Management of Cases and Contacts of COVID-19 in Ontario

September 8, 2020 (version 9.0)

Ontario

Version 9.0 – Significant Updates

Page #	Description
13	• Case Management Section: Information on serology testing and link to Appendix 8
15-19	• Updated guidance on case isolation period including Asymptomatic Cases with Low Pre-Test Probability. • New table: Assessing Scenario Likelihood in Asymptomatic Cases with Low Pre-Test Probability • Updates to 'negative' repeat test results
21-22	• Case Recovery and Post-Clearance section updates based on new evidence of persistent positive results
23-24	• Updates to Table 5: Management of Cases after Clearance with New Symptoms, Exposures and/or Positive Test Results
34	• Updates to 'Use of Non Medical Masks' section • New section: COVID Alert Exposure Notification App
38/39	• Additional information on asymptomatic return travelers, and domestic travelers
Throughout	• Clarifying that both cases and contacts must be entered into the case and contact management system (CCM)

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Table of Contents

List of Tables

Management of Cases and Contacts of COVID-19 in Ontario

Version 9.0 – September 8, 2020

This guidance document is not intended to take the place of medical advice, diagnosis or treatment. Where the document includes references to legal requirements, it is not to be construed as 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.

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 current available scientific evidence and expert opinion. This document is subject to change as the situation with COVID-19 continues to evolve and as new tools/strategies to support public health management of cases and contacts are developed.

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*. It is expected that all parties supporting case and contact management in Ontario will follow this guidance.

This document replaces 'Public Health Management of Cases and Contacts of COVID-19 in Ontario V8.0' (June 23, 2020).

For detailed information on case and contact management within congregate settings, please reference the COVID-19 Guidance: Congregate Living for Vulnerable Populations. Additional resources for congregate living settings are available from Public Health Ontario.

Sector specific guidance documents also provide additional information about outbreaks in different settings (i.e., acute care, long-term care homes/retirement homes, workplaces, Emergency Child Care). These documents are available on the Ministry's website.

This guidance document is being released as Ontario begins to enter Stage 3 of reopening, and a relaxation of some public health restrictions. As part of the gradual reopening of the province, it is critical that chains of illness are broken early and effectively – through strong case and contact management activities.

The changes made to this document incorporate many lessons learned from the intial response to COVID-19. The program is currently under review, with an eye to how to further strengthen the program and to create readiness for any future waves of COVID-19 and ensure a continued high quality of service is offered to the people of Ontario.

Case and Contact Management Responsibilities

Ministry of Health (MOH):

- Coordinate the provincial response to COVID-19.
- Support the coordination of complex case, contact and outbreak management activities, including access to specialized consultation and advice.
- Set provincial standards for case and contact management.
- Share information with the public.
- Report case details to the Public Health Agency of Canada (PHAC) as appropriate.
- Coordinate follow-up activities from the Self-Assessment Tool and the Canadian Border Services Agency.

All Public Health Units (PHUs):

- Review the case and contact management guidance in this document.
- Follow requirements of the *Health Protection and Promotion Act*, as well as related regulations.

- Conduct COVID-19 case management (for all probable and confirmed cases) as described in this document including: initial telephone calls to cases, daily monitoring of cases until cleared from self-isolation, and updating case status as required.
- Conduct COVID-19 contact management as described in this document including: ensuring that all new contacts are notified once identified, ensuring that there is appropriate follow-up and management for all close contacts of cases by:
    - Conducting daily monitoring for high-risk contacts
    - Verifying that high-risk contacts are compliant with self-isolation, and
    - Communicating MOH testing guidance to all contacts
- Track and report on own performance management indicators for case and contact management as described by the MOH.
- Ensure timely and complete data entry and reporting of case, contact and outbreak information.
- Identify to the MOH any capacity gaps (real or anticipated) and other challenges to meeting program standards via the Ministry Emergency Operations Centre (MEOC) (eocoperations.moh@ontario.ca).

Public Health Ontario (PHO):

- Participate in the MEOC's response activities.
- Provide scientific and technical advice to stakeholders in areas such as laboratory testing, case and contact management information, reporting of case information using data entry in the integrated public health information system (iPHIS), outbreak management recommendations, and advice on clinical management and infection prevention and control (IPAC) & occupational health and safety (OHS) measures.
- Provide instruction on data entry of cases and contacts including but not limited to: updating and maintaining relevant iPHIS bulletins, enhanced surveillance directives, quick reference guide/iPHIS user guide.
- Conduct and disseminate provincial epidemiological surveillance and analyses.
- Provide laboratory testing for COVID-19, along with other laboratories in Ontario.
- Support PHUs as needed with case and contact follow-up and data entry of cases and contacts into the case and contact management system (CCM).

Acute Care Settings:

- Acute care settings are responsible for monitoring close contacts who were exposed in the hospital and are currently admitted (i.e., inpatients), or were exposed in the community but are now admitted to hospital. This includes patients who were exposed in the emergency department and subsequently admitted. Acute care settings are also responsible for monitoring health care workers who were exposed at work.
- Acute care settings are not responsible for monitoring contacts of probable and confirmed cases in the community. This includes contacts who were exposed in an acute care setting or other health care setting (e.g., primary health care setting, urgent care clinic) but who are currently in the community and not hospitalized.
    - The responsibility for monitoring contacts that were exposed during their hospital admission (i.e., inpatients) and subsequently discharged prior to completing 14 days must be transferred from the acute care setting to the PHU.

Other Sectors:

- Other sectors also play a role in case and contact management including employers, congregate settings, primary care, assessment centres and education partners.
- Details around the role of these sectors can be found in existing guidance on the Ministry of Health website (outbreak guidance, sector specific guidance, etc)
- Work is ongoing to further refine the roles of these other sectors within the provincial case and contact management program.

Testing

PHUs must remain up to date on the latest provincial testing guidance. Table 1 outlines key documents/resources and their location. These documents are updated regularly.

Table 1: Testing Reference Documents

Document/Resource	Location	Notes
Case Definition	MOH Guidance for Health Sector - link	The case definition is for surveillance purposes only.
Provincial Testing Guidance	MOH Guidance for the Health Sector - link	This document outlines provincial testing guidance including considerations for specific settings/groups.
Quick Reference PH Guidance on Testing and Clearance	MOH Guidance for the Health Sector - link	This document can help guide decision making on clearing/testing contacts of cases or individuals suspected or confirmed to have COVID-19
COVID-19 Reference Document for Symptoms	MOH Guidance for the Health Sector - link	This document outlines symptoms associated with COVID-19
PHO COVID-19 Testing Website	PHO Website - link	Testing guidelines for COVID-19

As of April 3, 2020, individuals who are tested are able to access their results online through the Ministry of Health online lab results viewer. Once the individual learns of their testing result, the portal also informs the individual about next steps. The MOH also recently launched Contact + for individuals who test positive. Contact + is integrated with the online lab results viewer and assists with initiating contact tracing efforts.

