Ministry of Health

Management of Cases and Contacts of COVID-19 in Ontario

June 2, 2022 (version 14.2)

Ontario

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Management of Cases and Contacts of COVID-19 in Ontario

Version 14.2 – June 2, 2022

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

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

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

1 Background

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

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

This document replaces 'COVID-19 Reference Document for Symptoms'; 'COVID-19 Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge' (March 9, 2022); 'COVID-19 Fully Vaccinated and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance' (October 12, 2021); and COVID-19 Interim Guidance: Omicron Surge Management of Staffing in Highest-Risk Settings (March 31, 2021).

Guidance provided by the MOH and other relevant Ministries or organizations may provide additional information about outbreaks and preventative measures in

different settings (e.g., acute care, long-term care homes/retirement homes, congregate living settings, COVID-19 Provincial Testing Guidance).

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

2 COVID-19 Symptoms

The below symptoms, signs, and clinical features have been most commonly associated with COVID-19. The common symptoms of COVID-19 may change as new VOCs emerge.

To prevent community transmission of infectious diseases, all individuals with symptom(s) of **any** infectious illness should stay home when they are sick. Individuals with COVID-19 symptoms should seek assessment from a health care provider if required and/or if they may be eligible for COVID-19 treatment. Individuals with severe symptoms requiring emergency care should go to their nearest emergency department.

When assessing for the symptoms below, the focus should be on evaluating if they are new, worsening, or different from an individual's baseline health status (usual state). Symptoms should not be chronic or related to other known causes or conditions (see examples below). **One or more of the following most common symptoms of COVID-19 necessitate immediate self-isolation and, if eligible, COVID-19 testing:**

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

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

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

Other symptoms that may be associated with COVID-19 and should be monitored, include:

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

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

3 Highest Risk Settings

Highest Risk settings include:

- Hospitals (including complex continuing care facilities)
- Congregate living settings with medically and socially vulnerable individuals, including but not limited to long-term care homes, retirement homes, First Nation elder care lodges, group homes, shelters, hospices, correctional institutions, and hospital schools
- International Agricultural Workers

It is expected that all cases be contacted either by the Virtual Assistant or phone to determine if they are associated with a highest risk setting, as PHUs should continue to identify cases associated with highest risk settings for surveillance and outbreak management support.

At the discretion of the PHU, more extensive case management (e.g. communication of isolation requirements, sharing of local supports, etc.) may be provided to vulnerable individuals in their region (e.g., individuals who are homeless/underhoused) to support their isolation. Public health units should make specific considerations for case and contact management for First Nations, Inuit and Métis communities, in dialogue with the communities and/or Indigenous health service providers, to support ongoing surveillance and response that allows for differences in community needs, and recognizes differential impacts to communities.

Data Entry Requirements

Public health units are expected to (through case calls, Virtual Assistant, or other reasonable means) complete case surveillance requirements by following data entry requirements for individual cases (described in section 5.1 case reporting, and as per PHO's data entry guidance) for cases associated with (e.g., live or work in) highest risk settings.

Outbreak Investigation and Management

Public health units are expected to investigate and manage suspect and confirmed outbreaks in highest risk settings (as defined above). Highest risk settings as above should notify their local public health unit when they have a suspect or confirmed outbreak, as defined by relevant Ministry of Health guidance for their sector. Highest risk settings that are institutions or public hospitals must report suspect and confirmed outbreaks to their local public health unit as per the *Health Protection and Promotion Act.* PHUs should work with local highest-risk settings to ensure communication pathways are in place so that outbreaks can be reported directly to the PHU.

As a safeguard for highest-risk settings that do not yet have strong or established connections for engaging with the local PHU, PHUs should still use calls, Virtual Assistant or other reasonable means for all cases identified through a positive PCR test in order to identify and triage cases that are associated with highest risk settings for outbreak management support, as applicable. There is no expectation for routine individual case calling to occur outside of regular business hours or that cases be reached within 24 hours. However, when suspect outbreaks in highest risk settings are reported directly to the PHU, initial investigation steps (e.g., assignment of an outbreak number, initial recommendations) should be taken in a timely manner (e.g., same day if possible).

There are no expectations for COVID-19 respiratory outbreaks in institutions that are not a highest risk setting as above to be entered in the provincial Case and Contact Management system. If there is strong evidence of a non-COVID-19 aetiology for a respiratory outbreak, the outbreak should still be managed as per usual by the health unit. PHUs are still expected to investigate and manage reports of gastrointestinal outbreaks in institutions as per usual.

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

4.1 Testing Recommendations

- Individuals with COVID-19 symptoms should seek molecular testing (PCR or rapid molecular), if eligible. See the COVID-19 Provincial Testing Guidance for information on eligibility.

    - Where there is a high index of suspicion that an individual may be a COVID-19 case with a possible false-negative PCR or rapid molecular test result, re-testing as soon as possible is advised, and initiation of case isolation/outbreak management may be appropriate based on the health unit's risk assessment.

