Guidance for Primary Care Management of Adults in the Community with Suspected or Confirmed COVID-19

Target audience: Family physicians and primary care nurse practitioners

Effective since: 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.

Updated: July 16 2021. Full revision. Added references to immunization. Added recommendation that patients with COVID-19 infection who experience any sign of deterioration should seek care in person. References updated. Title updated.

Scope: Assessment and management of adult patients in the community with symptoms suggestive of COVID-19, suspected COVID-19, or confirmed diagnosis of COVID-19. Community living environments and correctional facilities are out of scope.

Detailed guidance on the following topics are also out of scope. Refer 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
- Health-care workers

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

Signs and Symptoms (Adult)

- Clinical judgement remains important in the diagnosis and work-up of individuals presenting with these symptoms,[2] regardless of immunization status.
    - Maintain awareness that patients with this symptom profile may have other serious illnesses such as influenza, COPD exacerbation pneumonia, and/or other infectious diseases.
- People can be infectious 48 hours before onset of symptoms. People with mild to moderate severity of disease and who are not moderately to severely immune compromised are considered infectious up to 10 days after onset of symptoms, as long as the symptoms have improved and there is no fever without the use of fever medication for at least 24 hours. Refer to Interim Guidance: Public Health Management of Cases and Contacts Associated with Novel Coronavirus (COVID-19) in the Community for more details on infectious period and related criteria for ceasing isolation in the community.
- Continue to pre-screen patients for symptoms of COVID-19 before in-person care.

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

Symptoms strongly associated with COVID-19	General symptoms	Non-specific symptoms
• Fever or chills • Cough (either new onset or worsening of chronic cough) • Difficulty breathing • Loss of sense of smell or taste	• Sore throat • Loss of appetite • Extreme fatigue or tiredness • Headache • Body aches • Nausea, vomiting or diarrhea	• 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 BC Centre for Disease Control's (BCCDC) current criteria.** Providers should have a low threshold for testing symptomatic individuals for COVID-19 infection.[2]
- Testing guidance is not meant to replace clinician assessment, and providers should continue using their clinical judgement in determining whether a COVID-19 test is required.
- In the interim while waiting for test results, evaluate and treat for other serious conditions including with in-person visit, if needed.
- **The general guidance for people who have new or worsening symptoms is:**

1. Recommend testing if **any one of the following symptoms** more predictive or strongly associated with COVID-19 is reported:	• Fever or chills • Cough (either new onset or worsening/exacerbation of chronic cough) • Loss of sense of smell or taste • Difficulty breathing
2. Recommend testing if **any two or more** of the following general symptoms persist after 24 hours, and are not related to any other pre-existing conditions:	• Sore throat • Loss of appetite • Extreme fatigue or tiredness • Headache • Body aches • Nausea, vomiting or diarrhea
3. **Testing is recommended for those who have had close contact with a COVID-19 case and have even a single symptom included above.**	

- Consider a lower testing threshold for **symptomatic** individuals who: [1]
    - Are residents or staff of long-term care facilities
    - Require admission to hospital or are likely to be admitted
    - Are health-care 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 medical health officer's (MHO's) direction.
- 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). Refer to the BCCDC's list of private pay clinics.

Where to get a test

- Refer to the online B.C. COVID-19 collection centre finder.
- Some practitioners who will perform testing in the office; refer to specimen collection instructions.

Outpatient Management of Patients with COVID-19

Criteria for outpatient management

- Most patients with confirmed COVID-19 have mild to moderate symptoms (e.g., cough, sore throat, fever, and rhinorrhea) and can be safely managed as outpatients in the community setting.
- Practitioners and patients should be aware that rapid deterioration may occur at any point after illness onset. If the patient has any concerns or signs of deterioration, they should immediately consult a health-care practitioner in person at an urgent clinic, emergency department or call 9-1-1.
- The following patient management recommendations are the same regardless of patient immunization status.
- Severe illness can still occur in patients who are partially or fully immunized.
- 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. Refer to the Serious Illness Conversation Guide and summary MOST form guidance.
- Determine if outpatient management is appropriate and if the patient is capable of self-care. Consider:

Criteria for outpatient management	**Adult patients should:** • Be able to: stay well hydrated; manage their comorbidities at home; reliably report worsening symptoms (e.g., speech, cognitive status); and, carry out their activities of daily living. • Have appropriate resources and social supports to self-isolate, monitor their condition and manage their comorbidities. • Have stable vitals and no signs of respiratory distress or persistent tachypnea.

