



## Changing the Way We Work

### January 21, 2022: Responding to the Omicron surge

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

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

#### CASE AND CONTACT MANAGEMENT | TESTING

- **Kids can return to school before five days if their cold symptoms are improving, and they have two negative RATs 24 hours apart. Does that then mean those parents can return to “highest risk settings” at that point as well, or does the 10-day isolation still apply?**

Individuals working in the highest risk settings should remain off work for 10 days, both as a case or a household contact, due to the risk to the vulnerable population being served. In times of critical staffing shortages, modified isolation can be considered, as described here –

[https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/early\\_return%20to\\_work.pdf](https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/early_return%20to_work.pdf)

- **If someone in a house has had COVID, then another member gets it a month later – does the original case have to quarantine again?**

[Yes, the original case would have to quarantine again since the new case is not part of the same household episode of COVID.]

- **Is it considered “safe” for those who have been fully vaccinated and have had Omicron to gather in person? I am assuming that those individuals are unlikely to get Omicron again in the short term. How long would it be considered low risk?**

Everything is relative. I'd say 30 days for now. [NOTE: Response reflects panelist’s opinion.]

- **Is there any increased accuracy with RAT if both throat and nasal swab done together?**

No published evidence on this, but there is an argument to be made based on where understand Omicron virus is more prevalent to add throat swabbing.

[UPDATE: As reported on Jan. 21, Nova Scotia Health recommends swabbing throat and nose based on its recent study: <https://www.cbc.ca/news/canada/nova-scotia/ns-combined-nose-throat-rapid-test-more-accurate-1.6322961>]

- **After someone has had COVID, for what period of time can we consider them somewhat immune (i.e. at work – not need to rapid test them twice a week?)**

I don't think clear guidelines yet, but 60 days is conservative, 90 days is likely what we will decide on.

- **How long does the RAT remain positive? If positive, is patient still infectious?**

If RAT is positive before day 10, then person is likely to be infectious. After day 10, unless the person is not recovering AND seriously immunocompromised, a positive RAT (which is very unlikely) is not meaningful. People are not infectious after 10 days.

## VACCINATION | THIRD/FOURTH DOSES

- **What is the data to support 4th dose boosters in the immunocompromised? I am having patients question if they really need this dose 3 months after their last. Can you also comment on the long-term vision/plan for the vaccines? I worry we are losing buy in as further boosters are suggested and that we don't have the HR to support further boosters.**

For individuals who are immunocompromised, 3 doses are necessary to complete their primary series. The 4th dose is a booster for someone who is immunocompromised, equivalent to the 3rd dose booster in other populations. NACI has guidance and a summary of the evidence here (<https://www.canada.ca/content/dam/phac-aspc/documents/services/immunization/national-advisory-committee-on-immunization-naci/guidance-booster-COVID-19-vaccine-doses/guidance-booster-COVID-19-vaccine-doses.pdf>) that strongly supports 4th doses in that group and the newest evidence around Omicron has further demonstrated the importance of the dose for immunocompromised individuals.

While hard to predict a long-term plan, most agree that COVID is moving to a flu-like endemicity and that yearly boosters are likely in the short term, similar to flu.

- **What evidence do we have for 4th doses in immunocompromised hosts and in the general public?**

[See preceding Q&A.] For the general population [who are not immunocompromised], data on 4th doses is very limited and 3 doses have been shown to be very effective at preventing severe disease from Omicron.

- **What is ideal timing for 4th shot for immunocompromised people?**

3 months (84 days) – see here for guidance from MOH  
[https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/vaccine/COVID-19\\_vaccine\\_third\\_dose\\_recommendations.pdf](https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/vaccine/COVID-19_vaccine_third_dose_recommendations.pdf)

- **Can you please clarify – does fully vaccinated now mean 3 doses of mRNA vaccine? I was not sure, based on latest guidelines.**

For the purposes of vaccine certification, most people with 2 doses are considered fully vaccinated. Ontario posts the definition of fully vaccinated here –

[https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/vaccine/COVID-19\\_fully\\_vaccinated\\_status\\_ontario.pdf](https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/vaccine/COVID-19_fully_vaccinated_status_ontario.pdf)

[NOTE: For individuals who are immunocompromised and people in certain populations, a complete vaccine series is three doses, and the fourth dose would be considered a booster – MOH guidance: Third Dose Recommendations:

[https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/vaccine/COVID-19\\_vaccine\\_third\\_dose\\_recommendations.pdf](https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/vaccine/COVID-19_vaccine_third_dose_recommendations.pdf)]

- **Is a 3rd dose still essential for those who were infected recently with Omicron? What benefit will that have in the short term?**

We don't know benefits definitively, but for prior VOCs, added doses were of benefit, and it is very likely that third doses will add protection – agree, may not in the short term (60 days) but after that.