- Individuals with COVID-19 symptoms who are not eligible for molecular testing and have access to rapid antigen tests can use rapid antigen tests to assess the likelihood that their symptoms are related to COVID-19.
    - A single negative rapid antigen test in an individual with COVID-19 symptoms does not mean that they do not have COVID-19 infection, and the symptomatic individual should not end their isolation on this basis.
    - If two consecutive rapid antigen tests, separated by 24-48 hours, are both negative, the symptomatic individual is less likely to have COVID-19 infection, and they are advised to self-isolate until they have no fever and symptoms are improving for at least 24 hours (or 48 hours if gastrointestinal symptoms).
        - Household members of these individuals **do no**t need to self-isolate, as long as they have no symptoms.
- A **positive rapid antigen test** in an individual with COVID-19 symptoms is highly indicative that the individual has COVID-19, and the individual should self-isolate as per the guidelines below.
    - If an individual with COVID-19 symptoms and a positive rapid antigen test has a subsequent negative molecular test within 48 hours then the symptomatic individual is less likely to have COVID-19 infection, and they are advised to self-isolate until they have no fever and symptoms are improving for at least 24 hours (or 48 hours if gastrointestinal symptoms).
- If the individual with COVID-19 symptoms does not have access to testing, they are advised to self-isolate as per guidelines below.
- There is no provincial public health requirement for workers who are test-positive cases or isolated due to COVID-19 symptoms to provide proof of a negative test result or a positive serological test result to their employers in order to return to work. It is expected that workers who have tested positive or who have symptoms of COVID-19 follow public health isolation recommendations as outlined in table 1 below (and occupational health, where applicable) for when they would be considered clear to return to work.

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

- Self isolation means:
    - The case is to stay home and not attend work, school, child care or other public places.
    - The case should only leave home if there is a medical emergency or if they need to get a clinical assessment or test. See the COVID-19 Clinical Assessments and Testing page for more information.
    - If the case must leave the home, they should travel in a private vehicle if possible. If this is not possible, the case should wear a medical mask, keep distance from others in the vehicle (e.g., sit in the backseat) and if possible and weather permitting, open the windows to increase air exchange in the vehicle.
    - As much as possible, the case should stay in a separate room away from other people in the home and use a separate bathroom if possible. If in the same room, they should wear a mask (medical mask if available) and improve ventilation (e.g. windows should be open if possible). Household members should also wear a mask when in the same room if possible. Household caregivers should refer to PHO's fact sheet on Self-Isolation: Guide for caregivers, family members and close contacts. Anyone who is at higher risk of severe complications from COVID-19 (e.g., immunocompromised and/or elderly) should avoid caring for or coming in close contact with a case.
    - The case may leave their home for independent outdoor exercise (or with a caregiver, as appropriate), but should maintain physical distance of at least 2 metres (6 feet) from others at all times. The case should not go to outdoor fitness classes or personal training sessions and should wear a mask in common areas when leaving the property if self-isolating in an apartment building, condo or hotel.
- The duration of self-isolation after the date of specimen collection or symptom onset (whichever is earlier/applicable) depends on relevant clinical factors such as setting, severity of infection, and immune status (see Table 1).

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

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

[1]Severe illness is defined as requiring ICU level of care for COVID-19 illness (e.g., respiratory dysfunction, hypoxia, shock and/or multi-system organ dysfunction).[2] Individuals are considered fully vaccinated if they have received a full primary series of a Health Canada authorized vaccine (e.g. two doses of AstraZeneca/Moderna/Pfizer or 1 dose of Janssen) at least 14 days ago.

Population	Isolation Period	Additional Precautions after Self-Isolation Period
• Individuals 12+ who are not fully vaccinated[2] • Individuals residing in a highest-risk setting • Individuals hospitalized for COVID-19 related illness (not requiring ICU level of care)	At least **10 days** (or at discretion of hospital IPAC) after the date of specimen collection or symptom onset (whichever is earlier/applicable) and until symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever present.	N/A

[2] Individuals are considered fully vaccinated if they have received a full primary series of a Health Canada authorized vaccine (e.g. two doses of AstraZeneca/Moderna/Pfizer or 1 dose of Janssen) at least 14 days ago.

Population	Isolation Period	Additional Precautions after Self-Isolation Period
Immunocompromised individuals[3]	**At least 10 days** (or at discretion of hospital IPAC) after the date of specimen collection or symptom onset (whichever is earlier/applicable) and until symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever present.	Follow the additional precautions listed in the row below for a total of **20 days** after the date of specimen collection or symptom onset (whichever is earlier/applicable).

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

Population	Isolation Period	Additional Precautions after Self-Isolation Period
• All other individuals not listed above, who have COVID-19 symptoms, or a positive COVID-19 test (PCR, rapid molecular or rapid antigen test)	At least **5 days** after the date of specimen collection or symptom onset date (whichever is earlier/applicable) and until symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever present.	For a total of **10 days** after the date of specimen collection or symptom onset (whichever is earlier/applicable), individuals should: • Continue to wear a well-fitted mask in all public settings (including schools and childcare, unless under 2 years old) and avoid non-essential activities where mask removal is necessary (e.g., dining out, playing a wind instrument, high contact sports where masks cannot be safely worn). [4] • Not visit anyone who is immunocompromised or at higher risk of illness (e.g., seniors) • Avoid non-essential visits to highest risk settings such as hospitals and long-term care homes. • Employees working in highest-risk settings should report their exposure and follow their workplace guidance on return to work.

