TOOLKIT

Expanding Community-Based Assessments and COVID-19 Testing of Patients with Febrile Respiratory Illness (FRI) / Influenza-Like Illness (ILI)

Ottawa Community Care & Testing Working Group

November 2021

‘Just the Facts’ Executive Summary

- There is a significant and growing need for more in-person care for patients with febrile respiratory illness (FRI) or influenza-like illness (ILI) symptoms who would have been seen by community providers prior to the COVID-19 pandemic. This is currently manifesting as extreme pressure on emergency department volumes, even before the real start of the seasonal respiratory virus surge.
- Testing for COVID-19 currently occurs mostly through hospital-run assessment centres; some centres also provide limited FRI/ILI clinical care.
- There are many barriers to primary care providers being able to fully resume all pre-pandemic care. However, some clinics are successfully navigating the transition. The health system needs each provider to find ways to provide care for FRI/ILI patients. Even a small amount of additional work, or working differently within the existing system, can significantly increase the cumulative capacity of our health care system.
- As the CPSO believes in-person care can be provided safely to symptomatic/screen positive/COVID unknown patients, this toolkit aims to help providers identify the opportunities that make the most sense for their individual situation and provide practical, easy-to-follow resources to help make those changes.

Background:

- In response to pandemic restrictions and ministry guidance, most community-based care stopped or pivoted to being "virtual first". With updated guidance, more access to PPE and vaccinations readily available, there has been a shift back to in-person care. Approximately 50% of visits in the community are in-person currently. We believe most in-person community care continues to be for those who screen negative for COVID-19 symptomatic/exposures or have tested negative for COVID. There are multiple reasons for in-person care of symptomatic patients to be not progressing as quickly.
- Patients with febrile respiratory illnesses (FRI)/influenza-like illnesses (ILI) have had limited options for in-person care – mostly through dedicated COVID-19 care clinics associated with assessment centres or through the emergency department.
- As schools return to in-class learning for most students, the number of children who have become sick with seasonal respiratory viruses has increased significantly. It is expected that Ottawa will experience further surges of respiratory illness like other jurisdictions that removed restrictions sooner (Southern Hemisphere, Southern US states, Montreal, etc.)
- Hospital emergency departments and inpatient units are already facing significant volume and staffing pressures even before these surges take place. There are high numbers of patients with low acuity FRI/ILI presentations who in the past, would have been served in community practices. Patients are facing extremely long waits in the emergency department, and hospitals are forced to consider postponing other care delivery to redeploy staff to meet these acute needs.
- It is recognized that there are backlogs of care for all types of patients, creating added pressures on all parts of the health system. The number of patients in our community without a primary care provider has grown significantly during the pandemic, especially for those most marginalized or needing care in languages other than English (includes a lack of French-speaking providers)
- With the context that CPSO believes in-person care can be provided safely to symptomatic/screen positive/COVID unknown patients, physicians have been reminded that needed in-person care cannot be denied because of the patient's vaccination status or lack of a negative COVID-19 test.

Approach:

- Many community providers are keen and willing to help. We recognize that fatigue and burnout must be considered when suggesting change. We aim to help make change 'easy' to implement.
- A 'toolkit' approach offers many possible solutions that individual community providers or groups of providers can choose from to apply to the problems outlined above.
- Not all solutions will work for all providers or in all settings. Hopefully, at least one can be applied in each setting to allow as many providers as possible to contribute to the goals outlined below.
- "Many hands make light work" and by most providers finding a way to see and/or test a few FRI/ILI patients each week, there will be a significant increase in the delivery of community-based care for these patients. Accordingly, a reduction in demand on emergency departments and COVID assessment and care clinics will follow.
- In addition to expanding care options, public messaging and education is needed to help patients better navigate self-care and care options when FRI/ILI symptoms occur. Patients face

increased anxiety when COVID-compatible symptoms develop and have decreased resilience from the pandemic. There is a large cohort of children who are experiencing their first illness, despite being almost 2 years old; their parents have not experienced their child being sick before to help gauge the seriousness of their symptoms, their response to symptom control, or to understand the typical length of time that fever and other symptoms may persist with simple viral illnesses.

- In collaboration between OPH and several organizations, patient-facing information is being prepared to help them manage minor illness symptoms and navigate the most appropriate care options for their situation (pending). FRI/ILI pathways have been developed in many jurisdictions (see examples in Appendix) and can be quickly tweaked and adopted for local use.

