COVID-19 Response Questions & Answers: Calgary Zone

Date Updated: March 18, 2020

Theme:	
Question	**Answer**
1. What are the basic facts of COVID-19?	SARS-Cov-2 is the virus that causes COVID 19 (the infection), it is a single stranded RNA virus. It is a respiratory virus that gets discharged from respiratory track and then settles, that is why keeping 2 meters distance from others is recommended and why vigorous public health campaigns have allowed the virus to be controlled. It is not as infectious as measles; it is spread through contact with droplets not through the air. Stand back from patients, use N95 only for high risk procedures such as field-nebulizing/intubation procedures (avoid if possible), otherwise surgical masks and eye protection shields are enough when dealing with symptomatic patients.
2. What is the impact of exposure to COVID-19?	Currently it seems that 80% have self-limited flu, 20% have serious disease requiring some sort of hospital visit, of which 5% will require ventilation/ECMO which can deteriorate to organ-failure and death. Everyone infected seems to infect 2.5 other people. Although the evidence is still coming in there is 10-15 times higher risk of dying than the flu. We have more people at risk for COVID-19 than the flu because we have ability to of immunize for flu. Highest risks are 65 or older, Htn, DM.
3. How long does the virus survive outside the body?	The evidence is still coming in, but it appears to be quite resilient outside of the body. It can survive for a few hours on copper/wood. It can survive for several hours on other surfaces as well. Very important to sanitize door handles, wash hands, avoid touching your face and not to sneeze or cough on people, keep 2 meters between people.
4. Can you clarify what to do if patients are on one of ACE/ARB's?	Do not use NSAIDS. If test positive for COVID-19, consider taking patients off ACE/ARB. Suggest providing comfort measures and better to go with Tylenol, acetaminophen.

5. Why did things get so bad in Italy?	Because of the demographics of the community. They had many older people with high levels of social networking that spread the disease quickly, overwhelming the medical system's ability to look after people.
6. Do you have immunity once you have been exposed?	This information is still being gathered. Initial indications are yes, you do have immunity once exposed, although there is one case in the literature of recurrent infection.
7. How common is it for rhinorrhea to be the only symptom in patients with COVID-19?	It is rare. ALL papers point to the prevalence of fever, dry cough and fatigue as the most prevalent symptoms. For practical purposes if patient has rhinorrhea and absence of other symptoms the likelihood it is COVID-19 is low.
8. How/who do we test for COVID-19?	First, we **do not test** someone who has no symptoms. The only test we have is a nasopharyngeal swab that can test for RNA. The lab first screens for EG and if positive they look for polymerase chain and precise virus. As of now we can't order IgG or IgM at this time. As with all tests sampling/timing is always an issue. Nasopharyngeal swab must always be used in clinical context. This is challenging because symptoms are very much like influenza like illnesses (ILI) so right now travel history is most helpful. Other clinical sign includes: Fatigue is often profound, occasionally productive cough. Hemoptysis more common in Chinese than in Italy. CBC=patient is lymphogenic, ALT, CRP may be elevated. CXR may be helpful infiltrates and interstitial changes. Interstitial pattern may help you think that something is going on. If progresses ground glass is natural history. • Check with your PCN to on current testing processes and access to supplies as this may change frequently.
9. If this goes on for months, when do we stop testing?	Knowing that we can't predict the course of the current pandemic, this question is difficult to answer. That being said, decisions about testing are made by the Chief Medical Officer of Health using many criteria.
10. Should we be using ARB/ACEI receptor?	If you're using those drugs it is possible you may give a boost to receptors that may attach to this virus, making the situation worse.
11. What about using steroids?	You should avoid them if possible. If underlying condition indicates steroid use, treat it. However, if they have the infection it seems as if there is compelling evidence to avoid.
12. Are there any promising treatments on the horizon?	Unfortunately, there aren't a lot of options yet. A vaccine is at least a year away. Hydroxychloroquine and Kaletra may be repurposed, but they are a great match. Remdesivir is in trials and does look promising.