Management of individuals awaiting testing results

- Symptomatic individuals should self-isolate
- Individuals who are contacts of a confirmed or probable case should self-isolate if they have had a high-risk exposure
- Asymptomatic individuals who did not have a high-risk exposure do not need to self-isolate while test results are pending
- Individuals awaiting testing results are **not** Probable cases. Test results should be obtained before deciding if the case is a confirmed case or does not meet the case definition.

Management of Potential False Positive/False Negative/ Indeterminate Results

False Positives: A positive test should prompt the appropriate public health actions, even if being investigated as a potential false positive. If the test is thought to be a false positive due to concerns about the test validity, repeat the test.

Where true laboratory issues have been identified with previously issued positive results leading to an amended test result, follow PHO guidance on updating case status. See section on Case Management for further detailed guidance on the management of asymptomatic positive results with low pre-test probability.

False Negatives: A false negative test may occur in an infected individual tested too early in their incubation period, or in a symptomatic individual due to the sensitivity of the test. Actions should not be made solely on the basis of a negative test result. False reassurance from a negative test is a concern. Where the clinical index of suspicion is high (e.g., based on clinical presentation and/or epidemiological context), a negative test does not rule out disease. For individuals with worsening/progressing symptoms, consider repeat testing. Individuals with an epidemiological link (e.g., exposure to a known case and/or outbreak) and test negative in their incubation period should continue their self-isolation or self-monitoring for the full 14 days.

Investigations of Potential False Postive/False Negative Results: Investigations should be done by the PHU and/or submitter in consultation with the testing laboratory. A review of the laboratory and epidemiological information of the case is necessary to inform the PHU and/or submitter on the public health and clinical management of the individual.

PHUs should consult PHO and/or the testing laboratory, for further interpretation of positive results where there is concern of a potential false positive. Different assays produce different results, have different limits of detection and different cutoff values for target detection. Values from one assay cannot be directly compared to another assay. Cycle threshold (Ct) or cycle number (CN) values and the number of gene targets detected may provide additional context in some situations, but require further interpretation based on the assay used and the clinical context of the patient.

Indeterminate Results: This may be due to low viral target quantity, or may represent a false signal. Of note, not all assays have an indeterminate range. For

public health follow-up purposes, an indeterminate result in an individual with symptoms compatible with COVID-19 is sufficient laboratory criteria for a probable case, and associated case and contact management practices. For clinical and public health purposes, specimens with indeterminate results may be investigated further with repeat testing.

- An indeterminate result in an asymptomatic individual does not meet the probable case definition. Repeat testing should be considered if the individual has an epidemiological link (e.g., is a contact with high-risk exposure to a confirmed case or lives/works in a setting with an active outbreak), or if the individual develops symptoms compatible with COVID-19 after the initial test.

Table 2: Managing Indeterminate Results

Symptoms?	**Epidemiological link?**	**Repeat Test Result**	**Management**
Yes/No	Yes/No	Positive	Manage as a confirmed case
Yes	Yes/No	Indeterminate	Manage as a probable case
Yes	No	Negative	No further management; Repeat test if symptoms worsen/progress
Yes/No	Yes	Negative	Continue self-isolation/self-monitoring (based on epidemiological link) until end of 14 days from last exposure; Repeat test if symptoms worsen/progress or develop symptoms (if asymptomatic)

Symptoms?	Epidemiological link?	Repeat Test Result	Management
No	Yes	Indeterminate	Continue self-isolation/self-monitoring (based on epidemiological link) until end of 14 days from last exposure; Repeat testing if symptoms develop

Case and Contact Management

The identification of a probable or confirmed COVID-19 case triggers an investigation by the PHU to assess potential exposures within the 14 days prior to symptom onset and to evaluate potential transmission among close contacts.

Public Health system capacity is an important criteria in decision making about other pandemic response activities (e.g., modification of public health measures). Resources are available to support PHUs with case and contact management, including a centralized workforce trained to conduct contact monitoring. PHUs who are or who anticipate they will experience capacity challenges in meeting case and contact management indicators are encouraged to contact the MEOC at (eocoperations.moh@ontario.ca).

Case and Contact Management Indicators

The MOH is working to enhance the provincial case and contact management program, and has set certain indicators to ensure a full understanding of capacity issues/challenges and performance/success. Indicators are subject to change as the program evolves and are applicable to cases detected by PCR.

Case Management Indicators:

- % of cases are reached within 24 & 48 hours from when the PHU was notified of the case.

Currently the performance target for this indicator is that 90% of all cases are reached within 24 hours.

Contact Management Indicators:

- Number of newly identified **contacts** are successfully reached within 24 & 48 hours

Case Management

Instructions to manage a **probable or confirmed case** are outlined below. Case management instructions also apply to asymptomatic cases who test positive. For information on testing and diagnosis of asymptomatic individuals, PHUs should follow the guidance in the COVID-19 Quick Reference Public Health Guidance on Testing and Clearance document.

For information on management of cases confirmed by positive serology results, and for reports of multisystem inflammatory syndrome in children (MIS-C) in confirmed or probable cases of COVID-19, see Appendix 8 for guidance.

The PHU interviews the case and/or household contacts/family members (i.e. if the case is too ill to be interviewed, has died, or is a child) as soon as possible to collect the information for case data entry and identify contacts with high risk exposures.

- As per data entry guidance, the PHU will complete the "investigation start date" as well as the case "reported date" which is the date the case was reported to the PHU by the laboratory. This information will be used for ministry reporting on timeliness of case investigation initiation. The investigation start date is defined as the date the PHU first had contact with the case or proxy.

Most PHU investigators conduct these interviews by telephone, however for interviews conducted in person, the investigator follows Routine Practices and Contact, and Droplet Precautions when entering the case's environment (see Guidance for Health Care Workers and Health Sector Employers for further information on OHS and IPAC measures).

For cases who are hospitalized or living in settings outside of an individual/ family home, the PHU can provide advice and guidance from setting-specific guidance documents found on the MOH Guidance for the Health Sector website.

