

Ministry of Health

COVID-19 Provincial Testing and Clearance Guidance

V. 14.0 November 10, 2021

This document is an update to the COVID-19 Provincial Testing Guidance Update issued August 25, 2021. This document has been combined with the previous stand-alone 'Quick Reference Public Health Guidance on Testing and Clearance' document. This information is current as of November 10 2021 and may be updated as the situation on COVID-19 continues to evolve.

It is expected that this guidance will be consistently applied across all regions in Ontario to guide decision making regarding COVID-19 testing of further priority population groups, in conjunction with other [setting-specific guidance](#) as appropriate.

In the event of any conflict between this guidance document and any applicable legislation or orders or directives issued by the Minister of Health or the Chief Medical Officer of Health (CMOH), the legislation, order or directive prevails. Please see Ontario's [COVID-19 website](#) for more general information as well as for updates to this document.

Updates to this document include:

- Combined with the previous Quick Reference Public Health Guidance on Testing and Clearance (See [Section 2](#))
- New clinical indication for laboratory-based serology testing ([page 3](#))
- Updated targeted testing groups ([page 6](#))
- Clarification for testing for the purposes of facility transfers ([page 7](#))

Table of Contents

1	COVID-19 Provincial Testing Guidance	3
1.1	Types of Tests Available	3
1.2	Diagnosing COVID-19	5
1.3	Variants of Concern (VOC).....	5
1.4	Guidance for Symptomatic Individuals	5
1.5	Guidance for Asymptomatic Individuals.....	6
	Contacts of confirmed positive cases:.....	6
	Outbreak Investigations:	6
	Targeted Testing Groups:.....	6
1.6	Guidance for Specific Settings.....	7
	Facility Transfers	7
	Hospitals.....	8
	Long-Term Care and Retirement Homes	9
	Other Congregate Living Settings and Institutions	9
	Remote/Isolated/Rural/Indigenous Communities	10
	Workplaces and Community Settings – Enhanced Contact-Based Testing	10
	Other Populations.....	10
2	COVID-19 Public Health Guidance on Clearance.....	12
2.1	Re-testing after Clearance and Testing Fully Vaccinated Individuals	12
2.2	Criteria for when to discharge someone with probable or confirmed COVID-19 from isolation	12
2.3	Approaches to Clearing Cases (including VOC cases).....	13
2.4	Recommendations for Health Care Workers’ Return to Work.....	14
2.5	Work Self-Isolation Guidelines	15
2.6	Recommendations for Return to Work in Non-Health Care Settings	16
2.7	Work Self-Isolation in Non-Health Care Settings	16

1 COVID-19 Provincial Testing Guidance

1.1 Types of Tests Available

There are three types of tests available in the province of Ontario:

1. Laboratory-based molecular testing: nucleic acid amplification test (NAAT), e.g., polymerase chain reaction (PCR) test detects virus or viral fragments

- a. Purpose: Laboratory-based molecular testing is primarily used for diagnostic purposes.
- b. [Preferred and Acceptable Specimen types](#): A nasopharyngeal swab (NPS) or lower respiratory tract specimen (e.g. sputum, tracheal aspirate) is the preferred specimen in hospitalized patients. Other specimen types may be used for non-hospitalized and asymptomatic patients to support access to testing. Refer to Public Health Ontario's [Coronavirus Disease 2019 \(COVID-19\)-PCR Test Information Sheet for further details](#). To support access to testing, less invasive specimen collection approaches may be considered to maximize test uptake.

2. Laboratory-based serology testing: detects antibodies to SARS-CoV-2

- a. Purpose: Serology testing is available for clinical use under specific clinical indications:
 - i. Patients presenting with symptoms compatible with [Multisystem Inflammatory Syndrome in Children \(MIS-C\)](#) or Adults (MIS-A) who do not have laboratory confirmation of COVID-19 by molecular testing.
 - ii. Testing may be considered for patients with severe illness who have tested negative for COVID-19 by molecular testing and where serology testing would help inform clinical management and/or public health action. Serology testing for these patients requires consultation and approval by the testing laboratory.
 - iii. To inform treatment decisions for monoclonal antibody treatment for certain patients who are critically ill (requiring ICU-level care for COVID-19) or moderately ill (i.e. those requiring admission to a hospital ward due to COVID-19 illness and requiring low-flow supplemental oxygen) patients.¹

Serology should NOT be used for screening and diagnosis of acute COVID-19 infection, or for determining immune status or vaccination status (outside the specific indication above).

