

Alberta
Public Health
Disease
Management
Guidelines

Coronavirus – COVID-19

Ministry of Health, Government of Alberta

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Coronavirus, Novel Public Health Disease Management Guideline

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Health and Wellness Promotion Branch

Public Health and Compliance Branch

Alberta Health

Table of Contents

| | |
|--|----|
| Case Definition | 5 |
| Confirmed Case..... | 5 |
| Probable Case..... | 5 |
| Suspect case | 6 |
| Exposure Criteria..... | 6 |
| Reporting Requirements | 7 |
| 1. Physicians | 7 |
| 2. Laboratories..... | 7 |
| 3. Alberta Health Services and First Nations Inuit Health Branch..... | 7 |
| Epidemiology..... | 8 |
| Etiology | 8 |
| Clinical Presentation..... | 8 |
| Reservoir | 8 |
| Transmission | 9 |
| Incubation Period..... | 9 |
| Period of Communicability..... | 9 |
| Host Susceptibility | 9 |
| Incidence | 10 |
| Public Health Management | 11 |
| Section 1: Diagnosis | 11 |
| Section 2: Testing Modality, Recommendations, Interpretation and Management | 12 |
| Table 2a: Symptom List for COVID-19 Testing | 13 |
| Testing of Symptomatic Individuals: | 14 |
| Testing of Asymptomatic Individuals: | 14 |
| Table 2b: Management of Tested Individuals who are NOT Previous Cases..... | 14 |
| Testing and Management of Resolved Cases..... | 15 |
| Table 2c: Testing and Management of Resolved Cases..... | 16 |
| Testing Recommendations for Residents Admitted to a Facility | 17 |
| Table 2d: Testing Recommendations for Residents Admitted to a Facility..... | 17 |
| Section 3: Key Investigation | 18 |
| Table 3a: Definition of Close Contacts | 19 |
| Section 4: Management of Cases | 20 |
| Management of Hospitalized Cases | 20 |

| | |
|--|-----------|
| Discharge/Transfer of a Hospitalized Case | 20 |
| Management of Non-Hospitalized Case | 20 |
| Management of a Laboratory Confirmed Case Asymptomatic at Testing..... | 21 |
| Section 5: Management of Close Contacts | 23 |
| Management of Close Contact of Confirmed or Probable Case | 23 |
| Guidance on the Use of Masks..... | 23 |
| Section 6: Mandatory Quarantine and Isolation: CMOH Order 05-2020 | 24 |
| Immunized Individuals | 25 |
| Section 7: Management of Health Care Workers (HCW) | 26 |
| Section 8: Preventative Measures | 27 |
| Annex A: Management of COVID-19 Outbreaks..... | 28 |
| Outbreak-related Definitions | 28 |
| Management of Community Outbreaks | 28 |
| Table A1: Outbreak Definitions of COVID-19 | 29 |
| Testing of Staff/Residents/Children | 30 |
| Table A2: Symptoms to Initiate Testing in Congregate Settings | 30 |
| Table A3: Management of COVID-19 Outbreaks in Facility/Other Congregate Settings | 31 |
| Other COVID-19 Outbreak Management Recommendations for Facilities..... | 32 |
| PPE Recommendations for Staff during a Confirmed Facility COVID-19 Outbreak | 32 |
| Management of COVID-19 Outbreaks in Child Care Settings | 33 |
| Table A4: Management of COVID-19 Outbreaks In Child Care Settings..... | 33 |
| Management of COVID-19 Outbreaks In Schools (K-12)..... | 34 |
| Table A5: Management of COVID-19 Outbreaks In Schools (K-12) | 34 |
| Management of COVID-19 Outbreaks in a Workplace..... | 34 |
| Notifications of Public Exposures of COVID-19..... | 34 |
| Annex B: Management of Travellers | 35 |
| References | 44 |
| Annex C: Revision History..... | 46 |

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 (SARS-CoV-2) that causes COVID-19 which consists of:

- Detection of at least one specific gene target by nucleic acid amplification tests (NAAT) 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^(B)

- A person (with NO laboratory testing done) with clinical illness^(C) **who** had close contact to a lab-confirmed COVID-19 case

OR

- A person (with laboratory testing done) with clinical illness^(C) who meets the COVID-19 exposure criteria:

AND

- in whom laboratory diagnosis of COVID-19 is inconclusive^(D)

^(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. **NOTE:** The performance characteristics of the Simplexa®, GeneXpert®, or BD Max™ NAT are similar to the COVID-19 lab-developed test being used at APL and additional confirmatory testing is not necessary. Individuals with a positive result from any of these assays should be considered a confirmed case. (see Diagnosis section)

^(B)All symptomatic contacts should be tested where feasible to confirm diagnosis. The probable case definition should only be used in the rare circumstances when the laboratory testing cannot be done or is inconclusive but clinical suspicion is high.

^(C) Clinical illness: fever (over 38 degrees Celsius), new onset/exacerbation of following symptoms: cough, shortness of breath (SOB)/difficulty breathing, sore throat or runny nose. **NOTE:** Individuals may present with other symptoms that qualify them to be tested. Refer to Section 2: Testing Modality, Recommendations, Interpretation and Management for [Table 2a: Symptom List for COVID-19 Testing](#) for more information.

^(D) Inconclusive is defined as an indeterminate test on a single or multiple real-time PCR target(s) without sequencing confirmation or a positive test with an assay that has limited performance data available.

Suspect case^(E)

A person with clinical illness^(C) **AND**

- who meets the [exposure criteria](#);
- OR**
- had [close contact](#) with a probable case of COVID-19.

Exposure Criteria

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

- Returned to Canada from outside the country;
- OR**
- Is a [close contact](#) of a person who had acute respiratory illness who returned from travel outside Canada in the previous 14 days before they became sick;
- OR**
- Was involved in a COVID-19 outbreak or cluster
- OR**
- Had laboratory exposure to biological material (e.g., primary clinical specimens, virus culture isolates) known to contain COVID-19.

^(E) Suspect cases are NOT reportable and should be tested to confirm diagnosis. Suspect cases (because they are symptomatic) [shall by order](#), be in isolation for 10 days from onset of the following symptoms: fever (over 38 degrees Celsius), new onset/exacerbation of: cough, shortness of breath (SOB)/difficulty breathing, sore throat or runny nose or until symptoms have resolved, whichever is longer. Suspect cases who meet criteria for quarantine as per [CMOH Order 05-2020](#) shall remain in quarantine for entire 14 days even if they test negative.

^(F) Current estimates of the incubation period range from 0-14 days with median estimates of 5-6 days between infection and the onset of clinical symptoms of the disease. 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 probable and confirmed cases 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](#) or use other mutually agreed upon reporting system, to report 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) via health.cd@gov.ab.ca within 24 hours:
 - 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.
- All **confirmed outbreaks** are to be reported to Alberta Health within 24 hours via the [Alberta Outbreak Report Form \(AORF\)](#) using existing processes (e.g., CDOM or fax).

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 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

Individuals infected with the virus that causes COVID-19 may have few or no symptoms and these symptoms may range from mild to severe with manifestations such as fever (>90% of cases), dry cough (80%) or shortness of breath (20%). In Canada, commonly reported symptoms among reported cases include cough (74%), headaches (56%) and weakness (54%).^(3,4) For some of the other symptoms that can be associated with COVID-19 infection, refer to [Table 2a: Symptom List for COVID-19 Testing](#). Complications include severe pneumonia, acute respiratory distress syndrome, sepsis, septic shock, multi-organ failure or death.⁽⁵⁾

Children infected with SARS-CoV-2 typically have mild or no symptoms and account for approximately 1-10% of reported cases.⁽⁶⁾ Although rare, severe illness and death have been reported. Since April 2020, there have been reports of children presenting with acute illness accompanied by a hyperinflammatory syndrome, leading to shock and multiorgan failure. This has been termed Multi-System Inflammatory Syndrome in children (MIS-C). Some cases have been associated with COVID-19, but a causal link with COVID-19 has not been definitively established. Research to further understand MIS-C is ongoing.⁽⁷⁻⁹⁾ For more information refer to the [WHO Multisystem inflammatory syndrome in children and adolescents temporally related to COVID-19](#) and the [MIS-C Public Health Disease Management Guideline](#).

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

COVID-19 is transmitted person-to-person via droplet (i.e. coughing and or sneezing) or close contact via contaminated objects or surfaces and then touching one's own mouth, nose, or possibly eyes.⁽⁷⁾ There is evidence of transmission occurring up to 48 hours before symptom onset or even from individuals who are asymptomatic who never develop symptoms or whose symptoms went unnoticed.^(6,9) The highest risk of virus spread would be from a person who has symptoms like fever or cough. Human coronaviruses are rarely spread via fecal contamination.⁽¹⁰⁾ Airborne spread has not been conclusively documented for COVID-19.

