



Changing the Way We Work

October 22, 2021: Testing for COVID-19 and “last mile” vaccination

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

[Post-session updates are also noted.]

BREAKTHROUGHS | BOOSTERS | THIRD DOSES

- **It appears the cases of vaccinated in ICU is rising at a much more rapid rate than I would expect. Is there any information regarding those demographics? Are they patients whose immunizations are 8–9 months old (like many of ours), those over a certain age etc.?**

If you take the data from <https://data.ontario.ca/> and then age standardized the data – there are very few vaccinated patients in the ICU. Unvaccinated people have a 7-fold higher risk of symptomatic COVID-19 disease, a 17-fold higher risk of being in the hospital and 23-fold higher risk of being in the ICU compared to the fully vaccinated.

- **Do you have the demographics for those vaccinated ending up in ICU? I have not been able to tease out that data.**

Ontario data is being teased out – numbers are overall still low for making significant correlation. Data from Israel is showing a trend to age over 65, and 6+ months post second dose.

- **When do we start booster dose? Any expected time?**

Boosters have started for certain groups [MOH guidance]:

https://health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/vaccine/COVID-19_vaccine_third_dose_recommendations.pdf

[**UPDATES** – On November 3, the ministry announced expanded eligibility for boosters, to be offered to everyone aged 12 and older, with those 70+ starting this week.

– See also latest NACI recommendations, released October 29:

<https://www.canada.ca/content/dam/phac-aspc/documents/services/immunization/national-advisory-committee-on-immunization-naci/recommendations-use-covid-19-vaccines/statement-guidance-booster-doses/summary/summary.pdf>

NACI recommends offering **booster doses** to people 70, older, adults living in congregate settings, and the following groups who received their second dose in a series at least six months earlier:

- people who received two doses of the AstraZeneca Vaxzevria/COVISHIELD vaccine or one dose of the Janssen vaccine;
- adults in or from First Nations, Inuit and Métis communities;

- and adults who are frontline healthcare workers who have direct in-person contact with patients and who were vaccinated with a very short interval [21 to 28 days between doses].

A **third dose** is recommended for those who are moderately to severely immunocompromised, as part of a complete series.

– On November 3, the ministry announced that boosters will be offered to everyone aged 12 and older, with those 70+ eligible starting this week: <https://www.cbc.ca/news/canada/toronto/covid-19-ontario-november-3-2021-booster-shots-details-1.6235235>]

- **When are we going to be eligible for the booster dose?**

[**UPDATES** – On November 3, the ministry announced expanded eligibility for boosters, to be offered to everyone aged 12 and older, with those 70+ starting this week.]

– See more details in answer to previous question and NACI recommendations released October 29: <https://www.canada.ca/content/dam/phac-aspc/documents/services/immunization/national-advisory-committee-on-immunization-naci/recommendations-use-covid-19-vaccines/statement-guidance-booster-doses/summary/summary.pdf>

- **I would presume that individuals who were on an immunosuppressant at time of COVID vaccine doses 1&2 would qualify them for a third dose had they remained on it and would also qualify if the immunosuppressant had been discontinued and are not on an immunosuppressant at this time. Are you able to confirm this?**

Active treatment is defined as those who have completed treatment within 3 months. See page 3 of the MOH guidance:

https://health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/vaccine/COVID-19_vaccine_third_dose_recommendations.pdf

- **Re 3rd doses – can you clarify if the Pfizer dose is same dosage while Moderna is half the dose; if someone has received two of one brand, can they still get a 3rd booster of the other brand?**

Pfizer dosage is the same as for doses 1 and 2.

[Third/booster dose does not have to be the same mRNA brand. Moderna dosage: full dose (100 mcg) for adults living in long-term care homes for seniors or other congregate living settings that provide care for seniors and adults 70 years of age and older. A half dose (50 mcg) should be used for other adults recommended to receive a booster dose.]

VACCINES | VACCINATING

- **Should children turning 12 in 2022 wait for the pediatric dosage if it is not available to them before January?**

We are all waiting for the Health Canada and NACI approval on the efficacy, safety of the smaller dose (10ug) of Pfizer for those 5–11 (and turning 12). That will be key to help in decision-making, hopefully we have the answer soon.