13. What do we do if we have patients present to the clinic who are symptomatic, but didn't disclose until the end of the visit?	If you have PPE, leave patient in the room gown up (gown, mask, eye protection/face shield) and assess the patient. No need for N-95 masks unless doing aerosol generating risk procedure, which an NP swab is not. If you don't have PPE send the patient home and have them do the online assessment or call 811 and follow that procedure. The average risk in the community is currently less than 0.5% (number of positives to number of tests). Sanitize the room and carry on. No need to shut clinic. If in doubt, call MOH. Clinic team needs to be diligent in recording who had contact with each patient. This will help with contact tracing if anyone should test positive in the future.
14. What is the recommended method for cleaning rooms after seeing symptomatic patients?	Contact/droplet precautions should be used to protect from COVID-19. Details on room cleaning and material handling are outlined here: https://www.albertahealthservices.ca/assets/healthinfo/ipc/hi-ipc-emerging-issues-ncov.pdf Recommendations include: • Using disposable patient equipment when possible • Cleaning/disinfection of room surfaces and equipment on a daily basis using a Canada broad spectrum virucidal • Special handling of linen or waste is not required
15. What if a family physician has mild URTI symptoms?	Right now, the guideline is that everyone with symptoms stays home. We don't yet know the correlation of symptoms and viral load, so we consider anyone with symptoms to be infectious. We are aware this will have considerable workforce implications and we are currently monitoring this situation to see if we need to reconsider. Physicians should call this direct line: 587-284-5302 to consult with a Health Link nurse for isolation or testing advice.
16. What if a physician or member of the clinic team tests positive? Do we need to shut down the clinic?	The MOH generally does not order clinics to shut down. If a member of the team tests positive the MOH will be in touch to do contact tracing and will assess the situation on a case by case basis.

	Remember, this virus doesn't seem to spread through casual contact so recommendation will be to clean the clinic (MOH can help advise on this, even provide some supplies), and some team members may be asked to self-isolate for 14 days, others might not.
17. I share a house with someone who is in self-isolation because of the travel advisory, do I need to self-isolate as well?	No, you do not need to self-isolate unless you become symptomatic. If anyone in the house develops symptoms you should do the online screen tool, call 811 if directed and follow their instructions.
18. Can Family Physician swab patients?	If the physicians have the swabs and the PPE yes, they can when it makes sense to do so. The recommendation is to keep symptomatic people away from your clinic and send them through 811 and the assessment centres. It reduces risk of exposure to you, your team and other patients as they have their processes designed to process a lot of test quickly and safely and are practiced in the use of PPE. Check with your PCN to on current testing processes and access to supplies as this may change frequently.
19. Is the test sensitive? How long to get results back?	For someone who is symptomatic the test seems to be a very good test. It is very sensitive. From the time when the swab is collected and transported to the lab, the turnaround can be up to 5 days. - People should not call 811 for their COVID-19 test results as Health Link does not have access to results - Results can take up to 5 days and people should remain on self-isolation or as instructed by Health Link as they await results - This is still the best process to use, despite frustrations with wait times
20. Can Family MDs notify patients of negative test results?	You can see on Netcare that swab is negative as soon as it has been completed at the lab. Family medicine can notify the patients as Public Health is prioritizing positive results. In your conversation with the patient advise them to continue to self-isolate if symptomatic for other illness.
21. What is the appropriate Personal Protection Equipment (PPE)?	1. Adjust habits to maintain social distance from all patients whenever possible and as common-sense dictates (don't shake hands, try to stay 2 meters away) 2. Appropriate PPE when taking a swab or assessing a symptomatic patient is: Gown, gloves, surgical mask and eye protection/faceshield. 3. The moment of highest risk for healthcare workers is in the doffing of the PPE. Be diligent in your practice of donning and doffing.

	4. N95 masks ARE NOT necessary unless doing procedures resulting in aerosolizing of respiratory excretions (nebulizing, intubation) 5. Refer to AHS site for more information on PPE and infection control: https://www.albertahealthservices.ca/topics/Page16956.aspx
22. How long can you wear PPE, does it need to be changed for every patient?	Yes, PPE must be changed for every patient interaction and treat each patient space as a private room. Remove PPE (if worn) and perform hand hygiene when leaving one bed space or before providing care to the other patients in the room. https://www.albertahealthservices.ca/assets/healthinfo/ipc/hi-ipc-emerging-issues-ncov.pdf
23. How are we doing managing the response to COVID-19 in Alberta?	Canada is doing well regarding spread. We've tested a lot. Alberta is in top 5 jurisdictions in the world for monitoring. AHS as one health authority and the PCNs have allowed for a well-organized response in relation to other provinces.
24. Will we get a reprieve over the Spring and Summer? Does seasonality impact COVID-19?	There is anecdotal evidence of seasonality as in general cold rates go down in the summer and the virus seems to be less stable in warmer/more humid climates, so we are hopeful.
25. What is the risk to healthcare workers of being infected by COVID-19?	Most of the health care workers who were infected got from sick contacts at home. Few young health care workers. We do know from all the data that we've seen do seem to affect the older healthcare works a fair amount. If we use PPE very effectively, we dramatically reduce the risk.
26. What is your advice to older healthcare workers?	There is an increased risk of more severe outcomes for Canadians: · aged 65 and over · with compromised immune systems · with underlying medical conditions https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/prevention-risks.html Vulnerable populations may include https://www.canada.ca/en/public-health/services/publications/diseases-conditions/vulnerable-populations-covid-19.html Anyone who is: · an older adult · at risk due to underlying medical conditions (e.g. heart disease, hypertension, diabetes, chronic respiratory diseases, cancer) · at risk due to a compromised immune system from a medical condition or treatment (e.g. chemotherapy)

