Managing COVID-19 in the community

January 7, 2021

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Dr. Janine McCready
Dr. Ullanda Niel
Dr. Daniel Warshafsky
Managing COVID-19 in the community

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   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\textsuperscript{1} Testing for COVID-19 Infection

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

- **Symptomatic\textsuperscript{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 \(\geq 30\)), 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, or 50 and older if First Nations, Inuit, or Métis with any of those risk factors\textsuperscript{3}
- Symptomatic people who are unhoused 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...
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.

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.

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

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. Derelic Mangin—Panelist
Twitter: @DeeMangin
Family Physician, McMaster Family Health Team, Hamilton and provincial lead, COVID@home program

Dr. Janine McCready—Panelist
Twitter: @janinemccready
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 guest’s 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 panel’s attention.

• Please use the chat box for networking purposes only.
Dr. Derelie Mangin—Panelist
Twitter: @DeeMangin
Family Physician, McMaster Family Health Team, Hamilton and provincial lead, COVID@home program

Dr. Janine McCready—Panelist
Twitter: @janinemccready
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Dr. Dan Warshafsky—Panelist
Senior Medical Consultant at the Office of the Chief Medical Officer of Health
Ontario COVID-19: Daily cases vs. Total hospitalizations

@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 @Illius27
Current COVID-19 Risk in Ontario by Vaccination Status

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

https://covid19-sciencetable.ca/ontario-dashboard/
Indlæggelser per 100.000
Angiver antal indlæggelser per 100.000 i alders- og vaccinationsgruppen

https://covid19danmark.dk/
Døde per 100.000
Angiver antal døde per 100.000 i alders- og vaccinationsgruppen

https://covid19danmark.dk/
Counts and rates of hospitalizations among recent COVID-19 cases by age group in Ontario - Last updated January 3, 2022 at 1:00 pm

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

<table>
<thead>
<tr>
<th>Age group</th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dose 1</td>
<td>Dose 2</td>
<td>Dose 1</td>
<td>Dose 2</td>
</tr>
<tr>
<td>5–11 years</td>
<td>0.0</td>
<td>4.3</td>
<td>Not calculated†</td>
<td>2.0</td>
</tr>
<tr>
<td>12–15 years</td>
<td>4.8</td>
<td>45.7</td>
<td>1.0</td>
<td>3.8</td>
</tr>
<tr>
<td>16–17 years (included for reference)</td>
<td>6.1</td>
<td>70.2</td>
<td>0.0</td>
<td>7.6</td>
</tr>
</tbody>
</table>

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

Caring for COVID in our Primary Care Practices
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
Assessment, Monitoring, and Management of COVID

COVID Pathways, Evidence and Practical Supports

1. Remote Assessment of COVID (Phone or Video)
2. History
3. Examination
4. Assessing COVID severity
5. When to Refer to ED and Who to Call for Acute Care Advice
6. Monitoring and Follow-up
7. Management
8. Isolation guidelines
10. Information resources
11. Pediatric Assessment and Referral

Using the HFAM.ca Pathway for COVID Care in the Community

Primary Care for COVID in the Community HFAM.ca

Please see HFAM.ca for most up-to-date COVID pathways, evidence and practical supports

One page summary of a monitoring consultation for those who haven’t done it before:

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
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).
Management

Go over key aspects of patient advice

Email the pdf HFAM patient information (🔗)

No formal FU arranged


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
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
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: consult

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
### Community COVID19 Ward Monitoring


**Date**

<table>
<thead>
<tr>
<th>Date</th>
<th>Symptom Presence (and Relative Change) or Absence</th>
<th>Vitals</th>
<th>Red Flags [Note]</th>
</tr>
</thead>
<tbody>
<tr>
<td>2021-01-15</td>
<td><img src="Y" alt="Dyspnea" /> <img src="Y" alt="Cough" /> <img src="Y" alt="Fever" /> <img src="Y" alt="Loss of Taste/Smell" /> <img src="Y" alt="DI Upset" /> <img src="Y" alt="Other" /></td>
<td><img src="16" alt="RR" /> <img src="90" alt="HR" /> <img src="127/88" alt="BP" /> <img src="98" alt="O₂ Sat" /></td>
<td><img src="Y" alt="Concern" /> <img src="Y" alt="Satisfactory" /> [Note]</td>
</tr>
<tr>
<td>2021-01-16</td>
<td><img src="Y" alt="Dyspnea" /> <img src="Y" alt="Cough" /> <img src="Y" alt="Fever" /> <img src="Y" alt="Loss of Taste/Smell" /> <img src="Y" alt="DI Upset" /> <img src="Y" alt="Other" /></td>
<td><img src="16" alt="RR" /> <img src="90" alt="HR" /> <img src="127/88" alt="BP" /> <img src="98" alt="O₂ Sat" /></td>
<td><img src="Y" alt="Concern" /> <img src="Y" alt="Satisfactory" /> [Note]</td>
</tr>
<tr>
<td>2021-01-18</td>
<td><img src="Y" alt="Dyspnea" /> <img src="Y" alt="Cough" /> <img src="Y" alt="Fever" /> <img src="Y" alt="Loss of Taste/Smell" /> <img src="Y" alt="DI Upset" /> <img src="Y" alt="Other" /></td>
<td><img src="16" alt="RR" /> <img src="90" alt="HR" /> <img src="127/88" alt="BP" /> <img src="98" alt="O₂ Sat" /></td>
<td><img src="Y" alt="Concern" /> <img src="Y" alt="Satisfactory" /> [Note]</td>
</tr>
</tbody>
</table>

