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Public Health Management of Cases and Contacts of COVID-19 in Newfoundland and Labrador

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Purpose

The information in this document is based on recommendations outlined by the Public Health Agency of Canada (PHAC) updated December 23, 2020, and released on January 5, 2021, and has been adapted to reflect the recommendations of the Government of Newfoundland and Labrador, Department of Health and Community Services, Public Health Branch. This document replaces the ***Guidelines for the Management of Cases, Suspect Cases, and Contacts of COVID-19, dated November 2nd, 2020*** and should be supplemented with the ***COVID-19 Variant of Concern: Case, Contact, and Outbreak Management: Interim Guidance for Newfoundland and Labrador.*** As the information related to COVID-19 continues to evolve, recommendations in this document will need to be updated.

Key Assumptions of COVID-19

COVID-19 is a disease caused by SARS-CoV-2 coronavirus, a novel virus that was first recognized in December 2019, and declared a global pandemic in March 2020. Genetic sequencing of the virus suggests that it is a betacoronavirus closely linked to the Sudden Acute Respiratory Syndrome (SARS) virus. Symptoms of COVID-19 include the following:

- Fever (including chills/sweats)
- Cough (new or worsening)
- Small red spots on hands and/or feet in a young child or an adult less than 20 years of age
- Shortness of breath or difficulty breathing
- Runny, stuffy, or congested nose (not related to seasonal allergies or other known causes/conditions)
- Sore throat or difficulty swallowing
- Headache
- Acute loss of sense of smell or taste
- Unusual fatigue, lack of energy
- New onset of muscle aches
- Loss of appetite
- Vomiting or diarrhea for more than 24 hours

SARS-CoV-2 Variants of Concern (VoC)

Current evidence suggests the circulating VoC's can produce the same symptoms as SARS-CoV-2. Many spread more easily and quickly, leading to an increase in cases of COVID-19. While it is not clear whether these variants tend to cause more severe illness, there is concern about the impact on health care resources if VoC's become common in our communities. There are recent concerns about decreased susceptibility to vaccines in some variants.

Multiple variants of the virus are circulating globally and those of current concern include:

- B.1.1.7 identified in the United Kingdom, in the fall of 2020
- B.1.351 emerged independently of B.1.1.7, identified in South Africa detected in early October 2020. B.1.351 shares some mutations with B.1.1.7.
- P.1 a variant identified in travellers from Brazil, emerged in early January 2021.

Risk Factors

Anyone can become infected with SARS-CoV-2, however, some individuals are at increased risk of exposure to the virus (e.g., work settings) and some individuals are more at risk of severe disease and outcomes from the virus (e.g., advanced age, pre-existing conditions, compromised immune systems, socioeconomic status). Any combination of these factors, as well as an individual's access to health care, can contribute to the disproportionate rates of infection, severe illness, hospitalizations, and/or deaths in some populations.

Transmission

Human coronaviruses are most commonly spread from an infected person through direct contact with the mucous membranes of another person's nose, mouth, or eyes, or inhaled into their nose, mouth, airways, and lungs. There are three ways COVID-19 infection can be spread.

- **Pre-symptomatic transmission**-an individual can transmit virus before they develop symptoms
- **Symptomatic Transmission**-an individual can transmit the virus while they are experiencing symptoms
- **Asymptomatic transmission-** an infected individual does not develop symptoms, but can still transmit the virus to others

Incubation Period

The incubation period for SARS-CoV-2 is believed to be 2-14 days with a median of 5 days. For public health follow-up purposes, a period of 14 days should be considered.

Period of Communicability

The period of communicability is considered to be from 48 hours before the onset of symptoms to 10 days after the onset of symptoms. However, live viral shedding may occur for longer in those with an illness of greater severity (e.g., admitted to hospital due to COVID-19) and those who are severely immunocompromised. In these cases, the period of communicability may extend to 20 days after the onset of symptoms.

Surveillance

Based on recommendations outlined by the PHAC, the surveillance objectives for COVID-19 include;

- the early detection of cases and identification of an outbreak
- characterization of the clinical and epidemiologic features of COVID-19

The information obtained from these objectives is used to better inform prevention and control efforts.

National Surveillance Definitions for COVID-19

Confirmed case:

A person with confirmation of infection with SARS-CoV-2 documented by:

- Detection of at least one specific gene target by a validated laboratory-based nucleic acid amplification test (NAAT)-based assay (e.g. real-time PCR or nucleic acid sequencing) performed at a community, hospital or reference laboratory (NML or a provincial public health laboratory)

OR

- The detection of at least one specific gene target by a validated point-of-care (POC) nucleic acid amplification test (NAAT) that has been deemed acceptable to provide a final result (i.e. does not require confirmatory testing)

OR

- Seroconversion or diagnostic rise (at least four-fold or greater from baseline) in viral specific antibody titre in serum or plasma using a validated laboratory-based serological assay for SARSCoV-2

Probable case:

A person who:

1. Has symptoms compatible with COVID-19

AND

- Had a high-risk exposure (i.e. close contact) with a confirmed COVID-19 case OR was exposed to a known cluster or outbreak

AND

- Has not had a laboratory-based NAAT assay for SARS-CoV-2 completed or the result is inconclusive

OR

- Had SARS-CoV-2 antibodies detected in a single serum, plasma, or whole blood sample using a validated laboratory-based serological assay for SARS-CoV-2 collected within 4 weeks of symptom onset

OR

2. Had a POC NAAT *or* POC antigen test for SARS-CoV-2 completed and the result is preliminary (presumptive) positive

OR

3. Had a validated POC antigen test for SARS-CoV-2 completed and the result is positive

Deceased Case

A probable or confirmed COVID-19 case whose death resulted from a clinically compatible illness, unless there is a clear alternative cause of death identified (e.g., trauma, poisoning, drug overdose). A Medical Officer of Health, relevant public health authority, or coroner may use their discretion when determining if a death was due to COVID-19, and their judgement will supersede the above-mentioned criteria. A death due to COVID-19 may be attributed when COVID-19 is the cause of death or is a contributing factor.

COVID-19 Outbreak

Two or more confirmed cases of COVID-19 epidemiologically linked to a specific setting and/or location. Excluding households, since household cases may not be declared or managed as an outbreak if the risk of transmission is contained. This definition also excludes cases that are geographically clustered (e.g., in a region, city, or town) but not epidemiologically linked, and cases attributed to community transmission.

COVID-19 Cluster

Two or more confirmed cases aggregated in time and by setting and/or location, without an epidemiological link (e.g., common exposure or transmission event), or until an epidemiological link is established. Aggregated in time means that the cases' symptom onset, or if asymptomatic, the date that the diagnostic laboratory sample was collected, occurred within 14 to 28 days (i.e., one to two maximum incubation periods). The identification of a cluster considers the setting/location type and level of community transmission, and is at the discretion of the investigating health authority.

Reporting and Notification

All laboratory-confirmed, suspect, and probable cases of COVID-19 must be reported to the Regional Medical Officer of Health (RMOH) and the Department of Health and Community Services (DHCS), Chief Medical Officer of Health (CMOH) per local reporting requirements. In Newfoundland and Labrador (NL), the COVID-19 Tracker is a database that has been developed for case and contact management at the regional level. It is expected that accurate COVID-19 case and contact information are appropriately documented in the COVID-19 Tracker within 24 hours of case finding to align with PHAC recommendations. Additionally, updates to case and contact information should be documented in the Tracker within 24 hours (e.g. changes in symptoms, hospitalization, recovery, death, etc.). With the recent availability of COVID-19 vaccines, Regional Health Authorities (RHAs) must capture vaccination history for each case and contact (e.g. vaccine product, date of vaccination, dose number).

During case investigation, it may be identified that the case acquired their infection, or was exposed, in another health authority, province, territory, or country (e.g., when a case traveled between jurisdictions during their communicable period or when contacts reside in a different jurisdiction than a case). RHAs should use established communication channels to enable timely case and contact management (e.g., collaboration between Regional Communicable Disease Control Departments, Provincial Disease Control Nurse Specialist).

Laboratory Testing

The gold standard for laboratory testing and diagnosis of SARS-CoV-2 infection is a reverse transcription-polymerase chain reaction (RT-PCR) test on a sample collected by a health care provider.

