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Our goal is to offer pharmacy CE activities in the areas of pharmacy law (ACPE topic designator "03") and patient safety (ACPE topic designator "05").

2 **Coronavirus 101 – The Basics, and Patient Safety in the Pharmacy**

ACPE Program Number: 0487-0000-20-002-H05-P and 0487-0000-20-002-H05-T (knowledge-based activity)
Release Date: March 17, 2020
Expiration Date: March 16, 2022
Contact Hour(s): 1.25
Program Fee: $12.00

Select CE® is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy

Program Title: **Coronavirus 101 – The Basics, and Patient Safety in the Pharmacy**

Target Audience: All Pharmacists and Pharmacy Technicians

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Accreditations: This CE activity is ACPE-accredited for 1.25 contact hours or 0.125 C.E.U.'s for pharmacists and pharmacy technicians.

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Media: Enduring print material and interactive test-taking at **www.selectce.org.**

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Estimated Time to Complete the Activity: 75 minutes

Procedures: To receive a credit for this CE activity, you must supply your CPE Monitor ID (also known as your NABP eProfile ID) and month/day of birth. Other procedures are to read this program, complete the post-test questions and evaluation questions on the Answer Sheet, and either:

i) mail the Answer Sheet and program fee to us. You will receive an Assessment Feedback mailed to you within 2 weeks. Checks or money orders are encouraged. Mail to: Select CE, P.O. Box 21186, Columbus, Ohio 43221- 0186;
or
ii) use the online test-taking website www.selectce.org. Follow the instructions on the website, using any major credit card to pay the program

fee. Upon passing the test, you will receive immediate confirmation via email, and your Assessment Feedback will be sent within 5 days. Refunds are not generally provided, unless you mistakenly make too many online payments or some such other snafu.

A minimum score of 70% on the post-test is required to earn credit.

Faculty: Patti Nussle, RPh, JD with peer review by Robyn Satterfield, PharmD.

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Objectives: At the conclusion of this program, all learners should be able to:

a) state basic characteristics of the known major coronaviruses;
b) state the most common symptoms of coronavirus disease;
c) state the Centers for Disease Control's and one state health department's safety guidelines as applied to the typical pharmacy setting.

Important Note: Colleagues, this is a continuing education program. Do not rely on this CPE program as legal or clinical authority.

Contact Us: By phone (614) 481-8711 or email at patti@selectce.org.

Thank you! We truly enjoy serving you!

Introduction

We are in the midst of the 2020 novel (or new) coronavirus pandemic, and people are being asked to stay 6 feet away from each other for their own safety. Yet, patients are standing at your pharmacy counter and gathered in your waiting area all day every day, often less than 6 feet away from each other. You are talking to patients across the pharmacy counter at a distance of less than 6 feet. You are likely working elbow to elbow behind the pharmacy with other pharmacy professionals. So, then, what is a good pharmacist and technician to do?

This CE activity is designed to help you learn the connection between the new coronavirus and other coronaviruses you already know about, the disease caused by the new coronavirus and the current health and safety guidelines as applied to the typical retail pharmacy setting.

The Novel Coronavirus and the Pharmacy

People see their pharmacist more often than they see their physician.[1] One study shows that on average people shop at their retail pharmacy about once each week.[2] Moreover, pharmacists are the only healthcare professional accessible without an appointment.[3]

In the midst of the 2020 novel coronavirus pandemic, some entire countries have closed all stores except pharmacies and grocery stores.[4]

All of this leads us to expect that people will continue to come into your pharmacy, and pharmacists and pharmacy technicians will continue to be the front-line caregivers and information providers during this pandemic.

