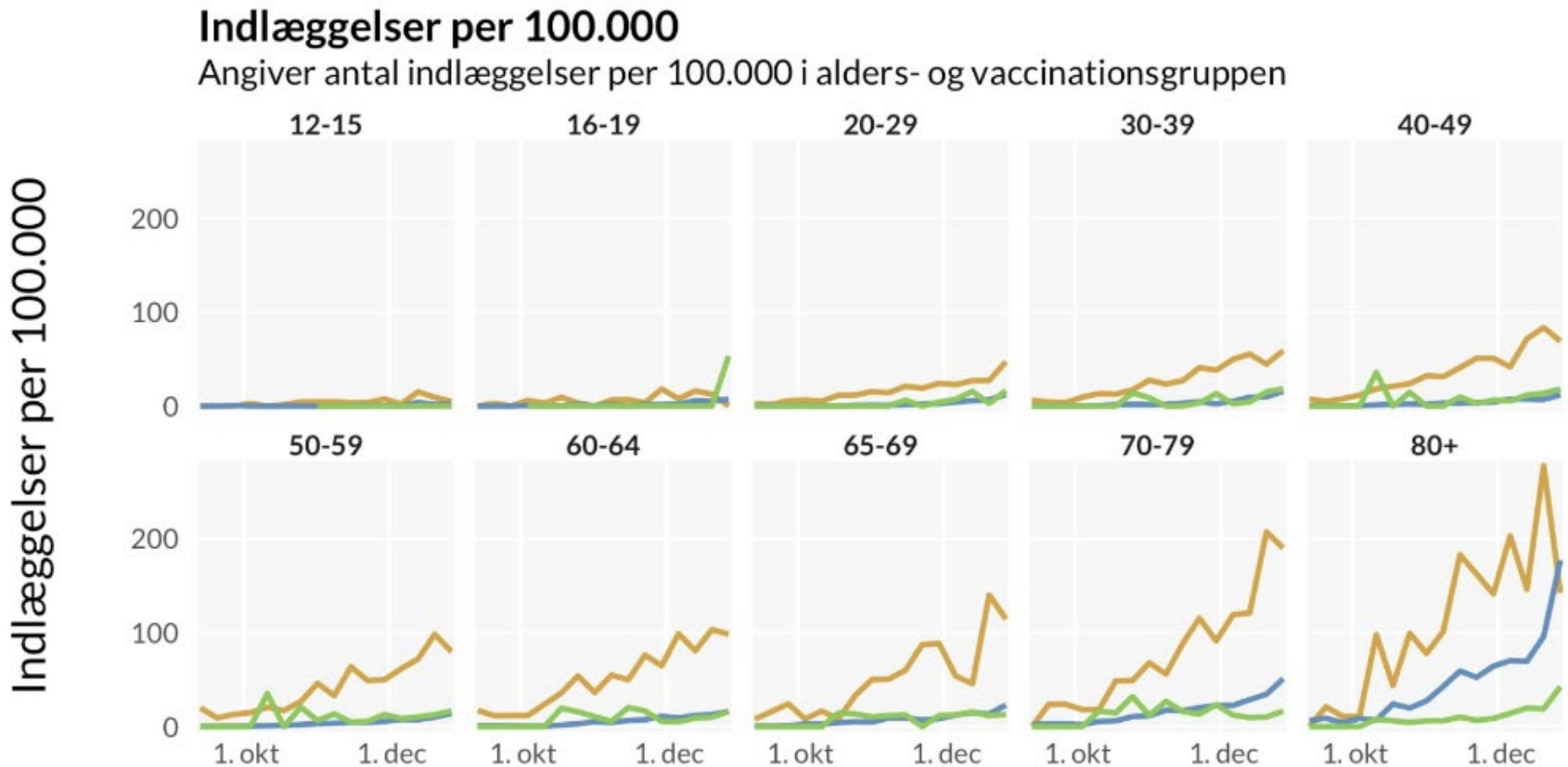

Ontario Hospitalizations and ICU
Hospitalizations 2,081 ⬆1355 vs last week
ICU Patients 288 ⬆98 vs last week Ventilators 138 ⬆34 vs last week
2022-01-05 Source. ONgov Open Data. Bill Comeau @Billius27
Currently Hospitalized (adj)
ICU
Ventilator
Recent ICU and Ventilators
300
200
100
0
288
138
Dec 10
Dec 20
Dec 30
2400
2200
2000
1800
1600
1400
1200
1000
800
600
400
200
0
2,081
288
138
Feb 1
Mar 1
Apr 1
May 1
Jun 1
Jul 1
Aug 1
Sep 1
Oct 1
Nov 1
Dec 1
Jan 1

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

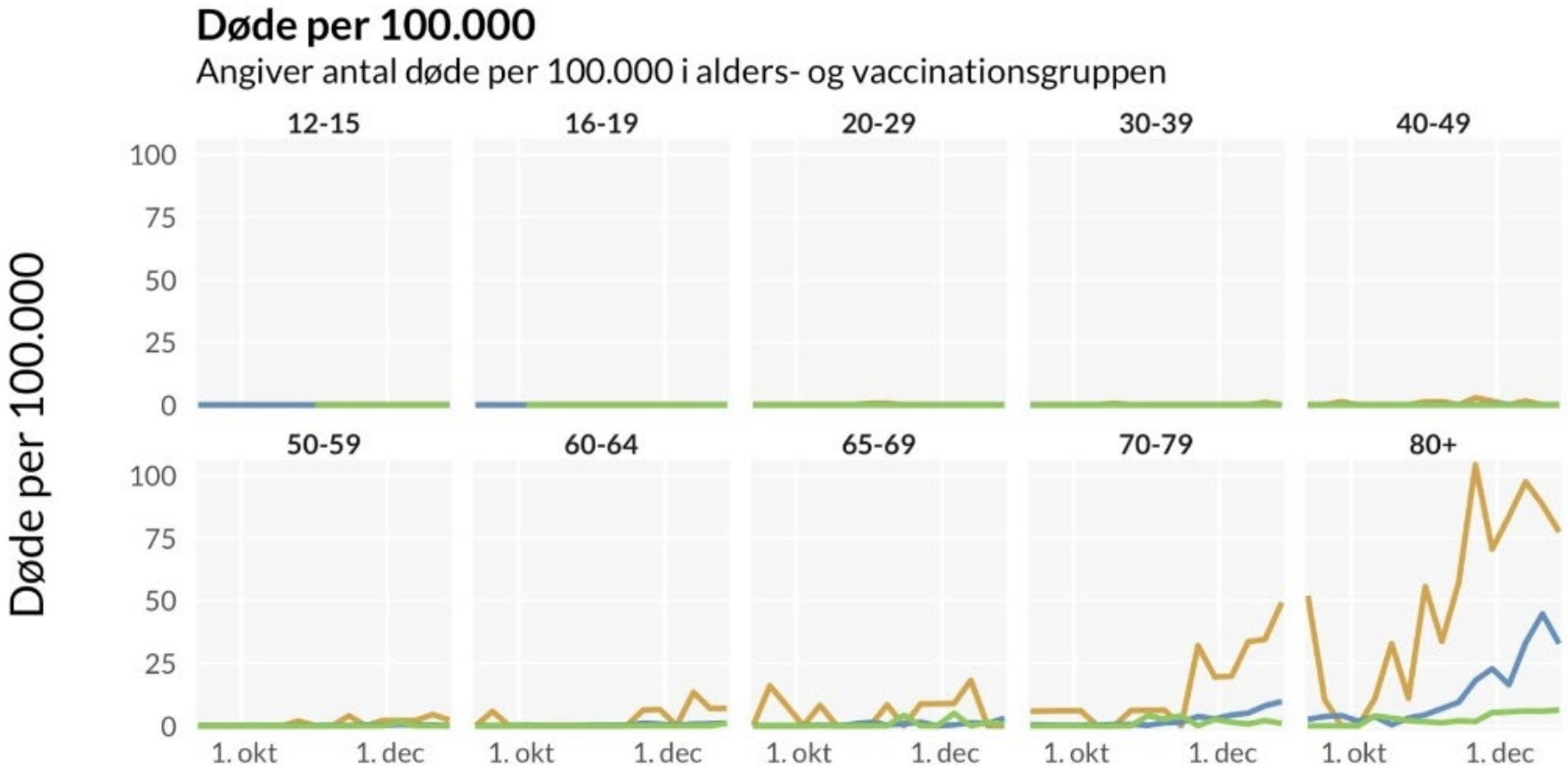
Current COVID-19 Risk in Ontario by Vaccination Status



https://covid19-sciencetable.ca/ontario-dashboard/



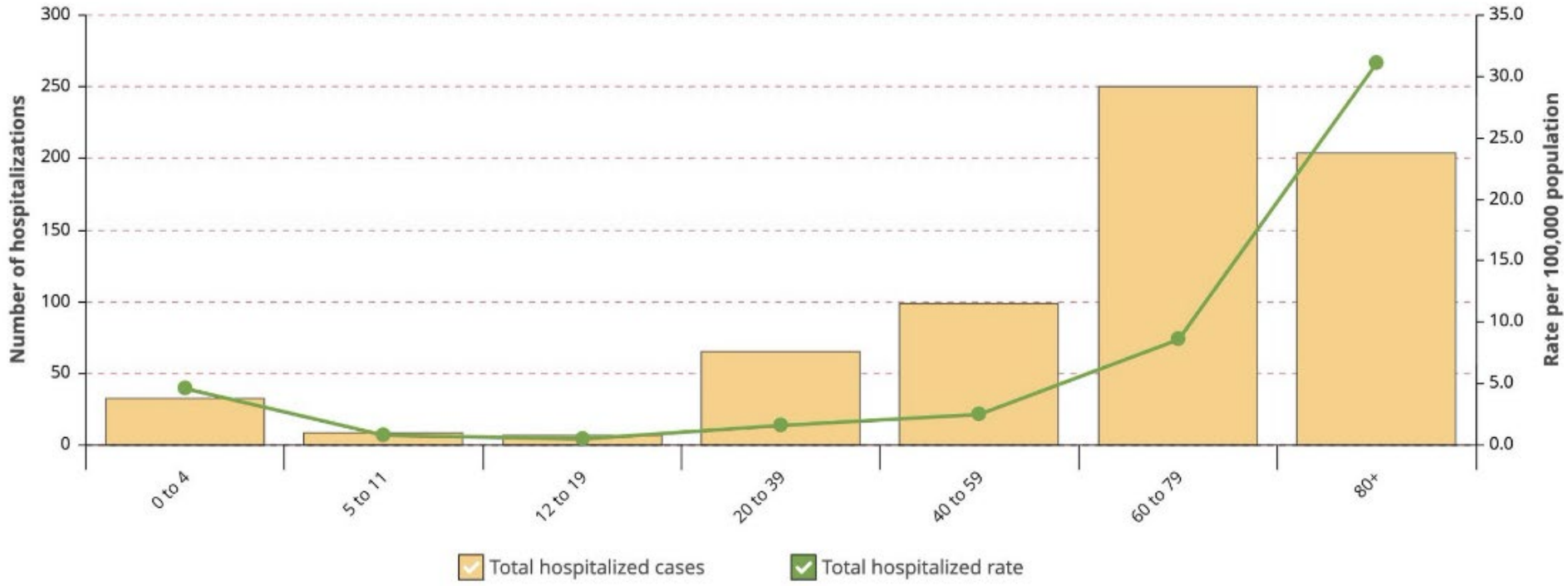
https://covid19danmark.dk/



https://covid19danmark.dk/

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Counts and rates of hospitalizations amongrecent COVID-19 cases by age group in Ontario - Last updated January 3, 2022 at 1:00 pm



https://www.publichealthontario.ca/en/data-and-analysis/infectious-disease/covid-19-data-surveillance/covid-19-data-tool?tab=ageSex

Reporting rates of myocarditis (per 1 million doses administered) after Pfizer-BioNTech COVID-19 vaccination, 7-day risk interval*

	Males		Females	
Age group	**Dose 1**	**Dose 2**	**Dose 1**	**Dose 2**
5–11 years	0.0	4.3	Not calculated†	2.0
12–15 years	4.8	45.7	1.0	3.8
16–17 years (included for reference)	6.1	70.2	0.0	7.6

- **37,810,998** total doses 1 and 2 of vaccine administered‡

https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2022-01-05/02-COVID-Su-508.pdf

McMaster University

Family Medicine

Caring for COVID in our Primary Care Practices

Dee Mangin

David Braley Chair in Family Medicine

@DeeMangin

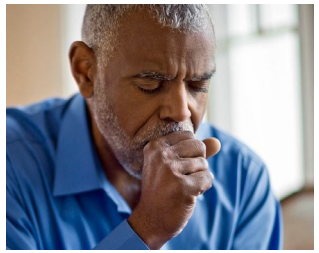
@McMasterFamMed

Michael G. DeGroote SCHOOL OF MEDICINE

Why?