Point of Care Testing (POCT)

Point of care testing for COVID-19 is available and allows for rapid case finding and can give a quick "snapshot" of transmission in a facility or community. Two point of care test are being used in Newfoundland and Labrador, a rapid antigen test, Abbott Panbio and a molecular PCR rapid test, Abbott ID Now. POCTs such as the Abbott Panbio COVID-19 Antigen Rapid Test can be used on site and can produce results within 15 minutes. A simultaneous RT-PCR is typically obtained and sent to the Newfoundland and Labrador Public Health Laboratory for confirmatory RT-PCR testing. In most circumstances a presumptive positive test will be confirmed by RT-PCR testing at PHML.

Serology

Serology testing should not be used for classification of cases who have been previously diagnosed with COVID-19 or who have received a SARS-CoV-2 vaccination. SARS-CoV-2 serology tests should not be used for screening or the routine diagnosis of acute infection. It may be considered as an adjunct to SARS-CoV-2 NAAT in individuals with compatible symptoms who present late and therefore may test negative, and in the diagnosis of multisystem inflammatory syndrome in children (MIS-C) and multisystem inflammatory syndrome in adults (MIS-A).

Management of Cases and Contacts of COVID-19

Case and contact management is a collaborative process that includes; assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs. This process assists in mitigating the health impacts of COVID-19. It is important to recognize that the health, disability, economic, social, or other circumstances faced by some individuals and households may limit their ability to follow the recommended measures, as such, adaptations to the case management and contact responses in some situations may be required.

At this time, vaccination history will not change the case or contact management process, or time required to self-isolate. This guidance will be updated as the evidence around COVID-19 vaccinations evolves.

NOTE: While the isolation of asymptomatic contacts is technically termed "quarantine", the common use of "self-isolation" will be used throughout this document to refer to both symptomatic/infected and exposed individuals.

Management of Positive Cases (confirmed and probable) of COVID-19

Clinical management of the case, whether in the home or an acute care setting, is based on the case's condition and at the discretion of the health care provider. Refer to guidance on clinical management of patients with COVID-19 for additional information. Cases of COVID-19 should be monitored until they have met the criteria for discontinuing isolation (*see Table 1*). The isolation period will be determined by public health based on symptom onset (if symptomatic) or positive test date (if asymptomatic).

If an individual in the school setting has been identified as a case of COVID-19, the collaboration between public health and the school will be required to determine who a case was in contact with during their period of communicability. Refer to COVID-19 Exposure, Case, and Outbreak Management in School Setting, for additional information. If the case is a health care worker, advise the Regional Occupational Health Department as soon as possible. If the case is a privately employed healthcare worker, the individual should be encouraged to notify the employer as soon as possible.

All COVID-19 cases should be contacted by public health within 24 hours to initiate the case investigation and complete the contact tracing interview. Each case should receive a minimum of three contacts from public health (day 0, day 5, and day 10).

If a case is hospitalized but discharged while they are still in isolation:

- Notification will be sent by the acute care facility to the Regional Communicable Disease Control Department for follow up by Public Health
- The individual will need to continue to self-isolate in their home until the isolation period is considered over by public health

Public health should provide information to the case related to:

- Self-isolation requirements
- Self-monitoring for symptoms consistent with COVID-19
- Steps to take if symptoms worsen, including how and when to access medical care
- Recovery criteria for discontinuing self-isolation

Isolation Requirements

During the self-isolation period the case should be advised to:

- Not leave the isolation setting (home, co-living setting, or alternate setting identified by public health) unless required or directed to do so to seek medical care.
- Have their own room and dedicated washroom and remain in their room as much as possible (if this is not possible, see section below on ***Recommendations for When Strict Isolation is Not Possible***).
- Avoid activities that put them in a shared space with others (e.g. watching television, eating with other household members, playing games, bed-sharing, etc.)
- Wear a medical mask or well-constructed, well-fitting non-medical mask, if sharing space is necessary.
- Disinfect any common touchpoints, such as doorknobs, light switches, and remote controls, if sharing space is necessary.
- Ensure shared spaces are well ventilated (e.g., windows open, as weather permits)
- Designate one household member as the care provider (if needed) and ensure the use of appropriate personal protective equipment (PPE)
- Avoid sharing personal items with others (e.g., toothbrushes, towels, bed linen, cigarettes, unwashed eating utensils, etc.).
- Not go to school, work, or other public places
- Postpone elective health care until the end of the isolation period

- See section below ***Additional Considerations for Household Contacts of COVID-19 Case***

If a household contact cannot isolate away from the case (e.g., due to care needs, interactions with/between young children, bed/room sharing) the individual will be required to self-isolate for an additional 14 days after the case finishes their isolation period (e.g., date case has "recovered").

Recommendations When Strict Isolation Is Not Possible

In situations where a dedicated room and washroom are not available for isolation, consider relocating the case, household members, or other occupants to another location to allow the case to isolate as per recommendations. When this is not possible the following approaches may be considered:

- Separate the case from others with dividers such as curtains in a shared space (e.g., home with limited rooms, sharing space for sleeping).
- If sleeping in the same room, maintain as much distance as possible from the case (minimum of 2 meters), separating beds, and having occupants sleep head-to-toe.
- If sharing a washroom, open the window, turn on the fan to improve ventilation, put the lid of the toilet down before flushing and, clean/disinfect surfaces touched by the case after each use.
- Wear a medical mask, or a well-constructed and well-fitting non-medical mask if required to be within 2 meters of others.
- Cohorting cases in co-living settings (e.g., those living in university dormitories, work camps, shelters, overcrowded housing). If two cases reside in a co-living setting and single rooms are not available, a double room could be shared.

If an individual is experiencing difficulty with the ability to self-isolate due to housing or economic concerns, support can be arranged through the RHA in collaboration with the DHCS.

If a case must leave the isolation setting to seek medical care, advise the individual to:

- Wear a medical mask, or a well-constructed and well-fitting non-medical mask
- Use a private vehicle (if possible) to attend a medical appointment
- If a private vehicle is not available, wear a procedure/surgical mask and sit in the rear passenger seat with the window open (weather permitting). See Guidance for Traveling in Vehicles
- Not take public transportation, if possible
- Notify health care provider or facility before accessing care

Additional information:

In situations where child care is shared between two homes, consider having the child stay in one home for the duration of the isolation or quarantine period. See Information for families with a custody and access order or agreement during the COVID-19 pandemic for more information.

Nursing mothers should continue breastfeeding their baby. It is recommended that the mother wear a mask, practice good hand hygiene, and respiratory etiquette. For more information, see Breastfeeding and COVID-19.

For Indigenous Peoples, mandatory isolation away from home due to COVID-19 may trigger re-traumatization based on the history of forced removals. To avoid relocation of persons with COVID-19 to locations outside of their community, many communities have re-purposed facilities or set up temporary structures to use as isolation sites so that cases may safely isolate in situations where their home setting is not suitable.

Recommended Infection Prevention and Control Precautions When Caring for a Case in the Home or Co-Living Setting

Individuals caring for a case of COVID-19 should wear a medical mask, or a well-constructed and well-fitting non-medical mask, eye protection, and disposable gloves whenever providing direct care, and/or handling soiled materials and surfaces. Additional documents are available to support individuals caring for someone with COVID-19 at home.

- How to care for a child with COVID-19 at home: Advice for caregivers
- How to care for someone with COVID-19 at home
- How to care for a person with COVID-19 at home: Advice for caregivers
- Self-Isolation Guide for caregivers, household members, and close contacts

Access to PPE can be facilitated by the RHA.

Criteria for Recovering Positive Cases of COVID-19

Public health officials will provide clearance to individuals diagnosed with COVID-19 to discontinue self-isolation. Repeat laboratory testing as the basis for discontinuing isolation is not recommended, as such, a non-test based approach should be applied. Once recovered/resolved, the case details must be updated in the COVID-19 Tracker within 24 hours**.** A case can be cleared from isolation and considered "resolved" once they meet the criteria in ***Table 1*** below.

Table 1: Criteria for Recovering Positive Cases of COVID-19

Mild to moderate illness AND no severe immune compromise	• Ten days have passed since symptom onset, afebrile, and improving clinically. • Absence of cough is not required for those known to have a chronic cough or who are experiencing reactive airways post-infection. • If symptoms remain after 10 days, isolation should continue for an additional 4 days. • If symptoms remain by day 14, recovery will be determined on a case-by-case basis in consultation with the RMOH. • A COVID-19 case which is classified as resolved may still have ongoing clinical indications and symptoms, but should no longer require isolation measures or public health follow up.