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[1] Pharmacists as Accessible Healthcare Providers: Review of the Evidence at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5755826/

[2] NCPA.org Full Industry Report 2013

[3] https://www.pharmaceutical-journal.com/news-and-analysis/event/how-to-increase-the-accessibility-of-pharmacists-when-the-pharmacy-is-open/20066487.article?firstPass=false

[4] https://www.bostonglobe.com/2020/03/11/world/italy-weighs-even-tougher-coronavirus-lockdown-boosts-aid-economy/

Coronaviruses[5]

Coronaviruses infect both humans and animals. Since the 1960s, globally endemic human coronaviruses have been identified as **frequent causes of respiratory infections such as the common cold**. More recently, new human coronaviruses were identified as causes of Middle East Respiratory Syndrome (MERS) and severe acute respiratory syndrome (SARS). S**evere acute respiratory syndrome coronavirus 2 (SARS-CoV-2)** is the most recently identified human coronavirus and is the cause of **coronavirus disease 19 (COVID-19).**

Coronaviruses are named for their characteristic "corona" appearance when seen under a microscope. The corona is caused by protein spikes on the spherical surface of the envelope membrane.

Coronavirus Subgroups

Coronaviruses are defined based on their protein components. These subtypes are now further defined by genotyping, resulting in the four main subgroups of coronaviruses: alpha, beta, gamma, and delta.

Alpha and beta coronaviruses are found in both humans and animals. Gamma and delta coronaviruses have only been identified in animals.

Human Coronaviruses

Since initial detection of human coronaviruses in the 1960's, four have been identified as common causes of human respiratory system illnesses such as the common cold:

1. 229E (alpha coronavirus)
2. NL63 (alpha coronavirus)
3. OC43 (beta coronavirus)
4. HKU1 (beta coronavirus)

[5] The information in this section is taken from From the American College of Physicians' COVID-19: An ACP Physician's Guide (last updated March 13, 2020) and the Centers for Disease Control's Information for Healthcare Professionals found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html

Genetic recombination readily occurs between members of the same and of different coronavirus groups. This results in increased genetic diversity and provides opportunities for viruses in animal reservoirs to emerge as novel human pathogens. Such genetic recombination led to emergence of three newer human coronaviruses and the associated disease:

5. MERS-CoV (beta coronavirus) - middle east respiratory syndrome (MERS)
6. SARS-CoV (beta coronavirus) - severe acute respiratory syndrome (SARS)
7. SARS-CoV-2 (novel beta coronavirus) – coronavirus disease (COVID-19)

Question 1:

Coronaviruses:

a. have been identified as frequent causes of respiratory infections;
b. are named for their characteristic "corona" appearance when seen under a microscope;
c. both of the above.

Question 2:

Coronaviruses are responsible for:

a. the common cold;
b. MERS-CoV, SARS-CoV and COVID-19;
c. all of the above.

Spread of SARS and MERS between people has generally occurred because of close contact

Full characterization of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) coronavirus disease (COVID-19) is ongoing. **For clinical response in the interim, we continue to be guided in part by what we learned about MERS-CoV and SARS-CoV**. Therefore, a review of SARS and MERS helps to frame our approach to COVID-19.

Spread of SARS and MERS between people has generally occurred between close contacts. Person-to-person spread is thought to have happened mainly via respiratory droplets (coughs, sneezes), although some spread may have occurred by touching contaminated objects then touching the mouth, nose, or eyes.

SARS

Severe acute respiratory syndrome (SARS) is a respiratory illness caused by the SARS-CoV beta coronavirus, usually resulting in pneumonia. Symptoms include a high fever, headache, body aches, and possibly diarrhea. There have been no known cases of SARS reported anywhere in the world since 2004[1].

MERS

Middle east respiratory syndrome (MERS) is an illness caused by the MERS-CoV beta coronavirus. Symptoms include fever, cough, and shortness of breath. Pneumonia is common, but not always present.

The spectrum of illness due to MERS-CoV infection is not fully defined. Although most reported cases have had severe acute lower respiratory illness, mild infections, and infections with no apparent symptoms, have been reported. Additionally, in some cases, diarrhea preceded respiratory symptoms. Other early symptoms have included headache, chills, myalgia, nausea/vomiting, and diarrhea.

Question 3:

The recent coronavirus outbreak is a new disease in humans, and so we are guided in part by what we learned about MERS-CoV and SARS-CoV, which includes:

a. person-to-person spread is thought to have happened mainly via respiratory droplets (coughs, sneezes);
b. some spread may have occurred by touching contaminated objects then touching the mouth, nose, or eyes;
c. both of the above.