¹ As described in the Ontario Science Advisory Table Brief on [Evidence-Based Recommendations for Use of Casirivimab + Imdevimab, and Sotrovimab for Adults in Ontario](#)

3. Point-of-Care Testing (POCT)

POCT refers to testing that employs a COVID-19 medical device authorized by the Minister of Health (Canada) for point-of-care use in which analysis is done at or near the point of specimen collection. For interpretation of results from POCT, see [Appendix 9: Management of Individuals with Point-of-Care Results](#) and [Point of Care Testing Use Case Guidance](#). Additional testing (e.g. laboratory-based molecular testing) may be advised for negative antigen tests due to the risk of false negatives or for positive molecular self-tests due to the COVID-19 reporting requirements.

a. Molecular POCT

- i. Purpose: Molecular POCT is for diagnostic or screening purposes, including for confirmatory testing of positive antigen POCT results.
- ii. [Specimen types](#): Upper respiratory tract, which can be collected using a NPS or other swabs approved by Health Canada. Other acceptable specimens to support access to testing include: a combined swab of throat and both nares, deep nasal swab, or anterior nares (both nares).

b. Antigen POCT

- i. Purpose: Antigen POCT is used for screening purposes only. **Antigen POCT should NOT be used to test for COVID-19 infection in symptomatic individuals, individuals with known contact with a COVID-19 case or in outbreaks.** Positive antigen POCT results do not have to be reported to the local public health unit but need to be confirmed by molecular testing.
- ii. [Specimen types](#): Upper respiratory tract specimen, which can be collected using an NPS or as outlined in the "[Considerations for Antigen Point-of-Care Testing Guidance](#)" document.

c. Self-Testing Kits

- i. Purpose: Self-testing kits should be used for screening purposes only. **Self-testing kits should NOT be used to test for COVID-19 infection in symptomatic individuals, individuals with known contact with a COVID-19 case or in outbreaks.** See the [MOH's website](#) for more information.

For all test types:

All testing must be performed on technologies approved by Health Canada (HC) or otherwise validated by the licensed laboratory (i.e., laboratory-developed test). Laboratories used to collect specimens and conduct testing for COVID-19 must be licensed under the *Laboratory and Specimen Collection Centre Licensing Act* ([LSCCLA](#)) or fall under an exemption under the [LSCCLA](#).

All molecular test results, including molecular POCT (except molecular self-tests), and clinical serology test results, should be entered with minimum data elements required for laboratory results into the Ontario Laboratories Information System (OLIS), or where OLIS is not available, results should be reported, as per Ontario Health guidelines and in accordance with the [Health Protection and Promotion Act](#).

With the exception of positive antigen POCT or molecular self-tests, all positive COVID-19 tests performed using a Health Canada approved test, or an assay validated by the laboratory must be reported to the local public health unit as per the [LSCCLA's Reg 682](#) and/or under [Health Protection and Promotion Act](#). Reporting of positive results must be in accordance with CMOH guidance.

1.2 Diagnosing COVID-19

Please refer to the current Ontario [Case Definition](#) for information on confirmed, probable and reinfection cases. While the case definition for confirmed reinfection is primarily based on laboratory findings, the clinical and epidemiological context of each episode of potential infection should also be considered, including symptoms, likelihood of exposure, time between episodes, and assessment of whether PCR assay results may be impacted by low viral load (high Ct value) specimens.

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](#) and the [COVID-19 Fully Vaccinated and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance](#).

1.3 Variants of Concern (VOC)

Information on VOC testing is available from Public Health Ontario's [COVID-19 Variants of Concern Test Information Sheet](#).

1.4 Guidance for Symptomatic Individuals

Any Ontarian presenting with at least one symptom or sign from the [COVID-19 Reference Document for Symptoms](#) should be considered for COVID-19 molecular testing. Clinicians should continue to use their clinical judgment during patient assessment and in deciding whether to order testing, in consideration of local epidemiology and exposure risks.

Influenza and other seasonal respiratory virus testing

The following populations who are symptomatic with acute respiratory infection (ARI) are eligible for molecular testing for influenza and other seasonal respiratory viruses:

- Symptomatic hospitalized patients.
- Symptomatic patients tested in institutional settings (non-outbreak).
- Outbreak investigations (up to 4 specimens) from symptomatic patients only. This includes [symptomatic residents, staff and/or essential visitors](#) in an institutional/congregate living setting (e.g., long-term care homes, retirement homes, correctional facilities, shelters, group homes) with ARI. For additional testing in outbreak settings, contact [PHO's Laboratory Customer Service Centre](#) and reference PHO Laboratory's [Respiratory Virus Test Information Sheet Update](#).
- Persons residing in remote communities.

