Ontario

COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance

Version 2.0 – August 11, 2021

Highlights of Changes

- Additional C&CM changes for 'previously positive' individuals (page 4)
- Updated recommendations for asymptomatic fully immunized individuals who test positive (page 5)
- Symptomatic individuals who test negative must have gastrointestinal symptoms resolving for at least 48 hours prior to ending self isolation (page 6)
- High risk contacts instructed to self-isolate may be cleared after 10 days (page 7)
- Updated Table 1 (page 8)
- New section for fully immunized or previously positive individuals that are part of an outbreak (page 10)

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.

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1 Background:

Ontario started to roll out its vaccine distribution implementation plan in December 2020. The following are Ontario's COVID-19 vaccine program goals (in the order identified below):

1. Prevent deaths
2. Prevent illness, hospitalization and ICU admissions
3. Reduce transmission

The purpose of this **interim guidance document** is to supplement or supersede (where applicable) the Management of Cases and Contacts of COVID-19 in Ontario guidance with updated recommendations for case and contact, and outbreak management of fully immunized and previously positive individuals in Ontario.

All fully immunized and previously positive individuals should continue to follow general public health guidance and recommended infection prevention and control measures.

2 Context

As Ontario continues COVID-19 vaccination rollout and in the context of emerging Variants of Concern (VOC), the province is approaching revisions to case and contact management guidance with caution. Decisions around adjustment to case and contact management practices balance the significant protection offered by the COVID-19 vaccines, and what is known about protection from natural immunity, against the risks of reinfection and concerns of the unknown risks associated with VOCs and their potential for vaccine/immune escape.

Evidence suggests that the vaccines reduce COVID-19 transmission, either by preventing infection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), or by reducing the incidence of symptomatic and asymptomatic disease. Additionally, Public Health Ontario is continuously monitoring the impact of vaccination and the emergence of SARS-CoV-2 VOCs including specifically those with potential vaccine/immune escape (e.g., Beta (B.1.351), Gamma (P.1) and Delta (B.1.617.2) variants) to inform and support decision-making related to relaxing individual, setting-specific and societal level public health measures.

As more evidence emerges regarding the spread of VOCs and the potential for vaccine/immune escape, case and contact management measures for vaccinated and previously positive individuals will be continuously reviewed and updated.

3 Definition of a Fully Immunized Individual

- For the purposes of case/contact/outbreak management, an individual is defined as fully immunized ≥14 days after receiving their second dose of a two-dose COVID-19 vaccine series or their first dose of a one-dose COVID-19 vaccine series that is listed for emergency use by the World Health Organization or approved by Health Canada.
- Confirmation of vaccination history is generally recommended for informing public health contact management guidance.
    - PHUs can assess vaccination status by accessing $COVax_{ON}$ data via CCM for proof of vaccination where possible or with other paper/electronic records.
- **This interim guidance does not apply to individuals who are "partially vaccinated"** i.e. individuals who have only received their first dose or are less than 14 days after vaccination with their second dose.
- Data is currently limited on vaccine effectiveness in individuals with immunocompromising conditions (e.g., organ or stem cell transplantation recipients, undergoing chemotherapy or immunosuppressive therapies, see Canadian Immunization Guide for details on these conditions. For these individuals, standard public health case and contact measures (as per Management of Cases and Contacts of COVID-19), including self-isolation after a high risk exposure should remain unchanged pending further information.

4 Definition of a Previously Positive Individual

- For the purposes of case/contact/outbreak management, an individual is defined as previously positive if they were a confirmed case of COVID-19 where their initial positive result was ≤ 90 days ago AND they have been cleared from their initial infection.
    - **Note:** this does not mean that re-infection is not possible within 90 days of infection, particularly given potential for immune escape with VOCs. However, the low risk of potential transmission from exposed resolved cases who remain asymptomatic are likely outweighed by the potential benefits of avoiding unnecessary self-isolation. PHUs may continue to advise self-isolation depending on risk assessment of epidemiological context of exposure

- Confirmation of previous infection episode is recommended for informing public health contact management.
- This interim guidance **does not apply** to previously positive individuals where their positive specimen result was more than 90 days ago; OR where it is uncertain whether their positive result represented a true infection (e.g., asymptomatic with high Ct value and repeat test negative) OR where the previous infection occurred outside of Canada.
- Data is currently limited on factors that reduce the natural immune response to infection and duration of protection from natural infection. For individuals with immunocompromising conditions (e.g., organ or stem cell transplantation recipients, undergoing chemotherapy or immunosuppressive therapies), standard public health case and contact measures (as per Management of Cases and Contacts of COVID-19), including self-isolation after a high risk exposure should remain unchanged pending further information.

5 Fully Immunized Individuals or Previously Positive Individuals who are Symptomatic or Test Positive for SARS-CoV-2

5.1 Individuals Who Are Symptomatic

- All fully immunized and previously positive individuals who have symptoms of COVID-19 should be managed in accordance with the Management of Cases and Contacts of COVID-19 in Ontario guidance (self-isolate and be tested for SARS-CoV-2 immediately).
    - **Household members:**
        - Fully immunized and previously positive asymptomatic individuals who are household members of a symptomatic person are not required to stay at home until the symptomatic individual tests negative.
        - If the household member is not fully immunized or previously positive they need to self-isolate until the symptomatic individual receives a negative test result.

- Upon receiving a negative PCR test result, symptomatic individuals who are fully immunized or previously positive can be cleared from isolation if afebrile and symptoms have improved for at least 24 hours, and gastrointestinal (GI) (nausea/vomiting, diarrhea, stomach pain) symptoms resolving for at least 48 hours (as per Quick Reference Guidance on Clearance and Testing).
    - As per the Management of Cases and Contacts of COVID-19 in Ontario guidance, if there is a concern about the accuracy of a test result (e.g., false negative in this case), it is recommended to repeat testing as soon as possible
    - Note: where a health practitioner has provided an alternative diagnosis, testing may not be required (as per Quick Reference Guidance on Clearance and Testing).

5.2 Individuals Who Test Positive

- Fully immunized individuals who test positive for SARS-CoV-2 and are **symptomatic:**
    - Should be managed in accordance with the Management of Cases and Contacts of COVID-19 in Ontario guidance.
- Fully immunized individuals who test positive for SARS-CoV-2 and are **asymptomatic:**
    - Can be managed as per section 4.6 "Asymptomatic cases- low pre-test probability" of the Management of Cases and Contacts of COVID-19 in Ontario guidance, including immediate repeat testing. These individuals must continue to isolate pending results from the repeat test.
    - Asymptomatic fully immunized individuals may be considered to have a "low pre-test probability" in their assessment, even if there has been a high-risk exposure or are part of an outbreak.
- Previously positive individuals who test positive for SARS-CoV-2 after clearance:
    - Should be managed as per section 4.10 "Management of Previously Cleared Cases with New Positive Results" of the Management of Cases and Contacts of COVID-19 in Ontario guidance. These individuals must continue to isolate pending results from the repeat test.

6 Fully Immunized or Previously Positive Individuals with High-Risk Exposures to Cases of SARS-CoV-2

- For 10 days after their last exposure, individuals who are fully immunized or previously positive with high-risk exposures should:
    - wear a mask and maintain physical distancing when outside of the home to reduce the risk of transmission to others in the event they become a case;
    - self-monitor for symptoms daily and self-isolate immediately if symptoms develop
- Individuals who are fully immunized or previously positive with high-risk exposures are encouraged to report their exposure to their employer and follow any restrictions from work, as specified by their manager and/or Occupational Health department.

6.1 Individuals Who Are Symptomatic

- All fully immunized or previously positive individuals who are symptomatic and have a high-risk exposure are recommended to get tested as soon as possible and must self-isolate pending test results. If the test is negative these individuals are not required to continue self-isolation provided their symptoms are improving and afebrile for at least 24 hours. If they are experiencing GI symptoms, symptoms need to be resolving for at least 48 hours. If they decline testing, they should remain in isolation for 10 days following their last exposure.
    - **Household members:**
        - Fully immunized or previously positive asymptomatic household members do not need to self-isolate while awaiting test results.
        - Household members that are not fully immunized or previously positive should self-isolate while awaiting the test results.

6.2 Individuals Who Are Asymptomatic

- Fully immunized or previously positive individuals who are asymptomatic with high-risk exposures are not required to self-isolate at home or in the community. These individuals should still be tested in accordance with the Provincial Testing Guidance but do not need to self-isolate while awaiting test results.

    - **Household members** of these individuals do not need to self-isolate.
- Self-isolation may still be required of the contact at the discretion of the local public health unit. For example, in the event that the local public health unit has information about the VOC testing results of the index case that the fully vaccinated or previously positive individual was exposed to (e.g., known or suspected VOC with known vaccine/immune escape), self-isolation may still be required of the contact.
    - If the contact is advised to self-isolate, household members of the asymptomatic and exposed individual who are not fully immunized should also be advised to stay at home except for essential reasons (e.g., attending school/work/buying groceries/picking up prescriptions).

6.3 Residents of Long-term Care/Retirement Homes, Inpatients and other Individuals with Increased Risk of Secondary Transmission

- Due to the uncertainty of level of protection from vaccine-induced or natural immunity in residents and admitted patients, and the increased risk of transmission to vulnerable residents/patients in these settings, self-isolation is still recommended. However, local public health decision-making may be applied in determining whether a resident or patient would be considered at high risk of exposure based on their vaccination status and nature of their exposure to the case.
- Fully immunized and previously positive residents in long-term care and retirement homes and admitted patients with high-risk exposures to a case should continue to be self-isolated and tested, even if they remain asymptomatic.
- In other situations where there is an increased risk to others should the fully immunized or previously positive individual with high-risk exposure become a case (e.g., living in remote communities, living with individuals at increased risk for severe disease, living in congregate settings), self-isolation may also be recommended/required for the contact.

6.4 Table 1. At a Glance: C&CM for Fully Immunized or Previously Positive Individuals without Immune Compromise

Symptomatic individuals

Population	Initial Contact Recommendations	Public Health Unit Follow-Up Responsibilities
Individuals who are fully immunized or previously positive.	Self-isolate and get tested as soon as possible.	If the test is negative these individuals are not required to continue self-isolation provided their symptoms are improving and afebrile for at least 24 hours. If they are experiencing GI symptoms, symptoms need to be resolving for at least 48 hours. If they decline testing they should isolate for 10 days.

Individuals who test positive for SARS-CoV-2

Population	Initial Contact Recommendations	Public Health Unit Follow-Up Responsibilities
Fully immunized individuals	Self-isolate	**Asymptomatic** individuals should be re-tested as soon as possible and managed in accordance with Section 4.6 of the Management of Cases and Contacts of COVID-19 in Ontario guidance as a "low pre-test probability" positive. **Symptomatic** individuals should be managed in accordance with the standard Management of Cases and Contacts of COVID-19
Previously positive individuals	Self-isolate	These individuals should be managed in accordance with Section 4.10 of the Management of Cases and Contacts of COVID-19 in Ontario

Asmptomatic with a High-Risk Exposure to a case of SARS-CoV-2

Population	Initial Contact Recommendations	Public Health Unit Follow-Up Responsibilities
Fully immunized or previously positive **Residents of high risk congregate living settings/ Inpatients**	Self-isolate and get tested as soon as possible	These individuals should be managed in accordance with standard Management of Cases and Contacts of COVID-19 in Ontario guidance.
Fully immunized or previously positive **Healthcare Workers**	Not required to self-isolate in the community.* Get tested as soon as possible. Maintain masking and physical distancing outside of the home and self-monitor for symptoms for 10 days from last exposure.	These individuals are encouraged to report their exposure to their employer and/or workplace Occupational Health Department and follow any work restriction requirements. These individuals must self-isolate immediately and get tested if they develop symptoms of COVID-19.
All other fully immunized or previously positive individuals	Not required to self-isolate in the community.* Get tested as soon as possible. Maintain masking and physical distancing outside of the home and self-monitor for symptoms for 10 days from last exposure.	These individuals are encouraged to report their exposure to their employer and/or workplace Occupational Health Department and follow any work restriction requirements. These individuals may continue to attend school/child care/camp. These individuals must self-isolate immediately and get tested if they develop symptoms of COVID-19.

* Contacts who are not required to self-isolate must be managed by the health unit, and cannot be referred to the Contact Tracing Initiative in PHO.

7 Fully Immunized and Previously Positive Individuals who are Part of an Outbreak of SARS-CoV-2

7.1 Testing

- In an outbreak setting, asymptomatic point prevalence testing can exclude fully immunized/previously positive individuals including healthcare workers, non-healthcare workers, essential caregivers, residents of long-term care homes or retirement homes, and patients admitted to hospital. These individuals should be included in point prevalence testing if:
    - A high risk exposure is determined or cannot be ruled out
    - Ongoing/uncontrolled transmission is is occuring
    - There is an indication that the outbreak strain has vaccine/immune escape (e.g., symptomatic cases are occurring among fully vaccinated individuals)
    - The outbreak is occurring in a particularly vulnerable population (e.g., transplant unit, dialysis unit)
    - It is operationally not feasible to distinguish fully immunized or previously positive individuals in a timely way to be excluded from point prevalence testing
- Repeat testing as soon as possible of asymptomatic fully immunized or previously positive individuals with a positive result from point prevalence testing is recommended to inform next steps in the case/contact/outbreak management.
- A more aggressive approach to contain the outbreak might be warranted if symptomatic cases are identified among fully immunized individuals. This can include quarantining of fully immunized individuals with high risk exposures in addition to the testing requirements as described above.

7.2 Cohort dismissals

- In settings with cohort-based dismissals of potentially exposed individuals (e.g., schools/childcare, camps, some workplaces), cohorts should continue to be dismissed to facilitate timely exclusion of potentially exposed individuals from the setting.

- Return of partial cohorts is permitted at the discretion of the PHU based on assessment of the individual level vaccination status, prior positive status of dismissed cohort members, and risk assessment of outbreak including risk of breakthrough infections. Fully immunized and previously positive individuals may be permitted to return to the setting if the outbreak is still ongoing while maintaining all infection prevention and control measures as required for outbreak management.
- Unless otherwise advised by the PHU, household members of dismissed cohorts are not expected to stay at home during the period of the dismissal.

Management of Cases and Contacts of COVID-19 in Ontario

August 11, 2021 (version 13.0)

Ontario

Version 13.0 – Significant Updates

Page #	Description
Throughout	The 'Case, Contact and Outbreak Management for Fully Immunized and Previously Positive Individuals' has been linked to and explained throughout.
7	Updated PHU responsibilities
13	Fully immunized individuals may be excluded from asymptomatic surveillance testing.
17	Updated case & contact management indicators (fully immunized contacts not required to self isolate but still require notification).
20	New section on notification of individuals identified through Backward Contact Tracing
22	Vaccination status may be factored in the assessment of 'low pre-test probability' and re-testing may be recommended.
24	Updated section: self-isolation of previous positives with new high-risk exposures.
28	Updated section: Testing and Self-Isolation of Asymptomatic High-Risk Contacts (release after 10 days of self-isolation instead of previous 14 days)
29	Follow up for high risk contacts is now day 5 and 10 of self-isolation
28	Section 5.2 update: In some situations, the period of self-isolation can be extended up to 20 days (10 days contact isolation period + 10 days case isolation) OR until a negative test result is obtained.
35	Updated table 4 and modified footnote 4 on PPE and eye protection.
47	Updated section: Travellers from Outside of Canada
50	New section: Contact tracing for train/bus/cruise ship passengers.

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Version 13.0 – August 11, 2021

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

This document provides information for public health management of cases and contacts in Ontario. The MOH has developed this document with contributions from Public Health Ontario (PHO) based on currently available scientific evidence and expert opinion. This document is subject to change as the situation with COVID-19 continues to evolve and as new tools/strategies to support public health management of cases and contacts are developed. 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*. It is expected that all parties supporting case and contact management in Ontario will follow this guidance.

This document replaces 'Public Health Management of Cases and Contacts of COVID-19 in Ontario V 12.0' (May 6, 2021).