Question 4:

The spectrum of illness due to MERS-CoV includes:

a. fever, cough, and shortness of breath;
b. early symptoms have included headache, chills, myalgia, nausea/vomiting, and diarrhea;
c. all of the above.

SARS-CoV-2 Clinical Presentation and COVID-19 Disease

Infection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) may be asymptomatic or may result in an acute respiratory disease. The acute respiratory disease may be mild but can result in a severe viral pneumonia. Full characterization of the spectrum of the novel coronavirus disease (COVID-19) is ongoing, but the primary presentation is an influenza-like illness with lower respiratory tract symptoms:

- fever
- cough
- shortness of breath

The acute respiratory disease caused by SARS-CoV-2 may progress to bilateral pneumonia, acute respiratory distress syndrome (ARDS), or death. Early reports describe the potential for clinical deterioration during the second week of illness, with roughly 25-30% of hospitalized patients requiring intensive support and median time between initial symptoms to onset of ARDS reported in one study as 8 days.

Frequently reported signs and symptoms include fever (83–98%), cough (46%–82%), myalgia or fatigue (11–44%), and shortness of breath (31%) at illness onset. Sore throat has also been reported in some patients early in the clinical course. Less commonly reported symptoms include sputum production, headache, hemoptysis, and diarrhea. Some patients have experienced gastrointestinal symptoms such as diarrhea and nausea prior to developing fever and lower respiratory tract signs and symptoms. The fever course among patients with [SARS-CoV-2] infection is not fully understood; it may be prolonged and intermittent.

Question 5:

Regarding the virus that causes COVID-19, early reports describe the potential for clinical deterioration during the second week of illness, with roughly 25-30% of hospitalized patients requiring intensive support and median time between initial symptoms to onset of ARDS reported in one study as 8 days.

a. True;
b. False.

SARS-CoV-2 Transmission

Characterization of SARS-CoV-2 transmission is ongoing but initial data reveal both asymptomatic and symptomatic spread:

- SARS-CoV-2 can spread from person-to-person through respiratory droplets, fecal-oral route, and asymptomatic spread.

- **Incubation period**: An pooled analysis of 181 confirmed COVID-19 cases reported between 4 January 2020 and 24 February 2020 estimated the median incubation period to be 5.1 days (95% CI, 4.5 to 5.8 days), and estimated that 97.5% of those who develop symptoms will do so within 11.5 days (CI, 8.2 to 15.6 days) of infection. Clinical descriptions of asymptomatic phases after possible exposure range from 2 to 14 days. A 14 day period for monitoring after potential exposure is generally recommended, and modeling predicts that 101 out of every 10 000 cases (99th percentile, 482) will develop symptoms after 14 days of active monitoring or quarantine.

- **Serial interval**: It is likely that SARS-CoV-2 is transmitted by asymptomatic persons during the incubation period. There have been reports of asymptomatic spread and of high titers of virus in the oropharynx early in the course of disease during the period of minimal symptoms. The serial interval (the time between successive cases in a chain of transmission) has been calculated as 4 to 4.6 days. This short interval compared with the described incubation period means asymptomatic spread is likely. The serial interval for SARS-CoV-2 is also likely shorter than the 2003 SARS mean calculated serial interval of 8.3 days.

Question 6:

The incubation period for the virus that causes COVID-19:

a. is estimated to be 5.1 days, based on 2020 data;
b. can range from 2 to 14 days;
c. both of the above are true.

Question 7:

The serial interval for the virus that causes COVID-19:

a. has been calculated as 4 to 4.6 days;
b. is a long interval when compared with the incubation period of the virus;
c. both of the above are true.

Question 8:

Spread of the virus that causes COVID-19:

a. can be person-to-person through respiratory droplets;
b. is always by a symptomatic spread of the virus;
c. both of the above are true.

