

Ministry of Health

COVID-19 Quick Reference Public Health Guidance on Testing and Clearance

This information can be used to help guide decision making on testing and clearance of contacts of cases or individuals suspected or confirmed to have COVID-19. This information is current as of February 18 2021 and may be updated as the situation on COVID-19 continues to evolve. At this time, there are no changes to the routine management of COVID-19 cases or contacts based on their vaccination history. This will be re-evaluated and updated as further information is available.

Who should be tested for COVID-19?

Please refer to the [COVID-19 Provincial Testing Guidance Update](#).

Diagnosing COVID-19

Please refer to the current Ontario [Case Definition](#) for information on confirmed, probable and reinfection cases.

Please refer to Public Health Ontario Test Information Sheets on:

- [COVID-19 – PCR](#)
- [COVID-19 – Serology](#)
- [COVID-19 – Variant of Concern \(VoC\) Surveillance](#)

For details on the assessment of laboratory results in the context of the clinical and epidemiological context of an individual, please refer to the [Management of Cases and Contacts of COVID-19 in Ontario](#).

Some point-of-care (POC) assays, both NAAT and antigen tests, are now approved by Health Canada. Please refer to the [Ontario Case Definition](#) for a list of approved POC assays for final reporting **and** the [Provincial Testing Guidance](#) for the specific clinical scenarios where a POC final report can be issued. All POC preliminary positives require parallel/repeat confirmatory testing at a licensed laboratory. Once an individual POC assay is approved by the Ministry of Health based on its evaluation, positive and negative results will no longer be reported as preliminary. All POC preliminary positives and final positives must be reported to the local public health unit, and are actionable for initiating clinical and public health management (see [Appendix 9: Management of Individuals with Point of Care Results](#)). However, the confirmatory laboratory test result should be used to direct final clinical and public health management. False negatives may be more likely with POC assays than laboratory-based assays. Depending on the clinical context of testing, final positive and negative POC tests may still require parallel/repeat testing using a laboratory-based NAAT to guide case and public health management (see [Appendix 9: Management of Individuals with Point of Care Results](#) for more details).

Asymptomatic testing for COVID-19

- An asymptomatic individual who has been advised by local public health to get tested due to exposure to a case or as part of an outbreak investigation should be tested within 14 days from their last exposure.
 - If the contact has their negative specimen collected on day 0 to day 6 of their quarantine period, they should repeat specimen collection on or after day 10 of their 14 day quarantine period. If the contact has their negative specimen collected on day 7 to day 14, then repeat testing is not recommended.
 - Contacts must remain in quarantine for the full 14 days from last exposure, regardless of negative test results.
 - Re-testing should be conducted if the asymptomatic individual who initially tested negative develops symptoms consistent with COVID-19.

Reinfection

- Re-testing after clearance should be based on clinical indications for testing (e.g., in the context of new [symptoms](#) compatible with COVID-19), or as directed in the context of new high-risk exposures or outbreak investigations.
- An asymptomatic individual that **previously had laboratory-confirmed COVID-19 AND was cleared**, should generally **not be re-tested** for asymptomatic surveillance purposes due to persistent shedding.
- Previously cleared individuals should continue to follow public health guidance for COVID-19 prevention, including self-isolating after new high risk exposures to unrelated cases.

- If there is uncertainty as to whether a new positive after clearance represents a potential new infection or persistent shedding, repeat testing as soon as possible.
- For confirmation of reinfection, please follow the [Ontario Case Definition](#).

Criteria for when to discharge someone with probable or confirmed COVID-19 from isolation

- For each scenario, isolation after symptom onset should be for the duration specified **provided that the individual is afebrile (without the use of fever-reducing medications), and symptoms are improving for at least 24 hours**. Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post-infection.
- If an individual has tested positive but has never had symptoms, isolation recommendations should be **based on date of specimen collection**.
- If an asymptomatic individual has tested positive AND has a prior history of symptoms compatible with COVID-19, clearance should still be based on specimen collection date. At the discretion of the local public health unit, the period of communicability and clearance may be based on symptom onset date depending on timing of symptoms (e.g., recent symptoms) and likelihood that symptoms were due to COVID-19 (e.g., known exposure to a confirmed COVID-19 case prior to symptom onset).
- After an individual completes their isolation period, they should continue to practice [physical distancing measures](#) and use of [masking for source control](#) as recommended for everyone at this time.