Goals:

The launch and application of the toolkit is meant to achieve several goals:

- To increase the number of community **practitioners** offering in-person FRI/ILI care
- To increase the number of community **practices** offering in-person FRI/ILI care
- To increase the number of community-based FRI/ILI patient interactions overall (in-person or virtual), with corresponding decline in low acuity FRI/ILI presentations to ED's
- To establish and gradually increase community-based COVID-19 testing (absolute numbers and as a proportion of all testing in the city)

Across all potential metrics, we must consider the age, geographic, socioeconomic, and cultural make-up of those who are receiving care from these initiatives to watch for issues related to inequity/access.

Early efforts are focused on establishing these care options; later attention must consider the quality of the care (opportunities to standardize and improve across all environments; implement Choosing Wisely *The Cold Standard*, etc.), as well as the patient and provider experience of providing care in these ways.

Barriers to Community-Based Care:

- Significant heterogeneity exists in the way community-based care is delivered, including practice size, type, business structure, payment models, and practice location. Individual clinicians face unique challenges when they contemplate resuming or expanding in-person FRI/ILI care for the patient populations they traditionally served.
- Common barriers that are cited include:
    - Purpose/Priorities
        - Many other non-infectious care pressures exist, occupying clinician's time, both virtually and in-person
    - Place/Products
        - Many practices are in older buildings with inadequate ventilation, waiting room space, or access from the outside to prevent cross-contamination of "clean" patients with "infectious" ones
        - Landlords may make it difficult for patients with infectious symptoms to enter the building

        - Community practitioners faced significant struggles to obtain PPE during the early part of the pandemic. While this has been addressed with access to the provincial stockpile, many may still feel they don't have easy or financially viable access to PPE
    - People
        - Practices may have lost staff through the pandemic and are not well resourced with administrative or nursing staff to expand additional care, especially in-person
        - Despite vaccination and access to PPE, clinicians and/or their staff continue to feel vulnerable to being exposed to COVID and may be hesitant to take that risk
        - Many primary care providers in Ottawa work independently or part of small group practices under a FFS model, compared to other large municipalities. In other cities, most providers are part of larger practices with more stable funding (FHTs, FHGs, FHOs) and can work together to support the care of FRI/ILI patients including in-person visits.
        - A significant number of independent practitioners have retired during the pandemic without a replacement provider, orphaning large numbers of patients. This contributes to greater reliance on COVID care clinics and emergency departments.
    - Policy/Payment
        - Traditional payment models have not been adjusted to account for the added complexities and costs associated with providing care to infectious patients within the COVID context
        - Financial incentives have not been established for community-based care, nor are most disincentives active (e.g., claw backs for rostered patients seeking urgent care are not triggered when patients are cared for in COVID assessment centres or emergency departments)
        - Ministry of Health expects clinicians/practices/regional testing leads to self-organize and develop solutions within existing assessment centre models and agreements with hospitals. No new infrastructure funding is currently available to help practices adapt, or to build new spaces for FRI/ILI care to be delivered
    - Processes/Procedures
        - Messaging about IPAC/cleaning/distancing have evolved but may have caused confusion or a sense that such requirements are not achievable. OPH would be the resource to guide individual practices but does not have the bandwidth to provide individual consultation/review/advice. Congregate Care/MCCSS has an IPAC Champion program – could a similar structure be created to address primary care office questions?
        - Community practitioners are unclear on how they order COVID tests for their patients

Financial Considerations

- Representatives from the Ministry of Health and Ontario Health have been clear that they are not creating new financial incentives for community-based in-person FRI/ILI assessment or testing. They are not offering new capital investments to create additional dedicated FRI/ILI assessment clinics beyond the existing Assessment Centre/Care Clinic infrastructure. In those settings, physicians working to support testing and/or provide FRI/ILI assessments can bill COVID-19 sessional fees (H409/H410) and the hospitals receive funding per test performed to offset operational expenses.
- While it is theoretically possible to create a satellite assessment centre/care clinic as a subcontractor to an existing hospital contract with Ontario Health, approval from Ontario Health requires proof that additional testing and care capacity is needed for the populations that will be served. Currently, testing demand overall is declining locally, regionally, and provincially, though shifting to be higher amongst the unvaccinated children and youth who remain vulnerable to COVID-19.

Suggested Opportunities to Contribute to the Goals

Possible opportunities are grouped into the following buckets. Further details/resources for each of these are available in the appendices of the toolkit.