	The incubation period is up to 14 days. · Current estimates of the incubation period range from 0-14 days with median estimates of 5-6 days between infection and the onset of clinical symptoms of the disease. Based on information from other coronavirus diseases, such as MERS and SARS, the incubation period of COVID-19 could be up to 14 days. WHO recommends that the follow-up of contacts of confirmed cases is 14 days.[Endnote 13]. https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/assumptions.html
27. Are there populations of physicians that should avoid contact with possible COVID pts and/or testing? Ie specific medical conditions, pregnancy, etc.	Older adults, people with immune compromising conditions and chronic diseases appear to be at greater risk of severe disease, so consideration should be given to protecting them from possible exposure to COVID-19 cases.
28. What is the risk to pregnant women and children?	As with any new virus the evidence is still emerging and evolving, as such a definitive answer is not readily available. The virus does not seem to affect pregnant women as much and children seem to be able to manage the virus as well as no children under 10 have died from the virus yet.
29. For an infected patient, how do we determine if they fall into the 20% who need to go to the hospital?	Assess symptoms in the same way as would previously. Status check phone call every 24 hours. Look for increasing respiratory distress over time, a sequence of declining 02 saturation. Remember you can use Community paramedics to assess patients you are concerned about at home. Also, use RAAPID if you are sending a patient to the hospital so they promote informational continuity.
30. How might we best manage patients who are symptomatic but need to be seen for other health issues?	1. Conduct phone screen to assess patient need and explore for alternatives (community paramedics) to them coming into the office. 2. Some physicians have been scheduling these patients at the end of the day when they can send most people home to limit risk. 3. Use PPE diligently.

31. Physicians are worried about financial security, what are we doing to support them?	We recognize there is a very real financial cost to family physicians. The AMA is actively advocating with the government for billing codes that can be helpful, including codes for providing virtual care.
32. What is the current status with phone calls with patients regarding billing codes and virtual care options?	What billing code should I use for telephone advice during the COVID-19 pandemic? Effective March 12, 2020, to minimize the risk of exposure to the COVID-19 virus and to ensure continuation of care if a patient or physician self-isolates, the Ministry of Health is amending and activating Health Service Code (HSC) 03.01AD. See the bulletin on telephone advice during COVID-19 epidemic and appropriate diagnostic codes at the link below: https://open.alberta.ca/publications/bulletin-alberta-health-care-insurance-plan-medical-services Physicians can use this billing code for non-COVID-19 issues as long as you are providing telephone advice because you feel this is necessary for the safety of the patient.
33. What is the rationale for the 14-day quarantine period? (see viral shedding response below)	The period of communicability is not completely understood and varies by type of coronavirus. Detailed medical information from people infected is needed to determine the infectious period of COVID-19. • It is possible that people infected with COVID-19 may be infectious before showing significant symptoms. However, based on currently available data, the people who have symptoms are causing the majority of virus spread. • Cessation of symptoms indicate that the period of communicability is ending. • Two consecutive negative laboratory test results, at least 24 hours apart, can be used to determine the end of the communicable period. https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/assumptions.html#fn15
34. Is there an opportunity for family physicians to be redeployed to help with the response?	There has not yet been a call out to support this, but a need to do so may emerge over time. We would recommend you reach out to the Medical Director of your PCN and indicate you would be willing to do so if needed.
35. Do we know how long viral shedding persists in those affected, particularly as they recover? (see period of communicability above)	As with the response above regarding the period of communicability, this is not yet completely understood and varies by type of coronavirus. The incubation period is up to 14 days.