Treatment

1. Promptly implement infection control measures;
2. Provide standard supportive management for respiratory disease and complications, including advanced organ support if indicated;
3. Unless otherwise required to treat septic shock or other disease processes (acute exacerbation of COPD, etc), do not use corticosteroids because of the potential for prolonging viral replication, based on lessons learned from observed MERS-CoV patients;
4. There is no clearly beneficial targeted treatment. Investigational treatment approaches have included lopinavir–ritonavir, interferon-1β, remdesivir, chloroquine, and a variety of traditional Chinese medicines. Intravenous hyperimmune globulin from recovered persons is in early treatment trials.

Question 9:

Treatment for COVID-19 includes:

a. prompt implementation of infection control measures;
b. standard supportive care for respiratory disease and complications;
c. both of the above are true.

Question 10:

Treatment for COVID-19 includes:

a. generous use of corticosteroids;
b. there is no clearly beneficial targeted treatment;
c. both of the above are true.

Where to Get Up-to-Date Guidance

University of Washington Medicine COVID-19 Resource Site

Western Washington state, including Seattle, has been an early epicenter of COVID-19 within the United States. The University of Washington health system and their partners Seattle Cancer Care Alliance have developed policies and protocols in response to the outbreak in Western Washington, and they are generously sharing these resources with the health care professional community through a public website. The documents are undergoing frequent revisions as the COVID-19 situation evolves:

UW Medicine COVID-19 Resource Site at
https://www.washington.edu/research/hsd/covid-19/

Centers for Disease Control's (CDC's) Information for Healthcare Professionals

The CDC has many resources for healthcare professionals grouped into topics including Clinical Care, Infection Control, Supply of Personal Protective Equipment, and Home Care of People Not Requiring Hospitalization.

CDC's Information for Healthcare Professionals
https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html

One State Health Department's COVID-19 Checklist for Pharmacies: Top Ten Things You Can Do[6]

The Ohio Department of Health has released a checklist for pharmacies. This checklist is a list of top ten things you can do to prepare for COVID-

[6] https://coronavirus.ohio.gov/wps/wcm/connect/gov/11453805-427f-4622-9da1-5c6532eb26eb/Checklist+for+Pharmacies+UPDATED-030920.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-11453805-427f-4622-9da1-5c6532eb26eb-n3eIkA5

19. COVID-19 disease is in all states, and this state's checklist has useful advice for pharmacies in any state:

Implement infection control procedures, especially for clinic waiting areas:

a. Make sure staff maintain a distance of 3 feet from asymptomatic patients and at least 6 feet from those actively coughing.

b. Regularly clean and disinfect counters, waiting areas, and other spaces where public interaction occurs with an EPA-approved disinfectant. Clean at least every hour or after every 10 patients, whichever is more frequent.

c. Place alcohol-based hand sanitizer next to the checkout window so people can sanitize their hands after using common items, such as the pen used to sign for prescriptions.

Question 11:

The state department of health in one state recommends that in retail pharmacies:

a. staff should maintain a distance of 3 feet from patients with no symptoms, and 6 feet from those actively coughing;
b. staff should clean and disinfect counters and waiting areas often, either every hour or after every 10 patients, whichever is more frequent;
c. both of the above.

From the CDC's Information for Healthcare Professionals[7] And One State Health Department's COVID-19 Guidance for Primary Care and Outpatient Providers[8]

We have scoured the reliable agency resources for sections that appear to be especially pertinent to pharmacies, and offer the following taken directly from the resources.

What is a close contact?

Close contact is defined as—

a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a health care waiting area or room with a COVID-19 case;

– or –

b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on).

This means, as a practical matter, that for patients who are at your pharmacy window for a short period of time, you will not be considered to be in "close contact" with them.

Question 12:

A close contact is:

a. being within 6 feet of a person with COVID-19 for 15 seconds;
b. having a person with COVID-19 cough on you;
c. both of the above.

[7] https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html
[8] https://coronavirus.ohio.gov/wps/portal/gov/covid-19/

What should I do when talking to patients who are asymptomatic patients with a history of exposure to COVID-19 who are being evaluated for a non-infectious complaint (e.g., hypertension or hyperglycemia)?