**Notes**

- [Dyspnea] Exertional dyspnea only
- [Dyspnea] CS only on exertion - is limiting exertion and monitoring with pulse ox to determine safe limits.

**Next Visit Date**

2021-01-18

- [ ] On Call Notified if Visit on Weekend

**Discharge Date**

### Other Areas of Assessment/Support

<table>
<thead>
<tr>
<th>Area</th>
<th>Concern?</th>
<th>Notes</th>
<th>Referral?</th>
<th>Referral Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td></td>
<td>Previous periods with anxiety but feeling OK - very grateful to know we will call RN for follow-up.</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Access to Food</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Access to Caregiver(s)</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Access to Needed Supports</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Financial Health</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

### Patient Advice/Education Checklist


- [ ] 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.rogers.ca/r/res/upload/documents/SADMAN-Rx.pdf])
- [ ] N/A OR Notes: Note
- [ ] Management of comorbidities discussed: 2DM: will monitor sugars four times daily

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

N/A
Outpatient Therapeutic Management of Adults with SARS-CoV2 Infection

Ullanda Niel, MD, CCFP
Family Physician, Scarborough Centre for Healthy Communities
Adjunct Lecturer DCFM University of Toronto
Member: Ontario Science Table Drugs & Biologics Clinical Practice Guidelines Working Group
This guidance applies to mildly ill patients in any setting, including the community, hospital (including nosocomial cases), and congregative 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

<table>
<thead>
<tr>
<th>Tier</th>
<th>RISK OF SEVERE DISEASE</th>
<th>MODERATE RISK</th>
<th>LOWER RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>Sotrovimab: 500 mg IV x 1 dose is recommended for these patients if they present within 7 days of symptom onset. Sotrovimab is not recommended for patients with moderate risk of progression to severe disease.</td>
<td>Fluronaivirine 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 SARS-CoV-2 cases due to the Omicron variant.</td>
<td>Reassurance and information for self-monitoring of symptoms (including self-monitoring of oxygen saturation) are recommended.</td>
</tr>
<tr>
<td>Tier 2</td>
<td>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:</td>
<td>Budesonide 800 mg inhalex 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 a reasonable safety profile during an anticipated spike in SARS-CoV-2 cases due to the Omicron variant.</td>
<td>Fluoronevirine is not recommended.</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Sotrovimab is not recommended for these patients. This recommendation is based on current limited supply of sotrovimab, and prioritizing its administration in patients at highest risk of progressing to severe disease.</td>
<td>Budesonide 800 mg inhalex daily for 14 days may be considered for these patients. See budesonide recommendation statement for higher risk mildly ill patients.</td>
<td>Budesonide is not recommended.</td>
</tr>
</tbody>
</table>

#### Notes

1. Framed of immunity: exposed or immunocompromised individuals include individuals with active treatment for solid tumor and hematologic malignancies, receipt of solid organ transplant and/or living related donor transplant, and/or living related organ transplant, and/or living related blood donor (2000-2021), and/or any individual who has received a blood product for any reason. Risks from immunosuppressive therapy and potential antiviral interactions are considered in the following statements.
2. Fluronaivirine is used in the treatment of SARS-CoV-2-infected patients who have been identified as having high-risk factors for severe disease.
3. Budesonide is not recommended for mild to moderate COVID-19 in patients with high-risk factors for severe disease.
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.

**Ontario COVID-19 Drugs and Biological Clinical Practice Guidelines Working Group: Therapeutic Management of Adult Patients with COVID-19 (DRAFT)**

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?

U. Niel. OCFP, Jan 7, 2022
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
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.

U. Niel. OCFP, Jan 7, 2022
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
CASE:
Although the patient has a risk factor (diabetes) she does not qualify for Sotrovimab at this time as she is <70 y/o. Also, she did not receive her booster but she has received at least one dose of vaccine.