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

As part of the ongoing assessment and adjustment of public health measures in the province, and the spread of Variants of Concern (VOC)s, it is critical that chains of transmission are broken early and effectively through strong and timely case and contact management activities. The MOH has also released guidance on a COVID-19 surge support model to help augment PHU capacity during a period of sustained high case counts, VOC spread, and COVID-19 vaccination rollout All efforts should be made to conduct full case and contact management programs, including through the use of provincial resources to augment local capacity. Issues with PHU capacity to complete all recommended case and contact activities in this guidance should be discussed with the Ministry of Health for assistance and/or prioritization.

1 Case and Contact Management Responsibilities

Ministry of Health (MOH):

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

All Public Health Units (PHUs):

- Review the case and contact management guidance in this document.
- Review the surge support model guidance; engage additional workforce resources and implement modifications as needed.
- Follow requirements of the *Health Protection and Promotion Act*, as well as related regulations.
- Conduct COVID-19 case management for confirmed cases (and probable cases where feasible) as described in this document including: initial contact with cases, monitoring of cases until cleared from self-isolation, and updating case status as required.

    - For hospitalized cases, the PHU is responsible for the initial interview but ongoing monitoring is the responsibility of the hospital while the patient remains in hospital.
    - For international travellers arriving in Ontario, the PHU is responsible for case management as described in this document, including cases that test positive within the 14-day Federal Quarantine period. Public Health Agency of Canada does not conduct case management.
- Should the public health unit become aware of a traveller not in compliance with the federal Quarantine period, they may contact their local police of jurisdiction with any concerns. The public health unit may also contact the Compliance and Enforcement office at PHAC at phac.isolation-isolement.aspc@canada.ca.
- Conduct COVID-19 contact management as described in this document, including:
    - ensuring that all contacts with high-risk exposures are notified once identified
    - ensuring that there is appropriate follow-up and management for all contacts that are followed by the PHU with high-risk exposures by:
        - Communicating with high-risk contacts over the course of their self-isolation
        - Verifying that high-risk contacts are compliant with self-isolation, and
        - Communicating MOH testing guidance to all high-risk contacts
    - ensuring that all contacts with low-risk exposures are followed up as appropriate as per Table 6
- Track and report on own performance management indicators for case and contact management as described by the MOH.
- Facilitate notification of testing recommendation to individuals identified through backwards contact tracing (PHU or case-led notification).
- Ensure timely and complete data entry and reporting of case, contact and outbreak information.
- Identify to the MOH any capacity gaps (real or anticipated) and other challenges to meeting program standards via the Ministry Emergency Operations Centre (MEOC) (eocoperations.moh@ontario.ca).

Public Health Ontario (PHO):

- Participate in the MEOC's response activities.

- Provide scientific and technical advice to stakeholders in areas such as laboratory testing, case and contact management, data entry requirements for reporting of cases, contacts and outbreaks, outbreak management recommendations, and advice on clinical management and infection prevention and control (IPAC) and occupational health and safety (OHS) measures.
- Provide instruction on data entry of cases, contacts and outbreaks, including but not limited to: updating and maintaining relevant data entry guidance documents and enhanced surveillance directives.
- Conduct and disseminate provincial epidemiological surveillance and analytic reports.
- Provide laboratory testing for COVID-19 and monitor the molecular evolution and epidemiology of the virus along with other laboratories in Ontario. Support interpretation of laboratory results, as needed.
- Support PHUs as needed with high-risk exposure, community contact follow-up through the case and contact management system (CCM).

Acute Care Settings:

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

Other Sectors:

- Other sectors also play a role in case and contact management including employers, congregate settings, primary care, assessment centres and education partners.

- Details around the role of these sectors can be found in existing guidance on the Ministry of Health website (outbreak guidance, sector-specific guidance, etc.).

2 Testing

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

Table 1: Testing Reference Documents

Document/Resource	Location	Notes
Case Definition	MOH Guidance for Health Sector - link	The case definition is for surveillance purposes only.
Provincial Testing Guidance	MOH Guidance for the Health Sector - link	This document outlines provincial testing guidance including considerations for specific settings/groups.
Quick Reference PH Guidance on Testing and Clearance	MOH Guidance for the Health Sector - link	This document can help guide decision making on clearing/testing contacts of cases or individuals suspected or confirmed to have COVID-19
Considerations for Antigen Point-of-Care Testing	MOH Guidance for the Health Sector - link	This document provides guidance for individuals or organizations conducting rapid antigen testing in Ontario.
COVID-19 Reference Document for Symptoms	MOH Guidance for the Health Sector - link	This document outlines symptoms associated with COVID-19
PHO COVID-19 PCR Test Information Sheet	PHO Website - link	This document outlines PCR-based test information and specimen collection guidelines for COVID-19
PHO COVID-19 Serology Test Information Sheet	PHO Website – link	These documents outlines serology based test information and specimen collection guidelines for COVID-19
PHO COVID-19 Variant of Concern Surveillance Test Information Sheet	PHO Website – link	These documents outline variant of concern surveillance testing guidelines for COVID-19

Document/Resource	Location	Notes
Appendix 8: Cases with Positive Serology Results and Management of Cases of MIS-C	MOH Guidance for the Health Sector - link	This document provides guidance on both serology testing and MIS-C in children.
Appendix 9: Management of Individuals with Point-of-Care Results	MOH Guidance for the Health Sector - link	This document provides guidance on how to manage individuals with results obtained from point-of-care testing technologies
Guidance for Employers Managing Workers with Symptoms within 48 Hours of COVID-19 Immunization	MOH COVID-19 Vaccine-Relevant Information - link	This document provides guidance for employers, including health care settings and long-term care homes, on planning for and supporting workers who have recently received a COVID-19 vaccine.

Individuals who are tested and have a valid Ontario health card are able to access their results online through the Ministry of Health online lab results viewer. Once the individual learns of their testing result, the portal also informs the individual about next steps.

2.1 Management of individuals awaiting testing results

Preliminary positive results

- "Preliminary positive" results from a molecular point-of-care (POC) assay should be considered sufficient laboratory evidence to initiate case and contact management as appropriate as a probable case, while awaiting confirmatory parallel testing.
- Assays that have been approved to provide final results will report results as "positive" if positive.
- For interpretation of POC testing results, see the Provincial Testing Guidance, and Appendix 9: Management of Individuals with Point-of-Care Results.

Symptomatic individuals

- All fully immunized individuals (**≥14 days** after a complete vaccine series) and previously positive individuals (cleared and within 90 days of their positive specimen result) who have symptoms of COVID-19 should be managed as indicated below (self-isolate and be tested for SARS-CoV-2 as soon as possible).

- PHUs may initiate public health case and contact management of symptomatic individuals with high-risk exposures who are awaiting test results, depending on the context of the symptoms, exposures, and exposure settings.
- For surveillance purposes, symptomatic individuals awaiting test results are not considered probable cases and will not need to be entered into CCM. Test results should be obtained before determining case classification.
- Symptomatic individuals should self-isolate while their test results are pending.
- Household members and other close contacts of a symptomatic individual should follow self-isolation guidance on the Ontario COVID-19 Self-Assessment site, the COVID-19 School Screening Tool, or the Workplace Screening tool, as applicable while the symptomatic individual is waiting for their test result. However, local PHUs may provide additional guidance within their region and based on the specific circumstances of the contact regarding self-isolation of household members, based on the local epidemiology and risk.
- All household members of symptomatic individuals are required to self-isolate until the symptomatic individual receives a negative COVID-19 test result or is provided an alternative diagnosis by a healthcare professional. If the household member is asymptomatic and fully immunized or previously positive within 90 days, they are not required to self-isolate.
- If the symptomatic individual does not seek COVID-19 testing, all household members advised to self-isolate by the PHU should self-isolate for 10 days from last exposure to that symptomatic individual.
    - Household members do NOT include those living in separate units in congregate living settings (for example: those who live in a separate unit within the same retirement home, or a separate self-contained basement suite in a house). PHUs should apply the specific congregate living advice guidance to individuals in self-isolation in those settings.
- Local PHUs may provide additional guidance regarding self-isolation of household members of a symptomatic individual, based on the local epidemiology and risk, and vaccination/previous positive status.

Asymptomatic individuals

- Fully Immunized or Previously Positive individuals are not required to self-isolate while awaiting test results, unless otherwise instructed by local public health. See the COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance for information.
- For surveillance purposes, asymptomatic individuals awaiting test results are **not** considered probable cases and should not be entered into CCM. Test results should be obtained before determining case classification.
- Asymptomatic individuals with high-risk exposure to a confirmed or probable case who are not fully immunized nor previously positive, should self-isolate while test results are pending and complete their full 10-day self-isolation in the event of negative test result(s). A positive result would require self-isolation until cleared.
- Asymptomatic individuals participating in approved screening/surveillance testing (as per the Provincial Testing Guidance) and who did not have a high-risk exposure do not need to self-isolate while their screening results are pending, but must self-isolate and obtain confirmatory testing immediately in the event of a positive screening test. Fully immunized individuals and previously positive individuals may be excluded from asymptomatic surveillance testing.
    - Household members of asymptomatic individuals participating in screening/surveillance testing who do not have a high-risk exposure do not need to self-isolate while the asymptomatic individual is awaiting screening testing results.

2.2 Management of Potential False Positive/False Negative/Indeterminate Results

If there is concern about the accuracy of a test result (e.g., false negative, false positive), recollect a specimen from the individual for REPEAT TESTING as soon as possible. If repeat testing is not possible, use the original test result as part of the overall public health decision-making.

False Positives: A positive test should prompt the appropriate public health actions, even if being investigated as a potential false positive. If the test is thought to be a false positive due to concerns about the test validity or low pre-test probability (including history of vaccination), recollect a specimen for **repeat testing**. Additional

information about the test (e.g., cycle threshold (Ct) value) is **not required** for public health decision-making.

Where true laboratory issues have been identified with previously issued positive results leading to an amended test result, follow PHO guidance on updating case status. See section 4 on Case Management for further detailed guidance on the management of asymptomatic positive results with low pre-test probability.

False positive results may occur when molecular point of care tests (POCT) are used in a low pre-test probability scenarios. For example, a symptomatic individual with a positive molecular POCT would generally be considered a confirmed case. However, if there was no prior high risk exposure and where incidence of COVID-19 is low, it may be recommended to seek immediate confirmatory testing following a molecular POCT positive result, as symptoms might be due to other causes (e.g., a circulating respiratory virus other than SARS-CoV-2).

False Negatives: A false negative test may occur in an infected individual tested too early in their incubation period, or in an infected individual at any time due to the sensitivity of the test. Actions should not be made solely on the basis of a negative test result. False reassurance from a negative test is a concern. **Where the clinical index of suspicion is high (e.g., based on clinical presentation and/or epidemiological context), a negative test does not rule out disease.** For individuals with worsening/progressing symptoms, consider **repeat testing**. Consideration should also be given to obtaining a lower respiratory sample (e.g., sputum or bronchoalveolar lavage in hospitalized patients). Individuals with a high-risk exposure to a case (e.g., exposure to a known case and/or outbreak) and test negative in their incubation period should continue with their full 10-day self-isolation or self-monitoring period.

Investigations of Potential False Positive/False Negative Results: Where there is concern of a false positive or false negative result based on an unexpected test result relative to the clinical and epidemiological information of the case, it is advised to **recollect a specimen for repeat testing as soon as possible**.

- Individuals should be managed using their initial specimen result until further information is available. If no additional testing information becomes available, the initial specimen result should be used for the overall public health assessment of the case.

- The repeat test on a subsequently collected specimen is not considered more accurate than the initial test; however, the combination of the two results provides additional context for interpreting the initial result.
- A second test on a recollected specimen that yields the same result as the first specimen is reassuring of the validity of the first result.
- A discordant second test needs to be interpreted in the context of clinical and epidemiological information to guide public health decision-making. Although this may represent a false positive initial test, it is known that testing of repeat specimen collections are often negative when an initial test is a true positive. This occurs when there is a low viral load in the initial specimen, which is close to the limit of detection of an assay, and will often not be reproducibly detectable from the repeat specimen.
- Repeat specimens should be collected as soon as possible after the first result to best inform public health management of the individual.
    - The shorter the interval between the first and second test, the quicker management decisions can be made for the case.
- There is no specific timeframe of when the repeat specimen should be collected; however, there is a diminishing return on the value of a repeat specimen collected several days after the initial specimen (the longer the interval between the initial and repeat test, the more likely the test will go from positive to negative).
- Interpretation of the repeat specimen should be within the overall context of the case, the implications for public health management, and the re-testing interval.
- In situations where a false positive laboratory result cannot be confirmed based on the laboratory investigation, but there is clinical and epidemiological evidence that the individual is unlikely to be currently infectious (e.g., high Ct value, asymptomatic, no known exposures, and immediately re-tests negative), public health case and contact management may be discontinued.

Further information on laboratory results and their interpretation is available on the PHO website. PHUs may consult PHO and/or the testing laboratory for further information on the results in question to support the investigation of discordant results where there is concern of a potential false positive; however, timely public health case/contact management decision-making should not rely on this process.

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

- For public health follow-up purposes, an indeterminate result in an individual with symptoms compatible with COVID-19 is sufficient laboratory criteria for a probable case, and associated case and contact management practices.
- For clinical and public health purposes, asymptomatic individuals with indeterminate results do not meet the probable case definition. **Repeat the test as soon as possible.**

Table 2: Managing Repeat Test Results for Asymptomatic Individuals with Initial Indeterminate Results

Repeat Test Result	Public Health Management
Positive	Manage as a confirmed case (unless fully immunized – these individuals can be managed as per section 4.6 "low pre-test probability positive") The most cautious approach to public health management is to extend the period of communicability for contact tracing to 48 hours prior to specimen collection of the indeterminate result and specimen collection of the positive result for determining clearance.
Indeterminate/Negative	Does not meet case definition
Not available	Does not meet case definition – the individual should be recommended to retest as soon as possible, but if no retest is obtained, public health management is at the discretion of the PHU based on likelihood of individual being an actual case

3 Case and Contact Management

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

Public health system capacity is an important criterion in decision making about other pandemic response activities (e.g., modification of public health measures to reduce cases and contacts). As outlined in the surge support model, resources are available to support PHUs with case and contact management, including a centralized workforce trained to conduct contact monitoring and the virtual assistant tool. PHUs who are or who anticipate they will experience capacity

challenges in meeting case and contact management indicators must contact the MEOC at (eocoperations.moh@ontario.ca).

3.1 Virtual Assistant

The Virtual Assistant (VA) is a case and contact management tool embedded in the CCM solution. The VA helps to support rapid notification of a positive result or an recent exposure to a COVID-19 positive case. It supports the distribution and collection of information regarding self-isolation, symptoms, and other details to support risk assessment. For cases, the VA can additionally be used to gather information on exposures and close contacts. Clients receive a text message with a link to the online tool. When they proceed, the VA offers a conversational flow, presenting cases and contacts with information and questions on COVID-19, self-isolation, symptoms and other important information. Responses are fed into CCM.

The VA can effectively support case investigators and contact tracers by reducing the CCM data entry requirements, supporting the initial case or contact phone call by priming the client in advance and providing automated support throughout the self-isolation period.

The VA can be used by PHUs at different stages of the investigation – at the beginning, to send rapid notification and collect information to support further prioritization and outreach; and during the case or contact's isolation period for ongoing monitoring of symptoms, provide reinforcement of isolation guidelines and additional support.

The VA should be used by PHUs wherever possible and should be integrated into existing workflows.

3.2 Case and Contact Management Indicators

The MOH is working with local PHUs to enhance the provincial case and contact management program and has set certain indicators to ensure a full understanding of capacity issues/challenges and performance/success. Indicators are subject to change as the program evolves and are applicable to cases detected by assays with direct feed into the Ontario Laboratories Information System.

Case Management Indicators:

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

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

Contact Management Indicators:

- Number of newly identified high-risk exposure **contacts** that are successfully reached within 24 & 48 hours
    - Note: initial contact within 24 & 48 hours with high-risk exposure contacts in large group settings (e.g., workplaces, schools) may be satisfied by mass notification through email/VA or other communication means, with individual follow-up phone call afterwards.
    - Contacts who do not require self-isolation (e.g., fully immunized or previously positive), still require notification of being a high-risk contact and are included in contact management indicators.