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

Incubation Period

Current estimates of the incubation period range from 1-14 days with median estimates of 5-6 days between infection and the onset of clinical symptoms of the disease. 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.⁽⁸⁾

Period of Communicability

The period of communicability may begin one to two days before symptoms appear, and throughout the symptomatic period, even if symptoms are mild or very non-specific. Evidence shows that after day 8 of illness/symptoms no live virus was recovered from patients with upper respiratory tract disease or limited lower respiratory tract disease. People with more severe disease are likely to be infectious for a few days longer.^(11,12) NAAT positivity from respiratory samples can be prolonged to 3-4 weeks after symptom onset even when no viable virus was detected.⁽¹³⁾ There have been case reports of persistent RT-PCR results for up to 82 days after symptom onset.⁽¹⁴⁾ Experience from other respiratory viral infections suggests that immunocompromised patients with COVID-19 may shed detectable SARS-CoV-2 viral material and potentially infectious virus longer.⁽¹⁶⁾

Host Susceptibility

Susceptibility is assumed to be universal. Older adults (>age 60 years) and people with existing chronic medical conditions (e.g., cardiovascular and liver disorders, diabetes and other respiratory diseases) or immune compromising conditions are likely more vulnerable to severe COVID-19 illness.⁽¹¹⁾ There is an evolving understanding of the immune response in COVID-19 disease, and the possibility of reinfection with SARS-CoV-2 has not been excluded. However, there have been no well substantiated cases of reinfection to date and most such reported cases are likely related to testing methodologies.⁽¹⁷⁾

Incidence

For cases reported in Alberta refer to the following link:

<https://www.alberta.ca/covid-19-alberta-data.aspx>

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

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.⁽¹⁸⁾

Section 1: Diagnosis

A diagnosis of SARS-CoV-2 infection is usually based on testing. Acceptable specimen types for COVID-19 testing include NP swab, throat swab, NP aspirate, endotracheal tube (ETT) suction/sputum, or bronchoalveolar lavage/bronchial wash (BAL/BW). Nasopharyngeal (NP) and throat swabs are recommended over nasal swabs for COVID-19 testing. If unable to collect a NP swab or throat swab, a deep nasal swab can be collected instead. It is recommended that hospitalized patients with COVID-19 symptoms be tested with an NP swab. For patients who have a lower respiratory tract infection and are intubated, also submit an ETT suction or BAL/BW.⁽¹⁹⁾ For more information, refer to the lab bulletins on [Public Health Laboratories \(formerly ProvLab\)](#) website.

COVID-19 rapid nucleic acid tests (NAT) such as Simplexa®, GeneXpert®, or BD Max™ are now available in certain settings in Alberta (e.g. Foothills Medical Centre (FMC) and the Peter Lougheed Centre (PLC) in Calgary) and provide test results within six hours of receipt at the hospital laboratory. The performance characteristics of these rapid tests are similar to the COVID-19 lab-developed test being used at the APL and additional confirmatory testing is not necessary.⁽²⁰⁾

Section 2: Testing Modality, Recommendations, Interpretation and Management

Molecular, antigen, and serology tests have been developed for COVID-19. Molecular tests detect the unique genetic sequence of the SARS-CoV-2 virus and antigen tests detect proteins on the surface of the virus. Both can be used to diagnose acute infection, but antigen tests are currently not authorized for use in Canada. Serology tests do not directly detect the virus but measure antibodies the body produces after infection with the virus. These antibodies can provide evidence of previous or current infection. Since it can take more than a week for antibodies to be produced following infection, serology tests are generally not recommended for use as a diagnostic tool to confirm acute infection.⁽²¹⁾ Currently in Alberta, serology tests are mainly used for population serosurveys. Serology testing is available for clinical use for certain situations (e.g. to assist in the diagnosis of children with MIS-C) in consultation with APL microbiologists/virologists.

Testing Performance:

Molecular Tests

The overall performance of COVID-19 molecular tests to determine or rule out lab-confirmed COVID-19 cases depends on sensitivity/specifity of the test, stage of illness, and the epidemiology of COVID-19 in the population.^(22,23)

Based on estimates from the end of June 2020, false negative rate of molecular tests in those with symptoms varies depending on timing and methodology of sampling, and is estimated to be approximately 20% (range 10-30%).^(G) The following may lead to false negative results:

- insufficient virus at the site of specimen collection or
- insufficient virus at the time of specimen collection (i.e. early in the incubation period or later in the course of illness) or
- incorrect specimen collection.

False negative results pose a challenge in public health management of COVID-19 cases as an individual may still be infected and be infectious to others. If the clinical index of suspicion is high, a negative result should not rule out disease and the test should be repeated.^(H)

Although considered rare, false positive results can happen because of non-specific PCR reactions. The proportion of false positive results increase as the prevalence of COVID-19 in the population decreases.⁽²³⁾ If a test is thought to be a false positive, the test should be repeated. For more information refer to the [COVID-19 Scientific Advisory Group Rapid Response Report](#).

^(G) From NML/CPHLN Testing 101 Companion Brief document not yet posted

^(H) While waiting for results of the repeat test, the suspect case should continue to self isolate or if hospitalized, continue to be on droplet and contact precautions.

Serology Testing

Limitations of serology tests include the following:

- They are not useful in the diagnosis of acute COVID-19 infection (see above for more information).
- The relationship of various antibody types, amounts and timing of appearance to immunity is currently unknown.
- The sensitivity of serology testing in immunocompromised individuals or the elderly is currently not known.

Serological assays may be useful in targeted sampling studies in the population to model the spread of the virus and the immune response dynamics to inform the risk of further epidemic waves. They may also be used for retrospective case identification, diagnosing post-infectious complications, and to more accurately determine the prevalence of COVID-19 infection.⁽²³⁾

Testing Recommendations

Testing is recommended for the diagnosis of individuals with COVID-19 compatible symptoms as listed in **Table 2a: Symptom List for COVID-19 Testing**. Individuals with these symptoms who are working in high risk settings, including HCWs, should always be offered testing to confirm the diagnosis as well as residents/clients in congregate settings. An individual with symptoms not listed in **Table 2a** such as COVID toes or altered mental status may also be considered for testing at the discretion of the individual's clinician.

Table 2a: Symptom List for COVID-19 Testing

| Symptoms |
|---|
| <ul style="list-style-type: none">- Fever*- Cough (new cough or worsening chronic cough)*- Shortness of breath/difficulty breathing (new or worsening)*- Runny nose*- Sore throat*- Stuffy nose- Painful swallowing- Headache- Chills- Muscle/joint ache- Feeling unwell/fatigue/severe exhaustion- Nausea/Vomiting/Diarrhea/Unexplained loss of appetite- Loss of sense of smell or taste- Conjunctivitis |

*NOTE: individuals with fever, cough, shortness of breath, runny nose or sore throat, require 10 day mandatory isolation according to [CMOH Order 05-2020](#). Refer to [Section 6: Mandatory Quarantine and Isolation CMOH Order 05-2020](#)

Testing of Symptomatic Individuals:

- In Alberta, testing is being done with consent to confirm diagnosis and to track the spread of COVID-19 in the population. Testing is recommended for any person exhibiting symptoms listed in [**Table 2a: Symptom List for COVID-19 Testing**](#).
- For more information on management, refer to [**Table 2b: Management of Tested Individuals**](#).

Testing of Asymptomatic Individuals:

- Any Alberta resident who wants to be tested can now access voluntary testing, even if they are asymptomatic. The following groups will be prioritized for testing:
 - close contacts of confirmed or probable COVID-19 cases,
 - staff/residents in licensed supportive living, long-term care (nursing homes and auxiliary hospital) when a NEW COVID-19 outbreak has been declared,
 - residents/staff in an existing COVID-19 outbreak if transmission appears to still be occurring.
 - staff, residents, workers etc during an outbreak in other settings (e.g. shelters, workplaces, workcamps, corrections etc.),
 - residents admitted to licensed supportive living (including lodges and group homes) and long-term care (nursing homes and auxiliary hospital) from community or hospital settings or returning to these settings post-hospitalization for non-COVID-19 illnesses.
- For more information on management refer to [**Table 2b: Management of Tested Individuals**](#).

