Ministry of Health

Management of Cases and Contacts of COVID-19 in Ontario

November 30, 2022 (Version 15.1)

Ontario

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18	Updates to the management of persistent positive and re-infection cases.
28	Updated staffing options for COVID-19 cases in highest risk settings, both for routine operations and for critical staffing shortages.

Management of Cases and Contacts of COVID-19 in Ontario

Version 15.1 – November 30, 2022

This guidance document provides basic information only. It is not intended to provide medical advice, diagnosis or treatment, or legal advice.

In the event of any conflict between this guidance document and any orders or directives issued by the Minister of Health or the Chief Medical Officer of Health (CMOH), the order or directive prevails.

- Please check the Ministry of Health (MOH) COVID-19 website regularly for updates to this document, mental health resources, and other information,
- Please check the Directives, Memorandums and Other Resources page regularly for the most up to date directives.

1 Background

This document provides information for public health management of cases and contacts in Ontario. The MOH has developed this document with contributions from Public Health Ontario (PHO) based on currently available scientific evidence and expert opinion. This document is subject to change as the situation with COVID-19 continues to evolve.

This document is intended to provide broad guidelines only and cannot cover every scenario that may be encountered; therefore, local public health unit (PHU) decision-making is required. Nothing in this document is intended to restrict or affect the discretion of local medical officers of health to exercise their statutory powers under the *Health Protection and Promotion Act*.

Guidance provided by the MOH and other relevant Ministries or organizations may provide additional information about outbreaks and preventative measures in different settings (e.g., acute care, long-term care homes/retirement homes, congregate living settings, COVID-19 Provincial Testing Guidance).

Surveillance reporting on variants of concern (VOCs) in Ontario, prevention and management of COVID-19, as well as information on testing, laboratory results, and their interpretation can be found on the Public Health Ontario webpage.

2 COVID-19 Symptoms

The symptoms, signs, and clinical features most commonly associated with COVID-19 are summarized by the Public Health Agency of Canada. The common symptoms of COVID-19 may change as new variants and sub-variants/lineages emerge.

Some symptoms such as runny nose, sneezing, sore throat, and headache may also be features of other non-COVID-19 respiratory infections. To prevent community transmission of all infectious diseases, all individuals with new symptom(s) of **any** infectious illness should **stay home when they are feeling sick**.

Individuals experiencing symptoms listed below may have COVID-19 and should seek assessment from a health care provider if required and/or immediately seek testing and assessment if eligible for COVID-19 treatment. Individuals with severe symptoms requiring emergency care should go to their nearest emergency department.

When assessing for the symptoms below, the focus should be on evaluating if they are **new, worsening, or different from an individual's baseline health status** (usual state). Symptoms should not be chronic or related to other known causes or conditions (see examples below).

One or more of the following most common symptoms of COVID-19 necessitate immediate COVID-19 testing and treatment if eligible:

- **Fever and/or chills**
- **Cough**
    - Not related to other known causes or conditions (e.g., chronic obstructive pulmonary disease)
- **Shortness of breath**
    - Not related to other known causes or conditions (e.g., chronic heart failure, asthma, chronic obstructive pulmonary disease)
- **Decrease or loss of smell or taste**
    - Not related to other known causes or conditions (e.g., nasal polyps, allergies, neurological disorders)

Two or more of the following symptoms of COVID-19 necessitate immediate COVID-19 testing and treatment if eligible:

- **Extreme fatigue** (general feeling of being unwell, lack of energy, extreme tiredness)
    - Not related to other known causes or conditions (e.g., depression, insomnia, thyroid dysfunction, anemia, malignancy, receiving a COVID-19 or flu vaccine in the past 48 hours)
- **Muscle aches or joint pain**
    - Not related to other known causes or conditions (e.g., osteoarthritis, fibromyalgia, receiving a COVID-19 or flu vaccine in the past 48 hours)
- **Gastrointestinal symptoms** (i.e., nausea, vomiting and/or diarrhea)
    - Not related to other known causes or conditions (e.g., transient vomiting due to anxiety in children, chronic vestibular dysfunction, irritable bowel syndrome, inflammatory bowel disease, side effect of medication)
- **Sore throat** (painful swallowing or difficulty swallowing)
    - Not related to other known causes or conditions (e.g., post-nasal drip, gastroesophageal reflux)
- **Runny nose or nasal congestion**
    - Not related to other known causes or conditions (e.g., returning inside from the cold, chronic sinusitis unchanged from baseline, seasonal allergies)
- **Headache**
    - Not related to other known causes or conditions (e.g., tension-type headaches, chronic migraines, receiving a COVID-19 or flu vaccine in the last 48 hours)

Other symptoms that may be associated with COVID-19 include:

- **Abdominal pain**
    - Not related to other known causes or conditions (e.g., menstrual cramps, gastroesophageal reflux disease)
- **Conjunctivitis (pink eye)**
    - Not related to other known causes or conditions (e.g., blepharitis, recurrent styes)
- **Decreased or lack of appetite**

- For young children and not related to other known causes or conditions (e.g., anxiety, constipation)

Individuals with *any* of the above symptoms are recommended to self-isolate and stay at home until fever is resolved and their symptoms have been improving for at least 24 hours (48 hours for gastrointestinal symptoms). Longer self-isolation is recommended in certain populations; see Table 1 for more information.

