COVID-19
Community of Practice for
Ontario Family Physicians

Family & Community Medicine
UNIVERSITY OF TORONTO

Ontario College of
Family Physicians

Changing the Way We Work

December 17, 2021

The latest on Omicron and what it means for you and your practice

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Co-hosts: Dr. Liz Muggah, Dr. David Kaplan | Moderator: Dr. Tara Kiran

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

[Post-session updates are noted]

PPE | IPAC

- **The acknowledgement of airborne transmission being a major, if not the main mode of transmission, has been frustratingly slow and quiet. Supply of medical grade masks is no longer an issue, but we are still seeing the general public wearing cloth masks. Given the interim guidelines by PHO released recently for the use of N95 masks for suspected COVID patients, should we not be using N95 masks for all patients given the exponential rise of asymptomatic transmission of Omicron?**

Obviously, ensure an adequate supply of well-fitting masks, including KN95 or N95. The recent update from MOH reconfirms the use of N95 where COVID is suspected or confirmed. Use your judgement to determine if N95/KN95 are necessary for other in-person encounters.
Note: KN95 do not require fit-testing and widely available for sale and therefore may be a good option for many of us in the community.

- **What mask should we wear when working in the vaccine clinics?**
- The recent guidance now is N95s should be used with any patient who has respiratory symptoms or confirmed/suspected to have COVID-19. Suspected would be a contact of a case specifically. So, my read is that medical masks at a vaccine clinic where patients are not symptomatic would suffice. **What types of masks should we be having pts in our offices wear?**

Medical grade masks or KN95 masks if they have them.

- **Should all physicians be wearing N95 masks these days, or is it about a proper fitting medical/surgical mask? There seems to be a lot of confusion about this.**

Ensure an adequate supply of well-fitting masks, including KN95 or N95. The recent update from MOH reconfirms the use of N95 where COVID is suspected or confirmed. Use your judgement to determine if N95/KN95 are necessary for other in-person encounters.

Note: KN95 do not require fit-testing and widely available for sale and therefore may be a good option for many of us in the community.

- **I presume we should all be wearing N95 especially in small exam rooms. given suppliers are out of stock, will the govt now approve release of some to us? they have refused in past claiming family doctors were not "high enough risk". (I presume that means we are expendable)**

Updated guidance is for use of n95 /kn95 where COVID is known or suspected ad use your judgement to make the point of care risk assessment for those patients, it is not indicated for all direct patient care

Note: the provincial stockpile of N95 masks are now available for use by family physicians given the updated guidance from the ministry on masking. (LINK)

- **Some colleagues are suggesting putting a HEPA filter into each and every exam room. Is there any rational reason to do so, if we continue to mask, wear eye protection, symptom screen? Please quote any evidence for and against. I don't want to "knee jerk" respond. I want to be rational not emotional in my response.**

I think it depends on the age of the office. Newer offices have better ventilation and some actually have outside air mixed in. HEPA filters in waiting rooms and staff rooms make sense. In smaller, older office it would cost ~1200 dollars to put HEPA filters in 4 exam rooms. It is definitely an office-by-office issue. Newer offices have better ventilation. Contact your building management and consider spending on HEPA filters if appropriate. [see response to the following question for reference.]

- **Should I have a HEPA filter in my examine room & how do I choose one?**

You could consider use of a HEPA filter as a part of "layering" of IPAC/PPE measures – here is a good guide form Mask4Canada about how to assess if extra ventilation/filtration is useful and how to find a HEPA filter. https://docs.google.com/document/d/17tKk8Da8tnchtnp9ZRe7fPazGAmXtvoA-n4GZcY0_fQ/edit?fbclid=IwAR1MqKcICB044P-uxxxZKtwkR1xs_b_ZCCQvdapz9uw6vRiKS5x_3QgeUaw

TESTING

- **Is there any benefit is having people do rapid testing before holiday gatherings? Patients are asking if this would be helpful.**

Small gatherings with RAT testing are safest. RATs are available free at LCBO locations and have been sent home with kids at school.
? Link to the provincial RAT holiday blitz site https://news.ontario.ca/en/release/1001353/ontario-launching-holiday-pop-up-testing-blitz

- **Could an mRNA booster dose in the a.m. cause a falsely positive rapid antigen test in the p.m.?**

No.