Table 2b: Management of Tested Individuals who are NOT Previous Cases[€]

| Symptoms** | COVID-19 Test | Management |
|--------------|---------------|---|
| Symptomatic | Positive | - Manage as a lab-confirmed case. |
| | Negative | <ul style="list-style-type: none">- With known exposure: Should quarantine for 14 days since the last exposure or isolate until symptoms resolve, whichever is longer- With no exposure: Strongly recommended to stay at home and limit contact with others until symptoms resolve. Retesting may be considered. |
| Asymptomatic | Positive | <ul style="list-style-type: none">- Manage as a lab confirmed asymptomatic case |
| | Negative | <ul style="list-style-type: none">- With known exposure: Quarantine for 14 days since the last exposure and monitor for symptoms- With no exposure: Continue with normal activities |

** See symptoms listed in [**Table 2a: Symptom List for COVID-19 Testing**](#)

€ This also applies to resolved cases after 90 days of the initial positive test

Testing and Management of Resolved Cases^(I)

- In lab-confirmed COVID-19 cases, studies have demonstrated prolonged detection of SARS-CoV-2 RNA beyond the resolution of symptoms and in most cases, prolonged RNA detection does not reflect infectious virus. The median range of viral shedding has been reported to be 3-4 weeks after symptom onset, with case reports of persistent RT-PCR results for up to 82 days after symptom onset.⁽¹⁴⁾
- Resolved cases should generally NOT be re-tested for COVID-19 within 90 days of the initial positive test result. However if the resolved case develops NEW COVID-19 symptoms within the 90 days, testing for other pathogens should still be considered depending on symptoms and the setting, and management of these individuals is based on symptoms and diagnosis.
- Re-testing for COVID-19 within the 90 day window from a previous positive test can be considered for a resolved case if a clinician has concerns about the risk of re-infection — NEW COVID-19 symptoms develop after the person's isolation period and a minimum of 48 hours have passed after resolution of previous COVID-19 related symptoms in the following situations:
 - new symptoms develop within 14 days after a new exposure (exposure to a COVID-19 case unrelated to their previous infection, e.g., people other than their household members who acquired infection from them) or
 - severe COVID-19 like illness, or
 - a HCW, or
 - immunocompromised person
- If the clinician decides to re-test for COVID-19 because of concerns about the risk of re-infection, a nasopharyngeal swab should be taken and a Respiratory Pathogen Panel (RPP) should also be ordered. The individual should be in isolation while waiting for the test result.
 - If the COVID-19 test result comes back positive, consultation with the MOH is recommended.
 - At the discretion of the MOH and in consultation with microbiologist/virologist on call, additional tests may be ordered to help with the assessment.
- The MOH should consult with the CMOH if lab results and epidemiological investigation suggest that a person may be re-infected within 90 days of an initial positive test result.
- Due to uncertainty regarding immunity after infection and the theoretical risk of re-infection, resolved cases should still take the same precautions to avoid exposure as anyone who has never had COVID-19. After 90 days of an initial positive test result, they should generally be treated as people who never had COVID-19 in terms of testing, quarantine and isolation.
- It may be possible for few individuals to shed detectable SARS-CoV-2 viral material longer than 90 days. If suspected to be the case, consultation with the local MOH and other specialists including microbiologists/virologists and infectious disease physicians can help with the management decision.
- Resolved cases who have a NEW exposure within 90 days of an initial positive test result to a case unrelated to their previous infection (people other than their household members who acquired infection from them) should be asked to avoid vulnerable populations, large groups or indoor gatherings and self-monitor for symptoms for 14 days after last exposure instead of doing a full quarantine. If any symptoms occur, isolate and seek testing. Please see testing guidance above. If the new exposure happens after 90 days of an initial positive test result,

^(I) These are previously lab-confirmed COVID-19 cases that have recovered from illness and completed isolation

the individual should be managed as any other close contact and should be quarantined for 14 days after their last exposure.

- For more information on testing and management of resolved cases refer to **Table 2c: Testing of Resolved Cases** below:

Table 2c: Testing and Management of Resolved Cases

| Timing of test from previous positive result** | New onset of COVID-19 Symptoms* | Testing Recommendations | Management Recommendations |
|--|---------------------------------|--|--|
| Less than 90 days | N/A (Asymptomatic) | No testing recommended | If inadvertently tested for COVID-19 within 90 days & result positive: <ul style="list-style-type: none"> - 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 |
| More than 90 days | N/A (Asymptomatic) | Testing indications are the same as people who have never had COVID-19 | <ul style="list-style-type: none"> - If tested for COVID-19 refer to Table 2b: Management of Tested Individuals and manage according to lab results and exposure. - Exceptions may be made to this management requirement in consultation with the local MOH and other specialists including microbiologists/virologists and infectious disease physicians. |
| Less than 90 days | Symptomatic | <ul style="list-style-type: none"> - Do not re-test generally. - Re-testing can be considered at a clinician's discretion (see text above) - If retest is done, order RPP as well - Consult with MOH and/or microbiologist/virologist on call for any additional tests if tested positive for COVID-19 again | <ul style="list-style-type: none"> - Testing for other pathogens should still be considered depending on symptoms and the setting and management of these individuals is based on symptoms and diagnosis - If a clinician has concerns about the risk of re-infection, the individual should be in isolation while waiting for the test result. Further management is based on lab results and assessment. |
| More than 90 days | Symptomatic | <ul style="list-style-type: none"> - COVID-19 - With or without RPP | <ul style="list-style-type: none"> - Isolate while laboratory and epidemiological investigation is being conducted. - If only COVID-19 is done, refer to Table 2b: Management of Tested Individuals and manage according to lab results and exposure. - Exceptions may be made to this management requirement in consultation with the local MOH and other specialists including microbiologists/virologists and infectious disease physicians. |

**This is 90 days from test date which yielded the initial positive result.

¥ Refer to [Table 2a: Symptom List for COVID-19 testing](#). NOTE: Individuals with fever, cough, shortness of breath, runny nose or sore throat, require a minimum 10 day mandatory isolation according to [CMOH Order 05-2020](#). Refer to [Section 6: Mandatory Quarantine and Isolation CMOH Order 05-2020](#).

Testing Recommendations for Residents Admitted to a Facility

- Testing is recommended for all new residents admitted to a congregate living facility as per [CMOH Order 23-2020](#) i.e. licensed supportive living (including lodges and group homes) and long-term care (nursing homes and auxiliary hospital), regardless of symptoms upon admission.
- Residents who return to these settings post-hospitalization for non-COVID-19 illnesses are also recommended to be tested whether they have symptoms or not.
- Refer to **Table 2d** below for more information.

Table 2d: Testing Recommendations for Residents Admitted to a Facility

| Previous COVID-19 Test Result | Previous Test done < or > 90 days | Testing Recommendations on Admission to Facility |
|-------------------------------|-----------------------------------|--|
| Positive | Less than 90 days | NO |
| | More than 90 days | Yes |
| Negative | Less than 90 days | Yes |
| | More than 90 days | Yes |

Section 3: 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. See [Table 2a: Symptom List for COVID-19 Testing](#).
- 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. **Clinical illness: fever (over 38 degrees Celsius), new onset/exacerbation of following symptoms: cough, shortness of breath (SOB)/difficulty breathing, sore throat or runny nose.**
 - 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 (e.g., healthcare worker^(J) or works with vulnerable individuals i.e., long-term care facilities/continuing care/group homes/shelters)
- Determine possible transmission settings (e.g., flight, household, healthcare setting, community setting).
- Identify close contacts that may have had exposure to the **confirmed/probable case** 48 hours prior to onset of symptoms in the confirmed/probable case or while the confirmed/probable case was symptomatic and not isolating. Refer to *Table 3a: Definition of Close Contacts*.
- Determine if a **laboratory confirmed case asymptomatic at testing** had two or more of the symptoms listed in clinical illness for at least 24 hours in the **seven** days prior to specimen collection date. (For more information refer to the [Management of a Laboratory Confirmed Case Asymptomatic at Testing](#)).
- For public health management of a **laboratory confirmed case asymptomatic at testing** not meeting the criteria of having two or more of the symptoms listed in clinical illness for at least 24 hours in the **seven** days prior to specimen collection, the period of communicability

^(J) Health Care Workers (HCW) are individuals who provide service in a clinical care setting, including hospitals, clinics, continuing care facilities, licensed supportive living sites (including group homes), public health centres, community assessment centres, and any other settings where face-to-face patient care is provided (including fire fighters and EMS)

- that may be used is 48 hours before laboratory specimen was collected to 10 days after the date of specimen collection. (**NOTE:** The period of communicability may be longer if they develop symptoms during the 10 days after lab specimen collection date).
- Identify close contacts that may have had exposure to a **laboratory confirmed case asymptomatic at testing^(K)** between 48 hours before the laboratory specimen collection date and isolation date of that case. Refer to *Table 3a: Definition of Close Contacts*.