PHUs must follow 4 general steps as part of case management which are detailed below: initial case reporting, case exposure assessment, case status monitoring, and case contact assessment

1. Initial Case Reporting

Only **Probable and Confirmed** cases are reportable to PHAC and to the World Health Organization. Within 24 hours of the identification of a **probable or confirmed** case in Ontario, the MOH will report the case to PHAC as part of the national notifiable disease reporting requirements, as well as in accordance with the International Health Regulations.

To meet this timeline, the PHU must enter the case into CCM within 24 hours. The initial phone call to a confirmed case is to ensure the case is isolating and to gather information for entry into CCM. PHUs need to enter a minimum data set as dictated by the most recent Enhanced Surveillance Directive for each probable and confirmed case.

*Note: PHUs are no longer required to complete and submit the SARI case report form to PHO, however, this tool (Appendix 1: Ontario's Severe Acute Respiratory Infection Case Report Form) may still be used to guide data collection and data entry.

2. Case Exposure Assessment

PHUs must assess for relevant acquisition exposures in the 14 days prior to symptom onset (or 14 days prior to positive specimen collection date if never symptomatic) - see Appendix 2 for a sample template. Ascertainment of exposures enables identification of locations/settings where transmission may be occurring, particularly if additional cases are associated with that location/setting. The most relevant acquisition exposures for entry are settings where the case spent the most time outside of the house. Potential settings include: a workplace; school/child care centre/camp; congregate living setting (including rooming house, hostel, bed and breakfast).

Data entry of exposures should follow data entry guidance by PHO.

3. Case Status Monitoring

Cases must be monitored daily for assessment of the illness, to ensure ability to comply with self-isolation, and to determine when they can be cleared from self-isolation - see Appendix 3 and Appendix 4 for a sample template. At a minimum, cases must be called on the phone within 24 hours from when the PHU was notified of the case, as well as on day 7 and day 14 of the isolation period. Methods of contact on the other days of self-isolation can include texts, emails or phone calls.

The determination of how to make contact on these days can be based on both PHU discretion, and the preference of the case. Ongoing communication may be required if the case is not cleared by day 14.

4. Case Contact Assessment

PHUs must conduct contact tracing activities (see Contact Management) to identify close contacts of probable or confirmed cases with high-risk exposures - see Appendix 5 for a sample worksheet to conduct close contact tracing activities. In addition, PHUs should ask about any identifiable groups of low-risk contacts to inform consideration of targeted group communication as outlined in Table 8. PHUs should ask the case about any other prompts they have received to initiate the process of contact tracing (such as Contact +), any information received at an Assessment Centre, or from another care provider. PHUs must assess contacts based on exposure setting and risk of exposure based on the interaction with the case.

Case Isolation Period

Guidance for recommendations on isolation measures for probable and confirmed cases of COVID-19 is detailed in Appendix 7. Detailed guidance on clearance from isolation is found in the COVID-19 Quick Reference Public Health Guidance on Testing and Clearance document.

For cases who are **symptomatic at/around the time of their positive result**, their isolation period is based on their symptom onset date.

Asymptomatic Cases- A first positive result in an asymptomatic individual is generally a confirmed case. Asymptomatic individuals may be tested for a variety of reasons under the provincial testing guidance, including for surveillance / targeted testing purposes, and may represent a recent infection that is currently infectious (either as someone who is pre-symptomatic or a truly asymptomatic case), a more remote infection that is no longer infectious, or in some cases, someone who was never infected (false positive). (For guidance on potential false-positive laboratory results, see above Management of Potential False Positive/False Negative/ Indeterminate results. For guidance on remote positives, see below including Table 3: Assessing Scenario Likelihood in Asymptomatic Cases with Low Pre-Test Probability).

For each case who was asymptomatic at or around the time of their first positive COVID-19 test result, PHUs should assess the pre-test probability of current, infectious COVID-19 (i.e., low vs. medium/high pre-test probability).

Assessment of pre-test probability should take into account the clinical and epidemiological context of the case that will guide the level of case and contact management required. For example, asymptomatic cases tested as a contact of a case or as part of an outbreak investigation have a higher pre-test probability; whereas, an asymptomatic case tested as part of routine surveillance testing and who has no known exposures or symptoms has a lower pre-test probability.

Specific factors that should inform assessment of pre-test probability of current, infectious COVID-19 in asymptomatic cases include:

- Symptom history, i.e., a prior history of symptoms compatible with COVID-19 that increases the likelihood of prior infection;
- Reason for testing (i.e., symptoms / epidemiological link vs. surveillance / targeted testing campaign / other);
- Epidemiological links (i.e., high-risk exposure to a known probable or confirmed case of COVID-19, or to a known COVID-19 outbreak) in the potential acquisition period;
- Local epidemiology of COVID-19 in regions where the case may have had high-risk exposures in the potential acquisition period (including, if applicable, other targeted/surveillance testing results);
- Risk behaviours of the case in the potential acquisition period (e.g., circle of close contacts, activities outside of the home), if/as appropriate.

Asymptomatic Cases with a Medium/High Pre-Test Probability - Asymptomatic cases assessed as having a medium/high (i.e., not low) pre-test probability of having current, infectious COVID-19 due to recent infection include, at minimum, case who were tested as a result of **an epidemiological link to a known COVID-19 case or a known COVID-19 outbreak**, or both. These cases should be managed as potentially infectious, and isolated for 14 days following the positive specimen collection date if they remain asymptomatic**. Re-testing is not indicated**, as a negative repeat test would not change public health management of the case or contacts.

If symptoms develop within 4 days of the specimen collection date (i.e., a pre-symptomatic positive), this would extend the case's isolation period for at least 14 days from symptom onset (see Testing and Clearance guidance document for details). This is based on a typical period of positivity prior to symptom onset is 2-3 days. However, discretion may be applied to extend the isolation period based on

symptoms starting ≥4 days after positive specimen collection date, as case reports have found positive results in pre-symptomatic individuals as much as 6 days prior to symptom onset.

Health Care Workers require an individual assessment, and should not automatically be assumed to be a medium/high pre-test probability. See Table 4 (below) for additional guidance on start date for assessing timing of clearance for asymptomatic positives with medium/high pre-test probability of having infectious COVID-19 due to recent infection.

Asymptomatic Cases with Low Pre-Test Probability- asymptomatic cases who are assessed as having a **low pre-test probability** of being a case that is currently infectious (which, as above, excludes those with an epidemiological link to a known COVID-19 case or outbreak) should have a **repeat test** (as soon as possible) to guide further case and contact management. This may include individuals who are part of a targeted asymptomatic testing campaign (for example a single case or small number of positive cases as part of a workplace testing campaign).