You have symptoms and are concerned you may have COVID-19. Now what?

Do you have any of these symptoms: Fever/chills, cough, shortness of breath, decrease/loss of smell and taste?

Yes

- It is highly likely that you have a COVID-19 infection. You must self-isolate immediately:
  - For at least **5 days**** (if fully vaccinated or under 12 years old) or **10 days** (if **not** fully vaccinated or if immunocompromised) after your symptom onset and until you have no fever and your symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms), whichever is longer in duration
- If available, perform a rapid antigen test. If you are eligible, get a PCR or rapid molecular test.
- Your household members that meet the below criteria **do not** need to isolate:
  - Have previously tested positive for COVID-19 in the past 90 days,
  - Are 18+ and have had a first booster dose
  - Are under 18 years old and are fully vaccinated
- Your household members that **do not** meet the above criteria must self-isolate while you are isolating.
- If your symptoms worsen, seek advice from Telehealth or your health care provider.
- Notify your workplace.

No

Do you have two or more of these symptoms?:

- **Sore throat**
- **Headache**
- **Extreme fatigue**
- **Runny nose/nasal congestion**
- **Muscle aches/joint pain**
- **GI Symptoms (i.e. vomiting or diarrhea)**

Yes

- It is less likely that you have COVID-19 infection.
- Self-isolate until your symptoms are improving for at least 24 hours (48 hours for gastrointestinal symptoms).
- Your household members do not need to self-isolate.

Note: Symptoms should not be related to any other known causes or conditions.

**For 10 days after symptom onset (or 20 days for immunocompromised individuals): maintain masking in public setting (including schools and childcare, unless under 2 years of age), do not visit or work in any highest risk setting, do not visit vulnerable individuals (e.g. immunocompromised individuals or seniors).

5 Case and Outbreak Management

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

Case management is at the discretion of the PHU and may be conducted as needed for certain cases in highest risk settings or other vulnerable populations (e.g., to support isolation). Public health units should make specific considerations for case and contact management for First Nations, Inuit and Métis communities, in dialogue with the communities and/or Indigenous health service providers, to support ongoing surveillance and response that allows for differences in community needs and recognized differential impacts to communities.

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

5.1 Case Reporting

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

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

It is expected that all cases be contacted either by the Virtual Assistant or phone to determine if they are associated with a highest risk setting, as PHUs should continue to identify cases associated with highest risk settings for surveillance and outbreak management support. PHUs should continue to link all COVID-19 cases that are outbreak-associated to the relevant outbreak in CCM.

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

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

5.2 Considerations for Cases and Outbreak Management in Highest Risk Settings

Relevant **sector-specific guidance** for highest risk settings (e.g., LTCHs) should be followed for those specific settings where conflicting with the below information.

Certain groups, such as home and community care staff and residents or paramedic service workers, are considered highest risk groups for the purposes of molecular testing eligibility, and access to testing for return to work. However, they are not considered part of highest risk settings for outbreak management unless they are part of a suspect or confirmed outbreak in a highest risk setting.

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

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

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

- Use of clinical assessment centres
- Use of isolation facilities, if applicable
- Use of community supports and agencies
- Psychosocial supports
- Courier, delivery supports for food and necessities
- Emergency financial supports through the provincial government and local regions
- Provincial unpaid job-protected infectious disease emergency leave and federal government financial supports including employment insurance

- Additional resources available to support isolation for marginalized populations through the High Priority Communities strategy

If the case **lives** in a highest risk setting, they should isolate for at least 10 days after date of specimen collection or symptom onset (whichever is earlier/applicable) AND until they are afebrile and symptoms are improving for 24 hours (or 48 hours if gastrointestinal symptoms), unless otherwise directed by the PHU or as per sector specific guidance.

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

- For routine operations, COVID-19 positive cases that work in highest-risk settings may return to work:
    - 10 days after symptom onset or date of specimen collection (whichever is earlier) **OR**
    - After a single negative molecular test (e.g. PCR, rapid molecular) any time prior to 10 days from the date of symptom onset or specimen collection (whichever is earlier) **OR**
    - After two consecutive negative rapid antigen tests that are collected at least 24 hours apart any time prior to 10 days from the date of symptom onset or specimen collection (whichever is earlier) **AND**
    - Provided they have no fever and other symptoms have been improving for 24 hours (or 48 hours if vomiting/diarrhea).
- See Appendix A for Staffing Options for Highest Risk Settings experiencing critical staffing shortages. Options listed above for return to work should be exhausted prior to progressing to options listed in critical staffing shortages options listed in Appendix A.