Table 3a: Definition of Close Contacts^(24–27)

| DEFINITION OF CLOSE CONTACTS |
|---|
| <p>Individuals that:</p> <ul style="list-style-type: none"> provided direct care for the case, (including HCW^(J), family members or other caregivers), or who had other similar close physical contact (e.g., intimate partner, hug, kiss, handshake) without consistent and appropriate use of personal protective equipment (PPE), OR lived with or otherwise had close prolonged^(L) contact which may be cumulative, i.e., multiple interactions for a total of 15 min or more and within two metres with a case without consistent and appropriate use of PPE and not isolating OR had direct contact with infectious body fluids of a case (e.g., shared cigarettes, glasses/bottles, eating utensils) or was coughed or sneezed on while not wearing recommended PPE |

^(K) Where feasible, contact tracing for asymptomatic cases should include close contacts that were exposed to the case 48 hours before the specimen collection date. If not feasible, the specimen collection date can be used as the starting point for contact tracing.

^(L) 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.

Section 4: Management of Cases

Management of Hospitalized Cases

- Isolation precautions apply for hospitalized cases. Consult with hospital IPC for recommendations for lifting isolation.
- 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](#)

Discharge/Transfer of a Hospitalized Case^(M)

- Hospitalized cases that are discharged to their own home before hospital isolation is complete, should remain on home isolation for 10 days from onset of symptoms or until symptoms have resolved, whichever is longer, after arrival at home.
- Hospitalized cases being discharged/transferred to long-term care facilities/continuing care/group homes/shelters etc. before their isolation period is complete should remain on isolation for **14 days** from onset of symptoms or until symptoms have resolved, whichever is longer.
 - This additional length of time (four more days from the 10 days) is recommended as the case had severe disease (i.e., hospitalized) and will be re-entering to a facility with other vulnerable persons (i.e., long-term care facilities/continuing care/group homes/shelters).

Management of Non-Hospitalized Case

- Provide information about disease transmission and measures to minimize transmission, including practicing proper hand hygiene and respiratory etiquette.
- A non-test based approach to clearance for COVID-19 is recommended for cases with mild and moderate illness. Since NAAT positivity from respiratory samples can be prolonged and generally does not reflect infectious virus, a “test of cure” is often misleading.
- Symptomatic confirmed and probable cases should be isolated for 10 days from onset of COVID-19 compatible symptoms or until these symptoms have resolved, whichever is longer.
 - Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post-infection.
 - Isolation may be lifted at the discretion of the MOH for cases with prolonged loss of sense of taste/smell.
 - Residents of licensed supportive living (including group homes and lodges), long-term care, nursing homes and auxiliary hospitals should be isolated with contact and droplet precautions for a minimum 10 days or until symptoms resolve, whichever is longer. Isolation may be extended to 14 days at the discretion of the MOH/Site IPC.
- Active daily surveillance by Public Health is not required.

(M) This refers to cases hospitalized due to COVID-19

- **NOTE:** If a person is determined to be at high risk of clinical decompensation and without necessary supports (e.g. elderly with comorbidities who lives alone), their primary care physician should provide active daily surveillance if feasible, or the case should be encouraged to arrange for family/friends/community organizations to provide wellness checks.
- If the case requires non-urgent medical attention, advise to contact 811 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. If they require urgent attention, advise them to call 911 and to let 911 know they have COVID-19 so that appropriate precautions can be taken to care for the case safely.
- **NOTE:** Non-hospitalized cases who were isolated for example in an isolation centre and are returning to congregate settings (e.g., long-term care facilities/continuing care/group homes/shelters etc.) shall be in isolation for at least 10 days from onset of symptoms or until symptoms have resolved whichever is longer.
- 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⁽²⁸⁾, so there may be a risk of spread through stool. For these reasons, the case 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.

Management of Immunocompromised Case

- There is currently no information on viral shedding in immunocompromised confirmed COVID-19 cases.
 - However based on experience from other respiratory viruses, especially influenza virus, immunocompromised confirmed cases may shed SARS-CoV2 for a longer period of time.⁽¹⁶⁾
 - These cases should be isolated for 14 days from onset of symptoms or until symptoms have resolved, whichever is longer.⁽¹⁶⁾
 - Duration of isolation for those hospitalized should be decided in consultation with hospital IPC.

Management of a Laboratory Confirmed Case Asymptomatic at Testing

- Provide information about disease transmission and measures to minimize transmission, including practicing proper hand hygiene and respiratory etiquette.
- Determine if the case had two or more of the following symptoms that lasted at least 24 hours in the **seven** days before laboratory specimen collection date:
 - fever (over 38 degrees Celsius),
 - new onset/exacerbation of following symptoms: cough, shortness of breath (SOB)/difficulty breathing, sore throat or runny nose.
 - If the case had two or more symptoms that lasted at least 24 hours in the **seven** days before laboratory specimen collection date, the positive result may indicate that the symptoms were due to COVID-19 and that date of symptom onset could be used for public health investigation and management purposes.

- However, it is possible that the previous symptoms were due to another respiratory pathogen, so the case should be instructed to monitor for COVID-19 symptoms for the next 10 days since lab specimen collection date.
- For a case that had two or more of the symptoms listed above, for at least 24 hours in the **seven** days prior to specimen collection date, the period of communicability is 48 hours prior to onset of symptoms to 10 days after symptom onset.
- A hospitalized asymptomatic case should be isolated and placed on contact and droplet precautions. Consult with hospital IPC for recommendations for lifting isolation/discharge.
- A non-hospitalized asymptomatic case should be isolated for at least 10 days from the laboratory specimen collection date.
- Instruct the case to monitor for symptoms in [Table 2a: Symptoms for COVID-19 Testing](#) and if symptoms develop during the isolation period, the (hospitalized/non-hospitalized) case must remain in isolation for 10 days after onset of symptoms, or until symptoms resolve, whichever is longer.

Treatment of Cases

- 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.](#)

Section 5: Management of Close Contacts

Management of Close Contact of Confirmed or Probable Case

- Determine the type of exposure, the setting, and the time since last exposure.^(N)
- Provide information about COVID-19 disease including signs and symptoms.
- Close contacts of **confirmed cases** [shall by order \(CMOH Order 05-2020\)](#) be in quarantine for 14 days from last day of exposure and should be offered testing with consent. Refer to [Section 2: Testing Modality, Recommendations, Interpretation and Management](#).
- Close contacts of **probable** cases should also be quarantined for 14 days.
- Close contacts of **laboratory confirmed cases asymptomatic at testing**, [shall by order \(CMOH Order 05-2020\)](#) be in quarantine for 14 days from last day of exposure and should be offered testing with consent. Refer to [Section 2: Testing Modality, Recommendations, Interpretation and Management](#).
- For more information refer to [Section 6: Mandatory Quarantine and Isolation CMOH Order 05-2020 section](#).
- **NOTE:** Contact tracing for any tested individual (symptomatic or asymptomatic) should be initiated once lab results have been received and the person has been determined to be a confirmed/probable case.

Guidance on the Use of Masks

- While non-medical masks and face coverings used in the community may reduce the risk of transmission of COVID-19 on the population level, they are not considered to be sufficient PPE in an exposure to a confirmed COVID-19 case when assessing whether an individual is a close contact. This includes self-reporting of use of medical masks, situations where the case is asymptomatic/pre-symptomatic, and where both persons involved in the exposure event are masked.
- Continuous masking (medical/surgical masks) and proper hand hygiene is considered to offer sufficient protection for HCWs who have cared for patients with presymptomatic/asymptomatic COVID-19 infection. This is not considered sufficient for HCWs who work with symptomatic patients.

Rationale:

- HCWs are trained in donning/doffing/using appropriate hand hygiene, are able to implement risk assessment practices, and are more aware of the types of interactions they are having with patients.
- In addition, mask quality specifications, fit and appropriate use are difficult to assess for members of the general public, and self-reports may not be accurate.

^(N) 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 or when symptoms resolve, whichever is longer.