A. Sign-up to staff a new or existing care clinic established to serve FRI/ILI patients
   - These include existing COVID Care Clinics and new initiatives that would function as a "primary care hub" or satellite to a hospital-based assessment centre (subcontractor agreement with the hospital)
     - Infrastructure set up to deal with infectious patients only, so no cross-contamination with other non-infectious patient assessments
     - May include access to diagnostic resources
     - Allows clinicians to use sessional COVID fees (H-codes) to bill a simple, hourly rate rather than having to process FFS submissions for patients that aren't already rostered within a provider's practice
     - Facilitates COVID testing
   - Examples:
     - Kids Come First COVID Care Clinic (CHEO Brewer – Dr. Mélissa Langevin)
     - East Ottawa Kids COVID Care Clinic (Dr. Kelley Zwicker)
     - Moodie Assessment and Care Clinic (QCH – not currently in need – Dr. Joseph Pollard)
     - Ray Friel Assessment and Care Clinic (Hôpital Montfort – not currently recruiting – Dr. Shaun Visser, and scheduled to stop MD assessments November 12)
     - Possible CHC clinic space after-hours – TBD (Dr. Alison Eyre, Dr. Laura Muldoon)

B. Open 1-4 slots for FRI/ILI patients
   - Serve your existing patients by providing urgent care slots for FRI/ILI patients with clear separation from the non-infectious patients. For example, this could be done at the end of day. We acknowledge this will involve balancing clinical demands and may require deferring some non-infectious elective care to have capacity for same-day FRI/ILI appointments without extending hours
   - Access PPE from the provincial stockpile (see Appendix)

- Utilize office IPAC toolkits (see Appendix) to manage cleaning, patient flow and other aspects to provide this care safely for both patients and staff
- Include option to test patients using DIY kit with clinician as the ordering provider responsible for results management to round-out the care of the patient as one-stop option

C. Participate in Testing as an Ordering Provider for Community Specimens
- Offer DIY kits from your office to existing patients
- Offer DIY kits from your office to other members of your neighborhood/community
    - Helps to move testing into a sustainable community model

Development Team

- This document and the associated resources have been compiled by a group of health leaders representing Family Medicine, Community Pediatrics, Pediatric Emergency Medicine, Kids Come First Health Team, COVID-19 testing, and Ontario Health. They include:
    - Dr. John Brewer, Family Physician & Chief of Family Medicine, TOH
    - Dr. Alison Eyre, Family Physician, Centretown CHC & Champlain Community of Family Practice
    - Dr. Tessia Falsetto, Community Pediatrician
    - Dr. Ken Farion, CHEO Emergency Physician & Ottawa COVID-19 Testing Taskforce
    - Alison Girouard, Kids Come First Health Team
    - Dr. Kathy Keely, Community Pediatrician & Division Chief, Community Pediatrics, CHEO
    - Dr. Mélissa Langevin, CHEO Emergency Physician & Kids Come First COVID Care Clinic
    - Dr. Jane Liddle, Community Pediatrician
    - Dr. Elizabeth Muggah, Family Physician, Bruyère Academic Family Health Team
    - Dr. Laura Muldoon, Family Physician, Somerset West CHC
    - Dr. Jessica Ngan, Family Physician
    - Eric Partington, Director, Ontario Health
    - Dr. Kamila Premji, Family Physician
    - Dr. Benoit Robert, Family Physician, Greenboro Family Medicine
    - Dr. Suzanne Rutherford, Family Physician & Medical Director, Kemptville Assessment Centre
    - Kelli Tonner, Executive Director, Southeast Ottawa CHC
    - Dr. Kelley Zwicker, Pediatrician, Founder, Ottawa Community Pediatricians Network

Suggestions for Improvement of the Toolkit

- Do you have a suggestion for improving this toolkit? Do you have additional resources that you found helpful that you would like to share with others? Have you successfully adjusted your practice to welcome FRI/ILI patients back and have lessons learned that you can share?
- If so, please reach out to any of the members above, or forward your thoughts/content to Ken Farion (farion@cheo.on.ca) so we can provide updates to this toolkit.

