

Coronavirus COVID-19

BC Centre for Disease Control | BC Ministry of Health



HOW YOU CAN SLOW THE SPREAD OF COVID-19

Take care of others by taking care of yourself.

Wash your hands, don't touch your face, and stay home if you are sick.

Stay at Home and Physically Distance

Stay at home whenever you can. Maintain 2 meters distance from those outside of your household.

Guidance for Primary Care Management of Adult Outpatients with Suspected or Confirmed COVID-19

Effective date: December 3, 2020

Updated: December 18, 2020 (Minor revision to align with updated testing guidance)

Updated: May 10, 2021 (Minor revision to add updated recommendations on inhaled budesonide and colchicine)

Scope: This guidance document provides recommendations to primary care practitioners (family physicians and nurse practitioners) for the assessment and management of adult patients with symptoms suggestive of COVID-19, suspected COVID-19, or confirmed diagnosis of COVID-19. Contact tracing management of confirmed cases and their contacts is the responsibility of public health and is outside the scope of this document.

Detailed guidance on the following topics is out of the scope of this document. However, we anticipate that primary care practitioners will be asked about these topics and we refer them to the following links: [School settings](#) (refer to Daily Health Check example on page 23), [Pediatrics](#), [Pregnancy](#), [Newborns](#), [Acute care](#), [Long-term care and assisted living facilities](#), and [Healthcare Workers](#). Community living environments and correctional facilities are also out of scope.

Revision history: This document is a revision of CRG 11: *Outpatient Management of Suspected and Confirmed COVID-19 (April 14, 2020)*. It aligns with, is adapted from, and makes reference to [Interim Guidance: Public Health Management of cases and contacts associated with novel coronavirus \(COVID-19\) in the community \(BCCDC, September 25, 2020\)](#) and [Clinical management of patients with COVID-19: Second interim guidance \(PHAC, August 17, 2020\)](#).

Hyperlinks: This document contains many hyperlinks to webpages and other guidance documents on the BC Centre for Disease Control's (BCCDC) website instead of reproducing information in the text. Due to the rapid pace of change to guidance documents, please refer to the current [BCCDC website](#) as the most accurate and current source of information.

Disclaimer: This guidance is also based upon current knowledge. It should be understood that guidance is subject to change as new data become available and new developments arise with this virus. Furthermore, unique situations may require some discretion in adjusting these guidelines which are meant to be supportive, not prescriptive.



Ministry of Health



BC Centre for Disease Control

If you have fever, a new cough, or are having difficulty breathing, call 8-1-1.

Non-medical inquiries (ex. travel, physical distancing): 1-888-COVID19 (1888-268-4319) or text 604-630-0300



Signs and Symptoms (Adult)

- COVID-19 illness can mimic many other illnesses including the common cold and influenza. If in doubt with respect to diagnosis, rule out COVID-19 first. Clinical symptoms of COVID-19 may be mild or severe.
- In B.C., of 266 COVID-19 associated deaths recorded in total by October 31, 2020, about two-thirds occurred before June 24, i.e. before the broader reopening of the economy and society. In total, two-thirds of those deaths were associated with a long-term care facility outbreak, and 85% were among people aged 70+ years.¹
- Figure 1 displays hospitalizations, ICU admissions and deaths among COVID-19 cases by age group in B.C.:

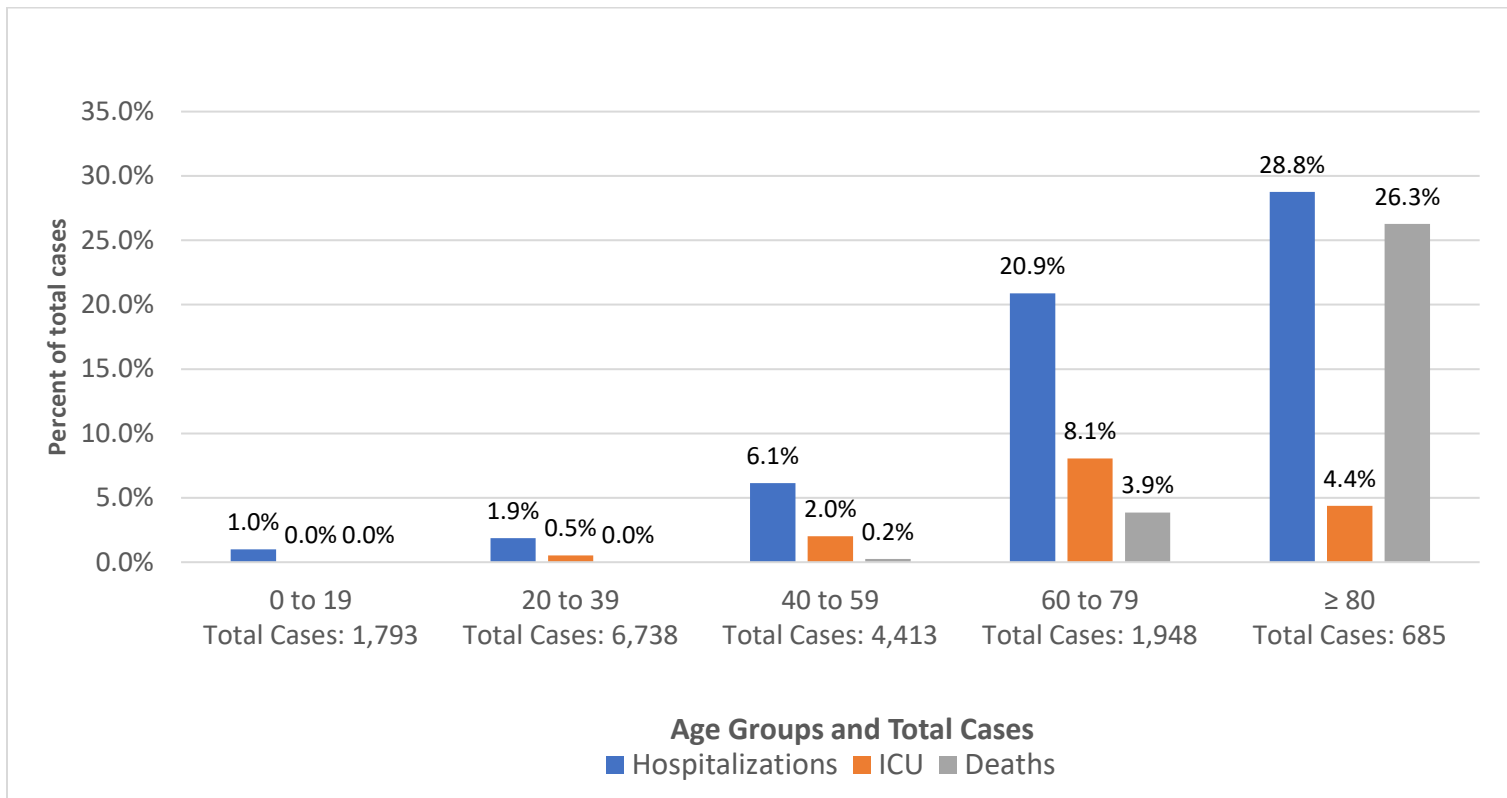


Figure 1. Hospitalizations, ICU admissions and deaths among COVID-19 cases by age group, British Columbia, January 15, 2020 – October 31, 2020. Data are provided in table format in the Appendix.

- Clinical judgement remains important in the diagnosis and work-up of individuals presenting with these symptoms.²
 - Maintain awareness that patients with this symptom profile may have other serious illnesses such as influenza, COPD exacerbation pneumonia, other infectious diseases, etc.
 - Providers are recommended to have a low threshold for testing symptomatic individuals for COVID-19 infection.²
- People can be infectious 48 hours before onset of symptoms and up to 10 days after onset of symptoms (up to 20 days depending on factors including immunocompromised status and severity of disease).³
- Continue to pre-screen patients for symptoms of COVID-19 in advance of in-person care.

Encourage all patients to obtain influenza and other appropriate vaccinations (e.g. pneumococcal).