3 Highest Risk Settings

3.1 Highest Risk settings include:

- Acute care settings such as hospitals, including complex continuing care facilities
- Congregate living settings with medically and socially vulnerable individuals, including but not limited to long-term care homes, retirement homes, First Nation elder care lodges, group homes, shelters, hospices, correctional institutions, and hospital schools
- Employer-provided living settings of International Agricultural Workers

PHUs are expected to identify cases associated with highest risk settings for outbreak management support. Cases should primarily be identified to the PHU by the highest risk setting when they have a suspect outbreak. PHUs may also use other means to identify cases associated with highest risk settings (e.g., regular communications with highest risk settings, Virtual Assistant, phone calls) to support early outbreak identification.

At the discretion of the PHU, more extensive case management, such as communication of isolation requirements or sharing of local supports, may be provided to vulnerable individuals in their region (e.g., individuals who are homeless/underhoused) to support their isolation.

3.2 First Nations, Inuit, and Metis Communities

PHUs should make specific considerations for case and contact management for First Nations, Inuit, and Métis communities, in dialogue with the communities and/or Indigenous health service providers, and with respect of the principle of self-determination, to support ongoing surveillance and response that allows for

differences in community needs, recognizes differential impacts to communities, and changing needs over time.

3.3 Data Entry Requirements

PHUs are expected to complete case surveillance requirements by following data entry requirements for individual cases associated with outbreaks in highest risk settings. For a description of the data entry requirements for case reporting, see section 5.1 of this document as well as PHO's data entry guidance.

3.4 Outbreak Investigation and Management

The aforementioned highest risk settings should notify their local PHU when they have a suspect or confirmed outbreak, as defined by relevant MOH guidance for their sector. Highest risk settings that are institutions or public hospitals **must report** suspect and confirmed outbreaks to their local PHU as per the *Health Protection and Promotion Act.*

PHUs are expected to investigate and manage suspect and confirmed outbreaks of COVID-19 in highest risk settings as defined above. PHUs should work with local highest risk settings to ensure communication pathways are in place so that suspected outbreaks can be reported directly to the PHU as soon as possible, including after-hours.

As a safeguard for highest risk settings that do not yet have strong or established connections for engaging with the local PHU, PHUs may also use other means to identify cases associated with highest risk settings (e.g., regular communications with highest risk settings, Virtual Assistant, phone calls) to support early outbreak identification.

When suspect outbreaks in highest risk settings are reported directly to the PHU by the highest risk setting, initial investigation steps (e.g., assignment of an outbreak number, initial recommendations) should be taken in a timely manner (e.g., same day if possible), with additional outbreak management follow-up on the next business day.

For institutions with a duty to report as per the *Health Protection and Promotion Act* but that are not a highest risk setting as listed above, there are no expectations that COVID-19 respiratory outbreaks be entered in the provincial Case and Contact Management (CCM) system.

For all institutions and public hospitals, if there is strong evidence of a non-COVID-19 aetiology for a respiratory outbreak, the outbreak should still be managed as per

usual by the PHU and in accordance with the Ontario Public Health Standards. PHUs are still expected to investigate and manage reports of gastrointestinal outbreaks in institutions as per usual.

4 Public Health Advice for Symptomatic and COVID-19 Positive Individuals

4.1 Testing Recommendations

Accessing laboratory-based or rapid molecular testing:

- Individuals with COVID-19 symptoms should seek molecular testing (laboratory-based or rapid) if eligible. See the COVID-19 Provincial Testing Guidance for information on eligibility.
    - Where there is a high index of suspicion that an individual may be a COVID-19 case with a possible false-negative laboratory-based or rapid molecular test result, re-testing is advised and initiation of case isolation/outbreak management may be appropriate based on the PHU's risk assessment.

Use of rapid antigen tests:

- Individuals with COVID-19 symptoms who use rapid antigen tests should be aware that they may produce false negative results, particularly early in COVID-19 infection. Repeat testing at least 24 hours after an initial negative test improves confidence in a negative test result. See the COVID-19 Provincial Testing Guidance for information about rapid antigen tests.
    - Individuals who may be eligible for treatment and have an initial negative rapid antigen test result are **strongly recommended** to seek laboratory-based or rapid molecular testing as soon as possible given the time frame for receiving therapeutics. At this time, a positive rapid antigen test result is sufficient to initiate COVID-19 treatment, for those who are eligible, and does not need to be confirmed.

Testing for clearance is not recommended:

- There is no provincial public health requirement for workers who are test-positive cases or isolated due to COVID-19 symptoms to provide proof of a negative test result or a positive serological test result to their employers in order to return to work. It is expected that workers who have tested positive or who

have symptoms of COVID-19 follow public health isolation recommendations as outlined in **Table 1** below, as well as occupational health recommendations where applicable, for when they would be considered cleared to return to work.