APPENDICES

Guidance Memos

1. Balancing Demands: Considerations for Family Physicians, OCFP August 2021
2. Guidance on the navigation of patients with influenza-like illness (Ontario Health – Oct 6, 2021)
3. Joint letter from CMOH/MOH/CPSO about In-Person Care, October 13, 2021
4. COVID-19 Guidance: Primary Care Providers in a Community Setting, Ministry of Health, Version 9.0 – October 19, 2021
5. Primary Care Operations in the COVID-19 Context, Centre for Effective Practice
6. COVID-19 FAQs for Physicians, CPSO
7. Tips for Scheduling, Managing Flow and Collecting Specimens for FRI Patients in a Community Office Setting

IPAC & Ventilation Resources

1. PPE and Infection Control for In-Office Assessments, OCFP, August 2021
2. Summary of Infection Prevention and Control Key Principles for Clinical Office Practice, PHO 09/02/2021
3. Infection Prevention and Control Key Principles for Clinical Office Practice During the COVID-19 Pandemic, PHO 13/09/2021
4. Heating, Ventilation and Air Conditioning (HVAC) Systems in Buildings and COVID-19, PHO, March 2021.
5. Air Quality Checks, PHO

PPE and other Supplies

1. How to order and obtain PPE from the provincial stockpile
2. How to order testing kits from the provincial stockpile

Physician Wellness Resources

1. OMA Physician Health Program
2. CMPA Physician Wellness Resources
3. University of Ottawa Faculty of Medicine – Faculty Wellness Program

Testing Resources

1. Understanding the Alphabet Soup of COVID-19 Testing
2. Current testing criteria – COVID-19 Provincial Testing Guidance Update
3. How to conduct Do-It-Yourself testing from your office practice
    a. BON method and Patient Resources
    b. PHOL requisition
    c. PHO list of test kits and instructions
    d. Getting Specimens to the Lab
    e. Patient Education and Results Management

Vaccination Resources

1. Ottawa Public Health Vaccination Resources for Children
2. Vaccine for 5-11 year olds: ACIP cliff notes

APPENDICES

TIPS FOR SCHEDULING, MANAGING FLOW AND COLLECTING SPECIMENS FOR FRI PATIENTS IN A COMMUNITY OFFICE SETTING

How to schedule patients with Febrile Respiratory Illnesses (FRI) into a primary care clinic.

In the interest of patient and staff safety, as well as PPE stewardship, it is best to cohort all FRI patients so that they do not mix with your regular patient population.

This can be done a variety of ways, depending on your hours of operation and the footprint of your clinic.

Scenario 1: After hour clinics already in operation. Group practice model

- Reserve all after hour appointment slots for patients exhibiting possible COVID-19 symptoms (these can be managed as walk-ins or same-day pre-bookings.)
- Hold 1-2 same-day spots/physician during regular daytime hours to see patients with urgent concerns unrelated to COVID-19 (i.e., UTI's, acute back pain, etc.)

Scenario 2: No after-hours capability for FRI. Unused exam space available. Group practice model

- Designate specific exam rooms for FRI patients during the day
- Have patients identify themselves with the screener at the entrance as an FRI patient
- Escort these patients directly into an exam room (do not have them share the same waiting room or use exam rooms used by other non-FRI patients).
- These patients could be booked throughout the day but are best cohorted to specific times of day (just before lunch or at the end of day).

Scenario 3: No after-hours capability for FRI. Extra exam space unavailable. Solo or group practice

- Reserve your last 1-3 appointment slots for the day for FRI patients (or as many as you can facilitate.)
- Instruct patients to not show up before their appointment time and possibly to wait in their car until all non-FRI patients have completed their visits.

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How to manage the flow of FRI patients in the clinic:

The following principles will help FRI patients flow safely through the clinic. As mentioned above, these patients should be scheduled as their own cohort so that they do not mix with the regular patient population.

Managing the waiting room:

1. Ideally, FRI patients will be escorted directly into their exam room (i.e., Booking patients every 15min will minimize the number of patients waiting at one time.)
2. If the waiting room is required, keep patients distanced (this is done by removing or blocking chairs in the exam room to ensure a separation of 6 feet.)
3. If a patient uses the waiting room chair, you will need a system to identify the chair as dirty and requiring cleaning after the patient departs it. (i.e., Laminated cards handed to the patient on arrival and left on the chair when they are escorted into the exam room.)

PPE Set up:

1. PPE donning and doffing stations should be set up outside of the exam rooms designated for FRI patients.
2. If space allows, a 4 wheeled cart stocked with gloves, masks, and gowns located outside of the exam room is ideal. These can be purchased at Canadian Tire or any hardware store
3. A large garbage can should be outside of the exam room for doffing of dirty PPE.
4. Hand sanitizer should be readily available (on the wall or PPE cart.)