- **Outcomes are better for populations when primary care systems are strongest (**Access, Comprehensiveness, Continuity)
- **Relationship based primary care matters even more in disaster**
  - knowledge of the patient
  - familiarity in unfamiliar times

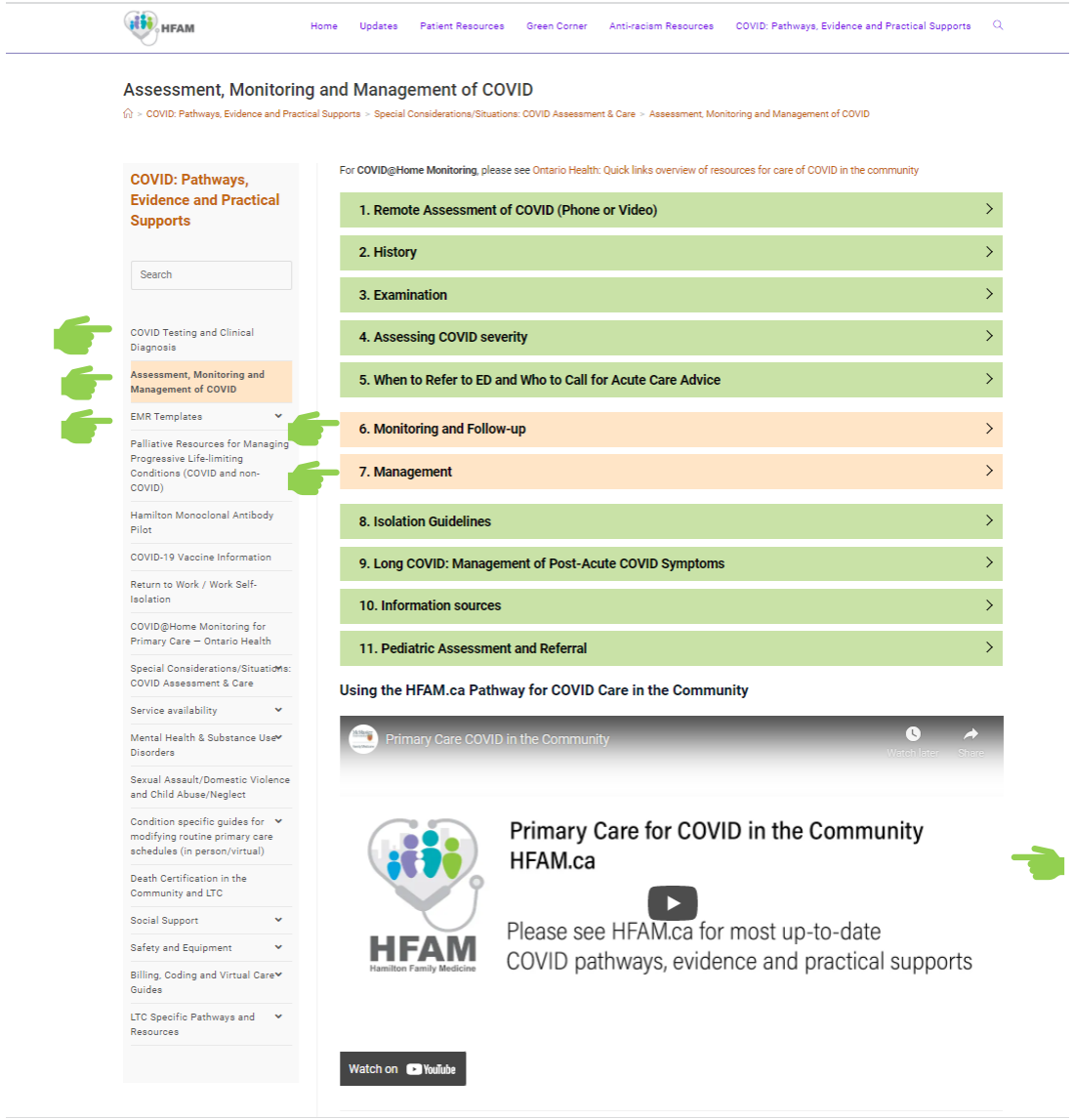
+/-



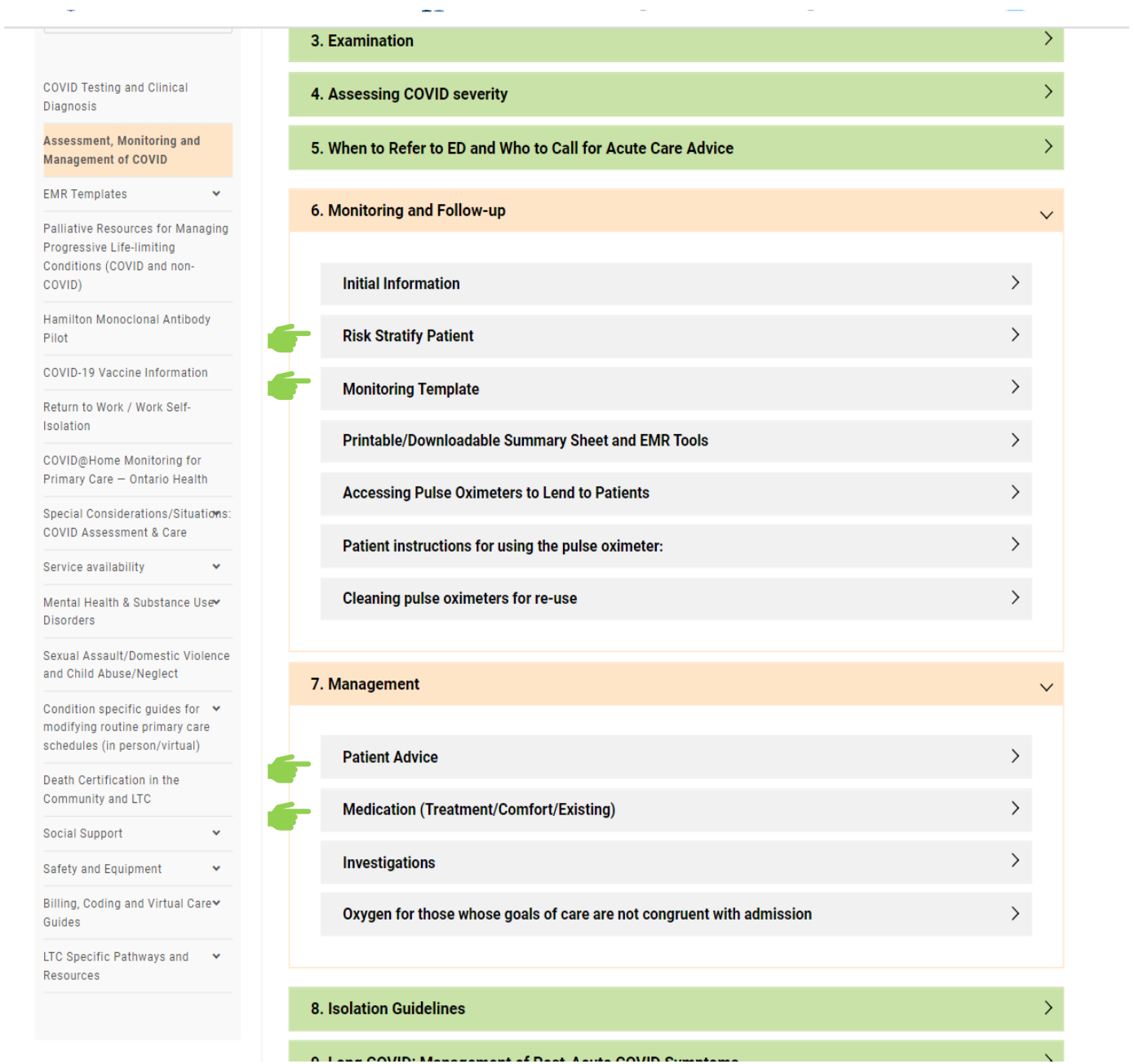
Ben 57yrs cough, fatigue, fever
double vaccinated

Anouk 66 significant cough, fatigue, myalgia
CKD, hypertension, ?PHx asthma
triple vaccinated

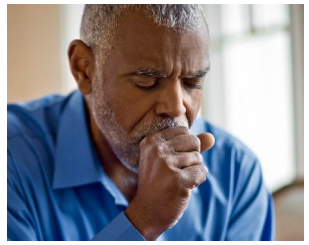
Asha 72 sore throat, fever, mild cough
Ischemic heart disease, COPD



https://hfam.ca/clinical-pathways-and-evidence/covid/assessment-diagnosis-and-management-of-covid/



One page summary of a monitoring consultation for those who haven't done it before:
https://hfam.ca/wp-content/uploads/2022/01/COVID-Patients-Ward-Round-Flow-for-hfam-2022-01-02.pdf



Ben 57yrs cough, fatigue, fever otherwise well

Initial assessment consult:

- Vacc x 2 no comorbidities

Low risk

History: very mild symptoms

No dyspnea or diarrhea

Hydrating well

Risk Stratify Patient

High Risk	Average Risk	Low Risk
Patients with any of the safety net flags		Otherwise healthy adults[2,4]; asymptomatic adults
Patients with symptom deterioration[2]	Pregnant women	1-60 years old with no medical comorbidities
Any age with medical comorbidities who are not triple vaccinated	Unvaccinated (excluding asymptomatic)*	No safety net flags
Age > 60 not fully vaccinated or non-mild symptoms	Patients > 60 or with comorbidities at any age who are triple vaccinated and have milder symptoms (i.e., no dyspnoea)	
MONITOR Daily for 7 days then every few days, depending on progress until symptoms resolve	MONITOR Every few days x 7 days; then could recommend self-monitor for additional 7 days depending on progress	MONITOR Consider self-monitoring only; check-ins determined by individual patient. (Consider at 5-7 days for children and symptomatic adults especially in the 40-60 age group)[3]

Monitoring Template

1. Assess current symptoms and change (better / worse). See symptoms / atypical symptoms in history section above.
2. Vitals – patient to record until symptoms resolve
    - once daily T, BP (if patient has access to a cuff)
    - twice daily HR, RR, +/- SPO2
3. Assess level of dyspnoea (see Examination/Remote Examination on this page for tips on assessing dyspnoea virtually)
4. Check urine output and fluid intake
5. Check for respiratory and other red flag symptoms (See When to Refer to ED section)
    - RESPIRATORY
        - Severe shortness of breath at rest
        - Difficulty in breathing
        - Increasing significant fatigue (reported in some patients as a marker for hypoxemia without dyspnea)
        - Blue lips or face
        - Hemoptysis

    OTHER
        - Cold, clammy, or pale and mottled skin
        - Reduced level of consciousness or new confusion
        - Little / no urine output
        - Pain or pressure in the chest
        - Syncope
6. Note underlying chronic disease that indicates increased risk. For patients with diabetes increase to daily monitoring.
7. Assess need for regular medication changes or advice (see "management" tab below).
8. Check mental health, access to food, support or carer, financial or housing stress.
9. Assess whether this patient can still be managed at home (see When to Refer to ED tab: consider whether goals of care conversation is appropriate).

