Alberta

Public Health Disease Management Guidelines

Coronavirus – COVID-19

Alberta

Ministry of Health, Government of Alberta

March 2020

Coronavirus, Novel Public Health Disease Management Guideline

https://www.alberta.ca/notifiable-disease-guidelines.aspx

For further information on the use of this protocol contact:

Health.CD@gov.ab.ca

Health and Wellness Promotion Branch

Public Health and Compliance Branch

Alberta Health

Case Definition

NOTE: Alberta Health will update this guideline as new information becomes available on the situation.

Confirmed Case

A person with laboratory confirmation of infection with the virus that causes COVID-19 (formerly 2019-nCoV) which consists of:

- positive nucleic acid amplification tests (NAAT) on at least two specific genomic targets or a single positive target with nucleic acid sequencing at a Provincial Public Health Laboratory where NAAT tests have been validated[(A)];

OR

- confirmed positive result by National Microbiology Lab (NML) by NAAT.

Probable Case

A person with clinical illness[(B)] who is epidemiologically-linked to a lab-confirmed COVID-19 case;

OR

A person with clinical illness[(B)] who meets the COVID-19 exposure criteria;

AND

- in whom laboratory diagnosis of COVID-19 is inconclusive[(C)], negative (if specimen quality or timing is suspect)

[(A)] As of March 9, 2020 this applies to Alberta Precision Laboratories (APL), where NAAT has been validated for detection of the virus that causes COVID-19.
[(B)] Clinical illness includes: fever (over 38°C) or new onset of (or exacerbation of chronic) cough or shortness of breath or pneumonia.
[(C)] Inconclusive is defined as a positive test on a single real-time PCR target or a positive test with an assay that has limited performance data available.

Person Under Investigation (PUI)

- A person[(D)] with clinical illness[(E)] who meets the exposure criteria.

EXPOSURE CRITERIA:

In the 14 days[(F)] before onset of illness, a person who:

- Had any history of travel outside Canada;

OR

- Had close contact with a person with acute respiratory illness who traveled outside of Canada within 14 days prior to their illness onset;

OR

- Laboratory exposure to biological material (e.g. primary clinical specimens, virus culture isolates) known to contain COVID-19.

[(D)] Laboratory test for COVID-19 has been or is expected to be requested.
[(E)] Clinical illness includes: fever (over 38°C) or new onset of (or exacerbation of chronic) cough or shortness of breath or pneumonia.
[(F)] The incubation period of COVID-19 is unknown. Allowing for variability and recall error and to establish consistency with the World Health Organization's COVID-19 case definition, exposure history based on the prior 14 days is recommended at this time.

Reporting Requirements

1. Physicians

Physicians shall notify the Medical Officer of Health (MOH) (or designate) of the zone, of all person under investigation (PUI), probable and confirmed cases in the prescribed form by the Fastest Means Possible (FMP).

2. Laboratories

All laboratories shall report all positive laboratory results by FMP (i.e. direct voice communication or secure electronic email) to:

- the MOH (or designate) of the zone , and
- the Chief Medical Officer of Health (CMOH) (or designate).

3. Alberta Health Services and First Nations Inuit Health Branch

- The MOH (or designate) of the zone where the case currently resides shall forward the Public Health Agency of Canada's *Interim Novel Coronavirus (2019-nCoV) Case Report Form* for all probable and confirmed cases to the CMOH (or designate) within 24 hours of initial laboratory FMP notification.
- For out-of-province and out-of-country reports, the following information should be forwarded to the CMOH (or designate) by FMP (i.e. direct voice communication):
  - name,
  - date of birth,
  - out-of-province health care number,
  - out-of-province address and phone number,
  - positive laboratory report, and
  - other relevant clinical / epidemiological information.