Managing the Exam Room:

1. Limit the amount of furniture that the patient comes in contact with. This can be done by removing chairs, turning furniture backwards etc.
   Direct the patient to sit directly on the bed.
2. All equipment used to examine the patient (BP cuff, stethoscope, otoscope, etc.) should be placed on the bed after their use to identify as them dirty.
3. When the consultation is complete, the clinician will clean all of the dirty equipment (including the bed) and place it back to its original “clean” location, before doffing their PPE
4. Consider turning computer monitor backwards to discourage its use and chart in a designated clean area after the encounter. Alternatively, should you wish to chart in the same room, be sure to clean the computer/printer/mouse/keypad after each patient encounter.

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How to handle swabs for FRI patients:

The handling of all swabs must be done in a manner that keeps the specimen bag clean for handling by clinic and laboratory staff. This can be done in a variety of ways.

1. A “clean” designated staff member acts an assistant to the clinician. The clean assistant can hand the labelled medium bottle and swab to the patient and hold the clean specimen bag open for the clinician to drop the test into. This process can be used for strep throat swabs, etc.
2. Specimen bags can be taped to the wall or door of the exam room. In this case, the clinician will need to collect all necessary testing supplies before touching the patient and contaminating themselves.
3. A garbage bin should be readily available to dispose of testing waste without having to open cupboards or touch any surfaces.

APPENDICES

UNDERSTANDING THE ALPHABET SOUP OF COVID-19 TESTING

BON – NP – RAT – PCR

There's no end of acronyms to wade through when trying to understand the COVID-19 testing landscape!

We hope this brief review will help remove some of the mystery...so that the right sampling method combined with the right testing technology yields a result that adds value for the patient and the broader community, based on the specific circumstances or reasons to be tested.

What is the PURPOSE of the test?

Testing can be done at an individual or population level for a variety of reasons:

- ***Diagnosis*** (individual has symptoms or recent exposure; do they now have COVID-19?);
- ***Screening*** (individual doesn't have symptoms or recent exposure; can we detect asx COVID-19 before they enter school/work/travel to prevent spread to others?);
- ***Surveillance*** (test a cohort to see how much COVID-19 exists undetected).

Understanding the purpose of the test, along with the pre-test likelihood that an individual or population will test positive, can help determine the required *sensitivity* and *specificity* that would be needed to yield more post-test certainty in interpreting the result - remember, no test is perfect!

What testing OPTIONS must be considered?

A COVID-19 test result comes from combining a sampling method with a testing technology.

Each combination yields a different test performance (sensitivity, specificity) that must then be considered in light of the reason for the test and the pre-test likelihood.

Essentially, if the individual being tested actually has COVID-19, will the sampling method and testing technology we choose accurately detect it? And if detected, does that positive result reflect active infection (contagious state shedding live virus) versus recent infection (resolved state shedding destroyed viral material).

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Sampling Method + Testing Technology = Result

Sampling Methods

NPS –classic "gold standard" approach; very uncomfortable; regulated act
Nasal –deep or anterior, usually bilateral; better tolerated but may miss cases; self-collection
BON – (buccal/oral/nasal) combination of tongue, cheeks & nares; very well tolerated & easy for self-collection, especially in kids; high accuracy
Throat/Nasal – combination post pharynx/tonsil + nasal; high accuracy but not for self-collection
Saliva – easy self-collection, though kids can struggle; not all labs can process

Testing Technology

PCR – "gold standard" lab-based detection of various genetic material, both active (contagious) virus and inactivated viral particle shedding for many weeks after acute infection (recovery)
Rapid Molecular – POCT using PCR approach and performance accuracy, but in 15-30 minutes (e.g., ID Now)
RAT - (Rapid Antigen Test) – lateral flow POCT like a home pregnancy test; rapid, easy-to-use; detects acute infection

Result

PCR, as the "gold standard" is touted as 100% sensitive but is dependent on the sampling method and integrity of the specimen before it reaches the lab – realistically 95-96%. Specificity is high but false positives can occur from cross-contamination.
RAT's are, at best, 75% sensitive with NPS sample in symptomatic individuals; ~50% if the patient is asymptomatic; performance lowered further by using lower quality sampling methods and self-collection

Summary of Choices by Purpose

Diagnostic – Lab-based PCR or Rapid PCR are best. Rapid antigen tests should NOT be used for diagnostic purposes (symptomatic or high-risk contacts).
Screening – Lab-based PCR or Rapid PCR is used for travel screening but is impractical for day-to-day or large volume screening prior to employment, school, or access to public venues. Rapid antigen tests are appropriate for screening purposes – all positive RAT results MUST be confirmed by a lab-based or rapid PCR, unless pre-test probability is extremely high.
Surveillance – Lab-based PCR is appropriate; Rapid PCR is not appropriate unless volumes are low. Rapid antigen tests are not appropriate for this purpose due to low sensitivity in asymptomatic individuals.

