SUBJECT **Novel Coronavirus** **(COVID-19 formerly 2019-nCoV)**	DATE FIRST ISSUED: January 29, 2020
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A printed copy of this document should be considered valid only on the date printed. The electronic version should always be considered the current procedure.	

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Case Definitions

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 or performed by a private accredited lab.

Probable Case

(This definition does not apply to Health Care Workers [HCW[B]] or residents/clients in congregate settings). All probable cases 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. Epi-linked symptomatic close contacts of probable cases must be tested for COVID-19 to be considered case defining.

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

OR

- a person (with laboratory testing done) with clinical illness who meets the COVID-19 exposure criteria;

AND

- in whom laboratory diagnosis of COVID-19 is inconclusive[D]

NOTE: All Health care workers (HCW) and residents/clients of congregate settings (e.g., long-term care facilities/continuing care/group homes/shelters etc.) who meet probable case definition should be tested.

Suspect Case

A person with clinical illness

AND

- who meets the exposure criteria

OR

- had close contact with a **Probable Case** of COVID-19

NOTE: Suspect Cases are NOT reportable and should be tested to confirm diagnosis. Suspect cases with symptoms of fever [over 38°C], new onset/exacerbation of cough, shortness of breath/difficulty breathing, sore throat or runny nose, shall by order, be in isolation for 10 days from onset of symptoms 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 the entire 14 days even if they test negative.

[A] As of March 09, 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] Health Care Workers are individuals who provide service in a clinical care setting, including hospitals, clinics, continuing care facilities, licensed supportive living sites, public health centres, community assessment centres, and any other settings where face- to-face patient care is provided (including fire fighters and EMS).

[C] Clinical illness includes: fever (over 38 °C), new onset/exacerbation of the following symptoms: cough, shortness of breath (SOB)/difficulty breathing, sore throat or runny nose.
NOTE: expanded testing criteria includes painful swallowing, stuffy nose, 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 (pink eye.) Additional symptoms may be identified by the clinical care provider e.g., COVID toes, altered mental status.

[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.

Exposure Criteria

In the 14 days[E] before onset of illness, a person who:

- returned to Canada from outside the country;

OR

- had close contact with a Probable or Confirmed case of COVID-19

OR

- is a close contact[F] of a person who had acute respiratory illness who returned from travel outside of 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.

NOTE: *There is limited evidence on the likelihood of COVID-19 presenting as a co-infection with other pathogens; identification of one causative agent should not exclude COVID-19 where the index of suspicion may be high.*

[E] 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.

[F] 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 contact (i.e., for more than 15 min and within two meters) with a case without consistent and appropriate use of PPE and not isolating, OR had direct contact with infectious body fluids of a person (e.g., was coughed or sneezed on) while not wearing recommended PPE. Consideration must also include cumulative exposures that add up to greater than 15 minutes. As part of the individual risk assessment, consider the duration of the contact's exposure (e.g., a longer exposure time likely increase the risk), the case's symptoms (coughing or severe illness likely increases risk) and whether exposure occurred in a health care setting. For more information refer to https://www.gov.uk/government/collections/coronavirus-covid-19-list-of-guidance.

Oct 21, 2020 – Quick Summary of Updates:

Case Definition	• Update and additional information regarding Private Accredited Lab • Simplexa, GenXpert and BD Max tests
Reporting Requirements, Investigator	• FMP reporting to AH & Dr. Laura McDougall • Update and additional information added for reporting out of Zone, including FNIHB and Out of Province, Out of Country and for Canadian Forces Military Personnel
Clinical presentation	• Added Multi-system inflammatory syndrome in children. • Clarification of CMOH Order 05-2020
Diagnosis	• Update and additional information added for COVID-19 Rapid Nucleic Acid Testing and Viral Shedding
Testing	• Symptomatic and Asymptomatic individuals • COVID-19 testing performance • Persistent PCR results • Industry-initiated COVID-19 Testing and Reporting • Serology testing • Management of resolved cases
Public Health Management	• Update on process for documentation when unable to contact case • Update to occupational exposures or transmissions in settings outside of AHS/Covenant Health OHS/APL • Update to information for case in Daycare • Update to information for case in School • Update to information for travel exposure • Updated definition of close contact • Immunized individuals and Clarification of Order CMOH 05-2020 • Update on travel advisory and exemptions • Guidance on use of masks • Clarification on home isolation • Assessment and management of close contacts related to sports
Management of Outbreaks	• Definitions • Alerts, Outbreaks and Public Notifications • CMOH Order 32-2020 • Expanded section to include childcare settings, schools and workplaces • Added information about notification of COVID-19 in public exposures
Appendix F	• Updated WHS and IPC Notification Template
Appendix G:	• Updated MOH Case Summaries and Escalation Notification Process
Appendix I:	• Updated Process and Documentation for follow up of COVID-19 Outbreaks in Work Sites/Camps
Appendix J:	• Updated information re Call Scripts for Contact Tracing
Appendix K:	• Updated Unable to Contact and Lost to Follow up Process for COVID Cases
Appendix L:	• Childcare facilities
Appendix M:	• Updated Single Case of COVID-19 in a School
Appendix N:	• Assessment of Close Contacts Related to Sports

Reporting Requirements

Investigator

- Confirmed, and probable (this DOES NOT include suspect) cases, deaths and newly identified outbreaks are reportable by the **fastest means possible (FMP)** i.e., direct voice communication, to Zone Medical Officer of Health (MOH)/MOH designate.
    - The Zone MOH will notify AH & Dr. Laura McDougall of deaths due to COVID urgently **by email as soon as possible** to the following email addresses AHSCOVIDreporting@gov.ab.ca, Laura.McDougall@albertahealthservices.ca .
    - Investigators will send notification of newly identified COVID Outbreaks urgently to AH **as soon as possible** to the following email addresses: AHSCOVIDreporting@gov.ab.ca and Laura.McDougall@albertahealthservices.ca using the template email in their internal AHS outbreak process documents.
    - AH also requires regular updates if there are any significant changes for outbreaks involving the types of settings below**. Investigators should consult with the Zone MOH to determine when an update email is required to be sent to AH. The updated information is to be sent to AHSCOVIDreporting@gov.ab.ca and Laura.McDougall@albertahealthservices.ca .
        - Acute care hospitals, corrections, homeless shelters
        - Long term care centres and other congregate living settings that are unusual (please specify in the initial notification if the site is a continuing care site or a group home),
        - Meat Packing Plants
        - Cross-jurisdictional settings – e.g., Oil Industry worksites/work camps, large gatherings involving significant numbers of out of province people
        - Outbreaks with rapidly increasing numbers or ones that are embarking on a round of asymptomatic testing and the results of such testing.
        - New or challenging setting/situations such as the first few outbreaks in settings not recognized previously or as restrictions are lifted:
            - Gyms
            - Night clubs
            - Large gathering such as protests
            - Once skiing starts – ski hills and lodges
            - Community wide – religious groups
            - Settings with challenging behaviours – e.g., singing.

    ** This list will change as situations evolve
- COVID-19 confirmed and probable cases **must be reported** to Alberta Health (AH) by submitting an Enhanced Surveillance Report (ESR) *within 24 hours of initial FMP notification*. See **Appendix A** for reporting and submission through CD/OM.
    - COVID-19 Suspect Cases are not reportable to Alberta Health

Management of Out of Zone and First Nations Inuit Health Branch (FNIHB) Cases and Contacts

The Zone MOH/Zone MOH designate first notified shall notify the Zone MOH/Zone MOH designate of the zone where the client currently resides by FMP for all confirmed, probable and suspect cases. For susceptible contacts requiring follow up, the Zone MOH/Zone MOH designate first notified shall notify the Zone MOH/Zone MOH designate of the zone where the contacts reside as soon as possible and provide contact information including name, date of birth (DOB), address and phone number for each identified contact.

- Contact numbers for FNIHB MOH team:
    - FNIHB CDC nurse: 780 495 5407
    - FNIHB MOH on call : 780 218 9929

Management of Out of Province (OOP) / Out of Country (OOC) Confirmed and Probable Cases

The Zone MOH/Zone MOH designate first notified shall notify the CMOH/CMOH designate of all case information by FMP. See following for responsibility for management and reporting of various scenarios based on where the case currently is and where the case likely acquired disease.

- **For OOP/OOC residents that are currently in their home province/country and likely acquired disease in Alberta**, case management will be the responsibility of the province/territory (P/T) or country where the individuals currently are. To transfer information to AH, email all details as below to health.cd@gov.ab.ca with cc to appropriate Zone MOH group and CDCCOVID.
  - In the CDOM DI for the case, complete minimum documentation as follows:
  - Demographics tab: All demographic information available, including OOP/OOC address, phone number and OOP health number.
  - Assessment tab: Assigned Zone = Alberta Health; Service Area = Out of Province
  - Summary tab:
    - Process status = Investigation complete
    - Investigator = AH – Default Investigator
    - Resolution status = Set as appropriate for case
    - Final Disposition = Unable to Contact
- **For OOC residents that are currently in Alberta and likely acquired disease in Alberta**, Alberta will report as Alberta cases; follow DSOP for management, documentation and reporting.
- **For OOP residents that are currently in Alberta and likely acquired disease in Alberta**, Alberta will NOT report as Alberta cases. These will be transferred to Alberta Health through CDOM for reporting in their own P/T of residence.
  - The responsibility for case management for these individuals will remain with AHS investigator.
  - CDOM Documentation: Document all case follow up as per usual for all cases. However for all of these cases set:
    - Assessment tab > Zone = Alberta Health; Service area = Out of Province
    - Summary tab > DO NOT SUBMIT AN ESR FOR THESE CASES.
- Notification to Alberta Health of OOP / OOC cases shall be done via transfer of DI from within CDOM **AND** by email to health.cd@gov.ab.ca.
  - Email health.cd@gov.ab.ca and cc CDCCOVID with the Email Subject line: DI # OOP Case or DI # OOC Case
    - **In the body of the email include the minimum information required below for transfer to Alberta Health:**
      - Case DI#
      - First and last name
      - Date of Birth (DOB)
      - Out of Province health care number
      - Symptom onset date or Specimen Collection date for asymptomatic cases
      - Phone number (at least one is required)
      - Address including City/Town, Province/Territory and Postal Code. State/Country also required if case is from Out of Country
      - Other relevant clinical/epidemiological information
      - Follow up Status (choose one):
        1. Client informed of isolation requirement and PT of residence should complete follow up
        2. Case follow up to be initiated by PT of residence
        3. FYI only as the case remains in Alberta and will be followed up by AHS
    - **Include if Available:**
      - Email
      - Details of any follow up that has been started
        - Client aware of isolation requirement?
        - Location of where they are isolating (AB, home jurisdiction)?
        - Does the client report symptoms at this time?
        - Any other issues identified by client or AHS?

Management of Out of Province (OOP) / Out of Country (OOC) Close Contacts

- AHS follows up all Albertan contacts, even if they are temporarily out-of-province or out of country
- Residents of other jurisdictions should be followed-up by their local public health, regardless of whether they are quarantining in Alberta, at home, or in another jurisdiction.
  - In order for Alberta Health to follow-up up with other provinces/territories in a timely way a minimum data set is required as outlined below.

  Exceptions to this include:
  - Industrial work sites (large oil sands / gas / mining operations) where OOP contacts may remain on site for their quarantine and be managed by the company's OHS (with the support of AHS)
  - If assistance is required for an Albertan in another jurisdiction (i.e., Albertans who have to delay return to Alberta to quarantine, but who require assistance, financial or otherwise, to quarantine appropriately), then the contact may require transfer of management to another jurisdiction, or some involvement by both jurisdictions.
- Notification to Alberta Health of OOP / OOC Close Contacts shall be done via transfer of CI from within CDOM and by email to health.cd@gov.ab.ca.
  - Create a CI in CDOM from within the case DI Assessment Tab. Complete minimum documentation as follows:
    - Demographics tab: All demographic information available, including OOP/OOC address, phone number and OOP health number.
    - Assessment tab: Assigned Zone = Alberta Health; Service Area = Out of Province
    - Intervention Tab >Communication Referrals Section: Document transfer actions, including type of communication, date, contact method, to/from, phone/fax numbers, reason for communication and any relevant notes.
    - Summary tab:
      - Process status = Entered
      - Investigator = AH – Default Investigator
      - Resolution status = No further action required
      - Final Disposition = Set as appropriate based on current investigation status
      - Document "COVID-19 Close Contact, detailed email sent to health.cd@gov.ab.ca" in the Summary Tab > Notes/Remarks! Section.
    - Save record
  - Email health.cd@gov.ab.ca and cc CDCCOVID with the Email Subject line: CI # OOP Contact associated with <insert DI#> or CI # OOC Contact associated with <insert DI#>
    - **In the body of the email include the minimum information required below for transfer to Alberta Health:**
      - Case DI#
      - Symptom onset date or Specimen Collection date for asymptomatic cases
      - First and last name of the Close Contact
      - Date of last contact with the case
      - Phone number (at least one is required)
      - City/Town, Province/Territory of the Close Contact. State/Country also required if Close Contact is from Out of Country
      - Follow up Status (choose one):
        1. Client informed of quarantine requirement and PT of residence should complete follow up
        2. Contact follow up to be initiated by PT of residence
        3. FYI only as the client remains in Alberta and will be followed up by AHS
    - **Include if Available:**
      - Date of Birth (DOB)
      - Address, including postal code
      - Email
      - Health number
      - Nature of the exposure (e.g. had dinner with case, stayed at case's house, rode bus together at work site, etc.)

- Details of any follow up that has been started
  - Client aware of quarantine requirements?
  - Location of where they are quarantining (AB, home jurisdiction)?
  - Does the client report symptoms at this time?
  - Any other issues identified by client or AHS?
- **For Contacts at Large Work Site Outbreaks (Oil Sands / Other Industrial Sites) see Appendix I for additional reporting requirements for Outbreaks in Work Sites/Camps.**

Management of Canadian Forces Military Personnel Case and Close Contacts:

The Zone MOH/Zone MOH designate first notified shall notify by FMP the applicable military base personnel listed below of all confirmed and probable COVID cases AND Close Contacts who are Canadian Forces Military Personnel.

- First Contact attempt should be made to base that member works out of:

LOCATION	POC	PHONE	EMAIL
Yellowknife	Maj Nathalie Sleno	867-873-0700 x6984	Nathalie.Sleno@forces.gc.ca
Calgary	WO Kylie Torney	780-973-4011 x2382	Kylie.Torney@forces.gc.ca
Suffield	Cpl Kassim	403-544-4929	Mohammed.Kassim100@mod.gov.uk
Wainwright	WO Kylie Torney	780-973-4011 x2382	Kylie.Torney@forces.gc.ca
Cold Lake	MCpl Ashley Patze	840-8000 x6318	Ashley.Patze@forces.gc.ca
Edmonton	Chantal Delisle WO Sonia Lavigne	780-973-4011 x 6289 or 4819	EdmPMed1FdAmb@forces.gc.ca

- If unable to contact the base above within the same shift, contact:
  - Base Link nurse (24/7 urgent base contact) 780-860-5787 or email: 1FdAmbClinicNLO@forces.gc.ca
- If unable to contact either of above within the same shift, contact:
  - Robin Lamoureux, 780-271-5717 OR AHS email: robin.lamoureux@ahs.ca

Disease Information

COVID-19 is a novel coronavirus (SARS-CoV-2), first identified in December 2019 in Wuhan, China as having caused an outbreak of respiratory infections, including pneumonia. CoVs are enveloped, single-stranded positive sense RNA viruses that are part of the *Coronaviridae* family that infect mammals and birds. In humans, CoVs typically cause upper respiratory tract illness. There are seven known types of CoVs and illness can range from mild to severe. Four types that generally cause mild illness are 229E, OC43, NL63 and HKU. Two other types that can cause severe illness are Middle East respiratory syndrome (MERS) and severe acute respiratory syndrome (SARS). MERS and SARS are not addressed in this DSOP.

Clinical Presentation

- Individuals infected with the virus that causes COVID-19 may have few or no symptoms and may range from mild to severe, life-threatening illness, with manifestations including fever greater than 38°C (>90% of cases), new onset or exacerbation of chronic cough (80% of cases), shortness of breath (20% of cases), difficulty breathing, sore throat or runny nose.
- Severe disease from COVID-19 infection can cause viral pneumonia and respiratory failure that requires support in an intensive-care unit, sepsis, septic shock and multi-organ failure or death.
- Susceptibility is assumed to be universal.
- The virus appears to cause more severe disease in older adults (greater than 60 years of age) and individuals with underlying comorbidities (e.g., cardiovascular and liver disorders, diabetes and other respiratory diseases) or immune compromising conditions.
- There is 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 reports are likely related to testing methodologies.
- Case fatality rate is not yet confirmed as the situation is still evolving at time of publication.
- Children infected with SARS-CoV-2 typically have mild or no symptoms and account for approximately 1-10% of reported cases. Although rare, severe illness and death have been reported. 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 established. Research to further understand MIS-C is ongoing. For more information refer to the WHO Multisystem inflammatory syndrome in children and adolescents temporarily related to COVID-19 and the MIS-C Public Health Disease Management Guideline.