	• Some patients have pulse oximetry at home. They should be specifically counselled to ensure they understand what an appropriate value is on their monitor and when to seek care. • If pulse oximetry is available, patients should have an SpO2 >93% on room air. Sp02 of 90% to 93% on room air may be acceptable if a patient has a pre-existing chronic lung disease. If outside these parameters, patient should be assessed for possible admission to hospital.
Possible risk factors for progression to severe illness[4]	**Encourage all patients to monitor their symptoms very closely and contact their provider if symptoms change.** **Patients with the following risk factors may be more likely to progress to severe illness:** • Age: Risk for severe disease increases in adults with each decade, with those older than 60 years old having very large increase in risk of severe disease and mortality from COVID-19.[,5] • Conditions associated with severe outcomes are: asthma, cancer, cardiovascular, chronic kidney disease, chronic respiratory disease, diabetes, Down syndrome, immunosuppression and immunodeficiency, obesity, organ transplant, pregnancy, sickle cell disease and substance use. • Be aware of other risk factors and that they may not be visibly apparent, e.g. obesity, substance use disorders. • Other factors that may warrant additional consideration include: race, ethnicity, socio-economic factors, and their intersection and sex at birth. • For more information refer to: Risk factors for severe COVID-19 disease

The decision regarding the location of care should be made on a case-by-case basis and will depend on the patient's 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.[5]

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.
- 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.
- For symptom management, there is limited data to suggest acetaminophen should be used preferentially over nonsteroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen.[6] However, NSAIDs can be considered if needed and patients who are already taking them can continue to do so. NSAIDs should not be discontinued solely on the basis of COVID-19.
- Angiotensin-converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARBs) should not be discontinued solely on the basis of COVID-19.
- 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 cautioned and advised against the use.
- Advanced imaging, or even conventional radiography, should **not** be used for the **diagnosis** of COVID-19 infection.[7]

Treatment

There are currently two potential treatments for patients with COVID-19 infection in the outpatient setting:

Inhaled budesonide

Dose	800 µg BID twice daily x 14 days
Indication	May be considered within 14 days of symptom onset for adults with mild COVID-19 who are: • aged ≥65 or • aged ≥50 with 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)
Possible benefit	Reduces time to symptomatic recovery by one to three days. Based on emerging research, COVID-19-related hospitalization may be reduced.
Possible harm	Adverse effects associated with short course inhaled budesonide include oral thrush and dysphonia. Instruct patient on proper technique, including rinsing mouth with water after use.
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

Dose	0.6 mg PO BID x 3 days, then 0.6 mg PO daily x 27 days
Indication	**May be considered** for adults aged 40 years or over with mild COVID-19 with at least one risk factor (indication) and no contraindications to colchicine. **Indications:** age >70 years, obesity (BMI >30 kg/m2), diabetes, hypertension (systolic >150 mmHg), respiratory or coronary disease, heart failure, fever >38.4C, or dyspnea.
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).
Cost	Course of colchicine treatment is approximately $15, plus professional dispensing fee. PharmaCare coverage: Regular benefit.

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

Self-isolation guidance

- Refer to IPC guidance for Community Health Care Providers for measures for patients that require self-isolation and how to conduct a point-of-care risk assessment before any patient interaction to determine the appropriate personal protective equipment.
- Public health provides self-isolation direction to COVID-19 infected persons and close contacts, based on provincial guidance. MHOs have discretion in the implementation of these guidelines and use their clinical judgement to manage cases, clusters, outbreaks and the COVID-19 pandemic in their region. There may be local variations.