A first positive result in an asymptomatic low pre-test probability individual may represent one of three scenarios:

1. A currently infectious case (pre-symptomatic or asymptomatic)
2. A previously infected case that is no longer infectious
3. The individual was never infected (i.e. false positive test).

There is no definitive way to distinguish among these three scenarios for immediate public health management of the individual

The immediate and most important step is repeating the test as soon as possible. A follow-up negative test is sufficient to clear the case from isolation and discontinue any contact follow-up. Whereas a follow-up positive test is sufficient to manage as a currently infectious case.

The following factors can help to assess the likelihood of the three scenarios for an asymptomatic individual with a low pre-test probability, and particularly distinguishing ‘remote positive’ from ‘never infected’.

Table 3: Assessing Scenario Likelihood in Asymptomatic Cases with Low Pre-Test Probability

Factor	**Result**	**Current infectious case**	**Previously infected but no longer infectious (Remote positive)**	**Never infected (false positive)**
Repeat test	**Positive**	Possible	Possible	Very unlikely
	Negative	Very unlikely	Possible	Possible
Ct or CN value (relative viral load)	Low (relative to assay positivity cut-off, high relative viral load)	Likely	Less likely	Very unlikely
	High (near assay positivity cut off, low relative viral load)	Less likely	Possible	Possible
Number of gene targets positive (when 2 or more targets included in assay)	1	Less likely	Possible	Possible
	2 or more	Possible	Possible	Less likely
	Yes	Less likely	Possible	Less likely

Factor	Result	Current infectious case	Previously infected but no longer infectious (Remote positive)	Never infected (false positive)
Remote symptoms and/or remote exposure	No	Not helpful	Not helpful	Not helpful

The case should be in isolation from the positive test result and while repeat testing is occurring. Identification of close contacts with high risk exposures should be initiated, but contacts do not need to self-isolate if follow-up testing is underway. For settings where a case may trigger additional considerations for potential outbreak measures, these should be held until follow-up testing is complete. Where additional information changes the pre-test probability assessment (e.g., multiple positives identified, new clinical information), manage as per above (medium/high risk probability).

Repeat Test Result:

- **Positive/Repeat Test Not Available:** Manage the case as if currently infectious.
    - Continue case management
    - Initiate Contact Management with previously identified contacts as usual.
- **Negative:** Manage as either "never infected" or "remote positive" based on the assessment of the case.
    - Case can stop isolating after negative test
    - Discontinue any contact follow-up
    - Follow data entry guidance to update case status to "Does Not Meet" case definition, or data entry guidance on flagging the case as a "Remote Positive" based on the assessment of the case.

See Table 4 below for assessing timing of clearance for cases with low pre-test probability of having infectious COVID-19, where repeat testing is positive/not available.

Table 4: Start Date for Assessing Timing of Clearance for Asymptomatic Positives

Symptoms compatible with COVID-19?	Known epidemiological link (e.g., close contact exposure) prior to symptom onset?	Start date for assessing timing of clearance
Symptoms at/around time of positive specimen collection date	Yes or No	Symptom onset date
Symptoms >4 weeks prior to positive specimen collection date[1]	Yes or No	Positive specimen collection date
Symptoms ≤ 4weeks prior to positive specimen collection date[1]	Yes	Symptom onset date
Symptoms ≤ 4 weeks prior to positive specimen collection date[1]	No	Positive specimen collection date
Symptoms <4 days after positive specimen collection date[2]	Yes or No	Symptom onset date
Symptoms ≥4 days after positive specimen collection date[2]	Yes or No	Positive specimen collection date
Never symptomatic	Yes or No	Positive specimen collection date

1. SARSCoV-2 RNA has been detected in specimens collected 3-4 weeks after onset; however, viral detection has also been identified in some cases well beyond 4 weeks (>90 days) in some cases. Assessing symptoms reported >4 weeks prior to first positive test date will have a greater degree of uncertainty as to whether they were related to the current

positive test. Discretion may be applied if there is a known epidemiological link prior to symptoms >4 weeks from first positive specimen date.

2. Typical period of positivity prior to symptom onset is 2-3 days. Case reports have found positive results in pre-symptomatic individuals as much as six days prior to symptom onset. Discretion may be applied to extend isolation period based on symptoms starting ≥4 days after positive specimen collection date.

Case Recovery and Post-Clearance

Guidance for management of cases is detailed in Appendix 7.

Once a case is **cleared from isolation** based on the COVID-19 Quick Reference Public Health Guidance on Testing and Clearance document, **self-isolation, and Droplet and Contact measures where applicable, can be discontinued.**

At this time, there is no evidence of true re-infection from COVID-19. Emerging information on immunity after infection suggests not all infected individuals mount the same immune response, and that the immune response wanes over time, raising the theoretical potential for re-infection.To further complicate understanding the possibility of re-infection, it is known that confirmed cases may continue to test positive on PCR, even after clearance from isolation and/or negative results, for several weeks after infection. Persistent detection >110 days from initial positive result has been reported in Ontario.

- Confirmed cases should generally **not** be re-tested unless clinically indicated, as positive results after clearance are not uncommon.
    - Clinical discretion should be used to consider re-testing after clearance if new onset of symptoms occur (particularly when there are new high-risk exposures to a known case or outbreak).
- PHUs may consult with the testing laboratory with respect to the details of a new positive test result after clearance to further assess likelihood that the new result represents ongoing viral RNA detection or a potential re-infection. There is no definitive Ct value that indicates viability of virus, and Ct values and cut-offs vary by assay and laboratory and should be discussed with the testing laboratory.
- Cases who happen to test positive after clearance from isolation are generally not considered infectious, do not need to re-isolate, and do not require contact follow-up. See below for scenarios where case follow-up may be warranted with a positive result after clearance.