Epidemiology

Etiology

Human coronaviruses are enveloped, ribonucleic acid (RNA) viruses that are part of the *Coronaviridae* Family.[1] There are 7 known human coronaviruses at present:

- Four types that cause generally mild illness- 229E, OC43, NL63 and HKU; and
- Two types that can cause severe illness: Middle East respiratory syndrome coronavirus (MERS-CoV) and severe acute respiratory syndrome coronavirus (SARS-CoV).[1] Refer to the *Public Health Disease Management Guideline for Coronavirus – MERS/SARS* for more information.
- COVID-19 is an illness caused by a new coronavirus (SARS-CoV-2) first identified in December 2019, in Wuhan, China as having caused an outbreak of respiratory infections, including pneumonia.[2,3]

Clinical Presentation

Symptoms of COVID-19 range from mild to severe, life threatening illness and may include fever (>90% of cases), dry cough (80%) or shortness of breath (20%).[3,4]

Complications include severe pneumonia, acute respiratory distress syndrome, sepsis, septic shock, multi-organ failure or death.[5]

Reservoir

Most coronaviruses are considered zoonotic. COVID-19 is thought to have emerged from an animal source although this has not yet been confirmed.

Transmission

To date COVID-19 has limited[G] person-to-person transmission that can occur via droplet or close contact with bodily fluids (blood, stool, urine, saliva, semen).[6] Although there is uncertainty on the issue of asymptomatic transmission, it is unlikely to contribute much to the spread of the virus. The highest risk of virus spread would be from a person who has symptoms like fever and cough. Human coronaviruses are rarely spread via fecal contamination.[7]

An aerosol-generating medical procedure (AGMP) has the potential to cause airborne transmission.

[G] Versus sustained transmission where the virus spreads easily from one person to another and is not limited to groups or people living or working in close proximity to one another.

Incubation Period

The incubation period of COVID-19 is unknown.[8] SARS-CoV demonstrated a prolonged incubation period (median 4-5 days; range 2-10 days) while the incubation period for MERS-CoV is approximately 5 days (range 2-14 days). Allowing for variability and recall error and to establish consistency with the World Health Organization's COVID-19 case definition, exposure history based on the prior 14 days is recommended at this time.

Period of Communicability

The period of communicability for COVID-19 is not currently known.

Host Susceptibility

Susceptibility is assumed to be universal. People with existing chronic medical conditions (e.g., cardiovascular and liver disorders, diabetes and other respiratory diseases) are likely more vulnerable to severe COVID-19 illness.[6]

Incidence

For cases reported in Canada refer to the following link:
https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html

World Health Organization provides daily updates on global case counts and situation reports:
www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports

Johns Hopkins COVID-19 Case Map
gisanddata.maps.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6

Resources on COVID-19

Alberta Health www.alberta.ca/coronavirus-info-for-albertans.aspx
Alberta Health Services www.albertahealthservices.ca/topics/Page16944.aspx
PHAC www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html
WHO www.who.int/emergencies/diseases/novel-coronavirus-2019
CDC www.cdc.gov/coronavirus/2019-ncov/index.html
ECDC www.ecdc.europa.eu/en/novel-coronavirus-china

Public Health Management

NOTE: *The strategy outlined in this guidance is containment (i.e. to reduce opportunities for transmission to contacts in the community) and is based on the assumption that the virus is primarily spread while the case is symptomatic. This guidance is based on current available scientific evidence and expert opinion and is subject to change as new information on transmissibility and epidemiology becomes available.*[9]

Diagnosis

As the COVID-19 outbreak continues to evolve, prompt collection and testing of specimens to confirm diagnosis is required. Zone MOH approval is no longer required for specimen collection. Symptomatic individuals should be considered for testing if in the clinician's opinion there is a reason to suspect COVID-19 (e.g., no travel history but hospitalized due to severe respiratory illness with no pathogen found). Symptomatic close contacts of cases do not require testing and should be considered probable cases. If inpatient, both upper (e.g. nasopharyngeal [NP] swab, NP aspirate, auger suction) and lower (if feasible) respiratory tract specimens (e.g., bronchalveolar lavage [BAL], endotracheal tube [ETT] or tracheal aspirates) should be collected for testing.[10] If outpatient (e.g., community), only a NP swab should be collected.