Table 1. Symptoms associated with COVID-19 infections in adults include:

Symptoms strongly associated with COVID-19	General symptoms	Non-specific symptoms
<ul style="list-style-type: none"> • Fever or chills • Cough (either new onset or worsening of chronic cough) • Difficulty breathing • Loss of sense of smell or taste 	<ul style="list-style-type: none"> • Sore throat • Loss of appetite • Extreme fatigue or tiredness • Headache • Body aches • Nausea, vomiting or diarrhea 	<ul style="list-style-type: none"> • Nasal symptoms (runny nose, sneezing, congestion, sinus involvement) • Conjunctivitis • Dizziness • Confusion • Abdominal pain • Skin rashes • Discoloration of fingers or toes

Testing

Indications for testing adults

- **Testing criteria are constantly evolving. [Refer to the most current criteria.](#)**
- As the COVID-19 pandemic has evolved, additional evidence now leads to more specific recommendations about the symptom complexes and clinical situations that result in recommendations for testing. In many instances, the bar for testing must remain low, but in other instances the threshold for testing may be higher. Detailed and thorough guidance on who should be tested and how are available at: [Viral Testing](#).
- In the interim while waiting for test results, do not fail to evaluate and treat for other serious conditions, including with in-person visit, if needed. Guidance for conducting safe office visits is outlined in: [Infection and Prevention Control Guidance for Community-Based Physicians, Nursing Professionals and Midwives in Clinic Settings](#).
- It is particularly important to test symptomatic individuals who: ¹
 - Are residents or staff of long-term care facilities
 - Require admission to hospital or are likely to be admitted
 - Are healthcare workers
 - Are contacts of a person diagnosed with COVID-19
 - Are travellers who in the past 14 days returned to B.C. from outside Canada, or from an area with higher infection rates within Canada
 - Are residents of remote, isolated, or Indigenous communities
 - Live in congregate settings such as work-camps, correctional facilities, shelters, group homes, assisted living and seniors' residences
 - Are homeless or have unstable housing
 - Are essential service providers, such as first responders

Non-indications for testing

- Testing of asymptomatic individuals is only recommended for use in public health investigations of a case, cluster or outbreak, and under the direction of a medical health officer.

- For more information about testing asymptomatic individuals, refer to: http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID19_Testing_Asymptomatic_Individuals.pdf (last updated August 20, 2020)
- Testing for asymptomatic persons for any other reason, e.g., for occupational, travel, other non-medical indications, is not funded by the Medical Services Plan (MSP). The BCCDC’s website includes a [list of private pay clinics](#).

Where to get a test

- The [BC COVID-19 Collection Centre Finder](#) is a regularly updated list of collection centres with instructions on how to access each site. It is the source for testing site information that 8-1-1 provides to callers.
 - Many sites are appointment-only and walk-in sites are available in some regions (refer to map).
 - There may be regional differences in testing site availability. There are also some practitioners who will perform testing in the office; refer to [specimen collection instructions](#).
- Ensure patients are aware of HealthLinkBC (8-1-1), which is an excellent resource for COVID-19 information including testing site locations and guidance.

Outpatient Management of Patients with COVID-19

Criteria for outpatient management

- Most patients with confirmed COVID-19 will have mild to moderate symptoms (e.g., cough, sore throat, fever, and rhinorrhea) and can be safely managed as an outpatient in the community setting.
- Consider a conversation about advance care directives. Remember to review code status and complete a [Medical Orders for Scope of Treatment \(MOST\) form](#) for patients at risk of decompensation or being referred to hospital.
- Determine if outpatient management is appropriate and if the patient is capable of self-care. Consider the following:

Criteria for outpatient management	Adult patients should: <ul style="list-style-type: none"> ● Be able to: stay well hydrated; to manage their comorbidities at home; reliably report worsening symptoms (e.g. language, cognitive status); and, carry out their usual activities of daily living. ● Have appropriate resources and social supports to self-isolate and manage their comorbidities. ● Have stable vitals and no signs of respiratory distress or persistent tachypnea. ● (If pulse oximetry is available) should have an SpO₂ >93% on room air. SpO₂ of 90% to 93% on room air may be acceptable if a patient has a pre-existing chronic lung disease. If outside these parameters, they should be assessed for possible admission to hospital.
Possible risk factors for progression to severe illness	Encourage patients with the following risk factors to monitor their symptoms very closely and contact their provider if symptoms change: <ul style="list-style-type: none"> ● Older age >60¹; risk increases with each decade.⁴ ● Underlying chronic medical conditions (e.g. lung disease, cancer, cardiovascular disease, obesity/elevated body mass index (BMI), hypertension, heart failure, cerebrovascular disease, renal disease, liver disease, diabetes, immunocompromising conditions, substance use disorders).⁴

¹ Source: unpublished BC COVID-19 data from health system planning; PHSA.