4.2 Isolation Guidelines for Individuals with COVID-19 Symptoms and/or with a Positive COVID-19 Test

- Self-isolation means:
    - The case is to stay home and not attend work, school, child care, or other public places.
    - The case should only leave home if there is a medical emergency or if they need to get a clinical assessment or test. See the COVID-19 Clinical Assessments and Testing page for more information.
    - If the case must leave the home, they should travel in a private vehicle if possible. If this is not possible, the case should wear a medical mask, keep distance from others in the vehicle (e.g., sit in the backseat), and if possible and weather permitting, open the windows to increase air exchange in the vehicle.
    - At home, the case should stay in a separate room away from other people in the home and use a separate bathroom as much as possible. If in the same room, they should wear a well-fitting mask (medical mask if available) for source control and improve ventilation (e.g., windows should be open if possible). Household members should also wear a mask when in the same room if possible. Household caregivers should refer to PHO's fact sheet on Guide for caregivers, family members and close contacts. Anyone who is at higher risk of severe complications from COVID-19 (e.g., immunocompromised and/or elderly) should avoid caring for or coming in close contact with a case.
    - The case may leave their home for independent outdoor exercise (or with a caregiver, as appropriate), but should maintain physical distance of at least 2 metres (6 feet) from others at all times. The case should not go to outdoor fitness classes or personal training sessions and should wear a mask in building common areas when leaving the property if self-isolating in an apartment, condo, or hotel.

- The duration of self-isolation after the date of specimen collection or symptom onset (whichever is earlier/applicable) depends on relevant clinical factors such as setting, severity of infection, and immune status (see **Table 1**).

4.3 Isolation Guidelines for Individuals with COVID-19 Symptoms Following Antiviral Treatment

- There have been reports of "COVID-19 rebound" in some individuals who have received Paxlovid for their COVID-19 illness. This refers to recurrence of COVID-19 symptoms in individuals 2-8 days following completion of treatment.
    - Given the limited evidence on this phenomenon thus far, it is recommended that these individuals be re-isolated using the date of rebound symptom onset. This is a precautionary measure under the presumption that the rebound in symptoms is associated with a rebound in infectiousness.

Table 1: Isolation Period for Test-Positive Cases and Individuals with COVID-19 symptoms

Population	Isolation Period	Additional Precautions after Self-Isolation Period
Individuals with severe illness[1] (requiring ICU level of care)	• At least **20 days** (or at discretion of hospital IPAC) after the date of specimen collection or symptom onset (whichever is earlier/applicable) and until symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever present.	• N/A

[1] Severe illness is defined as requiring ICU level of care for COVID-19 illness (e.g., respiratory dysfunction, hypoxia, shock and/or multi-system organ dysfunction).

Population	Isolation Period	Additional Precautions after Self-Isolation Period
Individuals who: • residing in a highest risk setting[2] • hospitalized for COVID-19 related illness (not requiring ICU level of care) • immunocompromised[3]	• At least **10 days** after the date of specimen collection or symptom onset (whichever is earlier/ applicable) and until symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever present. • Duration of isolation may be modified based on hospital IPAC direction (for inpatients) or health care provider direction (for individuals with immune compromise). • Setting-specific guidance prevails for case isolation in highest risk settings.	• N/A

[2] Isolation is recommended from others to prevent transmission within the highest risk setting. However, individuals may follow routine guidance on isolation duration when they are in the community.

[3] Examples of **immune compromise** include cancer chemotherapy, untreated HIV infection with CD4 T lymphocyte count <200, combined primary immunodeficiency disorder, taking prednisone >20 mg/day (or equivalent) for more than 14 days, and taking other immune suppressive medications. Factors such as advanced age, diabetes, and end-stage renal disease are generally not considered severe immune compromise impacting non-test based clearance.

Population	Isolation Period	Additional Precautions after Self-Isolation Period
All other individuals not listed above who have COVID-19 symptoms **OR** a positive COVID-19 test (PCR, rapid molecular or rapid antigen test)	• Until symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever present. • Asymptomatic individuals with a positive test result do not need to self-isolate unless symptoms develop. If symptoms develop, they should self-isolate immediately	• For a total of **10 days** after the date of specimen collection or symptom onset (whichever is earlier/applicable), individuals should: o Continue to wear a well-fitted mask in all public settings (including schools and childcare, unless under 2 years old) and avoid non-essential activities where mask removal is necessary (e.g., dining out, playing a wind instrument, high contact sports where masks cannot be safely worn) [4] o Not visit anyone who is immunocompromised or at higher risk of illness (e.g., seniors) o Avoid non-essential visits to highest risk settings such as hospitals and long-term care homes

5 Case and Outbreak Management

PHUs are not expected to conduct individual level case follow-up for case management purposes, only for surveillance and outbreak identification in highest risk settings (see section 3).

Case management is at the discretion of the PHU and may be conducted as needed for certain cases in highest risk settings or other vulnerable populations (e.g., to support isolation).

PHUs should make specific considerations for case and contact management for First Nations, Inuit, and Métis communities, in dialogue with the communities and/or Indigenous health service providers, and with respect of the principle of self-determination, to support ongoing surveillance and response that allows for differences in community needs, recognizes differential impacts to communities, and changing needs over time.