- **How long does the 3rd booster last, especially for HCP/those over 65?**

It is too early to tell.

- **Optimal timing for a vaccine after having COVID?**

Technically, any time after you are recovered and out of isolation; however for efficacy, it's best to do between 4-8 weeks after COVID infection.

- **I have had several calls from parents of kids who are now 4, turning 5 later this year, asking about getting their kids vaccinated now. Apparently, there are some vaccination clinics/doctor's offices that are willing to do this. Is there official recommendation?**

The official recommendation is that they need to be 5 years old on the day of vaccination. This is based on the Health Canada vaccine approval.

- **Are there many triply vaccinated patients in ICU or are those "fully vaccinated" in ICU only doubly vaccinated?**

There are a few triply vaccinated patients in the ICU; most of them are severely immunocompromised or frail and very elderly. Certainly, the rate of ICU admission is lower in triply vaccinated than in doubly vaccinated persons.

- **Are the mRNA vaccine makers incorporating the variants in their next vaccine productions? Timeline?**

Yes, the pharma companies are working on updated formulations to address variants. Unfortunately, there are no clear timelines, but nothing is expected to be available until the summer.

- **It seems that there has been a slowdown at a number of the vaccine clinics – when will we be opening up [boosters] to 12–17-year old's as they have in other countries?**

We are waiting for NACI guidance.

## COVID TREATMENTS

- **The dosage for treatment of Budesonide (Pulmicort) is 800 mcg bid?**

Yes, 800 mcg BID.

- **Are family doctors in the community expected to use medications as reported in therapeutics to treat patients with COVID infection in the community.?**

Yes, you can use the fluvoxamine and budesonide as per the Science Advisory Table guidance. Paxlovid and the monoclonal antibodies are both in short supply and are not available right now in the community, and the later requires.

- **Will OH be releasing an algorithm on Paxlovid so primary care knows where to send eligible patients within the 3–5-day window? KT will be essential here.**

[UPDATE: Jan. 21, updated Science Advisory Table brief, including guidance on Paxlovid: <https://covid19-sciencetable.ca/sciencebrief/clinical-practice-guideline-summary-recommended-drugs-and-biologics-in-adult-patients-with-covid-19-version-9-0/>]

- **Who will cover cost for new drugs? OHIP or patient?**

Drugs given at Clinical Assessment Centres (CACs) are paid for by the federal government.

## OTHER

- **Patients are asking for letters for travel particularly to say they are fit to travel after a recent positive COVID19 test and that they don't need testing (because of chance of false positive). Please advise if we should even write these letters and if so, what it should say.**

You can provide a letter stating they have recently had COVID and are cleared from isolation. They should also have the results of the previous test with them. Unfortunately, it can be difficult to predict what any individual border official will do.

- **Person 2 weeks after positive COVID test and fully recovered and traveling; should MD issue exception letter, so nobody will require PCR test on the border? Or it is between this person and authorities to have PCR done and event acknowledge, that positive test 2 weeks after positive test, means it's okay to let him go.**

A good idea to provide a letter (and a copy of the test documentation). But I would also think that the person needs to get a test, because I don't think you can absolutely predict what any particular border official might decide to do. [NOTE: the individual is responsible for meeting travel requirements. PCR testing for travel is not covered by the ministry's testing program.]

- **Pardon my ignorance, what does waste water have to do with Omicron rate?**

We can measure viral particles in wastewater – <https://www.thestar.com/news/gta/2022/01/17/what-wastewater-can-tell-us-about-where-Omicron-is-heading.html>

- **Will wastewater monitoring data be made publicly available?**

[Reports are that this data is being made available to the public. See this news update: <https://globalnews.ca/news/8524733/toronto-pilot-project-COVID-19-data-wastewater/>]

- **We talk about COVID becoming endemic like seasonal flu and that we're all going to get it eventually. Does seasonal flu ever produce asymptomatic or mild illness?**

Yes. As much as half of seasonal influenza is asymptomatic and a lot of it is mild.

- **Are we seeing resurgence of common viruses among children instead of actual COVID because of lack of exposure?**

At the moment, our public health measures are keeping regular respiratory viruses - with the notable exception of rhinovirus – under control. We won't see an increase until schools are back in person and restrictions are reduced. When that happens, we can expect to have a compensatory increase, at least in RSV. No one knows what will happen to influenza – it is increasing in the US (where restrictions are less than in Canada) but has pretty much vanished again in Canada since measures increased in January.

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

- What about Paxlovid?
- Pulmicort does not appear to be available. Are there other brands or is Symbicort is used what is the dosage?
- Report out of Israel saying that 4th shot not that helpful against Omicron. What do we know, if anything, so far?
- Could someone please comment on the recent evidence suggesting that Omicron in fact most contagious days 3-6 and infectivity does not steeply decline until day 10? Unfortunately, it does seem to be any shorter than its predecessors.