The decision regarding the location of care should be made on a case-by-case basis and will depend on the clinical presentation, need of supportive care, potential risk factors for severe disease, and living conditions, including the presence of other care providers and/or vulnerable persons in the household.⁴

Clinical management of outpatients with COVID-19

- The BC COVID-19 Therapeutics Committee meets regularly to discuss the most current research on the use/misuse of therapies in the management of COVID-19. Refer to their current treatment recommendations, which are revised regularly as evidence changes.
- At this time, there are two potential treatments for patients with COVID-19 infection in the outpatient setting:
 - **Inhaled budesonide**
Inhaled budesonide 800 µg BID twice daily x 14 days may be considered on a case-by-case basis for adults with mild COVID-19 within 14 days of symptom onset who are aged 65 or over **OR** aged 50 or over with underlying health conditions.²
Possible benefit = Inhaled budesonide reduces time to symptomatic recovery by one to three days. COVID-19-related hospitalization may be reduced, but this remains uncertain in the literature at this time.
Possible harm = Adverse effects associated with short course inhaled budesonide include oral thrush and dysphonia.
Cost = Budesonide Turbuhaler® 200 mcg/dose (200 doses/inhaler) is approximately \$75 and 400 mcg/dose (200 doses/inhaler) is approximately \$110, plus professional dispensing fee. PharmaCare coverage: Regular benefit
 - **Colchicine**
Colchicine 0.6 mg PO BID x 3 days, then 0.6 mg PO daily x 27 days may be considered on a case by case basis for adults aged 40 years or over with mild COVID-19 with at least one risk factor³ and no contraindications⁴ to colchicine.
Possible benefit = Colchicine may reduce hospitalization in one out of 71 patients (4.5% colchicine vs. 5.9% placebo).
Possible harm = Side-effects include diarrhea (14% colchicine vs. 7% placebo) and nausea (2% colchicine vs. 2% placebo), and pulmonary embolism (0.5% colchicine vs. 0.1% placebo).

² Inhaled budesonide – underlying health conditions: weakened immune system due to illness or medication, heart disease and/or hypertension, chronic lung disease, diabetes mellitus, hepatic impairment, stroke or other neurological condition, obesity or BMI above 35.

³ Colchicine – risk factors: age >70 years, obesity (BMI >30 kg/m²), diabetes, hypertension (systolic >150 mmHg), respiratory or coronary disease, heart failure, fever >38.4°C, or dyspnea.

⁴ Colchicine – contraindications: GFR <30 mL/min, inflammatory bowel disease, chronic diarrhea or malabsorption, neuromuscular disease, severe liver disease, chemotherapy, current colchicine treatment, hypersensitivity to colchicine, or concurrent medications that interact with colchicine (e.g. amiodarone, azoles, carvedilol, cyclosporine, estradiol, macrolides, propafenone, protease inhibitors, quinidine, quinine, verapamil). *In clinical practice, these are relative contra-indications and one could consider trial of colchicine if potential benefits outweigh potential risks. See product monograph: https://pdf.hres.ca/dpd_pm/00034804.PDF

Cost = Course of colchicine treatment is approximately \$15, plus professional dispensing fee. PharmaCare coverage: Regular benefit

- Additionally, supportive treatment should be based on the provider's assessment of the patient's clinical condition. For patients being cared for or recovering at home, standard treatment for cold-like symptoms and influenza-like illness is recommended.
 - a. For symptomatic management, there is limited data to suggest acetaminophen should be used preferentially over nonsteroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen.⁵ NSAIDs can be considered if needed and patients who are already taking them can continue to do so.
 - b. Dexamethasone IV or equivalent glucocorticoid is currently only indicated for COVID-19 patients who are hospitalized and require supplemental oxygenation.⁴
 - c. There is no evidence to support the use of chloroquine, hydroxychloroquine or ivermectin in patients with COVID-19. Patients who inquire about alternative remedies should be advised against them.
- ACE inhibitors and ARBs should not be discontinued solely on the basis of COVID-19
- NSAIDs should not be discontinued solely on the basis of COVID-19
- Advanced imaging, and even conventional radiography should not be used for the diagnosis of COVID-19 infection.⁶

Self-isolation guidance

- For patients that require self-isolation and need to be seen in the clinic setting, refer to the [IPC guidance for Community Healthcare Providers](#) for appropriate measures (e.g. contact and droplet precautions).
- Alternate arrangements for self-isolation may be needed for people in crowded living arrangements.