APPENDICES

BON METHOD AND PATIENT RESOURCES

BON Swab Technique

- Developed, studied* and used extensively in Toronto at Michael Garron Hospital
    - High sensitivity compared with Nasopharyngeal swab (87% vs 90%)
    - East to do, including for children/youth swabbing themselves (empowering)
    - Very well tolerated by most but not all children like it
        - Too many sites – prefer “one and done”
        - Putting saliva-soaked swab into the nose – “GROSS”
    - Can be used in adults as well
- Single flocked throat swab used to sample 5 areas, each for 3-5 seconds
    - Circles on the back of the tongue (as far back as tolerated)
    - Circles inside each cheek x 2
    - Circular sweeps of anterior nares (insert the full swab) x 2
- Tips
    - Use firm pressure when rubbing the tongue and cheeks
    - Insert the swab fully into the nose, firm sweep
    - Kids need help breaking the swab, capping the sample
- Processed using RT-PCR technology in the lab alongside other samples

* Kandel CE, Young M, Serbanescu MA, et al. Detection of severe acute respiratory coronavirus virus 2 (SARS-CoV-2) in outpatients: A multicenter comparison of self-collected saline gargle, oral swab, and combined oral–anterior nasal swab to a provider collected nasopharyngeal swab. *Infect Control Hosp Epidemiol* 2021 Jan 13:1-5. PMID 33436122

Take Home Test Kit for COVID-19
INSTRUCTIONS

Please follow these **10 steps** to complete the COVID-19 home kit and return it for testing.

This is the mouth & nose swab test that makes it easier for everyone to get tested for COVID-19. Anyone can collect this swab. Many kids will be able to do it themselves with support of an adult.

1. **Make a plan.** Determine when you will be dropping off the kit to designated collection site. Plan to do the swab about 20-30 minutes before that. It will take you about 10-15 minutes to read these instructions, watch the video, do the swab, and fill in the registration form. **Do not eat or drink, chew gum, smoke or brush your teeth for 30 minutes before the swab.**
2. **Get your supplies ready.** You will need the following materials:
   a. Your test kit containing a swab, tube, label, and Test Registration Form
   b. Hand sanitizer and tissues
   c. Your health card (if you have one)
   d. Computer or phone with internet access (optional)
   e. Insulated lunch bag or cooler, plus an ice pack to keep things cold during travel
3. **Read the instructions on the back of this page and watch the Swab Detective Video.**

   https:/youtu.be/nZOLJJlBs7M
4. **Practice with a Q-tip before doing the actual swab.** This is important if the person being tested is nervous, has never done a test before, had a bad experience with the NP swab in the past, or is a child under 10 who wants to do the swab themselves (with an adult helping).
5. **Complete the registration form**. Fill out the Test Registration Form completely**.**
6. **Print your name and date of birth on the label.**
7. **Do the swab**. Follow the steps closely, as shown on the back of this page. Make sure the lid is on tight and the label with your name is attached to the tube.
8. **Put everything back in the bag**. The swab gets zipped into the inner pocket. The Registration Form should be folded and placed in the outer pocket so that your name can be seen.
9. **Keep it COLD**. Please put the kit into an insulated lunch bag or cooler, along with a small ice pack, to keep it cold until you can drop it off. If there is a delay, please keep the kit in your refrigerator until you leave your house.
10. **Drop it off.** Return the kit to the designated collection site during regular hours.

You're Done!

Thank you for getting tested

THK Instructions EN - 2021/11/12

Instructions for the Combined Mouth & Nose Swab

Watch CHEO's
Swab Detective Video here:
https:/youtu.be/nZOLJJlBs7M

1. Take swab out of bag. Do not drink the liquid

2. Remove the swab from the package and hold the stick in the middle of at the breaking point where there is a small notch

3. 
Stick out your tongue and firmly draw 5 circles on the back of your tongue with the swab

4. 
Firmly rub the inside of your cheek 5 times with the swab

5. 
Do the same thing on your other cheek

6. 
Put the entire sponge of the swab (1 cm) into your nostril and rub all around 5 times

7. 
Do the same thing in your other nostril

8. 
Place the swab into the tube and snap it off at the line. Tighten the lid. Do not drink the liquid!

9. 