NOTE: Immunized Individuals and Clarification of CMOH Order 05-2020

- Following the administration of a vaccine product, individuals may experience side effects following the immunization. These reactions are usually short-term and self-limited, however these vaccine side effects are similar symptoms to COVID-19 and can include:
  - fever,
  - cough,
  - runny nose,
  - sore throat,
  - headache,
  - muscle/joint aches,
  - poor appetite, nausea, vomiting, stomach pain or diarrhea
- If the vaccine recipient develops these side after immunization they are usually mild and develop within 24 hours after immunization for inactivated vaccines; for MMR, Varicella and MMRV usually within 5-12 days.
- The individual with these symptoms should stay home and away from others. These symptoms should resolve within 24-48 hours of symptom onset.
- If these symptoms resolve within 48 hours of symptom onset, the individual can resume normal/routine activities, unless they have been instructed to isolate or quarantine for other reasons.
- If these symptoms do not resolve within 48 hours of symptom onset, the individual should continue to stay home and away from others and complete the COVID-19 self-assessment or call Health Link 811 to arrange testing.
- If testing is not done, the individual should remain at home for 10 days after onset of symptoms if they

exhibit any of the symptoms in CMOH Order 05-2020 (fever, cough, shortness of breath/difficulty breathing, runny nose or sore throat) or until symptoms resolve, whichever is longer.

- If the symptoms are in the expanded COVID-19 symptom list, but not included in CMOH Order 05-2020 the individual should stay at home until symptoms resolve.

Diagnosis

- Testing is recommended for diagnosis in all symptomatic individuals with COVID-19 like symptoms*. This includes all HCW and other close contacts of cases.
- 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.
- COVID-19 rapid nucleic acid tests (NAT) such as Simplexa®, GeneXpert®, or BD Max™ are now available in certain settings in Alberta (hospitals in Medicine Hat, Lethbridge, Red Deer, Grande Prairie Calgary and Edmonton, and in certain ED and ambulatory care centres) 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.
- 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.

NAAT positivity from respiratory symptoms can be prolonged (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).

Testing

Testing is recommended for the diagnosis of individuals with COVID-19 compatible symptoms. 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 such as COVID toes or altered mental status may also be considered for testing at the discretion of the individual's clinician.

Symptom List for COVID-19 Testing

- **fever***
- **cough (new cough or worsening chronic cough)***
- **shortness of breath/difficult breathing***
- **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 a minimum 10 day mandatory isolation as per CMOH Order 05-2020.

- Mandatory isolation is NOT required for individuals with only italicized symptoms in the Symptom List for COVID-19 Testing. However it is strongly recommended that individuals with these symptoms stay home and minimize contact with others. If they are tested and are positive, manage as a case.

Testing of Symptomatic Individuals

In Alberta testing is recommended with consent for all symptomatic individuals to confirm diagnosis and to track the spread of COVID-19 in the population. Testing is recommended for any person exhibiting symptoms in the Symptom List for COVID-19 Testing.

- Any person with any of the symptoms in the Symptom List for COVID-19 Testing should complete the online AHS COVID-19 SELF ASSESSMENT TOOL or call Health Link 811 to arrange for testing
- Any individual that is unwell with new onset of any COVID-19 symptom should NOT be at work or in public spaces

Testing of Asymptomatic Individuals

- Effective September 17, 2020, Alberta Health announced updated COVID-19 testing criteria for Albertans to reduce wait times, to speed up access to results, and to support Albertans during respiratory virus and influenza season. Asymptomatic testing with consent of the individual will focus on the following risk groups:

- Albertans who are close contacts of a confirmed case, whether symptomatic or not;
- Albertans who are linked to a known outbreak, whether symptomatic or not; and,
- Asymptomatic Albertans who are:
    - School teachers and/or school staff;
    - Healthcare workers;
    - Staff and/or residents at congregate living facilities, including long-term care;
    - Experiencing homelessness; or
    - Require asymptomatic testing for the purpose of travel

Asymptomatic testing is no longer recommended for Albertans who don't fall into these risk groups.

The following groups will be prioritized for testing:

- All close contacts (symptomatic and asymptomatic) of confirmed cases should be tested.
  NOTE: All close contacts that meet exposure criteria must remain in quarantine for 14 days following their last exposure, unless their test results come back positive and they become Cases (see Case Management).
- Symptomatic individuals in high risk settings including residents/clients/staff in congregate settings should always be tested to confirm the diagnosis.
- All new 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 will be tested regardless of symptoms.
    - Residents who return to these settings post-hospitalization for non-COVID-19 illness are also recommended to be tested, whether they have symptoms or not.
    - Individuals that return after transient clinical care (e.g., regular medical appointments, short term visits to emergency departments/hospitals for less than 24 hours) do not need to be tested.
- Asymptomatic close contacts of confirmed COVID-19 cases should also be tested. This includes:
    - Asymptomatic household and other close contacts
    - Asymptomatic 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 illness.
    - Residents/staff in confirmed COVID-19 outbreaks in congregate settings that fall under CMOH Order 32-2020 (including lodges, nursing homes, auxiliary hospitals [long term care] and group homes licensed for four or more residents).
    - Outbreaks in other settings (e.g., shelters, work camps, corrections, daycares, schools, and others, as determined by the MOH):
        - Testing of asymptomatic individuals in outbreak settings is at the discretion of the Zone MOH and may be considered as a tool for early detection of cases and outbreak control.

  NOTE: For outbreaks in congregate settings where a respiratory pathogen panel (RPP) is needed to detect other potential outbreak pathogens, a NP swab or throat swab (in ESwabs in ESwab medium) must be collected.

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/specificity of the test, stage of illness, and the epidemiology of COVID-19 in the population. Based on estimates from the end of June 2020, false negative rates of molecular tests in those with symptoms is estimated to be 20% (range 10-30%) 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.

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. 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.

Private Industry-Initiated COVID-19 Testing

Industry-initiated COVID-19 testing includes all COVID-19 testing requested and paid for by a private enterprise for their employees, contractors, or clients. For further information refer to AH Guideline for Industry-Initiated COVID-19 Testing. The onus is on the employer to identify the type of COVID-19 testing, i.e., Rapid Point of Care Tests or Private Accredited Lab Testing. If Private Accredited Lab testing is being done it is up to the employer to find out if the lab testing is accredited.

- **Rapid Point of Care Tests:**
  - Positive lab results are preliminary and not diagnostic; they require confirmatory testing through public lab testing
  - There is not a requirement for the CMOH or MOH to be informed of a positive test result in this process
  - Individuals are recommended to isolate until results are confirmed through repeat testing at public lab
  - No Public Health (contact tracing) will be done unless positive results are confirmed by public lab testing
- **Private Accredited Lab Testing:**
  - Positive test results do not require confirmatory testing
  - Individuals are required to isolate
  - MOH will be informed of lab result via usual processes
  - Public Health follow up would be initiated

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.

Testing and Management of Resolved Cases

- 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.
- 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. 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 Zone MOH is recommended.
  - At the discretion of the Zone MOH and in consultation with microbiologist/virologist on call, additional tests may be ordered to help with the assessment.
- The Zone 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 be treated as people who never had COVID-19 in terms of testing, quarantine and isolation.
- It may be possible for a few individuals to shed detectable SARS-CoV-2 viral material longer than 90 days. If suspected to be the case, consultation with the Zone 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, 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 1a: Testing of Resolved Cases** below:

Table 1a: 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: - 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
90 days or more	N/A (Asymptomatic)	Testing indications are the same as people who have never had COVID-19	- If tested for COVID, 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	- Do not re-test generally. - Re-testing can be considered at a clinician's discretion (see text above) - If test is re-done, order Respiratory Pathogen Panel (RPP) as well - Consult with MOH and/or microbiologist/virologist on call for any additional tests if tested positive again	- 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 for re-infection, the individual should be in isolation while waiting for the test result. Further management is based on lab results and assessment.
90 days or more	Symptomatic	- COVID-19 - With or without RPP	- Isolate while laboratory and epidemiological investigation is being conducted. - If only COVID-19 is done, 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 that yielded the initial positive result.
¥ Refer to 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.

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 32-2020 i.e., licensed supportive living (including lodges and group homes for four or more residents), 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 1b** below for more information.

Table 1b: Testing Recommendations for Residents Admitted to a Facility

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

Mode of Transmission

- COVID-19 is transmitted person to person via droplet (i.e., coughing and or sneezing) or close contact with bodily fluids of infected individuals. Transmission may also happen from contact with contaminated objects or surfaces and then touching one's own mouth, nose, or possibly eyes.
- There is evidence of transmission occurring up to 48 hours before symptom onset or even in individuals who are asymptomatic and never develop symptoms or whose symptoms went unnoticed.
- 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. Airborne spread has not been conclusively documented for COVID-19.
- Aerosol transmission is possible during aerosol-generating medical procedures (AGMP).
  NOTE: collection of a nasopharyngeal swab is not considered an AGMP.
- There is evidence that spread may also occur from animals to humans, (e.g., visited a live animal market while travelling outside Canada) although the source of potential zoonotic transmission has not yet been confirmed at time of publication.

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. 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 14 days prior to symptom onset is recommended at this time.

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 8 days 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.
- There have been case reports of persistent RT-PCR results for up to 82 days after symptom onset, though viable virus was not detected.
- 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.
- For public health management of laboratory confirmed asymptomatic cases, the period of communicability is considered to be 48 hours prior to collection of laboratory specimen and date the person was placed in isolation.

Reservoir

- Initial cases all detected in Wuhan City, Hubei Province of China.
- Most coronaviruses are considered zoonotic. COVID-19 is thought to have emerged from an animal source, although this has not yet been confirmed.

Preventive Measures

- Avoid close contact with people that have acute respiratory infections.
- Maintain physical distancing (i.e., 2 metres/6 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., 2 metres/6 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 on wearing a mask refer to the Contact Management section on Guidance on the use of masks in this DSOP 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

Case Management

NOTE: *The strategy outlined in this document 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.*

Investigator

See Appendix A for specific guidance regarding creation of a disease incident (DI) or contact investigation (CI) for individuals who may already have a DI or CI for COVID-19 in CDOM.

For the purpose of case and contact management:

- **Cases: Day 0 = onset of symptoms with isolation recommendations being maintained for the full 10 days (14 days for HCWs) and being lifted on the morning of the 11th day if case symptoms have resolved.**
- **Contacts: Day 0 = date of last contact with a case who is within their period of communicability with quarantine being maintained for the full 14 days from last contact and being lifted on the morning of the 15th day if contact does not become a case.**

FMP Initiate investigation and follow up: Immediately, including weekends and after hours.

- Upon notification of a potential case of COVID-19, the investigator will contact the physician/ client/parent or guardian to assess/review the following to determine if client meets case definition for a confirmed case, probable case or suspect case criteria:
  - Demographics.
  - Symptom history including additional symptoms, onset date, signs and severity of symptoms.
  - History of hospitalization, intensive care requirement, dates of admission, etc.
  - History of medical assessment related to current illness. Has there been any laboratory testing, radiological investigation, etc.?
  - Exposure risk/travel history to determine risk of infection (see Exposure Criteria in case definition for persons with clinical illness and exposure criteria).
- Based on assessment and in consultation with the Zone MOH, the investigator will determine if individual meets confirmed case, probable case, or suspect case definition and proceed with case investigation, management and reporting as needed.
- If unable to reach the client/parent/guardian for case/contact investigation, please proceed as follows:
  - If unable to contact client with initial phone call, attempt to leave a message. **Only** include:
    - Investigator first name (spell name) and designation (e.g., Registered Nurse with Alberta Health Services),
    - The phone number for the client to return call (1-888-522-1919).
    - Team you are on (Team A, B, C, Contact, etc.)
  - If alternate phone numbers are available, attempt calls to alternate numbers as well.
  - Do not include any other information in the message, such as reason for the call, as this would be a privacy breach.
  - If client does not return phone call or investigator is unable to leave a message, attempt 2 more phone calls at different times in the day on separate days.
  - If unable to contact **cases** after 2 more attempts on different days at different times, complete case investigation (i.e.; complete all ESR required fields marked by (!) in CDOM) and request clerical support to send unable to contact letter. ***See* Appendix K:** *Unable to Contact Process* OR see *Unable to Contact Process on the* ACeRT SharePoint Site - Templates.
  - If unable to reach **contacts** after 2 more attempts on different days at different times, complete contact investigation as unable to contact and close. No letter is sent to contacts.

Case Investigation and Management

Investigator

NOTE: *Alberta launched a voluntary contact tracing app on May 1, 2020 – please ask about this when doing case investigations and follow business process accordingly for clients that have it (**Appendix E**)*

- 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. These cases should be isolated for 14 days from onset of symptoms or until symptoms have resolved, whichever is longer.
- In consultation with the Zone MOH, ensure that all appropriate Infection Prevention and Control (IPC) and Workplace Health and Safety (WHS) notifications have been made.
- Determine if individual is a resident of a First Nations reserve, a prisoner in a federal correctional facility or is Canadian Military service personnel.
  - For individuals that reside on a First Nations reserve OR if you are unsure if the individual lives on a First Nations reserve, contact First Nations Inuit Health Branch (FNIHB) as per Reporting Requirements section to determine if individual lives on reserve and needs to be transferred to FNIHB for case follow up and reporting. Note, an attempt to reach the case should be made prior to transfer if there is any uncertainty about where the person resides.
    - First Nations individuals who do not live on a reserve are the responsibility of AHS to complete case management and reporting.
      - For cases or contacts that live off reserve and are being followed by AHS that are associated with a FNIHB outbreak that is not in CDOM, document in case/contact CDOM chart as follows:
        - Make a note in the Summary Tab notes field if they are a Primary link to the outbreak, "This case/contact is linked to a FNIHB outbreak, 2020-EI-XXXX. FNIHB outbreaks are not in CDOM and therefore this case cannot be linked to a CDOM outbreak".
        - Ensure that the following information is sent to FNIHB for each outbreak associated case or contact that lives off reserve:
          - Name
          - DOB
          - PHN
          - Address
          - Onset date
          - Confirmed, Probable, Suspect OR close contact (only those that were a primary contact of the OB)
          - Specimen collection date OR no specimen collected
          - Total number of close contacts identified for case
        - Please keep a list of Cases/Contacts as there may be additional documentation for reporting to FNIHB via email.
    - For individuals that are Canadian Military service personnel, ensure that the appropriate base is notified ASAP of cases/close contacts that are military members as per Reporting Requirements section.
      - Base personnel are responsible for case management of their own personnel and gathering information required for reporting to Alberta Health. AHS is responsible for documenting the required reporting information in CDOM for each case and reporting to Alberta Health through CDOM.
      - AHS is responsible for case and contact management for any non-military individuals e.g. any close contacts that are not enlisted including family members.
    - For individuals that are prisoners in federal correctional facilities, federal corrections health care staff are responsible for case management and gathering information required for reporting to Alberta Health. AHS is responsible for documenting the required reporting information in CDOM for each case and reporting to Alberta Health through CDOM.
- Determine occupation (e.g., HCW, works with vulnerable individuals, school staff, daycare staff, first responders, etc.).

- For HCWs who are cases and were either exposed in the workplace OR attended work during the period of communicability regardless of whether they work in patient care area or not, complete Workplace Health and Safety (WHS) notifications and IPC notifications.
  - Engage WHS/OHS (where available) to assist with identification of HCW contacts in the workplace (e.g., names and exposure time/location); IPC can provide information on discharged patients that were close contacts of hospitalized cases where appropriate IPC measures were not adhered to.
    - AHS and Covenant Health (CH) WHS/OHS can help support the CDC investigation by assessing workplace exposures for HCW that provided care for COVID-19 patients to determine if appropriate PPE was used.
      - Document and forward information using the Email Template in **Appendix F** and specific notification details for AHS, APL and CH employees to their WHS/OHS program for all confirmed cases who:
        - Received care or are currently an inpatient in an AHS, APL or CH facility during their period of communicability and potentially exposed HCWs.
        - Are a HCW and worked during the period of communicability in an AHS, APL or CH facility.
        - Are an AHS, APL, CH employee whose exposure site was in the workplace even if that workplace is not an AHS/APL/Covenant Health site
          NOTE: This template is not for reporting HCWs that are not AHS, APL or CH employees or AHS, APL and CH employees that were exposed in the community (not a workplace exposure) and did/will not work during the period of communicability.
    - The appropriate point of contact for workplace notification of HCWs exposures in settings outside of AHS/APL and Covenant Health is the manager or company/site OHS where the individual was present during the period of communicability and may have exposed others at the workplace.
      - Assess if AHS/APL or CH employees are close contacts of known cases in non-AHS/APL/CH health care sites and were exposed during the course of their work at that site. Notify AHS/APL/CH WHS of these individuals using the template in **Appendix F**.
    - When assessing HCW exposures consider the following:
      - All HCWs are required to practice proper hand hygiene and wear a surgical/procedure mask at all times when they are within two metres of a patient/client/visitor/ other HCW.
      - A surgical/procedure mask (continuous masking) and proper hand hygiene is considered sufficient PPE for asymptomatic HCW working with asymptomatic patients, unless patients are on contact/droplet or airborne precautions.
        - If a HCW followed the procedures above and becomes symptomatic, the patients they cared for and the co-workers they worked with in the 48 hours prior to HCW symptom onset are not considered close contacts.
      - If a patient becomes symptomatic, all HCWs that cared for the patient in the 48 hours prior to patient's symptom onset would not be considered close contacts if the HCW was wearing a surgical/procedure mask and practiced proper hand hygiene i.e., sufficient PPE, for patients not on contact/droplet or airborne precautions during the asymptomatic period.
      - A surgical/procedure mask and proper hand hygiene is NOT considered appropriate PPE for HCW caring for symptomatic COVID-19 patients or patients otherwise on contact/droplet or airborne precautions.
        - A hospitalized patient or individual who resides in a congregate care setting who is asymptomatic and is lab confirmed COVID-19 should be isolated and placed on contact and droplet precautions.
    - In light of asymptomatic transmission, full PPE is required (i.e., use of N95 respirator, with gown, gloves and face protection) for any Aerosol Generating Medical Procedures.
- For HCW cases identified as staff in a congregate living facility in which there was a possible workplace exposure or workplace transmission (worked at the facility during period of communicability):
  - The definition of an outbreak in a congregate living setting is one case in either a staff member or resident. Please ensure the CD Outbreak team is aware and you have spoken to a CD outbreak nurse

when you identify a case in either a staff member or resident before notifying the facility in order that they can initiate or maintain outbreak management as appropriate.