When completing the PHO Laboratory [COVID-19 and Respiratory Virus Test Requisition, the](#) appropriate test should be selected in the "Test(s) Requested" (box 5) – either COVID-19 virus alone, respiratory viruses alone, or COVID-19 and respiratory viruses.

1.5 Guidance for Asymptomatic Individuals

Only asymptomatic individuals who are high-risk should be considered for molecular testing, including asymptomatic individuals who have received a positive antigen POCT or positive self-test kit result, and individuals from targeted testing groups, as follows:

Contacts of confirmed positive cases:

Asymptomatic close contacts of a confirmed case should undergo PCR testing at a designated testing centre within 10 days of their last exposure or notification from the COVID Alert app. See the [COVID-19 Fully Vaccinated and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance](#) for testing of fully vaccinated and previously positive individuals.

- Contacts who have had ongoing exposure to the case while the case has been infectious, or who had similar acquisition exposures as the case, should be tested as soon as possible. If the initial specimen was collected on day 0-6 after the last exposure, a second specimen should be collected on or after day 7 after the last exposure.
- Contacts who are part of an outbreak investigation should be tested as soon as possible, and have repeat testing as directed by the local public health unit.
- Contacts who were only exposed to the case and who do not share acquisition exposures should be tested on or after day 7 after their last exposure to the case. If an initial test was collected between days 0-6 after their exposure, all high risk of exposure contacts need repeat testing on or after day 7.

If the test result is negative, asymptomatic contacts who have been advised to self-isolate by public health must remain in self-isolation for 10 days from their last exposure to the case. If an asymptomatic contact tests negative and then subsequently becomes symptomatic, they should be re-tested as soon as possible and self-isolate immediately if not already.

Outbreak Investigations:

Asymptomatic workers and residents at specific outbreak sites may be considered for testing at the direction of public health.

Targeted Testing Groups:

Asymptomatic individuals without known high-risk exposures and not part of outbreak investigations, but from certain populations may be considered for screening testing. Refer to section 2.1 "[Re-testing after Clearance and Testing Fully Vaccinated Individuals](#)" for more details on screening for fully vaccinated and previously positive individuals.

Eligible individuals include:

1. Workers (including support workers), visitors (including caregivers) and government inspectors of long-term care homes
2. Temporary Foreign Workers
3. Individuals who identify as Indigenous
4. Residents in homeless shelters
5. Individuals, and one accompanying caregiver, with written prior approval for out-of-country medical services from the General Manager, OHIP

6. Individuals who are travelling into remote/isolated First Nation and Indigenous communities for work purposes.

Note that individuals with a positive result obtained through an antigen POCT and requiring a confirmatory test (including, but not limited to, individuals who are part of an organization or setting that is participating in the Provincial Antigen Screening Program) are eligible for confirmatory testing using a laboratory-based molecular test or a rapid molecular POCT.

1.6 Guidance for Specific Settings

Facility Transfers

Examples of facility transfers include, but are not limited to:

- Admissions to hospital from another hospital, long-term care home, retirement home or other congregate living setting/institution (including group homes and equivalent higher-risk settings)
- Patients entering a residential treatment facility (e.g. a mental health or addiction program)
- Transfers from, or repatriation to community hospitals and regional tertiary/quaternary centres; or
- Transfers from an acute site to a post-acute site (e.g. patient transferred from hospital to complex continuing care/rehab) within a multi-site organization

Symptomatic Patients/Residents

Any symptomatic patient transferred between facilities (i.e. leaving one facility and entering another, even within same multi-site organization), should be tested (using molecular testing) upon admission to the destination facility.

At any time, an individual who has previously tested positive for COVID-19 and has since recovered should be tested if they have had a new high-risk exposure and symptoms. The decision to test should be based on the clinical judgment of a health care provider and/or be at the discretion of public health.

Asymptomatic Patients/Residents

Testing of fully vaccinated individuals who are asymptomatic with no known COVID-19 exposure: As per PIDAC's [Interim Guidance on Infection Prevention and Control for Health Care Providers and Patients Vaccinated Against COVID-19 in Hospital and Long-Term Care Setting](#), testing is no longer recommended for asymptomatic fully vaccinated people who are being transferred.