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

- Some laboratories have added the qualifier "detected (low level)" to positive PCR results where the cycle threshold (Ct) value is high (meaning the viral load level is low, e.g., a Ct value between 35 and 37). This result is still a POSITIVE result and should be interpreted in the clinical and epidemiological context of the case. It may represent an early stage of infection, a late stage of infection (e.g. residual non-infectious gene fragments), or a false positive result. This "detected (low level)" result is distinct from "indeterminate" results where the result cannot be

differentiated between the presence or absence of the target gene. Individuals with a "detected (low level)" target gene result should still be managed as a case. However, if the pre-test probability of COVID-19 is low (e.g., asymptomatic screen testing) and there are no other target genes reported as detected on the PCR assay report at the time, then repeat molecular testing as soon as possible may be warranted as for any other situations where there is a concern for a false positive result.

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

5.4 Management of Previously Cleared Cases with New Positive Results

- Findings of a new positive test result after completing isolation due to a COVID-19 infection may represent:
    - Persistent positive result from the previously cleared infection episode, especially likely if the new positive result occurred within 90 days if using molecular testing or within 30 days if using rapid antigen testing; OR
    - Reinfection from a new infection episode, especially likely if the new positive result occurred beyond 90 days if using molecular testing or beyond 30 days if using rapid antigen testing.
- If molecular samples from the previously cleared infection and molecular samples from the new positive result are available and of sufficient viral load to permit additional investigations (Ct value <30), VOC screening and/or whole genome sequencing may be requested to provide further laboratory evidence supporting a reinfection with a different SARS-CoV-2 variant as opposed to persistent positivity with the same SARS-CoV-2 variant (see Case Definition – Coronavirus Disease [COVID-19] Section C. Laboratory-Based Case of Reinfection).
- **Persistent positive:** If there is evidence that the new positive result is likely to be due to ongoing persistent detection from the previously cleared infection, then no further public health case management is required. Supporting evidence of a persistent positive include: testing done by molecular methods within 90 days of the previously cleared infection (persistent positives past 90 days are not to be expected unless the individual is immunocompromised), the Ct value of the new positive being equal or higher (suggestive of a lower viral load) than the Ct values reported during the previous infection (although no specific Ct value cut-off exists to distinguish persistent positives from

reinfection), and/or same variant identified with the new positive result as which was reported during the previous infection.

- **Reinfection:**
  - Case management
    - Evidence suggests that although rare, reinfections can occur less than 90 days after a previous confirmed infection. Cases where re-infection is suspected should be managed as currently infectious**.**
    - If helpful to their investigation, PHUs can request additional information from the testing laboratory on specimens tested using molecular methods from individuals suspected of re-infection (e.g., Ct values, gene targets detected) to further inform interpretation of the results.
  - Data Entry
    - Reinfections that meet either the lab-based or time-based Ontario Case of Reinfection Definitions should be entered as confirmed cases into CCM.
    - Suspected reinfections that DO NOT meet either the lab-based or time-based Ontario Case of Reinfection Definitions should follow PHO Data Entry Guidance for entry of new positive result in a previously cleared individual.
    - PHO is available for consultation on re-infection cases (whether confirmed or suspected) via epir@oahpp.ca

6 Guidelines for Close Contacts

6.1 Definition of Close Contacts

A close contact is defined as **an individual who has an exposure to a confirmed positive COVID-19 case, an individual with COVID-19 symptoms, or an individual with a positive rapid antigen test result.**

Close contacts have been in contact with the case/symptomatic person within the 48 hours prior to the case's symptom onset if symptomatic or 48 hours prior to the specimen collection date (whichever is earlier/applicable) and until they have completed their self-isolation period; AND

Were in close proximity (less than 2 meters) for at least 15 minutes or for multiple short periods of time without measures such as masking, distancing and/or use of personal protective equipment (see table 1 for examples).

Outside of suspect and confirmed outbreaks managed by the PHU, it is the **responsibility of the individual** with COVID-19 symptoms or COVID-19 positive test to determine who their close contacts are and to notify them of their potential exposure.

Employers must also follow requirements as per the *Occupational Health and Safety Act.*

Table 2: Examples of Close Contacts

Exposure Setting	**Examples of Close Contacts**
Household (includes other congregate settings)	• Anyone living in the same household, while the case **was self-isolating.** o This may include members of an extended family, roommates, boarders, etc. o This may include people who provided care for the case (e.g., bathing, toileting, dressing, feeding etc.) o This EXCLUDES individuals who live in a completely separate area/unit (e.g. self-contained basement apartment).
Community/Workplaces/ Schools/Child care/Camps	• Had direct contact with infectious body fluids of the case (e.g., coughed on or sneezed on) • Were in close proximity (less than 2 meters)[1] for at least 15 minutes or for multiple short periods of time without consistent and appropriate use of personal protective equipment[3] such as masking.