If case and contact management is initiated, the PHU may determine their frequency of communications based on a risk assessment and available staffing resources.

5.1 Case Reporting

For data that is not populated directly into the CCM system via the Ontario Laboratory Information System (OLIS) such as receipt of manual faxes, PHUs must enter the minimum set of data elements to create the case in CCM as indicated in the most recent Enhanced Surveillance Directive for each confirmed case (and probable cases where feasible). Data should also be entered in accordance with PHO data entry guidance.

PHUs must continue to make an effort to acquire (e.g., using ConnectingOntario), receive (e.g., information sent directly from hospitals), and enter hospital admissions, ICU admissions, and deaths into CCM for the purpose of COVID-19 surveillance. If received, PHUs may enter other case information (e.g., underlying medical condition, symptoms).

PHUs should continue to link all COVID-19 cases that are outbreak-associated to the relevant outbreak in CCM.

Cases that are part of a confirmed COVID-19 outbreak in one of the highest risk settings should be identified as residents, patients, or staff members in accordance with PHO data entry guidance.

In the event of a future VOC, there may be additional time limited requirements for additional data entry into CCM in order to gather pertinent initial surveillance on the emerging VOC, as directed by the MOH.

5.2 Considerations for Cases and Outbreak Management in Highest Risk Settings

Relevant **sector-specific guidance** for highest risk settings (see Section 3) should be followed for those specific settings where conflicting with the below information.

Certain groups, such as home and community care staff and residents or paramedic service workers, are considered highest risk groups for the purposes of molecular testing eligibility and guidance on return to work in this document (see below and Appendix A). However, they are not considered part of highest risk settings for the purpose of outbreak management (e.g., an ambulance service headquarters is not a highest risk setting).

Highest risk settings should notify their local PHU of individuals who test positive on a rapid antigen test and did not receive confirmatory molecular testing if they are associated with a suspect or confirmed outbreak in the setting.

Close contacts in highest risk settings that **develop symptoms should be managed as probable cases** for outbreak management purposes. PHUs should follow PHO data entry guidance and not enter these contacts as probable cases if test results are pending.

At the discretion of the PHU, case management of vulnerable individuals or as part of outbreaks in highest risk settings may be conducted to support those individuals. This may include:

- Regular (e.g., daily) calls to cases in highest risk settings and other vulnerable individuals who may have challenges following public health guidance.
- Use of clinical assessment centres;
- Use of isolation facilities, if applicable;
- Use of community supports and agencies;
- Psychosocial supports;
- Courier, delivery supports for food and necessities;
- Emergency financial supports through the provincial government and local regions;

- Provincial job-protected infectious disease emergency leave and federal government financial supports including employment insurance; and/or
- Additional resources available to support isolation for marginalized populations through the High Priority Communities strategy.

Individuals who reside in highest risk settings

Please refer to setting-specific documents for guidance on case isolation in highest risk settings (see section 3).

Individuals who work in highest risk settings

If the case **works** in a highest risk setting, they should speak with their employer and follow their workplace guidance for return to work.

- For routine operations (i.e., in the absence of staff shortages), COVID-19 positive cases that work in highest risk settings may return to work:
    - 10 days after symptom onset or date of specimen collection (whichever is earlier); **AND**
    - Provided they have no fever and other symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms).
- Testing for clearance is not recommended.
- See Appendix A for Staffing Options for Highest Risk Settings experiencing critical staffing shortages.

5.3 Detected (Low Level) PCR Target Gene Results and Indeterminate Results

- Some laboratories have added the qualifier "detected (low level)" to positive PCR results where the cycle threshold (Ct) value is high (meaning the viral load level is low, e.g., a Ct value between 35 and 37). This result is still a POSITIVE result and should be interpreted in the clinical and epidemiological context of the case. It may represent an early stage of infection, a late stage of infection (e.g., residual non-infectious gene fragments), or a false positive result. This "detected (low level)" result is distinct from "indeterminate" results where the result cannot be differentiated between the presence or absence of the target gene. Individuals with a "detected (low level)" target gene result should still be managed as a case. However, if the pre-test probability of COVID-19 is low (e.g., asymptomatic screen testing) and there are no other target genes reported as detected on the

PCR assay report at the time, then repeat molecular testing may be warranted as for any other situations where there is a concern for a false positive result.

- Follow up for indeterminate cases is at the discretion of the PHU.

5.4 Management of Previously Cleared Cases with New Positive Results

- If molecular samples from the previously cleared infection and molecular samples from the new positive result are available and of sufficient viral load to permit additional investigations (Ct value <30), VOC screening and/or whole genome sequencing may be requested to provide further laboratory evidence supporting a reinfection with a different SARS-CoV-2 variant as opposed to persistent positivity with the same SARS-CoV-2 variant (see Case Definition – Coronavirus Disease [COVID-19] Section C. Laboratory-Based Case of Reinfection).
- **Persistent positive:** If there is evidence that the new positive result is likely to be due to ongoing persistent detection from the previously cleared infection (e.g., incidental positive collected within 90 days of prior positive in an asymptomatic individual), then no further public health case management is required.
- **Re-infection:**
    - Case management
        - Evidence suggests reinfections can occur less than 90 days after a previous confirmed infection. Cases where re-infection is suspected (e.g., new onset of COVID-19 symptoms after prior infection) should be managed as currently infectious, regardless of whether they meet case definition as a re-infection case. This includes rebound of symptoms post treatment.
    - Data Entry
        - Reinfections that meet either the lab-based or time-based Ontario Case of Reinfection Definitions should be entered as confirmed cases into CCM.
        - Suspected reinfections that DO NOT meet either the lab-based or time-based Ontario Case of Reinfection Definitions should follow PHO Data Entry Guidance for entry of new positive result in a previously cleared individual.