	Current estimates of the incubation period range from 0-14 days with median estimates of 5-6 days between infection and the onset of clinical symptoms of the disease. Based on information from other coronavirus diseases, such as MERS and SARS, the incubation period of COVID-19 could be up to 14 days. WHO recommends that the follow-up of contacts of confirmed cases is 14 days. https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/assumptions.html#fn15
36. Have we seen worse outcomes from Covid in patients who are immunosuppressed (transplant meds, biologics, asplenia)?	Vulnerable populations may include Anyone who is: · an older adult · at risk due to underlying medical conditions (e.g. heart disease, hypertension, diabetes, chronic respiratory diseases, cancer) · at risk due to a compromised immune system from a medical condition or treatment (e.g. chemotherapy) https://www.canada.ca/en/public-health/services/publications/diseases-conditions/vulnerable-populations-covid-19.html
37. Once a case is confirmed, when can we be confident that the patient is no longer contagious?	The period of communicability, this is not yet completely understood and varies by type of coronavirus. The incubation period is up to 14 days. Current estimates of the incubation period range from 0-14 days with median estimates of 5-6 days between infection and the onset of clinical symptoms of the disease. Based on information from other coronavirus diseases, such as MERS and SARS, the incubation period of COVID-19 could be up to 14 days. WHO recommends that the follow-up of contacts of confirmed cases is 14 days. • It is possible that people infected with COVID-19 may be infectious before showing significant symptoms. However, based on currently available data, the people who have symptoms are causing the majority of virus spread. • Cessation of symptoms indicate that the period of communicability is ending.

	• Two consecutive negative laboratory test results, at least 24 hours apart, can be used to determine the end of the communicable period. https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/assumptions.html#fn15
38. What role will the PCNs play if family physicians need to shut down their office? Could PCNs step in to provide care?	We are hopeful that PCNs will be willing to support the response and conversations about the role continue to evolve amongst the leadership groups. There is a need for a mechanism to coordinate this activity, and the need to do so may emerge over time. We would recommend you reach out to the Medical Director of your PCN and indicate you would be willing to do so if needed.
39. COVID testing via (403) 943-1578 Number not in service? Why was this cancelled and how was this communicated? Is there another number that MD offices can use?	This is a number that was intended to be used only by physicians to assist with maintaining workforce business continuity in primary care (e.g. to support physicians who were returning to Canada after a vacation abroad, or a physician who was experiencing symptoms of COVID-19). Unfortunately, the number was introduced into the public and the calls quickly became overwhelming. There are new numbers available for physician symptom assessment: If you are a physician south of Red Deer call (587) 284-5302. If you are a physician in Red Deer or north call (780) 910-0385. These are being made available shortly (and may be available currently) in the online resources for primary care located at: https://www.albertahealthservices.ca/topics/Page16956.aspx
40. Can we counsel our patient for depression at home while they are in self isolation or quarantine?	It is important for patients to be able to maintain a relationship with their primary care providers during this time, especially for those who are in isolation and may need additional supports. Effective March 12, 2020, to minimize the risk of exposure to the COVID-19 virus and to ensure continuation of care if a patient or physician self-isolates, the Ministry of Health is amending and activating Health Service Code (HSC) 03.01AD. See the bulletin on telephone advice during COVID-19 epidemic and appropriate diagnostic codes at the link below: https://open.alberta.ca/publications/bulletin-alberta-health-care-insurance-plan-medical-services Physicians can use this billing code for non-COVID-19 issues as long as you are providing telephone advice because you feel this is necessary for the safety of the patient.

41. Would you suggest continuing on with elective appoints e.g. non urgent pap smears, physical exams?	It is important that day to day primary care needs continue to be addressed as appropriate. That being said, it is also reasonable that clinic hours may shift and types of appointments delayed (e.g. annual pap smears and physicals rescheduled for a later date).
42. Mental Health Support available?	In her address in March 12, 2020, Alberta's Chief Medical Officer of Health, Dr. Deena Hinshaw acknowledged that public health emergencies can significantly impact mental health and that mental health supports are available. Options that can be accesses for mental health support include: a. Multidisciplinary teams within their medical home: please have conversations and develop plans for how multidisciplinary teams can be optimized to support a range of patient needs during this public health emergency. b. Addictions Helpline 1-866-332-2322 (24/7) c. Mental Health Helpline 1-877-303-2642 (24/7): this is through HealthLink d. Kids Help Phone (24/7) 1-800-668-6868 As always, Mental health Emergencies should be directed to the Emergency Room or 911.