    - Cases who are immunocompromised may theoretically be more likely to have prolonged detection of virus, but evidence is limited as to whether it represents viable virus that warrants re-isolation of the case.
- PHUs must follow data entry guidance for any positive results after clearance, including identifying the case as a "RE-POSITIVE", and entering laboratory and case details for the new positive result and circumstances of its detection. PHUs should not enter a new case encounter for the individual.
- At this time, there is no case definition for '**re-infection'** for COVID-19
    - If the PHU has concern that a previously cleared case is presenting with a true "re-infection", the PHU should immediately notify PHO (epir@oahpp.ca) for case consultation and further investigation.
    - Due to uncertainty regarding immunity after infection, recovered individuals should still take the same precautions as someone who has never had COVID-19 in terms of avoiding exposure due to theoretical risk of re-infection in the future. This includes:
- Following physical distancing advice
- Following advice for HCWs for Personal Protective Equipment in Directives #1, 2, and 3 (as applicable)
- Self-isolating for 14 days after a NEW high risk exposure to a new unrelated case.
    - This does not apply to post-clearance exposures to related cases, such as cases within the same household or cases within an outbreak scenario. For example, in a long-term care home outbreak, if a cleared resident is exposed to a case within the outbreak, they do not need to re-isolate.
- Re-testing if clinically indicated based on symptoms compatible with COVID-19.
- Due to the prolonged persistence of virus RNA detection, previously cleared cases should not undergo asymptomatic testing for screening/surveillance purposes. Previously cleared cases with a new high risk exposure should only be tested if symptoms compatible with COVID-19 develop.

Table 5: Management of Cases after Clearance with New Symptoms, Exposures and/or Positive Test Results

Please note that this does not apply to COVID-19 cases known to be immunocompromised.

New Symptom Onset?	New High-Risk Exposure?	Laboratory Results	Public Health Management
No	No	Not generally recommended to re-test, but may occur inadvertently	Flag case as "RE-POSITIVE"; No case isolation; No contact management
Yes	Yes	Positive	Notify PHO (epir@oahpp.ca) for case consultation if concern of true "re-infection" Flag case as "RE-POSITIVE"; Case isolation and contact management if concern of transmission risk based on laboratory/epidemiological investigation
Yes	No	Positive	Flag case as "RE-POSITIVE" Notify PHO (epir@oahpp.ca) for case consultation if concern of true "re-infection" Case isolation and contact management if concern of transmission risk based on laboratory/epidemiological investigation

New Symptom Onset?	New High-Risk Exposure?	Laboratory Results	Public Health Management
No	Yes (new high-risk exposure to unrelated case)	N/A (repeat testing not recommended if asymptomatic)	Self-isolate (as a contact) for 14 days from last exposure to case; Clinical discretion to re-test if develop symptoms

Contact Management

The PHU should consult Table 7 to determine the exposure risk level of each contact of a COVID-19 case and Table 8 to determine the follow-up public health actions..

- A close contact is defined as **an individual with a high-risk exposure to a confirmed or probable case.**

PHUs must follow the guidance below when making initial contact, as well as for subsequent follow-up.

1. Initial Contact

The PHU provides an introduction and informs the contact of complete confidentiality of the interview process. In addition, the PHU provides information on resources available to support self-isolation or self-monitoring activities. The PHU must enter the contact details into CCM within 24 hours.

The PHU must recommend testing and ensure access to testing for:

- all high-risk exposure contacts regardless of symptoms, and
- all symptomatic contacts with a low-risk exposure

Where identifiable, PHUs must conduct an initial phone call within 24 hours of becoming aware of a low-risk contact, to ensure the individual is aware of how to self-monitor.

Testing of Asymptomatic High-Risk Contacts

Asymptomatic high-risk contacts should be tested within their self-isolation period (as per the Provincial Testing Guidance). Testing after the end of their self-isolation period is not recommended. Timing of testing should consider over what period exposure occurred and if the contact may have been exposed at the same time as the case (i.e., potential the contact is a co-primary asymptomatic case). The median incubation period is approximately 5 days.

If the contact may be a co-incident case, or even the index case to the known case, testing earlier in the incubation period allows earlier identification of the contact as a case, and initiation of their public health management. However, a negative result early in the incubation period can result in contacts refusing to maintain quarantine after false reassurance from a negative test. Negative tests later in the incubation period may be more reassuring that transmission has not occurred so far; however, a positive test later in the incubation period results in delayed management of the contact as a case.

Close contacts with high risk exposures must be advised that negative results within their 14 day incubation period **do not change** their self-isolation requirements, as they may still be incubating. Contacts who test positive should be managed as confirmed cases. High-risk contacts who test negative and remain asmyptomatic do not need to be re-tested in their self-isolation period unless they develop symptoms.

While asymptomatic contacts with low-risk exposures are not advised to test unless they become symptomatic, if they happen to test negative in their incubation period, they should be advised to continue to self-monitor for the remainder of their 14 day period.

All contacts must be informed of how to contact the PHU if they develop symptoms or have other questions. The PHU must advise contacts to call 911 if they require emergency care and inform paramedic services or health care provider(s) that they are a contact of a COVID-19 case.

2. Subsequent Follow-Up

The PHU may use the ***Close Contact Daily Clinical Update Form*** in Appendix 6 to monitor high risk contacts. The PHU should actively monitor (daily) any symptomatic contacts who are waiting on test results.

As part of daily contact assessments for high-risk exposures, the PHU must assess:

- Onset of symptoms since last assessment
- Reported compliance with self-isolation; and
- Needs in order to comply with self-isolation, referring supports as required to help to enable successful isolation.

Low risk contacts: Based on the initial assessment of the needs of the contact, further follow-up with the contact may be required throughout the self-monitoring period.

Period of Communicability for Contact Follow-Up

Cases who were **symptomatic** at/around the time of positive specimen collection – contact tracing extends from 48 hours prior to symptom onset to when the case began self-isolating (or was cleared from isolation if never self-isolated).

For cases who were **asymptomatic** at the time of positive specimen collection date, Table 5 below can be referenced.

Table 6: Contact Follow-up when Case is Asymptomatic at Time of Positive Specimen Collection

Symptom Onset	Contact Tracing Period	Notes
Case had no symptoms at/around time of testing	Extends from 48 hours prior to positive specimen collection to date to when case began self isolating.	If asymptomatic case with a low pre-test probability has a negative repeat test, contact follow-up may be discontinued.
Case's symptoms resolved prior to specimen collection date and case has a known high-risk exposure in 14 days prior to symptom onset	Extends from 48 hours prior to symptom onset to when case began self-isolating (or was cleared from isolation if never self-isolated).	For symptoms that occurred >4 weeks prior to specimen collection date, or where there is uncertainty about the relatedness of prior symptoms to the current positive test result, extending contact follow-up to 48 hours prior to symptom onset date is at the discretion of the PHU.
Symptoms develop after positive specimen collection date	Extends from 48 hours prior to positive specimen collection date to when case began self-isolating (or was cleared from isolation if never self-isolated).	

Self-Isolation/Self-Monitoring for Contacts

While the isolation of asymptomatic contacts is technically termed "quarantine", the common use of "self-isolation" to refer to both symptomatic and asymptomatic individuals means we have adopted the language of "self-isolation" for asymptomatic close contacts for ease of understanding.