How do they feel?
What are their vitals?
How is their dyspnea / diarrhea?
Any comorbidities or meds need managing?

CHANGE

Management

Go over key aspects of patient advice

Email the pdf HFAM patient information (👉)

No formal FU arranged

https://hfam.ca/wp-content/uploads/2021/05/Patient-Information-Long-Form-version-2021-05-19.pdf

https://hfam.ca/wp-content/uploads/2021/10/Caregiver-Information.pdf

Expectations

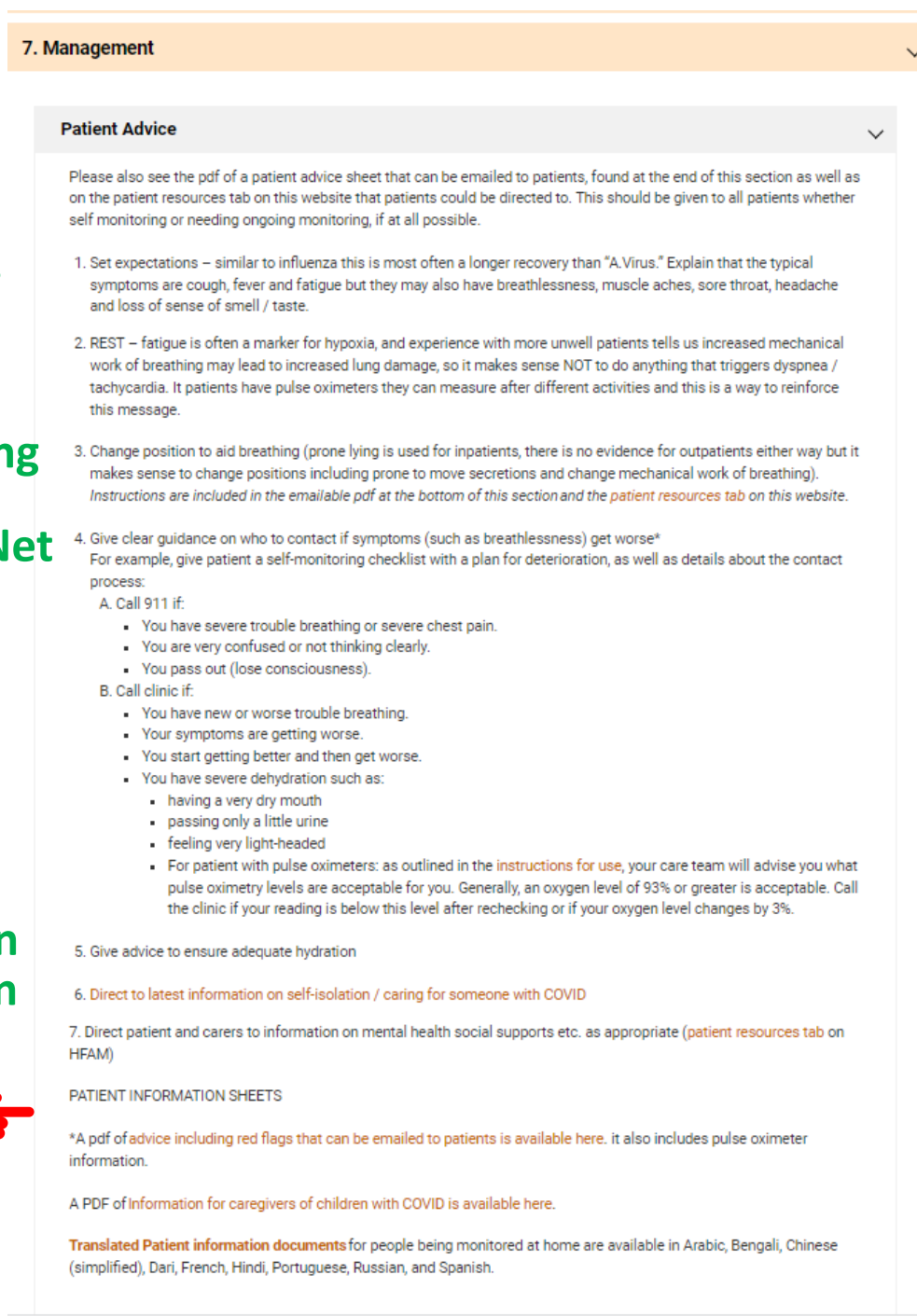
Rest

Breathing

Safety Net

Hydration

Isolation



7. Management

Patient Advice

Please also see the pdf of a patient advice sheet that can be emailed to patients, found at the end of this section as well as on the patient resources tab on this website that patients could be directed to. This should be given to all patients whether self monitoring or needing ongoing monitoring, if at all possible.

1. Set expectations – similar to influenza this is most often a longer recovery than "A.Virus." Explain that the typical symptoms are cough, fever and fatigue but they may also have breathlessness, muscle aches, sore throat, headache and loss of sense of smell / taste.
2. REST – fatigue is often a marker for hypoxia, and experience with more unwell patients tells us increased mechanical work of breathing may lead to increased lung damage, so it makes sense NOT to do anything that triggers dyspnea / tachycardia. It patients have pulse oximeters they can measure after different activities and this is a way to reinforce this message.
3. Change position to aid breathing (prone lying is used for inpatients, there is no evidence for outpatients either way but it makes sense to change positions including prone to move secretions and change mechanical work of breathing). *Instructions are included in the emailable pdf at the bottom of this section and the patient resources tab on this website.*
4. Give clear guidance on who to contact if symptoms (such as breathlessness) get worse*
   For example, give patient a self-monitoring checklist with a plan for deterioration, as well as details about the contact process:
   A. Call 911 if:
      - You have severe trouble breathing or severe chest pain.
      - You are very confused or not thinking clearly.
      - You pass out (lose consciousness).
   B. Call clinic if:
      - You have new or worse trouble breathing.
      - Your symptoms are getting worse.
      - You start getting better and then get worse.
      - You have severe dehydration such as:
        - having a very dry mouth
        - passing only a little urine
        - feeling very light-headed
        - For patient with pulse oximeters: as outlined in the instructions for use, your care team will advise you what pulse oximetry levels are acceptable for you. Generally, an oxygen level of 93% or greater is acceptable. Call the clinic if your reading is below this level after rechecking or if your oxygen level changes by 3%.
5. Give advice to ensure adequate hydration
6. Direct to latest information on self-isolation / caring for someone with COVID
7. Direct patient and carers to information on mental health social supports etc. as appropriate (patient resources tab on HFAM)

PATIENT INFORMATION SHEETS

*A pdf of advice including red flags that can be emailed to patients is available here. it also includes pulse oximeter information.

A PDF of Information for caregivers of children with COVID is available here.

Translated Patient information documents for people being monitored at home are available in Arabic, Bengali, Chinese (simplified), Dari, French, Hindi, Portuguese, Russian, and Spanish.

Anouk 66 RAT+, cough, fatigue, myalgia
mild CKD, hypertension, controlled T2DM

Initial assessment consult:

- Vacc x 3; comorbidities

- Average risk template
- History: moderate cough,
- No dyspnoea, hydrating well

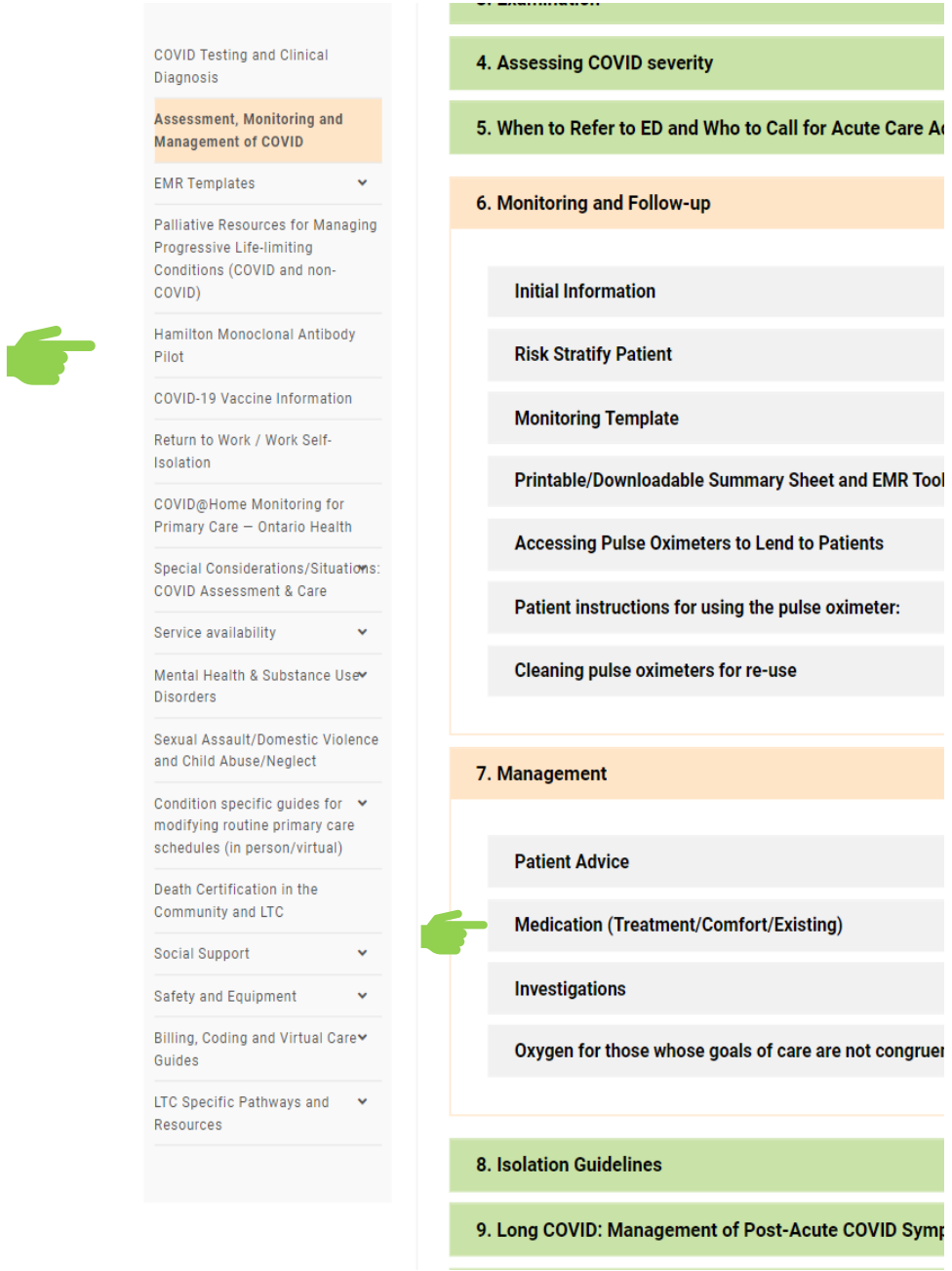
Risk Stratify Patient

High Risk	Average Risk	Low Risk
Patients with any of the safety net flags		Otherwise healthy adults[2,4]; asymptomatic adults
Patients with symptom deterioration[2]	Pregnant women	1-60 years old with no medical comorbidities
Any age with medical comorbidities who are not triple vaccinated	Unvaccinated (excluding asymptomatic)*	No safety net flags
Age > 60 not fully vaccinated or non-mild symptoms	Patients > 60 or with comorbidities at any age who are triple vaccinated and have milder symptoms (i.e., no dyspnoea)	
MONITOR Daily for 7 days then every few days, depending on progress until symptoms resolve	MONITOR Every few days x 7 days; then could recommend self-monitor for additional 7 days depending on progress	MONITOR Consider self-monitoring only; check-ins determined by individual patient. (Consider at 5-7 days for children and symptomatic adults especially in the 40-60 age group)[3]