Section 6: Mandatory Quarantine and Isolation: CMOH Order 05-2020

- **Quarantine** is required for the following individuals:
 - All returning international travelers **shall by order** be in quarantine for 14 days after arrival in Canada and monitor for symptoms. Refer to [Table 2a: Symptom List for COVID-19 Testing.](#)
 - If symptoms develop, complete the online [COVID-19 self assessment](#) or call 811 to arrange testing for COVID-19:
 - If COVID-19 test result is negative, continue quarantine for full 14 days.
 - If COVID-19 test result is positive, shall be in isolation for 10 days from onset of symptoms or until symptoms have resolved, whichever is longer.
 - Close contacts of **confirmed** cases **shall by order** be quarantined for 14 days since last exposure and monitor for symptoms. Refer to [Table 2a: Symptom List for COVID-19 Testing.](#)
 - Close contacts of **probable** cases should also be quarantined for 14 days.
 - Close contacts of confirmed and probable cases should be offered testing. For more information refer to [Table 2b: Management of Tested Individuals](#).
 - For more information on quarantine refer to [difference between quarantine and isolation](#).
- **Isolation** is required for individuals with new onset of the following symptoms: fever (over 38 degrees Celsius) and/or new onset of (or exacerbation of chronic) cough, SOB/difficulty breathing, sore throat or runny nose **shall by order** in isolation for 10 days from onset of symptoms or until symptoms resolve, whichever takes longer.
 - Individuals with any of these symptoms and others listed in [Table 2a: Symptom List for COVID-19 Testing](#) should complete the online [COVID-19 self assessment](#) or call 811 to arrange for testing.
 - Individuals with any of the symptoms in Table 2a should remain isolated until test results are available.
 - If person had NO **known** exposure to COVID-19 and if COVID-19 test result is **negative**, they are strongly recommended to stay at home and limit contact with others until symptoms resolve.
 - If person had known exposure to COVID-19 and if COVID-19 test result is negative, complete the 14-day quarantine since the last exposure.
 - If COVID-19 test result is positive, manage as a confirmed case and continue isolation for 10 days from onset of symptoms or until symptoms have resolved whichever is longer.
 - For more information on isolation requirements refer to the [COVID-19 Alberta website](#).

Immunized Individuals

- Following the administration of a vaccine, an immunized person should be counseled about the risk of short-term self-limited side effects, including local reactions and systemic reactions.
- Because some side effects following immunization such as fever, cough, runny nose, sore throat, headache, muscle/joint ache, vomiting/diarrhea are similar to symptoms for COVID-19, if a vaccine recipient develops these symptoms after vaccination in the expected timeframe for that vaccine (for most vaccines: within 24 hours; for MMR, Varicella and MMRV, usually within **five** to 12 days), they should stay home and away from others.
- If the symptoms resolve within **two** days (48 hours), they can resume normal activities, unless they have been instructed to quarantine or isolate for other reasons.
- If the symptoms do not resolve within **two** days (48 hours) of symptom onset, they should continue to stay home and complete the online [COVID-19 self-assessment](#) or call 811 to arrange testing.
- If testing is not done, they should remain at home for 10 days after onset of symptoms if they exhibit any of the symptoms included in [CMOH Order 05-2020](#) (fever, cough, runny nose, sore throat, shortness of breath) or until symptoms resolve, whichever is longer.
- If their symptoms are on the expanded COVID-19 symptom list but not included in [CMOH Order 05-2020](#), they should stay at home until symptoms resolve.

Section 7: Management of Health Care Workers (HCW)

- Refer to [COVID-19 Return to Work Guide for AHS Healthcare Workers](#)
- HCW^(J) who may have been exposed to COVID-19 should refer to the [COVID-19 Self-Assessment Tool for Healthcare Workers](#) for more information.
- HCW^(J) that tested positive for COVID-19 **shall by order** be isolated for 10 days from onset of symptoms or until symptoms have resolved, whichever is longer.
 - **NOTE: HCW should NOT go back to work in a health care setting for 14 days from the onset of symptoms, or until symptoms resolve, whichever is longer.**
- A surgical/procedure mask and good hand hygiene is considered sufficient PPE for asymptomatic HCW working with asymptomatic patients including within the 48 hours prior developing symptoms.
 - If HCW becomes symptomatic, all the patients who they cared for (or co-workers) in the **48 hours prior to symptom onset** in that HCW will **NOT** be considered close contacts if the HCW wore a surgical/procedure mask and practiced routine, frequent hand hygiene.
 - If a patient becomes symptomatic, all HCW that cared for the patient in the **48 hours prior to symptom onset** in that patient, would **NOT** be considered close contacts if they were wearing a surgical/procedure mask and practiced good hand hygiene i.e., sufficient PPE.
 - If the time of symptom onset for the patient cannot be reliably ascertained (e.g., patient with cognitive impairment), WHS/OHS/MOH/designate should be consulted regarding period of communicability and its relationship to appropriate PPE use.
- A surgical/procedure mask and good hand hygiene is **NOT** appropriate PPE for HCW caring for symptomatic patients.

Section 8: Preventative Measures

- Avoid close contact with people that have acute respiratory infections.
- Maintain physical distancing (i.e., two metres/six feet).
- Practice proper respiratory etiquette (i.e., cover coughs and sneezes with disposable tissues or clothing).
- Wash hands often with soap and water for at least 20 seconds.
- Avoid touching your face with unwashed hands.
- Stay at home as much as possible. Avoid non-essential travel.
- Monitor for [COVID-19 symptoms](#).
- Where physical distancing (i.e., two metres/six feet) cannot be maintained, wearing a non-medical mask or face covering while out in public may be helpful in protecting others around you. For more information refer to the section on [Guidance on the Use of Masks](#) and the [COVID-19 website](#).
- Health care workers should follow [guidelines for personal protective equipment](#) when caring for individuals who may have COVID-19.
- Enhance standard infection prevention and control practices in health care facilities especially in hospitals and emergency departments.
- 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

Annex A: Management of COVID-19 Outbreaks

Outbreak-related Definitions

- **Outbreak is defined as:** “*The occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season*” (World Health Organization, 2018). **NOTE:** A common source of infection or the identification of transmission between cases are not requirements for an outbreak. The epidemiologic features of an outbreak and subsequent public health actions are assessed through the outbreak investigation process.
- **Alert:** A warning sign that the situation may evolve into an outbreak. The threshold for triggering an alert is dependent on the specific setting. For more information, refer to [Table A1: Outbreak Definitions of COVID-19](#).
- **Public Reporting:** The minimum number of cases marking the threshold for public reporting of COVID-19 outbreaks.

Management of Community Outbreaks

- A COVID-19 outbreak may be declared for community settings based on outbreak definitions listed in [Table A1: Outbreak Definition of COVID-19](#). The *Alberta Outbreak Reporting Form (AORF)* **must** be completed and sent to Alberta Health when an outbreak is declared as described in Table A1.
- An outbreak in the community or workplace/workcamp may be declared over after two incubation periods from date of onset of symptoms in the last case.

Table A1: Outbreak Definitions of COVID-19

- **NOTE:** Different alert and outbreak definitions are developed for different settings according to the risk level of that specific setting.
- The risk level is based on the combination of vulnerability of the population to severe illness and ease of transmission within the setting. It is critical to take early action to investigate and institute control measures.

| Type of Setting | Risk | Example | Alert | Outbreak** | Public Reporting |
|---------------------|----------------------|---|---|--------------------------------------|--|
| Congregate Settings | Very High Risk | Continuing Care, Long-term Care, DSL | 1 symptomatic person (see Table A3) | 1 confirmed case | 2 confirmed cases |
| | | Acute care | See AHS Acute Care Outbreak document | See AHS Acute Care Outbreak document | |
| | High Risk | Prisons/Correctional Facilities | 1 symptomatic person (see Table A3) | 1 confirmed case | 5 confirmed cases |
| | | Homeless Shelters or Temporary Housing | 1 symptomatic person (see Table A3) | 1 confirmed case | |
| | | Child care setting: includes daycares, after school care, preschools, day homes. | 2 symptomatic individuals within 48 hours OR 1 confirmed case (see Table A4) | 2 confirmed cases [€] | |
| | High Risk Workplaces | Work Camps | 1 confirmed case [¥] | 2 confirmed cases [€] | 10 confirmed cases associated with at least 3 households |
| | | Food Processing Facilities, Warehouses, Distribution, and Manufacturing Facilities, other workplaces where individuals work in close proximity indoors for extended periods of time | | | |
| | Medium Risk | Schools | | | |
| Events | Medium Risk | <i>Including but not limited to weddings, funerals, religious gatherings, community events and small gatherings with more than one household</i> | N/A | 5 confirmed cases* | 10 confirmed cases associated with at least 3 households |
| Public Settings | Medium-Low Risk | <i>Including but not limited to hair salons, restaurants, retail spaces, indoor or outdoor recreation facilities, etc.</i> | N/A | 5 confirmed cases* | 5 confirmed cases |
| Other work places | Medium-Low Risk | <i>Workplaces that do not fit into the categories above (e.g. office buildings)</i> | N/A | 5 confirmed cases* | 10 confirmed cases |

^{**}Confirmed case/s needs to have been in the setting during their incubation period or infectious period

[¥] Work camps and other facilities: Consider involvement of Environmental Public Health to ensure knowledge of the worksite and workforce. For schools refer to the [Resource Guide for COVID-19 Outbreaks in Schools](#).