4 Case Management

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

Where there is a high index of suspicion that an individual may be a COVID-19 case with a possible false-negative test result, re-testing is advised, and initiation of case management may be appropriate based on the health unit's risk assessment (see Management of Potential False Positive/False Negative/Indeterminate Results for details).

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

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

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

Most PHU investigators conduct these interviews by telephone. However, for interviews conducted in person, the investigator should follow recommended IPAC measures when entering the case's environment (see Guidance for Health Care Workers and Health Sector Employers for further information on OHS and IPAC measures).

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

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

4.1 Initial Case Reporting

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

To meet this timeline, the PHU must enter the case into CCM within 24 hours. The initial contact to a confirmed case (by phone, or through VA) is to ensure the case is isolating and to gather information for entry into CCM. PHUs need to enter a minimum data set as dictated by the most recent Enhanced Surveillance Directive for each confirmed case (and probable cases where feasible). Virtual Assistant may be deployed as initial contact with a case, prior to the case investigator phone call, to prime the case for management; cases will be sent a text message to complete an online tool which provides information on COVID-19, self-isolation and includes a portal for contact identification, feeding into CCM.

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

4.2 Case Exposure Assessment/Backward Contact Tracing

PHUs must assess for the most relevant acquisition exposure(s) in the 14 days prior to symptom onset or 14 days prior to positive specimen collection date if never symptomatic (see Appendix 2 for a sample template). Ascertainment of exposures enables identification of locations/settings where transmission may be occurring, particularly if additional cases are associated with that location/setting and may also identify unrecognized chains of transmission and lead to more case finding through backward contact tracing. The most relevant acquisition exposures (after household members) for entry are settings where the case spent the most time outside of the house, and where acquisition is most likely to have occurred based on the "3 C's" (close contact where physical distancing cannot be maintained, crowded spaces, and closed environments with poor ventilation). The most likely exposure setting(s) of acquisition that should be included (where applicable):

- workplace with in-person attendance and co-worker/client interactions,
- school, child care centre, camp, before and after care, and/or post-secondary institution,
- congregate living setting (including long-term care, retirement home, shelter, group home, rooming house, hostel),
- social events, gatherings and/or places of worship, or
- other settings where the case may have had close, prolonged, unprotected contact where transmission may have occurred.

Case exposure assessment should be completed for travel history out of the province, and history of close contact with someone who travelled out of the province.

Data entry of exposures should follow data entry guidance by PHO. Virtual Assistant can be used to support rapid case exposure assessment.

Notification of individuals identified through Backward Contact Tracing

- For cases that do not have a known source of exposure (e.g., household member, part of an outbreak):

- PHUs should attempt to identify specific individuals/events that the case was exposed to in their most likely acquisition period (i.e., 2-7 days prior to their symptom onset/positive specimen collection, based on the median incubation period) where the exposure would meet criteria as "high risk of exposure" (see Table 4).
- This may include exposures such as (but not limited to) indoor social visits with friends/family, receipt of direct care/personal care services, close interactions with workplace colleagues.
- Mass settings (e.g., grocery stores, transit, public spaces) where specific individuals cannot be identified should not be included.
- These individuals are recommended to get tested as soon as possible (regardless of vaccination status) either by notification directly from the case or notification by the PHU (e.g. through a 1-way SMS message, or the use of the CCM email functionality, etc). The purpose of this testing is to identify possible source cases and/or other chains of transmission from a common source case.

These individuals do not require management as a contact to an infectious case and are not required to self-isolate.

4.3 Case Status Monitoring

Cases should be monitored for assessment of the illness, to ensure the ability to comply with self-isolation, and to determine when they can be cleared from self-isolation (see Appendix 3 and Appendix 4 for a sample template). At a minimum, cases must be called on the phone where feasible (or through VA) within 24 hours from when the PHU was notified of the case and should be contacted on day 5 and day 10 of the isolation period. In situations where a case is required to isolate for 20 days (as per the Quick Reference Public Health Guidance on Testing and Clearance), follow-up contact is required (e.g., day 5, day 10, day 15, and day 20) provided the case is discharged from hospital. All initial case contact must be done by phone call or VA, and methods of contact on the other days of self-isolation can include texts, emails, VA or phone calls. The determination of how to make contact on these days can be based on both PHU discretion/capacity and the preference of the case. **PHUs should provide support for case isolation**, including consideration of:

- Use of isolation facilities
- 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 through the High Priority Communities strategy

4.4 Case Contact Assessment

PHUs must conduct forward contact tracing activities (see Contact Management) to identify close contacts of probable or confirmed cases with high-risk exposures while the case was likely infectious (see Appendix 5 for a sample worksheet to conduct close contact tracing activities). In addition, PHUs should ask about any identifiable groups of low-risk contacts to inform consideration of targeted group communication as outlined in Table 6. PHUs should ask the case about any other prompts they have received to initiate the process of contact tracing (such as VA), any information received at an Assessment Centre, or from another care provider. PHUs must assess contacts based on exposure setting and risk of exposure based on the interaction with the case. Contacts identified by the case through the use of VA will be directly inserted into CCM for review by the case investigator. All contacts who are monitored by the VA are managed as high-risk.

4.5 Case Isolation Period

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

- For cases who are **symptomatic at/around the time of their positive result**, the start of their isolation period is based on their symptom onset date.
- For cases who are **asymptomatic at the time of their positive result**, the start date of their isolation period is their positive specimen collection date.
- For cases who are quarantining international travellers, the start date of their isolation period is based on their positive collection date.

4.6 Asymptomatic Cases

- Asymptomatic individuals with positive test results and tested as a **high-risk of exposure contact** or as part of an **outbreak investigation** are generally **Confirmed Cases**, and do not require repeat testing.
- Asymptomatic individuals with positive test results and tested as part of other groups described in the Provincial Testing Guidance should generally be managed as a **confirmed case**.
- **Immediate repeat testing may be required** if there is an **asymptomatic individual with an initial positive result with low pre-test probability** of being a currently infectious case. Low pre-test probability is based on the PHU's assessment of risk from community exposure AND confirmation that they are not part of an outbreak and had no known close contact with a probable or confirmed case. Vaccination status may also be factored in the assessment of 'low pre-test probability'.
    - Isolate the case, but do not initiate contact management (or outbreak management) while repeat test is pending.
    - If repeat specimen is **positive/indeterminate**, continue to manage as a confirmed case, and initiate contact management.
    - If no repeat specimen is available, continue to manage as a confirmed case, and initiate contact management.
    - If repeat specimen is **negative** and individual remains asymptomatic, there is sufficient evidence that the case is *not currently infectious and can discontinue case management.*
        - In most situations, PHUs should update the case classification to '**Does not meet**' case definition. See PHO data entry guidance on entry of asymptomatic low pre-test probability cases.
        - Due to the wide availability of testing, the likelihood of a 'remote positive' is lower now than in the first wave of the pandemic. However, if a case has a history of COVID-19 compatible symptoms and/or history of high-risk exposure but was not tested at the time or subsequently until now, the PHU may determine that the current positive result is a 'remote positive' (i.e., was likely to have previously been infected and is no longer infectious). There is no specific evidence required for the PHU to make this assessment other than clinical history. PHUs should enter as a confirmed case and flag as a 'remote positive'. See PHO data entry guidance on entry of remote positives.

- **"Detected (low level)" Results:** The Public Health Ontario Laboratory added this qualifier to positive PCR results where the cycle threshold (Ct) value is ≥35 but not in the 'indeterminate' range (as applicable). This result is still a POSITIVE result and should be interpreted in the clinical and epidemiological context of the case. Some other laboratories may also report 'low level positive' results.
    - For symptomatic individuals or asymptomatic contacts with a high-risk exposure to a case/outbreak, no further testing is recommended if they have a "detected (low level)" result, and they should be managed as a case.
    - For an asymptomatic individual testing for screening/surveillance purposes, repeat testing as soon as possible is recommended while the individual is managed as a case. If repeat testing is negative, case and contact management may be discontinued if the health unit determines the case is unlikely to be currently infectious. The case should be counselled that they should continue public health measures as if they were never infected, including participating in surveillance/screening testing.

4.7 Case Recovery and Post-Clearance

Guidance for management of cases is detailed in Appendix 7.

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

All recovered cases should resume usual public health measures to prevent exposure and the potential for re-infection.

4.8 Self-Isolation of previous positives with new high-risk exposures

- Individuals who are previously positive and cleared and within 90 days of their initial positive result should follow COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance.
- It is likely that the duration of natural immunity from infection is 180 days or longer based on current evidence. However, due to emergence of VOCs, a more cautious approach is recommended at this time for the management of previously positive individuals >90 days from first infection with a new high risk exposure or part of an outbreak.

- Previously positive cases that are not within 90 days of their initial positive result and are not fully immunized are recommended to self-isolate for 10 days after a **new** high-risk exposure to a case unrelated to the previous exposure.

4.9 Testing of previously cleared cases

- It is known that confirmed cases may continue to test positive with PCR, even after clearance from isolation and/or after receiving negative results, for several weeks to months after infection. Persistent detection >4 months from initial positive result has been reported in Ontario. See the MOH's Quick Reference Public Health Guidance on Clearance, which includes information on when test-based clearance for work is and is not appropriate.
- Re-testing after clearance should be based on clinical indications for testing (e.g., in the context of new symptoms compatible with COVID-19), OR as directed in the context of new high-risk exposures or outbreak investigations.
- Individuals who have previously been diagnosed with and cleared of COVID-19 infection may resume asymptomatic surveillance testing after 90 days from their COVID-19 infection (based on the date of their positive result), and where surveillance testing is indicated based on the Provincial Testing Guidance. If there is uncertainty about the validity of the initial COVID-19 infection (e.g., asymptomatic infection with high cycle threshold value result), may resume asymptomatic surveillance testing immediately.
    - Fully immunized individuals may be excluded from asymptomatic surveillance testing.
- Individuals who were previously a probable case or other situations where it is uncertain if the individual was a 'true' case **should continue to participate** in asymptomatic surveillance/screening testing (where applicable).
- Asymptomatic testing as a contact with high-risk exposure to a case or as part of an outbreak investigation may generate ongoing repeat positive results that may need to be investigated and/or repeated.

4.10 Management of Previously Cleared Cases with New Positive Results

- New positive results after clearance may represent:
    - Ongoing positive from initial infection ("Re-positive"); OR
    - Re-infection/suspected re-infection ("Reinfection")

- If specimens from the first and subsequent positive are available and of sufficient Ct value (generally <30), specimens may be sent to PHO Laboratory for sequencing, with approval.
- If there is uncertainty as to whether a new positive after clearance represents a re-positive or a re-infection, **repeat testing as soon as possible.** Manage the case (including contact management) as currently infectious if re-infection is suspected.
- In the event a previously positive individual is also fully immunized, manage the individual as fully immunized as per the COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance.

Re-positive

If there is evidence that the new positive result is likely to be ongoing persistent detection from the first infection, then no further public health case and contact management is required. Supporting evidence of a re-positive case includes: repeat testing is negative, both specimen(s) are close to limit of detection (e.g., cycle threshold >35 if tested at PHO laboratory).

Re-infection

- Confirmed reinfections should meet the Ontario Case Definition
- **Cases that do NOT meet the case definition for confirmed re-infection, but where re-infection is suspected should still be managed as a currently infectious.**
- PHUs can request additional information from the testing laboratory on specimens from individuals suspected of re-infection (e.g., cycle threshold values, gene targets detected) to further inform interpretation of the results.
- See PHO Data Entry Guidance for entry of new positive results in previously cleared individuals. Do NOT enter a new case entry for suspected reinfection that do not meet the case definition.
- PHO is available for consultation on re-infection cases (whether confirmed or suspected) via epir@oahpp.ca

5 Contact Management

See the COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance for information on contact management for fully immunized individuals and previously positive individuals.

The PHU should consult **Table 4** to determine the exposure risk level of each contact of a COVID-19 case and **Table 5** to determine the follow-up public health actions.

- A close contact is defined as **an individual with a high-risk exposure to a confirmed or probable case.**
- In the context of VOC emergence, **enhanced contact management is being adopted**. This means having a **lower threshold for classifying contacts as high risk of exposure** and requiring self-isolation, based on the risk assessment of exposure.

PHUs must follow the guidance below when making initial contact, as well as for subsequent follow-up with high-risk exposure contacts, and low-risk exposure contacts, as appropriate.

5.1 Initial Contact

The PHU provides an introduction and informs the contact of the complete confidentiality of the interview process. In addition, the PHU provides information on testing recommendations, self-isolation, subsequent follow ups, counseling of their household members and inform them of resources available to support self-isolation or self-monitoring activities. The PHU must enter contact details into CCM within 24 hours. All contact information generated through VA should be reviewed and verified for completeness. See table 5 for more details.

The PHU must recommend testing as per Section 5.2 and ensure access to testing for:

- all high-risk exposure contacts regardless of symptoms and vaccination status (see 'Testing of Asymptomatic High-Risk Contacts for timing of testing), and
- all symptomatic contacts with a low-risk exposure.

All high-risk exposure contacts (including fully immunized and previously positive individuals), and low-risk exposure contacts, where possible, must be informed of

how to contact the PHU if they develop symptoms or have other questions. The PHU must advise contacts to call 911 if they require emergency care and that they should inform the paramedic services or health care provider(s) that they are a contact of a COVID-19 case. Only the individual who had a high-risk exposure to a confirmed case should be tested; their contacts (i.e., contacts of the high-risk exposure contact) are not recommended to be tested if they remain asymptomatic.

5.2 Testing and Self-Isolation of Asymptomatic High-Risk Contacts

- See the COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance for information on contact management for fully immunized individuals and previously positive individuals.
- In the context of an outbreak, or if there has been ongoing exposure to a case over their period of communicability (e.g., household member), or if the contact had similar acquisition exposures as the case, high-risk exposure contacts are recommended to test immediately.
    - For contacts that test negative initially, (specimen collected on day 0 to day 6 of their self-isolation period), they are recommended to test again on or after day 7 of their 10-day self-isolation period. These individuals may end self-isolation after day 10 if they remain asymptomatic.
    - If the initial test was collected on or after day 7 of self-isolation, repeat testing is not required.
    - Repeat testing is recommended if the contact becomes symptomatic.
- If there has been a discrete exposure to a case (i.e., specific time(s) when the contact was exposed, such as during a visit), the contact should be advised to test on or after day 7 of self-isolation. Repeat testing is not required if the specimen was collected on or after day 7. However, repeat testing on or after day 7 of self-isolation is recommended clearance after day 10 if the initial specimen was collect on day 0-6 of self-isolation. Repeat testing is recommended if the contact becomes symptomatic.
    - These individuals may end self-isolation after day 10 if they remain asymptomatic.
- Close contacts with high risk exposures who are not fully immunized nor previously positive must be advised that they need to complete a full 10-day self-isolation period regardless of receiving a negative result, as they may still be incubating.

- In outbreak situations where uncontrolled transmission is ongoing or suspected, or at the discretion of the PHU when there is heightened concern for transmission from high-risk contacts, a more restrictive self-isolation period for contacts that are not fully immunized nor previously positive within 90 days may be applied. Specifically, if a negative test is not collected on/after day 7 of self-isolation, then the self-isolation period can be extended for an additional 10 days after completing the required 10-day quarantine, (i.e., 20 days from last exposure) to account for the maximum period that the contact may be infectious if they became a case on day 10. If a negative test is eventually obtained, release from self-isolation may occur earlier than day 20, but no earlier than day 10.
    - When PHUs decide to implement this contact management strategy, they should ensure the contact is advised of this requirement at the initial communication with the contact and have sufficient resources to follow-up with the contact.