Management

- Consider monoclonals but not eligible
- Discuss ICS and she is interested

  Rx Budesonide 800 BID (breath activated device)
- T2DM
  - on ACE but no diarrhea (SADMANs N/A)
  - monitor
- Patient advice and pdf as before
- Book in to review in 2-3 days



Follow up

2-3 days: review symptoms, vitals, hydration, comorbidities and CHANGE

Cough still prominent otherwise stable

6 days: c/o breathlessness for the first time

Lend her pulse ox (son picks up) O2sat 98

Shift to high risk monitoring

7 days: c/o increasing breathlessness

Sats 96 RR not elevated talking easily

8 days: c/o breathlessness

talking easily RR 20

sats 94

9 days: feeling much better

cough improved

sats 98

Risk Stratify Patient

High Risk	Average Risk	Low Risk
Patients with any of the safety net flags		Otherwise healthy adults[2,4]; asymptomatic adults
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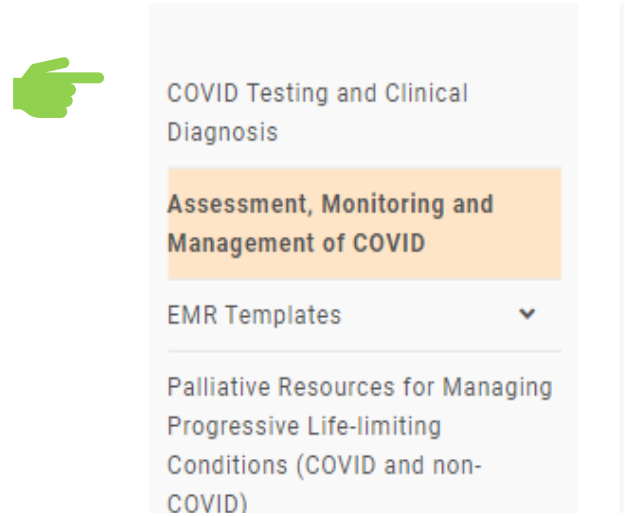
MONITOR Daily for 7 days then every few days, depending on progress until symptoms resolve	MONITOR Every few days x 7 days; then could recommend self-monitor for additional 7 days depending on progress	MONITOR Consider self-monitoring only; check-ins determined by individual patient. (Consider at 5-7 days for children and symptomatic adults especially in the 40-60 age group)[3]

Asha 72 sore throat, fever, mild cough
Ischemic heart disease, COPD

- Initial assessment consult:
- No RAT but symptom algorithm positive
- Unvaccinated
- Significant CVD / resp comorbidities
  - stable
- High risk template for monitoring



ONE of: Fever/chills, cough, shortness of breath, decrease/loss of smell and taste

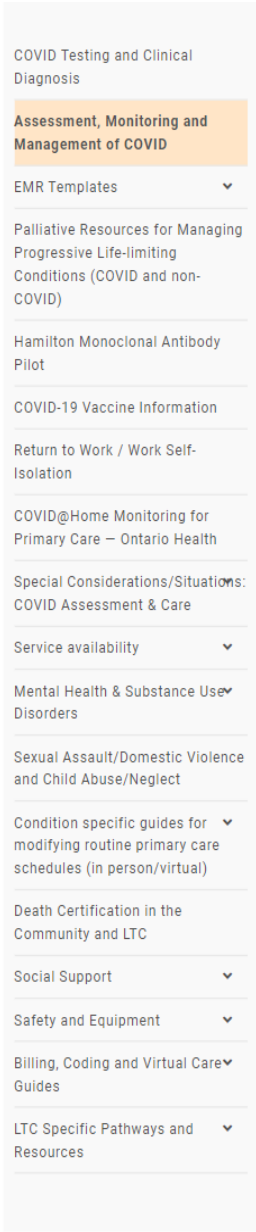
OR

TWO of: Coryza/nasal congestion, Headache, extreme fatigue, muscle of joint pain, sore throat, GI Sx (diarrhoea and vomiting)

Management

- Consider monoclonals and is eligible:
  do RAT (positive) and refer
- Already on ICS so you increase
- Patient advice and send pdf as before
- Consider pulse ox

- Monoclonal infusion next day
- Book appts to follow her daily – no issues,
  diabetes remains stable
- Change to self monitor at 7 days
  as Sx almost completely resolved.



Comfort: acetaminophen

Existing medications:

1. **Business as usual**
2. **Look after the kidneys**
3. **Immunosuppressants: cons**

Medication (Treatment/Comfort/Existing)

- Comfort: Acetaminophen is safer than NSAIDS (not specific to COVID but NSAIDs increase the cardiovascular risk in any viral illness). Read more here.
- Existing
  - ACEs and ARBs seem safe. Read more here.
  - Medications for COPD and Asthma should be continued. Read more here.
  - If the patient is at risk of dehydration (e.g. diarrhoea) think of acute kidney injury risk (SADMAN) if they are on an ACE / ARB plus diuretic plus aspirin these may need pausing to avoid AKI which is a significant feature of more severe COVID illness.
  - If the patient is on immunosuppressant medications consult with the relevant specialist – they may need pausing.

Investigations

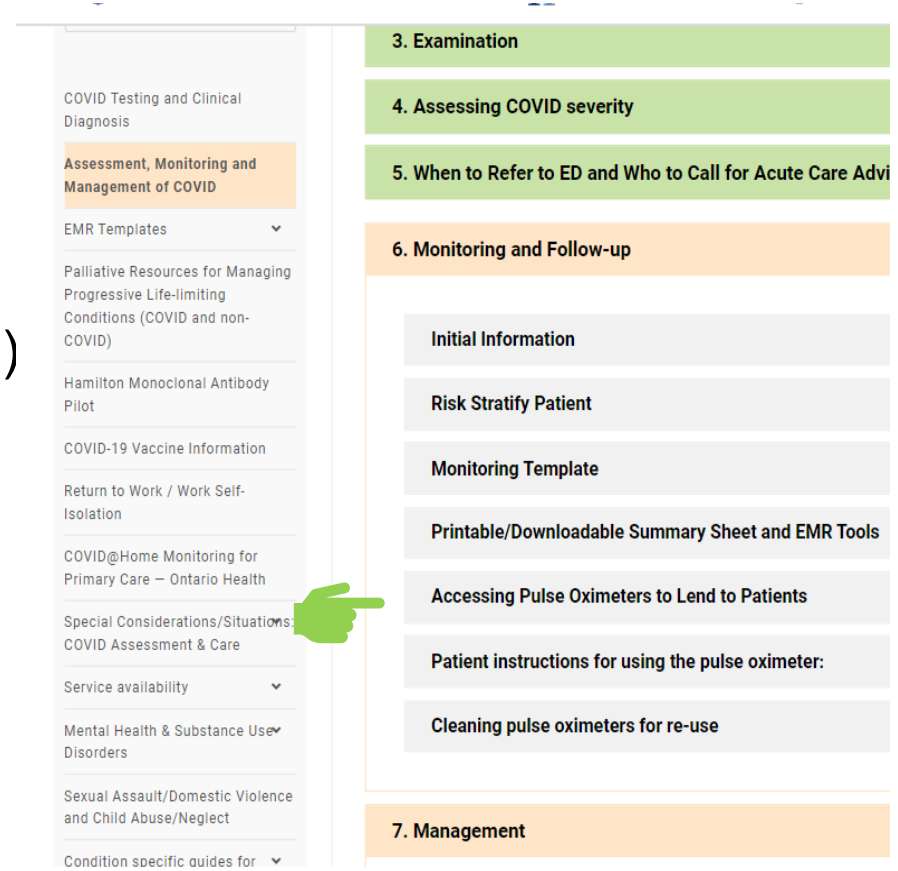
Managing Demand

- Inboxes are drying up
- Most cases need no monitoring: aim is target those who do
- Discouraging those who are low risk from calling for testing and providing the patient advice resource to download to help self-monitor
- Encouraging a higher risk subset to contact us to determine monitoring needs, give information and plan

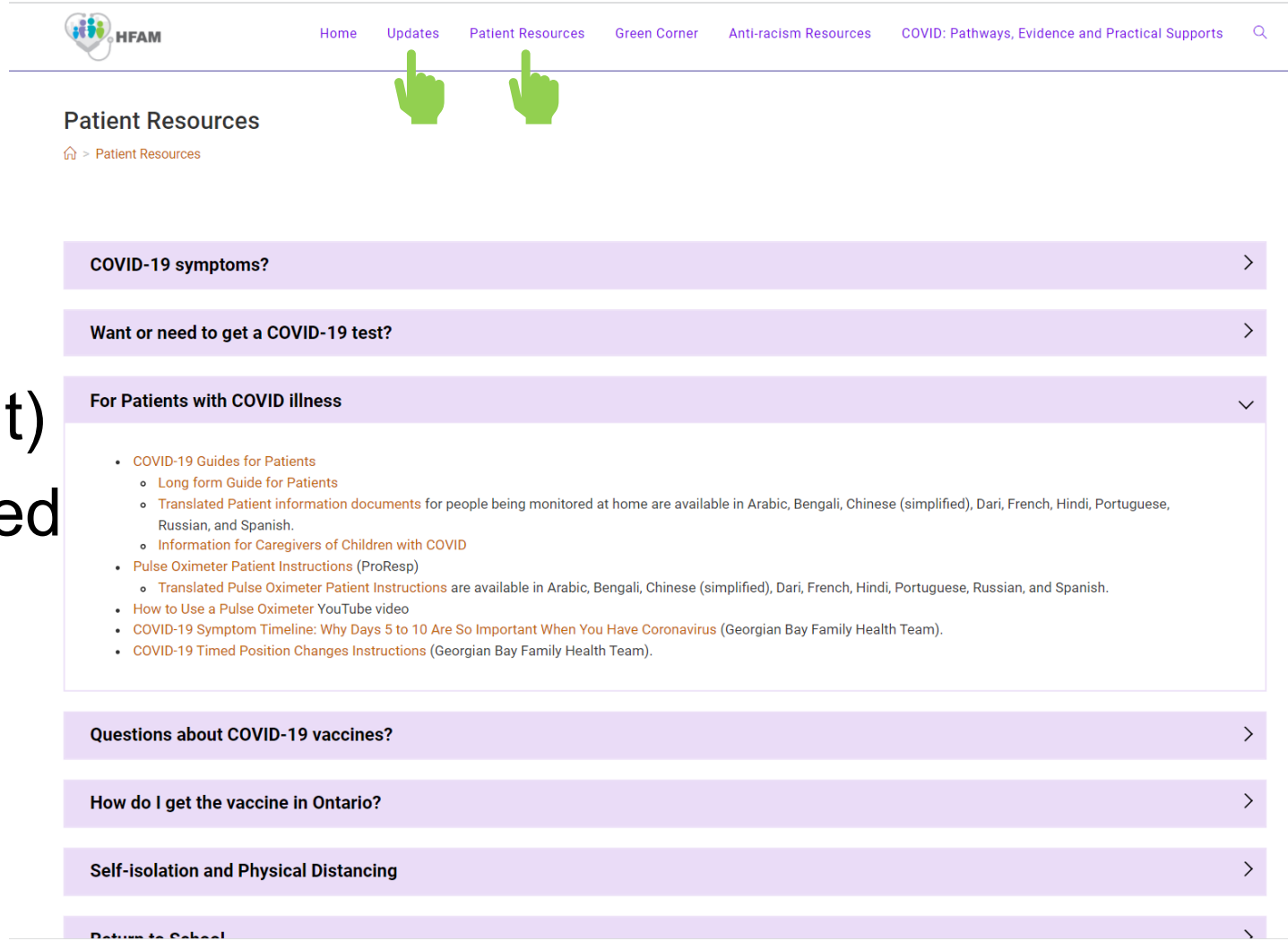
    (older, comorbidities or pregnant)

Practicalities

- Block time at the end of each day to do the virtual* monitoring: initial and followup calls – calibrate to demand
- Consider a “triage” message on your answerphone/website)
- Order (if you haven’t already) pulse oximeters from the Ministry to lend to small no of patients who need them
- Download the EMR monitoring template if you haven’t already



- Patient information
- COPD pathway shortly (exacerbation management)
- Pathway updates are flagged



Primary Care and mild-moderate COVID: We've got this……

Otherwise healthy adults and children can self-isolate, and will not need to seek medical care unless symptoms are increasing.

