

Wellforce Clinically Integrated Network (WCIN) COVID-19 Frequently Asked Questions (FAQ)

The [WCIN COVID webpage](#) is live and includes many of the common topics related to COVID-19. Below, we are providing guidance and answers to FAQs the WCIN has received directly from our providers and practice staff.

If you have any additional questions, not included below, please contact the WCIN COVID Answer Center by filling out the form [here](#).

What patients are eligible for outpatient treatment for Covid as of now?

See [criteria](#) below for patients with documented COVID infection and at high risk of progression to severe disease. This includes monoclonal antibody treatment, as well as oral antivirals and IV remdesivir. Additionally, understand criteria will be applied based on availability at the time and therapy will be reserved for highest risk patients.

Patients who are at [high risk for progression to severe COVID-19 infections including hospitalization](#):

- Age ≥65
- Cancer
- Chronic kidney disease (CKD)
- Chronic liver disease
- Chronic lung diseases
- Dementia
- Diabetes
- Down syndrome
- Heart conditions
- HIV infection
- Immunocompromised state
- Mental health conditions
- Overweight/obesity
- Pregnancy
- Sick cell
- Smoking
- Transplant
- Stroke
- Substance use disorder
- Tuberculosis

Overweight/obesity are listed as severe risk factors for severe disease, should we recommend these COVID positive patients for treatment with limited availability?

Depends on how available treatments are. If treatment is limited, refer those patients that have BMI >30 or BMI 25-29 with co-morbidities. BMI 25-29 within the CDC criteria is risk of progression to severe disease, but lower risk than those patients with BMI >30. Ultimately, the ordering physician will have to prioritize patients.

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COVID Testing

How effective are pool testings in a school setting? Are weekly testings recommended or is it better to be selective with these testings?

There are a variety of ways schools are handling this.

- **Pool testings** - good way to use fewer reagents but only works when prevalence is pretty low. During a high prevalence, pool testing not very helpful.
- **Regarding whether or not schools should test or not** - some schools are and others are not. There is no data available at this time that demonstrates a clear preference on whether to test or not.

Should rapid antigen test sampling include both throat and nasal swabs?

Throat vs nose swabbing

FDA has cautioned against using throat swabs with most at home rapid tests, primarily since most tests were validated using nasal swabs only. If a test has not been validated for a throat swab, there is a significant risk of either false-negative or false-positive results. Check the instructions for a specific test to determine if throat swabbing has been approved.

In symptomatic patients, how long after a positive rapid antigen test would you expect them to test negative again?

Depends on when the patient is initially tested. Antigen test is typically positive not too long before symptoms start and probably remains 2-3 days after symptom onset. Some patients it will be negative a day after symptom onset and for others it may be 5 days or more.

In the case of definite positive contact in a completely vaccinated asymptomatic person, if PCR testing 3-5 days post-exposure is not an option, is sequential antigen testing sufficient to identify possible infection? Recommendation from CDC has been to wear mask, and test daily with home test, isolation not needed

Isolation is not needed and patient should stay masked. Not much evidence-based literature if the ideal resources are not available, more based on availability of antigen testing. Antigen testing at 2, (3), (4), 5, days after last exposure is reasonable. (in parentheses means could skip if supply is limited.)

If rapid antigen testing were readily available, would population-based routine testing of asymptomatic people likely be helpful for curtailing the spread of COVID infection?

Many experts are pushing this approach. Issue is how sensitive/specific is the test. If prevalence is low, then there are more false-positives than true positives. Then the question is really prevalence, specificity, and sensitivity.

In a person with no symptoms and no known exposure, in a time and place with low prevalence, a single positive antigen test may be a false positive. Prompt confirmation with another antigen test (preferably a different brand) is appropriate. If the second test is also positive, it is likely the patient is infected. If negative, the first test was likely a false positive.

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How reassuring is a negative antigen test?

In a patient with symptoms, one negative antigen test is moderately reassuring; the test should be repeated in 24-48 hour, and if still negative, Covid is unlikely. If the patient's symptoms strongly suggest Covid, or the patient had intense exposure, PCR would be appropriate.

In an ASYMPTOMATIC patient, negative tests are less reassuring. If there was a known significant exposure, repeat the test in 24-48 hours. In this case, though, even two negatives should not preclude the possibility of the person having Covid, though they are not likely to be infectious at that point.

Administering COVID vaccine/booster to patients with certain conditions

How long should we recommend that a patient wait for their booster after a COVID infection?

Receive after isolation: From a safety and effectiveness point of view, the patient can get the vaccine, whether it's the 1st, 2nd, or booster, once out of isolation (don't want to have the patient receive during isolation because don't want them to expose the person who is administering the vaccine)

Delay: A reason to potentially delay receiving the booster is that the patient has some degree of natural immunity after infection. We don't know how good or how long it lasts, but a general rule of thumb is that it may last up to 90 days. So the patient could potentially wait to get the vaccine/booster until after 90 days. In general, sooner is better.

Any recommendations on the safety of a booster with myocarditis after the primary series?

If a patient has myocarditis with initial 1st or 2nd dose and deciding whether to give 2nd or booster, since we have alternatives, at that point it would be reasonable to switch from mRNA to adenoviral vector (J&J).

The risk is sufficiently low that if patient chose to get subsequent dose of mRNA vaccine, because effectiveness is a little bit higher, that would be a reasonable choice for an informed patient to make

Is there a standard for how long people should wear their KN95 masks/N95 masks before throwing them away?

Controversial depending on supply. With any kind of mask (surgical or N95), if it gets wet, soiled, or torn it should be thrown away immediately. Taking masks on and off is somewhat risky because the front part of the mask is filtering out COVID and therefore is likely contaminated with COVID, so the individual shouldn't touch it. When the supply of PPE is very limited (esp. e.g. N95) can take the mask off and save in a paper bag for a few days before reusing. Still shouldn't be worn for a cumulative total of more than 12 hours.

The easiest and most relevant way to think about it is to talk about extended use if going to be seeing patients and needing N95; leave on through a whole session of patients and then take off after the last patient in the string, that way you are not exposing yourself to the risk of taking the mask off and putting back multiple times.

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Miscellaneous

I've heard the flu is also rising. Is there actually a name for Omicron and Influenza? How would that be diagnosed?

Symptoms are very similar between COVID and flu, as they are for many respiratory viruses. Differences in symptoms between most respiratory viruses are pretty minimal and overlap a lot and can't generally distinguish very accurately on clinical grounds. It is a clear indication for testing. Flu testing can be very helpful. Can't assume someone positive for flu is negative for COVID. Likely not super common but common enough where we can't disregard the possibility. Don't think there is a specific name for co-infection between COVID and flu. Would diagnose with same tests we routinely use for flu and for COVID. There are also some kits available that do test for both at the same time.