5.3 Subsequent Follow-Up

The PHU may use the ***Close Contact Daily Clinical Update Form*** in Appendix 6 to monitor high risk contacts. The PHU must follow-up at least twice in the monitoring period (e.g., initial call, then day 5 and 10 after last known unprotected exposure) and where resources allow, PHUs can consider providing more frequent (e.g. every other day) communication to the asymptomatic high-risk exposure contact (e.g. via VA/email/text/phone). Follow up on day 5 and 10 for individuals who were not directed to self-isolate (i.e. fully vaccinated or previously positive) is not required but may be completed as capacity allows at the discretion of the PHU. The PHUs should determine the frequency of communication to the asymptomatic, high-risk exposure contact based on a risk assessment and available staffing resources. If PHU staffing resources are limited, see Modified CCM Surge Support Model for details on workforce supports available.

As part of the follow-up phone call and any additional contact assessments for high-risk exposure contacts the PHU must assess:

- Onset of symptoms since last assessment;
- Reported compliance with self-isolation;
- Needs in order to comply with self-isolation, referring supports as required to help to enable successful isolation.
- If testing was performed as recommended and result (verification if possible or verbal confirmation).

PHUs should provide support for contacts with self-isolation measures, including consideration of:

- Use of isolation facilities
- Use of community supports and agencies
- Psychosocial supports
- Accessibility to/awareness of testing facilities
- 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.

Should a contact develop symptoms, the PHU or contact tracer supports should actively monitor (daily) the contact while awaiting test results. High-risk exposure contacts that **develop symptoms should be managed as probable cases** and have contact tracing initiated prior to testing results being available. Further contact management may be discontinued if the probable case subsequently tests negative. Health units should follow PHO data entry guidance, and not enter these contacts as probable cases if test results are pending.

5.4 Household Members of High-Risk Exposure Contacts

PHUs should counsel all contacts with a high risk exposure to a case to tell their household members that are not fully immunized nor previously positive to **stay home** except for essential reasons for the duration of the contact's isolation period.

Essential reasons include: attending school/child care/work and essential errands such as, obtaining groceries, attending medical appointments or picking up prescriptions.

This messaging is recommended to alert the household members that they are at increased risk of exposure based on sharing a household with a self-isolating individual and reinforce adherence to strict public health prevention measures.

- Public health units are not expected to collect individual level information on the household members of the quarantining contact.
- Household members should not be entered as contacts.

- Public health units are not expected to provide individual level advice to the household members or assess their individual situation and ability to comply with their stay at home requirement.
- Household members include those living with, or having similar interactions with the contact (e.g., caregivers).
- Household members do NOT include those living in congregate living settings. Public health units should apply the specific congregate living advice guidance to individuals in self-isolation in those settings.
- Household members are NOT recommended to be tested for COVID-19 unless the high-risk of exposure contact tests positive or if the household members develops symptoms.

5.5 Period of Communicability for Contact Follow-Up

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

For cases who were **asymptomatic** at the time of positive specimen collection date, Table 3 below can be referenced.

Table 3: Contact Follow-up when Case is Asymptomatic at Time of Positive Specimen Collection

Symptom Onset	Contact Tracing Period	Notes
Case had no symptoms at/around time of testing and no known high-risk exposure in 14 days prior to positive specimen collection	Extends from 48 hours prior to positive specimen collection to date to when case began self isolating.	

Symptom Onset	Contact Tracing Period	Notes
Case had no symptoms at/around time of testing AND has a known high-risk exposure to a confirmed case in 14 days prior to positive specimen collection	Extends from 48 hours (minimum incubation period) after initial high-risk exposure to date when case began self isolating	Example: Case 1 is symptomatic January 1 and exposes Case 2 on January 2. Case 2 is asymptomatic with specimen collection date on Jan 7. Case 2's period of communicability should start from Jan 4 (48 hours after exposure to Case 1), instead of Jan 5 (48 hours prior to positive specimen collection). Only high-risk exposures to known confirmed cases should extend the period of communicability of the asymptomatic case.
Case's symptoms resolved prior to specimen collection date and case has a known high-risk exposure in 14 days prior to symptom onset	Extends from 48 hours prior to symptom onset to when case began self-isolating (or was cleared from isolation if never self-isolated).	For symptoms that occurred >4 weeks prior to specimen collection date, or where there is uncertainty about the relatedness of prior symptoms to the current positive test result, extending contact follow-up period to 48 hours prior to symptom onset date is at the discretion of the PHU.
Symptoms develop after positive specimen collection date	Extends from 48 hours prior to positive specimen collection date to when case began self-isolating (or was cleared from isolation if never self-isolated).	

5.6 Self-Isolation/Self-Monitoring for Contacts

While the isolation of asymptomatic contacts is technically termed "quarantine", the common use of "self-isolation" is used to refer to both symptomatic/infected and exposed individuals. Therefore, we have adopted the language of "self-isolation" for asymptomatic close contacts who are COVID-19 negative or not tested for ease of understanding, in addition to those who are symptomatic and/or infected.

The purpose of self-isolation is to prevent the risk of spread in the event a contact becomes infected prior to recognizing they are infectious. Due to varying degrees of

risk posed by different exposures, contacts can be categorized into two levels of risk exposure with corresponding requirements for self-isolation: high-risk, and low-risk contacts. **Only individuals with high-risk exposures are considered close contacts.**

- **Table 4** details contacts by their exposure setting and exposure type.
- **Table 5** details description of required PHU follow-up.

Details of the risk assessment approach to determining whether a contact had a high or low risk exposure to a case are available in the Focus On: Risk Assessment Approach for COVID-19 Contact Tracing. This background resource provides an overview of the factors related to the case, contact and nature of the exposure that must be integrated to determine the overall level of risk for the contact.

The period of self-isolation or self-monitoring for the contact of a case is 10 days following the last known unprotected exposure to an infectious case. High risk contacts that have been instructed to self-isolate by public health may end self-isolation after day 10.

In some situations (see section 5.2) the period of self-isolation can be extended up to 20 days (10 day quarantine as a contact + 10 days isolation as a potential case) OR until a negative test result is obtained.

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

- Cases should self-isolate as much as possible within the household, and the case should wear a mask (medical mask, if available) if tolerated when in the same room as others. Their close household contacts should also be encouraged to wear a mask when in the same room indoors, particularly when physical distancing from the case is not possible in the home, or when <2 m apart outdoors (e.g., on property).
- Vulnerable contacts in the household should consider options to reduce risk of exposure as much as possible (e.g., staying elsewhere).
- Where self-isolation is not possible within the household, consider alternate living arrangements for the case or contacts to reduce risk of transmission.
- Where alternate living arrangements are not available or practical, and self-isolation is reasonably maintained, last date of exposure to the case should be based on when the case started to self-isolate. Reasonable self-isolation includes consistent masking by the case and household members when in the same room, physical distancing as much as possible, frequent hand hygiene, and appropriate environmental cleaning (e.g., high touch surfaces)

- Household members **who are not fully immunized nor previously positive and cannot effectively self-isolate** from the case (e.g., due to care needs, interactions with/between young children) should continue to self-isolate for 10 days from last exposure to the case while the case was infectious. If **additional members of the household become cases**, duration of isolation for remaining asymptomatic household members would require a repeat assessment of exposure as above. If there has been significant ongoing exposure to the subsequent case, the asymptomatic household member may need to continue their self-isolation period based on their last exposure to the new case while that case was infectious or until effective self-isolation occurred (which ever is soonest).
- In **households with ongoing transmission**, and prolongation of self-isolation for asymptomatic household members, repeat testing among asymptomatic household members may be considered to ensure no undetected asymptomatic transmission and inform duration of self-isolation.

Table 4: Contact Management Based on Exposure Setting and Type

Exposure Setting	Exposure Type	Exposure Risk Level
Household (includes other congregate settings)	• Anyone living in the same household[1], while the case **was infectious.** o This may include members of an extended family, roommates, boarders, 'couch surfers' etc. o This may include people who provided care for the case (e.g., bathing, toileting, dressing, feeding etc.) o This may include congregate settings (e.g., dormitories, shelters, group homes, detention centres, child/daycare centres) where direct contact (<2 meters) is occurring in shared rooms/living spaces. (Follow Ministry of Health guidance for outbreak management in congregate living settings; if an outbreak is declared, outbreak measures should guide contact management). o This EXCLUDES individuals who live in a completely separate area/unit (e.g. self-contained basement apartment).	High risk exposure - self-isolate
Community/ Workplaces/ Schools	• Had direct contact with infectious body fluids of the case (e.g., coughed on or sneezed on) • Had other close[2], prolonged[3], and/or unprotected[4] contact. o E.g., contact with a case within 2 metres for more than a transient amount of time, particularly if case and/or contact was not masked. • See Table 5 for management of mass exposures where individual level contact follow-up is not feasible (e.g. bus/train exposures)	High risk exposure – self-isolate

Exposure Setting	Exposure Type	Exposure Risk Level
Community/ Workplaces/ Schools	• Contact had consistent and appropriate protected[4] contact for the duration of interaction and without other factors that would increase the overall risk of exposure (e.g., very prolonged duration of exposure, See Risk Assessment Approach for COVID-19 Contact Tracing for details) ○ Consistent mask use (surgical/procedure or non-medical) by both case and contact may be considered protected[4] contact	Low risk exposure – self-monitor
	• Only transient interactions (e.g., walking by the case or being briefly in the same room, grocery clerk passes bag and hands touch)	Notification not required
Healthcare (including all locations where health care is provided, e.g., community, acute care, long-term care)	**Patient is the case:** • HCW and/or support staff who provided direct care for the case, or who had other similar close physical contact (i.e., < 2 metres from patient for more than transient duration of time) **without** consistent and appropriate use of personal protective equipment[4] (PPE) • Other patients in the same semi-private/ward room • Other patients/visitors who had close[2], prolonged[3] contact with the patient case	High risk exposure – self-isolate
	HCW is the case: • All patients who had close[2] prolonged[3] contact to the HCW.[5] • All co-workers who had unprotected[4] close[2] and/or prolonged[3] contact with the HCW (e.g., within 2 metres in an enclosed common area)	High risk exposure – self-isolate

Exposure Setting	Exposure Type	Exposure Risk Level
Healthcare (including all locations where health care is provided, e.g., community, acute care, long-term care)	**Patient is the case:** • Healthcare worker and/or support staff who provided direct care for the case, or who had other similar close physical contact (i.e., < 2 metres from patient for more than transient duration of time) **with** consistent and appropriate use of PPE[4]	Low risk exposure- self-monitor
	HCW is the case: • All patients exposed to the HCW but where contact was neither close[2] nor prolonged[3], and the HCW appropriately wore a mask for source control for the entire duration[4],[5] (e.g., dropping a food tray in a room) • All co-workers with consistent and appropriate PPE use during close[2] or prolonged[3] contact with the HCW (e.g., within 2 metres in an enclosed common area)	Low risk exposure – self-monitor
	Patient or HCW is the case: • Only transient interactions (e.g., walking by the case, being briefly in the same room)	Notification not required
	• Laboratory worker processing COVID-19 specimens from case without appropriate PPE (including accidental exposures where appropriate PPE was breached).[4]	High risk exposure – self-isolate
	• Laboratory worker processing COVID-19 specimens from case **with** appropriate PPE.[4]	Low risk exposure – self-monitor

Exposure Setting	Exposure Type	Exposure Risk Level
Air Conveyance	• Passengers or crew seated within 2 meters of the case (approximately two seats in all directions, depending on type of aircraft/conveyance and seating).[6] • Other passengers/crew with close prolonged[3] contact or direct contact with infectious body fluids. • Consideration may be given to determining all passengers and crew of the flight at high-risk of exposure based on risk of contact in terminal, and during boarding/off-loading procedures.	High risk exposure – self-isolate
	• Crew members who do not meet criteria above.	Low risk exposure – self-monitor
	• Other passengers seated elsewhere in cabin/car as case who do not meet above criteria.	Low risk exposure – self-monitor
Travel to affected area	• Traveled outside of Canada in past 14 days and not exempt from Federal Quarantine.[7].	High risk exposure – self-isolate

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

[1] **Household Members:** Household members have the highest risk of transmission and should almost always be considered high risk of exposure. Individuals who live in a self-contained separate unit (e.g. basement suite) may be considered low risk exposure.

[2] **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.

[3] **Prolonged Contact:** 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 (see below – Footnote 4) or source control by the case was used. To aid contact follow-up prioritization, prolonged exposure duration may be defined as lasting cumulatively more than **15 minutes**; **however**, data are insufficient to precisely define the duration of time that constitutes a prolonged exposure, and exposures of <15 minutes may still be considered high risk exposures depending on the context of the contact/exposure. Transient exposures may in some circumstance be sufficient for transmission depending on the interaction, but are generally a low priority for contact follow-up.

[4] **PPE, Barriers and Source Control Use:**

Use of PPE, if worn consistently and appropriately for the nature of the interaction and for the entire duration of exposure, is generally considered a lower risk exposure for the contact. 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). See Focus On: Risk Assessment Approach for COVID-19 Contact Tracing and the Public Health Ontario Technical Brief on IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19 for more information.

Masks

Fit-tested N95 respirators, instead of medical masks, are required for PPE for aerosol-generating procedures. Non-medical masks are NOT considered PPE in health care settings (see Public Health Ontario Technical Brief).

Surgical/procedure masks or well-constructed, well-fitting non-medical masks may be considered sufficient as source control or PPE use in non-health care settings as part of the overall risk assessment, and depending on the nature of the exposure.

Eye Protection

- Transmission through the conjunctiva is possible, particularly when in close contact with an unmasked case.
    - Eye protection is part of PPE in health care settings when providing direct care for a known or suspected patient with COVID-19, therefore,

lack of eye protection is generally considered a high risk exposure in this specific scenario. However, lack of eye protection may not constitute a high risk exposure depending on the nature of contact with the patient and likelihood of direct droplet exposure.

- For all other interactions, lack of eye protection generally does not constitute a high risk exposure, if both case and contact are masked. However, depending on the nature of contact with the case and likelihood of direct droplet exposure (e.g., caregiver holding infected child, close prolonged contact with an unmasked case in an indoor environment), lack of eye protection may be considered a high risk exposure.

Gowns and Gloves

- While gowns and gloves are part of PPE in health care settings when caring for a known or suspected patient with COVID-19, lack of gowns/gloves generally do not constitute a high risk exposure.

Barriers

Other appropriate barriers, such as plexiglass barriers may also lower the risk if they provide sufficient and consistent coverage between the case and contact.

[5] **Patient/Resident Exposures from HCW cases:** universal medical masking by HCWs is expected to reduce the risk of exposure to their patients/residents if the HCW becomes a case. However, in circumstances of close, prolonged contact, source control by the case does not eliminate risk of exposure and follow-up of exposed patients/residents and co-workers as contacts with high risk of exposure is warranted. This is especially important to reduce the risk of ongoing nosocomial transmission when patients/residents remain within health care/congregate living settings.

[6] **Air Travel:** Medical or non-medical masks are required on all air travel and most other public conveyances. Due to increased transmissibility of emerging VOCs, use of masks in community settings are no longer included in the contact risk assessment.

[7] **Federal Quarantine:** Assessment is made by the Canadian Border Services Agency for quarantine exemptions for international travellers. PHU follow-up is not required for airplane/conveyance contacts already under federal quarantine, unless the traveller tests positive in which case the PHU would be responsible for routine case and contact management.

5.7 COVID Alert Exposure Notification App

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

In the event a PHU is contacted by an individual who has received an exposure notification alert, they should be directed to seek testing and if they are not fully immunized nor previously positive, self-isolate pending test results. If the individual tests positive, manage as a case.

If the individual receives a negative test result they should self-monitor for 10 days from when they received the notification and should seek re-testing if symptoms develop. If this same individual is later identified through traditional case and contact tracing, they must follow the advice of the public health authority which may include self-isolation and re-testing depending on the assessment of public health.

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

Table 5: Contact Self-Isolation and Self-Monitoring by Risk Level

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

See the COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance for information on contact management for fully immunized individuals and previously positive individuals.