Key Investigation

- Confirm the diagnosis and that individual meets case definition.
- Ensure appropriate clinical specimen(s) have been collected (see Diagnosis section for more information on specimen collection).
- Obtain history of illness including date of onset of signs and symptoms.
- Determine spectrum of illness and if case requires hospitalization or if they can be managed at home.
- Determine any underlying chronic or immunocompromising conditions.
- Determine possible source of infection:
    - Identify recent travel/residence history outside Canada, or contact with a recent traveler outside Canada, including dates of travel, itineraries and mode of transportation (e.g., airplane, train, etc.);
    - Identify type of contact within health care settings with known COVID-19 cases (e.g., work, visiting patient, etc.), if applicable;
    - Direct contact with animals (e.g. visited a live animal market or other animal contact while travelling outside Canada);
    - Recent contact with a known COVID-19 case or a person with COVID-19-like illness (i.e. fever, cough or difficulty breathing);
    - Assess if other members in the household have similar symptoms or if there has been any contact with a known COVID-19 case/person with COVID-19-like illness.
- Determine occupation (i.e. healthcare worker).
- Determine possible transmission settings (e.g. flight, household, healthcare setting).
- Identify close contacts that may have had exposure to the case while the case was communicable. Refer to *Table 1: Definition of Close Contacts.*

Table 1: Definition of Close Contacts

DEFINITION OF CLOSE CONTACTS
Individuals that: • provided care for the case, 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 (PPE), OR • lived with or otherwise had close prolonged[H] contact (within two metres) with a person while the case was ill, OR • had direct contact with infectious body fluids of a person (e.g. was coughed or sneezed on) while not wearing recommended PPE.

Management of a Hospitalized Case/PUI

- Isolation precautions apply until symptoms have resolved and laboratory investigation has ruled out COVID-19 infection.[I]
  - However, if the index of suspicion for COVID-19 infection is high, even if another infectious pathogen is identified, isolation should continue as appropriate.
  - For more information on criteria for lifting isolation, refer to Annex A: for Interpretation of Laboratory Results and Management.
- Provide information about disease transmission and measures to minimize transmission, including practicing proper hand hygiene and respiratory etiquette.
- For information on infection prevention and control precautions refer to the following:
  - *AHS IPC Resources*
  - *Infection prevention and control for novel coronavirus (2019-nCoV): Interim guidance for acute healthcare settings*

[H] As part of the individual risk assessment, consider the duration of the contact's exposure (e.g., a longer exposure time likely increases the risk), the case's symptoms (coughing or severe illness likely increases exposure risk) and whether exposure occurred in a health care setting.

[I] In hospitalized patients with confirmed COVID-19 infection, repeat upper and lower respiratory tract samples should be collected to demonstrate viral clearance. The frequency of specimen collection will depend on local circumstances but should be at least every 2 to 4 days until there are two consecutive negative results (both URT and LRT samples if both are collected) in a clinically recovered patient at least 24 hours apart. For more information refer to the WHO guidance on *Clinical management of severe acute respiratory infection when novel coronavirus (2019-nCoV) infection is suspected-Interim guidance*