- Notification of the case employed in an AHS or Covenant facility and follow-up of workplace contacts will be completed by either AHS WHS or Covenant OHS (as per who owns and operates the facility). See **Appendix F** for notification process and template.
  - Investigator must ensure to notify CD_Outbreak of the case in the facility.
- Notification of a case employed by Contracted LTC sites with their own OHS will be made to the site OHS.
  - Request the employee provide you the contact information for their OHS.
  - Discuss the follow-up of the workplace and whether the OHS will complete the staff assessments or send the CDC contact tracer/CDCCOVID a list of workplace contacts to complete follow-up.
  - Investigator must notify CD_Outbreak of the case in the facility.
- Notification of a case for a facility without an OHS department will be made by a CD Outbreak nurse covering the facility outbreaks within the Zone where the facility is located.
  - Investigator should connect with the CDC Unit Lead for the shift to assist in determining which CD Outbreak nurse to contact.
  - The CD Outbreak nurse will obtain the list of workplace contacts and connect back with CDCCOVID to pass on the list of workplace contacts to a contact tracer investigator to have follow-up completed.

- For potential occupational exposures or transmissions in settings that involve food handling and distribution, public food retail establishments and high risk settings where the public are present such as daycares and schools, Environmental Public Health (EPH) referral may be required on a Zone by Zone basis; consult Zone MOH to determine if referral is required.
- For all potential occupational exposures or transmissions in any settings, except for Alberta Health Services or Covenant Health facilities, AHS sends a list daily of any potential workplace exposures to Alberta Labour OHS for referral.
- For occupational exposures, connect with workplace/site specific occupational health/management/ occupational health designate to discuss contact investigation and follow up for the workplace.
  - Discuss the definition of close contacts
  - Confirm shifts that case(s) worked while communicable
  - Have site assess shifts and put together a list of workplace contacts that meet criteria as close contacts for follow up. This may include employees and members of the public who were present in the workplace/site who would meet close contact criteria.
  - Request that the sites send this list to CDCCOVID by encrypted email or password protected document for CDC follow up of close contacts, as needed. If the list is short this can be communicated over the phone.
    - Each individual that meets close contact criteria must be entered in to CDOM and linked to the case DI.
  - Advise that close contacts will be required to quarantine for 14 days from last contact with case.
  - Advise site that CDC will follow up with workplace contacts and then communicate back to the site if there are any employees identified on the list that require further discussion with the employer.
- For cases that are associated with an oil field industry work site/camp outbreak, please see **Appendix I** for additional assessment questions and documentation requirements from Alberta Health, including unique documentation and transfer of reporting responsibility based on case home province or territory of residence.
- Client should be referred for medical assessment if symptoms indicate that it is required.
- In consultation with the Zone MOH, refer client to appropriate site for immediate triage and assessment based on severity of symptoms (e.g., emergency department [ED] if severity of symptoms requires same, community clinic if symptoms do not require ED level of care).

- With COVID-19 the following symptoms are considered to be medical emergencies:
  - severe difficulty breathing (e.g., struggling for each breath, speaking in single words)
  - severe chest pain
  - having a very hard time waking up
  - feeling confused
  - loss of consciousness
- Investigator/Zone MOH MUST ensure appropriate and timely notification of selected site so that IPC measures can be implemented immediately upon client's arrival.
- If client is being transported via ambulance, ensure that EMS personnel are aware of symptoms, suspected diagnosis and exposure history so that appropriate IPC measures can be implemented based on symptoms.
- If laboratory specimens will need to be collected, arrange for collection using established Zone referral processes.
- Determine possible transmission settings since onset of symptoms. This would include, but not be limited to household, attendance at work, school, daycare, conferences, sporting events, faith-based gatherings, healthcare facilities for assessment/treatment, flight, cruise ship, etc.
  - For a case in a **childcare facility (daycare)**, see **Appendix L**: *Single case of COVID-19 in a Childcare Setting.*
    - For 2 or more cases in a childcare facility within a 14 day period, refer to outbreak team for follow up outbreak management of childcare facility. The case and close contacts outside of the childcare setting should be followed by the case investigation team.

    NOTE: Day homes are NOT considered a childcare facility and should be managed as a private residence.
  - For a case in a **school**, see **Appendix M**: *Single Case of COVID-19 in a School*
    - Cases that were not physically present at the school (e.g., students doing online school only) are not considered school associated cases. Be VERY clear with the school that there is no alert notification required for cases that have not been physically present at the school.
    - For 2 or more cases in a school within a 14 day period, refer to outbreak team for follow up outbreak management of the school. The case and close contacts outside of the school should be followed by the case investigation team.
  - Group homes with 3 or less residents, are not followed by the outbreak team. Group homes with 4 or more residents must be reported to the outbreak team for outbreak management. The cases must still be investigated by the case investigation team.
  - Consult with Zone CDC lead/Zone MOH/ND Associate Manager to determine if any transmission settings will require a ProvLab EI number for testing contacts.
  - Transmission settings such as workplaces/schools/daycares/care facilities may require specific notifications or implementation of outbreak management. Consult with Zone CDC lead/Zone MOH/ND Associate Manager to determine same.
  - There is a script for contact tracing of close contacts in workplaces outside of AHS or Covenant healthcare facilities and congregate care facilities, see **Appendix J**: *Call Scripts for Contact Tracing* for the web link to the Alberta COVID-19 Response Team SharePoint Site to access script. This script is meant to be an addition to the information for contact management provided in this DSOP.
- Identify close contacts who may have had exposure to a confirmed/probable case during the period of communicability. Generally, the period of communicability starts 48 hours prior to symptom onset and for the duration of case isolation. Isolation is usually for 10 days after symptom onset or until symptoms have resolved, whichever is longer. Follow close contacts as per **Contact Management Section.** Identify close contacts that may have had exposure to a **laboratory confirmed asymptomatic case** during the period of communicability. For asymptomatic cases, this is considered to be from 48 hours before the laboratory specimen collection date and for the duration of case isolation.
  - There is a script for contact tracing of both symptomatic and asymptomatic contacts, see **Appendix J**: *Call Scripts for Contact Tracing* for the web link to the Alberta COVID-19 Response Team SharePoint Site to access scripts. These scripts are meant to be an addition to the information for contact management provided in this DSOP.

- Collect travel and exposure history details (within the 14 days prior to onset of symptoms) including:
  NOTE: Airline, cruise and other conveyance notifications are only sent if the case was on the conveyance within their period of communicability.
  - Residence or travel anywhere outside of Canada.
  - Dates and purpose of travel.
    - **NOTE:** for cases that were exposed on a cruise or during an established outbreak in Alberta (e.g., facility, school, daycare, community event, etc.) see **Appendix A** for documentation related to cases associated with a ProvLab or Zone specific EI number.
    - Mode(s) of transportation and accommodation details including itineraries for any airline, ground or water transportation
    - Identify travel companions that may have had a similar exposure or exposure to the case.
    - **International/Inter-provincial non-charter** flight information is sent to Alberta Health (AH) at health.cd@gov.ab.ca. AH will forward to the Public Health Agency of Canada (PHAC).
    - The notification to AH can be completed by regular program CDC nurses as well as by the Contact Tracing designated Team Leads
      - Flights: Investigator should collect the following information and email to the Team Lead.
        - Case address and contact information,
        - Case Onset date,
        - Flight date,
        - Airline,
        - Flight number,
        - Departure and destination locations,
        - Case row and seat number.
      - Team leads will email the information to Alberta Health at health.cd@gov.ab.ca and CDCCOVID@albertahealthservices.ca.

        SUBJECT LINE: DI # Notification of COVID Case on flight
        Email should state the following "We confirm a confirmed (or probable) case was symptomatic on a specific flight <insert details above>.
    - **Provincial CHARTER** flight notifications are managed by AHS i.e., AHS notifies the airline directly.
    - The notification to AH can be completed by regular program CDC nurses as well as by the Contact Tracing designated Team Leads.
      - Canadian North (non-charter flights notification email sboone@canadiannorth.com
      - Flights: Investigator should collect the following information and email to the Team Lead.
        - Flight date,
        - Airline,
        - Flight number,
        - Departure and destination locations,
        - Affected rows.
      - Team leads will email the information to the Airline, AH at health.cd@gov.ab.ca and CDCCOVID@albertahealthservices.ca.

        SUBJECT LINE: DI # Notification of COVID Case on flight
        Email should state the following "We confirm a confirmed (or probable) case was symptomatic on a specific flight <insert details above>.
      - Documentation of notification for international, inter-provincial flights and charter flights should be completed in the **CDOM DI > Intervention Tab > Communications/referrals section**.
    - **Cruise ships:** Investigator should collect the following information and email to the Team Lead.
      - Case address and contact information,
      - Case Onset date,
      - Cruise Liner,
      - Departure Port,
      - Arrival Port,
      - Dates of Trip.

- Team leads will email the information to Alberta Health at health.cd@gov.ab.ca and CDCCOVID@albertahealthservices.ca.

  SUBJECT LINE: DI # Notification of COVID Case on cruise ship
  Email should state the following "We confirm a confirmed (or probable) case was symptomatic on a specific cruise <insert details above>.
- Documentation of notification sent should be completed in the **CDOM DI > Intervention Tab > Communications/referrals section**.

  NOTE: Contact ND Associate Manager/Zone CDC lead to determine if travel/exposure history (e.g., cruise ship contact) indicates that an EI is required.

  - Contact with healthcare settings areas anywhere outside of Canada, including details of type of contact (e.g., work, visiting a patient, hospitalized, etc.) and whether PPE was used consistently and appropriately.
  - Known contact with a confirmed and/or probable case or person with COVID-19-like illness that has a known exposure risk that has not been diagnosed, regardless of place of residence or history of travel.
  - Known contact with a recent traveler who has traveled anywhere outside of Canada.
  - Recent contact with a person with COVID-19 like illness from the expanded symptom list. Other possible exposures (e.g., live animal market or other animal contact while in an affected area).
- Determine any underlying chronic or immunocompromising conditions.
  NOTE: clients on Continuous Positive Airway Pressure (CPAP) or Bi-Level Positive Airway Pressure (BPAP or BiPAP) that are on home living should remain in a separate room with a door, away from family members, and the door must remain closed when CPAP or BPAP/BiPAP is in use. Ensure a good mask fit with very little leak.
- Provide information about disease transmission and measures to minimize transmission, including isolation, practicing proper hygiene and respiratory etiquette. 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.
- Zone MOH notification: In addition to all notifications noted in the rest of this document, a summary email for each case investigation must be submitted to the Zone MOH for the Zone where the case resides **(as per Appendix G)**.

Treatment

- At this time there is no specific treatment for COVID-19 or vaccine to prevent infection. Supportive treatment is recommended based on condition of the case.

Case Exclusion and IPC Recommendations

- Exclusion and infection control recommendations for both symptomatic and asymptomatic cases are dependent on whether the case is hospitalized or being managed in the home setting.
- Exclusion orders must be given either verbally or written and rescinded in the same format that they were given.
- Investigator must consult with Zone MOH to issue and rescind isolation orders for cases where it is not clear if case meets criteria to rescind same. Criteria to lift isolation as per case type listed below.
  - Verbal exclusion orders should be rescinded verbally, no written documentation is provided to the client.
  - Written exclusion orders must be rescinded in a written format. Both the exclusion order and the rescind order should be obtained through Zone MOH and Zone MOH administration staff.
  - For interpretation of lab results and case management, see **Table 1a**.
- If unable to contact client with initial phone call to lift isolation, attempt to leave a message. **Only** include:
  - Investigator first name (spell name) and designation (e.g., Registered Nurse with Alberta Health Services),
  - The phone number for the client to return call (1-888-522-1919).
  - Team you are on (Team A, B, C, Contact, etc.).
  - If alternate phone numbers are available, attempt calls to alternate numbers as well.
  - Do not include any other information in the message, such as reason for the call, as this would be a privacy breach.

- If client does not return phone call or investigator is unable to leave a message, attempt 2 more phone calls at different times in the day on separate days.
- Check Netcare to ensure client is not hospitalized or deceased and if unable to reach to lift isolation after all contact attempts by phone.
- If unable to contact **cases to lift isolation** after 2 more attempts on different days at different times, complete case investigation (i.e.; complete all ESR required fields marked by (!) in CDOM) and complete case investigation as per *Appendix K: Unable to Contact and Lost to Follow up Process* OR see *Unable to Contact and Lost to Follow up Process on the* ACeRT SharePoint Site - Templates. No letter is sent for lost to follow up for isolation lift.

Exclusion Criteria by Case Type

Isolation means avoiding situations where other people could be exposed and infected.

- Situations to be avoided includes but is 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 food/grocery shopping;
  - may go out ONLY if asymptomatic and if required for urgent errands such as essential medication that cannot be managed through delivery/pick up service. As a precaution to further reduce risk of spread, a surgical mask may be worn outside of the home;
  - use of public transportation including buses, trains, taxis, or ride sharing;
  - having visitors to your home (but friends, family or delivery drivers can drop off food or other essential items that may be needed).
- In rare circumstances, COVID-19 may spread through stool. For these reasons, any client on self- isolation should be reminded of effective infection control such as hand hygiene and safe food handling practices. It would be recommended to refrain from preparing foods for others in the household until isolation has been lifted.
- More information about isolation for Albertans is available at https://www.alberta.ca/isolation.aspx#isolate; and exemption order for isolated persons.

Hospitalized Cases:

- Isolation and precautions as per hospital IPC management guidelines for symptomatic cases and for asymptomatic cases that are RT-PCR positive for COVID-19. Consult with hospital IPC for recommendations for lifting isolation/discharge.
- Consult with Zone MOH and Zone IPC to ensure appropriate isolation and precautions are implemented if an asymptomatic case with positive laboratory tests for COVID-19 is hospitalized.
  - A hospitalized asymptomatic case should be isolated and placed on contact and droplet precautions. Consult with hospital IPC for recommendations for lifting isolation/discharge.
  - If symptoms develop during the isolation period, case must remain in isolation* for 10 days from onset of symptoms or until symptoms, resolve whichever is longer.
- For AGMPs (e.g., case is receiving nebulized therapy), the use of additional precautions, including using an N95 respirator, is recommended.
- Hospitalized cases being discharged to their own home should remain on home isolation for 10 days from onset of symptoms or until symptoms have resolved, whichever is longer after arrival home. NO test of clearance is required.
- Hospitalized cases being discharged/transferred to facilities/continuing care/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 (4 days) is recommended because they had severe disease (i.e., hospitalized) and are re- entering a facility with other vulnerable persons (e.g., long term care facilities/continuing care/group homes/shelters). NO test of clearance is required.