- **Is there a place for parents to call that have concerns about the ages 5-11 vaccination initiative? We are hearing from our clinical team that will be a huge demand.**

One resource is the VaxFacts Clinic: www.shn.ca/vaxfacts. See below in the following Q&A for more information. SickKids has a vaccine consult service: <https://www.sickkids.ca/en/care-services/support-services/covid-19-vaccine-consult/>

- **Does a visit to the VaxFacts clinic affect outside use in FHO models?**

No, it does not! [The VaxFacts Clinic offers individual 20-minute calls with a doctor to answer your questions about COVID-19 vaccines: <https://www.shn.ca/vaxfacts/>]

- **Please comment on administration of COVID vaccine with other vaccines. NACI guidance provides flexibility, but is this practice advisable? Thinking about separating vaccines to better identify AE. Particularly re: flu + COVID vaccines.**

The reason for the separation between vaccine administration was based on desire to be able to understand adverse effects and not for concerns about efficacy of the vaccine. We do administer other vaccines together so have experience with this. In the U.S. they have had co-administration for a longer period of time and no signals have been raised about efficacy. So, no worries to give at the same time. The hope, of course, is that vaccination rates can continue to go up with this allowance for coadministration.

- **What about COVID vaccination + Shingrix? I saw a recommendation to separate, but no indication of why or by how much time.**

Shingrix is an inactivated vaccine so the interval between it and other vaccines is not an issue.

- **For vaccine reaction, are there clinics where we can refer patient? I use the e-Consult group for questions but sometimes the answer is needed to refer to allergy/immunology. So where to send and would pt. be assessed in a reasonable time**

One way to find your local allergist is on the Ocean Health Map. Some are available for e-consult referral if you are set up.

[**Ontario eConsult – Allergy advice for COVID-19 vaccine:** <https://econsultontario.ca/allergy-advice-for-covid-19-vaccine-is-now-available-on-the-ontario-econsult-service/>]

- **How long after someone is ill with COVID can they be safely vaccinated? I have a patient who got quite ill getting vaccinated a couple of weeks after recovering from COVID?**

[People who are sick should wait until they have recovered from acute illness and are no longer in isolation as directed by Public Health.]

TESTING: PCR | RAPID ANTIGEN

- **In a vaccinated patient, is there a preferred test in my office for symptomatic patients?**

Symptomatic patients require PCR testing. [See **MOH guidance**, page 5: https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_testing_guidance.pdf]

- **High-risk exposure who tests PCR negative in days 1–4 post exposure – when should the test be repeated?**

Public Health in Ottawa told us that someone with high-risk exposure should re-test 7 days later. [Toronto Public Health (<https://www.toronto.ca/home/covid-19/covid-19-what-you-should-do/covid-19-what-you-should-do/>)]

[19-what-to-do-if-you-are-a-close-contact/](#)) is consistent: "Go for a second test at least 7 days after you last had close contact with the person with COVID-19 (this is Day 7 of your 10 day isolation/monitoring period). If your first test was 7 or more days after your most recent contact, you do not need to test a second time, unless you develop symptoms." Check with local Public Health for the recommendation in your area.]

- **The window for better sensitivities is at the beginning of symptoms. However, most of the patients who need to be admitted present to hospital about 1–2 weeks after the onset of symptoms. Any studies done on the sensitivity of the test at presentation for admitted patients, because classic COVID patients are having their isolation lifted based on a negative PCR test.**

PCR testing, which is used for admitted patients, is still highly sensitive – over 95 per cent – at the two-week mark post onset of symptoms. In wave 1, isolation was being lifted based on negative PCR test. This should no longer be the practice in hospitals whether for classic COVID or variant COVID. Whether at the two-week mark a positive PCR test reflects infectiousness is not well studied in a hospital setting with admitted patients, as essentially all patients are placed in isolation and common practice is to lift isolation based on admission date, not the actual symptom onset date.