Management of a Non-Hospitalized Case/PUI

- Provide information about disease transmission and measures to minimize transmission, including practicing proper hand hygiene and respiratory etiquette.
- Symptomatic cases/PUI managed at home should **be isolated** (see Annex B: Home Isolation Recommendations).
- PUI's should be isolated for 14 days after the last exposure even if laboratory investigation is negative for COVID-19 infection.
- Active daily surveillance is required for **confirmed and probable cases** (not for PUIs) until:
    - 10 days after the onset of their first symptom provided they are afebrile and have improved clinically. Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post-infection.
    - This criteria does not apply to hospitalized patients. Those who work in health care settings may need to meet additional requirements before returning to their workplace.
- The MOH ***shall* exclude** all known confirmed and probable cases from all public places[(J)] until 10 days since symptom onset and the cases are afebrile and have improved clinically.
- The MOH ***may* exclude** PUIs from sensitive situations and occupations[(K)] and public places for 14 days.
- If the case/PUI requires medical attention, advise to contact public health for further direction on where to go for care, the appropriate mode of transportation to use, and Infection Prevention Control (IPC) precautions to be followed.
- Due to the theoretical possibility that animals in the home could be affected by COVID-19, it is recommended that cases also refrain from contact with pets.
- COVID-19 virus RNA has been detected in the stool of some infected patients[(11)], so there may be a risk of spread through stool. For these reasons, the case/PUI should be instructed of the following:
    - effective infection prevention control such as hand hygiene.
    - safe food handling practices.
    - refrain from preparing foods for others in the household until isolation is lifted.

[(J)] As per the *Alberta Public Health Act*: Public places include any place in which the public has an interest arising out of the need to safeguard the public health and includes, without limitation public conveyances, places of business, learning institutions, dining facilities, recreation facilities, medical/social care facilities and any other building, structure of place visited by or accessible to the public.

[(K)] "Sensitive situations or occupations" *means*:

- Food handler who touches unwrapped food to be consumed and/or handles equipment or utensils that touch unwrapped food to be consumed;
- Healthcare, childcare or other staff who have contact through serving food to highly susceptible persons and/or provide direct patient care and are involved in the care of young, elderly or dependent persons;
- Child attending a school or place offering child care who is diapered or unable to implement good standards of personal hygiene;
- Individual attending a public place who is unable to implement good standards of personal hygiene (e.g., those with disabilities/challenges that may impact ability to perform good hand hygiene) and is involved in an activity that may promote disease transmission.

Treatment

- Currently, there is no specific treatment or vaccine to prevent infection.
- Supportive treatment is recommended based on condition of the case.
- For more information refer to WHO guidance on the clinical management of severe acute respiratory infection when novel coronavirus infection is suspected.

Management of Close Contacts of PUI

- Until laboratory results have ruled out or confirmed a PUI as a probable or confirmed case, the following recommendations apply to the close contact:
  - Determine the type of exposure, the setting and the time since last exposure with PUI;
  - Provide information about COVID-19 disease including signs and symptoms;
  - Follow good respiratory etiquette and hand hygiene practices; and
  - Self-monitor for the appearance of symptoms, particularly fever and respiratory symptoms such as coughing or shortness of breath. Refer to Annex D: Self-monitoring Recommendations for more information.

Management of Close Contacts of Confirmed and Probable Cases

- Close contacts should **self-isolate** (see Annex C: Self-Isolation Recommendations).
- The MOH ***may*** **exclude** known close contacts of confirmed and probable cases from all public places for 14 days from the time of last exposure.
- The MOH ***shall*** **exclude** health care workers who are known contacts of confirmed and probable cases until determine by the MOH to not pose a risk of infection.
- Determine the type of exposure, the setting, and the time since last exposure(L).
- Provide information about COVID-19 disease including signs and symptoms.
- Active daily monitoring is **not** required.
- A close contact who develops symptoms should be managed as a probable case. (Refer to *Key Investigation* section).

(L) For close contacts with on-going exposure, the last date of exposure is the date the case is determined to be non-infectious i.e. from 10 days since symptom onset

Management of Asymptomatic Returning Travelers (Non-HCW) from Abroad

- Recommendations for all asymptomatic travelers returning from abroad**:**
  - **Self-isolate** for 14 days after arrival in Canada (see Annex C: Self-Isolation Recommendations).
  - Call Health Link at 811 if they develop symptoms.