Patient group	Guidance for self-isolation
COVID-19 positive patients and patients with symptoms clinically suspect for COVID-19 (pending testing result or not yet tested)	• Patients with asymptomatic infection or mild-to-moderate symptoms, who are NOT moderately to severely immune compromised, and that can be managed at home must self-isolate at home at least until the following criteria are met: ▪ At least **10 days** have passed since the onset of symptoms; AND ▪ Symptoms (respiratory, gastrointestinal, and systemic) have improved; AND ▪ Fever has resolved for 24 hours while off fever-reducing medication. • Cough may persist for several weeks and does **not** mean the patient is infectious. They do not need to prolong self-isolation. • The period of isolation in the community is determined by public health. Patients who are moderately to severely immune compromised, and those with severe disease, need to isolate for at least 20 days (refer to Public Health Interim Guidance). • 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. • Provide patient with information on how to manage their symptoms. • If your patient is a health-care worker or works in a specific setting, they may need to follow different guidance for ending self-isolation as advised by public health and the MHO. If a person with COVID-19 lives in a First Nations community, 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 with the regional health authorities to guide the collaborative follow-up of such individuals.[3]
Patients with symptoms not clinically suspect for COVID-19	If you have patients who, in your or other health professional's clinical judgement, do not warrant COVID-19 testing, they do not need to be isolated. If their symptoms worsen, they should be re-assessed.
COVID-19 test-negative patients who remain symptomatic	• Patients who test negative but remain symptomatic must self-isolate at home until: ▪ Symptoms (respiratory, gastrointestinal, and systemic) have improved; AND ▪ Fever has resolved for 24 hours while off fever-reducing medication. • Provide patient with handout on what to do after your COVID-19 test
Asymptomatic close contacts	• Individuals who are notified by public health officials that they are close contacts of confirmed COVID-19 cases must self-isolate and follow public health direction. • Determination of a close contact and duration of self-isolation is determined by public health according to Public Health Interim Guidance. • If symptoms develop, self-isolation will be longer at the direction of public health.
Individuals returning from outside Canada	• Individuals who are arriving or returning from travel outside Canada must follow federal guidelines. • If symptoms develop, patients should be tested and self-isolate according to the federal requirements.

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 the patient has any concerns or signs of deterioration, they should consult a health-care practitioner in person through urgent care, emergency department or 9-1-1.
- If a patient with COVID-19 develops any symptoms below, refer them for further assessment:
    - unstable vitals
    - dehydration
    - sustained or downward trending SpO2≤93% (or <90% with a chronic lung condition)
    - shortness of breath, pain or pressure in the chest, confusion, drowsiness or weakness[5]
    - 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. Maintain a low threshold for referring patients 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. [5]
- 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, see the MOST form summary. Palliative care should be explored early if appropriate.
- If transferring a patient from the community to an acute care facility, notify BC Emergency Health Services 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 through the Hospital at Home program, which allows the patient to 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. Ensure that the patient knows who to contact if they are feeling unwell or their condition worsens after discharge.

Patients may be discharged in the following situations:

- when medically well and not on oxygen, unless previously on home oxygen program (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 primary care follow-up should be arranged.
- Older people are more likely to experience pronounced functional decline and may require coordinated rehabilitation or convalescent care.[5]
- 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.

Remote and Rural Considerations

There is limited capacity in remote and rural areas to provide care for those with severe illness. Communities may have different acute care services available, telehealth and medevac capacities. Supports are available for practitioners in rural areas: refer to the practitioner resources section in this document.

Consider the following measures in treatment:[5]

- Mild to moderate disease, including uncomplicated pneumonia, may be managed within the community, with appropriate precautions in place.
    - 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 (Table 1).
    - 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 (e.g., escalating oxygen needs) so that transfer can be arranged before intubation is required. Clinicians and patients should be aware of the potential for some patients to rapidly deteriorate at any point after illness onset.
    - 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.