Standard precautions using personal protective equipment should be followed when caring for any patient, regardless of suspected or confirmed COVID-19. If the patient is afebrile (temperature is less than 100.0°F) and otherwise without even mild symptoms that might be consistent with COVID-19 (e.g., cough, sore throat, shortness of breath), then personal protective equipment specific to COVID-19 are not required.

Question 13:

When talking to a patient at the pharmacy counter who has no fever and no cough, sore throat, or shortness of breath, then personal protective equipment specific to COVID-19 is not required.

a. True;
b. False.

What happens if I get coughed on by a patient, or patients in my waiting area are coughing on each other?

The CDC offers this advice for the healthcare professional:

Monitor for Workplace Exposure[9]

The CDC is available for consultation by calling the Emergency Operations Center at 770-488-7100.

Health care professionals (HCP) should regularly assess for absence of fever and symptoms prior to starting work each day, and should not report to work when ill. Due to the increased risk of exposure for HCPs, the signs and symptoms for monitoring their health are more inclusive than those used when assessing exposures for individuals not working in healthcare. HCPs should report recognized exposures and regularly monitor themselves for fever and symptoms of respiratory infection.

For HCP who are not wearing all recommended personal protective equipment (gown, gloves, N95 mask, eye/membrane protection) at the time of exposure to a person under investigation (PUI), low risk exposures can be self monitored (twice daily temperature and symptom assessment). These **low risk exposures** include:

- brief interactions with a PUI who is not wearing a face mask/respirator, without having contact with the patient's secretions/excretions (e.g. brief conversation at a triage desk; briefly entering a patient room but not having direct contact with the patient or their secretions/excretions)
- closer or more prolonged contact with a PUI who was wearing a face mask/respirator, without having contact with the patient's secretions/excretions.

HCPs with potential exposure to 2019-nCoV in a healthcare setting should follow CDC guidance for assessment of risk, monitoring, and work restriction decisions:

> "Facilities could consider allowing asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after options to improve staffing have been exhausted and in consultation with their occupational health program. These HCP should still report temperature and absence of symptoms each day prior to starting work. Facilities could have exposed HCP wear a facemask while at work for the 14 days after the exposure event if there is a sufficient

[9] https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

supply of facemasks. If HCP develop even mild symptoms consistent with COVID-19, they must cease patient care activities, don a facemask (if not already wearing), and notify their supervisor or occupational health services prior to leaving work."

Question 14:

Pharmacy personnel who are not wearing personal protective equipment (gown, gloves, N95 mask, eye/membrane protection) at the time of exposure to a person under investigation (PUI):

a. can be self monitored (twice daily temperature and symptom assessment);
b. must leave the pharmacy immediately;
c. must self-quarantine at home for 14 days.

Question 15:

Pharmacy personnel who develop a fever should:

a. cease patient care activities;
b. don a facemask, if available;
c. both of the above.

COVID-19 Guidance for Primary Care and Outpatient Providers[10]

The number of confirmed positive cases of COVID-19 in Ohio is low but rapidly increasing and public health experts expect the number of positive cases to expand significantly in the coming weeks and months. At the same time, Ohio and the nation are facing a dire shortage of personal protective equipment (PPE), including that maintained in the national cache.

This situation warrants a unified, consistent approach and requires primary care providers and other outpatient services providers to comply with the following course of action regarding screening and treatment of potential COVID-19 patients. Please note the course of action detailed below is a revision to the guidance issued on March 11, 2020.

Telephone Consult: Patients should be encouraged to receive a phone-based triage, which in most cases will be done by their primary care provider. Based on these phone consultations, and utilizing CDC guidance, providers will decide whether patients require an in-person assessment.

Hospital Assessment Locations Will be Coordinating the Testing:

- Temporary central assessment and testing locations are being established throughout the state of Ohio.
- Providers should contact the local hospital to which you would refer a patient for admission to learn where your community's assessment and testing location is.
- Trained primary care professionals will be at these central assessment locations to assess whether the patient should be tested, sent home or admitted to the hospital.
- Patients who present to an outpatient setting other than a central assessment and testing location and are determined to need testing for COVID-19 should be referred to the central location for testing. Providers are strongly discouraged from doing patient assessments for COVID-19 at sites other than central assessment and treatment facilities.