Table 5A: High Risk Exposure

Actions for the Individual	Public Health Monitoring/Activities
Self-Isolate: • Do not attend school or work • Avoid close contact with others, including those within your home, as much as possible, and particularly those vulnerable to severe infection • Follow advice in self-isolation fact sheet • Have a supply of procedure/surgical or non-medical masks available should close contact with others be unavoidable • Postpone elective health care until the end of monitoring period • Use a private vehicle if need to attend a medical appointment. Where a personal private vehicle is not available, private hired vehicle (e.g., taxi) may be used while wearing a procedure/surgical mask and sitting in the rear passenger seat with the window open (weather permitting). Do not take public transportation. • Remain reachable for monitoring by local PHU • Discuss any travel plans with local PHU. The PHU can seek consultation with the MEOC for inter-provincial travel plans as required • If symptoms develop, ensure self-isolation immediately, and seek testing	Initial contact (e.g., by phone) is required to provide information on self-isolation and who to call if become symptomatic. Note: initial contact within 24 & 48 hours with high-risk exposure contacts. In large group settings (e.g., workplaces, schools) may be satisfied by mass notification through email/other communication means, with individual follow-up phone call afterwards. Follow-up at the middle and end of the self-isolation/self-monitoring period (e.g., days 5 and 10) is required. More frequent monitoring should be considered, as resources allow and where more frequent follow-up is warranted, and can be via VA/email/text/phone at discretion of PHU and based on preference of contact. Consider providing a thermometer or assessing other needs/supports to facilitate self-isolation and monitoring of symptoms Provide fact sheet on Self-isolation Ensure contact is advised of recommendation for asymptomatic testing within their self-isolation period (including re-testing on or after day 7 of self-isolation if initially tested on day 0-6 of self-isolation), with the potential for the self-isolation to be extended up to 20 days if a negative test is not obtained on/after day 7 at the discretion of the PHU. - PHU may follow up with contacts to verify testing result as capacity allows.

Actions for the Individual	Public Health Monitoring/Activities
	- PHUs have the discretion to enhance their contact management process at the direction of their Medical Officer of Health/capacity. Ensure contact is advised of recommendation for re-testing if contact reports symptoms, and manage as a probable case if testing is refused/cannot be performed Counsel contacts to tell their household members to stay home except for essential reasons (household members can attend child care/school/work, medical appointments, obtain groceries/medications), while the contact is quarantining. For high-risk exposures in settings where individual level follow-up is not feasible due to the inability to identify and directly communicate with potential contacts (e.g., exposures on public transit), PHUs may rely on/utilize other mechanisms for contact notification (e.g., the COVID Alert App, transparently post transit routes/times, public advisory).

Table 5B: Low Risk Exposure

Actions for the Individual	Public Health Monitoring/Activities
Follow guidance on core public health measures recommended for everyone at all times including: • Self-monitoring for symptoms of COVID-19, • Seeking assessment and testing if symptomatic, and • Self-isolating and seek testing if symptoms develop, as per provincial guidance.	Where individuals self-identify to the PHU with information that indicates a possible high-risk exposure, the PHU must conduct an individual-level risk assessment. Communications to low risk individuals/groups should include information about symptoms, self-monitoring, how to self-isolate if symptoms develop and how to contact the local PHU. This should include: • Information on Self-monitoring, • Emphasizing need to be able to self-isolate immediately and seek testing if symptoms develop. • Advising HCWs to inform their employer/institution of their exposure. Where identifiable individuals/groups with low-risk contact are known to the PHU, the PHU should consider providing targeted and timely communication to low risk contacts, with supports from MOH if needed, and proportionate to the risk of exposure. Options for contacting low-risk contacts may include: • working with schools/institutions to send a letter • working with employers to send a letter to co-workers/clients in the same area in the workplace; • working with community/ religious leaders to inform other attendees of community activities/services; • use of public service announcements • public lists of exposure locations • initial phone calls/text blasts/Robo calls Notification of contacts with a very low risk of exposure is generally not recommended (e.g., stores/service locations where the case only had brief interactions with other customers/staff).

Table 6: Managing Testing Results in Contacts Who Are Not Fully Immunized or Previously Positive

See the COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance for information on contact management for fully immunized individuals and previously positive individuals.

Exposure Type	Testing Result	Instructions for PHU
High-Risk	Positive	Manage as a confirmed case
	Negative	Continue managing as high-risk exposure contact, including advising continued self-isolation until 10 days from last exposure. Facilitate re-testing if initially tested on day 0-6 of self-isolation or if symptoms develop or worsen. These individuals may end self-isolation after 10 days.
	Never Tested (i.e., refused testing)	Manage as a high-risk exposure contact and ensure completion of required self-isolation period (at least 10 days and up to 20 days from last exposure at the PHU discretion). If symptomatic, manage as a probable case where feasible including case and contact management.

Exposure Type	Testing Result	Instructions for PHU
Low-Risk	Positive	Manage as a confirmed case.
	Negative	While asymptomatic contacts with low-risk exposures are not advised to test unless they become symptomatic (as per MOH testing guidance for the general public), if they happen to test negative in their incubation period, they should be advised by the testing facility to continue to follow guidance on core public health measures recommended for everyone at all times, including: • Self-monitoring for symptoms of COVID-19, • Self-isolating if symptoms develop; and • Seeking assessment and testing If the PHU happens to be aware of these individuals, they may reinforce messaging. Advise re-testing if symptoms develop, or worsen.
	Never Tested	Not applicable, as no individual follow up is required, and PHU unlikely to be aware of this situation. If the PHU happens to be aware of these individuals, they must reinforce that symptomatic individuals should be tested.

6 Travellers from Outside of Canada

On February 21, 2021, the Government of Canada put emergency measures in place that require a mandatory 14-day self-isolation (or quarantine period) and pre-entry, arrival, and mid-quarantine (day 8) tests for travellers from outside of Canada. Effective July 5, 2021, fully vaccinated travellers meeting specific requirements, are exempt from quarantine, and not required to stay at a government-authorized hotel or take the day 8 test.

See the Government of Canada's website for requirements for non-exempt travellers arriving by air. Effective August 9, 2021, the three-night government authorized hotel stay requirement will be eliminated for all travellers arriving by air.

Travellers arriving by land are not required to quarantine in a federal government approved accommodation (e.g. hotel) while waiting for the results of their arrival test. After taking the arrival test, these travellers may proceed to a suitable place of quarantine (e.g., their home). If travellers quarantine plans are unsuitable or they have symptoms, they will be relocated to a federal designated quarantine facility.

Ontario recommends that travellers who are not exempt from federal quarantine should tell their household members who are also not fully immunized to stay home except for essential reasons (household members can attend child care/school/work, medical appointments, obtain groceries/medications) while the return traveller is quarantining.

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. Some travellers entering Canada may also be approved for a limited release from quarantine restrictions for compassionate reasons.

Ontario strongly recommends that HCW's that are not fully immunized quarantine (self-isolate) for 10 days after international travel, whenever it is possible. If a HCW

that is not fully immunized is required to work within 10 days of returning from travel, they may do so with specific precautions. Refer to the How to Self-isolate while Working fact sheet . HCWs should contact their employer's department for occupational health and safety for specific advice.

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 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 should be managed as having a high risk exposure requiring isolation. They should be managed in consultation with the local PHU and local health care providers, including IPAC. Where possible, travellers should receive healthcare remotely through services including Telehealth Ontario and Seethedoctor.ca

Travellers who develop symptoms or are exposed to another person under Federal Quarantine Orders who develop signs and symptoms during the 14-day quarantine period are required to extend their quarantine period for an additional 14 days from symptom onset date. Travellers may leave self-isolation in order to be tested. In doing so, they should take appropriate precautions including wearing a well-fitting, well constructed non-medical mask and avoiding public transportation. If they test negative, they should continue to self-isolate since COVID-19 may develop later. If travellers test positive, they should seek advice from a health care provider regarding the next steps.

Asymptomatic travellers must follow testing requirements including arrival and mid quarantine (day 8) tests. Please note, the day 8 test is self-administered and does not require the traveller to leave quarantine (self-isolation).

If an asymptomatic traveller presents for testing at an assessment centre, the traveller should be tested.

NOTE: The Emergency Orders regarding travel are updated regularly. For the latest information regarding self-isolation requirements, see the Government of Canada website.

Table 7: Assessment and Management of Asymptomatic Travellers

Travel outside of Canada in the past 14 days and not exempt from Federal Quarantine	Consider as 'High risk exposure'. Follow Table 6 – 'High risk exposure'.
Travel within Canada	Individuals who have travelled within Canada are not required to self-isolate, but should self-monitor for symptoms for 10 days from their return. If any individuals have COVID-19 exposure concerns and self-identify to their PHU as having travelled within Canada, the PHU should assess the individual's exposure history to determine whether they should be managed as a high or low risk exposure contact. as per Table 5.

6.1 Contact tracing for airplane passengers

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

PHUs should send a travel notification task **via CCM** to PHO if they identify a flight with a confirmed case who meets any of the following criteria for travel during their period of communicability: symptomatic before or during travel; symptomatic within 48 hours after the flight or; if asymptomatic, has tested positive within 48 hours of the flight. Information to include in the comment box include:

- Flight number, date of flight, city of departure and country of origin

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

exposures) will be required for appropriate contact follow up in the other jurisdiction.

PHO will provide reported flight exposure information to PHAC who will then post the details on the "Coronavirus disease (COVID-19): Locations where you may have been exposed to COVID-19" webpage. PHAC will also directly notify the air carrier of this exposure.

As per Table 4 (Footnote 7), PHU follow-up for international flights where travellers are under federal quarantine is not required, unless the traveller tests positive during their 14-day quarantine period.

Direct notification of travellers on domestic flights by the public health unit is generally not recommended due to the incomplete and untimely information from the flight manifest.

6.2 Contact tracing for train/bus/cruise ship passengers

PHAC will post travel notifications for individuals who travelled by train, bus or cruise ship during their period of communicability. PHUs should send a travel notification task **via CCM** to PHO, as described in Section 6.1, for individuals who travelled by these conveyances, if they meet the criteria in Section 6.1 for airline passengers.

7 Tools

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

- Appendix 1: Ontario's Severe Acute Respiratory Infection (SARI) Case Report Form – PHUs may use this form to help guide their case interview and collection of information from probable and confirmed cases or their proxies. PHUs must enter all cases and contacts in CCM.

- Appendix 2: Routine Activities Prompt Worksheet for Cases – PHUs may use this sample worksheet (or a similar tool) to identify potential exposures that may have led to disease acquisition in a case. Along with the SARI Case Report Form in Appendix 1, this worksheet can also be used to interview the case or their proxy to collect detailed information and to investigate potential exposures in the 14 days before onset of symptoms.
- Appendix 3: Daily Clinical Update Form for a Case Managed in an Acute Care Setting and Appendix 4: Daily Clinical Update Form for a Case Managed in a Household Setting – PHUs may use these sample forms (or a similar tool) to monitor the health status of a probable or confirmed case until they are cleared.
- Appendix 5: Close Contact Tracing Worksheet – PHUs may use this sample worksheet (or a similar tool) to identify close contacts of a probable or confirmed case.
- Appendix 6: Daily Contact Clinical Update Form – PHUs may use this sample form (or a similar tool) to follow-up and monitor contacts with high-risk exposures.
- Appendix 7: Self-Isolation for COVID-19 Cases or Other Individuals in the Household - This guidance can be used to support individuals undergoing testing (with symptoms or known contact to a confirmed or probable case), anyone being asked to self-isolate, and others in the household of a case.
- Appendix 8: Serology Testing and MIS-C - This can be used to provide guidance on cases with positive serology results as well as cases with multisystem inflammatory syndrome in children (MIS-C)
- Appendix 9: Management of Individuals with Point-of-Care Results - This document provides guidance on how to manage individuals with results obtained from point-of-care (rapid) testing technologies.
- Appendix 10: Surge Support Model – This document outlines supports available to PHUs for case and contact management and how/when to access them. It also provides a sample triage tool to assist with distributing cases/contacts across the operational response and provides several tables of modifications to case and contact management practice based on PHU caseload.

- Appendix 11: High Risk Contact Flow Chart – This diagram provides a public-facing overview of recommendations for high risk contacts and their household members based on vaccination status.

8 Additional Resources

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

9 Document History

Revision Date	Document Section	Description of Revisions
January 30 2020		Document was created.
February 5 2020	Contact Management – Public Health Advice	Language included to reflect policy change: self-isolation of 14 days for those returning from Hubei province and for close contacts of cases.
February 7, 2020	Throughout Document	Updates to reflect changes to case definition and self-isolation
February 12 2020	Case and Contact Management Travellers from Affected Areas	Updates to language around risk level and corresponding level of self isolation/ self monitoring Addition of Table 3
March 3 2020	Updates throughout document	Updates based on new case definition and evolving advice based on travel history of patient
March 25 2020	Updates throughout document	Change in Purpose section; guidance on testing, explanation on case definition, assessment and management of persons suspected of COVID-19, Information on pets
April 15 2020	Updates throughout document	Updates on case definition description, travellers from outside of Canada, link to other guidance (e.g. provincial testing), updates to streamline language throughout
June 23 2020	Updates throughout document	Major updates to most sections, addition of several reference tables, moved to 2 risk exposure levels: low and high risk, moved appendices to become separate documents.

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

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

Ontario

Ministry of Health

COVID-19 Guidance: School Case, Contact, and Outbreak Management

Updated August 11, 2021

Summary of key updates

- Asymptomatic contacts of confirmed or probable cases are not required to isolate if they are fully immunized, or if they were previously positive within the past 90 days and have since been cleared, unless otherwise specified by the health unit.
- Asymptomatic household members of symptomatic individuals are not required to isolate if they are fully immunized, or if they were previously positive within the past 90 days and have since been cleared.
- High-risk contacts of a case are to isolate for 10 days, unless they are fully immunized or if they were previously positive within the past 90 days and have since been cleared, unless otherwise specified by the health unit.
- If there is a known source of exposure, isolation period and testing dates should generally be counted from the day of last known exposure to the confirmed case. If the source of exposure is unknown, the isolation period should begin from the last exposure to the cohort.
- For asymptomatic high-risk contacts who are not fully immunized or previously positive within the past 90 days and have since been cleared, testing is to be recommended on or after day 7 of their isolation period. If a test is collected before day 7, a repeat test on or after day 7 is recommended.
- For high-risk contacts who are fully immunized or were previously positive within the past 90 days, testing is to be recommended as soon as possible upon notification of exposure.
- A range of options are outlined for more stringent approaches to case/contact and outbreak management depending on outbreak situations (e.g., if symptomatic cases are identified among fully immunized individuals).

Introduction

This guidance document provides information for local public health units (PHUs) investigating cases, outbreaks, and suspected outbreaks associated with elementary or secondary (K-12) school settings. It is intended to supplement existing public health guidance on the Management of Cases and Contacts of COVID-19 in Ontario and COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance. In the event of a discrepancy between this Guidance and a Directive of the Chief Medical Officer of Health, the Directive prevails. **PHUs may also implement additional measures that are not outlined in this guidance, based on local circumstances and/or PHU investigation and risk assessment.**

Please check the Ministry of Health (MOH)'s COVID-19 Guidance for the Health Sector website regularly for updates to this document, the case definition, reference document for symptoms, testing guidance, and other guidance documents and information. In addition, the COVID-19 Screening tool outlines screening questions and provides recommendations to support decision making by students/children, parents (on behalf of students/children), employees, and visitors about whether they or the student/child can attend school/child care.

This guidance applies to PHU investigations associated with all schools as that term is defined in the *Health Protection and Promotion Act* (HPPA), which includes private schools, and schools as defined in the *Education Act*. This guidance also supports PHU investigations associated with child care and before/after school programs.