People who are at higher risk of more serious illness* may benefit from regular monitoring by their primary care clinic. This may include check in calls and sometimes loan of a pulse oximeter to use. You may also be eligible for COVID treatments to prevent more serious illness.

* If you have symptoms and are:

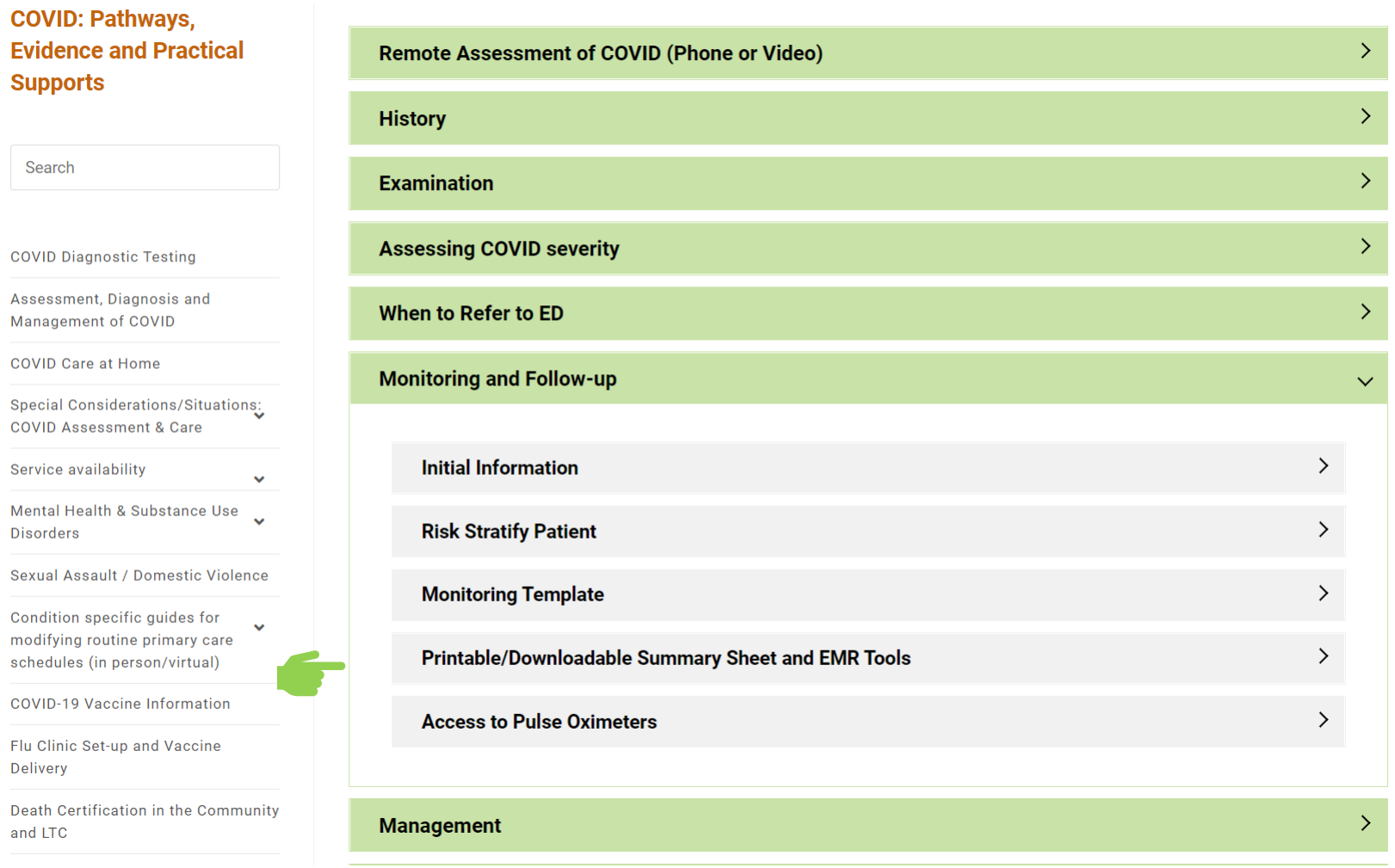
- over 60 OR
- have any long-term medical conditions OR
- are pregnant OR
- unvaccinated.

Contact your usual primary care clinic for an assessment of whether closer monitoring is required and for information about managing your illness. Contact your family doctor early in your illness rather than waiting for symptoms to worsen.

EMR Tools

- Downloadable
- Manual / printable

(doc and spreadsheet)



NB Watch for and use the updated versions for Omicron in the next few days

1/18/2021

Community COVID19 Ward Monitoring

Please follow specific history and exam details per HFAM Monitoring Template (https://hfam.ca/clinical-pathways-and-evidence/covid/assessment-diagnosis-and-management-of-cc
Dyspnea (https://hfam.ca/clinical-pathways-and-evidence/covid/assessment-diagnosis-and-management-of-covid/tips-for-assessing-dyspnea-virtually/) and Vitals (https://hfam.ca/c
diagnosis-and-management-of-covid/assessing-vital-signs-virtually/) virtually.

Date	Symptom Presence (and Relative Change) or Absence						Vitals						Red Flags (https://hfa content/up Flag-Symp	Safe to Continue
	Dyspnea	Cough	Fever	Loss of Taste/ Smell	GI Upset	Other	RR	HR	BP	T	O2 Sat (%)	Hydration		
2021-01-15	◉ Y ○ N ○ Better ○ Worse ◉ Stable Note	◉ Y ○ N ○ Better ○ Worse ◉ Stable Note	○ Y ◉ N Note	◉ Y ○ N ○ Better ○ Worse ◉ Stable Note	○ Y ◉ N Note	○ Y ◉ N Note	16 Note	90 Note	N/A Note	37.8 Note	98 Note	○ Concern ◉ Satisfactory Note	○ Y ◉ N Note	○ Y ◉ N Note
	Notes	[Dyspnea] Exertional dyspnea only												
2021-01-16	◉ Y ○ N ○ Better ○ Worse ◉ Stable Note	◉ Y ○ N ○ Better ○ Worse ◉ Stable Note	◉ Y ○ N ○ Better ◉ Worse ○ Stable Note	○ Y ○ N Note	○ Y ○ N Note	○ Y ○ N Note	16 Note	90 Note	N/A Note	37.8 Note	98 Note	○ Concern ◉ Satisfactory Note	○ Y ◉ N Note	○ Y ◉ N Note
	Notes	[Dyspnea]S till only on exertion - is limiting exertion and monitoring with pulse ox to determine safe limits.												
2021-01-18	○ Y ○ N Note	○ Y ○ N Note	○ Y ○ N Note	○ Y ○ N Note	○ Y ○ N Note	○ Y ○ N Note	Note	Note	Note	Note	Note	○ Concern ○ Satisfactory Note	○ Y ○ N Note	○ Y ◉ N Note
	Notes													

Next Visit Date

2021-01-18

☐ **On Call Notified if Visit on Weekend**

OR

Discharge Date (https://hfam.ca/clinical-pathways-and-evidence/covid/assessment-diagnosis-and-management-of-covid/discharge/)

Other Areas of Assessment/Support

Area	Concern?	Notes	Referral?	Referral Instructions
Mental Health	○ Y ◉ N	Previous periods with aniety but feeling OK - very grateful to know we will call each day.	○ Y ◉ N	
Access to Food	○ Y ◉ N		○ Y ◉ N	
Access to Caregiver(s)	○ Y ◉ N		○ Y ◉ N	
Access to Needed Supports	○ Y ◉ N		○ Y ◉ N	
Financial Health	○ Y ◉ N		○ Y ◉ N	
Housing	○ Y ◉ N		○ Y ◉ N	

Patient Advice/Education Checklist

Please refer to "Patient Advice Guide" (https://hfam.ca/clinical-pathways-and-evidence/covid/assessment-diagnosis-and-management-of-covid/patient-advice-guide/)

- ☑ Illness course explained
- ☑ Information about hydration and comfort medications given: Note
- ☑ Direction given to limit exertion and education provided about breathing position: Note
- ☑ Return to care instructions given
- ☑ Advice given about regular medications (SADMAN (https://www.rxfiles.ca/rxfiles/uploads/documents/SADMANS-Rx.pdf)): ☑ N/A OR Notes: Note
- ☑ Management of comorbidities discussed: T2DM: Will monitor sugars four times daily

Summary of Goals of Care Conversation (if relevant and appropriate)

N/A

Save

This form was developed by the McMaster University Department of Family Medicine and may be modified and used as needed, subject to retaining this acknowledgement in all versions. In the spirit of collaborative improvement, we welcome your feedback. Thank you v1.2

Outpatient Therapeutic Management of Adults with SARS-CoV2 Infection

Ullanda Niel, MD, CCFP

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Adjunct Lecturer DCFM University of Toronto

Member: Ontario Science Table Drugs & Biologics Clinical Practice Guidelines Working Group

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]

Tier 4

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. • 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. *If remdesivir is unavailable or contraindicated:* 🔺 **Fluvoxamine** 50 mg PO daily titrated up to 100 mg PO TID for 15 days **may be considered** for these patients if they present within 7 days of symptom onset. This recommendation is based on very low certainty evidence of reduction in hospitalization, 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. Pharmacist consultation and outpatient provider follow-up is important to avoid any significant adverse drug interactions with fluvoxamine. 🔺 **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. • 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. *If remdesivir is unavailable or contraindicated:* 🔺 **Fluvoxamine** 50 mg PO daily titrated up to 100 mg PO TID for 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. Undervaccinated is defined as individuals who have received two or more doses of a COVID-19 vaccine but are >6 months from their last dose.
3. Risk factors include obesity (BMI ≥30), dialysis or stage 5 kidney disease (eGFR <15 mL/min/1.73 m^2), 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.

Case

- 65 y/o African-Caribbean Canadian F telephone appointment for positive RAT for Covid-19 at home

"I don't want to end-up in the hospital! What medication can you give me doc?"

What do you need to know?

- Symptoms started 3 days ago with nausea and one episode of vomiting. She currently has a fever and mild headache. No respiratory symptoms. Her 30 y/o son, who lives with her, also has similar symptoms and tested positive with RAT at home. They are both self-isolating, they do not have any other close contacts.
- She has received 2 doses of the Pfizer vaccine. She noted she "wasn't sure if the booster was needed so she didn't go get one".
- She has well-controlled hypertension and diabetes.

What are her current medication options?