Exposure Setting	Examples of Close Contacts
Health Care and congregate care/living highest risk settings (e.g. long-term care homes, retirement homes, First Nation Elder Care Lodges, group homes, shelters, hospices, correctional institutions, hospital schools).	See the relevant sector specific guidance documents for more information. **Patient/resident is the case:** • Health care worker and/or staff who provided direct care for the case, or who had other similar close physical contact (i.e., less than 2 metres from patient for more than transient duration of time)[1] **without** consistent use of personal protective equipment (PPE)[3] as recommended by their organization's IPAC guidelines or best practice guidance for their sector. • Other patients/residents in the same semi-private/ward room • Other patients/residents who had close[1], prolonged[2] contact with the patient case
	Health care worker/staff is the case: • All patients/residents who had close[1] prolonged[2] contact to the health care worker/staff. • **Note:** Patients exposed to the HCW where contact was neither close nor prolonged, AND the HCW was masked for the entire duration would generally not be considered high risk exposures. Consideration may also be given if the patient was consistently masked during the interaction. • All co-workers who had unprotected close[1] and/or prolonged[2] contact with the case (e.g., within 2 metres in an enclosed common area) • Close contacts as identified by hospital IPAC

For further details see: Focus On: Risk Assessment Approach for COVID-19 Contact Tracing

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

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

[3] **PPE**

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

6.2 Close Contacts Outside of Highest-Risk Settings

6.2.1 Non-Household Close Contacts

- For a total of 10 days after the last exposure to the COVID-19 positive case or individual with COVID-19 symptoms, the non-household member notified by a case should:
    - Self-monitor for symptoms and self-isolate if they develop any symptom of COVID-19;

- Wear a well fitted mask in all public settings;
    - Individuals should maintain masking as much as possible in public settings (including school and child care, unless under 2 years old). Reasonable exceptions would include removal for essential activities like eating, while maintaining as much distancing as possible;
    - Participation in activities where masking can be maintained throughout may be resumed, but individuals should avoid activities where mask removal would be necessary (e.g. dining out; playing a wind instrument; high contact sports where masks cannot be safely worn);
    - Individuals who are unable to mask (e.g., children under two years of age, etc.) may return to public settings without masking
- Not visit anyone who is immunocompromised or at higher risk of illness (e.g., seniors);
- Avoid non-essential visits to highest risk settings such as hospitals and long-term care homes.
- Employees working in highest risk settings should report their exposure and follow their workplace guidance.

- In some scenarios, close contacts who are part of outbreak investigations may be contacted by public health and advised of additional recommendations.

6.2.2 Household Close Contacts

- COVID-19 positive cases/individuals with COVID-19 symptoms should isolate away from household members where possible to avoid ongoing exposures.
- Household members of the COVID-19 positive case/individual with COVID-19 symptoms should **self-isolate** while the case is isolating, **with the following exceptions:**
    - Household members who are **18 years of age or older and have already received a first booster dose**

- Household members who are **under 18 year of age and are considered fully vaccinated**[5]
- Household members who have **previously tested positive for COVID-19 in the last 90 days** (based on a positive PCR, molecular or rapid antigen test result) and have since completed their isolation period. These individuals may also attend highest risk settings, as long as they are currently asymptomatic.

- If self-isolation is complete at less than 10 days, or if self-isolation is not required, then, **for a total of 10 days after the last exposure**[6] **to the COVID-19 case, ALL household members should:**
  - Self-monitor for symptoms and self-isolate if they develop any symptom of COVID-19;
  - Wear a well fitted mask in all public settings;
    - Individuals should maintain masking as much as possible in public settings (including school and child care, unless under 2 years old). Reasonable exceptions would include removal for essential activities like eating, while maintaining as much distancing as possible;
    - Participation in activities where masking can be maintained throughout may be resumed, but individuals should avoid activities where mask removal would be necessary (e.g. dining out; playing a wind instrument; high contact sports where masks cannot be safely worn);
    - Individuals who are unable to mask (e.g., children under two years of age, etc.) may return to public settings without masking

[5] Individuals are considered fully vaccinated if they have received a full primary series of a Health Canada authorized vaccine (e.g. two doses of AstraZeneca/Moderna/Pfizer or 1 dose of Janssen) at least 14 days ago.

[6] "Last exposure" refers to last day the contact was exposed to an individual who was still isolating with either COVID-19 symptoms or a positive test result (e.g., household contacts would have ongoing exposure until the end of the cases isolation period if unable to effectively self-isolate in the home. If a child with COVID-19 was self-isolating from Monday to Saturday, the 'last exposure' for the parent who was caring for the COVID-19 positive child would be the Saturday.

- Not visit anyone who is immunocompromised or at higher risk of illness (e.g., seniors);
- Avoid non-essential visits to highest risk settings such as hospitals and long-term care homes.
- Employees working in highest risk settings should report their exposure and follow their workplace guidance.

You've been identified as a close contact of someone who has tested positive for COVID-19 or someone with COVID-19 symptoms. Now what?

Does the COVID-19 positive/symptomatic person live with you?

No

Do you have COVID-19 symptoms?