Asymptomatic	• Discontinue isolation 10 days from positive test collection date.
Severe illness OR severe immune compromise • 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, and taking immune suppressive medications	• 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. • The absence of cough is not required for those known to have a chronic cough or who are experiencing reactive airways post-infection.

Situations may occur where an individual may have been hospitalized, had no known exposure to COVID-19, and test negative but are considered suspicious for COVID-19 based on their clinical presentation. Under these circumstances, if the individual is discharged from the hospital, consultation with the RMOH is recommended to determine if the individual should remain in isolation while at home and receive follow-up by public health.

Contact Tracing

Contact tracing is a process used by Public Health professionals to understand how the infectious disease is spreading in a community through active case finding during a case investigation. This process facilitates the rapid identification of additional cases of COVID-19 and facilitates the early implementation of public health measures. Contact tracing is detailed and time-intensive work but is crucial during an outbreak to control the spread. Contacts should be identified and managed as per the recommendations in this document. See ***Table 2*** below for contact classification.

Traditional (Forward) Contact Tracing

The goal of traditional contact tracing is to identify and self-isolate potentially exposed individuals to stop the chain of transmission. Given that transmission of SARS-CoV-2 can occur from cases who are pre-symptomatic, symptomatic, or asymptomatic, contact tracing should include:

- Identifying people who were exposed to a symptomatic case, starting 48 hours before the case developed symptoms consistent with COVID-19, and until the case was no longer considered infectious (e.g., 10 days following symptom onset for a non-hospitalized case).
- Identifying people who were exposed to an asymptomatic case, starting 48 hours before the date of their positive laboratory test, and until the case was no longer considered infectious (e.g., 10 days after specimen collection date).

Backward Contact Tracing

'Backward' contact tracing focuses on trying to determine where and when the case likely acquired their infection. This process may help find additional cases by focusing on a setting where a case's exposure

may have occurred. This method is routinely used as part of a case or outbreak investigations and is most useful for localized outbreaks.

The table below provides guides the classification of contacts as either high or low risk, depending on their exposure and managed accordingly. For public health contact identification and management purposes only, a period of 15 cumulative minutes over 24 hours has been selected by the PHAC to distinguish between brief and prolonged exposure.

Table 2: Classification of Contacts of Positive Cases of COVID-19, Public Health Agency of Canada, December 23, 2020

RISK LEVEL	DESCRIPTION
High-Risk Exposure (Close Contact*)	Healthcare Worker (HCW) who provided direct physical care to a case, or a laboratory worker handling COVID-19 specimens, **without** consistent and appropriate use of recommended PPE and infection prevention and control (IPAC) practices.
	Anyone who lives with a case, has **direct** physical contact with a case or is exposed to their infectious body fluids, including the case's caregiver, intimate partner, a child receiving care from the case, etc.
	Anyone who has shared an indoor space (e.g., same room) with a case for a prolonged period (15 cumulative minutes over 24 hours), including closed spaces, crowded places, or settings where close interactions may occur (e.g., social gatherings, workplaces, etc.), **without** adhering to appropriate personal protective practices (e.g., wearing a mask, handwashing, and physical distancing).
	Anyone who has had a close-range conversation with a case or has been in settings where a case engaged in singing, shouting, or heavy breathing (e.g., exercise), **without** adhering to appropriate personal protective practices (e.g., wearing a mask, handwashing and physical distancing).
Low-Risk Exposure (Non-close contact)	HCW who provided direct physical care to a case, or a laboratory worker handling COVID-19 specimens, **with** consistent and appropriate use of recommended PPE and infection prevention and control practices.
	Anyone who has shared an indoor space (e.g., same room) with a case, including closed spaces, crowded places, or settings where close interactions occur (e.g., social gatherings, workplaces, etc.), **with** consistent and appropriate use of recommended PPE and infection prevention and control practices.
	Anyone who has had a close-range conversation with a case or has been in settings where a case engaged in singing, shouting, or heavy breathing (e.g., exercise), **with** consistent and appropriate use of recommended PPE and infection prevention and control practices.

**** Determination of a close contact could change, based on the risk assessment of the RMOH. The information in this table is not intended to replace more personalized advice, based on individual risk assessments conducted by public health.***

Management of Close Contacts/High-Risk Exposure

If the circulating virus is a VoC, please refer to ***COVID-19 Variant of Concern: Case, Contact, and Outbreak Management: Interim Guidance for Newfoundland and Labrador*** *for* management of close contacts. Contacts of confirmed cases will receive an initial follow-up within 24-48 hours from public health. If during contact tracing interview a staff member or student has been identified as a contact of a confirmed case of COVID-19, refer to the COVID-19 Exposure, Case, and Outbreak Management in School Setting guidance document. If the contact is a health care worker, the employee must notify Regional Occupational Health Department as soon as possible. If contact is a privately employed healthcare worker, the individual should be encouraged to notify the employer. **If a contact has had a previous COVID-19 infection, they are still required to isolate for 14 days post-exposure to case.** All contacts must be added to the NL COVID-19 Tracker within 24 hours. Symptomatic and asymptomatic contacts will be offered testing for COVID-19 and advised to self-isolate for 14 days after the last exposure to the case. Contacts should be instructed to avoid the use of fever-reducing medications (e.g., acetaminophen, ibuprofen) as they could mask an early symptom of COVID-19.

During the public health interview, the following information should be discussed:

- Testing information (appointment to be arranged through public health, or the COVID-19 Self-Assessment tool, or by calling 811)
- How to obtain COVID-19 test results (using the online COVID-19 Patient Results portal)
- Isolation requirements
- How to self-monitor for the appearance of symptoms consistent with COVID-19
- What to do if symptoms develop or worsen (call 811 or use the COVID-19 Self-Assessment tool).

If the test results for COVID-19 are positive, the contact will be managed as a case. If results are negative, isolation must continue for 14 days from the last exposure to the case.

- Symptomatic contacts who test negative may be considered for re-testing if they have a worsening or progression of symptoms.
- If laboratory testing is **not** completed, the contact who develops symptoms should be managed as a probable/suspect case and should complete at least 10 days of isolation post-symptom onset.

Isolation Requirements

During the isolation period contacts should be advised to:

- Stay at home, do not go to work or school for the isolation period. Individuals can go outside on their property (if social distancing can be maintained).
- Have their own room and dedicated washroom and remain in their room as much as possible (if this is not possible, see section above on ***Recommendations for When Strict Isolation is Not Possible***).

- Avoid activities that put them in a shared space with others (e.g. watching television, eating with other household members, playing games, bed-sharing, etc.)
- Wear a medical mask or well-constructed, well-fitting non-medical mask, if sharing space is necessary.
- Ensure shared spaces are well ventilated (e.g., windows open, as weather permits).
- Disinfect any common touchpoints, such as doorknobs, light switches, and remote controls, if sharing space is necessary.
- Avoiding close contact with people with chronic conditions, compromised immune systems, and older adults.
- Avoid sharing personal items with others (e.g., toothbrushes, towels, bed linen, cigarettes, unwashed eating utensils, etc.).
- Not provide case for the case if they are at risk for developing more severe disease or outcomes and should stay elsewhere if feasible.
- Postpone elective health care until the end of the monitoring period

If symptoms occur or worsen, contact public health, complete COVID-19 Self-Assessment or call 811 for further direction (e.g., where to go for testing or treatment).

If a contact must leave the isolation setting to seek medical care, advise the individual to:

- Wear a medical mask, or a well-constructed and well-fitting non-medical mask
- Use a private vehicle if need to attend a medical appointment
- If a private vehicle is not available, wear a procedure/surgical mask and sit in the rear passenger seat with the window open (weather permitting). See Guidance for Traveling in Vehicles
- Not take public transportation, if possible
- Notify health care provider or facility before accessing care

Additional Considerations for Household Contacts of COVID-19 Case

The time frame for self-isolation of household contacts will be case-specific and will depend on the ability of the case to self-isolate away from household members for their full isolation period (i.e. use of a separate bedroom and bathroom).

- If the household contact cannot isolate away from the case (e.g., due to care needs, interactions with/between young children, bed/room sharing) the individual will be required to self-isolate for an additional 14 days after the case finishes their isolation period (e.g., date case has "recovered").
- If additional members of the household become cases, the duration of isolation for remaining asymptomatic household members would require a repeat assessment of exposure as above.

Household contact or other occupants should avoid further exposure to the case by wearing:

- A well-constructed and a well-fitting non-medical mask when they are unable to avoid sharing a space (e.g., the same room) with the case.
- A medical mask, or a well-constructed and well-fitting non-medical mask if required to be within 2 meters of the case.
- A medical mask (if available) if at high risk of more severe disease or outcomes.