- PHO is available for consultation on re-infection cases (whether confirmed or suspected) via epir@oahpp.ca.

6 Guidelines for Close Contacts

6.1 Definition of Close Contacts

A close contact is defined as an individual who has a high-risk exposure (see Table 2) to a confirmed positive COVID-19 case, an individual with COVID-19 symptoms, or an individual with a positive rapid antigen test result.

- In general, this refers to individuals who have had a high-risk exposure (see **Table 2**) with the case (or symptomatic person):
    - During the case's infectious period – i.e., within the 48 hours prior to the case's symptom onset if symptomatic or 48 hours prior to the specimen collection date (whichever is earlier/applicable) and until the case has completed their self-isolation period; AND
    - Were in close proximity (less than 2 meters) for at least 15 minutes or for multiple short periods of time without measures such as masking, distancing, and/or use of personal protective equipment depending on the nature of contact.
- For acute care settings, it is the **responsibility of the acute care setting** to identify and notify close contacts of cases within the setting. It is up to the discretion of the acute care setting and/or PHU to notify close contacts who are no longer admitted in the acute care setting.
- For other highest risk settings, identification and notification of close contacts of cases in the setting is the responsibility of the PHU in collaboration with the setting. It is up to the discretion of the PHU to notify close contacts who are no longer residing in the highest risk setting.
- In the community, it is the **responsibility of the individual** with COVID-19 symptoms or COVID-19 positive test to determine who their close contacts are and to notify them of their potential exposure.
- Employers must also follow requirements as per the *Occupational Health and Safety Act*.
- Note: The public health guidance within this document is intended for close contacts with high-risk exposures as per **Table 2**. Contacts with other exposures that would not be considered high risk exposures as per this guidance may still

be at some risk of infection. For further details see: Focus On: Risk Assessment Approach for COVID-19 Contact Tracing.

Table 2: Examples of High-Risk Exposures

Exposure Setting	Examples of High-risk exposures
Household (includes other congregate settings)	• Anyone living in the same household during the infectious period. ○ This may include members of an extended family, roommates, boarders, etc. ○ This may include people who provided care for the case (e.g., bathing, toileting, dressing, feeding etc.) ○ This may include individuals who spent substantial time in the home with the case (e.g., care givers, guests) ○ This **excludes** individuals who live in a completely separate area/unit (e.g., self-contained basement apartment)

Exposure Setting	Examples of High-risk exposures
Community (includes workplaces, schools, childcare, camps)	• Had direct contact with infectious body fluids of the case (e.g., coughed on or sneezed on) • Were in close proximity (less than 2 meters) [5] for at least 15 minutes [6] or for multiple short periods of time without consistent and appropriate use of masking [7]

[5] **Close Contact:** Maintenance of physical distancing measures (> 2 metres) for the entire duration of exposure decreases the risk of transmission. However, **physical distancing of 2 metres does not eliminate the risk of transmission,** particularly in confined indoor and poorly ventilated spaces and during exercise, talking loudly, yelling, or singing activities.

[6] **Prolonged Contact:** Prolonged exposure duration may be defined as lasting cumulatively more than **15 minutes**; however, individuals with exposures of <15 minutes may still be considered close contacts depending on the context of the contact/exposure. As part of the individual risk assessment, consider the cumulative duration and nature of the contact's exposure (e.g., a longer exposure time/cumulative time of exposures likely increases the risk, an outdoor only exposure likely decreases the risk, whereas exposure in a small, closed, or poorly ventilated space may increase the risk even if individuals are distanced or masked), the case's symptoms (e.g., coughing or severe illness likely increases exposure risk), physical interaction (e.g., hugging, kissing), and whether PPE by the contact or source control by the case was used.

[7] **Personal Protective Equipment (PPE):** If PPE is worn consistently and in accordance with organizational recommendations for the nature of the interaction and for the entire duration of exposure, the individual would generally not be considered a close contact; however, it is important to assess the context of the interactions with the case and other factors that may increase risk of exposure (e.g., physical touching, prolonged duration, confined space with poor ventilation). **Note: Workers should follow organizational policies on the use of PPE for patients with suspected and confirmed COVID-19.**