Patient group	Guidance for self-isolation
COVID-19 positive patients	<ul style="list-style-type: none"> • Patients with mild-to-moderate symptoms that can be managed at home are able to their routine activities once the following criteria are met: <ul style="list-style-type: none"> ▪ At least 10 days* have passed since the onset of symptoms; AND ▪ Symptoms (respiratory, gastrointestinal, and systemic) have improved; AND ▪ Fever has resolved while off fever-reducing medication. • Cough may persist for several weeks and does not mean the patient is infectious. The patient does not need to prolong their self-isolation. • All outpatients with COVID-19 and their high risk close contacts (as defined by public health) should be instructed to follow public health protocols for self-isolation. The minimal period of isolation is determined by public health. <p>*Those with more severe illness or who are severely immunocompromised (e.g. on chemotherapy, untreated HIV with CD4 <200) require 20 days instead of 10 days of self-isolation.</p> <p>If a person with COVID-19 lives in a First Nations community, lives off-reserve and receives services in a First Nations community, or has identified contacts within a First Nations community, the COVID-19 Adapted Regional Health Authority - First Nations Health Authority Communicable Disease Protocol provides information on the roles, responsibilities and activities of the First Nations Health Authority and the regional Health Authorities to guide the collaborative follow-up of such individuals.³</p>
Patients with symptoms clinically suspect for COVID-19 (pending testing result, or not yet tested)	<ul style="list-style-type: none"> • Patients who have symptoms, and who are either waiting for a test result or not yet tested, must self-isolate at home until: <ul style="list-style-type: none"> ▪ At least 10 days* have passed since the onset of symptoms; AND ▪ Symptoms (respiratory, gastrointestinal, and systemic) have improved; AND ▪ Fever has resolved while off fever-reducing medication. • Cough may persist for several weeks and does not mean the patient is infectious. The patient does not need to prolong their self-isolation. • Provide patient with: Instructions for symptomatic patients • Healthcare workers and workers in specific settings may need to follow different guidance for ending self-isolation. <p>*Those with more severe illness or who are severely immunocompromised (e.g. on chemotherapy, untreated HIV with CD4 <200) require 20 days instead of 10 days of self-isolation.</p>
Patients with symptoms not clinically suspect for COVID-19	<p>Patients whose symptoms in the judgment of their clinician do not warrant COVID-19 testing need not be isolated. If symptoms worsen, the patient should be re-assessed.</p>
COVID-19 Test-negative patients who remain symptomatic	<ul style="list-style-type: none"> • Patients who test negative but remain symptomatic must self-isolate at home until: <ul style="list-style-type: none"> ▪ Symptoms (respiratory, gastrointestinal, and systemic) have improved; AND ▪ Fever has resolved while off fever-reducing medication. • Provide patient with: Handout on when to end self-isolation after a test
Asymptomatic high-risk close contacts	<ul style="list-style-type: none"> • Individuals who are notified by public health officials that they are close contacts of confirmed COVID-19 cases must self-isolate for 14 days from their last exposure to the case, and follow public health's direction. If symptoms develop, self-isolation will be longer at the direction of public health. • The determination of a high-risk close contact is made by public health according to Interim Guidance: Public Health Management of cases and contacts associated with novel coronavirus (COVID-19) in the community (#3 on page 9).
Individuals returning from outside Canada	<ul style="list-style-type: none"> • Individuals who are arriving or returning from travel outside Canada must self-isolate for 14 days (or longer, if symptoms develop) and follow public health direction. • If symptoms develop, patients should be tested and self-isolate according to the directions for symptomatic persons above.