[€]Case numbers within a 14 day period, OR cases with an epi link

^{*}Case numbers within a 14 day period, OR cases with an epi link AND at least two or more households are involved

Management of COVID-19 Outbreaks in Facility/Other Congregate* Settings

Testing of Staff/Residents/Children

- Testing should be done for the following symptomatic individuals:
 - Residents/staff in facilities as per [CMOH Order 23-2020](#) (i.e., licensed supportive living (including group homes and lodges), long-term care, nursing homes and auxiliary hospitals),
 - Residents/staff in other congregate settings* not covered by [CMOH Order 23-2020](#) (e.g. corrections, shelters)
- Refer to **Table A2: Symptoms to Initiate Testing**.
- For more information on testing refer to [Section 2: Testing Modality, Recommendations, Interpretation and Management](#).

*Congregate settings are defined as locations where individuals live, work or are cared for within close quarters in a communal environment.

Table A2: Symptoms to Initiate Testing in Congregate Settings

| • Staff in Facility • Staff/Resident in Other Congregate Setting • Staff/Children in Childcare Setting/School | Residents in Facility |
|---|--|
| <ul style="list-style-type: none">- Fever*- Cough (new cough or worsening chronic cough)*- Shortness of breath/difficulty breathing (new or worsening)*- Runny nose*- Sore throat* <p>New/unusual onset of any of the following:</p> <ul style="list-style-type: none">- Stuffy nose- Painful swallowing- Headache- Chills- Muscle/joint ache- Feeling unwell/fatigue/severe exhaustion- Nausea/Vomiting/Diarrhea/Unexplained loss of appetite- Loss of sense of smell or taste- Conjunctivitis | <ul style="list-style-type: none">- Fever (37.8°C or higher)*- Cough (new cough or worsening chronic cough)*- Shortness of breath/difficulty breathing (new or worsening)*- Runny nose*- Sore throat* <p>NEW ONSET of any of the following:</p> <ul style="list-style-type: none">- Stuffy nose/Sneezing- Hoarse Voice/Difficulty or Painful swallowing- Headache- Chills- Muscle/joint ache- Feeling unwell/fatigue/severe exhaustion- Nausea/Vomiting/Diarrhea/Unexplained loss of appetite- Loss of sense of smell or taste- Conjunctivitis- Altered/change in mental status |

NOTE: individuals with fever, cough, shortness of breath, runny nose or sore throat, require 10 day mandatory isolation or until symptoms resolve, whichever is longer according to [CMOH order 05-2020](#).

- For recommendations on management of outbreaks in facilities and other congregate settings refer to **Table A3: Management of COVID-19 Outbreaks in Facility/Other Congregate Settings**

Table A3: Management of COVID-19 Outbreaks in Facility/Other Congregate Settings

| Setting | Management of a Single Symptomatic Person | Definition of COVID-19 Outbreak | Management of Confirmed COVID-19 Outbreak |
|--|---|--|--|
| Facility (e.g, long term care facility) | <ul style="list-style-type: none"> For any staff/resident with symptoms listed in Table A2 above, the following actions apply: <ul style="list-style-type: none"> Resident must be isolated, placed on contact and droplet precautions and tested for COVID-19. Any symptomatic staff MUST NOT work. They must self-isolate at home and arrange for COVID-19 testing on site or via the HCW screening online tool. | A COVID-19 Outbreak is defined as: <ul style="list-style-type: none"> Any resident who is confirmed to have COVID-19 and/or Any staff member who is confirmed to have COVID-19^(O) | <ul style="list-style-type: none"> All confirmed outbreaks that meet the COVID-19 outbreak definition should be investigated and reported |
| Other Congregate Setting (e.g corrections, shelters) | <ul style="list-style-type: none"> Determine any urgent issues for the site/facility e.g., access to testing, personal protective equipment (PPE) etc. No reporting to Alberta Health (AH) required. If test results are negative for COVID-19, usual influenza like-illness (ILI) or gastrointestinal illness (GI) outbreak protocols (e.g., daily line lists, enhanced IPC and other control measures) should be followed, as appropriate to the identified organism causing the outbreak and report to AH as per usual processes. | | |

^(O) This refers to staff in facilities as per [CMOH Order 23-2020](#) and in other congregate settings who **worked** at the site/s during the incubation period or during the communicable period **WITHOUT** appropriate PPE. (See section on Management of HCW).

- The communicable period is defined as 48 hours before symptom onset to isolation date in symptomatic cases, OR 48 hours before lab specimen collection date to isolation date in asymptomatic cases.
- Where feasible, contact tracing for asymptomatic cases should include close contacts that were exposed to the case 48 hours before the specimen collection date. If not feasible, the specimen collection date can be used as the starting point for contact tracing.
- NOTE:** If staff worked at multiple sites in the 48 hours prior to symptom onset/lab test **WITHOUT** appropriate PPE, outbreak should be declared at those sites.

Other COVID-19 Outbreak Management Recommendations for Facilities

- For more information refer to the [AHS Guidelines for COVID-19 Outbreak Prevention, Control and Management in Congregate Living Sites](#) and the [CMOH Order 23-2020](#).
- An outbreak in licensed supportive living (including group homes and lodges), long-term care, nursing homes and auxiliary hospitals) may be declared over after 28 days (two incubation periods) from date of onset of symptoms in the last case, with the following exceptions
 - If a staff member is the only confirmed case at the outbreak site, the outbreak can be declared over after 14 days from their last day of work.
 - **NOTE:** Asymptomatic staff and residents should NOT be retested during a site outbreak if they were a lab confirmed COVID-19 case within the past 90 days. For more information, refer to the [Testing and Management of Resolved Cases](#) section.

PPE Recommendations for Staff during a Confirmed Facility COVID-19 Outbreak

- Where there is evidence of transmission (defined as two or more lab-confirmed COVID-19 cases), continuous use of surgical/procedure mask and eye protection (e.g. goggles, visor, face shield) is recommended for all staff providing direct face-to-face care of residents/patients.
- Full contact and droplet precautions should be applied when providing care to any symptomatic person (including any lab-confirmed case of COVID-19) until that person is determined by IPC (where available) or the MOH/designate to be non-infectious.
- **NOTE:** Continuous use of surgical/procedure mask and proper hand-hygiene is recommended for all other patient care areas in AHS and community settings with NO COVID-19 outbreak.

Management of COVID-19 Outbreaks in Child Care Settings

- Child care setting includes daycares, after school care, preschools, day homes.
- For one staff or child with COVID-19 symptoms listed in [Table A2: Symptoms to Initiate Testing](#) or a child with rash, the following actions apply:
 - Child must NOT enter the setting, or must be sent home if becomes symptomatic on site, and isolated. Instruct parents to complete online [COVID-19 self assessment](#) or call 811 to arrange testing.
 - Any symptomatic staff MUST NOT work. They must self-isolate at home and arrange testing via the online [COVID-19 self assessment](#) or call 811.
 - Refer to Table A4: Management of COVID-19 Outbreaks in Child Care Setting for more information.
 - An outbreak in a child care setting can be declared over 28 days (two incubation periods) after date of onset of symptoms in the last case.