Individuals in the above settings who are not fully vaccinated can receive laboratory-based PCR testing for the purposes of facility transfers.

Local PHUs and health organizations may make alternate testing recommendations/policies based on local epidemiology and within outbreak contexts.

There is one exception to the above guidance:

Newborn infants (<48 hours old at time of transfer) born to individuals who are asymptomatic and screen negative for symptoms: Such newborns should be considered exempt from routine COVID-19 testing on admission to the destination facility. See [Appendix A](#) on newborn testing.

Hospitals

Testing prior to a scheduled (non-urgent/emergent) surgery in a hospital or other surgical setting (e.g. independent health facility, etc):

- Testing prior to surgery will be determined by COVID-19 Regional Steering Committee/Response Table, and may vary across Ontario regions.
 - For areas with low community transmission of COVID-19, testing prior to a scheduled surgical procedure is not required. In areas where community transmission of COVID-19 is not low (>10 cases per 100,000/week), any patient with a scheduled surgical procedure requiring a general anaesthetic and who is not fully vaccinated should be tested 24-48 hours prior to procedure date. Pre-procedure testing is not recommended for fully vaccinated patients who are asymptomatic and do not have a high-risk exposure to a COVID-19 case.
 - Patients who are not fully vaccinated should only go out for essential reasons (e.g. work, school) for as close to 10 days prior to a scheduled procedure as is feasible.
 - In the event of a positive test result, the scheduled non-urgent/emergent procedure should be delayed for a period of at least 10 days and until cleared by public health and/or infection control.

Testing of hospitalized patients:

In the event a patient develops **laboratory-confirmed COVID-19**, within a 14-day period where the case could have reasonably acquired their infection in the hospital, and the case was not cared for on Droplet/Contact Precautions, asymptomatic contacts of the confirmed case should be tested regardless of vaccination status, including:

- All patients on the unit/care hub
- All staff working on the unit/care hub while the case was not on Droplet/Contact Precautions
- All essential visitors that attended the unit/care hub
- Any other contacts deemed appropriate for testing based on a risk assessment by Infection Prevention and Control

Infection Prevention and Control/Occupational Health may also, based on a risk assessment, determine if any additional testing is required, or whether any of the above-mentioned individuals do not require testing.²

In asymptomatic inpatients, a negative result should not change contact management, as the individual may still be in their incubation period.

In the event a hospitalized patient is diagnosed with community acquired **laboratory-confirmed COVID-19**, and the patient was not cared for on Droplet/Contact Precautions, asymptomatic contacts of the confirmed patient, while the confirmed case was infectious,

² Note: Testing recommendations based on a single case are at the direction of the acute care Infection Prevention and Control and Occupational Health. If an outbreak is declared, additional testing recommendations are determined by the Outbreak Management Team including the local public health unit.

should be tested, determined in consultation with Infection Prevention and Control and Occupational Health:

- Any patient in the same patient care area when the case was not under Droplet/Contact precautions
- Any staff who cared for the patient who had close prolonged contact within 2 meters not wearing appropriate personal protective equipment.

Infection Prevention and Control/Occupational Health may also, based on a risk assessment, determine if any additional testing is required, or whether any of the above-mentioned individuals require testing.

See the [COVID-19 Fully Vaccinated and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance](#) for the definition of fully vaccinated and previously positive individuals and recommendations on infection control management.

Long-Term Care and Retirement Homes

Definitions:

- **Long-term care homes:** has the same meaning as in the *Long-Term Care Homes Act, 2007*
- **Retirement homes:** Privately-owned, self-funded residences that provide rental accommodation with care and services for seniors who can live independently with minimal to moderate support.

In the event a resident living in a long-term care or retirement home develops [symptoms of COVID-19](#), asymptomatic residents, regardless of immunization status, living in the same room should be tested immediately along with the symptomatic resident under the direction of local public health.

For asymptomatic residents who have been identified as a close contact of a known case, regardless of their vaccination status, a negative result should not change public health management as the individual may still be in their incubation period.

Re-testing of asymptomatic individuals who initially test negative is recommended if they develop symptoms.

In the event of an outbreak, the local public health unit is responsible for managing the outbreak response. For more information, refer to MOH's [COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units](#).