Sector-specific guidance documents provide additional information and guidance for the operation of schools, child care, and before/after school programs, including:

- COVID-19: Health, safety and operational guidance for schools (2021-2022)
- Operational Guidance for Child Care During COVID-19 Outbreak
- Before and After School Programs Kindergarten – Grade 6: Policies and Guidelines for School Boards

Roles & Responsibilities

Role of Public Health Units (PHUs)

PREVENTION AND PREPAREDNESS

- Advise school administrators and school boards on COVID-19 prevention (including hierarchy of controls) and preparedness for managing COVID-19 cases, contacts, and outbreaks, in conjunction with any advice provided through the Ministry of Education (EDU) and Ministry of Health (MOH).
- Provide local school administrators and staff with public health resources.
    - Examples of resources include:
        - How to wash your hands (fact sheet)
        - How to Self-Isolate (fact sheet)
        - Self-isolation: Guide for caregivers, household members and close contacts (fact sheet)
        - How to put on and take off PPE (videos)
        - Putting on and taking off PPE (poster)
        - Non-medical Masks and Face Coverings (fact sheet)
        - Cleaning and Disinfection for Public Settings (fact sheet)
        - When and where to get tested for Covid-19
        - You were tested for COVID-19: What you should know
        - How to Protect Yourself from COVID-19 (fact sheet)
        - When to Self-isolate for Household Members (fact sheet)
        - Additional School and COVID-19 resources

CASE AND CONTACT MANAGEMENT

- Receive, investigate, and manage reports of cases and contacts of COVID-19, including decisions on case and contact management, in accordance with public health guidance on the Management of Cases and Contacts of COVID-19 in Ontario and COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance, the HPPA, and any other relevant MOH guidance.
- Consider notifying the school's principal or designate and the Director of Education or designate if a case of COVID-19 is identified in a staff, student, or

visitor associated with an elementary or secondary school setting.

- Have a dedicated communication process to allow for timely notification, such as a dedicated email address for school reporting.
- Provide recommendations on cohort dismissal and isolation[1] in response to a case.
    - The PHU may ask that school principals, or their designates, dismiss individuals or cohorts while awaiting the results of a public health investigation.
- Provide appropriate resources and supports to principals (e.g., decision guides, instructions for reporting potential or suspected onsite exposure to the PHU and/or when to seek urgent PHU direction).

OUTBREAK ASSESSMENT AND MANAGEMENT

- Investigate cases and clusters of cases associated with school locations (e.g., school transportation, in-person attendance or work at a physical school location, other facilities shared with schools), child care settings, and before/after school programs.
- Determine if an outbreak exists and declare an outbreak.
- Provide guidance and recommendations to the school on outbreak control measures, in conjunction with any advice provided by EDU, MOH, and PHO.
- Provide recommendations on isolation of cohorts and the potential need for full or partial school dismissal based on the scope of the outbreak.
- Make recommendations on who to test and frequency of testing as part of a case or outbreak investigation, in alignment with the province's broader testing strategy; facilitate a coordinated, equitable, and accessible approach to testing (e.g., on site, walkable, drop-in, approved take-home kits), with consideration for acceptability of specimen type for optimizing uptake, in collaboration with Ontario Health/local testing partners, including provision of an investigation or outbreak number.

[1] While the isolation of asymptomatic contacts is technically termed "quarantine," the common use of "isolation" or "self-isolation" is used to refer to both symptomatic/infected and exposed individuals. Therefore we have adopted the language of "isolation" for asymptomatic close contacts who are COVID-19 negative or not tested for ease of understanding, in addition to those who are symptomatic and/or infected.

- Conduct an on-site investigation as part of the outbreak investigation, where necessary, in accordance with the HPPA and in coordination with school administrators and school boards, and other relevant stakeholders (e.g., Ministry of Labour, Training and Skills Development - MLTSD).
- Issue orders by the medical officer of health in accordance with the HPPA, if necessary.
- Declare the outbreak over.

SURVEILLANCE

- Monitor and assess local epidemiology related to the burden of COVID-19 cases, transmission risks in the local community, and absenteeism in schools.
- Enter cases, outbreaks, and school exposures in the provincial surveillance system, in accordance with data entry guidance provided by Public Health Ontario (PHO). Confirmed cases associated with before/after care should be reported as a child care setting, not as a school setting.

COORDINATION AND COMMUNICATION

- In the event that a case or contact resides in a PHU that is different than that of the school, discussions between the impacted PHUs should take place to coordinate contact follow-up.
    - The PHU of the school is typically the lead PHU for school follow-up.
    - Request support from the Ministry of Health's Emergency Operations Centre (MEOC) if coordination between multiple PHUs is required for outbreak management.
- Notify the MEOC of:
    - Potential for significant media coverage or if media releases are planned by the PHU and/or school.
    - Any orders issued by the PHU's medical officer of health to the school, and share a copy.
- Engage and/or communicate with relevant partners, stakeholders, and ministries, as necessary.
- Assist school administrators and school boards with development of key messages and communication tools that can be provided to members of the school community in the event of a COVID-19 case, COVID-19 outbreak, or suspected COVID-19 outbreak. Coordinate public communications, including media, regarding school outbreaks with school administrators and school board

partners, and the MOH, as needed. Identifying a spokesperson in each organization should occur prior to an outbreak being publicly declared.

Role of Ministry of Health (MOH)

- Provide legislative and policy oversight to Boards of Health.
- Issue provincial guidance to PHUs on the management of COVID-19 cases, contacts, and outbreaks.
- Advise on regional and provincial school interventions.
- Provide ongoing support to PHUs with partner agencies, ministries, health care professionals, and the public, as necessary.
- Support PHUs during investigations, through the MEOC and/or Office of the Chief Medical Officer of Health (OCMOH), with respect to coordination, communications, etc., if requested and as appropriate.
- Support and coordinate teleconferences, as needed (e.g., if multiple PHUs are involved) via the MEOC.
- Receive notification through the MEOC:
    - If the PHU believes there is potential for significant media coverage or if media releases are planned by the PHU and/or school.
    - If orders are issued by the PHU's medical officer of health to the school.

Role of Ontario Health (OH)

- Coordinate local planning among health system partners for testing to ensure the availability of testing resources.
- Work with PHUs, schools/school boards and local testing partners (e.g., designated assessment centres / hospitals) to develop plans for timely, accessible, local testing options (e.g., on site, walkable, drop in, take home kit) for students, with consideration to the acceptability of specimen type, their families (as appropriate) and staff, to support uptake of testing when testing is recommended by the local PHU (e.g., as part of testing in response to a case or outbreak investigation).
- Identify and support addressing equity considerations related to testing, e.g., minimize barriers to accessing timely testing and results, and coordinate with testing initiatives for High Priority Communities.
- Coordinate the deployment of testing resources and modalities to meet the priority testing needs identified by the PHU.

- Collaborate with PHU, school boards, and schools to monitor testing demands and access.
- Work with testing centres and partners to optimize sample collection and distribution to reduce turnaround times.

Role of Public Health Ontario (PHO)

- Provide scientific and technical advice and support to PHUs for case and contact management, outbreak investigations (including IPAC measures), and data entry.
- Advise on and support laboratory testing, as needed.
- Provide scientific and technical support to MOH and PHUs, including during multi-jurisdictional teleconferences.
- Produce provincial epidemiological and surveillance reports related to COVID-19 in schools to support PHUs and provincial ministries, and evidence-informed resources and learning opportunities relevant to schools and school boards.

Role of Ministry of Education (EDU)

- Provide legislative and policy oversight to school boards.
- Communicate expectations and provincial guidance on COVID-19-related policies, measures, and practices for schools and school boards.
- Ensure that school boards are aware of their duties as employers under the *Occupational Health and Safety Act* (OHSA) and its regulations, including to report occupational illness to the MLTSD.
- Provide ongoing support and communication to school boards with partner agencies, ministries, and the public, as necessary.
- Support the procurement of supplies of personal protective equipment (PPE).

Role of school administrators and school boards

- Report a communicable disease to their local PHU, as per s.28 of the HPPA.
- Follow duties and processes under OHSA and its regulations.
- Implement prevention (e.g., infection prevention and control) measures found in guidance or as directed by the EDU, MOH, MLTSD, and the local PHU.
- Coordinate with the local PHU and other stakeholders as appropriate, as part of the investigation of cases, contacts, and outbreaks.
- Maintain accurate records of staff and student attendance, for all common school locations attended by staff and students (e.g., school transportation, in-

person attendance or work at a physical school location, before/after school programs located at a school, or other facilities shared with the school) for the last 30 days, as well as up to date contact information for staff and students. This information should be available to be accessed and shared with the local PHU in a timely manner (within 24 hours) for investigations and communications.
    - Facilitate access for PHUs to staff lists for staff not directly employed by the school board (e.g., transportation staff, before/after school program staff). Keep a log of all visitors (e.g., essential volunteers, contractors, parents/guardians, etc.) who enter the school, location(s) visited and dates/times of visit to facilitate contact follow-up if needed.
- Provide PHU with the name(s) and contact information of a designated point of contact for use during and after business hours, to ensure timely investigation and follow up cases, contacts, and outbreaks.
- In collaboration with the PHU, communicate proactively with the school community about COVID-19 prevention measures and about how symptomatic/ asymptomatic individuals, cases, and outbreaks will be handled.
    - Develop a communication plan, in collaboration with the local PHU, for managing concerns in the school setting, and use this proactively and responsively as needed in schools.
- Provide training to school staff with respect to outbreak prevention and control measures, including IPAC measures and the use of PPE.
- Make masks available to students, as needed.
- If requested by the PHU, school principals may dismiss individuals and/or cohorts while awaiting the results of the public health investigation.
- In general, schools should not report all instances of ill or symptomatic individuals in the school setting to the PHU, as these are frequent occurrences and typically students have non-specific symptoms.
    - In accordance with the reporting obligations under s.28 of the HPPA, school principals are required to report to the medical officer of health of the health unit in which the school is located if they are of the opinion that a pupil has or may have a communicable disease, which includes but is not limited to COVID-19 (e.g., mumps, chicken pox).
- Where there is sufficient concern that an individual may have COVID-19 (e.g., school is informed by a parent/guardian that a student has been diagnosed with

COVID-19, or informed by a staff member that they have been diagnosed with COVID-19), or there are concerns about multiple symptomatic/asymptomatic individuals in a cohort, the school should report this to the PHU, or follow pre-established protocols from the local PHU. Cases that occur in itinerant workers and occasional staff should be flagged to the PHU.

Role of Ministry of Labour, Training and Skills Development (MLTSD)

- Proactively inspects workplaces to monitor compliance with OHSA and its regulations.
- Investigates occupational illness notifications under s. 52(2) of the OHSA to determine if the employer is in compliance with the Act and that appropriate measures have been taken to prevent further illnesses.
- Investigates unsafe work practices, critical injuries, fatalities, work refusals, and occupational illness as related to worker health and safety. This may include investigation of reports of COVID-19 by employers to MLTSD.
- Issues orders under the OHSA.
- Operates the MLTSD Health and Safety Contact Centre (1-877-202-0008), available for anyone to report health and safety concerns, complaints or to provide notices of occupational illnesses.

While this document focuses in part on the role of the MLTSD's health and safety program, the ministry also administers the *Employment Standards Act*. If workplace parties request information regarding employment standards, they can be referred to the Employment Standards Information Centre: 1-800-531- 5551.

Management of symptomatic individuals in the school setting and their household contacts

- The information below is intended to complement the following guidance:
    - Management of Cases and Contacts of COVID-19 in Ontario
    - COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance
    - Quick Reference Guidance on Testing and Clearance

Management of a symptomatic individual who has NOT had a high-risk exposure and/or been identified as a high-risk contact

NOTE: PHUs do not need to be notified of every symptomatic student/staff; there are some instances where they may become aware of symptomatic individuals with pending results, such as through investigations of cases and clusters of illness.

- Staff and students with symptoms compatible with COVID-19 (as listed in the screening tool) should get tested and isolate while test results are pending or not available, unless there is a known alternative diagnosis provided by a health care provider.
    - Household contacts of the symptomatic individual (e.g., siblings, parents, roommates and other individuals who live with the symptomatic individual) who are not fully immunized[2] or previously positive[3] are to isolate, in accordance with Management of Cases and Contacts of COVID-19 in Ontario.
- Unless the symptomatic individual is being managed as a probable case or tests positive, dismissal and isolation of asymptomatic contacts in the school is not generally recommended.

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[2] For the purposes of case/contact/outbreak management, an individual is defined as fully immunized ≥14 days after receiving their second dose of a two-dose COVID-19 vaccine series or their first dose of a one-dose COVID-19 vaccine series that is listed for emergency use by the World Health Organization or approved by Health Canada. Individuals who are immunocompromised are excluded from this definition, in accordance with COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance.

[3] For the purposes of case/contact/outbreak management, an individual is defined as previously positive if they were a confirmed case of COVID-19 where their initial positive result was ≤ 90 days ago AND they have been cleared from their initial infection. Individuals who are immunocompromised are excluded from this definition, in accordance with COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance

- If the individual tests negative or has a known alternative diagnosis provided by a health care provider, and there is no known high-risk exposure and they were not advised by the PHU or health care provider to quarantine or isolate, the individual can return to school if afebrile and symptoms have improved for at least 24 hours.
    - If the individual is experiencing gastrointestinal (GI) (nausea/vomiting, diarrhea) symptoms, these symptoms should be resolved for at least 48 hours before the individual can return to school.
    - If symptoms compatible with COVID-19 are persisting/worsening, the symptomatic individual is to continue to stay home from school/work and seek medical attention. A repeat COVID-19 testing should be considered.
    - Medical notes or proof of negative tests should not be required for staff or students to return to school.
- If the symptomatic individual is not tested/does not seek testing and there is no known alternative diagnosis, the individual must isolate for 10 days from symptom onset, in accordance with Quick Reference Guidance on Testing and Clearance.
    - Household contacts of the symptomatic individual must isolate for 10 days from break in contact (i.e., last contact) from the symptomatic individual, unless fully immunized or previously positive. If there is no break in contact, this would start at the end of the symptomatic individual's isolation period.
- In general, all sick individuals with any symptoms of illness – including those with symptoms not included on the screening tool – should stay home from school and child care, as per usual school/child care policy, and seek assessment from their regular healthcare provider if required.

Management of a symptomatic individual who HAS had a high risk exposure and/or been identified as a high risk contact

- If isolating after a high-risk exposure (e.g., close contact of a known COVID-19 case or travel out of country) and does not have a known alternative diagnosis, the individual meets case definition for a probable case, until they test negative. Manage as per Management of Cases and Contacts of COVID-19 in Ontario and

the COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance.

- Household contacts of the symptomatic individual must isolate for 10 days from break in contact (i.e., last contact) from the symptomatic individual, unless fully immunized or previously positive. If there is no break in contact, this would start at the end of the symptomatic individual's isolation period.

- If the individual tests negative, they must complete their isolation period as a high risk contact of a known case, unless they are fully immunized or previously positive .
    - If fully immunized or previously positive, the individual can return to school if afebrile and symptoms have improved for at least 24 hours, and gastrointestinal (GI) (nausea/vomiting, diarrhea) symptoms resolved for at least 48 hours. If symptoms compatible with COVID-19 are persisting/worsening, the symptomatic individual is to continue to stay home from school/work and seek medical attention; consider repeat testing.

Management of Cases and Contacts of Cases

- The information below is intended to complement the following guidance:
    - Management of Cases and Contacts of COVID-19 in Ontario
    - COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance
    - Quick Reference Guidance on Testing and Clearance
- Please see Appendix A for a flow chart on the isolation and testing of high-risk contacts, adapted from Appendix 11 of Management of Cases and Contacts of COVID-19 in Ontario
- Please see Appendix B for a flow chart on the isolation and testing of household members of high-risk contacts, adapted from Appendix 11 of Management of Cases and Contacts of COVID-19 in Ontario

Case management

- Cases should be tested and isolated as per Management of Cases and Contacts of COVID-19 in Ontario.

Case acquisition assessment

- Ensure relevant acquisition exposures in the 14 days prior to symptom onset (or 14 days prior to positive specimen collection date if never symptomatic) are captured for cases, in accordance with the COVID-19 CCM Case Investigation Data Entry Guide, including:
    - Household
    - Family
    - School (classroom cohort, recess cohort, etc.)
    - School transportation
    - Before/after school programs
    - School extra-curricular activities
    - Staff break rooms/staff meetings
    - Staff/student social interactions during breaks/carpooling
    - Child care settings
    - Other potential acquisition exposures outside of school (in the community), including non-school extracurricular activities, work, and recreational activities
- It is important to determine if the student or staff member likely acquired their infection outside of the school. For example, if a student or staff has known exposure to a case in the household or in their community.
- If acquisition for a case was known to have occurred outside the school and the student or staff did not attend while communicable, no isolation or testing should be required for the cohort. Any additional high-risk contacts of the case (outside of school) should be identified and advised to isolate according to provincial guidance. For additional considerations, see Risk Assessment Approach for COVID-19 Contact Tracing. There may also be situations when the PHU recommends more expansive testing.