Immunization

Encourage all patients to obtain COVID-19, influenza and other appropriate immunizations (e.g., pneumococcal).

- If patients have symptoms of COVID-19, they should stay home from the immunization clinic and use the COVID-19 self-assessment tool to determine if they need to be tested.
- If they have a new illness preventing them from performing their regular activities, they should wait to get immunized until they have recovered. This will help to distinguish side effects of the vaccine from worsening of their other illness. If they had a recent, confirmed COVID-19 infection, they should complete their self-isolation and wait until they no longer have symptoms before attending an immunization clinic.
- Patients should defer COVID-19 immunization for at least 90 days following receipt of anti SARS-CoV-2 monoclonal antibodies or convalescent plasma for the treatment or prevention of COVID-19 to avoid potential interference of the antibody therapy with vaccine-induced immune response. Deferral is not required following treatment with tocilizumab or sarilumab.[8]

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.[9] Patients have experienced the following health problems after recovery from acute COVID-19[9,10]:

- 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 provincial post-COVID recovery clinics, post COVID-19 clinical resources, and patient self-management guides are available here. Patients can be referred from any geographic location in B.C. Physicians are also available for rapid consultation on the provincial Rapid Access to Consultative Expertise (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 post-traumatic stress disorder. Be aware of the emotional impacts and impacts on all areas of life. Pay particular attention and make your instructions to patients clear, simple and empathetic.
    - Resources to support patients' mental well-being during COVID-19
    - 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
- COVID-19 Immunization Communication Tool: A resource for health-care providers.
- Immunize BC: COVID-19 Vaccine Frequently Asked Questions
- Public Health Agency of Canada: Clinical management of patients with COVID-19: Second interim guidance
- Spectrum Infectious Disease Clinical Support App

Rapid consultation services for practitioners

- The RACE Line – available 8 a.m.-5 p.m., Monday through Friday, to help clinicians with differential diagnoses, work-up and management recommendations.

        - Infectious Diseases – COVID-19 (Clinical)
        - COVID – GIM (General Internal Medicine) Post Infection Care
- Electronic Consultative Access to Specialist Expertise (eCASE) offers e-consults within seven days. Users can submit questions, patient history and attachments via a secure messaging app. The specialty is listed as "Post-COVID-19 Care".
- Rural Urgent Doctor in-aid (RUDi) – physicians with emergency medicine and rural experience are available 24/7 by Zoom and phone to support rural health-care providers looking for support with a patient or preparatory simulation.
- Rural Outreach Support (ROSe) Critical Care – Intensivist/critical care specialists are available 24/7 by Zoom, mobile app, and phone to support rural health-care providers looking for a consultation, second opinion or ongoing virtual support for patients.

Contact tracing: How public health contact traces

Patient guides:

- BCCDC resources for patients who are being tested, self-isolating and/or self-monitoring
- Post COVID-19 care and recovery
- For First Nations community members and their families who have limited or no access to their own doctors: First Nations Virtual Doctor of the Day offers virtual appointments with doctors of Indigenous ancestry, and all doctors are trained to follow the principles and practices of cultural safety and humility.

B.C. COVID-19 data: Including map of cases by geographic areas, weekly situation report, and dashboards

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List of Contributors

This document was developed by the clinical reference group (CRG) 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. Veronic Clair, BCCDC. Project lead/research officer: Fritha Munday.

This document was reviewed by the CRG IPC subcommittee (Tara Donovan, Ka Wai Leung, Dr. Titus Wong); the emergency medicine subcommittee (Dr. Andrew Kestler), the 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 updated by the CRG primary care subcommittee: Dr. Jeanette Boyd (co-chair), Dr. Bruce Hobson (co-Chair), Dr. Doug McTaggart, Dr. Kelsey Louie, Celia Evanson NP, Dr. Mitchell Fagan, Dr. Tracey Parnell, Dr. Serena Verma, and Dr. William Cunningham.

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, April 15, 2021)* and *Clinical management of patients with COVID-19: Second interim guidance (PHAC, August 17, 2020)*.