Management of Asymptomatic HCW

- **ALL** Health Care Workers (HCW) who may have been exposed to COVID-19 in the preceding 14 days should be assessed before returning to work.
  - Alberta Health Services (AHS) or Covenant Health employees – must contact Workplace Health and Safety (WHS)/Occupational Health Services (OHS) for assessment and to determine when to return to work.
  - Non AHS/Covenant Health employees – should connect with Public Health by calling Health Link at 811 for individual exposure risk assessment and to determine when to return to work.
- Complete risk exposure assessment. For more information, refer to *Table 2: Risk Exposure Assessment Criteria.*

Table 2: Management of HCW based on Risk Exposure Assessment Criteria

Potential Risk Exposure	Self-Isolation*	MOH *shall* exclude£	MOH *may* exclude€
• Close contact (see definition of close contact) with a probable/confirmed case of COVID-19	✓	✓	
• Travel/residence outside of Canada; • Close contact with a person with acute respiratory illness who has been outside Canada within 14 days prior to their illness onset. • Laboratory exposure¥ to biological material (e.g. primary clinical specimens, virus culture isolates) known to contain COVID-19	✓		✓
Other: • Work or hospitalization in a facility where patients with COVID-19 are being treated		Consult MOH	

** Refer to Annex C: Self Isolation Recommendations for more information.*

£ The MOH may exclude a HCW from work (e.g., acute care facilities) for 14 days since last potential exposure. If returning from anywhere outside Canada, it is advisable to continue to monitor for symptoms for a full 14 days after arrival in Canada.

€The MOH may exclude a HCW from work (e.g., acute care facilities) for 14 days since last potential exposure. If returning from anywhere outside Canada, it is advisable to continue to monitor for symptoms for a full 14 days after arrival in Canada.

¥ If exposure occurred in a healthcare facility or laboratory in Canada, where appropriate PPE is used, risk assessment is not required and there are no workplace or other restrictions required.

Management of Contacts on an Airplane

- Flight manifests are no longer being requested. Flight numbers and dates of travel for flights with symptomatic cases will be posted on the Alberta Health COVID-19 coronavirus info for Albertans website on an on-going basis in order to alert the public to possible exposures.

Preventative Measures

- Avoid close contact with people suffering from acute respiratory infections.
- Frequent hand-washing, especially after direct contact with ill people or their environment.
- People with symptoms of acute respiratory infection should practice proper cough etiquette (maintain distance, cover coughs and sneezes with disposable tissues or clothing, and wash hands).
- Within healthcare facilities, enhance standard infection prevention and control practices in hospitals, especially in emergency departments.
- People travelling outside Canada should check for current travel notices on the Government of Canada website prior to travel.

ANNEX A: Interpretation of Lab Results and Management

RPP*	COVID-19 (ProvLab)	COVID-19 (NML)	Management of PUI/Cases
Negative	Negative	N/A	Lift isolation¥
Positive£	Negative	N/A	Isolate as appropriate to RPP results
Negative	Positive	Positive	- Maintain isolation for at least 14 days from symptom onset. - Repeat testing when symptoms have resolved to demonstrate viral clearance€
Negative	Positive	Negative	- Consult with VOC - Repeat COVID-19 testing, if necessary - If repeat testing required, maintain isolation until results for repeat testing are available - May consult with OCMOH on case-by-case basis

* *Respiratory Pathogen Panel Results*

¥ *PUI who are self-isolated due to exposure risk (e.g. travel/residence outside of Canada) and who have negative RPP and COVID-19 results, should remain isolated for the full 14 days.*

£ *Positive result for anything that explains symptoms. This may also include positive tests results outside of RPP.*

€ *Demonstration of viral clearance: two negative tests for COVID-19 conducted 24 hours apart is required for hospitalized cases and HCWs. For release from isolation of non-hospitalized cases with mild symptoms should be from 10 days after symptom onset as long as they are afebrile and have improved clinically.*

ANNEX B: Home Isolation Recommendations

Definition of Isolation for Non-Hospitalized Cases/PUI:

- Isolation means avoiding situations where other people could be exposed and infected.
- Situations to be avoided include but are not limited to:
  - social gatherings, work, school/university, child care, athletic events, faith-based gatherings, healthcare facilities, grocery stores, restaurants, shopping malls, and any public gatherings.
    - consider delivery or pick up services for errands such as grocery shopping
    - may NOT go out especially if symptomatic
  - use of public transportation including buses, taxis, or ride sharing.
  - having visitors to your home (but friends, family or delivery drivers can drop off food or other things that may be needed).