The purpose of self-isolation is to prevent the risk of spread in the event a contact becomes infected and prior to recognizing they are infectious. Due to varying degrees of risk posed by different exposures, contacts can be categorized into two levels of risk exposure and corresponding requirements for self-isolation: high-risk, and low-risk contacts. **Only individuals with high-risk exposures are considered close contacts.**

- **Table 7** details contacts by their exposure setting and exposure type.
- **Table 8** details description of required PHU follow-up.

The period of self-isolation or self-monitoring is 14 days (maximum incubation period) following last known unprotected exposure to an infectious case. This should be based on the earlier date of when the case self-initiated self-isolation or was advised to self-isolate by the PHU.

Household, or similar, contacts with ongoing exposure to the case:

- Cases should self-isolate as much as possible within the household, and wear a mask when physical distancing is not possible in the home.
- Where self-isolation is not possible within the household, consider alternate living arrangements for the case or contacts to reduce risk of transmission
- Where alternate living arrangements are not available, last date of exposure to the case should be based on the date the case was advised to start self-isolating by the PHU (rather than using the end of the case's infectious period as the date of the last exposure).
    - Where there are shared common spaces/kitchen/bathroom, self-isolation is maintained if physical distancing (or mask use when <2m) and appropriate environmental cleaning is in place (e.g. of high-touch surfaces).
    - Emerging evidence suggests COVID-19 is spread mainly from person-to-person. It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes; however, this is not thought to be the main way the virus spreads.

- If additional members of the household become ill, asymptomatic household members generally do not need to extend their period of self-isolation based on last exposure to the new case, as the presumption is that everyone in the household was exposed at the same time to the first case, subsequent cases are associated with the same original exposure, and household members are maintaining their own self-isolation as close contacts. In some circumstances (e.g. parent/child cases) where there has been significant ongoing exposure to subsequent cases, asymptomatic household contacts may be advised to extend self-isolation based on a risk assessment of exposure to the new case in the household. Asymptomatic household members generally do not need to be re-tested based on exposure to the second case, if they have already been tested after exposure to the first case, but may be advised to re-test based on the risk assessment.

Table 7: Contact Management Based on Exposure Setting and Type

Exposure Setting	Exposure Type	Exposure Risk Level
Household (includes other congregate settings)	• Anyone living in the same household, while the case **was not self-isolating and infectious**: o This may include members of an extended family, roommates, boarders, 'couch surfers' etc. o This may include people who provided care for the case (e.g., bathing, toileting, dressing, feeding etc.) o This may include congregate settings (e.g., dormitories, shelters, group homes, detention centres, child/daycare centres) where direct contact (<2 meter) is occurring in shared rooms/living spaces (Follow Ministry of Health guidance for outbreak management in congregate living settings; if an outbreak is declared, outbreak measures should guide contact management). ▪ This includes household contacts as above who only had exposure to the case after the case started **self-isolating,** if this is supported by a risk assessment.[1]	High risk exposure - self-isolate
	• Household contacts as above who only had exposure to the case while the case **was self-isolating** and applying consistent and appropriate precautions (i.e., physical distancing, hand hygiene, use of mask when unable to physically distance). Shared use of bathroom/kitchen while maintaining physical distancing and frequent environmental cleaning would not be considered inappropriate precautions.	Low risk exposure – self-monitor

Exposure Setting	Exposure Type	Exposure Risk Level
Community/ Workplaces	• Had direct contact with infectious body fluids of the case (e.g., coughed on or sneezed on) • Had close (<2m) prolonged[2] unprotected contact	High risk exposure – self-isolate
	• Had prolonged unprotected contact but only while the case was consistently physically distancing (e.g., attendees at a gathering, co-workers in a common work area). • Only transient interactions (e.g., walking by the case or being briefly in the same room)	Low risk exposure – self-monitor
Healthcare (including all locations where health care is provided, e.g., community, acute care, long-term care)	**Patient is the case:** • HCW and/or support staff who provided direct care for the case, or who had other similar close physical contact (i.e., < 2 metres from patient for any duration of time) **without** consistent and appropriate use of personal protective equipment[3] (PPE) in relation to the care provided. • Other patients in the same room when the case **was not** on Droplet and Contact precautions • Other patients in waiting room/common areas (i.e., < 2 metres from case for any duration of time) when the case **was not wearing** a surgical/procedure mask	High risk exposure – self-isolate
	HCW is the case: • All patients for whom the HCW provided direct care, or who had other similar close physical contact (i.e., patient was < 2 metres away from HCW for any duration of time), when the HCW **was not wearing** a surgical/procedure mask • All co-workers who had close prolonged unprotected contact[2] with the HCW (e.g., within 2 metres in an enclosed common area when the HCW was **not wearing** a surgical/procedure mask)	High risk exposure – self-isolate (or work self-isolation if critical to operations)

Exposure Setting	Exposure Type	Exposure Risk Level
Healthcare (including all locations where health care is provided, e.g., community, acute care, long-term care)	**Patient is the case:** • Healthcare worker and/or support staff who provided direct care for the case, or who had other similar close physical contact (i.e., < 2 metres from patient for any duration of time) **with** consistent and appropriate use of PPE[3] in relation to the care provided	Low risk exposure- self-monitor
	HCW is the case: • All patients for whom the HCW provided direct care, or who had other similar close physical contact (i.e., patient was < 2 metres away from HCW for any duration of time), when the HCW **was wearing** a surgical/procedure mask • All co-workers who had close prolonged contact[1] with the HCW (e.g., within 2 metres in an enclosed common area when the HCW **was wearing** a surgical/procedure mask)	Low risk exposure – self-monitor
	• Laboratory worker processing COVID-19 specimens from case **without** appropriate PPE (including accidental exposures where appropriate PPE was breached).[3]	High risk exposure – self-isolate (or work self-isolation if critical to operations)
	• Laboratory worker processing COVID-19 specimens from case **with** appropriate PPE.[3]	Low risk exposure – self-monitor
Conveyance (e.g., aircraft, train, bus)	• Passengers or crew seated within 2 meters of the case (approximately two seats in all directions, depending on type of aircraft/conveyance and seating) while the case **was not** wearing a surgical/procedure mask • Other passengers/crew with close prolonged[2] contact while case **was not** wearing a surgical/procedure mask or direct contact with infectious body fluids	High risk exposure – self-isolate