Note: Antigen POCT must not be used to test symptomatic individuals or in settings in outbreak.

Other Congregate Living Settings and Institutions

Definition: Other congregate living settings and institutions include homeless shelters, group homes, community supported living, disability-specific communities/congregate settings, short-term rehab, hospices, and other shelters.

Note: Correctional facilities should follow sector-specific guidance on testing.

The approach to outbreak testing in congregate living settings and institutions may vary depending on the nature of the setting. In general, in the event of an outbreak declared in the setting, consideration should be given to testing all staff in the facility AND all residents/attendees in the facility, based on the direction of local public health. Local public health may also, based on a risk assessment, determine if any additional testing is required.

In asymptomatic persons, a negative result should not change public health management as the individual may still be in their incubation period. See [the Management of Cases and Contacts of COVID-19 in Ontario](#) and the [COVID-19 Fully Vaccinated and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance](#) for more information.

Remote/Isolated/Rural/Indigenous Communities

In the event of a confirmed case of COVID-19 in a remote, isolated, rural or Indigenous community, testing of contacts at low-risk of exposure as well as contacts at high-risk of exposure, should be considered, in consultation with the local public health unit.

Workplaces and Community Settings – Enhanced Contact-Based Testing

In the event of **one laboratory-confirmed case of COVID-19** identified in a workplace or community setting (e.g. religious gathering, recreational centre) during their period of communicability, exposed individuals in the workplace or community setting, determined in consultation with local public health, should be tested including:

- Close contacts of the case
- In settings where contacts are difficult to determine, broader testing may be considered

In the event of an **outbreak in a workplace or community setting**, as determined by local public health, all individuals associated with the outbreak area should be considered for testing.

In asymptomatic persons who are not fully vaccinated and were not previously positive within the past 90 days, a negative result should not change public health management as the individual may still be in their incubation period. In the event of ongoing transmission in an outbreak, repeating testing of asymptomatic persons who initially tested negative during the outbreak may be advised by the local public health unit to assess for additional asymptomatic/pre-symptomatic cases in an outbreak.

Testing Newborns

Newborns born to people with confirmed COVID-19 at the time of birth should be tested for COVID-19 within 24 hours of delivery, regardless of symptoms.

If maternal testing is pending at the time of mother-baby dyad discharge, then follow-up must be ensured such that if maternal testing is positive the baby is tested in a timely manner. If bringing the baby back for testing is impractical, the baby should be tested prior to discharge.

Newborns currently in the NICU/SCN born to mothers with confirmed COVID-19 at the time of birth should be tested within the first 24 hours of life and, if the initial test is negative, again at 48 hours of life, regardless of symptoms.

Testing People with Cancer who are Asymptomatic

Routine testing of all patients prior to radiation or systemic treatment is not recommended. Rather, a regional approach should be adopted after reviewing local epidemiology by regional COVID response committees. In regions with low community transmission of COVID-19, routine testing prior to treatment is not required but should be done at the discretion of the treating physician if he/she feels it is necessary or indicated, in particular when:

- High dose multidrug chemotherapy is planned
- Radiation treatment will involve treatment of lung tissue
- Treatment is planned in patients with a new ground glass lung opacity
- Treatment (radiation or systemic) is planned in patients who are significantly immunosuppressed

Recommendations for Hematopoietic Cell Therapy

- 1) All patients booked for hematopoietic cell therapy should be tested 24-48 hours before their appointment apart from exceptional circumstances, e.g., Priority A case requiring urgent same day treatment.

Testing for Hemodialysis Patients

1. Testing for symptomatic in-centre hemodialysis patients

- Test symptomatic patients using a low-threshold approach, incorporating ["atypical symptoms"](#)
- Patients with persistent respiratory symptoms or fever despite a negative test should be managed on Droplet and Contact Precautions and be retested as appropriate, based on clinical judgement.

2. Testing for in-centre hemodialysis patients who reside in LTC/retirement homes (~450 patients total) or other congregate living settings

- Periodic testing of asymptomatic patients from LTC or retirement homes is not recommended where the home does not have known cases.
- Periodic testing of hemodialysis patients in LTC/retirement homes with known cases or outbreaks should continue regularly until the outbreak is considered cleared.
- If a LTC/retirement home patient comes from a home where there is currently a COVID-19 outbreak or one is subsequently declared and the patient becomes a laboratory-confirmed case, decisions around additional testing of asymptomatic patients and staff should be left to the discretion of local infection prevention and control as testing decisions will be informed by the size and layout of the unit.
- Testing for in-centre hemodialysis patients who reside in LTC or retirement homes to be conducted in the hemodialysis unit, or in accordance with hospital and local public health protocols, if not already done in the home.