The following recommendations also apply:

- **Suitable home care environment.** In the home, the case should stay in a room of their own so that they can be isolated from other household members.
  - If residing in a dormitory, such as at a post-secondary institution or where there is overcrowded housing, efforts should be made to provide the case/PUI with a single room (e.g. relocate any other roommates to another location) with a private bathroom.
  - If a separate room is not feasible, ensure that shared spaces are well ventilated (e.g. windows open, as weather permits) and that there is sufficient room for other members of the home setting to maintain a two-metre distance from the case/PUI whenever possible.
  - If it is difficult to separate the case/PUI physically in their own room, hanging a sheet from the ceiling to separate the ill person from others may be considered.
  - If the ill person is sleeping in the same room as other persons, it is important to maintain at least 2 meters of separation from others (e.g. separate beds and have people sleep head-to-toe, if possible).
  - If a separate bathroom is not available, the bathroom should be cleaned and disinfected frequently.
- **Cohorting cases/PUIs in co-living settings (e.g. those living in university dormitories, shelters, overcrowded housing).** If it is not possible to provide the case/PUI with a single room and a private bathroom, efforts should be made to cohort ill persons together.
  - If there are two cases/PUIs who reside in a co-living setting and single rooms are not available, they could share a double room.

- **Access to supplies and necessities.** The case/PUI should have access to food, running water, drinking water, and supplies for the duration of the period of self-isolation.
  - Those residing in remote and isolated communities may wish to consider stockpiling the needed supplies, as well as food and medications usually taken, if it is likely that the supply chain may be interrupted or unreliable.
- **Risk to others in the home.** Household members with conditions that put them at greater risk of complications of COVID-19 (e.g. underlying chronic or immunocompromising conditions, or the elderly) should not provide care for the case/PUI and alternative arrangements may be necessary.
  - For breastfeeding mothers: considering the benefits of breastfeeding and the insignificant role of breast milk in transmission of other respiratory viruses, breastfeeding can continue. If the breastfeeding mother is a case, she should wear a surgical/procedure mask when near the baby, practice respiratory etiquette, and perform hand hygiene before and after close contact with the baby.[(M)]
- **Access to care.** While it is expected that the case/PUI convalescing at home will be able to provide self-care and follow the recommended preventative measures, some circumstances may require care from a household member (e.g. the case/PUI is a child).
  - The caregiver should be willing and able to provide the necessary care and monitoring for the case/PUI.
- People in the household should avoid sharing toothbrushes, cigarettes, eating utensils, drinks, towels, washcloths or bed linen.
- Other types of possible exposure to contaminated items should be avoided. Dishes and eating utensils should be cleaned with soap and water after use.
- High-touch areas such as toilets, bedside tables and door handles should be cleaned daily using regular household cleaners then disinfected using diluted bleach (one part bleach to nine parts water); clothes, handkerchiefs and bedclothes of the case/PUI can be cleaned using regular laundry soap and water (60-90°C). Use disposable gloves and protective clothing (e.g., plastic aprons, if available) when cleaning or handling surfaces, clothing, or linen soiled with bodily fluids.
- Dispose of items such soiled tissues paper in a sealed garbage bag and leave out for garbage collection.