Non-Hospitalized Cases:

- The Case Investigator shall exclude all known confirmed and probable cases from public places[G] until 10 days since symptom onset and the cases are afebrile and clinically improved on behalf of the MOH.
- Active daily surveillance by Public Health is **not required**.
  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.
- Provide all cases with contact information for Alberta's COVID-19 Exposure Response Team (ACeRT).
- Advise all cases that if they require urgent medical attention and need to access medical care, transport staff (if ambulance is required) and staff at the Emergency Department (ED)/Urgent Care Centre (UCC) must be advised immediately that the individual is infected with COVID-19 and the Zone MOH on call should be notified immediately.
  - The following symptoms are considered to be medical emergencies:
    - severe difficulty breathing (e.g., struggling for each breath, speaking in single words)
    - severe chest pain
    - having a very hard time waking up
    - feeling confused
    - loss of consciousness
- Non-hospitalized cases who were previously isolated (e.g., in an isolation centre) and are returning to congregate settings (e.g., long term care facilities, continuing care, group homes, shelters) shall be isolated with contact and droplet precautions for a minimum 10 days from onset of symptoms or until symptoms have resolved whichever is longer. Isolation may be extended to 14 days at the discretion of the MOH/Site IPC
- To decrease possibility of spread to household contacts, review IPC recommendations in **Appendix B**: I*nfection Control Measures and Isolation of Cases in a Non-healthcare Community Setting with case and/or household contacts.*
- 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.
- Discuss household resources including space for safe isolation, access to food, running water, drinking water, and supplies for the duration of the period of isolation. Determine if there is a need for additional resources or supports to address isolation, food security, accommodation or financial assistance to meet this requirement and support client to access additional resources as indicated. If client is in a community setting at time of assessment (home, community healthcare site) review immediate IPC measures to reduce risk of transmission as per the following appendices:
  - **Appendix B:** *Infection Control Measures and Isolation in a Non-healthcare Community Setting.* More information about isolation is available at https://www.alberta.ca/isolation.aspx#isolate, and exemption order for isolated persons
  - **Appendix C:** *Infection Control Measures in a Community Healthcare Setting*

  Refer to Hotel Isolation Coordinator through SharePoint process for zones where this is available.
- **Symptomatic Cases (confirmed and probable)** shall by order (CMOH Order 05-2020) be isolated and shall not attend work, school, daycare or visit any other public places until the Zone MOH has advised that they are no longer on isolation (see **Table 1a**) and meet criteria as described below:
  - Members of the public must continue to isolate for at until 10 days from symptom onset and be afebrile and have improved clinically. (Absence of cough is not required for those known to have chronic cough or are experiencing reactive airways post-infection).
  - If the member of the public has any of the 'other' symptoms they shall stay home and limit contact with other people until symptoms resolve.

[G] 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

- Previously lab confirmed COVID-19 cases that have recovered should NOT be re-tested for clearance if they are asymptomatic. However, if the person is re-tested, collect a detailed symptom inquiry to determine whether further investigation is required (see **Table 1a**).
- HCW have additional requirements and must not work in any health care setting for 14 days from onset of symptoms or until symptoms have resolved whichever is longer (by order). AHS, Covenant Health and Alberta Precision Lab employees can be referred to the COVID-19 Return to Work Guide for AHS Health Care Workers for further instructions. No test for clearance is required.
- Recommend repeat testing for HCW that have new symptoms even if they have been previously reported as a case. Based on the current evidence, it is most likely these people are immune. However, out of an abundance of caution and until serology testing is available and validated, we will recommend isolation and re-testing, and continue to re-evaluate this practice as the situation unfolds (see **Table 1a**)

  NOTE: Asymptomatic HCWs that already received Public Health follow-up for lab confirmed COVID-19 do not need to be retested.
  - If they become symptomatic with COVID-19 symptoms, re-testing for both COVID-19 and respiratory pathogen panel (RPP) should be completed.
- If at any time the status of a case changes and they are hospitalized or die, notification of hospitalization or death must be sent to Alberta Health and the Zone MOH FMP, see *Appendix G* for notification process.

  NOTE: An updated CDOM ESR must be transmitted to AH to indicate that client has recovered, died or is hospitalized.

- **Asymptomatic Cases (confirmed)** who are RT-PCR positive:
  - Must **remain isolated** and shall not attend work, school, daycare or visit any other public areas until the Zone MOH has advised that they are no longer on isolation.
  - Advise to avoid taking any antipyretics that may suppress a fever.
  - A non-hospitalized asymptomatic case should be isolated for at least 10 days from the laboratory specimen collection date.
  - If an asymptomatic case develops symptoms during the isolation period, the case must remain in isolation* for 10 days from onset of symptoms or until symptoms resolve whichever is longer.
  - In addition, asymptomatic lab confirmed cases should be assessed to determine whether they were symptomatic prior to specimen collection:
    - Determine if the case had two or more symptoms (fever over 38˚C, new onset/exacerbation of the following symptoms: cough, shortness of breath (SOB)/difficulty breathing, sore throat or runny nose) in the 7 days‡ before specimen collection that lasted at least 24 hours.
      - If yes, consider that symptoms may be indicative of COVID-19 and that date of symptom onset could be used for public health investigation and management. However, it is possible that these symptoms may be associated with another respiratory pathogen. The case should be instructed to monitor for COVID-19 like symptoms for 10 days following specimen collection date and they should be advised to contact 811 or number provided for ACeRT (if available) immediately for assessment.

      ‡ *In the context of a complex outbreak, the Medical Officer of Health may adjust this period based on the outbreak epidemiology and extend the review of symptom inquiry (for two or more symptoms as noted above that lasted at least 24 hours) to 14 days before the specimen collection date. This would be determined at the time of the outbreak investigation.*
  - If symptoms develop that require urgent medical attention and access to medical care, case should call 911. EMS staff (if ambulance is required) and nursing staff at the ED/UCC should be advised immediately that they may have been in contact with COVID-19 and the Zone MOH on call should be notified immediately.
  - If at any time the status of a case changes and they are hospitalized or die, notification of hospitalization or death must be sent to Alberta Health and the Zone MOH FMP, see Appendix G for notification process.

  NOTE: An updated CDOM ESR must be transmitted to AH to indicate that client has recovered, died or is hospitalized.

- **Suspect Cases**
  - Advise client to maintain isolation* at home for 10 days from onset of symptoms or until symptoms resolve whichever is longer.
  - If they meet criteria for quarantine as per CMOH 05-2020 they must remain in quarantine for the entire 14 days even if they test negative.
  - Suspect Cases who meet lab testing criteria (e.g., HCWs) should be tested to confirm diagnosis for public health management.
  - If medical attention is required advise to contact Public Health for further direction which will include where to go for care, the appropriate mode of transportation to use and IPC precautions to follow.
  - If symptoms develop that require urgent medical attention and access to medical care, EMS staff (if ambulance is required) and nursing staff at the ED/UCC should be advised immediately that they may have been in contact with COVID-19 and the Zone MOH on call should be notified immediately.

Table 2: Interpretation of Lab Results and Management

RPP (Respiratory Pathogen Panel)	COVID-19 (ProvLab)	Management of Cases
Positive	Pending	Maintain isolation until ProvLab COVID-19 results available
Negative	Negative	• Lift isolation. Individuals who are isolated due to exposure risk (e.g., travel/residence outside of Canada, close contact of a confirmed case) and who have negative RPP and COVID-19 results, must remain isolated for the full 14 days. If they are hospitalized during the 14 days, they should be placed on contact and droplet precautions.
Positive**	Negative	• Lift isolation. Individuals who are quarantined due to exposure risk (e.g., travel/residence outside of Canada, close contact of a confirmed case) and who have negative COVID-19 results, should remain isolated for the full 14 days. • Recommend appropriate measures for identified respiratory pathogen.
Negative	Positive	• Maintain isolation for at least 10 days from symptom onset or until symptoms resolve whichever is longer. • For asymptomatic cases; maintain isolation for 10 days from specimen collection date when there are no identified symptoms that lasted longer than 24 hours within the 7 days before specimen collection OR symptoms of any duration identified in the 10 days following specimen collection. • For hospitalized cases, consult with hospital IPC about recommendations for lifting isolation/discharge. • For non-hospitalized cases with mild symptoms, release of isolation should be from 10 days after symptom onset as long as they are afebrile and have improved clinically i.e., well enough to resume normal activities, whichever is longer (absence of cough is not required for those known to have chronic cough or are experiencing reactive airways post-infection). • To determine when to lift isolation, onset date of symptoms = day0 • Initiate FMP reporting of confirmed/probable case as per *Reporting Requirements* section. • Initiate contact tracing and management of close contacts as per *Contact Management* section.

** Positive results for anything that explains symptoms. This may also include positive test results outside of the RPP.

Contact Management
(Includes asymptomatic returned travelers and close contacts of Confirmed and Probable Cases)

There are scripts for contact tracing of both symptomatic and asymptomatic contacts and for contact tracing in workplaces outside of AHS or Covenant Healthcare facilities and Congregate Care sites, see **Appendix J**: *Call Scripts for Contact Tracing* for the web link to the Alberta COVID-19 Response Team SharePoint Site to access scripts. These scripts are meant to be an addition to the information for contact management provided in this section.

- **Close contacts** are defined as individuals:
  - who provided direct care for an infected individual, including HCW, family members or other caregivers, or who had other similar close physical contact (e.g., intimate partner, hug, kiss, handshake) without consistent appropriate use of personal protective equipment (PPE),

  OR
  - had direct contact with infectious bodily fluids of a case (e.g., shared cigarettes, food, glasses/bottles, eating utensils) or was coughed or sneezed on while not wearing recommended appropriate PPE.

  OR
  - lived with or otherwise had close prolonged[H] contact which may be cumulative (i.e., for a total of 15 minutes or more and within two metres) with a case without consistent and appropriate use of PPE up to 48 hours prior to symptom onset or while the case was symptomatic and not isolated.
- A close contact who develops symptoms should be managed as a Probable Case and referred for testing (see definition for a Probable Case on page 1). Manage as per **Case Management** Section.
- Close contacts of Probable and Confirmed Cases shall by order be in quarantine for 14 days from last day of exposure to the case during their defined period of communicability, with day 0 = last day of exposure to case during case period of communicability.
- Close contacts of laboratory confirmed asymptomatic cases shall by order be in quarantine for 14 days from last known exposure to the case during their defined period of communicability. Symptomatic close contacts require testing to confirm diagnosis.
- Symptomatic close contacts should be advised to follow guidance set out in the CMOH Exemption when they go for testing if it cannot be facilitated via home based collection. If they do not get tested, they must isolate for a minimum of 10 days from onset of symptoms, or until symptoms resolve, whichever is longer.
  - Symptomatic individuals must be isolated while awaiting test results.
    NOTE: Contact tracing for symptomatic individuals that meet exposure criteria who were tested and are waiting for lab results should be initiated once lab results have been received and the person has been determined to be a confirmed/probable case.
    - Household contacts of the symptomatic individual who meets probable case definition should quarantine while awaiting test results.
    - Contact tracing for all non-household contacts should be initiated once lab results are received.
- Individuals that test positive for COVID-19 must be isolated for 10 days from onset of symptoms and until symptoms resolve whichever is longer. Refer to **Case Management, Exclusion Criteria by Case Type** section
- If testing is negative, maintain quarantine for the full 14 day incubation period from last known exposure AND until symptoms have resolved, whichever is longer.
  - If there is a change in symptoms within their quarantine period, it could be considered on a case by case basis whether repeat testing would be appropriate and beneficial.
- Asymptomatic close contacts of confirmed COVID-19 cases should also be tested. This includes household and other close contacts, and residents and staff in confirmed COVID-19 outbreaks and as determined by the MOH for outbreaks in other complex settings.
- For contact management of HCW **(**see **Appendix D)**, engage WHS/OHS and IPC (where available) to assist with investigation and identification of workplace contacts e.g., obtain lists of exposed staff, use of PPE and exposure times/locations[H].

[H] 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., 10 days after symptom onset in a case who is now asymptomatic, this would be day 0 when calculating lift date for the close contacts.

- IPC is responsible for management of any exposed in-patients and to provide lists for Public Health follow-up of discharged patients that may have been exposed.
  - The MOH shall exclude close contacts of all known confirmed cases from all public places for 14 days from the time of last exposure.
  - The MOH should also exclude close contacts of probable cases from all public places for 14 days from the time of the last exposure.
- For assessment of close contacts related to sports, see Appendix N.

Risk Assessment and Public Health follow-up of contacts and people at risk of exposure

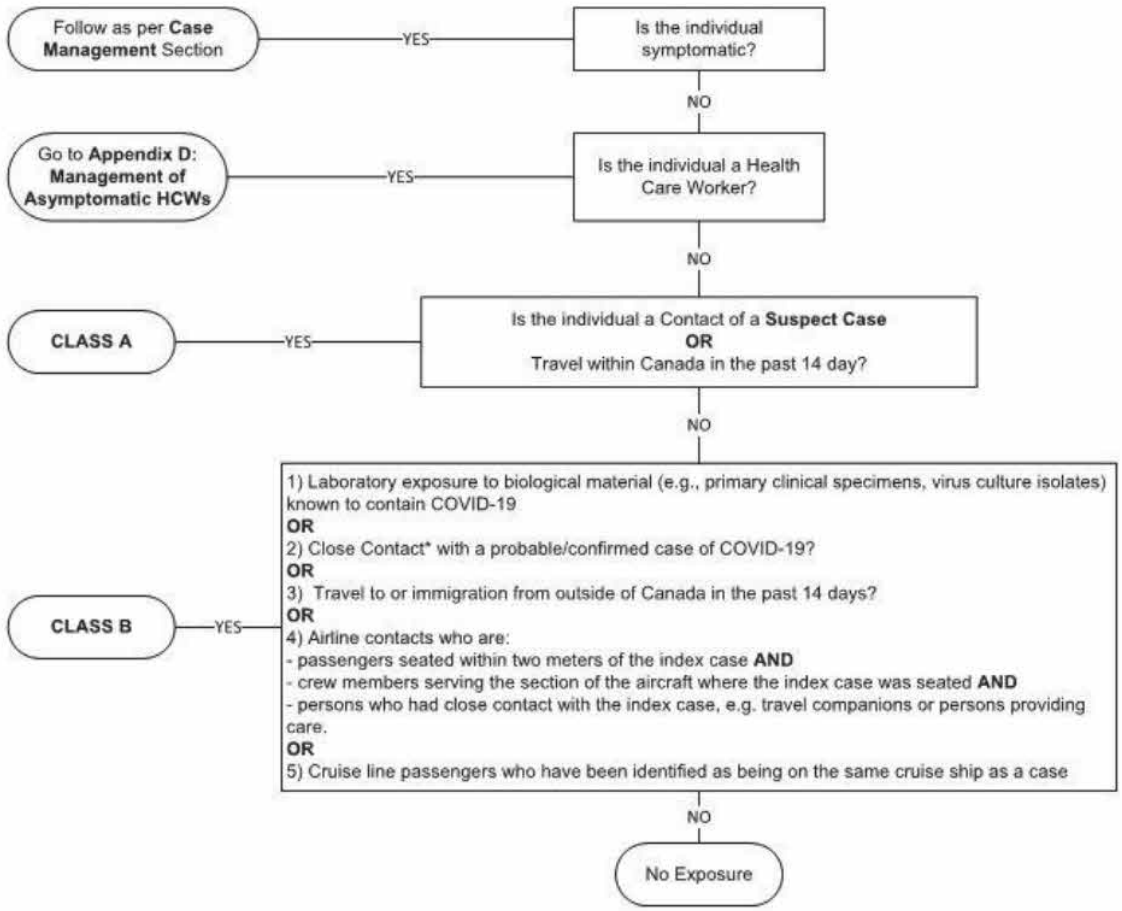
Investigator

- Each potential contact should be assessed for the type of exposure, the setting and the time since last exposure as follows.
  - If unable to reach the client/parent/guardian with initial phone call:
    - Attempt to leave a message which should include Investigator first name and designation (e.g., Registered Nurse with Alberta Health Services) and the phone number for the client to return call.
    - Do not include any information in the message that would breach client privacy regarding the reason that investigator is attempting contact.
    - If client does not return phone call or investigator is unable to leave a message, the investigator should attempt 2 more phone calls at different times in the day on separate days.
- Provide information about COVID-19 disease including signs and symptoms.
- Contacts who may have been exposed to COVID-19 should be referred to the most appropriate online assessment tool to determine eligibility for testing and for additional advice on COVID-19 including the need to isolate.
- Collect travel and exposure history details (within the last 14 days):
  - Residence or travel anywhere outside of Canada.
  - Dates and purpose of travel.
    - Mode(s) of transportation and accommodation details including itineraries for any air, ground or water transportation (An official global travel advisory is in effect and non-essential travel is NOT recommended).
    - Any returning travelers to Canada, must follow mandatory requirements as laid out in the COVID-19 Emergency Order in Council under the Federal Quarantine Act and CMOH Order 05-2020.
  - Includes inter-provincial travel (.e.g., work camp.)
    - 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.
  - Contact with healthcare settings anywhere outside of Canada.
    - In which hospital where they exposed?
    - Where is the hospital located?
    - What was the purpose for their visit to the hospital?
    - Did they have direct contact with COVID-19 patients?
    - Was appropriate and consistent PPE used?
  - Close contact of a confirmed and/or probable case of COVID-19.
  - Close contact of a traveler with acute respiratory illness who returned from outside of Canada in the previous 14 days.
- There is no post-exposure prophylaxis for contacts.

Guidance on the Use of Masks

- While 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 the 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 working in healthcare facilities where PPE is routinely used or where staff are trained in the appropriate use of PPE (e.g., acute care, long term care, supportive and home living, physician offices, dentist offices etc.) who care for patients with pre-symptomatic/asymptomatic COVID-19 infection, if there were no identified PPE breaches. *This is not considered sufficient for HCWs who work with symptomatic patients. See Alberta Health Risk Assessment Algorithm for HCW (forthcoming at time of publication).*
- For police exposure assessment, case investigator should refer assessment and follow up of police close contacts to the police services' OHS. They will be responsible for carrying out a risk assessment to determine if police officers were exposed.
    - If a police service does not have OHS, AHS contact tracer should consult with zone MOH for risk assessment of potential exposures and identification of close contacts.
    - Police services should be reminded of the essential worker exemption if there are concerns about capacity to continue operations if too many officers are quarantined at one time. https://www.alberta.ca/COVID-19-assessment-tool-for-health-care-workers-and-public-health-enforcement.pdf.