Assessment of high-risk contacts in schools

- Work closely with the school to determine with whom a case was in contact in the school environment during their period of communicability. Consider Management of Cases and Contacts of COVID-19 in Ontario in determining the case's period of communicability for contact follow up, including direction on the

start and end of the contact tracing period when a case is asymptomatic at/around the time of testing.

- Students in the case's classroom cohort(s) and before/after school cohort(s) are to be considered high-risk contacts of the case, regardless of where they were seated/positioned in relation to the case, to facilitate timely contact management. PHUs may ask principals to initiate timely dismissals of these cohorts.
- Consider whether other cohorts (or partial cohorts, or specific individuals in other cohorts) are to be deemed high-risk contacts, including those that only mix outdoors or indoors with distancing and/or masking. For student cohorts that only interact outdoors (e.g., recess cohorts sharing outdoor space and times), exposure risk would generally be considered lower than for indoor interactions. However, PHUs may assess some outdoor-only exposures as high risk.
    - Bus cohorts: Given indoor, enclosed bus environment, and potential for students from multiple cohorts to share a bus, PHUs should have a low threshold for identifying high risk exposures in bus cohorts based on their risk assessment. Generally, this may be limited to those seated within two metres of the case (provided consistent non-medical mask wearing on the bus), and any other close contacts associated with the bus.
- For staff and essential visitors, follow Management of Cases and Contacts of COVID-19 in Ontario for exposure risk assessment.
- PHUs should request that schools provide information regarding the students and staff members in the case's cohort(s), as well as information on any other known potential contacts that a case may have been in contact with in the school setting or school transportation environment, including itinerant workers and occasional staff (e.g., teachers/staff who regularly interact with multiple cohorts).

Dismissal of asymptomatic high-risk contacts of a case

- In accordance with COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance, asymptomatic fully immunized individuals and previously positive individuals are generally not required to isolate following a high-risk exposure to a case, and therefore do not need to be dismissed.
    - If immunization coverage is unknown, or in a cohort with unimmunized students, PHUs may consider dismissal of the entire cohort, regardless of

immunization status, to facilitate timely exclusion of potentially exposed individuals from the setting. Return of partial cohorts may be permitted as per the Interim Guidance on Fully Immunized and Previously Positive individuals.
    - In cohorts with a known high proportion of immunized individuals (i.e., immunization information is available), immediate dismissal of the entire cohort may not be necessary. Dismissal of a smaller number of specific contacts who are not fully immunized or previously positive may be sufficient.
    - Fully immunized and previously positive individuals permitted to return must continue to maintain all infection prevention and control measures in the school setting.
- Isolation period for high-risk contacts who are not fully immunized or previously positive is 10 days, in accordance with Management of Cases and Contacts of COVID-19 in Ontario.
    - For school exposures, if there is a known source of exposure, isolation period should generally be counted from the day of last known exposure to the confirmed case. If the source of exposure is unknown, the isolation period should begin from the last exposure to the cohort.
- Dismiss any individuals who have been identified as having high-risk exposure to the case when the case was infectious, including cohort(s), siblings, and individuals who had close contact with the case in the community (e.g., at social gatherings, extracurricular activities), unless the contacts are fully immunized or previously positive.
    - If the household contacts (e.g., those who live in the same house or unit) of asymptomatic individuals identified as high-risk contacts are not fully immunized or previously positive, they should be advised to stay at home except for essential reasons, which may include attending work, school, or child care settings.
- If an individual dismissed as a high-risk contact develops symptoms, they are considered a probable case.
    - Their household members and other high-risk contacts, including any cohorts or contacts at school who have not yet been dismissed, should be managed as high-risk contacts of a case, dismissed, tested and directed to isolate in accordance with Management of Cases and Contacts of COVID-19 in Ontario.

Management of asymptomatic household contacts of a case and their cohorts

- Where a case has siblings/other household members who also attend school or child care, the cohort(s) of asymptomatic household members of a case (e.g., sibling of a case) do not need to be dismissed.
- If the sibling/household member of a case becomes symptomatic, they should be managed as a probable case, with immediate dismissal of their high-risk contacts who are not fully immunized or previously positive, including their cohort(s).

Testing of high-risk contacts of a case

- Recommend and coordinate/facilitate testing (in collaboration with testing partners) for all individuals who have been identified as having had a high-risk exposure in the school setting regardless of immunization status as below.
  - PHUs should work with local testing partners to optimize uptake by offering accessible, timely testing and results.
  - The PHU may, in collaboration with Ontario Health, help facilitate a coordinated approach to testing, including provision of an investigation or outbreak number, requisitions, and potentially on-site testing at the school.
    - Advise anyone associated with the school who requires testing to provide the investigation or outbreak number, or use the provided requisition, so that they are captured as part of the investigation.
    - Mechanisms should be established to ensure that the PHU is aware of all probable cases and positive laboratory results (e.g., investigation number).
    - PHUs are not responsible for trackng negative results.
    - PHUs should follow PHO Laboratory Test Information Sheet information on inclusion of non-covid respiratory virus testing, if applicable to the situation of a potential respiratory outbreak.
- All asymptomatic high-risk contacts who are NOT fully immunized or previously positive should be recommended for testing on or after day 7 of their isolation period.
    - If an initial test was collected prior to day 7 of their isolation period, repeat testing on or after day 7 is recommended.
    - A negative test does not change the requirement to complete 10 days of isolation.

    - Negative test results are not required to end isolation. PHUs to follow-up with contacts to verify testing results as capacity allows.
    - Repeat testing is also recommended if the contact becomes symptomatic.
- Asymptomatic high-risk contacts who ARE fully immunized or previously positive individuals should be recommended for testing as soon as possible upon notification of the exposure. These individuals are not required to isolate while awaiting test results, unless otherwise instructed by the PHU.
    - Repeat testing is recommended if the contact becomes symptomatic.
- Symptomatic high-risk contacts should be strongly encouraged to get tested, and managed as probable cases if testing does not occur.

Outbreaks

- An outbreak in a school, child care setting, or before/after school program is defined as **two or more lab-confirmed COVID-19 cases in children/students and/or staff or other visitors, with an epidemiological link, within a 14-day period, where at least one case could have reasonably acquired their infection in the school, child care setting, or before/after school program (including transportation**).
- Examples of reasonably having acquired infection in school include:
    - No known source of infection outside of the school setting (i.e., no known contact with a probable or confirmed case/outbreak outside school).
    - Known exposure in the school setting.
- Please see the CCM Data Entry Scenarios resource from PHO for detailed instructions about linking cases to school outbreaks for surveillance purposes.
    - Household and other high-risk contacts of cases linked to outbreaks in schools should not be linked to these outbreaks unless they themselves are directly part of the outbreak (e.g., transmitted to others in the school or acquired in the school). However, they may be linked to an outbreak-related case via an exposure Location in CCM to indicate the total exposures in a school.

Outbreak Measures

- Outbreak measures may be scaled up/down based on the transmission risk and outbreak epidemiology in the school and the assessment of outbreak control

measures, from dismissal of a single cohort through to consideration of whole school dismissal.
    - PHUs may wish to consult PHO to consider the potential role of genomic sequencing to help interpret school transmission patterns where epidemiological links are not clear.
- Review COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance for additional guidance on Fully Immunized and Previously Positive Individuals who are Part of an Outbreak of SARS-CoV-2, including when to consider more stringent approaches to outbreak management when there is evidence of an ongoing or uncontrolled outbreak or symptomatic/severe illness among fully immunized individuals.
- Review the COVID-19 Preparedness and Prevention in Elementary and Secondary (K-12) Schools checklist (or PHU equivalent) to identify IPAC practices/prevention measures requiring immediate improvement, such as reviewing practices related to staff interactions (e.g., avoid in-person staff meetings, review IPAC practices for minimizing risk associated with staff break areas).
- Outbreak measures that could be recommended to the school, particularly if the school remains open, may include:
    - Outbreak signage at entrances and affected area(s).
    - Informing outside agencies that use the school/child care centre of the outbreak.
    - Further restricting visitors to the school.
    - Further minimizing the movement of staff between cohorts.
    - Limiting student activities to their required cohorts and discontinuing extra-curricular activities, as much as possible.
    - Considering additional measures for immunized and previously positive high-risk contacts who are not dismissed, such as restricting mixing between cohorts.
    - Considering inclusion of fully immunized and previously positive high-risk contacts in dismissals to facilitate timely exclusion of potentially exposed individuals from the setting.

- Restricting all staff (including school, transportation, and staff from home care agencies or others that provide medical services to those in school) from working in other school or child care locations.
- Recommending to staff, students, and their families/household contacts to strictly avoid close contact/interactions with other households for non-essential reasons (e.g., no visiting, no playdates, no carpooling).
- Reinforcing masking of students for source control based on requirements for their age, use of masks and eye protection for staff members, hand hygiene for all, and maintaining physical distancing. Ensure availability of masks for students who may require them (i.e., do not have sufficient supply of their own masks) and encourage those who can supply their own to bring multiple masks per day.
- Reinforcing the daily symptom screening process for all staff/essential visitors and students, and enhance screening procedures if needed (e.g., on site confirmation).
- Reviewing environmental cleaning and disinfection protocols, enhancing cleaning and disinfection for the outbreak area(s), and ensuring that products are being used as per manufacturers' instructions.
- Ensuring families are aware of the outbreak.
- Increasing availability and accessibility of testing for the broader school community impacted by outbreak for additional case finding.
- Increasing availability and accessibility of COVID-19 vaccination for the broader school community impacted by the outbreak.

When to declare the outbreak over

- At least 14 days have passed with no evidence of ongoing transmission that could reasonably be related to exposures in the school.

AND

- No further symptomatic individuals have been reported by the school who are associated with the initial exposed cohorts.

Whole school testing

Note: The considerations outlined in this section do not apply to indications for whole school testing unrelated to case/outbreak investigation (e.g., surveillance testing).

- The aim of offering timely, accessible whole school testing is to assess the extent of transmission in a school (i.e., case finding), and to inform whether additional cohort dismissals or whole school dismissal are needed to interrupt transmission at school.
- Some scenarios where this may be considered as part of a PHU investigation, based on an assessment of risk, may include the following.
    - Multiple cohorts (e.g., 2 or more and/or 10-25%) have been dismissed within a 14-day period due to high-risk exposures to case(s).
    - A high percentage (e.g., 5-10%) of staff and students detected as probable or confirmed COVID-19 cases within a 14-day period.
    - A high attack rate in a single cohort.
    - Multiple cases with unknown acquisition.
    - Concern about potential vaccine escape.
- Individuals dismissed due to high-risk exposures must complete their 10 day isolation period, regardless of their testing result, unless otherwise specified by the PHU (e.g., based on their COVID-19 immunization status).
- Asymptomatic individuals without a known high-risk exposure (e.g., not from a dismissed cohort exposed to a case), and who have not otherwise been advised to quarantine or isolate, can continue attending school while awaiting test results.
- PHUs should advise the school administration and community of the potential for the results of whole school testing to lead to additional cohort dismissals, up to and including whole school dismissal, to enable school administrators, staff and parents/guardians and students to prepare (e.g., to transition to virtual learning, to arrange child care). PHUs should communicate in a timely manner with the school community regarding public health actions following whole school testing (e.g., additional cohort dismissals, decision regarding whole school dismissal).
- Testing offered to individual students/staff/others (e.g., household members) should be guided by current MOH Testing Guidance.
- Coordinate with Ontario Health to plan broader testing and ensure timely access and accessibility of testing options (e.g., testing at school site, take home kits,

access to drop in hours at an assessment centre within walking distance, outreach supports with partners such as paramedics).

Whole school dismissal

Note: The considerations outlined in this section do not apply to situations in which a whole school may be closed for in-person instruction due to operational reasons alone (e.g., related to staffing).

- It is anticipated that the likelihood of whole school dismissal will be exceptionally low in schools with high immunization coverage among students.
    - For example, whole school dismissal should be considered in the event a vaccine escape variant is identified among the cases.
- Based on the results of the PHU investigation, including results of any whole school testing, PHUs may consider whole school dismissal if there is evidence suggestive of widespread or very rapid transmission at school outside of previously identified cohorts, which may include:
    - At least one of the considerations for whole school testing (see above), or other similar consideration, is observed
      AND
    - >1 cohort in the school is affected
      AND
    - There are cases reasonably likely to have been acquired at school (e.g., no known exposure to a probable/confirmed case outside school) for whom NO epidemiological link (acquisition source) at school has been identified.
- Examples that would typically not be considered evidence of widespread transmission within a school may include:
    - Cases in multiple cohorts, each with likely acquisition via known exposures to cases outside school;
    - Multiple cases in students in one cohort only;
    - Single introduction of epidemiologically linked cases in multiple cohorts (e.g., siblings in different classes) and effective implementation of outbreak/IPAC measures;
    - The PHU determines that the identified cases in multiple cohorts without epidemiological links at school reflects independent introductions into the school compatible with widespread community transmission and does not indicate transmission occurring within the school.

- The decision to recommend a whole school dismissal for public health purposes is at the discretion of the PHU. In addition to the considerations above, there may be additional, context-specific considerations related to specific PHU investigations of school cases/outbreaks and particular school settings/populations that inform PHU decisions to recommend whole school dismissal.
- If whole school testing has not already been offered prior to initiating a whole school dismissal, PHUs should work with relevant partners to offer testing to all school attendees.
- During a whole school dismissal, staff and students who are not fully immunized or previously positive and who are not identified as high-risk close contacts of a known case should be advised to stay home except for essential reasons, which may include attending other work, school, or child care settings.
- The outbreak does not necessarily need to be declared over to recommend that the school reopen to some/all cohorts. Based on advice from the PHU, cohorts without evidence of transmission can be gradually brought back to school as additional information and test results become available. Consideration should be given to implementing additional preventive measures and active surveillance as part of reopening.

Occupational Health & Safety

- Employers have obligations under the *Occupational Health and Safety Act* (OHSA) to protect the health and safety of their workers, including from the transmission of infectious disease in the workplace.
- If COVID-19 is suspected or diagnosed in staff, return to work should be determined by the individual in consultation with their health care provider and the local PHU, whose advice should be based on provincial guidance.
- Occupational health and safety guidance for COVID-19 is available on the MOH COVID-19 website and the Ministry of Labour, Training and Skills Development's website on resources to prevent COVID-19 in the workplace.