- **Can you make recommendations for rapid antigen tests that are currently available to the general public for purchase?**

All tests licensed in Canada have about the same performance characteristics.

- **Does a triple vaccinated asymptomatic person who has contact with someone COVID + need to test? Rapid antigen test is enough?**

Yes, if high-risk contact. RATs are good, but PCR better.

- **LCBO is giving free rapid tests, but the line ups are incredible. This will be a super spreader event on its own. Where else can these be picked up by the general public?**

Eventually the plan is for it to be distributed more widely including at pop-up sites see here for provincial info on this "holiday testing" plan : https://news.ontario.ca/en/release/1001353/ontario-launching-holiday-pop-up-testing-blitz

- **When someone tests positive for COVID-19, are they told if it is Omicron when they check their result?**

No. It takes several days to get results [re Omicron] and different ways of testing. And by the time we can get it into OLIS, everything will be omicron.

- **How soon would an asymptomatic person tested with rapid antigen test turn positive after a potential close contact?**

Minimum 2 days, median 4-5 days, upper 95% confidence 10 days, maximum 14 days

- **Any feasibility of providing the rapid antigen test kit one per household through the mailbox to avoid unnecessary line up and social distancing and chaos?**

I haven't heard about that plan, the only distribution to households is via the kits being given proactively to school-aged kids.

- **Any way Family Physicians can get the rapid testing kits distributed to our clinics or where can we access these?**

Order here through the province's provincial stockpile https://ehealthontario.on.ca/en/health-care-professionals/ppe-intake

- **So, are you indicating our staff (all triply vaccinated) should be tested with rapid tests? Daily? 2x per week? How do we access those tests?**

You can get the RATs through your usual channels or the [Provincial Pandemic] stockpile. Yes, this is suggested as case counts rise that in that "layering approach" that we include this as a tool to reduce transmission in office. [https://ehealthontario.on.ca/en/health-care-professionals/ppe-intake]

- **Why does a positive rapid test have to be confirmed with a PCR test?**

Because you can get false positives, and we don't want people isolated for 10 days if they don't have COVID.

VACCINES (including boosters) | VACCINATION

- **Is there any data to help us guide patients who are asking about which vaccine to receive as a booster?**

For >70, frail older adults, and severely immunocompromised adults there is some data that Moderna might be better - but difference is NOT enough to worry about Pfizer if that is what there is. For the rest of us, whatever vaccine you can get is just fine.

- **Those 18-29 who have had Moderna as the initial 2 doses, should they get Pfizer this time because of lower risk of myocarditis?**

For those aged 18-24, Pfizer is recommended:
https://news.ontario.ca/en/statement/1000907/ontario-recommends-the-use-of-pfizer-biontech-COVID-19-vaccine-for-individuals-aged-18-24-years-old

- **What is the research showing on the effectiveness of 3 doses vs 2 doses in Canada (not in South Africa, where HIV immunity may be playing a role)?**

No data on Canada yet. U.K. data says post dose 2, VE [vaccine effectiveness] against any disease (including mild) 0-40% (still wide CI), post dose 3, 50-80%.

- **Is third dose recommended in someone with 2 vaccines and then had COVID mild infection?**

Yes. you don't always get a great response after COVID when you have mild disease, and getting a booster is safer.

- **Is there any thought of giving children the vaccine if they are just under 5 years old, e.g., turning 5 in Feb. or Mar. 2022?**

Yes, people are thinking about it. Decision not made yet.