Indications for referral of COVID-19 patients to hospital

- Counsel patients with mild COVID-19 and their caregivers about the signs and symptoms of complications that should prompt urgent care. If they develop symptoms below, they should be referred for further assessment:
 - a. unstable vitals
 - b. dehydration
 - c. SpO₂ ≤ 93% (or <90% with a chronic lung condition)
 - d. shortness of breath, pain or pressure in the chest, confusion, drowsiness, or weakness⁴
 - e. any other deterioration in status
- If the patient's status deteriorates and they require a higher level of care or cannot be managed at home, refer to hospital.
- Early identification of those with severe illness, pneumonia, or high risk for deterioration allows for optimized supportive care treatments and safe, rapid referral and admission to a hospital.⁴
- Identify if there is an advance care plan and clarify code status. Complete a [MOST form](#) for patients at risk of decompensation or being referred to hospital. Palliative care should be explored early as appropriate.
- If transferring a patient from the community to an acute care facility, notify BC Emergency Health Services (BCEHS) and the receiving facility prior to transfer/arrival to ensure appropriate infection prevention and control measures can be put in place.³

Care of COVID-19 patients discharged from hospital

Discharge discussions should take place in collaboration with the primary care practitioner and/or community of care, and public health. In some locations, patients may be transferred to a bed at home via Hospital at Home and remain under hospital care. Ensure that the patient's individual context, including access to transportation, living situation and family/household supports, is taken into consideration when deciding when and how to discharge.

Patients may be discharged in the following situations:

- when medically well and not on oxygen, unless previously on home O₂; or
- palliative care at home.

When patients are discharged back to home, either alone or with family:

- Routine follow-up takes place with the primary care practitioner. Patients who have been hospitalized because of COVID-19 infection are at higher risk of complications and should be connected with primary care follow up.
- Public health follow-up takes place regarding any ongoing COVID-19 public health issues for patient or family, including living arrangements, isolation, and follow-up COVID-19 testing.
- Older people are more likely to experience pronounced functional decline and may require coordinated rehabilitation or convalescent care.⁴

Remote and Rural Considerations

There is limited capacity in remote and rural areas to provide care for those with severe illness. Variation may exist from community to community regarding the types of acute care services available, telehealth and medivac capacities. Supports are available for practitioners in rural areas: refer to Practitioner Resources.

Treatment considerations include the following measures:⁴

- Mild to moderate disease, including uncomplicated pneumonia, may be managed within the community, with appropriate precautions in place.
 - a. Mild cases may progress to lower respiratory tract disease. Be aware of the risk factors for progression to severe illness including older age and underlying chronic medical conditions (refer to Table 1).
 - b. Some communities may need to consider arrangements for patients at higher risk to live closer to an acute care facility.
- Alternate arrangements for self-isolation may be needed for people in crowded living arrangements.
- Fluid management should be conservative when there is no evidence of shock because aggressive fluid management may worsen oxygenation.
- Patients should be carefully monitored for signs of impending deterioration (i.e. escalating O₂ needs) so that transfer can be arranged before intubation is required. Clinicians should be aware of the potential for some patients to rapidly deteriorate 1 week after illness.
- Anticipate delays in accessing hospital care (e.g., awaiting air-ambulance, weather issues). Therefore, a low threshold should be considered for medevac options. Receiving hospitals may need to tailor their policies for accepting COVID-19 patients.

Long-term complications of COVID-19

Many patients report long-term health effects after recovering from acute COVID-19 infection that may persist for months. This is an area of emerging evidence. Public Health England has found that approximately 10% of mild COVID-19 cases who were not admitted to hospital have reported symptoms lasting more than four weeks. A number of hospitalised cases reported continuing symptoms for eight or more weeks following discharge.⁷ Patients have experienced the following health problems after recovery from acute COVID-19^{7,8}:

- Extreme fatigue
- Muscle weakness
- Low grade fever
- Inability to concentrate
- Memory lapses
- Changes in mood
- Depression, anxiety, and cognitive difficulties
- Sleep difficulties
- Headaches
- Paresthesia in arms and legs
- Diarrhea and intermittent vomiting
- Loss of or change of taste and smell
- Sore throat and swallowing difficulties
- New onset of diabetes or hypertension
- Respiratory symptoms and conditions such as chronic cough, ongoing shortness of breath, lung inflammation and fibrosis, and pulmonary vascular disease
- Skin rash
- Chest pains, chest tightness
- Acute myocarditis
- Heart failure
- Palpitations
- Inflammatory disorders such as myalgia, multisystem inflammatory syndrome, Guillain-Barre syndrome
- Liver and kidney dysfunction
- Clotting disorders and thrombosis
- Lymphadenopathy

Referral information for the St. Paul's Hospital COVID-19 Recovery Clinic is available [here](#). Patients can be referred from any geographic location in B.C. Physicians are also available for rapid consultation on the provincial RACE Line.