Yes

- Self-isolate immediately for at least 5 days (if fully vaccinated or under 12)** or 10 days (if **not** fully vaccinated or immunocompromised) after symptom onset and until you have no fever and other symptoms are improving for 24 hours (or 48 hours for gastrointestinal symptoms).
- Get tested if eligible and follow the guidance for cases.

No

- Self-monitor for symptoms for 10 days after your last exposure.**
- Report your exposure to your employer and follow any work restrictions.
- If you develop symptoms, get tested if eligible and self-isolate immediately.

Yes

- If you meet any of the below criteria you **do not** need to self-isolate**:
  - You have previously tested positive for COVID-19 in the last 90 days
  - You are 18+ and have had a first booster dose
  - You are under 18 years old and are fully vaccinated
- If you **do not** meet the above criteria you must self-isolate while the positive/symptomatic person is isolating.
- If you develop symptoms, continue/start to self-isolate and get tested if you are eligible. Follow the guidance for cases.
- If anyone else in your household develops symptoms, if you are isolating and still have no symptoms then you should extend your self-isolation until the newly symptomatic person has finished isolating.

Wear a well-fitted mask in public (including schools and childcare, unless under 2 years of age), physical distance and maintain other public health measures for 10 days following your last exposure if leaving home. You should **NOT visit or attend work in any highest risk settings and not visit individuals who may be at higher risk of illness (i.e. seniors or immunocompromised) for 10 days after your last exposure.

6.3 Close Contacts in Highest-Risk Settings

- Close contacts **working/volunteering/attending** highest-risk settings who develop **any** symptom(s) of COVID-19 should self-isolate and be tested by molecular testing as soon as possible.
- Close contacts who **live** in a highest risk setting may need to isolate following an exposure, based on the sector-specific isolation guidance (e.g. COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units), direction from local public health unit or direction from the local hospital infection prevention and control team for hospitalized patients.
- Employees in highest risk settings who have had a COVID-19 exposure should speak with their employer and follow their workplace guidance for return to work.
    - Employees who are close contacts who have previously tested positive for COVID-19 in the last 90 days (based on positive rapid antigen test or molecular test results) **can** attend work in the highest-risk setting, as long as they are currently asymptomatic. These individuals are advised to self-monitor for symptoms for 10 days after last exposure.
    - For routine operations, asymptomatic close contacts that work in highest-risk settings may participate in testing for early return to work:
        - Following a negative molecular test (e.g., PCR, rapid molecular) collected on/after day 5 after last exposure[7] **OR**
        - Following a negative molecular test (e.g., PCR or rapid molecular) prior to first shift (if collected before day 5) **AND** perform daily rapid antigen testing for 10 days after last exposure **or** until a second

[7] "Last exposure" refers to last day the contact was exposed to an individual who was still isolating with either COVID-19 symptoms or a positive test result (e.g., household contacts would have ongoing exposure until the end of the cases isolation period if unable to effectively self-isolate in the home. If a child with COVID-19 was self-isolating from Monday to Saturday, the 'last exposure' for the parent who was caring for the COVID-19 positive child would be the Saturday).

negative molecular test is collected on/after day 5 from last exposure [8]

    - See Appendix A for Staffing Options for Highest Risk Settings experiencing critical staffing shortages. Options listed above for return to work should be exhausted prior to progressing to options listed for critical staffing shortages in Appendix A.

- Additional workplace measures for individuals returning after a negative molecular test collected before day 5 of last exposure may include:
    - Active screening for symptoms ahead of each shift
    - Individuals on early return to work should not remove their mask when in the presence of other staff to reduce exposure to co-workers (i.e. not eating meals/drinking in a shared space such as conference room or lunch room.
    - Working in only one facility, where possible;
    - Ensuring well-fitting source control masking for the staff on early return to work to reduce the risk of transmission (e.g. a well fitting medical mask or fit or non-fit tested N95 respirators or KN95s).

7 Risk of COVID-19 Spread Between People and Animals

- There have been some infrequent confirmed reports of the SARS-CoV-2 virus spreading from animals to individuals (e.g., in mink farms)
- Based on available information to date, animal-to-human transmission is likely very uncommon and the risk to most people in Canada for acquiring COVID-19 from animals appears to be very low.

[8] If the individual tests positive on a test before day 10, they should not continue testing on subsequent days and wait 10 days after specimen collection date prior to returning to work. Routine molecular testing of positive cases is NOT recommended due to the high likelihood of ongoing positivity, but may be considered if initial test was indeterminate or low level positive.

- See the Government of Canada's website for more information on the risk of COVID-19 spreading from animals to people, for information on how to keep your pets safe when you have COVID-19 or COVID-19 symptoms and guidelines for individuals who have had contact with farm animals or wild life.

8 Travellers from Outside of Canada

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

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

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

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

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

9 Appendix A: Management of Staffing in Highest-Risk Settings

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

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

When available, use of testing options is preferred to other options. Close contacts should be prioritized for return to work over COVID-19 positive cases.