Table A4: Management of COVID-19 Outbreaks In Child Care Setting

| Setting | COVID-19 Alert | | COVID-19 Outbreak | Management of Confirmed COVID-19 Outbreak |
|--------------------|--|---|--|--|
| | Two Symptomatic Individuals | One Confirmed Case | | |
| Child Care Setting | <ul style="list-style-type: none"> Two symptomatic individuals (child/staff) within 48 hours The child care setting must call 1-844 to connect with public health who will: <ul style="list-style-type: none"> advise on additional IPC measures, recommend testing for symptomatic persons via the online COVID-19 self assessment tool or call 811 refer to EPH or CDC if investigation determines symptoms may be due to another pathogen No reporting to Alberta Health (AH) required. If test results are negative for COVID-19, usual influenza like-illness (ILI) or gastrointestinal illness (GI) outbreak protocols (e.g., daily line lists, enhanced IPC and other control measures) should be followed, as appropriate to the identified organism causing the outbreak and report to AH as per usual processes. | <p>When there is one confirmed case (staff/child) in a child care setting, actions include but not limited to the following:</p> <ul style="list-style-type: none"> Case investigation and contact follow-up Engagement with the child care setting as appropriate to ensure measures are in place to prevent spread, identify additional cases early and communicate with parents in a timely manner Report to AH | <p>A COVID-19 Outbreak is defined as:</p> <ul style="list-style-type: none"> Two confirmed cases (staff/child) within 14 days (one incubation period) OR Two confirmed cases (staff/child) that are epidemiologically linked | All confirmed outbreaks that meet the COVID-19 outbreak definition should be investigated and reported |

Management of COVID-19 Outbreaks In Schools (K-12)

- For one staff or child with COVID-19 symptoms listed in [Table A2: Symptoms to Initiate Testing](#), the following actions apply:
 - Child must NOT enter the setting, or must be sent home if becomes symptomatic on site and isolated. Instruct parents to complete online [COVID-19 self assessment](#) or call 811 to arrange testing.
 - Any symptomatic staff MUST NOT work. They must self-isolate at home and arrange testing via the online [COVID-19 self assessment](#) or call 811.
- Refer to Table A5: Management of COVID-19 Outbreaks in Schools for more information. For full guidance, please refer to the [Resource Guide for COVID-19 Outbreaks in Schools](#).
- An outbreak in a school can be declared over 28 days (two incubation periods) after date of onset of symptoms in the last case.

Table A5: Management of COVID-19 Outbreaks In Schools (K-12)

| Setting | COVID-19 Alert | COVID-19 Outbreak | Management of Confirmed COVID-19 Outbreak |
|---------|---|---|--|
| School | <ul style="list-style-type: none">One confirmed case (staff/child) in a schoolActions during an alert include but not limited to the following:<ul style="list-style-type: none">Engagement with the school as appropriate to ensure measures are in place to prevent further spreadCommunication with parents/ school boardReport to AH | <p>A COVID-19 Outbreak is defined as:</p> <ul style="list-style-type: none">Two confirmed cases (staff/child) within 14 days (one incubation period) ORTwo confirmed cases (staff/child) that are epidemiologically linked | <ul style="list-style-type: none">All confirmed outbreaks that meet the COVID-19 outbreak definition should be investigated and reported |

Management of COVID-19 Outbreaks in a Workplace

- Any staff/client with COVID-19 symptoms listed in [Table A2: Symptoms to Initiate Testing](#) MUST NOT work and testing should be arranged by completing the online [COVID-19 self assessment](#) or calling 811.
- Refer to [Table A1: Outbreak Definitions of COVID-19](#) for information on COVID-19 alerts and confirmed outbreaks.

Notifications of Public Exposures of COVID-19

- In instances where it is determined that a known COVID-19 positive case attended a public space/event while infectious, every effort should be made by public health to identify close contacts and notify them individually. Additional communication tools may be considered to notify potentially exposed individuals of their risk and actions they should take (e.g. distribution of letters or a media announcement).
- These tools should be utilized on the recommendation of the Zone Medical Officer of Health and in collaboration with public health teams, impacted stakeholders, and Alberta Health.

Annex B: Management of Travellers

- An official global travel advisory is in effect and non-essential travel is NOT recommended.
- Any returning travellers to Canada, must follow mandatory requirements as laid out in the *Federal Emergency Order* under the *Quarantine Act* and [CMOH Order 05-2020](#).
- Some individuals may be exempt from travel restrictions e.g., if they provide critical services and have no symptoms, or meet other exemption criteria. For more information refer to the Public Health Agency Canada website on [Exemptions to travel restrictions](#).

National/International Flights

- At this time flight manifests are not being requested for domestic/international flights.
- Information for domestic/international flights with infectious cases will be sent to the Public Health Agency of Canada by Alberta Health to be posted on the [Government of Canada Coronavirus disease \(COVID-19\): Locations where you may have been exposed](#).
- Alberta Health must be notified of any cases that travelled by plane while infectious. This includes:
 - Cases who were symptomatic during travel or
 - Cases with symptom onset/lab specimen collection date no more than 10 days BEFORE the date of travel
 - Cases with symptom onset no more than 48 hours AFTER the date of travel. **NOTE:** since pre-symptomatic/asymptomatic transmission of COVID-19 can occur, individuals do not have to have been symptomatic while on the flight in order to post flight information on the website.
- Notification is not required for flights that occurred more than 14 days ago.
- Please include the following information for all flight notifications to Alberta Health including those who reside outside Alberta (regardless of whether the case is being counted here):
 - ULI or CDOM DI#,
 - Name
 - Onset of illness date,
 - Dates of travel,
 - Airline(s),
 - Departure and arrival cities for each flight (include country if outside of Canada) and
 - Seat number(s) (if known).

Provincial Chartered Flights

- Flight manifests, especially those relating to work camps, should be requested by local Public Health as part of the case/contact investigation and followed up as per guidance below. (To request a flight manifest for a chartered flight, refer to internal Public Health process).
- Alberta Health should be notified of any cases that reside outside Alberta, and that travelled **while infectious**, regardless of whether or not Alberta is counting the case. The following information should be included:
 - ULI or CDOM DI#,
 - Contact information (address, phone #)
 - Onset date,
 - Dates of travel,
 - Airline(s), and
 - Seat number(s) (if known).
- Alberta Health should be notified of any **close contacts that reside outside of Alberta** and that travelled on the same flight as a confirmed case that require notification.
 - ULI or CDOM DI# (if available)
 - Contact information (address, phone #)
 - Dates of travel,
 - Airline(s), and
 - Seat number(s) (if known).
- Contact tracing of travelers on a chartered airplane who may have been exposed to case of COVID-19 during a flight should be made on a case-by-case basis based on the following:
 - case's classification (e.g. confirmed),
 - the type and severity of symptoms of the case during the flight, and
 - movement of case around the plane cabin.
- There is currently no evidence of transmission risk related to flight duration. The following recommendations apply regardless of length of flight.
- When a case(passenger) was symptomatic on the flight contact tracing should focus on the following:
 - passengers seated within two meters of the index case, AND
 - crew members serving the section of the aircraft where the index case was seated, AND
 - persons who had close contact with the index case, e.g. travel companions or persons providing care.
- Expanding the scope of contact tracing may be considered based on the severity of symptoms of the case (passenger) during the flight e.g. persistent coughing, sneezing, diarrhea or vomiting.
- If the case on the flight was a symptomatic crew member, contact tracing may also be considered for all passengers seated in the area where the crew member provided service and all other crew members.
- Refer to [Management of Close Contacts of Confirmed/Probable Cases](#) section for further management of these contacts.

Annex C: Revision History

| Revision Date | Document Section | Description of Revision |
|---------------|---|--|
| 2020-01-29 | Case Definition | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> The affected area in the exposure criteria has been expanded to mainland China. |
| 2020-02-11 | Epidemiology/PH Management | <ul style="list-style-type: none"> Added full guideline. |
| 2020-02-20 | Case definition | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> Added a note regarding transmission of COVID-19 in stool and management of case/PUI |
| | Management of HCW | <ul style="list-style-type: none"> Updated in consultation with AHS. Risk assessment table included and public health actions based on risk assessment |
| | Management of contacts on airplane | <ul style="list-style-type: none"> Added criteria on when PH may consider expanding contact tracing on an airplane. |
| 2020-02-27 | Case definition | <ul style="list-style-type: none"> “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. |

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| | Diagnosis | <ul style="list-style-type: none"> Zone MOH approval no longer required for specimen collection. |
| | Management of Non-Hospitalized Case/PUI | <ul style="list-style-type: none"> Active daily surveillance is no longer required for PUIs only. |
| | Management of Asymptomatic Returning Travelers | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> Table updated to include expanded affected areas. Active daily isolation is no longer required for self-isolated contacts. |
| | Management of Contacts on Airplane | <ul style="list-style-type: none"> Added "movement of case around the cabin" as a consideration. |
| | Additional Annexes | <p>Removed text from main guidance and put into Annexes:</p> <ul style="list-style-type: none"> Annex B: Home Isolation Recommendations Annex C: Self-Isolation Recommendations Annex D: Self Monitoring Recommendations |
| | Home Isolation Recommendations | <ul style="list-style-type: none"> Updated based on new recommendations in <i>PHAC Public Health Management of Cases and Contacts Associated with COVID-19</i> document (soon to be posted). |
| 2020-03-02 | Close contacts | <ul style="list-style-type: none"> A footnote was added for close contacts with ongoing exposure to help with determination of "last date of exposure". |
| | Management of Asymptomatic Returning Travelers (non-HCW and HCW) | <ul style="list-style-type: none"> Iran was added to Hubei province with recommendations to self-isolate x 14 days. |
| | Management of Contacts on an Airplane | <ul style="list-style-type: none"> Added info on requesting a flight manifest. |
| | Annex A | <ul style="list-style-type: none"> 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 | <p>Confirmed Case:</p> <ul style="list-style-type: none"> Added APL testing is now validated Changed the AND to OR <p>Probable Case</p> <ul style="list-style-type: none"> Deleted: positive but not confirmed by the NML by NAAT |