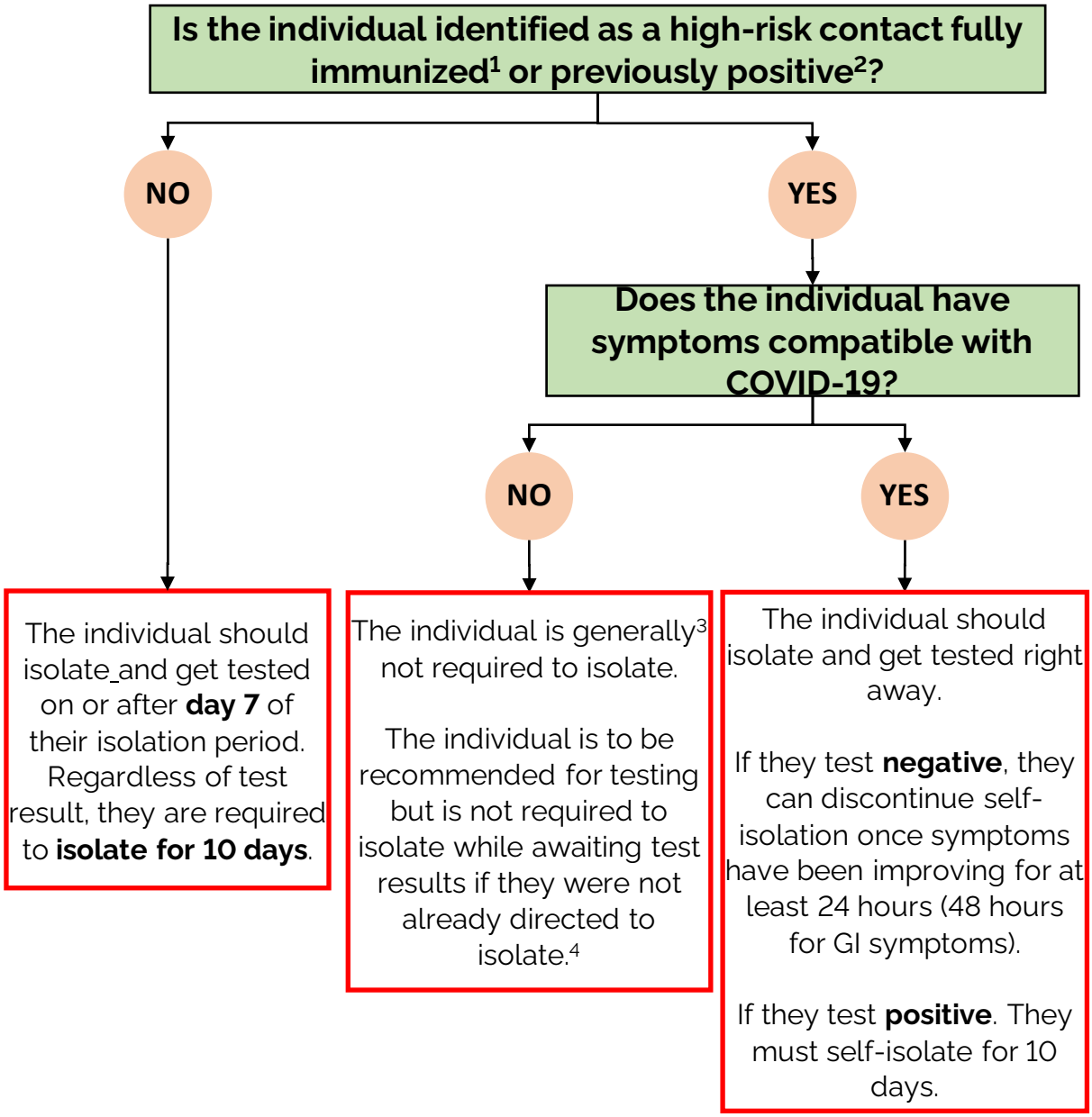
Reporting staff illness

- Workers who are unwell should not attend at a workplace. They should report their illness-related absence to their supervisor or employer.

- In accordance with the *Occupational Health and Safety Act* and its regulations, if an employer is advised that a worker has an occupational illness or that a claim with respect to an occupational illness has been filed with the Workplace Safety and Insurance Board (WSIB) by or on behalf of the worker, the employer must provide written notice within four days to:
    - A Director appointed under the OHSA of the Ministry of Labour, Training and Skills Development;
    - The workplace's joint health and safety committee (or health and safety representative); and
    - The worker's trade union, if any.
- This includes providing notice of an infection that is acquired in the workplace. The employer does not need to determine where the infectionwas acquired, if it is reported as an occupational illness, it must be reported to the MLTSD.
- The employer must also report any instance of an occupationally acquired disease to the WSIB within 72 hours of receiving notification of said illness.
- For more information, please contact the Ministry of Labour, Training and Skills Development:
    - Employment Standards Information Centre: Toll-free: 1-800-531-5551
    - Health and Safety Contact Centre: Toll-free: 1-877-202-0008
- For more information from the Workplace Safety and Insurance Board, please refer to the following:
    - Telephone: 416-344-1000 or Toll-free: 1-800-387-0750

Appendix A: Case and Contact Management in Schools for High-Risk Contact

Adapted from Appendix 11 of Management of Cases and Contacts of COVID-19 in Ontario



[1] For the purposes of case/contact/outbreak management, an individual is defined as fully immunized ≥14 days after receiving their second dose of a two-dose COVID-19 vaccine series or their first dose of a one-dose COVID-19 vaccine series that is listed for emergency use by the World Health Organization or approved by Health Canada.

Individuals who are immunocompromised are excluded from this definition, in accordance with COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance.

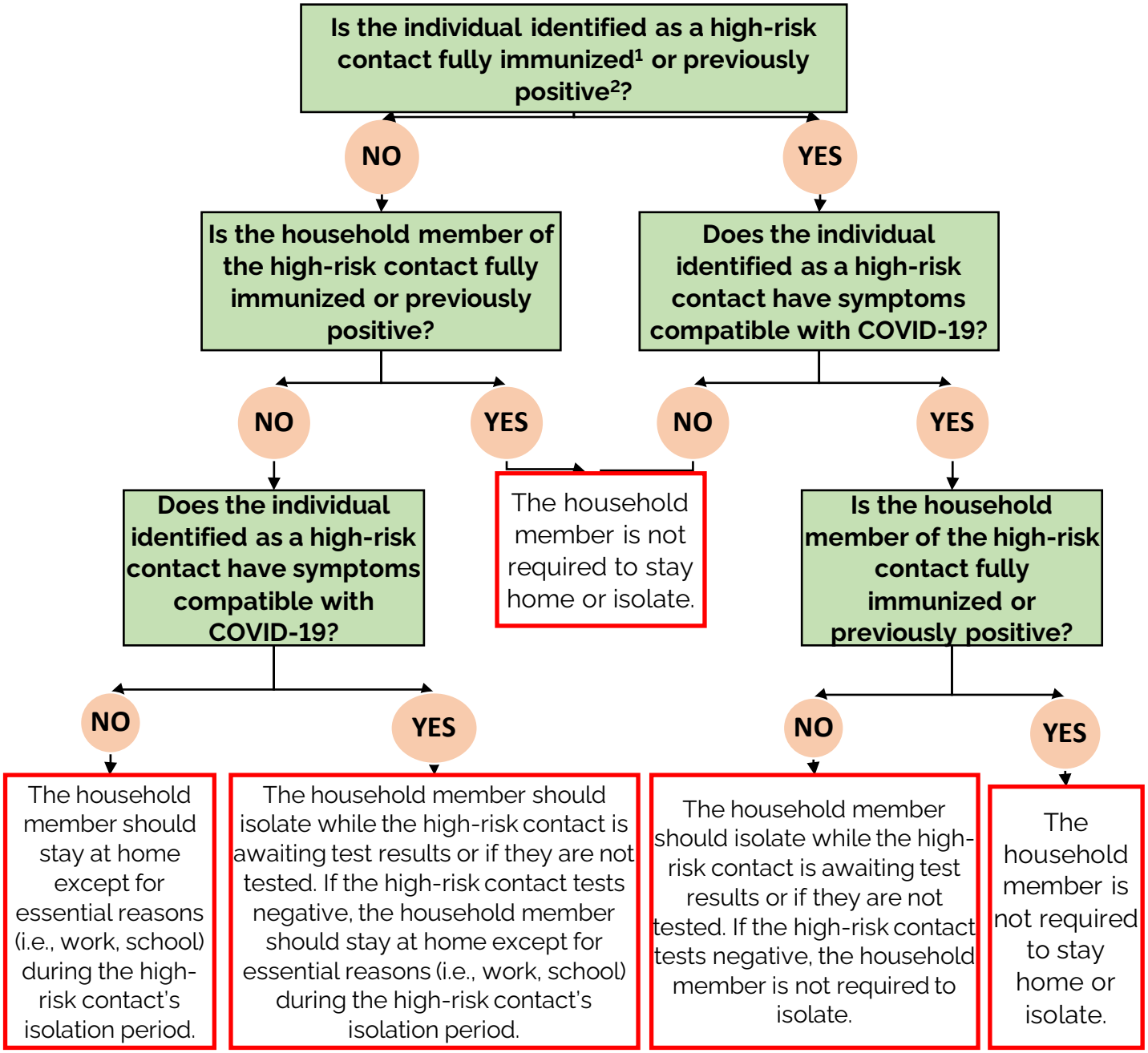
[2] For the purposes of case/contact/outbreak management, an individual is defined as previously positive if they were a confirmed case of COVID-19 where their initial positive result was ≤ 90 days ago AND they have been cleared from their initial infection. Individuals who are immunocompromised are excluded from this definition, in accordance with COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance.

[3] Self-isolation still may be required at the discretion of the local public health unit. Refer to the COVID-19 Fully Immunized Individuals: Case, Contact and Outbreak Management Interim Guidance for individuals with immunocompromise, and residents of high risk congregate living settings / inpatients.

[4] Refer to Provincial Testing Guidance.

Appendix B: Case and Contact Management in Schools for Household Members of High-Risk Contacts

Adapted from Appendix 11 of Management of Cases and Contacts of COVID-19 in Ontario



[1] For the purposes of case/contact/outbreak management, an individual is defined as fully immunized ≥14 days after receiving their second dose of a two-dose COVID-19 vaccine series or their first dose of a one-dose COVID-19 vaccine series that is listed for emergency use by the World Health Organization or approved by Health Canada. Individuals who are immunocompromised are excluded from this definition, in accordance with COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance.

[2] For the purposes of case/contact/outbreak management, an individual is defined as previously positive if they were a confirmed case of COVID-19 where their initial positive result was ≤ 90 days ago AND they have been cleared from their initial infection. Individuals who are immunocompromised are excluded from this definition, in accordance with COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance.

Ontario

Ministry of Health

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

This information can be used to help guide decision making on testing and clearance of contacts of cases or individuals suspected or confirmed to have COVID-19. This information is current as of August 11, 2021 and may be updated as the situation on COVID-19 continues to evolve. See the Ministry of Health's COVID-19 Fully Immunized/Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance for management of COVID-19 cases or contacts for the following individuals:

1. Fully immunized (for the purposes of C&CM: ≥ 14 days after second dose of a 2-dose COVID-19 vaccine series or ≥ 14 days after a single dose of a 1-dose COVID-19 vaccine series that is listed for emergency use by the World Health Organization or approved by Health Canada) or
2. Previously positive (where their initial positive result was ≤ 90 days ago AND they have been cleared from their initial infection in the prior 90 days.

All other individuals should follow the standard Management of Cases and Contacts Management in Ontario guidance.

Who should be tested for COVID-19?

Please refer to the COVID-19 Provincial Testing Guidance Update.

All antigen Point-Of-Care Testing "POCT" results are screening results only and positive antigen POCT results must be confirmed by diagnostic PCR testing at a licensed laboratory. See COVID-19 Guidance: Considerations for Antigen Point-of-Care Testing (gov.on.ca).

All molecular POCT final positive results must be reported to the local public health unit according to the *Health Protection and Promotion Act* (HPPA) and are actionable for initiating clinical and public health management (see Appendix 9: Management of Individuals with Point of Care Results).

Home-based testing kits for self-testing (either purchased or provided through pilot programs) are now available and considered screening tests. Positive results must be confirmed by an approved diagnostic PCR test. Confirmatory testing of negative results in individuals who are symptomatic or who have had a high-risk exposure is also recommended.

Version 15.0
August 11, 2021

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.

Asymptomatic COVID-19 testing for Individuals who are not Fully Immunized or Previously Positive

- An asymptomatic individual **who has been advised by local public health to get tested** due to exposure to a case or as part of an outbreak investigation should be tested on or after day 7 following their last exposure. If the contact has an initial negative specimen collected on day 0 to day 6 after their last exposure, they should repeat test on or after day 7.
- High risk contacts who are not fully immunized or previously positive must isolate for 10 days from their last exposure to a positive case regardless of negative test results. They can be released from self-isolation after day 10 if they remain asymptomatic. Should capacity allow, PHUs should follow up to ensure testing was done (i.e. verification if available or verbal confirmation). PHUs have the discretion to enhance their contact management process at the direction of their Medical Officer of Health/capacity.
- Re-testing should be conducted if the asymptomatic individual who initially tested negative develops symptoms consistent with COVID-19.

Re-testing after Clearance and Testing Fully Immunized Individuals

- Re-testing after clearance and testing fully immunized 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 symptomatic and were previously positive or fully immunized should be tested. For more details, refer to COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance
- Fully immunized or previously positive asymptomatic individuals may not be required to self-isolate following a high risk exposure but they should follow testing recommendations as per the COVID-19 Provincial Testing Guidance.
- Repeat testing is recommended as soon as possible for fully immunized or previously positive asymptomatic individuals who test positive. Refer to COVID-19 Fully Immunized 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 surveillance 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 surveillance testing immediately.
    - Fully immunized individuals may be excluded from asymptomatic surveillance testing.

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.

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

Approach	When to Use	Instructions
Non-Test Based Waiting **10 days** from symptom onset (or 10 days from specimen collection date if persistently asymptomatic)	Mild to moderate illness AND no severe immune compromise	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. 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).
Non-Test Based Waiting **20 days** from symptom onset (or 20 days from specimen collection date if asymptomatic and severe immune compromise)	Severe illness (requiring ICU level of care) **OR** severe immune compromise	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. Studies informing this approach did not have a consistent definition of severe illness or severe immune compromise. For the purposes of a clearance assessment: • **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
Test Based One negative specimen tested by laboratory-based NAAT assay after a positive result	Asymptomatic Fully Immunized individuals who have tested positive	Can discontinue isolation immediately if a single negative result is obtained and the fully immunized individual has remained asymptomatic. The individual should remain in isolation pending the second test result following an initial positive result.
Test Based Two consecutive negative specimens tested by a laboratory based NAAT assay, collected at least 24 hours apart	Not routinely recommended, but may be used at the discretion of a hospital to discontinue precautions for admitted patients	Continue isolation until **2 consecutive negative specimens tested by a NAAT and collected at least 24 hours apart**. • Testing for clearance may begin after the individual has become afebrile and symptoms are improving for at least 24 hours. Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post-infection. • If swab remains positive, test again in approximately 3-4 days. If swab is negative, re-test in 1-2 days (and at least 24 hours apart). • Tick the box labelled 'Other' and clearly write 'For clearance of disease' on the PHO Laboratory COVID-19 Test Requisition, or clearly write this on the requisition if submitting to another laboratory. • Serological testing cannot be used for test based clearance. • Test based clearance should not be used in an attempt to reduce the length of isolation.

Recommendations for Health Care Workers Return to Work

- Asymptomatic fully immunized 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 Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance for more information.
- HCWs who are not fully immunized 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 immunized 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 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.

Work self-isolation 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. While at work, the HCW must adhere to universal masking recommendations, maintain physical distancing (remaining greater than 2m/6 ft from others) except when providing direct care, and perform meticulous hand hygiene. These measures at work are required to continue until non-test based clearance (or test based clearance if required by employer/Occupational Health and Safety). The COVID-19 positive HCW should ideally be cohorted to provide care for COVID-19 positive patients/residents if possible. The HCW on work self-isolation should not work in multiple locations.

Work Self-Isolation Guidelines

Symptoms at/around time of testing	Test Result	Instructions
Yes	Positive	• 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	• 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.
Never symptomatic at time of test	Positive	• 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 immunized or was previously positive), see Management of Cases and Contacts of COVID-19 in Ontario and the COVID-19 Fully Immunized 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.

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 immunized 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.

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 Public Health Unit may consider work self-isolation for workers who are in self-isolation from a high-risk exposure, excluding the scenarios outlined above. This should be done in consultation with the Ministry Emergency Operations Centre and Public Health Ontario.
- Work self-isolation is generally **not** recommended for any workers in non-healthcare settings due to the potential for contacts with high risk exposures to be infectious, and barriers to ensuring appropriate and consistent infection prevention and control measures to prevent transmission.
    - Considerations for exceptional circumstances could include:
        - health and safety, and ethics and equity, including whether the worker(s) serve a “critical” function, and promoting the well-being of and minimizing harm to the self-isolating worker, other workers and the community
        - minimizing risk related to transportation to and from work (e.g., no carpooling / ride-sharing or public transit use); the availability of 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 implemented including whether there are barriers to measures such as: symptom screening, physical distancing, appropriate PPE use and masking for source control
- To be in compliance with the Occupational Health and Safety Act, the employer must take into consideration the safety of all workers and take all steps reasonable in the circumstances to protect their workers.