Recommendations for Management of Non-Close Contacts/Low-Risk Exposure

If the circulating virus is a VoC, please refer to ***COVID-19 Variant of Concern: Case, Contact, and Outbreak Management: Interim Guidance for Newfoundland and Labrador*** *for* management of non-close contacts. Following the public health contact tracing investigation, if an individual is not considered a close contact, they should self-monitor for symptoms consistent with COVID-19 for 14 days after their last exposure to the case. These individuals do not need to isolate but should be advised to continue following public health advice (e.g., mask-wearing, physical distancing, handwashing). If an individual is not considered a close contact but still has a level of risk identified from the contact tracing investigation, consultation with the RMOH is recommended. If symptoms occur, advise the individual to self-isolate away from others as quickly as possible, put on a medical mask or well-constructed and will-fitting non-medical mask, and complete COVID-19 Self-Assessment or call 811 for further information and direction regarding testing. Where possible, advise contact to avoid interactions with individuals at higher risk for severe illness. If contact is a health care worker, advise the individual to contact the Regional Occupational Health Department or their private employer.

Management of Immunized Contacts of Positive Cases of COVID-19

All recommendations for contacts of COVID-19 cases apply **regardless of vaccination status** or vaccine rollout progress. At this time, there is insufficient evidence on the duration of protection and effectiveness of COVID-19 vaccines in preventing asymptomatic infection and reducing transmission of SARS-CoV-2.

Management of Contacts on Airplanes-Flight Crew and Passengers

Potential exposure to SARS-CoV-2 among passengers and crew during air travel is a topic of concern; however, risk mitigation measures such as mandatory use of masks, physical distancing, reduced occupancy, environmental cleaning, and hand hygiene, can significantly reduce the likelihood of transmission. Decisions related to contact tracing individual airplane passengers and flight crew who may have been exposed to a confirmed case of COVID-19 on any flight should be made based on a risk assessment which should considering the following:

- Type, severity, and onset date of symptoms for symptomatic cases, or specimen collection date for asymptomatic cases, in relation to the flight date
- Timing of notification and the ability to obtain sufficient passenger contact information (e.g., within 14 days of flight)
- Benefit of individual communication to those seated within 2 metres (or more) of the case versus public communication of the flight number.
- Circulating VoC's

If contact notification is required, the RHA can publicly communicate when a case has had a history of travel during their period of communicability. The information required is the flight number, flight date, departure/arrival locations, and affected rows of the flight.

Investigations of Potential False Positive/False Negative/Indeterminate Results

False Negative/False Positive Results

Where there is a concern of false positive or false negative results based on an unexpected test finding relative to the clinical and epidemiological information of the case, it is advised to **recollect a specimen for repeat testing as soon as possible**. Public Health may consult the Newfoundland and Labrador Public Health Laboratory Microbiologist on call for further information to support the investigation where there is a concern. Timely public health case and contact management decision-making should not rely on this process.

- Individuals should be managed as a probable case until further information is available.
- Repeat specimens should be collected as soon as possible after the first result to best inform public health management of the individual (the longer the interval between the initial and the repeat test, the more likely the test will go from positive to negative).

Indeterminate/Inconclusive Results

Indeterminate results may be due to low viral target quantity or may represent a false signal.

• 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.**

• For clinical and public health purposes, asymptomatic individuals with indeterminate results do not meet the probable case definition. Testing should be **repeated as soon as possible.**

Testing and Management of Individuals Who Previously Tested Positive for SARS-CoV-2

Table 3: Testing and Management of Individuals Who Previously Tested Positive for SARS-CoV-2

Less than 90 days since testing positive			
Symptoms	***Exposure***	***Testing Recommendations***	***Management Recommendations***
No symptoms: (recovered case*)	No new exposure	No further testing is recommended including for screening/surveillance purposes. *Note that a test of cure is not recommended.	If inadvertently tested for COVID-19 within 90 days and the result is positive: ○ No repeat isolation ○ No contact follow-up ○ Note: positive test result

			generally indicates residual non-viable virus and this person is considered not infectious and NOT a new case. Review the CT values of the test with the Medical Microbiologist. A very low viral load likely represents residual viral load.
No symptoms (recovered case*)	NEW exposure to an unrelated case** **OR** outbreak	Consider re-testing an asymptomatic person in some circumstances such as a new exposure **or** a high degree of interaction with populations who are at high risk of more severe disease or outbreaks [e.g., healthcare workers (HCWs), staff and residents in long term care homes, prisons, shelters, single-room occupancy residences, work camps].	Avoid vulnerable populations, large groups, or indoor gatherings and isolate for 14 days after last exposure. If symptoms develop isolate and test.
New symptoms in a recovered case *	No new exposure **OR** Travel to or residence in an area with high community prevalence.	In general, consider not testing. However, consider testing for the following groups if COVID-19 is considered a potential diagnosis: o Immunocompromised o Hospitalized and severely ill o Hospitalized for a prolonged period o Member of, or a high degree of interaction with populations who are at high risk, vulnerable, and/or who live in congregate settings e.g., HCW. Also, order Respiratory Pathogen Panel (RPP).	Isolate while waiting for test results.
New symptoms in a recovered case	**NEW** unprotected or high-risk exposure to a case or outbreak unrelated to the previous source of infection	Re-testing can be considered at a clinician's discretion or to inform public health and infection prevention and control measures. If re-test is done, order RPP as well	May represent prior infection or reinfection. PCR positivity may persist or fluctuate for weeks or in some cases months. While it is not clear how early following initial infection reinfection may occur it has been reported <2

	OR Travel to or residence in an area with high community prevalence.	Consult with MOH and/or microbiologist on call for any additional tests if tested positive for COVID-19	months after the first episode of infection. Testing for other pathogens should still be considered depending on symptoms and the setting. The management of these individuals is based on symptoms and diagnosis. If a clinician has concerns about the risk of re-infection, the individual should remain in isolation while waiting for the test result. Further management is based on lab results and assessment.
New symptoms in a recovered case	No known exposure to a new unrelated case or outbreak **OR** travel **OR** residence in an area with high community prevalence **BUT** A high degree of interaction with populations who are at high risk of more severe disease **or** outbreaks (e.g., HCWs, staff, and residents in LTCHs, prisons, shelters, single-room occupancy residences, work camps).	Testing should be considered to inform public health and infection prevention and control measures to prevent transmission.	May represent prior infection or reinfection. PCR positivity may persist or fluctuate for weeks or in some cases months. While it is not clear how early following initial infection reinfection may occur, it has been reported < 2 months after the first episode of infection.
More than 90 days since testing positive			

In general treat similarly to people who have never been knowingly exposed to nor tested positive for COVID-19. Consider the possibility of re-infection.

- Isolate while laboratory and epidemiological investigation is being conducted.
- Testing, isolation, and contact tracing if the individual develops symptoms (with or without a known or presumed exposure)
- Asymptomatic testing in the context of an outbreak investigation

*** A recovered case refers to an individual with complete resolution of symptoms associated with COVID-19, if present, or passage of sufficient time since**

Reinfections

Individuals can become re-infected with SARS-CoV-2. Evidence is evolving on the frequency of occurrence of re-infection, and timing relative to prior infection. Refer to guidance for laboratory testing for individuals suspected of being re-infected for more information.

Management of Symptomatic Individuals with No Exposure Criteria to COVID-19

An individual with symptoms of COVID-19 who;

- does not work in healthcare or a high-risk area
- who does not meet other exposure criteria
- tests negative for COVID-19

These individuals should be advised to stay at home for 24 hours after symptoms have resolved, without the use of fever-reducing medication. If symptoms worsen, individuals should be advised to use the COVID-19 Self-Assessment or to call 811 for direction. Household contacts are encouraged to self-monitor for symptoms as an additional precaution.

Management of Individuals Alerted Through the COVID-19 Alert Application

The Government of Canada recommends the use of the free COVID-19 Alert App as an additional measure to support and augment public health's existing contact tracing efforts. This app works by quickly identifying new contacts who may not have been easily notified through traditional methods. Since the alert notification process is anonymous, public health will not be aware of individuals who receive an alert through the application.