For all contacts, complete follow up based on the algorithm below - **Contact Management Follow Up.**



Class A

Asymptomatic Contacts of Suspect Cases OR Travel within Canada in the past 14 days

NOTE: There is no need to actively collect information about these contacts. (If it is obtained during the investigation, document as a contact within the DI in CDOM).

Until the Suspect case or a traveler within Canada is confirmed as a Probable or Confirmed Case, the following recommendations apply to their contacts:

- ✓ Provide information about COVID-19 disease including signs and symptoms.
- ✓ Advise them of the following precautions:
  - Follow good respiratory etiquette and hand hygiene practices
  - Self-monitor for the appearance of symptoms, particularly fever and respiratory symptoms of cough or shortness of breath.
    - ✓ Advise them that if symptoms develop they must isolate immediately and engage the online COVID-19 self-assessment tool for testing or by calling Health Link 811 immediately (or other number if provided locally by zone).
  - If symptoms develop that require urgent medical attention and access to medical care, EMS staff (if ambulance is required) and nursing staff at the ED/UCC should be advised that they may have been in contact with COVID-19 and the Zone MOH on call should be notified immediately.

- ✓ With COVID-19 the following symptoms are considered to be medical emergencies:
  - severe difficulty breathing (e.g., struggling for each breath, speaking in single words)
  - severe chest pain
  - having a very hard time waking up
  - feeling confused
  - loss of consciousness

Class B

- **Asymptomatic individuals who have had known contact with a confirmed or probable case within the past 14 days**

OR

- **Asymptomatic individuals with travel anywhere outside of Canada in the past 14 days**

OR

- **Asymptomatic individuals with laboratory exposure to biological material (e.g., primary clinical specimens, virus culture isolates) known to contain COVID-19 where consistent and recommended PPE was not used.**
  - ✓ Contact individuals to initiate follow-up on the same day as the case investigation where possible, or within 24 hours of receiving referral.
  - ✓ Asymptomatic close contacts of confirmed COVID-19 cases should also be tested. This includes household and other close contacts, and residents and staff in confirmed COVID-19 outbreaks and as determined by the MOH for outbreaks in other complex settings.
    - If test results come back positive for COVID-19 manage as per guidance outlined in **Case Management** section.
    - Quarantine period for **household contacts** should be determined based on their ability to meet all of the criteria below. If all criteria below cannot be met, household contacts with ongoing exposure to the case will need to continue to quarantine until 14 days after case isolation lift date:
      - *If the Case is able to remain completely separate (own room/suite including bathroom) or physically distant from other household contacts at all times (and also have their own bathroom) for the duration of their isolation, practice stringent hand hygiene, conduct rigorous cleaning and disinfecting of shared household surfaces, and always wears a mask in the presence of household contacts in addition to physical distancing – all on the honor system.*
        - ✓ *can share kitchen facilities as long as they are the sole occupant when they use the kitchen, don't prepare food for anyone else, and thoroughly clean and disinfect all surfaces before other members enter*
        - ✓ *if there is a shared entrance to their isolation quarters, door knobs/rails etc. must be thoroughly cleaned and disinfected promptly*
        - ✓ *must not share household and personal items e.g., phone, computers, laptops, books, utensils, personal grooming items*
        - ✓ *must wear non-medical mask and remain at least 6 feet/2 metres apart from household members when in shared living space, including hallways and limit the time in a shared living space as short as possible*
        - ✓ *could receive meal tray left outside a closed door where possible, as long as the person leaving/picking up tray practices physical distancing and hand hygiene. If face to face interaction within 6 feet/2 metres is unable to be avoided, it must be limited to as short as time as possible and case should wear a mask*
  - ✓ Daily active monitoring by Public Health is **not required**.
  - ✓ Advise that assessment indicates potential risk of exposure and as per CMOH Order 05-2020 they must be in quarantine (staying home from work, school/daycare or other public places) and self- monitor for symptoms of COVID-19 for **14 days a**fter their last known exposure. Individuals should:
    - Self-monitor for fever greater than or equal to 38.0 C/100.4 F twice daily.
    - Avoid taking any antipyretics that may suppress a fever.
    - Self-monitor for other symptoms of COVID-19 such as new onset cough or change in existing cough, shortness of breath, difficulty breathing, sore throat or runny nose.

- Maintain good respiratory etiquette and hand hygiene.
- Be advised that if symptoms develop they must isolate immediately and contact local Public Health/number provided for ACeRT (if available) for assessment by calling Health Link 811 immediately (or other number if provided locally by zone.)
- Be advised that if symptoms develop that require urgent medical attention and access to medical care, EMS staff (if ambulance is required) and nursing staff at the ED/UCC should be advised immediately that they may have been in contact with COVID-19.

✓ With COVID-19 the following symptoms are considered to be medical emergencies:
- severe difficulty breathing (e.g., struggling for each breath, speaking in single words)
- severe chest pain
- having a very hard time waking up
- feeling confused
- loss of consciousness

✓ Discuss access to food, running water, drinking water, and supplies for the duration of the quarantine period. Determine if there is a need for resources or supports to address food security, accommodation or financial assistance to meet this requirement.

NOTE: Refer to **Appendix B** for instructions on infection prevention control during quarantine.

- **Appendix B**: *Infection Control Measures and Isolation in a Non-healthcare Community Setting*. More information about isolation is available at https://www.alberta.ca/isolation.aspx#isolate, and exemption order for isolated persons

**Refer to internal process documents on AHS provincial shared drive for situation-specific information as relevant for complex community exposures e.g., industrial worksites*

✓ Review disease information and preventive measures, and provide the AH Website for more information on self- isolation at: www.alberta.ca/coronavirus.

Management of Contacts on an Airplane or Cruise Line

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 care providers.
- 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.

National/International Flights

Flight manifests are not being requested for national/international flights. PHAC has launched a public website that provides information on COVID-19 exposures on flights and cruise ships. This will allow for the sharing of relevant information with the general public and/or key stakeholders collected through international notices of COVID-19 conveyances, case reports from provinces/territories and the Canadian National Public Health Intelligence (CNPHI) alerts on confirmed COVID-19 cases reporting travel.

✓ 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).

Provincial Chartered Flights

AHS will request interprovincial flight manifests, especially those relating to work camps, as part of the case/contact investigation.

- ✓ Contact tracing of travelers on a chartered airplane who may have been exposed to case of COVID-19 during a flight is made on a case-by-case basis based on the following:
  - case definition (e.g. confirmed),
  - type and severity of symptoms of the case during the flight, and movement of case around the plane cabin.
- ✓ *For Canadian North Charter flights to Northern Alberta for Imperial Oil (Flight numbers that are 1400 series), CNRL (Flight numbers are 1700 series) and Husky (Flight numbers are 1200 series) these will not follow the posting process through PHAC. The companies will provide to AHS the list of passengers needed for follow up. Canadian North should be contacted directly for follow up related to flight crews. The contact person for Canadian North is Steve Boon, email sboone@canadiannorth.com, phone 403-537-5745, cell 403-461-3176.*

Asymptomatic Individuals with No Risk of Exposure:

Returned traveler who reports no travel history outside of Canada or has returned greater than 14 days prior to assessment for COVID-19.

- ✓ Advise that assessment indicates no exposure and, therefore no risk of transmission.
- ✓ Review disease information, reassure regarding low risk of exposure. Provide website links as above for more information about to COVID-19.
- ✓ Advise to contact Health Link 811 for any questions or concerns.
- ✓ Documentation related to these individuals should be captured in the Consult Log with the **Title**=nCoV. If more documentation is required a CI for Coronavirus, Novel can be created at the discretion of the Investigator. No DI is created.

Mandatory Quarantine and Isolation: CMOH Order 05-2020

- ✓ **Quarantine** will be legally enforced 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.
  - Close contacts of confirmed shall by order be quarantined for **14 days** since last exposure and monitor for symptom.
- ✓ Close contacts of probable cases should also be quarantined for 14 days
- ✓ Close contacts of confirmed and probable cases should be offered testing.
- ✓ For additional information regarding quarantine and isolation refer to https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/prevention-risks.html?topic=tilelink#self
- ✓ **Isolation** will be legally enforced for the following individuals:
  - Returning international travelers, close contacts of Confirmed and Probable Cases who develop symptoms, shall by order be in isolation for **another 10 days** from onset of symptoms or until symptoms have resolved, whichever is longer.
  - Individuals with new onset of the following symptoms: fever (over 38ºC), new onset of (or exacerbation of chronic) cough, SOB/difficulty breathing, sore throat or runny nose shall by order must be in isolation for 10 days from onset of symptoms or until symptoms resolve, whichever takes longer.

Management of Outbreaks

Outbreaks **shall by order** be reported in a facility with vulnerable people e.g., shelter, hospital, long-term care facility, licensed supportive living, lodges, senior's residence or similar settings such as any facility in which residential addiction treatment services are provided, daycare, school, or correctional facility. The AHS Coordinated COVID-19 Response team (**1-844-343-0971** is available 0800-2200h x 7 days/week) is a collaborative effort to assist with site support for facilities with vulnerable populations for implementation of outbreak management and control measures including testing, isolation protocols, staffing, personal protective equipment (PPE), education, etc. Team membership includes representatives from Zone Operations, Senior's Health, IPC, MOH, CDC, Environmental Public Health, and Public Health Nursing.

Definitions (see Table 3)

- ✓ **Outbreak:** *"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). A common source of infection or the identification of transmission between cases are not required. 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.
- ✓ **Public Reporting:** The minimum threshold for public reporting of COVID-19 outbreaks.

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.*

Table 3: COVID-19 Thresholds for Alert, Outbreak and Public Reporting based on Setting

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	5 confirmed cases
		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 Work places	Work Camps	1 confirmed case¥	2 confirmed cases€	
		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	*Including but not limited to weddings, funerals, religious gatherings, community events and small gatherings with more than one household*	N/A	5 confirmed cases*	10 confirmed cases associated with at least 3 households
Public Settings	Medium -Low Risk	*Including but not limited to hair salons, restaurants, retail spaces, indoor or outdoor recreation facilities, etc.*	N/A	5 confirmed cases*	5 confirmed cases
Other work places	Medium -Low Risk	*Workplaces that do not fit into the categories above (e.g. office buildings)*	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*

Investigation and Management

Investigator

Outbreak investigations for congregate settings are categorized differently, depending on whether or not they are included in the CMOH Order 32-2020. A single symptomatic resident/staff in any congregate setting must be isolated appropriately as per infection prevention and control measures, and should be asked for consent to be tested for COVID-19 (see Table 4). No Public Health reporting to Alberta Health is required until a case is confirmed and a COVID-19 outbreak is declared (see Table 5).

Table 4: Symptoms to Initiate COVID-19 Testing

* Staff in Facility under CMOH Order 32-2020 * Staff/Resident in other Congregate setting * Staff/Children in Child care setting	Residents in Congregate Living Facility under CMOH Order 32-2020
• 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	• Fever (37.8°C or higher)* Any new or worsening respiratory symptoms • Cough (new cough or worsening chronic cough)* • Shortness of breath/difficulty breathing (new or worsening)* • Runny nose* • Sore throat* Any new symptoms including but not limited to: • 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.*

COVID-19 Outbreaks in Congregate Settings: CMOH Order 32-2020 (licensed supportive living (including group homes and lodges), long-term care, nursing homes and auxiliary hospitals, and hospice settings).

- Sites must call the AHS Coordinated COVID-19 Response line to report symptomatic individual(s), and to obtain guidance and decision-making support. All confirmed outbreaks in licensed supportive living (including group homes and lodges), long-term care, nursing homes and auxiliary hospitals, and hospice settings shall by order be investigated and reported.
- 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.

Table 5: 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) Other Congregate Setting (e.g. corrections, shelters)	• For any staff/resident with symptoms listed in Table A2 above, the following actions apply: - Resident must be isolated, placed on contact and droplet precautions and tested for COVID-19. - Any symptomatic staff MUST NOT work. They must isolate at home and arrange for COVID-19 testing on site or via the HCW screening online tool. • 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.	A COVID-19 Outbreak is defined as: - Any resident who is confirmed to have COVID-19 and/or - Any staff member who is confirmed to have COVID-19(O)	- All confirmed outbreaks that meet the COVID-19 outbreak definition should be investigated and reported

- ✓ Symptomatic staff and residents with COVID-19 like symptoms (**Table 4**) must be isolated and should be asked for consent to be tested. Follow site specific protocols for appropriate infection prevention and control measures. Symptomatic staff must not work.
- ✓ Asymptomatic staff who are not considered HCW should NOT be retested during a site outbreak if they were a lab confirmed COVID-19 case within the past 90 days.
- ✓ When a COVID-19 outbreak is confirmed in licensed supportive living sites (including lodges but NOT group homes), long term care (nursing homes and auxiliary hospitals):
  - Asymptomatic residents as well as staff that are part of a **NEW** COVID-19 confirmed outbreak on their site/unit should be asked to consent to be tested.
  - Asymptomatic residents as well as staff that are part of an existing COVID-19 confirmed outbreak on their site/unit should be asked for consent to be tested if there appears to be ongoing transmission.
  - Owner/operator/managers/staff that would like more information about asymptomatic testing can be directed to one page information sheets on the AHS Seniors Health portal and AHS website at:
    - https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-congregate-site-swabbing-asymptomatic-staff.pdf
    - https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-congregate-site-swabbing-asymptomatic-residents-staff.pdf
  - When a COVID-19 outbreak is confirmed in other complex outbreaks (e.g., group homes etc. as determined by the MOH), testing of asymptomatic individuals may be considered as a tool for early detection of cases and outbreak control at the discretion of the Zone MOH, depending on the context and epidemiology of the outbreak.
- ✓ For more information on site management and roles and responsibilities refer to the AHS Guidelines for COVID-19 Outbreak Prevention, Control and Management in Congregate Living Sites and the CMOH Order 32-2020.
- ✓ Refer to AHS DSOP Outbreak Identification, Reporting, Investigation and Control and CDC Nursing - CDOM Documentation for Outbreaks. In addition, see detailed Outbreak Process document on the AHS provincial

shared drive > ND and Outbreaks > Provincial ND OB Team > Outbreaks > Training Documents.

- ✓ Documentation of new positive lab results, deaths and new onset illness in both staff and residents must be updated in the CDOM Outbreak Case Count tab no later than 1130h every day.
- ✓ Advise sites that Alberta Health publishes the names of all confirmed COVID-19 outbreak sites by municipality and zone for any outbreak that meet the workplace transmission threshold for public reporting (congregate care settings = two (2) or more cases; community settings = five (5) or more cases.)
- ✓ An outbreak in licensed supportive living (including group homes and lodges), long-term care, nursing homes and auxiliary hospitals, and hospices) may be declared over after 28 days (two incubation periods) from date of onset of symptoms in the last case, with the following exception:
    - When confirmed COVID-19 cases are only identified in staff at the site, the outbreak can be declared over 14 days after their last day of work if no further cases were identified at that site.
      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 (see Table 1a).

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

- ✓ Where there is evidence of continued transmission (defined as 2 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 asymptomatic residents/patients.
- ✓ Contact and droplet precautions should be applied when providing care to any symptomatic person (including any lab-confirmed case of COVID-19) until 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.

COVID-19 Outbreaks in Community settings

- ✓ A COVID-19 outbreak may be declared for community settings (shopping malls, recreation centres, churches or other public places) or gatherings (e.g. dinner parties where more than one household is involved) if there are **five** or more COVID-19 cases within one incubation period. The *Alberta Outbreak Reporting Form (AORF)* ***must*** be completed and sent to Alberta Health when an outbreak is declared.
- ✓ An outbreak in the community or workplace/work camp may be declared over after two incubation periods from date of onset of symptoms in the last case.
- ✓ Advise that effective May 4, 2020, Alberta Health publishes the names of all confirmed COVID-19 outbreaks by municipality and zone for outbreaks with evidence of linked transmission. See *Appendix H: Process for follow up of COVID-19 Outbreaks in Community Settings* for CDC nurse roles and responsibilities for management of outbreaks in these settings.

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.