9.1 Routine Operations Staffing Options

Asymptomatic Close Contacts

- For routine operations, **asymptomatic close contacts** that work in highest-risk settings may return to work:
    1) Following a negative molecular test (e.g., PCR, rapid molecular) collected on/after day 5 from last exposure[9] **OR**
    2) Following a negative molecular test (e.g., PCR or rapid molecular) collected before day 5 after last exposure **AND** performing daily rapid antigen tests for 10 days after last exposure **or** until a second negative molecular test is collected on/after day 5 after last exposure.[10]

[9] "Last exposure" refers to last day the contact was exposed to an individual who was still isolating with either COVID-19 symptoms or a positive test result (e.g., household contacts would have ongoing exposure until the end of the cases isolation period if unable to effectively self-isolate in the home. If a child with COVID-19 was self-isolating from Monday to Saturday, the 'last exposure' for the parent who was caring for the COVID-19 positive child would be the Saturday).

[10] If the individual tests positive on a test before day 10, they should not continue testing on subsequent days and wait 10 days after specimen collection date prior to returning to work. Routine molecular testing of positive cases is NOT recommended due to the high likelihood of ongoing positivity, but may be considered if initial test was indeterminate or low level positive.

- Asymptomatic close contacts who are returning after a negative molecular test collected before day 5 after last exposure are recommended to follow the Workplace Measures below for reducing risk of exposure.

COVID-19 Positive Cases

- For routine operations, **COVID-19 positive cases** that work in highest-risk settings may return to work:
    1) 10 days after symptom onset or date of specimen collection (whichever is earlier) **OR**
    2) After a single negative molecular test any time prior to 10 days from the date of specimen collection or symptom onset (whichever is earlier) **OR**
    3) After two consecutive negative rapid antigen tests that are collected at least 24 hours apart any time prior to 10 days from the date of specimen collection or symptom onset (whichever is earlier)

    AND

    4) Provided they have no fever and other symptoms have been improving for 24 hours (or 48 hours if vomiting/diarrhea).

Note: If the staff is well (I.e., meets criteria 4), they may return to work regardless of ongoing positivity (PCR or RAT) on/after 10 days after symptom onset or date of specimen collection.

9.2 Moderate COVID-19 Transmission Risk Staffing Options (For Critical Staffing Shortages)

Asymptomatic Close Contacts

- For critical staffing shortages, **asymptomatic close contacts** that work in highest-risk settings may return to work under the following conditions:
    1) After two negative rapid antigen tests collected 24 hours apart[11] **AND**
    2) Given they perform daily rapid antigen testing for 10 days after last exposure **or** until a negative molecular test is collected on/after day 5 from last exposure.[9]
- If testing is not available, asymptomatic close contacts may return to work 7 days after last exposure, with workplace measures for reducing risk of exposure until day 10.

[11] Maintain workplace measures for reducing risk of exposure for 10 days after last exposure.

COVID-19 Positive Cases

- For critical staffing shortages, **COVID-19 positive cases** that work in highest-risk settings and **ONLY** care for COVID-19 positive patients/residents or patients/residents who have recently recovered from COVID-19 infection, may return to work:
    1) 7 days after symptom onset or date of specimen collection (whichever is earlier/applicable) without testing[11] **AND**
    2) Provided they have no fever and symptoms improving for 24 hours (48 hours if vomiting/diarrhea).

9.3 Higher COVID-19 Transmission Risk Staffing Options (For Critical Staffing Shortages)

Asymptomatic Close Contacts

- For critical staffing shortages, **asymptomatic close contacts** that work in highest-risk settings may return to work under the following conditions:
    1) After a single negative rapid antigen test prior to first shift[12] **AND**
    2) Given they perform daily rapid antigen testing for 10 days after last exposure **or** until a negative molecular test (e.g. PCR, rapid molecular) is collected on/after day 5 from last exposure.[9]
- If testing is not available, asymptomatic close contacts may return to work 5 days after last exposure, with workplace measures for reducing risk of exposure until day 10.

COVID-19 Positive Cases

- For critical staffing shortages, **COVID-19 positive cases** that work in highest-risk settings and **ONLY** care for COVID-19 positive patients/residents or patients/residents who have recently recovered from COVID-19 infection, may return to work:
    1) Earlier than day 7 (i.e., day 6, preferable to day 5, etc) without testing[12] **AND**
    2) Provided they have no fever and symptoms improving for 24 hours (48 hours if vomiting/diarrhea).

Note: In health care settings where there is IPAC and occupational health oversight of return-to-work decision-making, COVID-19 positive staff meeting the criteria above may return to work and care for all patients, but every attempt should be made to avoid working with immunocompromised, elderly patients or patients who are unvaccinated.

[12] Maintain workplace measures for reducing risk of exposure for 10 days after last exposure.