Asymptomatic Individuals Advised of COVID-19 Exposure through the COVID Alert Application

Individuals without symptoms, who have been notified through the COVID Alert App of exposure to COVID-19, should complete the COVID-19 Self-Assessment or call 811 to arrange a test and self-isolate until test results are available. If test results are negative, they should continue to monitor for symptoms for a total of 14 days from the exposure notification. If the individual is identified as a close contact of a confirmed case during a public health investigation, they must isolate for 14 days from the exposure notification. If test results are positive, the individual would be followed by public health as a case.

Symptomatic Individuals Advised of COVID-19 Exposure through the COVID Alert Application

Symptomatic individuals who have been notified through the COVID Alert App of exposure to COVID-19 should self-isolate and complete the COVID-19 Self-Assessment or call 811 to arrange a test. Household contacts of the individual should monitor for symptoms as a precaution. If test results are negative, the individual should stay at home until 24 hours after symptoms resolve, without the use of fever-reducing medication. If the individual is identified as a close contact of a confirmed case during a public health investigation, they must isolate for 14 days from the exposure notification. If test results are positive, the individual would be followed by public health as a case.

Management of an Individual Working in Healthcare or a High-Risk Area

The management of COVID-19 involving individuals working in healthcare or a high-risk area differs from that of the general population. Occupational health staff will provide guidance and follow-up for the management of COVID-19 with health care workers in facilities where dedicated occupational health staff are available. In facilities that do not have occupational health staff, public health will provide follow-up for the management of COVID-19. See ***Table 4*** for Return to Work Considerations for Healthcare Workers and Individuals Working in High-Risk Areas.

For the recommendations outlined in this document, individuals working in healthcare include:

- administrative staff
- paramedicine
- staff of acute care or primary care facilities
- staff of long term care facilities
- staff of personal care homes
- home support workers
- Community health
- Physicians

High-risk areas include individuals working in or attending:

- correctional facilities
- fire and ambulance
- RNC, RCMP
- daycares
- emergency shelters
- transition houses or other housing programs serving systemically marginalized populations

Table 4: Return to Work Considerations for Healthcare Workers and Individuals Working in High-Risk Areas.

Clinical Presentation	COVID-19 Test Results	Return to Work Considerations
Symptomatic	Positive	Following a minimum of 10 days of isolation, if respiratory symptoms have resolved (including resolution of fever without the use of fever-reducing medication), the individual can receive clearance to return to work. The absence of cough is not required for individuals known to have a chronic cough or experience reactive airways post-infection. In rare situations (i.e. extreme shortage of healthcare workers) upon consultation with the regional MOH, the individual can return to work 24 hours after symptom resolution without the use of fever-reducing medication. They must wear a mask and appropriate PPE at work at all times until their isolation period ends. The individual should continue with self-isolation when not at work until their isolation period ends.
Symptomatic – no exposure	Negative	For an individual with no exposure history or tested to rule out an outbreak, they can return to work 24 hours after symptoms have resolved. If symptoms recur, they should stay home from work, self-isolate, and contact Occupational Health within their region for further direction.
Asymptomatic	Positive	Follow the guidance for a symptomatic, positive case.
Asymptomatic	Negative	If the individual has exposure criteria for COVID-19, refer to the guidelines for the management of contacts of cases for the applicable scenario. In rare situations (i.e. extreme shortage of healthcare workers) upon consultation with the regional MOH, the individual can return to work. They must wear a mask and appropriate PPE at work at all times until their quarantine period ends. The individual should also continue with self-isolation when not at work until the isolation period ends. If the individual has low to no risk of exposure, such as no breach of PPE or tested due to outbreak screening, the individual can return to work after one negative test result. The individual must wear a mask and appropriate PPE at work at all times.

Situations may occur where a healthcare worker could be exposed to a patient being tested for COVID-19. Please refer to Appendix A for a COVID-19 risk classification tool in determining the appropriate use of PPE and potential work restrictions. If a healthcare worker is tested for COVID-19 due to exposure criteria, refer to the Contact Management section of this guidance document. Household contacts should self-monitor for symptoms as a precaution.

If a healthcare worker is being tested for COVID-19 because of symptoms with no exposure criteria, household contacts of the healthcare worker should self-monitor while the healthcare worker awaits test results. If a negative test result is obtained, the household contacts should continue to monitor for symptoms as a precaution. If a positive test result is obtained, the individual will be managed by public health as a case. At this time, household contacts should immediately self-isolate.

Individuals working in healthcare or other high-risk settings who have previously tested positive for SARS-Co-V should follow the testing and management guidance outlined in '*Testing and Management of Individuals Who Previously Tested Positive for SARS-CoV-2'* from the Department of Health and Community Services, Public Health Branch, Government of Newfoundland and Labrador (last updated November 2, 2020), see table above.

Assessment and Management of Asymptomatic Travelers

Travel outside of Newfoundland and Labrador in the past 14 days	**Consider as 'high-risk exposure'**
Domestic or International Travel	All individuals must self-isolate for 14 days upon arrival to Newfoundland and Labrador. **The arrival day is day zero**. All individuals should be advised to should self-monitor for symptoms consistent with COVID-19 for 14 days. If symptoms arise, individual should complete the COVID-19 Self-Assessment or call 811 to arrange a test.

Self-Isolation Considerations for Rotational Workers

Please review the following link for the most current guidance for Canadian Rotational Workers returning to Newfoundland and Labrador.

Travel Exemptions

Individuals can apply for an exemption from the special measure order to travel to Newfoundland and Labrador and be granted permission to enter. Unless the traveler is considered an essential worker, or they have received approval for a specific exemption from the office of the CMOH, they are required to self-isolate for 14 days. If the individual is considered an essential worker they are permitted to go to work but must otherwise self-isolate while in the province.

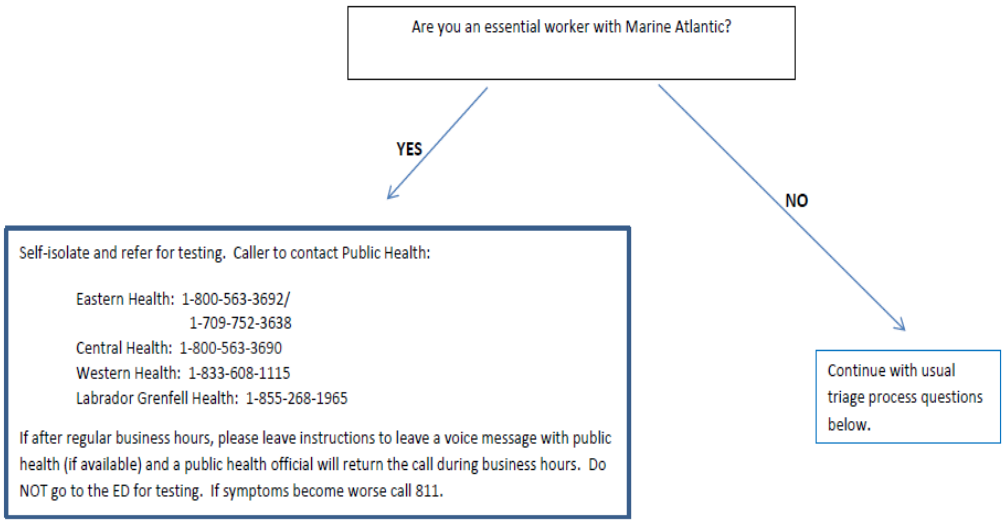
Travel exemptions can be requested through the exemptions request email: exemptionrequests@gov.nl.ca.