COVID-19 Outbreaks in Child Care Settings

- Child care setting includes daycares, after school care, preschools, day homes (Table 6)

For one staff or child with COVID-19 symptoms listed in Symptom List for COVID-19 Testing or a child with rash:

- 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 tool or call Health Link at 811 to arrange testing.
- Any symptomatic staff MUST NOT work. They must isolate at home and arrange testing via the online COVID-19 self-assessment tool or call Health Link at 811.
- 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 6: Management of COVID-19 Outbreaks in a 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	• Two symptomatic individuals (child/staff) within 48 hours • The child care setting must call 1- 844 to connect with public health who will: - 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.	When there is one confirmed case (staff/child) in a child care setting, actions include but not limited to the following: - 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	A COVID-19 Outbreak is defined as: - 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 6, 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 isolate at home and arrange testing via the online COVID-19 self-assessment or call 811.
  - See Appendix M for guidance on cases that have attended school during their period of communicability.
  - Refer to **Table 7**: Management of COVID-19 Outbreaks in Schools for more information.
  - 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 7: Management of COVID-19 Outbreaks in Schools (K-12)

Setting	COVID-19 Alert	COVID-19 Outbreak	Management of Confirmed COVID-19 Outbreak
School	• One confirmed case (staff/child) in a school • Actions during an alert include but not limited to the following: - Engagement with the school as appropriate to ensure measures are in place to prevent further spread - Communication with parents/ school board - Report to AH	A COVID-19 Outbreak is defined as: - 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 a Workplace

- Any staff/client with COVID-19 symptoms listed **Symptom List for COVID-19 Testing** MUST NOT work and testing should be arranged by completing the online COVID-19 self-assessment tool or calling Health Link at 811.
- Refer to Table 3 for information on COVID-19 alerts and confirmed outbreaks.

References

Alberta Health, Public Health Notifiable Disease Management Guidelines. *Coronavirus – COVID-19,* Aug 28, 2020

American Society for Microbiology. Journal of Virology. *Animal Origins of the Severe Acute Respiratory Syndrome Coronavirus: Insight from ACE2-S-Protein Interactions.* Retrieved December 04, 2018 https://jvi.asm.org/content/80/9/4211

Centres for Disease Control and Prevention. *2019 Novel Coronavirus, Wuhan, China* web page, accessed January 23, 2020 from https://www.cdc.gov/coronavirus/COVID-19/summary.html

Heymann, D. (2015). *Control of Communicable Diseases Manual.* (20th Ed.). Washington, DC: American Public Health Association

Public Health Agency of Canada. *Novel Coronavirus in China*. Retrieved January 23, 2020 from https://travel.gc.ca/travelling/advisories/pneumonia-china

World Health Organization. *Novel Coronavirus (COVID-19)* webpage. Technical guidance documents and Situation Reports. Retrieved January 23, 2020 from https://www.who.int/emergencies/diseases/novel-coronavirus-2019

Appendices

Appendix A: CDOM Procedures: Documentation and Reporting of COVID-19

Appendix B: Infection Control Measures and Isolation of Cases in a Non-healthcare Community Setting

Appendix C: Infection Control Measures in a Community Healthcare Setting

Appendix D: Management of Asymptomatic Health Care Workers (HCWs) with Potential Exposure to COVID-19

Appendix E: Contact Tracing App Process

Appendix F: CDC and WHS Actions and Messaging for AHS/APL (and Covenant) Workers with Possible Occupational Exposures

Appendix G: MOH Case Summaries and Escalation Notification Process

Appendix H: Process for follow up of COVID-19 Outbreaks in Community settings

Appendix I: Process and Documentation for follow up of COVID-19 Outbreaks in Work Sites/Camps

Appendix J: Call Scripts for Contact Tracing

Appendix K: Unable to Contact and Lost to Follow up Process for COVID-19 Cases

Appendix L: Single case of COVID-19 in a Childcare Setting

Appendix M: Single Case of COVID-19 in a School

Appendix N: Sports Contacts

Appendix A: CDOM Procedures, Documentation and Reporting of COVID-19

COVID-19 confirmed and probable cases must be reported to Alberta Health (AH) by submitting the enhanced surveillance form (ESR) through CDOM, electronically.

- COVID-19 Suspect cases are not reportable to Alberta Health. This definition is only provided for the purpose of Public Health investigation.
- See Reporting Requirements for details.

Create a New DI or CI in CDOM for individuals when:

- There is a new exposure to someone or a site/space/event/facility other than what the existing record is for. Create a new CI/DI if individual is not part of an ongoing exposure situation (e.g., multiple household contacts, outbreak situation, etc.)
- A positive lab test is received for an individual who was previously identified as a contact and tested negative for an exposure that was more than 14 days prior to onset of current symptoms or date of current specimen collection if asymptomatic,
- Individual meets suspect or probable case definition for symptoms that have started after the end of the incubation period has passed from any previous exposure.
- Individual was previously investigated as a lab confirmed case, has a new positive lab and has discrete onset of new symptoms after having been asymptomatic for at least 14 days since previous symptom resolution.
- If a new DI or CI for COVID-19 is created, ensure to document in Summary Tab > Notes (Common) NOT A DUPLICATE, DO NOT DELETE.

Use an existing DI or CI in CDOM for individuals who already have a COVID-19 record DI or CI when:

- Lab test is received for an individual who was either never tested from an exposure that occurred within the previous 14 days,
- Lab test was previously tested negative for an exposure that occurred within the 14 days prior to onset of current symptoms or date of current specimen collection if asymptomatic,
- Individual was followed as an asymptomatic contact from an exposure within the previous 14 days and is now symptomatic and requires investigation and/or testing,
- Individual was previously investigated as a lab confirmed case, has a new positive lab within 30 days of symptom resolution and has never had onset of new symptoms since symptoms resolved.

Documentation of Cruise line/Cruise ship passengers, Facility or Community Event Outbreaks:

- Obtain a ProvLab EI or Zone specific EI (e.g., 2020-CAL-A005, 2020-EDM-A071) asrequired, create an outbreak investigation (OI) in CDOM for the EI:
    - All DIs and CIs for individuals present at the site/space/event/facility where the exposure occurred should directly linked to the OI,
        - Individuals who are contacts of cases, but who were not present at the site/space/event/facility where the exposure occurred, should be linked to the case's DI but should not be directly linked to the OI.
    - Follow instructions below for documentation related to any confirmed or probable cases as each case requires its own OI.

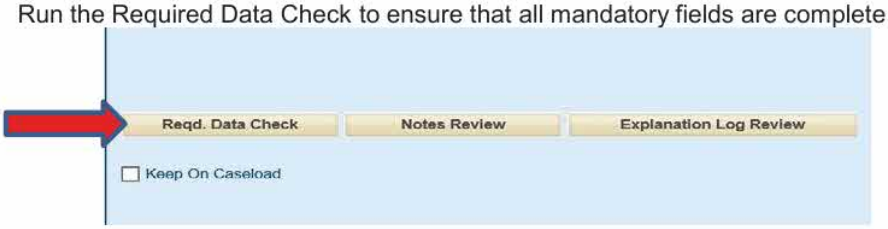
Documentation of Confirmed and Probable cases and their contacts:

- Create a DI for COVID-19 for all confirmed, probable, suspect and lab specimen pending cases.
- Create a contact investigation for each contact from within the DI assessment tab for cases with less than 35 contacts.
- If there are more than 35 contacts, in addition to creating a DI for the case, create the contacts separately from the DI and link using the contact investigation > summary tab> link to disease incident field. Full first and last name of the DI will be required to search and link the CI.
- If the case is associated with a common transmission site where others may have all been exposed to the same source, create an outbreak investigation (OI) with a Zone specific EI number or a ProvLab EI number (whichever is required based on the need to coordinate specimen collection) and set **Resolution status =** Outbreak.
    - Epi-link the DI to the OI.

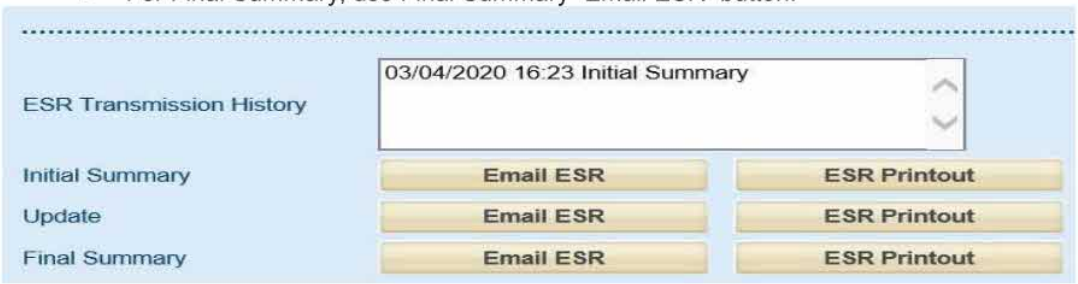
- **In the** Intervention Tab > Outbreak Associated field >
  - Choose "Yes" for cases that are associated with a defined outbreak in Alberta.

- If the OI is for a defined outbreak in Alberta, complete all mandatory fields for AORF reporting as per the document: *CDC Nursing-CDOM Documentation of Outbreaks Nov 2018*
- If the OI is being set as "Not an Outbreak" complete the following fields and then use the rest of the fields as needed:
  - Outbreak Investigation Tab:
    - Outbreak Investigation Number = ProvLab or Zone-Specific EI
    - Outbreak Type = Respiratory (incl. ILI) Non Care Facility
    - Investigator = Assigned investigator
    - Process status = As appropriate for status
    - Resolution status = Not an Outbreak
  - Definition Tab:
    - Suspected Organism/Disease = COVID-19
    - Enteric/Non-Enteric = Non-enteric
    - Outbreak Assigned Zone/Service Area = As appropriate for case Zone
    - Outbreak Setting (Common)!
      - Outbreak Setting type! = Community
      - Location Name! = Community
      - Municipality = As appropriate for case location
    - Primary Organism/Disease Identified = COVID-19.
  - Progress Tab:
    - Date investigation opened/closed (Common)!

- Create a CI for COVID-19 <u>for every contact</u> associated with each confirmed and probable case that CDC will be calling directly for follow up.
  - Epi-link each CI to the case's DI or OI, whichever is appropriate for the case as per instructions above.
  - If a close contact becomes a DI:
    - Epi-link the new DI to the index case DI, if not already done, in the Interpretation tab.
    - Follow documentation instructions for DIs as above.
- Document all relevant lab information in the lab tab for DIs, including negative test results that would rule out other infections. (See **Laboratory Tab** section)
- Complete all marked (!) ESR required fields in CDOM.
  - **Set** Resolution status > as appropriate based on case definitions
    - **Set Process status >:**
    - **Under Investigation** if case is remaining on isolation.
    - **Investigation Complete** if case is resolved and isolation is lifted.
  - Run the Required Data Check to ensure that all mandatory fields are complete and correct.



- Submit confirmed and probable cases to AH using **'email ESR'** process.
  - For initial submission, use Initial Summary "Email ESR" button.
  - For any updates, use Update "Email ESR" button.
  - For Final Summary, use Final Summary "Email ESR" button.



NOTE: An updated ESR submission is required when a case is hospitalized, dies or infection resolves.

Documentation of Probable Cases with tests pending:

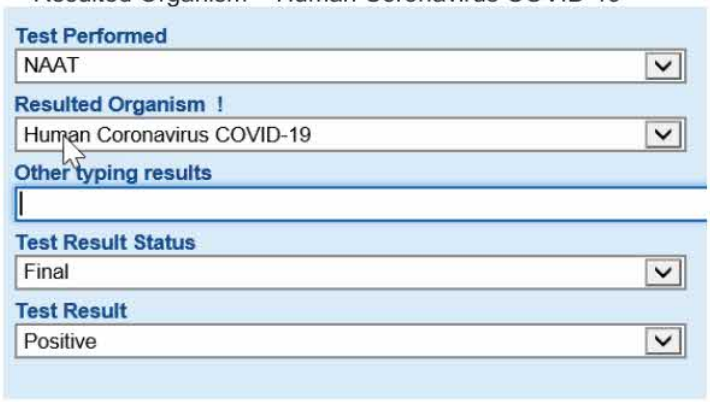
- Create a DI for COVID-19
- Complete all other relevant fields to capture investigation and assessment
- **Set** Resolution Status > Pending
- If tested and becomes a confirmed or probable case, document as per above.

Documentation of Suspect cases:

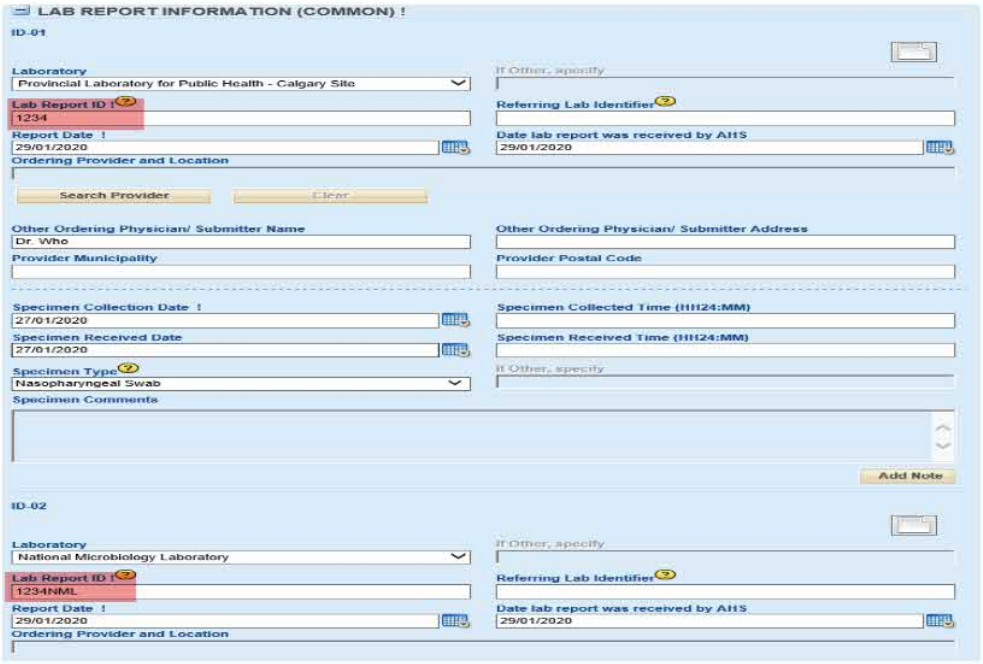
- Create a DI for COVID-19
- Complete all other relevant fields to capture investigation and assessment
- **Set** Resolution Status > Suspect
- If tested and becomes a confirmed or probable case, document as per above.

Laboratory Tab:

- Documentation of novel coronavirus test results must be entered as follows:
  - ProvLab results:
    - Test Performed – NAAT
    - Resulted Organism – Human Coronavirus COVID-19



  - NML results (if required):
    - Create a Laboratory Report Information ID for documentation of NML results.
      - If the same accession number is used by ProvLab and NML, create the Laboratory Report ID for the NML specimen by adding the letters "NML" after the ProvLab accession number as shown below.



- Test Performed – NAAT
- Resulted Organism – Human Coronavirus COVID 19
- Test Results – If NML result is the final and confirmatory test, document as final. Otherwise document as appropriate for test result status.

Appendix B: Infection Control Measures and Isolation of Cases in a Non-healthcare Community Setting

CD investigator must ensure that appropriate infection prevention and control practices to prevent spread to other household members are discussed (for Symptomatic Case or Asymptomatic RT-PCR positive case.) More information about isolation for Albertans is available at https://www.alberta.ca/isolation.aspx#isolate, and exemption order for isolated persons

IPC Recommendations-Case:

- Stay home and do NOT leave to attend social gatherings, work, school/university, child care, athletic events, faith-based gatherings, healthcare facilities, grocery stores, restaurants, shopping malls and any public gatherings.
- Avoid close contact with other people, including household members but especially seniors and people with chronic conditions or compromised immune systems.
- Use delivery or pick up services for errands such as grocery shopping.
- Do not go outside for a walk through your neighborhood or park. This includes children in mandatory isolation.
- You can get fresh air in your backyard, if you have one, but must remain on private property not accessible by others. If you live in an apartment building or high rise, you must stay inside and cannot use the elevators or stairwells to go outside. If your balcony is private and at least two metres away from your closest neighbor's you may go outside on the balcony.
- Do not use public transportation including buses, taxis or ride sharing.
- Avoid having visitors to your home (but friends, family or delivery drivers can drop off food, medicine or other things that may be needed) and leave on your door step.
- Isolate in a room with the door closed and use a dedicated bathroom if possible. If case cannot be in their own room a distance of at least two metres from the case should be maintained whenever possible by others in the room. When possible, wear a face mask when in the same room as other people or if needing to visit a healthcare provider. (If the case cannot wear a face mask, those who need to be in the same room with the case should wear one.)
- Ensure shared air spaces have good air flow (such as an air conditioner or open window) when possible and weather permitting.
- If residing in a dormitory, efforts should be made to provide the case with a single room with a private bathroom. If a private bathroom is not available, the bathroom should be cleaned and disinfected frequently.
- If unable to provide a separate room, ensure that there is sufficient room for other members of the home setting to maintain a two metre distance from the case whenever possible (e.g., multiple families living in the same household, multiple generations living in the same household, large number of household contacts and possible overcrowding).
- If sleeping in the same room, maintain a two metre distance from the case. Separate beds orient beds head to toe if possible.
- If physical separation is difficult, hanging a sheet from the ceiling to separate the ill person from others may be considered.
- People on Continuous Positive Airway Pressure (CPAP) or Bi-Level Positive Airway Pressure (BPAP or BiPAP) should remain in a separate room with a door, away from family members, and the door must remain closed when CPAP or BPAP/BiPAP is in use. Ensure a good mask fit with very little leak.
- If there are cases who reside in a co-living setting and single rooms are not available, cohorting cases to a separate room should be considered.
- The case should have safe access to food, running water, drinking water, and supplies for the duration of the period of 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.