- **Can we know about efficacy of Moderna and Pfizer against Omicron after 3rd dose received? How about kids will they be protected against omicron with two doses? Is there any comparison of efficacy of Moderna vs Pfizer against Omicron?**

Two estimates from the UK available post dose 3 – one from UK Health Security 78% against any infection – expecting update today, and one from Imperial College yesterday – 50-80%. We are expecting that protection against severe disease will be higher, but we won't have data for another 2-3 weeks. Moderna will be same.

- **What was the final consensus regarding safety/risks of getting mRNA COVID vaccines during the first trimester of pregnancy? Can patients be reassured, especially now with urgency to get 3rd boosters?**

SOGC statement from November 2021 states the vaccine is recommended in any trimester and while breastfeeding:
https://sogc.org/common/Uploaded%20files/Latest%20News/SOGC_Statement_COVID-19_Vaccination_in_Pregnancy.pdf

- **For those taking immunosuppressive meds and who received 3 COVID vaccine doses for the initial series, when should they get their booster dose?**

Minimum 84 days [Ministry guidance here, see page 7:
https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/vaccine/COVID-19_vaccine_third_dose_recommendations.pdf.]

Moderately to severely immunocompromised individuals who are eligible for a three-dose primary series may receive a booster dose (i.e. 4th dose) ≥6 months (168 days) after completion of the extended primary series

- **What is the time interval from dose 1 and dose 2 of COVID vaccine now?**

[Recommended interval between first and second doses is eight weeks: https://COVID-19.ontario.ca/getting-COVID-19-vaccine]

- **You mentioned three months after second dose. What about us physicians who are coming up to three months after the 'booster'. Should we be getting a 4th vaccine? We are dealing with sick patients daily and we are tired, and I am sure immunity is lower because of this.**

Right now, there is no guidance on 4th doses for HCW or others at high risk, but we do need keep close watch on immunity and what happens over time post 3rd dose. We need to reallypush now for those who haven't yet had 3rd dose with a focus on highest risk/most vulnerable.

- **I am working at a large vaccination clinic. I am pushing to have clients leave soon after vaccination and not waiting 15 minutes. With the numbers we are pushing through, I don't like the idea of having 50-60 people waiting together at the same time. I think risk of [nosocomial] infection in waiting area greatly exceeds risk of anaphylaxis. This would hold only for 3rd dose clients. I would be interested in panel's thoughts.**

The U.K. has just changed its recommendation. NACI is considering.

- **Is there any specific guidance about boosters for near term pregnant patients?**

They should be offered boosters.

- **How soon after dose 3 are you protected? 1 week or 2 weeks?**

14 days for full immunity

- **As we are accelerating COVID booster vaccination, does it matter if patients very recently have had other vaccinations? Specifically, Shingrix 3 days ago? Any other interval concerns with other vaccines?**

No reason to worry about other vaccines. No restrictions on concomitant vaccination.

CONTACT | CASE MANAGEMENT

- **Should we isolate the contact of COVID positive Omicron patient if the contact is tested negative two days after contact?**

Contacts of COVID+ Omicron patients without adequate PPE (regardless of vaccine status) need to isolate for 10 days as per the guidance.

- **The province recommends that any close contact of a positive Omicron case self isolate for 10 days regardless of vaccination status. Will this be changed for HCWs? Given the spread of Omicron, we may run out of HCWs to work!**

The province will have to assess if a test to go to work plan should be in place or if +COVID HCWs can look after COVID+ patients. We have to plan for a policy in short order.

- **For isolation and Omicron exposure – will triple-vaccinated individuals like HCW also be required to isolate?**

Yes – HCW, regardless of vaccination status, need to isolate if they have had a household contact with a confirmed case. For other contacts that aren't household, you don't need to isolate so long as asymptomatic.