Exposure Setting	Examples of High-risk exposures
Health care and other highest risk settings (including long term care homes, retirement homes, First Nation Elder Care Lodges, group homes, shelters, hospices, correctional institutions, hospital schools)	See the relevant sector specific guidance documents for more information. **Patient/resident is the case:** • Health care worker and/or staff who provided direct care for the case, or who had other similar close physical contact (i.e., less than 2 metres from patient for more than transient duration of time) **without** consistent use of PPE for the setting and interaction [8] • Health care workers and/or staff who had direct contact with infectious body fluids of the case. • Other patients/residents in the same semi-private/ward room • Other patients/residents who had close [5], prolonged [6] contact with the patient case without consistent masking [7-8] **Health care worker/staff is the case:** • All patients/residents who had close [5], prolonged [6] contact to the health care worker/staff • **Note:** Patients exposed to the health care worker/staff where contact was neither close nor prolonged, AND the health care worker/staff was masked for the entire duration would generally not be considered high risk exposures. Consideration may also be given if the patient was consistently masked during the interaction.[7] • All co-workers who had unprotected close and/or prolonged contact with the case (e.g., within 2 metres in an enclosed common area) [5-8] • Close contacts as identified by workplace occupational health & safety or hospital IPAC (as appropriate)

6.2 Close Contacts Outside of Highest Risk Settings

Household and Non-Household Close Contacts

- For a total of 10 days after the last exposure to the COVID-19 positive case or individual with COVID-19 symptoms, the individual notified by a case should:
    - Self-monitor for symptoms. They should **self-isolate immediately if they develop any symptom of COVID-19 and seek testing if eligible;**
    - Wear a well fitted mask in all public settings:
        - Individuals should maintain masking as much as possible in public settings (including school and child care, unless under 2 years old). Reasonable exceptions would include removal for essential activities like eating, while maintaining as much distancing as possible;
        - Participation in activities where masking can be maintained throughout may be resumed, but individuals should avoid activities where mask removal would be necessary (e.g., dining out; playing a wind instrument; high contact sports where masks cannot be safely worn); and
        - Individuals who are unable to mask (e.g., children under two years of age, etc.) may return to public settings without masking.
    - Avoid non-essential visits to anyone who is immunocompromised or at higher risk of illness (e.g., seniors); and
    - Avoid non-essential visits to highest risk settings such as hospitals and long-term care homes. Where essential visit cannot be avoided, close contacts should wear a medical mask, maintain physical distancing, and notify the highest risk setting of their recent exposure.

[8] For the **purposes of public health follow-up** and guidance for close contacts with high-risk exposures, where there has been exposure to an individual who was *not previously identified* as a suspect or confirmed COVID-19 case, if the exposed worker had consistent medical masking (without the use of eye protection, gowns, and/or gloves), this would generally **not** be considered a high-risk exposure. **Note: Workers should follow organizational policies on the use of PPE for patients with suspected and confirmed COVID-19.**

6.3 Close Contacts in Highest Risk Settings

Those who live in the setting:

- Close contacts who **live** in a highest risk setting may need to isolate following a high-risk exposure, based on the sector-specific isolation guidance (see Section 3), direction from local PHU, or direction from the local hospital IPAC team for hospitalized patients.

Those who work in the setting:

- Employees working in highest risk settings who have had a high-risk exposure (see **Table 2**) to a COVID-19 case should speak with their employer to report their exposure and follow their workplace guidance for return to work.
- Employees working in highest risk settings should **self-monitor for symptoms for a total of 10 days** after the last exposure to the COVID-19 positive case or individual with COVID-19 symptoms.
- **All employees should self-isolate immediately if they develop any symptom of COVID-19 and seek testing if eligible.**
- Individuals who are required to work in person may attend the highest risk setting right away following the guidance below.
- Close contacts should self-monitor for 10 days from last exposure [9].
- Close contacts who develop **any** symptom(s) of COVID-19 should **self-isolate immediately and be tested by molecular testing as soon as possible**.
- Where feasible, additional workplace measures for individuals who are self-monitoring for 10 days from last exposure may include:
    - Recommending that close contacts with a household (ongoing) exposure obtain an immediate PCR or rapid molecular test, and re-testing at day 5 from initial exposure if initial test was negative.

[9] "Last exposure" refers to the last day the contact was exposed to an individual with COVID-19 symptoms or a positive test result. Individuals who have ongoing exposure to a case (i.e., case is unable to effectively self-isolate) would have their last exposure on the date the case ended their self-isolation period. For example, if a parent was caring for a child with COVID-19 and the child was to be self-isolating from Monday to Saturday, the 'last exposure' for the parent would be Saturday.

- Recommending that close contacts with a discrete (one-time) high-risk exposure obtain PCR or rapid molecular testing at day 5 from initial exposure.
- Testing of close contacts with rapid antigen testing for 10 days may be recommended (as an alternative to PCR/molecular testing and/or in addition to PCR/molecular testing) based on setting specific IPAC and/or Occupational Health direction.
- Where testing is recommended, individuals may continue to attend the highest risk setting even if test results are pending or if testing was not obtained, unless otherwise directed by their IPAC/Occupational health lead.
- Active screening for symptoms ahead of each shift.
- Individuals should not remove their mask when in the presence of other staff to reduce exposure to co-workers (i.e., not eating meals/drinking in a shared space such as conference room or lunch room).
- Working in only one facility, where possible.
- Ensuring well-fitting source control masking for the staff to reduce the risk of transmission (e.g., a well-fitting medical mask or fit or non-fit tested N95 respirator or KN95).