Place the label with your name and date of birth horizontally on the tube

THK Instructions EN - 2021/11/12

CHEO

Les trousses de dépistage à domicile de la COVID-19

INSTRUCTIONS

Ottawa Public Health

Veuillez suivre ces **10 étapes** pour compléter et retourner la trousse de dépistage COVID-19.
Ces trousses de test de dépistage à emporter comprennent un test combiné d'écouvillonnage combiné de la bouche et du nez que tout le monde peut effectuer seul ou qui peut être effectué par un parent/tuteur ou gardien. Nous distribuons ces trousses afin de faciliter le dépistage de COVID-19 chez les élèves.

1. **Faire un plan.** Déterminez quand vous déposerez le kit au site de collecte désigné. Prévoyez faire le prélèvement 20 à 30 minutes avant de le retourner. Il vous faudra environ 10-15 minutes pour lire les instructions, visionner le vidéo, faire le prélèvement et remplir le formulaire d'inscription. **Ne pas manger, boire, mâcher de la gomme, fumer ou brosser les dents les 30 minutes avant le test.**
2. **Préparation.** Vous aurez besoin des matériaux suivants :
   a) Votre trousse de dépistage contenant le long coton-tige, le tube, l'étiquette et le formulaire d'inscription
   b) Désinfectant des mains et mouchoirs
   c) Votre carte santé (si vous en avez une) et le numéro du dossier médical de CHEO (si vous le savez)
   d) Ordinateur ou téléphone avec accès au réseau mobile (facultatif)
   e) Boîte à dîner et de la glace pour garder la trousse froide pendant le transport
3. **Lisez les instructions à l'arrière de cette page et visionnez le vidéo de détective SWAB.**
   https://youtu.be/6ql0BmL6YLo
4. **Pratiquez avec un coton-tige (Q-tip) avant de faire le test.** Ceci est important si l'enfant est nerveux et n'a jamais fait un test de dépistage auparavant, ou a eu une mauvaise expérience avec le test de dépistage habituel (nasopharynx), ou est un enfant moins de 10 ans et veut faire le test lui-même (avec la supervision d'un adulte).
5. **Remplissez le formulaire d'inscription.** Sinon, remplissez la copie papier du formulaire.
6. **Inscrire votre nom et votre date de naissance sur l'étiquette.**
7. **Faites le test de dépistage.** Suivez les étapes de près, comme indiqué à l'arrière de cette page. Assurez-vous que le couvercle est bien serré et que l'étiquette avec votre nom est bien collée au tube.
8. **Remettez le tout dans le sac.** Placez le coton-tige dans la poche intérieure. Le formulaire d'inscription doit être plié et placé dans la poche extérieure afin de bien identifier votre nom.
9. **Gardez la trousse FROIDE.** Vous devez mettre la trousse dans une boîte à dîner avec de la glace ou dans une glacière pour le garder au froid jusqu'à ce que vous le retourniez. S'il y a un délai, veuillez mettre la trousse dans votre réfrigérateur jusqu'à ce que vous quittiez votre maison.
10. **Retournez la trousse.** Retournez le kit au site de collecte désigné pendant les heures normales.

Vous avez fini !
Merci d'avoir fait votre test de dépistage

THK Instructions FR - 2021/11/12

Comment effectuer le prélèvement combiné buccal et nasal

Regardez la vidéo du Détective SWAB

https://youtu.be/6ql0BmL6YLo

1. **Sortir le coton-tige du sac.**
   Ne bois pas le liquide du tube!

2. **Sortir le coton-tige de l'emballage. Tenez-le au milieu près du point de rupture**

3. 
   Sors ta langue. Dessiner fermement 5 cercles à l'arrière de ta langue avec le coton-tige

4. 
   Utilisez le coton-tige pour frotter fermement à l'intérieur de l'une de tes joues, 5 fois.

5. 
   Fais la même chose à l'intérieur de l'autre joue.

6. 
   Mettre toute l'éponge du coton-tige (1cm) à l'intérieur d'une narine et frotte autour 5 fois

7. 
   Fais la même chose dans ton autre narine.

8. 
   Placez le coton-tige dans le tube. Casse le bâton sur la ligne. Serre le couvercle. Ne boit pas le liquide du tube !