For more information, refer Interim guidance: Public health management of cases and contacts associated with novel coronavirus (2019-nCoV)

[(M)] WHO. Home care for patients with suspected novel coronavirus (nCoV) infection presenting with mild symptoms and management of contacts. [Online] 4 February 2020. www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-(ncov)-infection-presenting-with-mild-symptoms-and-management-of-contacts

ANNEX C: Self-Isolation Recommendations

Definition of Self-Isolation:

- Self-isolation means avoiding situations where other people could be exposed and infected.
- Situations to be avoided include but are not limited to:
  - Social gatherings, work, school/university, child care, athletic events, faith-based gatherings, healthcare facilities, grocery stores, restaurants, shopping malls, and any public gatherings.
    - Consider delivery or pick up services for errands such as grocery shopping.
    - May go out ONLY as required for urgent errands such as essential medication. As a precaution to further reduce risk of spread, a surgical mask may be worn out of the home.
  - Use of public transportation including buses, taxis, or ride sharing.
  - Having visitors to your home (but friends, family or delivery drivers can drop off food or other things that may be need).

During the self-isolation period, contacts should be advised to:

- Follow good respiratory etiquette and hand hygiene practices.
- Monitor for the appearance of symptoms, particularly fever and respiratory symptoms such as coughing or shortness of breath.
- Take and record temperature daily; avoid the use of fever-reducing medications (e.g., acetaminophen, ibuprofen) as these medications could mask an early symptom of COVID-19.
- Stay in an area where health care is readily accessible in case symptoms develop.
- Should symptoms develop, self-isolate within the home as quickly as possible and contact public health for further direction – where to go for care, the appropriate mode of transportation to use, and IPC precautions to be followed.

ANNEX D: Self-Monitoring Recommendations

The following recommendations apply for contacts who need to self-monitor:

- Self-isolation is not required and the contact is not required to stay at home.
- Active daily monitoring by Public Health is not required.

During the self-monitoring period contacts should be told to:

- Follow good respiratory etiquette and hand hygiene practices.
- Stay in an area where health care is readily accessible in case symptoms develop.
- If symptoms develop, self-isolate as quickly as possible and contact Health Link at 811 for further direction on where to go for care if needed, the appropriate mode of transportation to use, and IPC precautions to be followed.
  - NOTE: HCW should contact WHS/OHS or Public Health as appropriate for further direction on where to go for care, the appropriate mode of transportation to use, and IPC precautions to be followed.
- Avoid crowded public spaces or travel on conveyances where rapid self-isolation upon onset of symptoms may not be feasible.

ANNEX E: Revision History

Revision Date	Document Section	Description of Revision
2020-01-29	Case Definition	• Probable Case definition – Clinical illness moved into Footnote section. - Changed from “fever AND…” to “fever and/or…” - Removal of “breathing difficulty” and “Evidence of severe illness…” from clinical illness criteria.
		• Person Under Investigation – “fever and acute respiratory illness, or pneumonia” changed to “fever and/or cough”.
		• Exposure criteria expanded from city of Wuhan to include all of Hubei Province, China.
2020-02-07	Case definition	• The affected area in the exposure criteria has been expanded to mainland China.
2020-02-11	Epidemiology/PH Management	• Added full guideline.
2020-02-20	Case definition	• Close contact definition changed from “had direct contact with infectious bodily fluids of a probable or confirmed case…” to “had direct contact with infectious bodily fluids of a person…”
	Management of non-hospitalized case/PUI	• Added a note regarding transmission of COVID-19 in stool and management of case/PUI
	Management of HCW	• Updated in consultation with AHS. • Risk assessment table included and public health actions based on risk assessment
	Management of contacts on airplane	• Added criteria on when PH may consider expanding contact tracing on an airplane.
2020-02-27	Case definition	• “Testing not available” removed from probable case definition. • “Affected areas” expanded beyond China to Hong Kong, Iran, Italy, Japan, Singapore and South Korea. • Added “Or a provincial public health laboratory where nucleic acid amplification tests has been validated for detection of the virus that causes COVID-19.” to footnote for confirmed and probably case definitions. • Footnote G – add two more examples of other possible scenarios.