7 Risk of COVID-19 Spread Between People and Animals

- There have been infrequent confirmed reports of the SARS-CoV-2 virus spreading from animals to individuals (e.g., in mink farms).
- Based on available information to date, animal-to-human transmission is likely very uncommon and the risk to most people in Canada for acquiring COVID-19 from animals appears to be very low.
- See the Government of Canada's website for more information on the risk of COVID-19 spreading from animals to people, for information on how to keep your pets safe when you have COVID-19 or COVID-19 symptoms and guidelines for individuals who have had contact with farm animals or wild life.

8 Travellers from Outside of Canada

PHU follow-up for international flights where travellers are under federal quarantine is not required unless the traveller tests positive for COVID-19 during their quarantine period and the case information is forwarded to the PHU.

See the Government of Canada's website for testing and quarantine requirements and exemptions for travellers within and outside of Canada. The Government of Canada's website also provides quarantine requirements for travellers who have an exposure or test positive during the federal quarantine period.

All individuals permitted to enter Canada should follow the Federal Emergency Orders and public health and workplace rules, self-monitor for symptoms, and immediately self-isolate should symptoms develop.

Compliance with the orders is managed by the PHAC with support from other agencies, including the Canada Border Services Agency (CBSA), local police, the Ontario Provincial Police (OPP), and the Royal Canadian Mounted Police (RCMP). In addition, in some regions private security have been contracted to assist with in-person follow-up. Local PHUs do not have a direct role in enforcement of the Quarantine Orders but are able to provide support and information (e.g., requirements of self-isolation) and, if required, refer cases to the local police. PHUs may also contact the Compliance and Enforcement office at PHAC (phac.isolation-isolement.aspc@canada.ca) to request a quarantine breach assessment.

Should an individual require essential health care during the 14-day quarantine period, these individuals may seek service but should be managed as an individual in isolation. Where possible, travellers should receive healthcare remotely through services such as Health Connect Ontario (formerly Telehealth Ontario).

9 Appendix A: Management of Staffing in Highest Risk Settings

It is the responsibility of the organization implementing this guidance to determine what early return to work option to use under their current circumstances and populations served. In the event of conflicting guidance, specific direction on which staffing options can be used for early return to work from other relevant ministries (e.g., Ministry of Long-Term Care) should be followed.

If staffing shortages are impacting care, routine return to work options listed below should be exhausted prior to progressing to options for critical staff shortages, which have more risk of COVID-19 transmission within the setting. The use of options with more risk of COVID-19 transmission should be commensurate to the risk of insufficient staffing to patients/residents to provide adequate care.

9.1 Routine Operations Staffing Options

Asymptomatic Close Contacts with high-risk exposures

See Section 6.3 for guidance on return to work of staff who are close contacts.

COVID-19 Positive Cases

- For routine operations, **COVID-19 positive cases** that work in highest-risk settings may return to work if they have no fever and other symptoms have been improving for 24 hours (or 48 hours if vomiting/diarrhea) **AND** meet at least one of the following criteria:

    1) 10 days after symptom onset or date of specimen collection (whichever is earlier) **OR**
    2) After a single negative molecular test any time prior to 10 days from the date of specimen collection or symptom onset (whichever is earlier) **OR**
    3) After two consecutive negative rapid antigen tests that are collected at least 24 hours apart any time prior to 10 days from the date of specimen collection or symptom onset (whichever is earlier).

  NOTE: Testing for clearance is NOT recommended. For settings that are using testing to support return to work, staff may routinely return to work earlier than day 10 if criteria 2 or 3 are met.

9.2 Options For Critical Staffing Shortages

COVID-19 Positive Cases

- For critical staffing shortages, if routine best practice operations (see Section 9.1 Routine Operations Staffing Options) cannot be met, COVID-19 positive staff may return to work earlier with adherence to Workplace Measures for Reducing Risk of Exposure (Section 9.3) in place, and making organizational decisions with the following principles for reducing risk of spread:

    1) Staff must be afebrile and their symptoms have been improving for 24 hours (48 hours if vomiting/diarrhea).

    2) While there is no specific minimum time prior to returning to work, staff who are closer to day 10 from their symptom onset date/specimen collection date should be prioritized for early return to work ahead of staff closer to their symptom onset/specimen collection date (for staff who do not meet test-based criteria in Section 9.1).

    3) Staff who have never had symptoms should be prioritized ahead of staff who have been symptomatic.

    4) Assignment of staff on early return to work should be prioritized to caring for COVID-19 positive/recovered patients/residents, if possible. With appropriate IPAC oversight, staff on early return to work may be assigned to care for all patients/residents (including COVID-19 negative patients/residents), with strict adherence to workplace measures for reducing risk of transmission, and avoiding caring for patients/residents at highest risk of severe COVID-19 infection, where possible.