Approaches to Clearing Cases (including cases with variants of concern)

Approach	When to Use	Instructions
<p>Non-Test Based</p> <p>Waiting 10 days from symptom onset (or 10 days from specimen collection date if persistently asymptomatic)</p>	<p>Mild to moderate illness AND no severe immune compromise</p>	<p>Can discontinue isolation after 10 days from symptom onset (or 10 days from positive test collection date if never had symptoms), provided that the individual is afebrile (without the use of fever-reducing medications) and symptoms are improving for at least 24 hours. Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post-infection.</p> <p>Mild to moderate illness includes the majority of cases of COVID-19, and includes all those who do not meet the definition of severe illness or severe immune compromise (below).</p>
<p>Non-Test Based</p> <p>Waiting 20 days from symptom onset (or 20 days from specimen collection date if asymptomatic and severe immune compromise)</p>	<p>Severe illness (requiring ICU level of care) OR severe immune compromise</p>	<p>Can discontinue isolation 20 days from symptom onset (or 20 days from positive test collection date if asymptomatic and severe immune compromise), provided that the individual is afebrile (without the use of fever-reducing medications) and symptoms are improving for at least 24 hours. Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post-infection.</p> <p>Studies informing this approach did not have a consistent definition of severe illness or severe immune compromise. For the purposes of a clearance assessment:</p> <ul style="list-style-type: none"> • 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). • Examples of severe 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.

Approach	When to Use	Instructions
<p>Test Based</p> <p>Two consecutive negative specimens tested by a NAAT, collected at least 24 hours apart</p>	<p>Not routinely recommended, but may be used at the discretion of a hospital to discontinue precautions for admitted patients</p>	<p>Continue isolation until 2 consecutive negative specimens tested by a NAAT and collected at least 24 hours apart.</p> <ul style="list-style-type: none"> • Testing for clearance may begin after the individual has become afebrile and symptoms are improving for at least 24 hours. Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post-infection. • If swab remains positive, test again in approximately 3-4 days. If swab is negative, re-test in 1-2 days (and at least 24 hours apart). • Tick the box labelled 'Other' and clearly write 'For clearance of disease' on the PHO Laboratory COVID-19 Test Requisition, or clearly write this on the requisition if submitting to another laboratory. • Serological testing cannot be used for test based clearance. • Test based clearance should not be used in an attempt to reduce the length of isolation.

Recommendations for Health Care Workers Return to Work

- Health care workers (HCWs) should follow **isolation and clearance with a non-test based approach**; if they have required hospitalization during the course of their illness, a test based approach may be used at the discretion of the hospital while they are admitted (see above). Some HCWs may be directed to have test based clearance by their employer/Occupational Health and Safety.
- Symptomatic HCWs awaiting testing results must be off work
- Asymptomatic HCWs awaiting testing results may continue to work using the appropriate precautions recommended by the facility, which will depend on the reason for testing (i.e., asymptomatic HCW is not on self-isolation following a high-risk exposure)

In **exceptional circumstances** where clinical care would be severely compromised without additional staffing, an earlier return to work under work self-isolation may be considered for an asymptomatic HCW who is self-isolating due to a high-risk exposure.

In **exceptionally rare circumstances** where clinical care would be severely compromised without additional staffing, an earlier return to work of an asymptomatic COVID-19 positive HCW that has not been cleared may be considered under work self-isolation recognizing the HCW may still be infectious (see table below). Any COVID-19 positive worker who is, in an exceptionally rare circumstance, being allowed to return to work earlier than would otherwise be the case must not pose a risk to other workers or patients.