Sotrovimab

- Monoclonal antibody targeting spike protein of Covid-19 virus, created in a lab and works in a similar way that the antibodies our body would create from natural infection or vaccination would work
- Multi-center RCT:
  - The risk of COVID-19 progression was significantly reduced in the sotrovimab arm (85% relative risk reduction [1% vs 7%], 97.24% CI 44-96, p = 0.002) compared to placebo

  - Gupta A, Gonzalez-Rojas Y, Juarez E, et al. Early Covid-19 treatment with SARS-CoV-2 neutralizing antibody sotrovimab. Published online May 28, 2021. https://doi.org/10.1101/2021.05.27.21257096

Sotrovimab

- RECOMMENDED unvaccinated or under-vaccinated mildly ill patients (no O2 requirement) who are **aged ≥ 70**, **≥ 60** and Indigenous or **≥ 60 at high risk**.
- **High risk factors**
  - Obesity (BMI>=30)
  - Dialysis or stage 5 kidney disease (eGFR <15ml/min/1.73m2)
  - Diabetes
  - Cerebral palsy
  - Intellectual disability (any severity)
  - Sickle Cell Disease
  - Receiving active cancer treatment
  - Solid organ or stem cell transplant patients.
- ~~MAY BE CONSIDERED~~ RECOMMENDED for patients with immunosuppression/ on immunosuppressive therapy who are not expected to mount an adequate immune response to Covid-19 vaccination or SARS-Cov-2 infection.
- NOT RECOMMENDED for vaccinated individuals- based on current limited supply of sotrovimab, and prioritizing its administration in patients at greatest risk of progressing to severe disease.

Sotrovimab

- THE GOOD NEWS:
  - Serological testing not necessary
- THE BAD NEWS:
  - Must be within 7 days of symptom onset
  - IV infusion- regional infusion sites are still being established….

Currently Hamilton has an operational infusion site
https://www.stjoes.ca/coronavirus/st.-joseph%E2%80%99s-healthcare-hamilton-monoclonal-antibody-clinic

Sotrovimab

CASE:
Although the patient has a risk factor (diabetes) she does not does not qualify for Sotrovimab at this time as she is <70 y/o. Also, she is did not receive her booster but she has received at least one dose of vaccine.

Are there other medications can you offer?

ST. JOSEPH'S HEALTHCARE HAMILTON MAB CLINIC REFERRAL FORM

Patient Information

Name:_____**Sex: M / F** **Date of birth:** _____

Allergies: _____

Address:_____**City/Prov:**_____/_____

Postal:_____**Phone:**_____**HCN:** _____

NOTE: For patients with mild COVID-19 with confirmed COVID-19. These products are available for use under an interim authorization (Interim Order) by Health Canada to prevent progression of mild to moderate COVID-19 in adults and pediatric patients (12 years of age and older weighing at least 40 kg) who are at high risk for progression to severe COVID-19, including hospitalization or death.

In order to qualify for therapy, patients need to a) Be symptomatic b) Be within 7 days of symptom onset c) Meet 1 criteria under vaccinated or unvaccinated d) Be willing to travel to the clinic to receive therapy e) Expected survival > 1 year from all causes

Criteria for Use (all fields must be completed to be eligible for treatment)

- ❑ **Date of symptom onset:**_____Treatment must be given within 7 days of symptom onset.
- ❑ **Symptoms:** _____
- ❑ **Date of positive COVID-19 test:** _____
- ❑ **Does this person have a history of prior COVID-19 within the past 90 days?**
- ❑ **Has this person received at least one dose of vaccine ?**

Yes – do they meet any of the following criteria?

- Hematologic malignancy or Bone Marrow Transplant (Please specify:_____)
- Solid Organ Transplant (Please specify:_____)
- Significant immunosuppression (Please indicate type: high-dose corticosteroids > 2 weeks, alkylating agents, antimetabolites, cancer chemotherapy, TNF blockers, anti-CD20 agents and other immunosuppressive biologic agents)
- Primary immunodeficiency (Please specify:_____)
- Advanced or untreated HIV
- Age >=70 AND single medical condition listed in the unvaccinated criteria below: Specify: _____
- Age >=50 AND first nations/Inuit/metis AND single medical condition in the unvaccinated criteria below: Specify: _____

No – do they meet any of the following criteria?

- Age >= 60
- Indigenous (First Nations, Inuit, or Métis)
- Obesity (BMI > 35)
- Cardiovascular Disease (Excluding Hypertension) (Please Specify:_____)
- Chronic Lung Disease (Excluding Mild Asthma not on ICS) (Please specify: _____)
- Diabetes Mellitus
- Chronic Kidney Disease (GFR < 30)
- Chronic Liver Disease with Cirrhosis
- Immunosuppressed or on Immunosuppressants (Please Specify:_____)
- Pregnancy
- Sickle Cell Disease
- Intellectual disability
- Cerebral Palsy

Prescriber Attestation (Must be checked to be eligible for treatment)

- ❑ I affirm that my patient meets above criteria for use

U. Niel. OCFP, Jan 7, 2022

Prescriber Name (print):_____Direct Contact Number (not office line): _____

Remdesivir

- Antiviral drug- previously used only for patients with moderate illness
- MAY BE CONSIDERED for patients at high risk of disease progression 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 of this drug is not a barrier.
  - Tier 1: unvaccinated or under-vaccinated mildly ill patients (no O2 requirement) who are **aged ≥ 70**, **≥ 60** and Indigenous or **≥ 60 at high risk**.
    - Tier 2: Unvaccinated or under-vaccinated individuals at risk of severe disease (anyone **aged ≥60 years**, or anyone **aged <60 years** Indigenous, or anyone **aged ≥60 years** with risk factors)
      - Tier 3. Vaccinated individuals at highest risk of severe disease (anyone **aged ≥70 years**, or anyone **aged ≥60 years** Indigenous, or anyone **aged ≥60 years** with risk factors).
        - Tier 4: Vaccinated individuals at risk of severe disease (anyone **aged ≥60 years**, or anyone **aged <60** Indigenous, or anyone aged **≥60 years** with risk factors)

Fluvoxamine

- SSRI currently used for OCD, Depression.

- **Postulated Primary Mechanism of Action:** Sigma-1 Receptor (S1R) Agonist-endoplasmic reticulum chaperone protein involved in cytokine production
- S1R agonist activity of SSRIs:
  - fluvoxamine>fluoxetine>escitalopram>citalopram>paroxetine>duloxetine
  - Venlafaxine, milnacipran, and mirtazapine showed weak affinity while sertraline also shows strong **antagonist** activity.

- Fluvoxamine and other SSRIs also have mild effects on platelet aggregation

- Currently there is no evidence for the use of SSRI other than fluvoxamine

Fluvoxamine

STOP COVID trial, TOGETHER multi-platform trial- reduced hospitalization, need for supplemental oxygen

- https://jamanetwork.com/journals/jama/fullarticle/2773108
- https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(21)00448-4/fulltext

- MAY BE CONSIDERED for patients with mild Covid-19 infection within 7 days of symptom onset.

Fluvoxamine

- Common Side effects:
  - mild: nausea, constipation, diarrhea, dry mouth, insomnia, somnolence, nervousness, agitation, headache, dizziness
- Cannot be used in patients with a history of bipolar disorder
- QT prolongation:
  - Rare- baseline ECG not needed
- **Drug interactions:**
  - Can be used with other SSRI (if at low dose), EXCEPT Setraline which can counteract the anti-inflammatory action of fluvoxamine.
  - Can be used with ASA
  - **Use with caution** –with Warfarin and NSAIDS, haloperidol, phenytoin, propranolol, verapamil
  - **CAFFEINE**
    - Increases serum concentrations of caffeine up to 5 fold
    - (limit caffeine intake to 1 cup per day)
  - potent inhibitor of CYP1A2 and CYP2C19 and a moderate inhibitor of CYP2C9, CYP2D6 and CYP3A4
    - **Contraindicated** with clopidogrel- will reduce anti-platelet activity of clopidogrel
    - **Contraindicated** with tacrolimus, MAO inhibitors, clozapine, olanzapine, methadone, or linezolid- can increase levels of these drugs causing toxicity

Fluvoxamine

Dosing:
50mg PO at bedtime x 1 day
then 100mg BID x 2 days if tolerated
then 100mg TID if tolerated through to day 15

Note: The above titration is based on the STOP-COVID trial. For tolerability reasons, a slower titration may be required. A final dose of 100mg BID may be considered based on the dose used in the TOGETHER trial.
https://www.ontariofamilyphysicians.ca/tools-resources/covid-19-resources/covid-outpatient-management-2021-12-30.pdf

Case

f/u visit: 3 days later

The patient admits she brought the prescription to the pharmacy but it was out of stock and they had to order it. After thinking about the things you said about the medication, she isn't sure she wants to take it anyway. She is very worried because she woke up this morning with a cough. No current shortness of breath. Are there any other drugs she can try?

Budesonide

- 2 Open Label RCTs: Principle trial, Stoic trial
  - Reduced time to recovery, reduced need for ED assessment/hospitalization
- MAY BE CONSIDERED for symptomatic high-risk outpatients
- **Dosing:** Budesonide 800mcg inh BID x 14 days

QUESTIONS? Email: uniel@schcontario.ca

Outpatient Therapeutic Management of Adults (≥18 years of age) with Mild COVID-19[1,2]

Mildly ill patients are defined as those who do not require new or additional supplemental oxygen from their baseline status.

Treatments that are RECOMMENDED for High Risk patients

Drug	Criteria	Comments
Sotrovimab 500mg IV x 1 dose over 30 min Monitor x 60 min after infusion	For mildly ill patients presenting within 7 days of symptom onset who meet the following criteria: • Symptomatic residents of LTC facilities, retirement homes or other congregate living conditions • Symptomatic inpatients with nosocomial infections • **High risk patients:** a) ≥70 years AND have at least 1 additional risk factor OR b) ≥50 years AND is First Nations, Inuit or Métis, AND have at least 1 additional risk factor Risk Factors include: Obesity (BMI ≥30), dialysis or stage 5 kidney disease (eGFR <15 ml/min/1.73m^2), diabetes, cerebral palsy, intellectual disability of any severity, sickle cell disease, receiving active cancer treatment, solid organ or stem cell transplant recipients	Previous SARS-CoV2 infection and vaccination status do not need to be considered. Serological testing for IgG antibody does not need to be done. At this time, regional infusion sites are being established. More information will be circulated as it becomes available. Hamilton has an operational infusion site. A direct physician referral can be made here if a patient is outside of catchment area. See here for a summary of the clinical evidence for sotrovimab from the Ontario Science Table.

Please refer to the Ontario Science Table 's Science Briefs for more detailed information on treatment options in this document.