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| | Case Definition—Exposure criteria | <ul style="list-style-type: none"> “Affected area” changed to “any travel outside of Canada”. |
| | Epidemiology/PH management | <ul style="list-style-type: none"> “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 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> Added “Symptomatic close contacts of cases do not require testing and should be considered probable cases.” |
| | Management of Non-Hospitalized PUI/Cases | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> Changed recommendation to: all travelers returning from Italy should self-isolate for 14 days after arrival in Canada |
| | Management of Asymptomatic HCW | <ul style="list-style-type: none"> Removed lower risk exposure row as all travel is now considered high risk. |
| | Management of Contacts on an Airplane | <ul style="list-style-type: none"> Updated to indicate that flight manifests will no longer be requested but flights with known symptomatic travelers will be posted on AH website. |

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| | Annex A: Lab Interpretation of Laboratory Results and Management | <ul style="list-style-type: none"> 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. |
| 2020-03-28 | Case definition | <ul style="list-style-type: none"> Definition of clinical illness changed to: New onset of Fever, Cough, Shortness of breath/Difficulty breathing, Sore throat, Runny nose. PUI title changed to Persons with clinical illness and exposure criteria |
| | Epidemiology | <ul style="list-style-type: none"> Updated transmission, incubation and communicability sections based on current evidence. |
| | Close Contacts | <ul style="list-style-type: none"> Prolonged case definition has been included. |
| | Discharge/Transfer of hospitalized cases | <ul style="list-style-type: none"> New section added |
| | Mandatory Quarantine Isolation | <ul style="list-style-type: none"> New section added to account for legal requirement for Quarantine and Isolation |
| | Management of returning travelers | <ul style="list-style-type: none"> Deleted |
| | Management of HCW | <ul style="list-style-type: none"> Table 2 deleted as a Self-assessment tool for HCW has been developed. Hyperlink to self assessment tool included Included definition for HCW |
| | Management of Outbreaks | <ul style="list-style-type: none"> New section added |
| | Annex A | <ul style="list-style-type: none"> Deleted column regarding tests results from NML as all confirmatory results are being done at Provlab Removed information on viral clearance for hospitalized cases. These should follow hospital IPC recommendations. |
| | Annex B | <ul style="list-style-type: none"> Updated home isolation and information so that it's consistent with what is posted on the Alberta COVID-19 website |
| 2020-04-02 | Case definition | <ul style="list-style-type: none"> Title changed to Quarantine Requirements |
| | Hospitalized Cases | <ul style="list-style-type: none"> Deleted. Self-monitoring information embedded in rest of document. No testing for clearance is required |

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| | Discharge/Transfer of Hospitalized cases | <ul style="list-style-type: none"> Updated to 14 days isolation and no testing for clearance |
| | Management of HCW | <ul style="list-style-type: none"> Updated to 14 days isolation and no testing for clearance |
| | Management of Facility Outbreaks | <ul style="list-style-type: none"> Updated with new outbreak case definition |
| | Management of Contacts on Airplane | <ul style="list-style-type: none"> Updated website to Government of Canada for airline travel info. |
| 2020-04-10 | Case definition | <ul style="list-style-type: none"> The following have been changed based on updated PHAC case definition <ul style="list-style-type: none"> Suspect case definition added Confirmed case definition updated Exposure criteria updated |
| | Epidemiology | <ul style="list-style-type: none"> Transmission, incubation period and period of communicability updated to include possible asymptomatic transmission 48 hours prior to symptom onset |
| | Public Health management | <ul style="list-style-type: none"> Updated key investigation section to include identifying close contacts that may have been exposed to the case 48 hours before onset of symptoms in the case or 48 hours before lab specimen collection for asymptomatic cases |
| | Management of Laboratory Confirmed Asymptomatic Case | <ul style="list-style-type: none"> New section added |
| | Management of HCW | <ul style="list-style-type: none"> Updated to include information on sufficient PPE |
| | Diagnosis | <ul style="list-style-type: none"> Updated to include specimens that can be submitted for testing for COVID-19. Added section on testing of asymptomatic individuals |
| 2020-04-24 | Management of non-hospitalized cases | <ul style="list-style-type: none"> Added a bullet that cases active daily surveillance should ideally be done by primary health care provider for cases at risk for complications. |
| | Management of Asymptomatic cases | <ul style="list-style-type: none"> Added information on determining if the case may have had symptoms in the 7 days prior to lab specimen collection date. |
| | Management of Facility Outbreaks | <ul style="list-style-type: none"> Section moved to Annex B and C <ul style="list-style-type: none"> Annex B: Management of Facility Outbreaks: CMOH Order 12-2020. Included information on PPE recommendations for staff during an outbreak. Annex C: Management of Congregate Settings Outbreaks |

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| | | <ul style="list-style-type: none"> - Added new Annex D: Management of Community Outbreaks |
| | Annex A: | <ul style="list-style-type: none"> • Added that hospitalized individuals with negative RPP and COVID-19 lab results should be placed on contact and roplet precautions for full 14 days or until discharge/transfer |
| 2020-05-20 | Table of Contents | <ul style="list-style-type: none"> • Included |
| | Case Definition | <ul style="list-style-type: none"> • Suspect case definition updated to: "...had close contact with a probable case of COVID-19" • Exposure criteria: added the following: Was involved in a COVID-19 outbreak or cluster |
| | Period of communicability | <ul style="list-style-type: none"> • Added: NAAT can be prolonged for 3-4 weeks after symptom onset even when no viable virus is detected. |
| | Host susceptibility | <ul style="list-style-type: none"> • Added: There is an evolving understanding of the immune response in COVID-19 disease, and the possibility of reinfection with SARS-CoV-2 has not been excluded. However, there have been no well substantiated cases of reinfection to date and most such suspect cases are likely related to testing methodologies. |
| | Resources for COVID | <ul style="list-style-type: none"> • Added to preventative measures. |
| | Public Health Management | <ul style="list-style-type: none"> • Divided into sections that align with the the table of contents |
| | Testing Recommendations, Interpretation and Management | <ul style="list-style-type: none"> • New section added • Includes the expanded symptom list for testing • Includes testing of different individuals e.g. asymptomatic/ symptomatic/ previously tested cases. |
| | Management of Immunocompromised Cases | <ul style="list-style-type: none"> • New section added |
| | Annex B | <ul style="list-style-type: none"> • New section Management of Outbreaks • All the outbreak information is now in one section i.e. facility, congregate and childcare outbreaks. |
| | Annex C | <ul style="list-style-type: none"> • Management of Travellers put into an annex and updated with new processes for management of travelers and flights |
| | Annex E- Isolation Requirements and Annex F-Quarantine Requirements | <ul style="list-style-type: none"> • Annex E and F that had detailed information on isolation and requirements removed. Links to the information added to Section 6: Mandatory Quarantine and Isolation: CMOH Order 05-2020. |

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| 2020-08-25 | Case definition | <ul style="list-style-type: none"> Under footnote A added information on the performance characteristics of the Simplexa®, GeneXpert®, or BD Max™ NAT |
| | Clinical presentation | <ul style="list-style-type: none"> Added information on Multi-system inflammatory Syndrome in Children (MIS-C) |
| | Diagnosis | <ul style="list-style-type: none"> Added information on Simplexa®, GeneXpert®, and BD Max™ NAT test results are considered confirmatory |
| | Section 2: Testing Modality, Recommendations, Interpretation and Management | <ul style="list-style-type: none"> Added information on COVID-19 testing performance for molecular tests and serology Added new section on management of resolved cases |
| | Section 3: Key Investigation | <ul style="list-style-type: none"> Expanded close contact definition |
| | Section 5: Management of Close Contacts | <ul style="list-style-type: none"> Added information on Guidance on the use of masks |
| | Section 6: Mandatory Quarantine & Isolation | <ul style="list-style-type: none"> Added new information regarding immunized individuals with COVID-19 symptoms post immunization |
| | Annex A- Management of Outbreaks | <ul style="list-style-type: none"> Expanded section to include outbreak definitions, management of COVID-19 outbreaks in childcare settings, schools and workplaces Added section on notification of COVID-19 in public exposures |
| | Annex B: Management of Travellers | <ul style="list-style-type: none"> Updated section on national and international flights |

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