9.4 Workplace Measures for Reducing Risk of Exposure

- Where possible, avoid assigning staff on early return to work to vulnerable patients/residents (e.g., immunocompromised, unvaccinated, other underlying risks for severe disease).
- Personal Protective Equipment (PPE) and IPAC practices should be reviewed (including audits) to ensure meticulous attention to measures for staff on early return to work.
- Prioritize cohorting of staff who are early returned cases to working with COVID-19 positive patients only, due to their residual risk of transmission.
- Additional workplace measures for individuals on early return to work may include:
    - Active screening ahead of each shift
    - Individuals on early return to work should not remove their mask when in the presence of other staff to reduce exposure to co-workers (i.e. not eating meals/drinking in a shared space such as conference room or lunch room.
    - Working in only one facility, where possible;
    - Ensuring well-fitting source control masking for the staff on early return to work to reduce the risk of transmission (e.g. a well fitting medical mask or fit or non-fit tested N95 respirators or KN95s).

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

- The fewest number of staff who are close contacts or who are COVID-19 cases should be returned to work early to allow for business continuity and safe operations.
- Staff who are nearest to completion of their self-isolation period should be returned first.
- Where possible, preferential return to work for those who have received all recommended doses of the COVID-19 vaccine (including booster doses) should be considered due to decreased risk of developing symptomatic infection with Omicron infection compared to those with two doses or those who have not completed a primary series.
- Those who have an exposure to a COVID-19 case that does **not** live with them should be prioritized to return before those who have ongoing exposure to a household member with COVID-19, because the risk of transmission is higher among those with ongoing exposures (e.g., providing direct, ongoing care to a COVID-19 positive household member).

10 Additional Resources

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

11 Document History

Revision Date	Document Section	Description of Revisions
January 30 2020		Document was created.
February 5 2020	Contact Management – Public Health Advice	Language included to reflect policy change: self-isolation of 14 days for those returning from Hubei province and for close contacts of cases.
February 7, 2020	Throughout Document	Updates to reflect changes to case definition and self-isolation
February 12 2020	Case and Contact Management Travellers from Affected Areas	Updates to language around risk level and corresponding level of self isolation/ self monitoring Addition of Table 3
March 3 2020	Updates throughout document	Updates based on new case definition and evolving advice based on travel history of patient

Revision Date	Document Section	Description of Revisions
March 25 2020	Updates throughout document	Change in Purpose section; guidance on testing, explanation on case definition, assessment and management of persons suspected of COVID-19, Information on pets
April 15 2020	Updates throughout document	Updates on case definition description, travellers from outside of Canada, link to other guidance (e.g. provincial testing), updates to streamline language throughout
June 23 2020	Updates throughout document	Major updates to most sections, addition of several reference tables, moved to 2 risk exposure levels: low and high risk, moved appendices to become separate documents.
September 8 2020	Updates throughout document	Additional information on asymptomatic cases with low pre-test probability; new appendix 8; new table: Assessing Scenario Likelihood in Asymptomatic Cases with Low Pre-Test Probability; minor update to travel section; new information on COVID Alert
October 9 2020	Updates throughout document	Updates on frequency/nature of contact with low/high risk contacts Updated messaging to align with new guidance on case clearance timelines.

Revision Date	Document Section	Description of Revisions
December 1 2020	Updates throughout document	New section on Re-Infection; updates to case isolation for asymptomatic cases; updates to contact follow-up; further detail on risk assessment for contact tracing; removal of Non-Medical Mask section; addition of Appendix 9; updated section on Travellers from Outside of Canada
January 12 2021	Updates throughout document	Specify collection of vaccine information, clarify that vaccination does not change case & contact management at this time, updates to informing PHO of flight notifications, updates to federal quarantine guidance, clarification to extension of POC of some asymptomatic cases, clarify guidance on PPE for HCW exposures, clarify guidance on patient exposures to HCW cases
May 6 2021	Updates throughout document	New section on preliminary positive results from point-of-care assays; new section for testing of previously cleared cases (re-positive, re-infection) and self-isolation of previous positives with new high-risk exposures; new section on enhanced case management for VOC screen positive cases; new section on testing of asymptomatic high-risk contacts; updates to contact management in the context of VOC emergence (lower threshold for classifying contacts as HR exposure and requiring self-isolation); travellers from outside of Canada update.

Revision Date	Document Section	Description of Revisions
August 11 2021	Updates throughout the document	Incorporation of fully immunized/previously positive individuals; New section on notification of individuals identified through Backward Contact Tracing; Updated section: self-isolation of previous positives with new high-risk exposures (10 day self isolation); Updated section: Testing and Self-Isolation of Asymptomatic High-Risk Contacts; Follow up for high risk contacts is now day 5 and 10 of self-isolation; Section 5.2 update; Updated table 4 and modified footnote 4 on PPE and eye protection. ;Updated section: Travellers from Outside of Canada; New section: Contact tracing for train/bus/cruise ship passengers.
April 6 2022	Updates throughout document	Incorporation of COVID-19 Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge; Incorporation of COVID-19 Interim Guidance: Omicron Surge Management of Staffing in Highest-Risk Settings; Incorporation of COVID-19 reference document for symptoms; PHUs not expected to conduct case management for individual confirmed or probable cases, but must complete case surveillance requirements by following data entry requirements for individual cases, PHUs must investigate and manage suspect and confirmed outbreaks in congregate care/living highest risk settings