Self-Isolation Exemptions

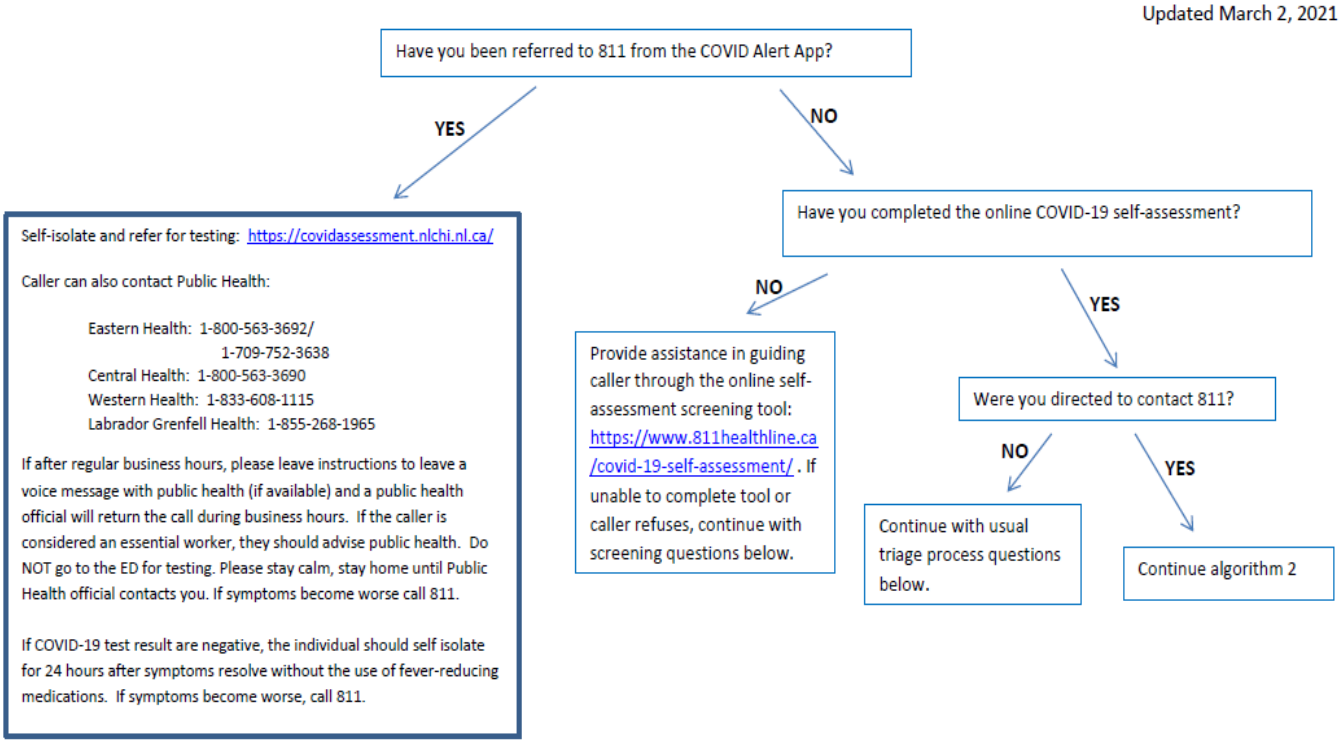
In extenuating situations such as the end of life, an individual in self-isolation may be approved to visit a family member who is dying. The health care provider for the family member who is nearing the end of life (i.e. acute care, palliative care) provides the approval however, public health may be asked to provide guidance on how to safely visit the family member. During the visit, the individual must wear a mask, maintain physical distancing, practice good hand hygiene, and visit alone (unless accompanying a child). When not visiting the palliative family member, self-isolation must continue for 14 days. Individuals that are self-isolating are not permitted to attend a funeral. If the individual is providing bereavement support, they are required to self-isolate for 14 days before providing support. If the individual develops symptoms during the isolation period, visiting is not permitted; they should be advised to complete the COVID-19 Self-Assessment or call 811 to arrange a test.

APPENDIX A-Screening Algorithm for 811

Updated March 2, 2021



Updated March 2, 2021



Updated March 2, 2021

COVID-19 Screening Question

Do you have **ONE** of the following symptoms:

Fever (including chills/sweats);
Cough (new or worsening);
Shortness of breath or difficulty breathing;
Runny, stuffy or congested nose (not related to seasonal allergies or other known causes/conditions);
Sore throat or difficulty swallowing;
Headache;
acute loss of sense of smell or taste;
Unusual fatigue, lack of energy;
New onset of muscle aches;
Loss of appetite;
Vomiting or diarrhea for more than 24 hours;
OR a child displaying small red or purple spots on hands and/or feet*?

If **NO**, proceed to screening algorithm 1
If **YES,** proceed screening algorithm 2

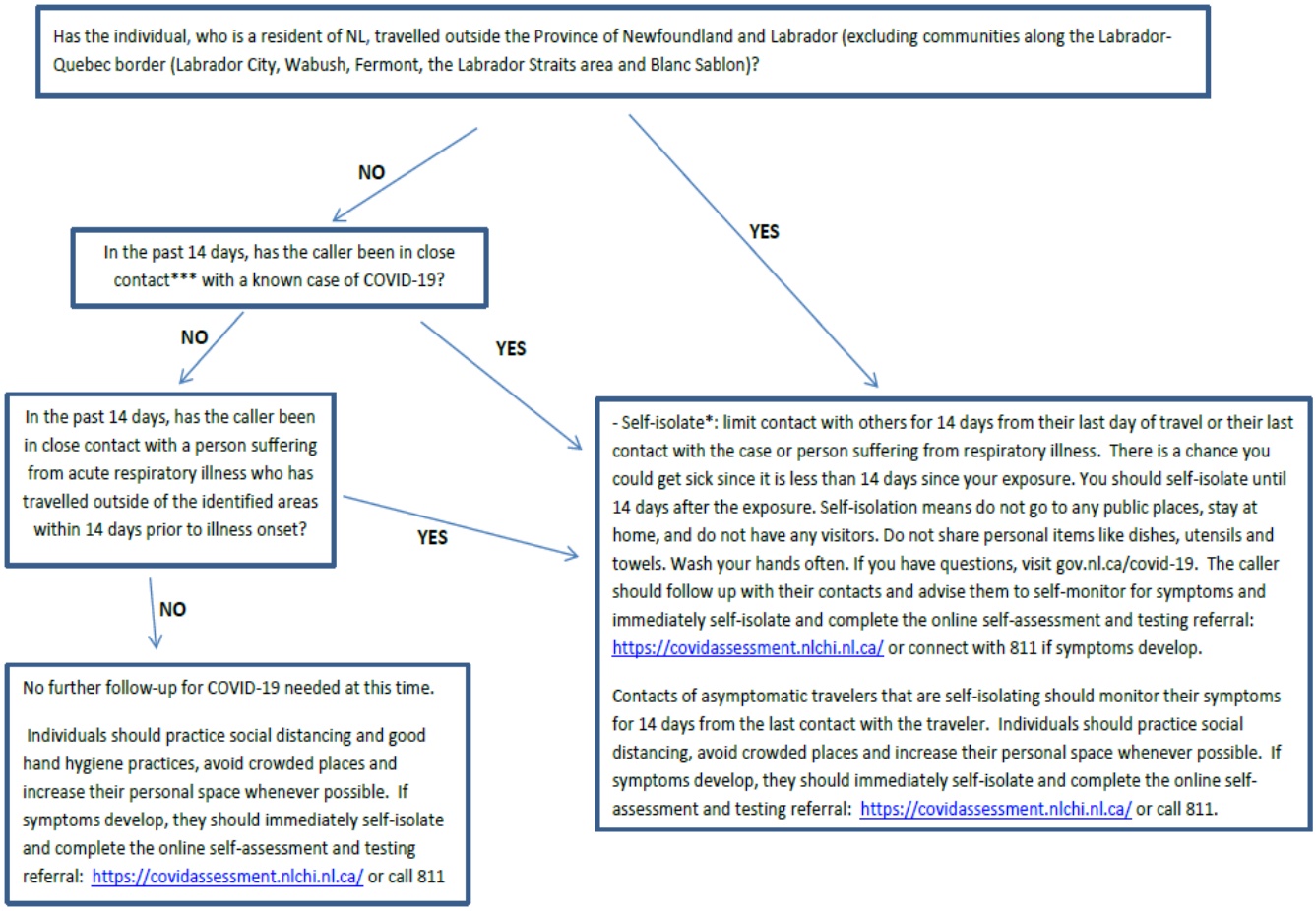
*small red or purple spots on hands and/or feet in children is an indication for COVID-19 testing. Children should still be screened using question 2. If the child has no other symptoms with the exception of small red or purple spots on hands and/or feet, they should be referred to the appropriate RHA to arrange testing but can attend school. If the child has two or more of the symptoms listed in question 2 in addition to small red or purple spots, follow the guidelines outlined in screening algorithm 2.

Following screening, if it is determined a caller should self-isolate and be referred to public health for COVID-19 testing, priority-testing appointments will be provided to individuals working in essential services. If the caller works in the following areas, advise them to inform the public health official (voicemail if necessary) they are an essential worker. Essential workers include:

- Individuals working in healthcare (hospital, long term care, personal care home, home support, paramedicine, first responders), coast guard, RNC, RCMP, fire, correctional facility, transport of essential goods, grocery stores.
- Individuals that work in or attend a daycare, emergency shelters, transition house or other housing programs serving vulnerable populations.