Treatments that are NOT RECOMMENDED

Due to insufficient evidence to support use

- Anticoagulation
- Colchicine
- Vitamin D

Due to lack of benefit, potential for harm, and system implications of overuse

- Antibiotics (e.g. azithromycin)
- Dexamethasone
- Hydroxychloroquine/Chloroquine
- Ivermectin
- Lopinavir-ritonavir (Kaletra®)

Treatments that MAY BE CONSIDERED for High Risk and Other patients at risk of adverse outcomes

Drug	Criteria	Comments
Sotrovimab 500mg IV x 1 dose over 30 min Monitor x 60 min after infusion	For mildly ill patients who DO NOT meet the above criteria BUT who, in the opinion of the physician, have other important **risk factors for disease progression (e.g. immunosuppression, on immunosuppressive therapy)**	Previous SARS-CoV2 infection and vaccination status do not need to be considered. Serological testing for IgG antibody does not need to be done. See comments above for information on infusion sites.
Budesonide (Pulmicort®) 800mcg inhaled BID x 14 days	For mildly ill patients presenting within 7 days of symptom onset who meet the **high risk patient** criteria under sotrovimab above.	See next page for relevant clinical trial data on budesonide in non-hospitalized patients. Cost (based on Ontario Drug Benefit pricing):[3] Pulmicort Turbuhaler 400mcg x 200 doses = $100.29; 200mcg x 200 doses = $68.70 *Note: The 100mcg strength does not provide enough doses for the full 14-day treatment course.*
Fluvoxamine (Luvox® and generics) 50mg PO at bedtime x 1 day, then 100mg BID x 2 days if tolerated, then 100mg TID if tolerated through to day 15 *Note: The above titration is based on the STOP-COVID[7,8] trial. For tolerability reasons, a slower titration may be required. A final dose of 100mg BID may be considered based on the dose used in the TOGETHER[9] trial.*	For mildly ill patients presenting within 7 days of symptom onset. This is based on very low certainty of evidence of reduction in hospitalization, and the need for outpatient treatment options with a reasonable safety profile during an anticipated spike in COVID-19 cases due to Omicron. Please consult your **clinic pharmacist** for consideration of drug interactions and dose titration where appropriate. *Note: In the STOP-COVID[7,8] trials, caffeine intake was limited to no more than 1 cup/day.*	See next page for relevant clinical trial data on fluvoxamine in non-hospitalized patients and postulated mechanism of action of fluvoxamine as an immune modulator. *Note: Other SSRIs may possibly exhibit similar immune modulating activity. Providers should weigh benefits and risks of switching patients currently on other antidepressants to fluvoxamine for the relatively small clinical benefits noted in the trials. Note also that individuals on SSRIs were excluded in the TOGETHER[9] trial but permitted in the STOP-COVID[7,8] trial if the doses were low.* Common side effects:[4] Sedation, headache, insomnia, dizziness, nervousness, weakness, nausea, diarrhea, dry mouth, anorexia. *Note: Preference for larger doses to be given at bedtime for tolerability if required..* Drug interactions (strong inhibitor of CYP1A2, CYP2C19) – *the following is NOT all inclusive:*[4] Buprenorphine, caffeine, citalopram, clopidogrel, clozapine, haloperidol, olanzapine, methadone, phenytoin, propranolol, warfarin, verapamil Cost (based on Ontario Drug Benefit pricing):[3] Generic fluvoxamine 50mg tab = $0.21; 100mg tab = $0.38

Updated Jan 6, 2022. Prepared by: Brenda Chang, RPh, Reviewed by: Doret Cheng, RPh, Sharan Lail, RPh, Elizabeth Leung, RPh and Reem Haj, RPh , St. Michael's Hospital - Unity Health Toronto

https://www.ontariofamilyphysicians.ca/tools-resources/covid-19-resources/covid-outpatient-management-2021-12-30.pdf

Casirivimab + imdevimab

- Brand name: REGEN-COV
- Monoclonal Antibody that was previously recommended
- NO LONGER RECOMMENDED- due to lack of neutralizing activity to Omicron Variant

Recommend against

- Due to lack of benefit/potential harm/system implications for overuse
  - Antibiotics (e.g. azithromycin)
  - Dexamethasone for patients with mild covid-19
  - Hydroxychloroquine/Chloroquine
  - Ivermectin
  - Lopinavir-ritonavir (Kaletra®)
- Due to insufficient evidence to support use
  - Anticoagulation
  - Colchicine
  - Vitamin D

Ministry of Health

Public Health Measures and Guidance in Response to Omicron

Provincial Preparedness and Pandemic Response WG
January 4, 2022

Ontario

Omicron & the Current Environment in Ontario

- As Omicron cases continue to rise rapidly, the pandemic response effort will need to prioritize resources to where they are most needed to protect the most vulnerable from severe disease:
  - **Preserve and target key resources** (e.g. testing and case and contact management resources, critical surveillance capacity) to focus on high-risk individuals and settings, and redeploy for vaccination where appropriate.
  - Ensure that there is **clear guidance** in place for response partners and the public about the changes being implemented to the pandemic response approach.

- **The key goals** for the response effort remain to:
  1. Prevent morbidity and mortality, especially in vulnerable populations.
  2. Protect public health and health system capacity.
  3. Protect critical infrastructure.
  4. Protect in-person learning (keep schools and childcare open).
  5. Prevent businesses closures.

Key changes to the guidelines

	Current	New Guidance
Testing	Symptomatic individuals. High risk close contacts of confirmed cases regardless of symptoms.	Symptomatic individuals living or working in high risk settings only; vulnerable populations (eg FNIM, homeless). Close contacts no longer require testing. Low risk individuals and mild symptoms do not require testing.
Diagnosis	* PCR +ve	• PCR +ve • RAT +ve (do not require confirmatory PCR test) • Symptoms consistent with COVID are presumed positive
Isolation requirement (non high-risk settings)	• 10 days for confirmed cases • 10 days for close contacts of confirmed cases • Asymptomatic fully vaccinated high risk close contacts do not require isolation but recommended for immediate testing. Isolation only when symptoms or PCR +ve	• **5 days for confirmed cases** in the community who received 2 doses of vaccine and otherwise healthy, and their households. • **10 days self-monitoring for close contacts** in the community who are asymptomatic, received 2 doses of vaccine and otherwise healthy.
Vulnerable populations (e.g., LTCH/RH residents, hospitalized patients, and workers in these settings)	• 10 days for confirmed cases • 10 days for close contacts in high-risk settings • Outbreak with 2 or more confirmed cases	• **No change to case and contact management. Continues to be the top priority for public health** • 10 days isolation for confirmed cases who live in settings • 10 days isolation for close contacts who live in high-risk settings • Outbreak declaration (low threshold) – even with RAT +ve • **10 days away from work for positive workers or contacts in high-risk settings** unless cleared by –ve PCR, or –ve RAT day 6 & 7 (both negative to attend work on day 7).

I live in the community (do not work in highest risk health care setting) and I have COVID symptoms. Now what?

- **If you have mild symptoms** – you do not require testing
  - Do not go to assessment center or emergency department for testing
- **If you are fully vaccinated** or under the age of 12 years
  - You and your family should self-isolate for 5 days since the onset of symptoms. You must be asymptomatic or symptoms resolving for at least 24 hours (48 hours if gastrointestinal symptoms)
  - 10 days or longer if you are immunocompromised
- **If you are unvaccinated**
  - You and your family should self-isolate for 10 days since the onset of symptoms. You must be asymptomatic or symptoms resolving for at least 24 hours (48 hours if gastrointestinal symptoms).
- Contact Telehealth or your healthcare provider if you have any concerns about your symptoms
- If your symptoms worsen, contact your healthcare provider for further guidance
- Notify your close contacts

I am a contact of someone who has COVID (do not work in highest risk health care setting). Now what?

- ❑ Do not go to the assessment center for testing.
- ❑ **If you live with the person** that has COVID
  - ❑ Isolate for 5 days, or until the person you live with has resolved
  - ❑ If you develop symptoms, follow the pathway for cases
- ❑ **If you are fully vaccinated** or under the age of 12 years, and don't live with the person who has COVID
  - ❑ If you are asymptomatic, you do not need to self-isolate.
  - ❑ If you have symptoms, follow the pathway for cases.
- ❑ **If you are unvaccinated or immunocompromised**
  - ❑ You should self-isolate for 10 days since the last exposure.
  - ❑ If you develop symptoms, follow the pathway for new cases including self-isolation for your household.
- ❑ Contact Telehealth or your healthcare provider if you have any concerns about your symptoms

I am a case or a close contact of someone who has COVID and I work in a highest risk health care setting. Now what?

- ❑ You should notify your employer
- ❑ Do not go to the assessment center for testing unless directed by your employer
- ❑ If you are fully vaccinated
  - ❑ If you are a case – You and your family should self-isolate for 5 days since the onset of symptoms. You must be asymptomatic or symptoms resolving for at least 24 hours (48 hours if gastrointestinal symptoms)
  - ❑ If you are a contact – you do not need to self-isolate. If you develop symptoms, follow the pathway for cases.
- ❑ If you are unvaccinated
  - ❑ If you are a case - You and your family should self-isolate for 10 days since the last exposure.
  - ❑ If you are a contact – you must self-isolate for 10 days since the last exposure.
    - ❑ If you develop symptoms, follow the pathway for new cases including self-isolation for your household.
- ❑ Contact Telehealth or your healthcare provider if you have any concerns about your symptoms
- ❑ For 10 days - you should avoid visiting any highest risk settings (hospitals, LTCH/RH, congregate living settings, individuals who are immunocompromised)
- ❑ Your employer may require you to work before you complete your isolation. You must follow all workplace specific direction e.g., clearing vaccinated cases and contacts to attend work on day 7 with two negative RAT collected on Day 6 and 7 24 hours apart or other Test to Work requirements depending on your sector requirements.

Management of critical staffing shortages

In the event of critical staffing shortages in health care settings:
Can be cleared from 10 day isolation, and return early on day 7:

- Negative PCR on day 6 OR negative RAT day 6 & 7 (both negative to attend work on day 7).

Key considerations for those returning to work early:

- Workers must have received at least 2 doses of vaccine
- Fit tested N95 masks must be used at all times for not only the early returning HCW but all other support staff that work along side the HCW.
- All efforts must be made to avoid direct patient interaction with returning HCW
- Returning HCW must not work with patients that are immunocompromised (e.g., cancer ward etc.)
- Consider reducing the number of days and hours worked for these returning HCW to minimize the need for breaks, minimize exposure time and minimize the risk for the HCW
- Workplace occupational health and safety direction can go above the requirements in this guidance
- Address any other concerns of bringing staff to healthcare settings such as transportation, break rooms, shared entrance and exits, availability of RATs, PPEs

Appendices

Who will get access to PCR testing?

- Symptomatic people who fall into one of the following groups:
  - Hospitalized patients
  - Patients seeking emergency medical care, at the discretion of the treating clinician
  - Patient-facing healthcare workers
  - Staff, volunteers, residents/inpatients, essential care providers, and visitors in hospitals and congregate living settings, including Long-Term Care, retirement homes, First Nation elder care lodges, group homes, shelters, hospices, temporary foreign worker settings, and correctional institutions
- Symptomatic outpatients for whom COVID-19 treatment is being considered
  - includes those 70 and older who have a risk factor including 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, or 50 and older if First Nations, Inuit, or Métis with any of those risk factors
- Symptomatic people who are underhoused or homeless
- Symptomatic elementary and secondary students and education staff who have received a PCR self-collection kit through their school
- Symptomatic/asymptomatic people who are from First Nation, Inuit, and Métis communities and individuals travelling into these communities for work
- Symptomatic /asymptomatic people on admission/transfer to or from hospital or congregate living setting
- High risk contacts and asymptomatic/symptomatic people in the context of confirmed or suspected outbreaks in highest risk settings, including hospitals, long-term care, retirement homes, other congregate living settings and institutions, and other settings as directed by the local public health unit
- Individuals, and one accompanying caregiver, with written prior approval for out-of-country medical services from the General Manager, OHIP
- Asymptomatic testing in hospital, long-term care, retirement homes and other congregate living settings and institutions as per provincial guidance and/or Directives, or as directed by public health units.

Highest Risk Health Care Settings

For case and contact management, and isolation purposes, highest risk settings include:

- Hospitals and health care settings, including complex continuing care facilities and acute care facilities
- Congregate living settings, e.g. long-term care homes, retirement homes, First Nation elder care lodges, group homes, shelters, hospices, temporary foreign worker settings, and correctional institutions
- First Nations, Inuit, Métis communities.

You have symptoms and are concerned you may have COVID-19. Now what?

Do you have any of these symptoms: Fever/chills, cough, shortness of breath, decrease/loss of smell and taste?

No

Do you have two or more of these symptoms?:

- **Runny nose/nasal congestion**
- **Headache**
- **Extreme fatigue**
- **Sore throat**
- **Muscle aches/joint pain**
- **GI Symptoms (i.e. vomiting or diarrhea)**

Yes

NO

- It is less likely that you have COVID-19 infection.
- Self-isolate until your symptoms are improving for at least 24 hours (48 hours for gastrointestinal symptoms).
- Your household members do not need to self-isolate.