Mental well-being of patients and providers

- Practitioners are reminded that in assisting patients with suspected or known COVID-19, there may be heightened levels of both new and worsening anxiety, depression and PTSD. Be aware of the emotional impacts and impacts on all areas of life. Pay particular attention to the need to make the instructions to patients clear, simple and empathetic.
 - [Resources to support patients' mental well-being during COVID-19](#)
- Remember to take good care of yourself.
 - [Resources to support health care providers' well-being during COVID-19](#)

Practitioner Resources

Clinical guidance

- [List of the most recent updates to BCCDC Clinical Guidance and PHO Orders and Guidance](#)
- [Infection Prevention and Control Guidance for Community-Based Physicians, Nursing Professionals and Midwives in Clinic Settings](#)
- [Doctors of BC: Resources for supporting physicians in re-opening offices](#)
- [BC Family Doctors: Deciding between virtual and in-person consultations](#)
- [Public Health Agency of Canada: Clinical management of patients with COVID-19: Second interim guidance](#)
- [Spectrum Infectious Disease Clinical Support App](#)
- Settings out of scope of this document: [School settings](#) (refer to Daily Health Check on p. 23), [Pediatrics](#), [Pregnancy](#), [Newborns](#), [Acute care](#), [Long-term care and assisted living facilities](#), [Healthcare Workers](#)
- [Choosing Wisely Canada: The Cold Standard – Three clinical tools that can support virtual and in-person management of respiratory tract infections](#)

Rapid consultation services

- For practitioners:
 - [The RACE Line](#) – Infectious Diseases – COVID-19 (Clinical) is available 8am-5pm, Monday through Friday, to help clinicians with differential diagnoses, work-up and management recommendations.
 - [RUDi \(Rural Urgent Doctor in-aid\)](#)
 - [ROSe Critical Care](#)
- For First Nations community members and their families: [First Nations Virtual Doctor of the Day](#)

Contact tracing: [How public health contact traces](#)

Patient guides: [BCCDC resources for patients who are being tested, self-isolating, and/or self-monitoring](#)

Statement regarding sick notes: [BC Family Doctors: Statement regarding sick notes](#)

BC COVID-19 data: [Including map of cases by geographic areas, weekly situation report, and provincial, Canadian and global epidemiology dashboards](#)

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List of Contributors

This document was developed by the Primary Care Working Group: Dr. Doug McTaggart (Co-Chair), Dr. Sandra Lee (Co-Chair), Dr. Terri Aldred, Dr. Jeanette Boyd, Dr. Jaron Easterbrook, Celia Evanson NP, Dr. Mitchell Fagan, Dr. Bruce Hobson, Dr. Kelsey Louie, Dr. Tracey Parnell, Dr. Julia Stewart, and Dr. Serena Verma. Public health consultation regarding management of cases and contacts provided by Dr. Veronica Clair, BCCDC. Project Lead/Research Officer: Fritha Munday.

This document was reviewed by: the Clinical Reference Group IPC Subcommittee (Tara Donovan, Ka Wai Leung, Dr. Titus Wong); the Clinical Reference Group Emergency Medicine Subcommittee (Dr. Andrew Kestler), the Clinical Reference

Group Pediatrics Subcommittee (Dr. Esther Lee); the Public Health Reference Group (Drs. Veronic Clair, Trevor Corneil, Gina Ogilvie, and Troy Grennan); and Public Health Leadership (Dr. Andrew Gray). This document was approved by: the Clinical Reference Group, Public Health Reference Group, BCCDC COVID-19 Oversight Committee, Public Health Leadership, and the Ministry of Health.

Appendix

Hospitalizations, ICU admissions and deaths among COVID-19 cases by age group, British Columbia, January 15, 2020 (week 3) – October 31, 2020 (week 44)

Age group (years)	Cases	Hospitalizations		ICU		Deaths	
	n	n	%	n	%	n	%
<10 - 19	1,793	18	1.0%	0	0%	0	0%
20-39	6,738	125	1.9%	36	0.5%	0	0%
40-59	4,413	271	6.1%	89	2.0%	11	0.2%
60-79	1,948	407	20.9%	157	8.0%	75	3.9%
80-90+	685	197	28.8%	30	4.4%	180	26.3%
Total	15,577	1,018	7%	301	2%	266	2%