- Wash hands thoroughly with soap and water. Alcohol hand sanitizer can be used if soap and water are not available.
- Cover mouth and nose with a tissue when coughing or sneezing or cough and sneeze into their sleeve. Used tissues should be thrown into a lined trash can, wash hands thoroughly with soap and water immediately.
- Avoid sharing household items such as dishes, utensils, cups/glasses, towels, clothes, bedding or other items with other people in the house. After use these items should be washed thoroughly with soap and water.

IPC Recommendations-Caregivers/Contacts:

- Other individuals in the household should limit contact with the case as much as possible.
- Individuals who are at increased risk of severe disease (e.g., immunocompromised, chronic heart, lung or kidney disease, diabetes, blood disease and older adults) should not provide care for or come into contact with the case 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.
- Restrict visitors who do not have an essential need to be in the home.
- Individuals providing care for or living in the same residence should avoid contact with client's body fluids when possible and practice strict hand hygiene.
  - Wash hands often and thoroughly with soap and water. Alcohol hand sanitizer can be used if soap and water are not available and hands are not visibly soiled. Hands should always be washed immediately after providing care, after removing face masks, gowns or gloves, after cleaning surfaces and after handling soiled items or interacting with the ill person or their environment.
  - Wear a disposable face mask, gown and gloves when possible if having to touch or have contact with the ill person's blood, body fluids or secretions. Throw out items after one use in a lined trash can and wash hands thoroughly after handling these items or disposing of trash.
  - Wear disposable gloves when handling soiled items e.g., clothes, bedding, used household items.
- Wear disposable gloves when cleaning surfaces that may be contaminated with ill person's blood, body fluids or secretions.

IPC Recommendations-Cleaning and Laundry:

- Laundry:
  - Immediately remove and wash soiled clothes or bedding.
  - Wear disposable gloves when possible while handling soiled items and wash hands thoroughly with soap and water after handling.
  - Wash as per instructions on labels of laundry items and detergent of choice. Generally wash and dry with the warmest temperatures recommended on labels of laundry items.
- Cleaning:
  - Clean any contaminated surfaces as well as all high touch surfaces such as table tops, counters, doorknobs, bathroom fixtures, toilets, bedside tables, keyboards, tablets, phones, etc. at least daily.
  - Wear disposable gloves when cleaning surfaces and wash hands thoroughly with soap and water after removing and disposing of gloves.
  - Follow cleaning instructions on labels of products being used to clean surfaces, regular household cleaners can be used. A diluted bleach solution of one part bleach to nine parts water may also be used if appropriate for surfaces being cleaned.
  - Dispose of items such as soiled tissue paper in a sealed garbage bag and leave out for garbage collection.

Appendix C: Infection Control Measures in a Community Healthcare Setting

MOH/designate must ensure that appropriate infection prevention and control practices are being followed.

- In a community healthcare setting (including physician offices and public health centers but excluding urgent care center/ED settings):
    - **Asymptomatic contact or asymptomatic possible contact:**
        - Consistent with the Public Health Agency of Canada (PHAC) and Alberta's Chief Medical Office of Health (CMOH), AHS has implemented a continuous masking strategy for HCWs, in addition to the use of PPE as part of droplet and contact precautions to improve safety for both HCW and patients.
        - IPC recommendations and Notification processes:
            - ❖ Routine practices for current symptoms
        - Cleaning and disinfection:
            - ❖ Routine cleaning and disinfection as per type of contamination
    - **Symptomatic, probable or confirmed case/contact or Asymptomatic confirmed case:**
        - IPC recommendations and notification processes (see ACeRT SharePoint):
            - ❖ Provide client with a procedure mask to wear and place in an examination room (or other single room) as soon as possible. If unable to do so right away place in a separate waiting area or advise to avoid others in the waiting room if space allows. **Close the door.**
            - ❖ Place in a single room.
            - ❖ Implement contact and droplet precautions
            - ❖ Aerosol-generating medical procedures (AGMP) should be avoided
            - ❖ Encourage the individual to practice respiratory hygiene by covering mouth and nose with a tissue when coughing or sneezing or coughing and sneezing into their sleeve. Used tissues should be thrown into a lined trash can and hands should be washed thoroughly with soap and water immediately.
            - ❖ Clinic staff should limit the number of staff that interact with the individual and limit interactions to providing necessary care.
            - ❖ Clinic staff should practice strict hand hygiene. Wash hands often and thoroughly with soap and water. Alcohol hand sanitizer can be used if soap and water are not available and hands are not visibly soiled. Hands should always be washed immediately before and after providing care, before donning personal protective equipment (PPE), after removing PPE, after cleaning and after handling soiled items or interacting with the ill person or their environment.
            - ❖ Whenever possible single use, disposable equipment should be used.
            - ❖ In consultation with Zone MOH and responsible physician, arrange for client to be assessed at the clinic or directed to an ED based on presenting symptoms and risk or exposure. If not already done by Zone MOH, CD investigator should notify the receiving site that the client will be presenting and is suspected of having COVID-19.
            - ❖ Sites should keep a list of all individuals who had direct contact with the patient or with respiratory secretions or surfaces contaminated with respiratory secretions. Public Health will work with the site to conduct exposure risk assessment for identified contacts from the site.
                - Potential occupational/community exposure to COVID-19, (i.e., direct exposure without appropriate PPE or an inadvertent breach of PPE) should be reported to immediate supervisor and occupational health services or delegate as well as to local Public Health authorities.
                - The exposure should be reported immediately to employer and immediate medical attention should be obtained.
                    - The Zone MOH should be consulted immediately.
                - Mucous membranes of the eyes, nose or mouth should be flushed with running water if contaminated with respiratory secretions or other body fluids.
                - Non-intact skin should be rinsed thoroughly with running water if contaminated with blood or body fluids.

- All other first aid should be performed after consultation with WHS/Zone MOH if there is no immediate risk to the affected individual.

- Cleaning and disinfecting:
  - ❖ Dispose of all contaminated items in a lined trash can and close bag before placing with clinic waste for disposal.
  - ❖ Wear rubber/disposable gloves when cleaning surfaces and wash hands thoroughly with soap and water after removing and disposing of gloves.
  - ❖ Clean and disinfect any contaminated surfaces, high touch surfaces and non- disposable clinic equipment as per current clinic processes using a two-step process.
    - Cleaning and disinfecting refers to a two-step process i.e., must clean before you disinfect. Where a surface disinfectant claims to have both cleaning and disinfecting properties the product may be used for both steps.

Appendix D: Management of Asymptomatic Health Care Workers (HCWs) with Potential Exposure to COVID-19

- **Management of Asymptomatic HCWs with exposure risk:**
  - Health Care Workers who think they may or may have been exposed to COVID-19 should be directed to complete the online assessment tool for Healthcare and Shelter Workers/Enforcement Personnel/First Responders.
  - **ALL** Health Care Workers who have been exposed to COVID-19 in the preceding 14 days, must be assessed regarding fitness to work. AHS, Covenant Health and Alberta Precision Lab employees can be referred to the COVID-19 Return to Work Guide for AHS Health Care Workers for further information.
  - A surgical/procedure mask and proper hand hygiene is considered sufficient PPE for asymptomatic HCW working with asymptomatic patients, including with the 48 hours prior to specimen collection and up to the time the person is on appropriate precautions.
  - If a HCW becomes symptomatic, all patients who they cared for (or co-workers) in the 48 hours prior to symptom onset in the HCW will not be considered close contacts if the HCW wore a surgical/procedure mask and practiced proper hand hygiene.
  - If a patient becomes symptomatic, all HCWs 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 proper hand hygiene.
  - A surgical/procedure mask and good hand hygiene is not considered appropriate PPE for HCWs caring for COVID-19 symptomatic patients.

- **For Positive Test Results – refer to Case Management:**
  - Regardless of when isolation began, if test results for COVID-19 are positive, HCWs are **legally** required to isolate for **at least 10 days** from when symptoms started and until symptoms have resolved (whichever is longer).
    - Discuss rationale for isolation with HCW, the requirement to stay home and avoid close contact with other people, including household members but especially seniors and people with chronic conditions or compromised immune systems; handy hygiene, respiratory etiquette and proper cleaning and disinfection in the home.
  - Health care workers have additional requirements and **may not work in any health care setting until 14 days have passed** since symptom onset and symptoms have resolved (whichever is longer)
    - AHS, Covenant Health and Alberta Precision Lab employees can refer to COVID-19 Return to Work Guide for AHS Healthcare Workers for further instructions.

- **For Negative Test Results:**
  - HCWs who are a contact of a known case of COVID-19 OR have returned from travel outside of Canada OR are a close contact of an ill person who has returned from travel outside of Canada within the last 14 days
    - Even if results are negative, asymptomatic contacts must stay on quarantine for a full **14 days** and self-monitor for new symptoms (fever, cough, shortness of breath, difficulty breathing, sore throat or runny nose).
      - Self-monitor for fever ≥ 38.0 C/100.4 F twice daily.
      - Avoid taking any antipyretics that may suppress a fever.
      - Maintain good respiratory etiquette and hand hygiene.
      - Be advised that if symptoms develop, contact local Public Health for assessment by calling Health Link 8-1-1 immediately or other number if provided locally by zone.
      - Be advised that if symptoms develop that require urgent medical attention and access to medical care, EMS staff (if ambulance is required) and nursing staff at the ED/UCC should be advised immediately that they may have been in contact with COVID-19 and the Zone MOH on call should be notified immediately.

NOTE: Refer to Appendix B for further instructions on infection prevention control during isolation.

- AHS, Covenant Health and Alberta Precision Lab employees can be referred to the COVID-19 Return to Work Guide for AHS Health Care Workers for further information.
- Review disease information and provide the AH Website for more information on isolation at: www.alberta.ca/coronavirus and/or Public Health Agency of Canada website links for more information COVID-19 https://travel.gc.ca/travelling/advisories/pneumonia- china, https://www.albertahealthservices.ca/topics/Page16944.aspx
- Documentation related to these individuals should be captured in a CI for Coronavirus, Novel. No DI is created.

NOTE: Asymptomatic HCWs who are NOT a contact of a known case of COVID-19 AND have NOT returned from travel outside of Canada AND are NOT a close contact of an ill person who has returned from travel outside of Canada within the last 14 days can be advised:

- If an AHS, Covenant Health and Alberta Precision Labs employees to refer to COVID-19 Return to Work Guide for AHS Healthcare Workers for further instructions.

Appendix E: Contact Tracing App

https://contacttracer.secure.abtracetogether.ca/

- **What is ABTraceTogether?** The Government of Alberta released a mobile Contact Tracing application on May 1, 2020 that enables community-driven contact tracing to support existing efforts to fight COVID-19. This tool is used to complement existing Contact Tracing measures. Additional information can be found in the FAQ at https://www.alberta.ca/ab-trace-together-faq.aspx
- **How will this impact existing Contact Tracing?** The process for Contact Tracing will remain relatively the same, except Contact Tracers will now ask COVID-19 positive individuals if they have the Contact Tracing application, and if they do (and consent to sharing their data), Contact Tracers will collect the encounter logs from the application to augment their current process of contacting potentially exposed close contacts of the individual. Contact Tracers will analyze the close contact logs from the infected individual's phone only after they have completed the initial interview. Again, the intention of the mobile application is simply to augment the current process.
- COVID Alert is a national contact tracing app that is in use in some parts of Canada (ON, SK, MB). At the time of publication, this app is not yet set up for use in Alberta. Presently, if an Albertan has downloaded this app and receives notification from the app that they are a close contact of a case, then there is no information provided about when that exposure occurred and it is not possible to know how long they should quarantine for from this app notification.

Summary Process

1) Contact Tracer **calls COVID-19 positive individual** and runs through their script to perform phone interview.
2) After asking about the personal activities 48 hours prior to symptom onset, Contact Tracer **asks the Individual if they have the ABTraceTogether mobile application** and if they are willing to share their data with AHS.
3) If the Individual responds with their data with AHS mobile **guides the individual to their data with** in their mobile application to successfully upload the individual locations https://contacttracer.secure.abtracetogether.ca/
4) Contact Tracer **continues the interview** (and writes notes into CDOM).
5) Contact Tracer **ends phone interview** and writes final notes in CDOM.
6) Contact Tracer **calls all Close Contacts identified from Interview** following regular protocol.
    - Contact Tracer will ask these Close Contacts if they have the ABTraceTogether application and if they do they will jot down their phone number (to prevent contacting the individual twice).
7) Contact Tracer **goes into Contact Tracer Web Application and searches through the Encounter logs** to identify who additionally to contact.
    - They use the phone numbers from the previously contacted Close Contacts to search amongst the encounter log list to ensure they are not contacting the same individuals twice.
8) Contact Tracer **filters through encounter logs** according to their desired start/end dates and minimum encounter duration.
9) Contact Tracer **prints/downloads this list** and then starts **calling the outstanding identified Close Contacts.**
10) Contact Tracer **puts Close Contact information into CDOM.**
11) Contact Tracer marks in Contact Tracing Web Application which **Close Contacts are now Contact Tracing Web.**

Appendix F: CDC and WHS Process and Messaging for AHS/APL (or Covenant Health) Healthcare Workers with Possible Occupational Exposures – June 1, 2020

Section 1: Roles and Responsibilities for Managing COVID-19 Exposures

Communicable Disease Control (CDC), Workplace Health and Safety (WHS) and Infection Prevention and Control (IPC) each have a role in investigating exposures to communicable diseases including COVID-19.

- CDC is responsible for community contact tracing – i.e. outside of AHS/APL (or Covenant Health) environments.
- WHS at AHS/APL (or Covenant) does workplace contact tracing and investigates possible occupational exposures.
- IPC at AHS/APL (or Covenant) does contact tracking with patients or visitors that may have been exposed or exposed others in AHS settings.

The departments need to notify each other of potential exposures when the source (positive case) meets certain conditions.

Source (Positive case)	Condition	CDC	WHS	IPC
1. AHS/APL or Covenant HCW	a) They worked in-between being exposed and being confirmed positive	Notifies WHS and IPC at AHS/APL (or Covenant)	Determines if other HCW were exposed	Determines if patients/clients or visitors were exposed
	b) They may have been exposed at work	Notifies WHS at AHS/APL (or Covenant)	Determines if the HCW was exposed at work	n/a
2. A non-AHS/APL non-Covenant HCW from a facility where AHS/APL or Covenant HCW provide services	They worked in-between being exposed and being confirmed positive *and* identify an AHS/APL (or Covenant) HCW from their workplace as a close contact	Notifies WHS at AHS/APL (or Covenant)	Follow up with AHS/APL or Covenant HCW to reinforce or provide clinical and process guidance based on CDC's assessment of their exposure	
3. A member of the public that received healthcare services	They received healthcare services from AHS/APL or Covenant at some point between being exposed and being confirmed positive	Notifies WHS and IPC at AHS/APL [or] Covenant Health	Determines if HCWs were exposed Notifies CDC of exposed HCW for CDC's contact tracing database	Determines if patients/clients or visitors were exposed

Section 2: CDC and WHS Processes

In scenarios #1 and 2 above, both CDC and WHS are speaking to HCWs. When this happens, HCWs need to know that their information will be shared and what to expect from each department. Here is more information about these scenarios:

1. **AHS/APL or Covenant Health HCW that tests positive**
    - An AHS/APL or Covenant HCW tests positive for COVID and may have been exposed at work (i.e. source is thought to be positive patient or other HCW) [OR] may have exposed others at work (i.e. the HCW that tested positive is the source)
        - In this scenario we need to communicate to HCW that there will be a **handover from CDC to WHS**. CDC does community contact tracing and WHS does workplace contact tracing and advises exposed HCWs on isolation.
    - **NOTE:** Sometimes a positive AHS/APL or Covenant HCW will give the CDC names of people they work with as part of community contact tracing. If these other HCW are also linked to an occupational exposure, they may receive calls from both CDC and WHS.
        - In this scenario the possible close contacts are identified through both community [AND] workplace contact tracing – which means **CDC and WHS are both assessing the exposure and advising the HCW on isolation.** WHS makes the final determination on if the exposure occurred at work. This information will be shared with CDC through a centralized data extract (OHNs / RNs do not need to send it themselves).

2. **A non-AHS/APL HCW that tests positive in a facility where AHS/APL HCW provide services**
    - A non-AHS/APL HCW tests positive for COVID-19 and may have exposed AHS/APL HCWs at the non-AHS site (i.e. the HCW that tested positive is the source)
        - CDC will notify WHS that a positive case or outbreak has occurred in a non-AHS facility when an AHS/APL HCW has been identified as a close contact related to their role as an AHS/APL employee.
        - CDC will send WHS a list of AHS/APL HCWs that have been identified as a close contact in the non-AHS facility through a workplace exposure to complete the follow up or to be notified those HCWs have been restricted from work.
        - Any AHS/APL HCWs that are exposed in non-AHS facilities but not in connection to their AHS role/workplace will be followed by CDC as any community exposure.