[10] https://coronavirus.ohio.gov/wps/portal/gov/covid-19/home/local-health-districts-and-providers/covid-19-guidance-for-primary-care-and-outpatient-providers

Testing:

- Patients with mild systems will not be tested and will return home to self-monitor;
- Patients with moderate symptoms with other risk factors should receive a test at a commercial laboratory;
- Patients with severe symptoms should be tested through hospital laboratories (if available) or the ODH laboratory and be admitted to the hospital. Test results from the ODH laboratory will be returned within 24 hours.

Why are these steps required?

- PPE is very limited (including the national cache).
- Those providers who do currently have PPE are using it at a rate that cannot be sustained.
- The need to minimize in-person interactions to the extent possible.
- The complexity and scope of the public health issues involved in mitigating this problem requires a centralized, coordinated approach.
- It is absolutely vital that hospital capacity be reserved for the sickest patients.

Question 16:

People with mild symptoms of COVID-19 will:

a. not be tested for the disease;
b. will return home to self-monitor;
c. both of the above.

For Patients with COVID-19 Under In-Home Isolation:

The decision to discontinue in-home isolation for patients with COVID-19 should be made on a case-by-case basis in consultation with clinicians and public health officials. This decision should consider disease severity, illness signs and symptoms, and results of laboratory testing for COVID-19 in respiratory specimens. Guidance for discontinuation of in-home isolation precautions is the same as that to discontinue Transmission-

Based Precautions for hospitalized patients with COVID-19. Considerations to discontinue in-home isolation include all of the following:

- Resolution of fever, without use of antipyretic medication
- Improvement in illness signs and symptoms
- Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal and throat swabs specimens collected ≥24 hours apart* (total of two negative specimens—modified guidance as of March 17, 2020). See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation (PUIs) for 2019 Novel Coronavirus (2019-nCoV) for specimen collection guidance.

Footnote

*Initial guidance is based upon limited information and is subject to change as more information becomes available. In persons with a persistent productive cough, SARS-CoV-2-RNA might be detected for longer periods in sputum specimens than in upper respiratory tract (nasopharyngeal swab and throat swab) specimens.

Question 17:

Considerations for when to stop in-home isolation for patients with COVID-19 include:

a. the patient's fever is gone, without the use of medicines;
b. other symptoms have improved;
c. both of the above.

Return this ANSWER SHEET with the $12.00 Program Fee payable to:

Select CE, P.O. Box 21186, Columbus, Ohio 43221-0186

NAME:
ADDRESS:
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ANSWERS: Coronavirus 101: The Basics, and Patient Safety in the Pharmacy

(ACPE #0487-0000-20-002-H05-P and T; Expires March 16, 2022; 1.25 contact hours)

Circle the answer for each question (questions are imbedded in the program).

1.a	b	c	7.a	b	c	13.a	b	
2. a	b	c	8.a	b	c	14.a	b	c
3.a	b	c	9.a	b	c	15.a	b	c
4.a	b	c	10.a	b	c	16.a	b	c
5.a	b		11.a	b	c	17.a	b	c
6.a	b	c	12.a	b	c			

18. I am a pharmacist: Yes No
19. I am a pharmacy technician: Yes No
20. I am another type of healthcare professional: Yes No

After completing this CE activity, I am able to state:

21. Basic characteristics of coronaviruses: Yes Neutral No
22. Most common symptoms of coronavirus disease: Yes Neutral No
23. CDC guidance for settings such as pharmacies: Yes Neutral No
24. This CE activity met my educational needs: Yes Neutral No
25. The learning material was useful: Yes Neutral No
26. The teaching and learning methods (e.g., format; questions embedded in the program) fostered active learning and were effective: Yes Neutral No
27. The test questions were relevant to the CE activity: Yes Neutral No
28. The test questions were appropriate for me: Yes Neutral No
29. The CE activity was presented in a fair and unbiased manner: Yes No
30. If you perceived any bias or commercialism, please describe:

_____

31. Other comments are welcome!_____