Work self-isolation means maintaining self-isolation measures outside of work for 14 days from their last exposure (for contacts with high-risk exposures); or 10 days from symptom onset (or 10 days from positive specimen collection date if consistently asymptomatic) for cases. While at work, the HCW must adhere to universal masking recommendations, maintain physical distancing (remaining greater than 2m/6 ft from others) except when providing direct care, and perform meticulous hand hygiene. These measures at work are required to continue until non-test based clearance (or test based clearance if required by employer/Occupational Health and Safety). The COVID-19 positive HCW should ideally be cohorted to provide care for COVID-19 positive patients/residents if possible. The HCW on work self-isolation should not work in multiple locations.

Work Self-Isolation Guidelines

Symptoms at/around time of testing	Test Result	Instructions
Yes	Positive	<ul style="list-style-type: none"> Work self-isolation could start after a minimum of 72 hours after illness resolving, defined as resolution of fever (without the use of fever-reducing medications) and improvement in respiratory and other symptoms
Yes	Negative	<ul style="list-style-type: none"> May return to work 24 hours after symptom resolution If the HCW was self-isolating due to an exposure at the time of testing, return to work should be under work self-isolation until 14 days from last exposure
Never symptomatic at time of test	Positive	<ul style="list-style-type: none"> If there has been a recent potential exposure (e.g., tested as part of an outbreak investigation or other close contact to a case), work self-isolation (i.e., return to work) could start after a minimum of 72 hours from the positive specimen collection date to ensure symptoms have not developed in that time, as the positive result may represent early identification of virus in the pre-symptomatic period If there is a low pre-test probability (e.g., there has been no known recent potential exposures such as tested as part of surveillance and no other cases detected in the facility or on the unit/floor, depending on the facility size), see Public Health Management of Cases and Contacts of COVID-19 in Ontario for repeat testing guidance. If follow-up testing is negative, the HCW is cleared and can return to work as per usual.

Recommendations for Return to Work in Non-Health Care Settings

- [Return to work](#) for workers who are confirmed or probable cases and work in non-health care settings requires clearance as outlined earlier in this document and in the [Public Health Management of Cases and Contacts of COVID-19 in Ontario](#) guidance.
- Workers are not required to provide proof of a negative test result (by NAAT) or a positive serological test result to their employers in order to return to work. It is expected that workers who have tested positive abide by public health direction and advice on when they would be considered clear to return to work.
- Return to work for workers who are self-isolating due to a high-risk exposure can occur after the end of their self-isolation period.

Work Self-Isolation in Non-Health Care Settings

- [Work self-isolation](#) should NOT be considered for confirmed or probable COVID-19 cases in non-healthcare setting (including asymptomatic positive workers within their isolation period), for large workplace outbreaks, for large numbers of exposed workers in a given workplace, or for any worker linked to an outbreak where workers also live in a congregate living setting.
- There may be **exceptional circumstances** where the Public Health Unit may consider work self-isolation for workers who are in self-isolation from a high-risk exposure, excluding the scenarios outlined above. This should be done in consultation with the Ministry Emergency Operations Centre and Public Health Ontario.
- Work self-isolation is generally **not** recommended for any workers in non-healthcare settings due to the potential for contacts with high risk exposures to be infectious, and barriers to ensuring appropriate and consistent infection prevention and control measures to prevent transmission.
 - Considerations for exceptional circumstances could include:
 - health and safety, and ethics and equity, including whether the worker(s) serve a “critical” function, and promoting the well-being of and minimizing harm to workers and the community
 - minimizing risk related to transportation to and from work (e.g., no carpooling / ride-sharing or public transit use); alternatives to work-self isolation (e.g., work from home, alternate staff)
 - availability of in-house supports for training and monitoring of correct PPE use
 - whether required IPAC measures can be implemented including whether there are barriers to measures such as: symptom screening, physical distancing, appropriate PPE use and masking for source control
 - To be in compliance with the Occupational Health and Safety Act, the employer must take into consideration the safety of all workers and take all steps reasonable in the circumstances to protect their workers.