Exposure Setting	Exposure Type	Exposure Risk Level
Conveyance (e.g., aircraft, train, bus)	• Passengers or airplane crew seated within 2 meters of the case (approximately two seats in all directions, depending on type of aircraft and seating) while the case **was** wearing a surgical/procedure mask • Other passengers/crew with close prolonged[2] contact while case **was** wearing a surgical/procedure mask	Low risk exposure – self-monitor
	• Crew members who do not meet criteria above	Low risk exposure – self-monitor
	• Other passengers seated elsewhere in cabin/car as case who do not meet above criteria.	Low risk exposure – self-monitor
Travel to affected area	• Exposure by travelling outside of Canada in past 14 days[4]	High risk exposure – self-isolate

[1] Based on an individual risk assessment, it may be reasonable to consider household contacts who only had exposure after the case was self-isolating as having low-risk exposures, **if** the PHU is confident that consistent and appropriate physical distancing, hand hygiene, and environmental cleaning is in place (e.g., frequent cleaning of shared bathroom/kitchen, if applicable). If assessed has having low-risk exposure, self-monitoring rather than self-isolation would be required (see Table 7 for details).

[2] As part of the individual risk assessment, consider the 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), the case's symptoms (coughing or severe illness likely increases exposure risk) and whether personal protective equipment (e.g., procedure/surgical mask) was used. To aid contact follow-up prioritization, prolonged exposure duration may be defined as lasting more than **15 minutes**; **however**, data are insufficient to precisely define the duration of time that constitutes a prolonged exposure, and exposures of <15 minutes may still be considered high risk exposures depending on the context of the contact/exposure.

[3] Refer to relevant guidance for health care professionals on what constitutes appropriate PPE for the type of interaction with the case. PHO IPAC guidance on PPE

[4] Health Care Workers returning from travel should not attend work if they are sick. If there are particular workers who are deemed critical, by all parties, to continued operations, these workers undergo regular screening, use appropriate Personal Protective Equipment (PPE) for the 14 days and undertake active self-monitoring. This includes taking their temperature twice daily to monitor for fever, and immediately self-isolate if symptoms develop and self-identify to their occupational health and safety department.

Use of Non-Medical Masks

Non-medical masks may be used in non-health care settings for source control and prevention. There is some evidence to suggest they may reduce the risk to contacts if worn consistently and appropriately by the case; however, there is variability in the types of non-medical masks used, and the appropriateness/consistency of use by wearers in the community. In general, the use of non-medical masks by the contact does not alter the risk assessment of contacts in Table 7 as non-medical masks are not considered PPE.

COVID Alert Exposure Notification App

Ontario has launched the exposure notification app, COVID Alert. This app is meant to support and augment public health's existing contact tracing efforts by quickly identifying new contacts that may not have been easily identified through traditional case and contact management methods. Exposure notifications are not a substitute for traditional contact tracing, but the app can expand reach and rapidly notify unknown contacts and augment information available to contact tracers.

In the event a PHU is contacted by an individual who has received an exposure notification alert, they should be directed to seek testing and self-isolate pending test results. If the individual tests positive they must self-isolate from the date of specimen collection.

If the individual receives a negative test result they should self-monitor for 14 days from when they received the notification and should seek re-testing if symptoms develop. If this same individual is later identified through traditional case and contact tracing, they must follow the advice of the public health authority which may include self-isolation and re-testing depending on the assessment of public health.

More information on COVID Alert can be found at the Ontario COVID Alert website.

Table 8: Contact Self-Isolation and Self-Monitoring by Risk Level

Note: If an outbreak is declared (e.g., in a workplace, congregate living setting, long-term care home, acute care, child care), relevant Ministry of Health guidance on outbreak measures apply and should guide management of contacts and may exceed recommendations for low-risk contacts of non-outbreak cases listed here:

Category	Actions for the Individual	Public Health Monitoring/Activities
High risk exposure	Self-Isolate: • Do not attend school or work • Avoid close contact with others, including those within your home, as much as possible • Follow advice in self-isolation fact sheet • Have a supply of procedure/surgical masks available should close contact with others be unavoidable • Postpone elective health care until end of monitoring period • Use a private vehicle if need to attend a medical appointment. Where a private vehicle is not available, private hired vehicle may be used while wearing a procedure/surgical mask and sitting in the rear passenger seat with the window open (weather permitting). Do not take public transportation. • Remain reachable for daily monitoring by local PHU • Discuss any travel plans with local PHU • If symptoms develop, ensure self-isolating immediately, and contact local PHU and health care provider prior to visiting a health care facility	Initial contact (e.g., by phone) to provide information on self-isolation and who to call if become symptomatic Daily monitoring is required. Phone calls are required at the beginning, middle and end of the self-isolation period (e.g., days 1, 7 and 14). Contact on the other days can be via email/text/phone at discretion of PHU and based on preference of contact. Consider providing thermometer or assessing other needs/supports to facilitate self-isolation and monitoring of symptoms Provide handouts: Self-isolation Ensure contact is advised of recommendation for asymptomatic testing within their self-isolation period (based on availability of testing) Ensure contact is advised of recommendation for re-testing if contact reports symptoms (based on availability of testing), and manage as a probable case if testing is refused/cannot be performed

Category	Actions for the Individual	Public Health Monitoring/Activities
Low risk exposure	Follow guidance on core public health measures recommended for everyone at all times including: • Self-monitoring for symptoms of COVID-19, • Seeking assessment and testing, and • Self-isolating if symptoms develop, as per provincial guidance.	Where identifiable (for example: low risk household contacts), PHUs must conduct an initial phone call within 24 hours of becoming aware of the contact, to ensure the individual is aware of how to self-monitor. Based on the initial assessment of the needs of the contact, further follow-up with the contact may be required. Where individuals self-identify to the PHU with information that indicates a possible high-risk exposure, the PHU must conduct an individual-level risk assessment. Communications to low risk individuals/groups must include information about symptoms, self-monitoring, how to self-isolate if symptoms develop and how to contact the local PHU. This should include: • Information on Self-monitoring, • Emphasizing need to be able to self-isolate immediately and seek testing if symptoms develop. • Advising HCWs to inform their employer/institution of their exposure. Where identifiable individuals/groups with low-risk contact are known to the PHU, the PHU must provide targeted and timely communication to low risk contacts such as: • working with employers to send a letter to co-workers/clients in the same area in the workplace; • working with community/ religious leaders to inform other attendees of community activities/services; • household contacts of cases with exposure only after the case was self-isolating consistently and appropriately (if assessed as low risk exposures). This does not include notifying stores/services where the case was shopping/picking up items/had brief interactions and physically distancing with other customers/staff.