9. 
   Colle l'étiquette fournie, à l'horizontale, sur le tube.

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APPENDICES

GETTING SPECIMENS TO THE LAB

Once you decide to collect COVID-19 specimens in your office (or provide kits for your patients to collect their own specimens), those specimens need to get to an appropriate lab for processing with you as the ordering provider. Specimens can be processed by the Public Health Ontario Laboratory (PHOL) located in Ottawa (St. Laurent Blvd) or one of the private lab providers (Dynacare, LifeLabs, Bio-Test, etc.) That lab would then provide you with a result in the usual way that you receive results from them (eFax, direct upload into your EHR, etc.) as well as upload the result to the provincial portal for patients to see their results (see next section).

There are several possibilities for getting specimens to the lab:

1. **Existing Lab Provider** – If you already send samples out to a private lab and they provide a courier to pick up samples from your office, inquire with them whether they can also accept COVID-19 specimens. Be sure to clarify that you are sending BON swabs on flocked throat swabs to ensure they have validated processing this type of specimen. They may also have questions about the specific swab and/or media that you have received from the province. Be sure to understand the timing between when specimens would be picked up from your office and when you could expect a result, as some labs send specimens to Toronto for processing.

2. **Existing Courier to PHOL** – Your office may already send specialty microbiology samples to PHOL through an existing courier network or service. Confirm that they can also accept COVID-19 specimens. Understand the timing between when specimens would be picked up from your office and when they would receive at PHOL. Results from PHOL are typically 12-18 hrs after they have received the specimen. PHOL can receive all specimen and media types listed on their website (https://www.publichealthontario.ca/en/laboratory-services/covid-19-pcr-collection-kits). If you are not yet registered with PHOL to receive results by eFax, you can do so by contacting their Customer Service Centre (1-877-604-4567, customerservicecentre@oahpp.ca)

3. **Liaise with Nearby Practices –** Are there other practices in your building or in close vicinity that are doing testing and have a courier solution that you can participate in?

4. **Hire a New Courier to Deliver Specimens to PHOL -** If your office were doing many swabs each day, it could be beneficial for you to arrange a dedicated courier to transport your specimens to PHOL on a schedule that makes sense for your practice. However, the cost of this is typically $30-50 per trip, making it cost-prohibitive. There are many medical couriers to approach for this service.

APPENDICES

PATIENT EDUCATION AND RESULTS MANAGEMENT

5. Patients who are tested should be counselled on ongoing isolation requirements, pending results, in addition to instructions on managing/monitoring symptoms for progression. Their vaccination status along with whether they have been identified as a high-risk exposure will determine whether a negative COVID-19 test permits them to end isolation (assuming their symptoms have resolved). An excellent resource for patients is the Ottawa Public Health handout *Tested for COVID-19, What Now?* (available in Arabic, Chinese, Somali and Spanish on their website).

6. Just like other tests you order, you are responsible to follow-up on results of completed tests, as well as identify those that have not been completed as expected (i.e., lost, not reported, etc.). Therefore, it is important to have a good process to record who you have tested and to regularly review those that remain outstanding – if there is no result 24-48 hrs past when you would expect it, it is time to start looking.

7. Patients should be provided with an expected timeline for when their result will be available to them and how you will handle the result. They should have a timeline for when they should reach out to you if they have not heard or have been unable to obtain their own result (see #4).

8. According to the CPSO, it is reasonable to rely on patients to obtain their own negative results from the provincial portal (https://covid19results.ehealthontario.ca:4443/agree) or from your practice patient portal if this exists. Accessing the provincial portal assumes that the patient has an Ontario Health card, has internet access, and is internet savvy. For patients that will not be able to obtain their own result, it is best to flag their chart and communicate the result to them.

9. All positive results must be communicated to the patient as soon as possible. This ensures that they continue their isolation practices and begin contacting their contacts (anyone they were in contact with in the 48 hrs prior to symptom onset, or prior to testing if asymptomatic, unless that contact was transient and distanced while both parties were masked). Ottawa Public Health Case and Contact Management staff will reach out to all individuals as well, unless they are overwhelmed with cases, to initiate contact tracing. But this can sometimes be a few days after the result is back.

10. Patients who test positive should be instructed on signs and symptoms that would prompt seeking medical attention – increasing shortness of breath, chest pain, excessive fatigue/lethargy making ambulation difficult, syncope or confusion, etc. Ideally, you would continue to check in with higher-risk individuals on a regular basis or ensure that someone is. Individuals who need food or shelter support (isolation from other household members) can contact 211 to be connected to those supports.

11. There is no need for you to report positive cases to the local public health officer unless you have concerns about a large outbreak, especially in a congregate or vulnerable population, or where you are concerned that the patient is not following appropriate isolation instructions. Public health is automatically notified of all positive cases based on the patient's postal code.