COVID CARE IN THE COMMUNITY

- **I have several patients (double vaccinated) who have COVID now and having SOB lying flat which makes me worry about pericarditis—oxygen sats are all normal even with exercise—any direction you can give me on triggers to send to ER given young healthy no other issues?**

Here is the clinical guidance from COVID at Home - https://hfam.ca/clinical-pathways-and-evidence/COVID-at-home-monitoring-for-primary-care/

- **Is there any information emerging about Omicron and the likelihood and intensity of long COVID? I am worried about the impact on people and the health system if long COVID is associated with Omicron and we know that the numbers are going to be very high.**

No data yet. Too early.

- **Can you comment on the rates of reinfection after previously having COVID? What is the risk for these patients/how long the natural immunity lasts?**

We just don't know. Sometimes third doses provide long-term protection, but not always. We just need to wait to see.

BALANCING DEMANDS

- **Primary care being asked to "step up" again to help with the vaccine effort over the next 10-14 days. What advice can you give those of us in leadership positions who are dealing with tired, overworked colleagues who are looking for a break over the holidays. If we push too hard, it may create resentment.**

We need to ensure we "secure our ship" and that means keeping ourselves and staff safe (from COVID) and also with enough rest and recovery time. I think open discussions about capacity and balancing the most essential activities we do in our offices is critical. I would also encourage were possible looking for possible partnerships with your clinic and others perhaps via your local OHT or regional contacts to share the load/resources.

- **Should we be restricting in-person visits again to only absolutely necessary exams? So, for example, hold off doing paps?**

Everyone will need to make their own decisions on what can be delayed as you know your patient needs best, but yes non-essential care could be deferred or delayed if you are attending to other critical services (urgent care/new conditions/keeping patients out of hospital/ED).

- **I don't understand why family physicians are being asked to reduce access to care to vaccinate – something that can be done by other health care professionals. I doubt our patients think the care we provide is "non-essential"**

It's a very short-term request – next 2-4 weeks. A highly unusual situation; if you can support then do, if you can't then that is ok – your work in office to encourage your own patients to be vaccinated is so important.

- **Will Ontario Health be putting out clear messaging to Ontario patients about the pivoting away from non-routine care that Ontario physicians are being asked to do?**

We have OH assurance about this pivot in the short term, but not sure if they are going to put out something formal.

- **Should we be returning to mostly virtual care other than "essential" visits?**

Yes. [ADDITION: With the Omicron situation evolving at rapid speed, this decision will evolve and depend on clinical judgement. See the following Q&A for another opinion on this issue.]

- **Should we go mostly virtual again?**

No, we don't need to go mostly virtual - I think there will be a shift for some cases to virtual makes sense (i.e., vulnerable coming in for noncritical care for example) but we do need to keep providing in person care.

OTHER

- **Patients are asking about travel within Canada and family gatherings over the holidays - what is your advice?**

People need to decide what is absolutely essential. If it isn't absolutely essential, don't do it.

- **Are children included in the statistics that are sent to us daily on new cases, ICU admissions, etc.?**

Yes.

- **We've received calls from family members asking our advice re: family gatherings, when not all are vaccinated. What would your recommendations be this holiday season?**

Small gatherings with vaccinated fully (where possible), consider rapid tests.

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

- Will kids age 12-17 be offered a booster

- Any changes on recommendations on when our patients should be tested if asymptomatic and exposed to COVID positive person, now they Omicron is the likely source? I.e., what is the timeframe of exposure to infection and when test is likely to be accurate with this variant?
- Why are boosters not being recommended for 12–17-year-olds? They attend school and that seems like a huge risk for high case numbers in schools that could be mitigated by third doses in this age group
- What interval is being advised between doses 1 and 2 r vaccination of children?
- The Globe had an article today that is recommending decreasing interval duration for kids now to be less than 8 weeks. thoughts?
- I'm light of Omicron surge, do you recommend children 5-11 get their second dose earlier than 8wks for max protection?
- If our goal now is immunity and children are the main vector of transmission here now, why are we not shortening the pediatric vaccine interval to the minimum 21 days?
- Just to clarify. All staff and docs in my office should have rapid testing 2 X per week? Assuming we can order enough RAT to cover this?