Table 9: Managing Symptomatic Contacts

Exposure Type	Testing Result	Instructions for PHU
High-Risk	Negative	Continue managing as high-risk exposure contact including advising continued self-isolation until 14 days from last exposure. Facilitate re-testing if symptoms worsen or progress.
	Never Tested (ie. Refused testing)	Manage as probable case including case and contact management.
Low-Risk	Negative	While asymptomatic contacts with low-risk exposures are not advised to test unless they become symptomatic (as per MOH testing guidance for the general public), if they happen to test negative in their incubation period, they should be advised by the testing facility to continue to follow guidance on core public health measures recommended for everyone at all times, including: • Self-monitoring for symptoms of COVID-19, • Self-isolating if symptoms develop; and • Seeking assessment and testing If the PHU happens to be aware of these individuals, they may re-inforce messaging. Advise re-testing if symptoms worsen or progress.
	Never Tested	Not applicable, as no individual follow up, and PHU unlikely to be aware of this situation. If the PHU happens to be aware of these individuals, they must re-inforce that symptomatic individuals should be tested.

Travelers from Outside of Canada

On March 26, 2020, the Government of Canada put emergency measures in place that require a mandatory 14-day self-isolation (or quarantine period) for returning travelers from outside of Canada.

All individuals permitted to enter Canada are subject to this Order, with the exception of certain persons who cross the border regularly to ensure the continued flow of goods and services, and those who provide essential services.

Essential Service Workers returning from any destination outside of Canada are not required to self-isolate upon their return from travel providing they are asymptomatic. These workers should self-monitor for symptoms and immediately self-isolate should symptoms develop.

HCWs are not required to self-isolate after travel, however it is strongly recommended that they do so for 14 days upon return, wherever possible. If an HCW is required to work within 14 days of returning from travel, they may do so with specific precautions. Refer to the How to Self-isolate while Working fact sheet .

All incoming travellers, at point of entry, are required to provide their contact information and where they are staying. They also must inform the officer if they have symptoms.

Oversight and enforcement of these orders is being done by Peace Officers and the Royal Canadian Mounted Police (RCMP), and will include random touch points with returning travellers to ensure compliance. At this time, 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).

Should an individual subject to a federal quarantine order require non-COVID related health care outside of a federal quarantine facility (e.g., if transfer from a federal quarantine facility to a local hospital is required, during the quarantine period), these individuals should be managed as having a high risk exposure requiring isolation. They should be managed in consultation with the local PHU and local health care providers, including IPAC.

Returning travelers who develop symptoms may leave self-isolaton in order to be tested. If they test negative, they should continue to self-isolate since COVID-19 may develop later. If travellers test positive, they should seek advice from a health care provider regarding the next steps.

Returning travelers who are asymptomatic should not seek testing unless personally advised by their local public health unit (e.g., as part of contact tracing) or their health care provider.

If an asymptomatic traveler presents for testing at an assessment centre, the traveller should be tested. If the assessment centre becomes aware that the traveller broke self-isoation, the centre should inform the PHU. PHUs should contact the traveller to reinforce messaging around self-isolation.

Table 10: Assessment and Management of Asymptomatic Travelers

Travel outside of Canada in the past 14 days	Consider as 'High risk exposure'. Follow Table 8 – 'High risk exposure'
Travel within Canada	Individuals who have traveled within Canada are not required to self-isolate, but should self-monitor for symptoms for 14 days from their return. If any individuals have COVID-19 exposure concerns and self-identify to their PHU as having traveled within Canada, the PHU should assess the individual's exposure history to determine whether they should be managed as a high, or low risk exposure contact. as per Table 7.

Contact tracing for airplane passengers

As travel restrictions ease over time, the most timely way to share information about potential exposures on conveyances is through public posting of flight/conveyance information, and notification to the airline for informing crew members. This applies to both international and domestic flights.

PHUs should send the following information to PHO (EPIR@oahpp.ca) if they identify a flight/cruise with a confirmed case:

- Airline, flight number, date, departure location, arrival location, relevant rows
- Cruise line, dates of travel, departure port, arrival port

- Symptom onset date, or positive specimen date if case is asymptomatic

In addition to information for public posting of flight/conveyance information, PHUs may be required to provide further information regarding international travel for PHAC to process the International Jurisdiction Notification, e.g., whether or not the case is a Canadian national; detailed travel information while abroad (i.e., accommodation information, potential exposures).

Tools

PHUs may use the following tools to conduct case and contact management activities. Additional resources and appendices may be added to support case and contact management activities, and updated documents can be found on the Ministry of Health website.

- Appendix 1: Ontario's Severe Acute Respiratory Infection (SARI) Case Report Form – PHUs may use this form to help guide their case interview and collection of information from probable and confirmed cases or their proxies. PHUs must enter all cases and contacts in CCM.
- Appendix 2: Routine Activities Prompt Worksheet for Cases – PHUs may use this sample worksheet (or a similar tool) to identify potential exposures that may have led to disease acquisition in a case. Along with the SARI Case Report Form in Appendix 1, this worksheet can also be used to interview the case or their proxy to collect detailed information and to investigate potential exposures in the 14 days before onset of symptoms.
- Appendix 3: Daily Clinical Update Form for a Case Managed in an Acute Care Setting and Appendix 4: Daily Clinical Update Form for a Case Managed in a Household Setting – PHUs may use these sample forms (or a similar tool) to monitor the health status of a probable or confirmed case until they are cleared.
- Appendix 5: Close Contact Tracing Worksheet – PHUs may use this sample worksheet (or a similar tool) to identify close contacts of a probable or confirmed case.
- Appendix 6: Daily Contact Clinical Update Form – PHUs may use this sample form (or a similar tool) to follow-up and monitor contacts with high-risk exposures.
- Appendix 7: Self-Isolation for COVID-19 Cases or Other Individuals in the Household - This guidance can be used to support individuals undergoing testing (with symptoms or known contact to a confirmed or probable case), anyone being asked to self-isolate, and others in the household of a case.
- Appendix 8: Serology Testing and MIS-C - This can be used to provide guidance on cases with positive serology results as well as cases with multisystem inflammatory syndrome in children (MIS-C)

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 IPAC for COVID-19: Interim Guidance for Home Care Settings
- 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

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 Travelers 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, travelers from outside of Canada, link to other guidance (e.g. provincial testing), updates to streamline language throughout
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.

Revision Date	Document Section	Description of Revisions
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