- **How long do we expect a negative PCR test result, or a patient can be retested after a previous positive PCR test? Is it still 90 days?**

Guidance for repeated PCR testing in individuals previously positive for COVID-19:

<https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/guidance-documents/repeated-pcr-testing-individuals-previously-positive-covid-19.html>

[MOH guidance for re-testing after clearance: “An asymptomatic individual that previously had laboratory-confirmed COVID-19 AND was cleared, may **resume asymptomatic surveillance testing after 90 days from their COVID-19 infection** (based on the date of their positive result)”]

- **If we wanted to set up a school swab pick up program for our region, who would we contact/is there a guidance document for setting this up? We spoke with our local school board, and they had never heard of this but were open to it.**

I'd reach out to your Public Health or the organization [ie: hospital/OHT] running the local community assessment centre. [Ideally, they will be able to provide the kits, and may also] allow the kits to be dropped off by parents at that assessment centre.

[**UPDATE:** Starting November 15, the Government of Ontario is making take-home test kits available at all publicly funded schools, with the ability to drop off completed kits at assessment centres or select pharmacies: <https://news.ontario.ca/en/release/1001065/government-takes-further-action-to-protect-schools>]

- **What about using rapid antigen tests in people who have symptoms with a low pre-test's probability of COVID? So "low level" symptoms (runny nose) in a vaccinated person? So, the kid or HCW can go to work?**

The yield would be low with rapid antigen tests in this scenario, especially in a vaccinated person who may not have a high enough viral load and with more viruses circulating this season. The child or HCW would still not be able to go to work if they have acute onset of any symptoms until improving for 24 hours. A lab-based test would be needed if symptoms change/worsen. To detect infectious cases early, a positive test in this scenario would be informative, but with a low pre-test probability would need to be confirmed by lab-based testing.

- **I'm still confused about what to do with minor symptoms, i.e., runny nose or sore throat. Everyone gets PCR? Nothing? ID Now tests?**

Even one minor symptom, especially in kids has been shown to correlate with active infection if no other potential cause and persists. PCR test is most sensitive, but if ID NOW is available and more accessible, that can also be used. School guidance in some districts have advised to monitor 'one' minor symptom and test if no improvement or additional symptoms come up.

- **As a follow-up to the question regarding an initially asymptomatic contact who tested negative on early PCR but later develops symptoms on day 7–10, is the date of reference for 10-day isolate period based on symptom onset (hence extended for another 10 days) or from time of last exposure/contact to index case (assuming the household contacts are isolating from each other)?**

This would be based on the day of symptom onset.

- **Follow up to my question about rapid antigen tests – instead of using it at a population level when the pre-test probability is low (because case counts are currently low) and then the false positive rate will be higher, why not use it targeted in our offices for those with "low level" symptoms? Why can businesses and governments get RAT, but primary care cannot??**

We can get RAT. I posted the link in the Q&A.

[Order swab kits through [Ontario Health Digital Health Services: https://ehealthontario.on.ca/en/health-care-professionals/ppe-intake?a=ppe-intake](https://ehealthontario.on.ca/en/health-care-professionals/ppe-intake?a=ppe-intake)

- **How can we order PCR and rapid antigen test kits?**

Provincial stockpile, same place as for PPE: <https://ehealthontario.on.ca/en/health-care-professionals/ppe-intake>

- **Can we use the rapid test kits given to us through Ontario Health to screen our asymptomatic patients/kids? I thought it's only for the staff.**

The rapid test kits from the government are for workers in high-risk communities/organizations (and not intended to test patrons/patients/customers).

- **Do positive rapid tests done in pharmacies get reported to [Public Health] and the family doctor?**

No. [Use rapid antigen tests (RAT) for asymptomatic individuals with no known exposure. A positive RAT result must be confirmed with a molecular test. See [slide 2 of this flowchart](#) and [MOH guidance, Appendix 9](#)]

- **Our private labs in community will only do NP swabs. I've reached out to advocate for accepting other swabs (especially for children). It was an absolute "no, we cannot do that". Very disappointing. How can we move this forward?**

You could try to connect directly with the Public Health lab directly for this.

<https://www.health.gov.on.ca/en/common/system/services/phl/>

- **LifeLabs is offering a swab for COVID 19 + other respiratory viruses (including influenza a/ b etc.). Can this be done in community? In past years testing for influenza from the community was not indicated.**

Testing for other respiratory viruses is available through the province but limited to testing kids in ED, and hospitalized patients and others in congregate settings.