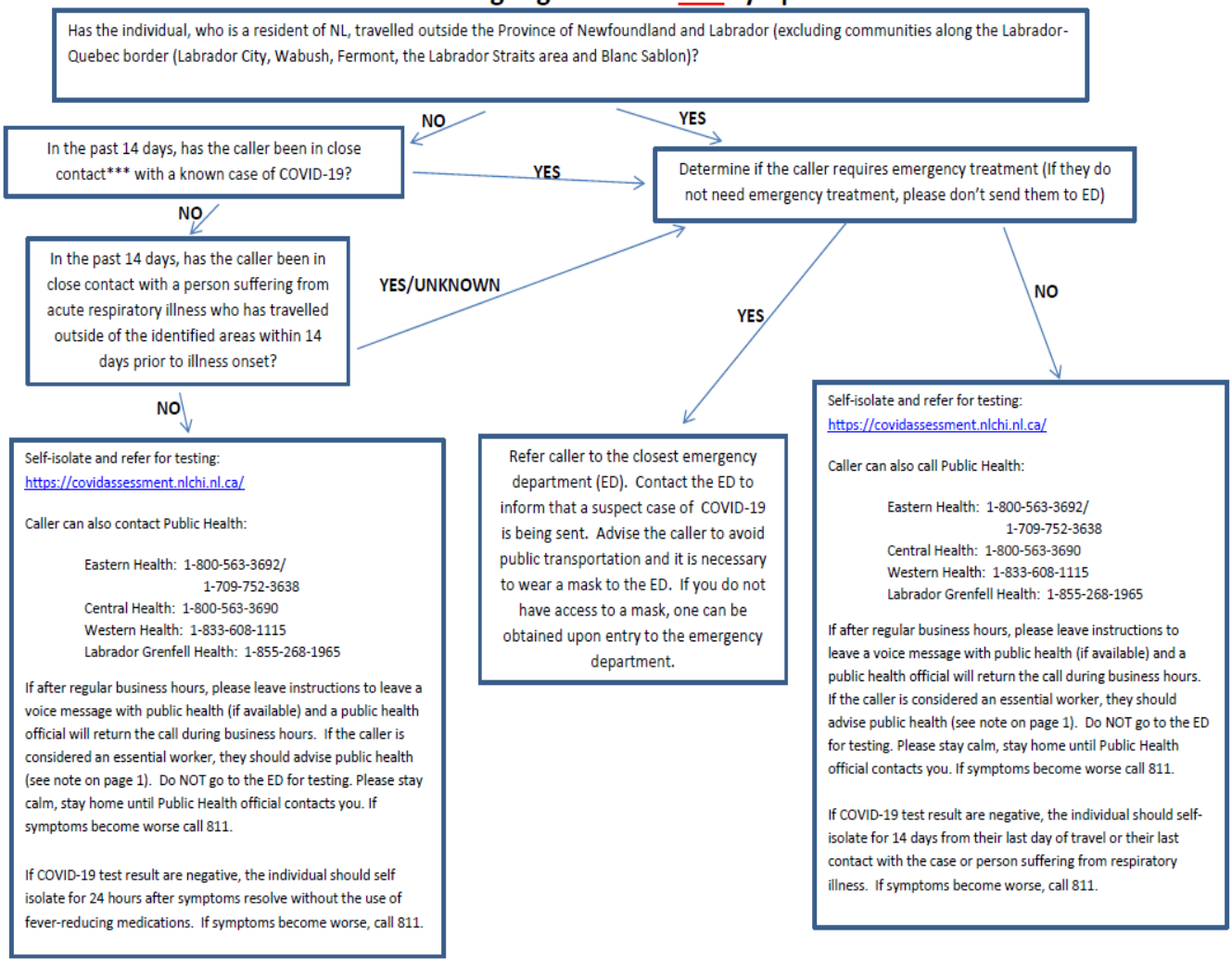
It is important to note this is not an exhaustive list. Professional judgment should be used in determining if a caller should be considered an essential worker.

Screening Algorithm 1 - No symptoms



Updated March 2, 2021

Screening Algorithm 2 - Has symptoms



Updated March 2, 2021

*Steps for self-isolation include:

- do not have face-to-face contact with individuals with chronic conditions, compromised immune systems and senior citizens;
- do not have visitors to your home;
- do not attend/visit social gatherings, work, school, daycare, health care facilities and seniors residences;
- do not take public transit, taxis or share rides ;
- wash hands often with soap and warm water frequently for at least 20 seconds; and
- cover mouth and nose with your arm when coughing or sneezing;
- If you have symptoms, isolate within household, for example: separate bedroom, separate bathroom if possible, limit contact with other household members, maintain 2 metres (6 feet) of distance between people as much as possible, routine cleaning of high touch surfaces, regular hand washing, respiratory etiquette (cover/contain cough and sneezes).

**steps for self-monitoring include:

- Self-monitor for symptoms for 14 days following their last contact.
- Self-isolation (see above) is not required.
- Self-isolate as quickly as possible should symptoms develop, and contact 811 or visit our website gov.nl.ca/covid-19 to complete self-assessment.
- Avoid crowded public spaces and places where rapid self-isolation upon onset of symptoms may not be feasible. Examples of crowded public spaces and places include mass gatherings, such as concerts and sporting events.

***A close contact is defined as a person who:

- provided care for the individual, including healthcare workers, family members or other caregivers, or who had other similar close physical contact without consistent and appropriate use of personal protective equipment OR
- who lived with or otherwise had close prolonged contact (within 2 meters) with the person while they were infectious OR
- had direct contact with infectious bodily fluids of the person (e.g. was coughed or sneezed on) while not wearing recommended personal protective equipment

Appendix B-Risk Classification for Asymptomatic Health Care Workers with Potential Exposure to COVID-19 Patients/Residents/Clients in Healthcare Settings

Purpose: To provide guidance on the HCW exposure risk for contact with a patient who is a suspect, probable or confirmed COVID-19 case.

Healthcare workers who develops signs and symptoms of COVID-19 must immediately self-isolate and contact Occupational Health (OH)

Note: Staff in Paramedicine, Emergency Rooms, Operating Rooms, Non-COVID ICUs, and Case Rooms will continue to follow PPE guideline document updated May 15, 2020 as per below:

If the screening of the patient reveals that the patient has influenza-like symptoms and/or suspect or confirmed COVID-19, the HCWs should follow Droplet-Contact Precautions:

A Level II gown or approved equivalent standard
Medical mask or approved equivalent standard
A face shield must be worn when providing patient care
Nitrile gloves – 12 inch with extended cuffs
N95 respirator or approved equivalent standard, with face shield, must be worn for AGMPs
Neck protection for AGMP as determined by PCRA

Table 1. Covid-19 positive patient/resident/client that is not wearing a mask or face covering consistently during interactions with HCW (beginning 48 hours prior to symptom onset)

Risk Factors (Potential Scenarios) – patient/client/resident NOT WEARING MASK	Risk level	Contact Type	Work Restrictions for Asymptomatic HCWs and Recommended Monitoring
HCW PPE: None	**High**	Close Contact	**Exclude** from work, self-isolate for 14 days after last exposure, self-monitoring recommended. If symptoms develop call OH.
HCW PPE: Performing an Aerosol Generating Medical Procedure (AGMP) & No N95 respirator/No eye protection	**High**	Close Contact	**Exclude** from work, self-isolate for 14 days after last exposure, self-monitoring recommended. If symptoms develop call OH.
HCW PPE: Not wearing a procedural mask or not wearing it properly (no eye protection)	**High**	Close Contact	**Exclude** from work, self-isolate for 14 days after last exposure, self- monitoring recommended. . If symptoms develop call OH.
HCW: Wearing a procedural mask and no eye protection	**Medium**	Close Contact	**Exclude** from work, self-isolate for 14 days after last exposure, self-monitoring recommended. If symptoms develop call OH.
HCW PPE: Wearing all recommended PPE	**Low** *	Non-close Contact	No work restrictions continue to wear appropriate PPE for contact/droplet precautions. Continual self-monitoring with for 14 days after last exposure. If symptoms develop call OH.
HCW PPE: Wearing all recommended PPE ***except*** gown and gloves	**Low** *	Non-close Contact	No work restrictions continue to wear appropriate PPE for contact/droplet precautions. Continual self-monitoring with for 14 days after last exposure. If symptoms develop call OH.
HCW PPE: No PPE; interaction greater than 2 meters apart and less than 15-minutes	**None**	Not a Contact	No work restrictions, continual self-monitoring, and contact OH if symptoms develop