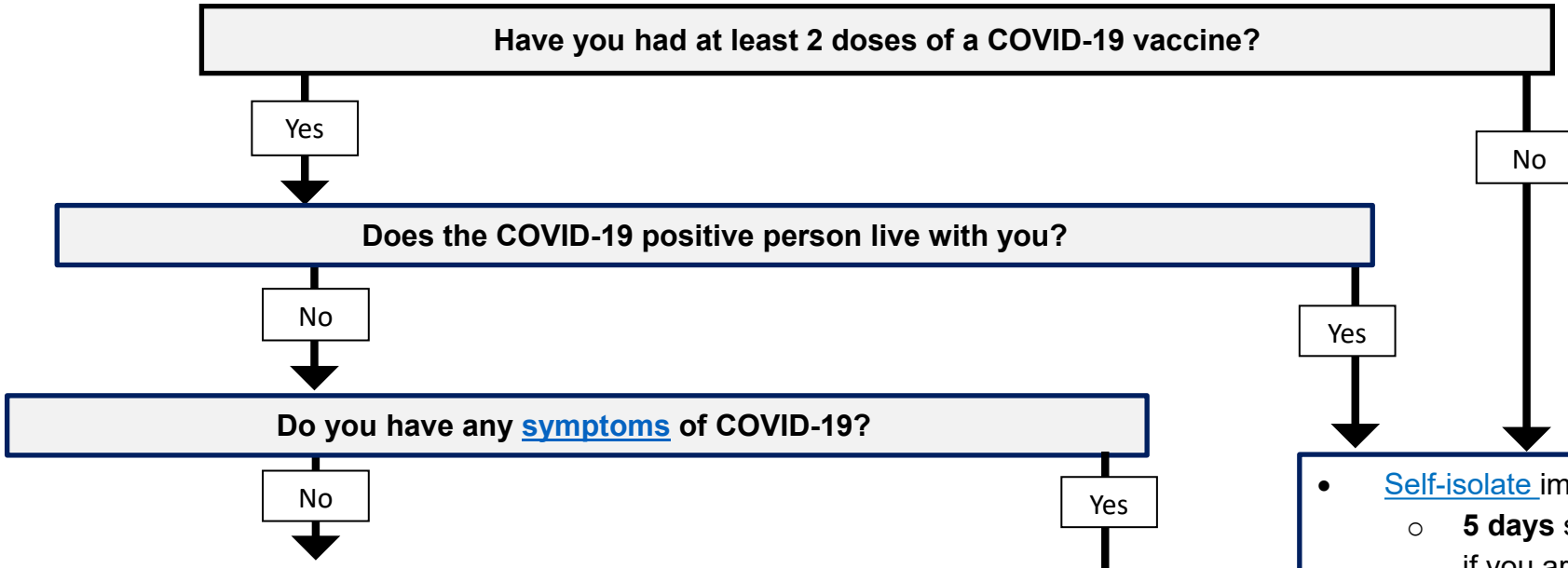
Yes

- It is highly likely that you have a COVID-19 infection.
- You must self-isolate immediately:
  - For at least **5 days** from your symptom onset and until your symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) whichever is longer in duration if you are:
    - 12 years of age or older AND fully vaccinated.
    - 11 years old or younger, regardless of your vaccination status
  - For **10 days** from your symptom onset if you are:
    - 12 years of age or older AND either partially vaccinated or unvaccinated.
    - Immune compromised, regardless of your age
- All of your household members (regardless of their vaccination status) must self-isolate while you are self-isolating.
- Most individuals do not need a COVID-19 test. If you are in the eligible individual list, get PCR test, rapid molecular test or rapid antigen tests (if you have access). If testing is not available, you must fulfill the self-isolation.
- If your symptoms worsen, seek advice from Telehealth or your health care provider.
- Notify your workplace.

*Highest risk settings/individuals include hospitals, Long-Term Care, retirement homes, congregate living settings, and health care workers providing care to immunocompromised people.
Note: In the context of Omicron, individuals who are previously positive in the last 90 days and not fully vaccinated are **not** considered equivalent to fully vaccinated.

You've been exposed to someone who has tested positive for COVID-19 on PCR, rapid molecular, or rapid antigen test. Now what?

This guidance does not apply to individuals that live, work, volunteer or are admitted in a highest-risk setting*



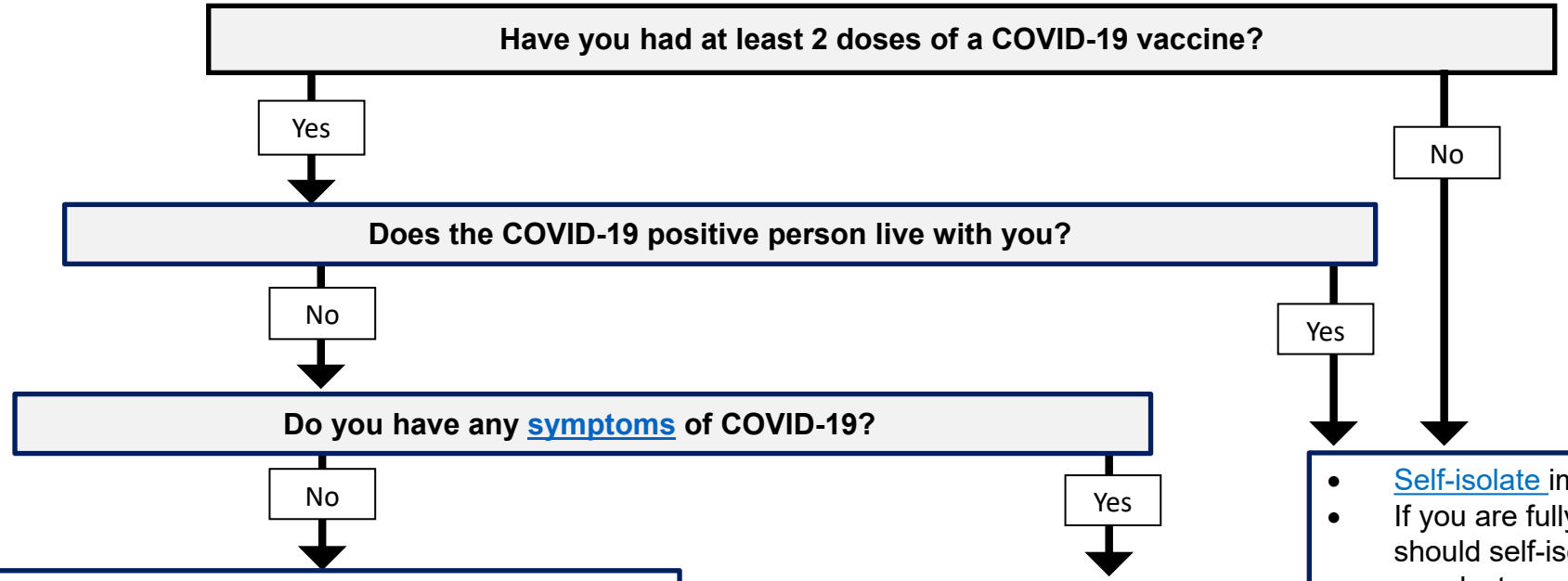
- Self-monitor for symptoms for 10 days.**
- If leaving home, you should maintain masking, physical distancing and all other public health measures. You should **NOT** visit any highest risk settings* or individuals who may be at higher risk of illness (e.g., seniors) for 10 days from your last exposure.
- Report your exposure to your employer and follow any work restrictions.
- If you develop any symptoms, self-isolate immediately, get tested if eligible and follow the guidance for cases.

- Self-isolate immediately for at least 5 days following your symptom onset. and until your symptoms have been improving for at least 24 hours (48 hours if gastrointestinal symptoms), whichever is longer.
- If you are eligible for testing, get tested and follow the guidance for cases.

- Self-isolate immediately for:
  - **5 days** since your last exposure if you are fully vaccinated or under 12 years of age
  - **10 days** since your last exposure if you are partially vaccinated or unvaccinated or immune compromised.
- Self-monitor for symptoms for 10 days.
- If you develop symptoms continue to self-isolate and get tested if you are eligible. Follow the guidance for cases.

*Highest risk settings include hospitals, Long-Term Care, retirement homes, HCW providing care to immunocompromised, congregate living settings
Note: In the context of Omicron, individuals who are previously positive in the last 90 days and not fully vaccinated are **not** considered equivalent to fully vaccinated.

You've been exposed to someone who has tested positive for COVID-19 on PCR, rapid molecular, or rapid antigen test and you work in a highest risk setting.* Now what?



- Self-monitor for symptoms for 10 days.
- Get tested if recommended by the public health unit.
- If your test is **positive** you must self-isolate. Follow the guidance for cases.
- If leaving home, you should maintain masking, physical distancing and all other public health measures.
- You should **NOT** attend work for 10 days from your last exposure.
- Report your exposure to your employer and follow any work restrictions. If there is a critical staff shortage, you may be able to attend work under work-self isolation (WSI). Follow WSI guidelines.
- If you develop any symptoms, get tested as soon as possible and self-isolate until you get your result.

- Self-isolate immediately.
- Get tested as soon as possible.
- If your test is **negative** you can discontinue self-isolation once symptoms have been improving for at least 24 hours (or 48 hours if you have gastrointestinal symptoms).
- If your test is **positive** you must self-isolate. Follow the guidance for cases.
- Notify your employer and follow any work restrictions and early clearance guidance.

- Self-isolate immediately.
- If you are fully vaccinated, you should self-isolate for **5 days** since your last exposure.** If you are partially vaccinated or unvaccinated or immune compromised, you should self-isolate for 10 days.
- Notify your employer and follow any work restrictions and early clearance guidance.
- If you develop symptoms, get tested and follow the guidance for cases.

*Highest risk settings include paramedics, hospitals, Long-Term Care, retirement homes, health care workers providing care to immunocompromised, congregate living settings
** After 5 days of self-isolation, do NOT attend work until 10 days from your last exposure. Report your exposure to your employer and follow any work restrictions.
Note: In the context of Omicron, individuals who are previously positive in the last 90 days and not fully vaccinated are **not** considered equivalent to fully vaccinated.

Provincial Pandemic Stockpiles – Primary Care

- The PPE and Testing Pandemic Stockpiles were established to provide health care providers with access to PPE and testing supplies at no cost and over and above what could be fulfilled by regular supply chains
- Product Scope:
  - **PPE:** disinfectant wipes, surgical masks, hand sanitizer, gloves, gowns, eye protection (face shields and goggles), and N95 Masks
    - Note: The 3M domestically produced N95 1870+ Respirator is the model of choice and recommended. Orders for other models will be based on availability and provided only on an emergency basis.
  - **Rapid Antigen Tests**
  - **SWAB kits**
- PPE and testing supplies are requested via an online platform and are distributed through provincial warehouses

https://ehealthontario.on.ca/en/health-care-professionals/digital-health-services

COVID@Home

- Due to rising case counts the new Omicron variant the Ministry of Health has procured more oxygen saturation monitors to support those already doing monitoring with additional supply and to provide monitors to any new providers who need to monitor their high-risk patients.
- Monitors are due to arrive Dec. 30th. Ordering link https://survey.alchemer.com/s3/6240240/O2-Saturation-Monitor-Survey. Processing and delivery of orders will begin the week of January 3rd.
- Clinical pathways, EMR templates and CoP are available supports

Ontario Health

COVID@Home: Resources

- Link to ordering O2 at monitors: https://survey.alchemer.com/s3/6240240/O2-Saturation-Monitor-Survey (link not active until Dec 29th)
- Assessment and Management of COVID clinical pathway
- EMR Templates for monitoring
- Palliative Pathway for Managing Progressive Life Limiting Conditions (COVID and non COVID)
- Post-hospitalization pathway (exists, is password protected currently)
- Primary Care and COVID-19 Support CoP Group
- COVID@Home Resource Toolkit
- Working with Oxygen Providers
- Recordings of past sessions (#18 and onward)

Ontario Health

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, January 21, 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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