9.3 Workplace Measures for Reducing Risk of Exposure

- Ensuring well-fitting source control masking for the staff on early return to work to reduce the risk of transmission (e.g., a well-fitting medical mask or fit or non-fit tested N95 respirator or KN95).
    - PPE and IPAC practices should be reviewed (including audits) to ensure meticulous attention to measures for staff on early return to work.
- Providing supports (e.g., separate breakroom) such that individuals on early return to work do not remove their mask in the presence of other staff who are unmasked to reduce the risk of exposing co-workers.

- Staff cases on early return to work should be prioritized to work on a single ward or area of the facility for at least 10 days after date of specimen collection or symptom onset (whichever is earlier) in order to prevent transmission across the setting, as much as possible.
- Staff should be working only in one facility, as much as possible.

9.4 Administrative Considerations for Selecting Staff for Return to Work Under Critical Staff Shortages

- The fewest number of staff who are COVID-19 cases should be returned to work early to allow for business continuity and safe operations.

10 Additional Resources

- Public Health Ontario Public Resources
- Public Health Agency of Canada's Public Health Management of Cases and Contacts for COVID-19
- Public Health Agency of Canada's COVID-19: For Health Professionals website
- Centers for Disease Control and Prevention's COVID-19 website
- European Centre for Disease Prevention and Control's COVID-19 website
- Ministry of Health's COVID-19 website
- Provincial Infectious Diseases Advisory Committee's Tools for Preparedness: Triage, Screening and Patient Management of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) Infections in Acute Care Settings
- Government of Canada's COVID-19 Affected Areas list
- World Health Organization's Disease Outbreak News website, and COVID-19 website

11 Document History

Revision Date	Document Section	Description of Revisions
January 30 2020		Document was created.
February 5 2020	Contact Management – Public Health Advice	Language included to reflect policy change: self-isolation of 14 days for those returning from Hubei province and for close contacts of cases.
February 7, 2020	Throughout Document	Updates to reflect changes to case definition and self-isolation
February 12 2020	Case and Contact Management Travellers from Affected Areas	Updates to language around risk level and corresponding level of self isolation/ self monitoring Addition of Table 3
March 3 2020	Updates throughout document	Updates based on new case definition and evolving advice based on travel history of patient
March 25 2020	Updates throughout document	Change in Purpose section; guidance on testing, explanation on case definition, assessment and management of persons suspected of COVID-19, Information on pets
April 15 2020	Updates throughout document	Updates on case definition description, travellers from outside of Canada, link to other guidance (e.g. provincial testing), updates to streamline language throughout

Revision Date	Document Section	Description of Revisions
June 23 2020	Updates throughout document	Major updates to most sections, addition of several reference tables, moved to 2 risk exposure levels: low and high risk, moved appendices to become separate documents.
September 8 2020	Updates throughout document	Additional information on asymptomatic cases with low pre-test probability; new appendix 8; new table: Assessing Scenario Likelihood in Asymptomatic Cases with Low Pre-Test Probability; minor update to travel section; new information on COVID Alert
October 9 2020	Updates throughout document	Updates on frequency/nature of contact with low/high risk contacts Updated messaging to align with new guidance on case clearance timelines.
December 1 2020	Updates throughout document	New section on Re-Infection; updates to case isolation for asymptomatic cases; updates to contact follow-up; further detail on risk assessment for contact tracing; removal of Non-Medical Mask section; addition of Appendix 9; updated section on Travellers from Outside of Canada
January 12 2021	Updates throughout document	Specify collection of vaccine information, clarify that vaccination does not change case & contact management at this time, updates to informing PHO of flight notifications, updates to federal quarantine guidance, clarification to extension of POC of some asymptomatic cases, clarify guidance on PPE for HCW exposures, clarify guidance on patient exposures to HCW cases

Revision Date	Document Section	Description of Revisions
May 6 2021	Updates throughout document	New section on preliminary positive results from point-of-care assays; new section for testing of previously cleared cases (re-positive, re-infection) and self-isolation of previous positives with new high-risk exposures; new section on enhanced case management for VOC screen positive cases; new section on testing of asymptomatic high-risk contacts; updates to contact management in the context of VOC emergence (lower threshold for classifying contacts as HR exposure and requiring self-isolation); travellers from outside of Canada update.
August 11 2021	Updates throughout the document	Incorporation of fully immunized/previously positive individuals; New section on notification of individuals identified through Backward Contact Tracing; Updated section: self-isolation of previous positives with new high-risk exposures (10 day self isolation); Updated section: Testing and Self-Isolation of Asymptomatic High-Risk Contacts; Follow up for high risk contacts is now day 5 and 10 of self-isolation; Section 5.2 update; Updated table 4 and modified footnote 4 on PPE and eye protection. Updated section: Travellers from Outside of Canada; New section: Contact tracing for train/bus/cruise ship passengers.

Revision Date	Document Section	Description of Revisions
April 6 2022	Updates throughout document	Incorporation of COVID-19 Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge; Incorporation of COVID-19 Interim Guidance: Omicron Surge Management of Staffing in Highest Risk Settings; Incorporation of COVID-19 reference document for symptoms; PHUs not expected to conduct case management for individual confirmed or probable cases, but must complete case surveillance requirements by following data entry requirements for individual cases, PHUs must investigate and manage suspect and confirmed outbreaks in congregate care/living highest risk settings.