	Diagnosis	• Zone MOH approval no longer required for specimen collection.
	Management of Non-Hospitalized Case/PUI	• Active daily surveillance is no longer required for PUIs only.
	Management of Asymptomatic Returning Travelers	• Updated to include expanded affected areas. • Active daily surveillance is no longer required for self-isolated contacts. • Separated returning travelers from mainland China (given info at airport) from other affected areas (not given info at airport) but who should all self-monitor none-the-less.
	Management of Asymptomatic HCW	• Table updated to include expanded affected areas. • Active daily isolation is no longer required for self-isolated contacts.
	Management of Contacts on Airplane	• Added "movement of case around the cabin" as a consideration.
	Additional Annexes	Removed text from main guidance and put into Annexes: • Annex B: Home Isolation Recommendations • Annex C: Self-Isolation Recommendations • Annex D: Self Monitoring Recommendations
	Home Isolation Recommendations	• Updated based on new recommendations in *PHAC Public Health Management of Cases and Contacts Associated with COVID-19* document (soon to be posted).
2020-03-02	Close contacts	• A footnote was added for close contacts with on-going exposure to help with determination of "last date of exposure".
	Management of Asymptomatic Returning Travelers (non-HCW and HCW)	• Iran was added to Hubei province with recommendations to self-isolate x 14 days.
	Management of Contacts on an Airplane	• Added info on requesting a flight manifest.
	Annex A	• Added a footnote for symptomatic PUIs to remain on isolation, depending on their exposure risk, even if lab result returns as negative.
2020-03-09	Case definition	Confirmed Case: • Added APL testing is now validated • Changed the **AND** to **OR** Probable Case • Deleted: positive but not confirmed by the NML by NAAT

	Case Definition– Exposure criteria	• "Affected area" changed to "any travel outside of Canada".
	Epidemiology/PH management	• "Affected area has been changed to any travel outside Canada". • Diagnosis - Updated recommendations for specimens. • Updated close contacts exposure should be while case was communicable (not after the onset of symptoms). • Added exclusion section for cases, PUIs, close contacts.
2020-03-17	Case Definition	• Probable Case: added "person with clinical illness who is epi-linked to a lab-confirmed COVID-19 case". • Clinical illness changed to: fever (over 38oC) or new onset of (or exacerbation of chronic) cough or shortness of breath or pneumonia • PUI – clinical illness changed to match Confirmed and Probable cases. • Exposure criteria: removed "Had close contact with a confirmed or probable case of COVID-19" as this is now probable case.
	Diagnosis	• Added "Symptomatic close contacts of cases do not require testing and should be considered probable cases."
	Management of Non-Hospitalized PUI/Cases	• Added bullet that PUI should be isolated for 14 days even if COVID-19 testing comes back negative • Changed viral clearance of 2 negative tests 24 hrs apart to 'from 10 days after symptom onset' • Changed that PUI's may be excluded for 14 days
	Management of Close Contacts of Confirmed and Probable Cases	• Changed bullet to "A **close** contact who develops symptoms should be managed as a **probable** case".
	Management of Asymptomatic Returning Travelers (Non-HCW) from Abroad	• Changed recommendation to: all travelers returning from Italy should self-isolate for 14 days after arrival in Canada
	Management of Asymptomatic HCW	• Removed lower risk exposure row as all travel is now considered high risk.
	Management of Contacts on an Airplane	• Updated to indicate that flight manifests will no longer be requested but flights with known symptomatic travelers will be posted on AH website.

	Annex A: Lab Interpretation of Laboratory Results and Management	• Footnote € updated to: Demonstration of viral clearance: two negative tests for COVID-19 conducted 24 hours apart is required for hospitalized cases only. For release from isolation of non-hospitalized cases with mild symptoms should be from 10 days after symptom onset as long as they are afebrile.

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