Table 2. Covid-19 positive patient/resident/client that is wearing a mask or face covering appropriately (source control covering mouth and nose)

Risk Factors (Potential Scenarios) – patient/client/resident WEARING MASK	**Risk Level**	**Contact Type**	**Work Restrictions for Asymptomatic HCW and Recommend**
HCW PPE: None	**Low** *	Non-close Contact	No work restrictions, continual self-monitoring, for 14 days after last exposure and complete self-assessment tool as required.
HCW PPE: Not wearing a procedural mask or not wearing it appropriately	**Low** *	Non-close Contact	No work restrictions, continual self-monitoring, for 14 days after last exposure and complete self-assessment tool as required.
HCW PPE: Wearing a procedural mask but ***NOT*** wearing eye protection	**Low** *	Non-close Contact	No work restrictions, continual self-monitoring, for 14 days after last exposure and complete self-assessment tool as required.
HCW PPE: Wearing all recommended PPE ***except*** gown and gloves	**Low** *	Non-close Contact	No work restrictions, continual self-monitoring, for 14 days after last exposure and complete self-assessment tool as required.
HCW PPE: Wearing all recommended PPE	**Low** *	Non-close Contact	No work restrictions, continual self-monitoring, for 14 days after last exposure and complete self-assessment tool as required.
HCW PPE: No PPE; interaction greater than 2 meters apart and less than 15-minutes	**None**	Not a contact	No work restrictions, continual self-monitoring, for 14 days after last exposure and complete self-assessment tool as required.

***NOTE: Risk levels can be elevated:**

- If other infection control practices were not met (i.e.: Hand hygiene – 4 moments)
- If assessment by OH determines that there was a risk of exposure
- If there was exposure to an environment where an AGMP was performed before settle time complete
- Breach in PPE (i.e.: N95 becomes unsealed, eye protection becomes dislodged)
- Inconsistent use of mask/face covering by case

Table 3: Symptomatic patient/resident/client that is not wearing a mask or face covering appropriately (source control covering mouth and nose)

Note: If swab positive contact OH

Risk Factors (Potential Scenarios) – Patient/resident/client develops symptoms after admission, (with negative swab on admission) or a resident in LTC, and clinician swabs for Covid 19-based on these symptoms.	Risk Level	Contact Type	Work Restrictions for Asymptomatic HCW and Recommended Monitoring
HCW PPE: None	**Low** *	Close Contact	HCW practices droplet/contact precautions with interaction with patient and mask throughout day with all other interactions. No work restrictions call OH if symptoms develop and complete self-assessment tool as required. NO SELF-ISLOATION AT HOME REQUIRED.
HCW PPE: Not wearing a procedural mask or not wearing it appropriately	**Low** *	Close Contact	HCW practices droplet/contact precautions with interaction with patient and mask throughout day with all other interactions. No work restrictions call OH if symptoms develop and complete self-assessment tool as required. NO SELF-ISLOATION AT HOME REQUIRED.
HCW PPE: Wearing a procedural mask but ***NOT*** wearing eye protection	**None** *	Non-close Contact	HCW practices droplet/contact precautions with interaction with patient and mask throughout day. No work restrictions call OH if symptoms develop and complete self-assessment tool as required. NO SELF-ISLOATION AT HOME REQUIRED
HCW PPE: Wearing all recommended PPE ***except*** gown and gloves	**None***	Non-close Contact	HCW practices droplet/contact precautions with interaction with patient and mask throughout day. No work restrictions call OH if symptoms develop and complete self-assessment tool as required. NO SELF-ISLOATION AT HOME REQUIRED
HCW PPE: Wearing all recommended PPE	**None** *	Non-close Contact	No restrictions
HCW PPE: No PPE; interaction greater than 2 meters apart and less than 15-minutes	**None***	Not a contact	No restrictions.

Definitions

Close contact is defined as a person who:

- Provided direct care for the case without consistent and appropriate use of recommended Personal Protective Equipment (PPE); OR
- Close prolonged (≥15 minutes) contact within two meters of a confirmed COVID-19 case; OR
- Had direct contact with infectious body fluids of a case (e.g., was coughed or sneezed on) without the appropriate use of recommended PPE

Non-close contact is defined as a person who:

- Provided care for the case with consistent and appropriate use of PPE; OR

Not a Contact *is defined as a person who*:

- Only transient interactions (e.g. walking by the case or being briefly in the same room) or as a result of local community transmission
- Had prolonged (≥15 minutes) contact but not was not within two meters of a confirmed COVID-19 case

Health Care Worker *(HCW) is defined as:*

- Individuals who provide health care or support services. For this purpose, includes HCWs working in the intensive care unit, emergency room, environmental services (selected employees), laboratory services (selected employees), paramedicine/emergency medical service (public and private), community health nurses and home care workers who visit homes.

Risk Levels

High-risk exposures *refers to* HCWs who have had prolonged close contact with patients with COVID-19 (beginning 48 hours before onset of symptoms or date of diagnosis if asymptomatic) who were not wearing a cloth face covering/facemask while HCW eye, nose and/or mouth were exposed to material potentially infectious with the virus causing COVID-19 (e.g., being present in the room for AGMP procedures that generate aerosols or when respiratory secretions are likely to be poorly controlled).

Medium-risk exposures refers to HCWs who had prolonged close contact with patients with COVID-19 (beginning 48 hours before onset of symptoms or date of diagnosis if asymptomatic) who were not wearing a cloth face covering/ facemask while HCW nose/mouth were covered but eyes were exposed to material potentially infectious with the virus causing COVID-19.

Some *low-risk* exposures may be considered *medium-risk* depending on the type of care activity performed. For example, HCW who was wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosol generating procedure would be considered to have a medium-risk exposure. If an AGMP had not been performed, they would have been considered *low risk*.

Low-risk exposures refers to brief interactions with patients with COVID-19 (beginning 48 hours before onset of symptom or date of diagnosis if asymptomatic) or prolonged close contact with patients (beginning 48 hours before onset of symptoms or date of diagnosis if asymptomatic) who were wearing a cloth face covering or facemask for source control. HCW PPE use of eye protection in addition to a facemask or respirator would further lower the risk of exposure. Low-risk exposures can be elevated dependent on point of care assessments and environmental factors.

No-risk exposures refers to interactions greater than 2 meters apart and less than 15-minutes

Recommendations for Monitoring Based on COVID-19 Exposure Risk

HCWs in any of the risk exposure categories who develop signs or symptoms compatible with COVID-19 must contact OH for referral for testing and for evaluation prior to returning to work.

High or Medium-risk Exposure Level

HCWs in the *high or medium-risk* category should undergo self monitoring, self-isolation and restriction from work in any healthcare setting until 14 days after their last exposure. If they develop any **fever*** OR symptoms consistent with COVID-19 (see appendix A) they should promptly call the OH for referral to testing. OH will contact the HCW after testing for evaluation prior to returning to work.

Low-risk Exposure Level

HCW in the *low-risk* category should perform self-monitoring and tracking (for potential contact tracing purposes) until 14 days after the last potential exposure. Asymptomatic HCWs in this category are not restricted from work. HCW's should remain alert for symptoms consistent with COVID-19 (as per Appendix A). They should complete the staff-screening tool to ensure asymptomatic before leaving home and reporting for work. If they develop **fever*** OR symptoms consistent with COVID-19 they should immediately self-isolate (separate themselves from others) and call the OH for referral to to testing. OH will contact the HCW after testing for evaluation prior to returning to work.

No-risk Exposure Level

Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCW having prolonged

direct contact with patients infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, HCW should still perform self-monitoring with self-screening as described under the low-risk exposure category.

* **Fever** is either measured temperature $\geq$ 38.0°C or subjective fever. Note that fever may be intermittent or may not be present in those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of HCWs in such situations.

Additional Scenarios:

- Refer to the asterisk * above for scenarios that would elevate the risk level for exposed HCW. For example:
- HCWs who were wearing a gown, gloves, eye protection, and a facemask (instead of a respirator) during an AGMP would be considered to have a medium-risk exposure.
- HCWs not using all recommended PPE who have only brief interactions with a patient regardless of whether patient was wearing a cloth face covering or facemask are considered low risk. Examples of brief interactions include brief conversation at a triage desk; briefly entering a patient room but not having direct contact with the patient or the patient's secretions/excretions; entering the patient room immediately after the patient was discharged.
- HCWs who walk by a patient or who have no direct contact with the patient or their secretions/excretions and no entry into the patient room are considered to have no identifiable risk.

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