3. Testing for hemodialysis patients in hemodialysis unit where outbreak declared

- If an outbreak is declared in a hemodialysis unit, test all patients in that unit regardless of whether they are symptomatic. In addition, all staff working in that hemodialysis unit must be tested.
- Retesting should be directed by the outbreak management team overseeing the outbreak, in collaboration with local public health.

2 COVID-19 Public Health Guidance on Clearance

See the Ministry of Health's [COVID-19 Fully Vaccinated/Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance](#) for management of COVID-19 cases or contacts for fully vaccinated and previously positive individuals and definitions.

All other individuals should follow the standard [Management of Cases and Contacts of COVID-19 in Ontario](#) guidance.

2.1 Re-testing after Clearance and Testing Fully Vaccinated Individuals

- Re-testing after clearance and testing fully vaccinated individuals 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.
- Individuals who are fully vaccinated or were previously positive should be tested. For more details, refer to [COVID-19 Fully Vaccinated and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance](#)
- Repeat testing is recommended as soon as possible for fully vaccinated or previously positive asymptomatic individuals who test positive. Refer to [COVID-19 Fully Vaccinated and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance](#).
- An asymptomatic individual that **previously had laboratory-confirmed COVID-19 AND was cleared**, may resume asymptomatic screening testing after 90 days from their COVID-19 infection (based on the date of their positive result). If there is uncertainty about the validity of the COVID-19 infection (e.g., asymptomatic infection with high cycle threshold value result), resume asymptomatic screening testing immediately.
 - Fully vaccinated individuals may be excluded from asymptomatic screening testing.

2.2 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](#).

2.3 Approaches to Clearing Cases (including VOC cases)

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 One negative specimen tested by laboratory-based NAAT assay after a positive result</p>	<p>Asymptomatic Fully Vaccinated individuals who have tested positive</p>	<p>Can discontinue isolation immediately if a single negative result is obtained and the fully vaccinated individual has remained asymptomatic. The individual should remain in isolation pending the second test result following an initial positive result.</p>
<p>Test Based Two consecutive negative specimens tested by a laboratory based NAAT assay, 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.

2.4 Recommendations for Health Care Workers' Return to Work

- Asymptomatic fully vaccinated health care workers (HCWs) who meet test-based clearance above are still encouraged to report to their employer/workplace Occupational Health and Safety department and follow any work restriction requirements. See the [COVID-19 Fully Vaccinated and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance](#) for more information.
- HCWs who are not fully vaccinated 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).

- Asymptomatic HCWs who are not fully vaccinated or previously positive and are exposed to a symptomatic household member should isolate until the symptomatic individual has received a negative COVID-19 test result. If testing is not conducted then the HCW should self-isolate for 10 days from last 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 was 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, which means the below should be followed:

While at work, the HCW under work self-isolation 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 also means maintaining self-isolation measures outside of work for 10 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.

2.5 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, i.e. resolution of fever (without the use of fever-reducing medications) and improvement in respiratory and other symptoms. If they are experiencing gastrointestinal (GI) symptoms (nausea/vomiting, diarrhea, stomach pain), symptoms need to be resolving for at least 48 hours. • 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 10 days from last exposure.

Symptoms at/around time of testing	Test Result	Instructions
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 OR the individual is fully vaccinated or was previously positive), see Management of Cases and Contacts of COVID-19 in Ontario and the COVID-19 Fully Vaccinated and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance for repeat testing guidance. If follow-up testing is negative, the HCW is cleared from work self-isolation and can return to work as per usual.

2.6 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 who are confirmed cases 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.
- Asymptomatic workers who are not fully vaccinated or previously positive and are exposed to a symptomatic household member should isolate until the symptomatic individual has received a negative COVID-19 test result or an alternative diagnosis from their healthcare provider. If testing is not conducted then the worker should self-isolate for 10 days from last exposure.

2.7 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 settings (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 PHU 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 the self-isolating worker, other workers and the community
 - minimal risk related to transportation to and from work (e.g., no carpooling / ride-sharing or public transit use)
 - no available 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 at the workplace
 - whether required IPAC measures can be fully and consistently implemented including 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.