Are there other medications can you offer?
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

U. Niel. OCFP, Jan 7, 2022
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.

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 (218 years of age) with Mild COVID-191,2

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

<table>
<thead>
<tr>
<th>Drug</th>
<th>Criteria</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sotrovimab</td>
<td>500mg IV x 1 dose over 30 min</td>
<td>Previous SARS-CoV2 infection and vaccination status do not need to be considered. Serological testing for IgG antibody does not need to be done.</td>
</tr>
<tr>
<td>Monitor &gt; 60 min after infusion</td>
<td>High risk patients: a) &gt;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</td>
<td>At this time, regional infusion sites are being established. More information will be circulated as it becomes available.</td>
</tr>
<tr>
<td>Monitor &gt; 60 min after infusion</td>
<td>Risk Factors include: Obesity (BMI ≥30), diabetes or stage 5 kidney disease (eGFR &lt;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</td>
<td>Hamilton has an operational infusion site. A direct physician referral can be made here if a patient is outside of the catchment area.</td>
</tr>
</tbody>
</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
- Antiaggregation
- 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

<table>
<thead>
<tr>
<th>Drug</th>
<th>Criteria</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sotrovimab</td>
<td>500mg IV x 1 dose over 30 min</td>
<td>Previous SARS-CoV2 infection and vaccination status do not need to be considered. Serological testing for IgG antibody does not need to be done.</td>
</tr>
<tr>
<td>Monitor &gt; 60 min after infusion</td>
<td>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)</td>
<td>See comments above for information on infusion sites.</td>
</tr>
<tr>
<td>Budesonide (Pulmicort®) 800mcg inhaled BID x 14 days</td>
<td>For mildly ill patients presenting within 7 days of symptom onset who meet the high risk patient criteria under sotrovimab above.</td>
<td>See next page for relevant clinical trial data on budesonide in non-hospitalized patients. Cost (based on Ontario Drug Benefit pricing): Pulmicort Turbuhaler 400mcg x 200 doses = $100.28; 200mcg x 200 doses = $68.70 Note: The 100mcg strength does not provide enough doses for the full 14-day treatment course.</td>
</tr>
<tr>
<td>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</td>
<td>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-193 cases due to Omicron.</td>
<td>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 trial but permitted in the STOP-COVID trial if the doses were low. Common side effects: Sedation, headache, insomnia, diarrhea, dry mouth. 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: Bupropion, amitriptyline, citalopram, clomipramine, clonazepam, hydroxyzine, olanzapine, methadone, phenytoin, prazosin, warfarin, verapamil. Cost (based on Ontario Drug Benefit pricing): Generic fluvoxamine 50mg tab = $0.21; 100mg tab = $0.38</td>
</tr>
</tbody>
</table>

Note: The above titration is based on the STOP-COVID3 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.

Disclaimer: The information in this document is based on the available information at the time of preparation. Please consult the latest guidelines update from the Ontario Science Table where relevant.

Updated Jan 6, 2023. Prepared by: Brinnia Chung, RPh, Reviewed by: David Chang, RPh, Sharan Lall, RPh, Elizabeth Leung, RPh and Kees Hg, RPh., St. Michael’s Hospital – Unity Health Toronto

Casirivimab + imdevimab

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

U. Niel. OCFP, Jan 7, 2022
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
Public Health Measures and Guidance in Response to Omicron

Provincial Preparedness and Pandemic Response WG
January 4, 2022
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

<table>
<thead>
<tr>
<th>Testing</th>
<th>Current</th>
<th>New Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatic individuals. High risk close contacts of confirmed cases regardless of symptoms.</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Current</th>
<th>New Guidance</th>
</tr>
</thead>
</table>
| * PCR +ve | • PCR +ve  
  • RAT +ve (do not require confirmatory PCR test)  
  • Symptoms consistent with COVID are presumed positive |

<table>
<thead>
<tr>
<th>Isolation requirement (non high-risk settings)</th>
<th>Current</th>
<th>New Guidance</th>
</tr>
</thead>
</table>
| • 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. |

<table>
<thead>
<tr>
<th>Vulnerable populations (e.g., LTCH/RH residents, hospitalized patients, and workers in these settings)</th>
<th>Current</th>
<th>New Guidance</th>
</tr>
</thead>
</table>
| • 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.
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

Yes

• Sore throat
• Muscle aches/joint pain
• GI Symptoms (i.e. vomiting or diarrhea)

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:
  o 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
  o 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.

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.

*Highest risk settings/individuals include hospitals, Long-Term Care, retirement homes, congregate living settings, and health care workers providing care to immunocompromised people.
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*

Have you had at least 2 doses of a COVID-19 vaccine?
- Yes
  - Does the COVID-19 positive person live with you?
    - No
      - No
        - No
          - Yes
            - 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.
    - Yes
      - 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.
  - No
    - Do you have any symptoms of COVID-19?
      - No
        - Yes
          - 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.
      - Yes
        - 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?

Have you had at least 2 doses of a COVID-19 vaccine?

Yes

Does the COVID-19 positive person live with you?

No

Do you have any symptoms of COVID-19?

No

- **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.

Yes

- **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.
- If you develop symptoms, get tested and follow the guidance for cases.

No

- **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:
  o 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.
  o Rapid Antigen Tests
  o 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.


- Clinical pathways, EMR templates and CoP are available supports
COVID@Home: Resources

- **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)
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.**