- **Are CT counts routinely being reported with COVID test results?**

Not all labs report the CT values. Some report "low", "high" based on pre-determined parameters on their reports. All labs will give verbal results if a clinician inquires

SEROLOGY/ANTIBODY TESTING

- **I assume that a negative serology [test result] post vaccination does not indicate a lack of protection.**

There is no role for serology testing post vaccination.

- **When do you use serological tests?**

Currently, only for specific clinical situations: multisystem inflammatory syndrome, severe illness who have tested negative by PCR, not for screening/diagnosis of acute infection, immune status or vaccine status. More here, see page 3:

https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_testing_guidance.pdf

- **When I explain to patients that serology does not correlate with immunity, it seems to “fuel the fire” for people who believe we have a poor handle on the science. Is there another example of an infectious disease where this is possible?**

Absolutely – Mumps serology is a classic example of this.

- **What do we tell patients who are insisting on getting antibody testing? It's getting difficult to keep arguing with patients. Any pearls of advice for us?**

I'll give them the requisition, but explain that it is NOT instead of getting a vaccine or doing all the other things to be safe.

- **My 40-year-old patient has positive antibodies to COVID, post COVID infection at end of April. She still has occasional dizziness and fatigue and headache since the infection that limits her job as fitness instructor – where she has to rest before continuing with exercise again. Will she need vaccination and if so, when will she be able to get COVID vaccination?**

Everyone – even if they had COVID – should be immunized.

PPE | INFECTION CONTROL

- **What is the current Public Health advice re doing active screening of all patients at the door? Is this still recommended?**

Yes. Active screening is still required as per the CMOH guidance this week.

[**Updated guidance**, Oct. 19:

https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_primary_care_guidance.pdf]

- **Can you comment on patients who refuse/reluctant to wear facemask & only drape bandana over face? What is adequate protection to us/staff/vulnerable patients in letting those people in the door?**

If they don't have a proper mask, we give them a medical mask and require that they wear it – they've always happily done so.

- **Apparently, we are supposed to provide [patients without masks] with medical grade masks, at our expense. Frankly, if hospitals insist that those entering put on medical grade masks, and if an individual refuses to mask appropriately to enter our office, should we not be able to refuse to allow them to enter?**

[The ministry PPE stockpile is not available to patients and so the cost for PPE for a patient where required does fall to the individual physician. The question of the burden of this added cost to the provider has been raised and per the MOH (as noted in this [CPSO FAQ](#)), was deemed to fall within the insured services we provide.]

- **Has the IPAC guidelines changed regarding office room cleaning after each patient?**

If screen negative, you can return to “standard cleaning process” as in what was normally done pre-pandemic. For screen +vs clean patient-contact surfaces after the patient.

[OCFP summary of PPE and Infection Control requirements for in-person visits:

<https://www.ontariofamilyphysicians.ca/tools-resources/timely-trending/novel-coronavirus-2019-ncov/ocfp-ppe-for-hpc-visual-june-2020.pdf>]

- **Last time I tried, Government was still refusing to send us fitted N95 masks as they claimed family doctors were not high enough risk. Are you saying that has changed?**

You can request a fitted N95 if you can say what size and that you've been fitted for it.

[Note that N95 masks (<https://ehealthontario.on.ca/en/health-care-professionals/ppe-intake>) are available through the pandemic stockpile for use by healthcare workers in conducting aerosol-generating medical procedures.]

These additional questions were answered live during the session. To view responses, please refer to the [session recording](#).

- Can rapid COVID tests replace NP swabs when any symptoms of covid? People are frustrated with time to an appt for COVID swab in CACs and turn around time- esp. when more places are working in person now. How do I best advise patients?
- Is there any new data regarding the difference in rate of transmission when vaccinated patients are infected vs non vaccinated patients? What about those vaccinated who are vaccinated but asymptomatic who would not normally go for testing?

- Cost of tests? Length of time for results?
- If a patient has URTI and tests negative for COVID (using a PCR swab) - how certain are we that they do not have COVID? is it safe to assess them in our clinics presuming, we see the neg test?
- In a symptomatic patient with a negative PCR test early on in their symptoms should we be repeating testing if their symptoms persist in the 7–10-day range (in case they were false negative)?