NOTE: WHS may contact CDC for additional required information as contact tracing evolves.

Section 3: CDC and WHS Processes and Messaging for HCWs

Messaging for…	WHS / CDC Processes	CDC Messaging	WHS Messaging
1. Positive AHS/APL or Covenant HCW	CDC/WHS Steps and Handover i) CDC notifies HCW of positive result ii) CDC begins community contact tracing iii) CDC tells the HCW their information will be sent to WHS iv) CDC sends the email notification template to WHS v) WHS contacts the HCW to investigate the possible occupational exposure	"I am calling from CDC – our role is to tell you about your test result, how long you need to isolate, and identify any one you may have exposed in the community. I am also going to send your information to AHS Workplace Health & Safety or Covenant Occupational Health & Safety so they can talk to you about your possible workplace exposure and ask about anyone else that you may have exposed."	"I am calling from WHS. CDC gave us your information so we could talk to you about your possible workplace exposure and ask about anyone else may have been exposed so we can follow up on contacts appropriately."
2. Close contacts	CDC Steps i) A positive HCW names other AHS/APL HCWs as possible close contacts during **community contact tracing** ii) CDC speaks to the possible close contacts to assess the exposure iii) CDC provides clinical guidance (advises on isolation/ work restrictions) based on the community exposure WHS Steps i) A positive HCW names other AHS/APL HCWs as close contacts during **workplace contact tracing** ii) WHS speaks to the possible workplace close contacts to assess the workplace exposure iii) WHS provides clinical guidance (advises on isolation / work restrictions) based on their assessment of the occupational exposure iv) If WHS becomes aware that the WHS clinical guidance is different than what CDC provided, WHS will notify CDC at CDCCOVID@albertahealthservices.ca	"Tell your manager about your quarantine / work restrictions. If your possible exposure occurred in the workplace, AHS WHS or Covenant OHS will also be contacting you."	"I am calling from WHS. If you have already spoken to CDC, it is because you were identified as a possible close contact through community contact tracing. If you have not, you should be hearing from them as well. WHS makes the final determination on if you have been exposed to COVID-19 at work and if you need to isolate because of that exposure. Under the Public Health Act, WHS will let the CDC know that you've met the definition of an occupational exposure to COVID-19." *Find out if the WHS clinical guidance is different than what was provided by CDC. If so, see *WHS Step iv).*

Messaging for…	WHS / CDC Processes	CDC Messaging	WHS Messaging
3. Positive Non-AHS/APL HCW	CDC Steps i) A positive Non-AHS/APL HCW names other AHS/APL HCWs as possible close contacts during **workplace contact tracing for a NON-AHS facility** ii) CDC speaks to the possible close contacts to assess the exposure iii) CDC provides clinical guidance (advises on isolation/ work restrictions) based on the workplace exposure WHS Steps i) WHS is notified of AHS/APL HCWs who are considered close contacts by CDC during **workplace contact tracing for a NON-AHS facility** v) WHS speaks to the AHS/APL HCW to confirm their discussion with CDC and clinical guidance provided (isolation and work restrictions) vi) WHS provides further clinical guidance - HCW to contact WHS if they become symptomatic and provide return to work information. If WHS becomes aware that the WHS clinical guidance is different than what CDC provided, WHS will notify CDC at CDCCOVID@albertahealthservices.ca	"Tell your manager about your isolation / work restrictions. I am also going to send your information to AHS Workplace Health & Safety and they will provide more information regarding follow up and work restrictions."	"I am calling from WHS. If you have already spoken to CDC, it is because you were identified as a possible close contact through contact tracing."

ABOUT THIS NOTIFICATION FORM:
Workplace Health & Safety (WHS) and/or Infection Prevention & Control (IPC) at AHS/APL [or] Covenant Health request notification from CDC on positive COVID-19 cases when the source (positive case) meets certain conditions:

Source (Positive case):	**Conditions:**	**CDC will:**
1. HCW (healthcare worker) at AHS/APL/Covenant site	HCW tests positive for COVID-19 and worked at any time during the period of 48 hours prior to symptom onset until time excluded. OR The HCW may have been exposed at work in the 14 days prior to symptom onset.	Notify WHS and IPC at AHS/APL [or] Covenant
2. A HCW from a non-AHS/APL/Covenant facility where other AHS/APL HCW provide services	HCW worked during the period of 48 hours before symptom onset until time excluded from work *and* identify an AHS/APL (or Covenant) HCW from their workplace as a close contact	Notify WHS at AHS/APL [or] Covenant
3. A member of the public that received healthcare services	Person received healthcare services from AHS/APL [or] Covenant site or program (e.g., home care, environmental public health, etc) in the time period of 48hrs prior to symptom onset until no longer infectious.	Notify WHS and IPC at AHS/APL [or] Covenant

NOTIFICATION PROCESS IS THROUGH CONTACT EMAILS:

	AHS/APL
WHS	AHS.WHSCDCNotif@AHS.ca
IPC	Edmonton Zone IPC EDMZoneIPCOnCall@albertahealthservices.ca Calgary Zone IPC CalZoneIPCOnCall@albertahealthservices.ca Central Zone IPC IPCCentralZoneTeam@albertahealthservices.ca South Zone IPC IPCSouthZoneTeam@albertahealthservices.ca North Zone IPC PCH.IPCNorthZoneTeam@albertahealthservices.ca

	Covenant Health
WHS	occhealthnurse@covenanthealth.ca
IPC	Covenant Health sites include the following: Edmonton Zone Misericordia Community Hospital (Edmonton), Grey Nuns Community Hospital (Edmonton), Villa Caritas (Edmonton), South Zone St. Michael's Health Centre (Lethbridge), St. Therese Villa (Lethbridge), St. Joseph's Home (Medicine Hat), Calgary Zone Banff Mineral Springs Hospital (Banff), Central Zone Our Lady of the Rosary Hospital (Castor), St. Mary's Health Centre (Trochu), Killam Health Centre (Killam), Mary Immaculate (Mundare), St. Mary's Hospital (Camrose), St. Joseph's General Hospital (Vegreville), North Zone Bonnyville Health Centre (Bonnyville) **Email** (for sites listed above): IPC Covenant Health Team IPCCovenantHealthTeam@albertahealthservices.ca For the following **other Covenant sites**, please email the ICPs directly: Edmonton Zone Edmonton General Continuing Care Centre (Edmonton) – email Charlene.warawa@covenanthealth.ca St. Joseph's Auxiliary (Edmonton) – email elaine.stlaurent@covenanthealth.ca Youville Home (St. Albert) – email Meghan.richardson@covenanthealth.ca

WHS and IPC Email Template

INSTRUCTIONS:
1. Add the **zone to the subject line and facility name**
2. Enter the appropriate contact email in "To"
3. Enter the Zone MOH contact email in "Cc"
4. Complete the information below
5. **Do NOT attach ESR** as it contains more information than is needed by WHS or IPC.

SECTION 1: CONFIRMED COVID-19 CASE INFORMATION

CDOM DI#:
Name (First/Last):
Date of Birth:
Provincial Health Number:
Date & Time of symptom onset:
Symptoms:

SECTION 2A: CONFIRMED CASE IS A HEALTHCARE WORKER WITH AHS, APL OR COVENANT HEALTH OR EXPOSED AN AHS, APL OR COVENANT HEALTH STAFF

Zone (AHS/APL):
Work location (s):
Last day worked:
Suspected occupational exposure:
Name and DOB of AHS, APL or Covenant Health Staff exposed to Confirmed Case:

SECTION 2B: CONFIRMED CASE RECEIVED HEALTH CARE SERVICES FROM AHS, APL OR COVENANT HEALTH
Facility information (if multiple, please list):
Dates/times of health care services:
Date of admission:
Date of discharge (if available):
Location(s)/unit(s):

For more information, contact CDC COVID-19 Team at 1-888-522-1919

Appendix G: MOH Case Summaries and Escalation Notification Process

Case summaries will be sent to the Zone MOH group where the case resides upon completion of initial investigation for all new COVID-19 cases.

Email addresses and all contacts needed by Zone for sending templates are listed after the template.

Routine Cases:

- ✓ Complete and include your case summary for all routine cases that do not meet any of the escalation criteria below and add to the Intervention Tab > Communication/Referral Section Notes field for the entry where the communication to the MOH is documented in the case DI.
- ✓ Routine case should be sent to the Zone MOH group where the client resides for North Zone and Central Zone.
- ✓ DO NOT send routine case summaries to the Edmonton Zone MOH, Calgary Zone MOH OR CDCCOVID.

Cases that meet Escalation Criteria:

- ✓ Complete and include your case summary for **all** cases being escalated and add to the Intervention Tab > Communication/Referral Section Notes field for the entry where the communication to the MOH is documented in the case DI.
- ✓ Case summaries for cases that meet the escalation criteria below must be sent to ALL Zones to the appropriate Zone MOH group for the Zone where the client resides.

MOH Escalation Notification

- Any cases in staff or students who were present at the school during their incubation period and the source of infection is most likely the school require Zone MOH consultation PRIOR to reporting school under Disease Acquired in CDOM. Before sending the MOH notification:
  - Consult with your team lead regarding your assessment of the likely sources of infection
    - In order to determine if the "most likely source of acquisition" in the school the following criteria should be considered:
      - Was the case identified as a classroom or other school contact of a case that was infectious at school?
      - Did the case have an onset date within 14 days of exposure at school?
        - NOTE: While the incubation period of COVID-19 extends from 1 to 14 days, the most common is 5-6 days. Disease onset approx. 5 days after a school exposure would increase the index of suspicion that transmission occurred at school.
      - Does the case have another more likely source of transmission such as:
        - Do they have a close contact outside of school with an onset day prior to theirs? This could include household contacts who also attend the school.
        - Do they have another potential source of infection? E.g., symptomatic family member with earlier symptom onset date who has not been tested/pending results
        - Are they linked to another exposure setting? E.g., attendance at a daycare/OSC that is on outbreak
      - Is the case symptomatic or asymptomatic?
        - A case with symptoms and a definitive onset date can be more clearly linked to an exposure source vs. an asymptomatic cases which may be related to prolonged viral shedding
  - If the school is the most likely source of infection **Use the specific School Acquired Case Notification and Consultation** summary template below for MOH notification and consult to ensure the MOH agrees with your assessment.

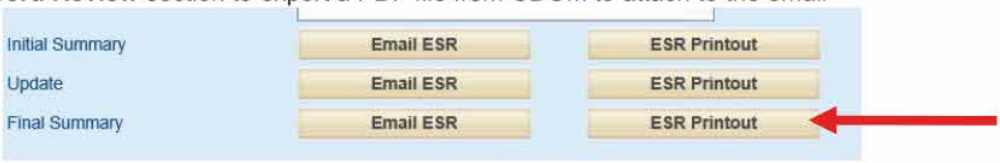
- New cases in settings that could trigger an "outbreak response" including a: shelter, evacuation centre, meat production facility, large scale food production facility, work camp, work site, place of worship, daycare, school, post-secondary institution, correctional facility, congregate care setting (long term care, home living, supportive living, hospice, etc.) during period of communicability:
  - Individual case reporting will occur until 10 cases are linked to the outbreak;
- Cases in individuals living on reserve with summary that the case has been transferred to FNIHB for follow-up;
- New cases in settings where there are is potential for spread amongst essential service workers (e.g., health care settings, emergency services workers, municipal infrastructure settings such as power and water supply, etc.);
- When consultation is required including for clarity on guidance documents, when symptoms or lab results are atypical, or when tailored IPC recommendations may be needed;
- When the case is of particular interest, such as large exposure events where more than 4 individuals are exposed, atypical exposure settings, and cases/exposures that may be of political or AH interest;
- Out of province cases and contacts;
- Cases / exposures that require enforcement actions;
- Known hospitalizations and deaths related to COVID. **Zone MOH will notify Alberta Health <u>& Dr. Laura McDougall</u> by FMP for deaths.**

<u>PROCESS FOR SENDING MOH Case Summaries</u>:

Before sending any case summaries:

✓ Ensure that all mandatory fields are complete in the CDOM DI for the case by running the Required Data check from the **Summary Tab > Record Review** section

✓ Once all required data fields are complete, use the Final ESR Printout button in the **Summary Tab > Record Review** section to export a PDF file from CDOM to attach to the email



✓ Compose an email with Case Summary in the body of the email using the appropriate template and subject line below:

Subject Heading for Routine: FYI COVID [Community Name where case resides] DI #, initial case investigation (confirmed vs probable)

Subject Heading for Escalation/Consultation: MOH/EPH ATTN [Community Name where case resides] COVID DI #, initial case investigation (confirmed vs probable)

Email body template for FYI OR Escalated cases that are NOT thought to be acquired at a school (*delete heading when not applicable, e.g., associated outbreak)*:

Public health actions:
- Client AHS Zone:
- Hospitalization status:
- Most likely exposure (e.g., unknown, work, household, friend, outbreak):
- Symptom onset:
- If asymptomatic, swab date:
- Days worked during communicability period (including 48 hrs. prior to symptom onset):
    - If attended workplace while communicable:
        - Name of workplace, including municipality:
        - Is workplace/employer aware?
- Days attended school/attended daycare during communicability period (including 48 hrs. prior to symptom onset):
    - If attended school or daycare while communicable:
        - full name of school, including municipality:
        - Student/attendee or staff member?:
        - Was case symptomatic while at school?:
        - Is school administration aware?:
- # of contacts, is contact follow up complete for all?
    - Identified issues with quarantine for any contacts?
- Associated cluster/outbreak:
- Conveyance exposure notifications completed (e.g., flights, cruise, etc.):
- Other Actions (be very clear if requesting MOH action and exactly what you want or if it is only an FYI that there are red flags):
    - IP&C or WHS follow up notification completed?
    - EPH or OHS referral needed?
    - MOH actions/consultation needed?
    - MOH Red flags as FYI?
    - Public health actions: pending + who is responsible for each action

Tracer Name & Designation

Subject Heading for School Acquired Escalation/Consultation: MOH/EPH ATTN [Community Name where case resides] COVID DI #, **query school acquired** initial case investigation (confirmed OR probable)

Email body template for all cases that are ARE thought to be acquired at a school (*delete heading when not applicable, e.g., associated outbreak)*:

- Client AHS Zone:
- Hospitalization status:
- Most likely Exposure: **School**, choose staff or student
- Symptom onset:
- If asymptomatic, swab date:
- **For School Staff:** Days worked during communicability period (including 48 hrs. prior to symptom onset):
    - If attended school while communicable:
        - Was case symptomatic while at school?:
        - Name of school, including municipality:
        - Has CDC made school administration aware?:
        - Classroom names/numbers case attended?:
- **For Students:** Days attended school during communicability period (including 48 hrs. prior to symptom onset):
    - If attended school while communicable:
        - Was case symptomatic while at school?:

        - Name of school, including municipality:
        - Has CDC made school administration aware?:
        - Classroom names/numbers case attended?:
- Case likely acquired disease at a school? Likely Acquired at school MOH CONSULT REQUIRED
    - Was the case identified as being in the same classroom or other type of at school contact of a case that was infectious at school? Y/N
    - Did the case have an onset date within 14 days of an exposure date at school? Y/N
        - IF YES: How many days after exposure date was the onset date?
    - Does the case have another more likely source of transmission such as:
        - Do they have a close contact outside of school with an onset day prior to their onset date, including household contacts who also attend the school? Y/N
        - Do they have another potential source of infection? (e.g., symptomatic family member with earlier symptom onset date who has not been tested/pending results) Y/N
        - Are they linked to another exposure location/setting? (e.g., attendance at a daycare/out of school care that is on outbreak) Y/N
    - Is the case symptomatic or asymptomatic?
- # of contacts, is contact follow up complete for all?
    - Identified issues with quarantine for any contacts?
- Associated cluster/outbreak:
- Conveyance exposure notifications completed (e.g., flights, cruise, etc.):
- Other Actions (be very clear if requesting MOH action and exactly what you want or if it is only an FYI that there are red flags):
    - IP&C or WHS follow up notification completed?
    - EPH or OHS referral needed?
    - MOH actions/consultation needed? MOH Please reply all to indicate whether you agree or disagree with case being classified as Disease Acquired at school.
    - MOH Red flags as FYI?
    - Public health actions: pending + who is responsible for each action

Tracer Name & Designation

✓ Email case summaries using the template to the MOH from Zone where the case lives as below and cc CDCCOVID@albertahealthservices.ca on all summaries that are being sent.

- Calgary MOH: **mohcovidyyc@albertahealthservices.ca and**
    - Cc Calgary Zone EPH: PHI-COVID19@albertahealthservices.ca;

    NOTE: For Calgary zone only – case summaries are **only** required for cases meeting escalation criteria.
        - When applicable, please ensure that the workplace/sites have been contacted prior to sending initial summary.

OR

- Edmonton MOH: **MOH.Edmonton@albertahealthservices.ca and**
    - Cc Edmonton Zone EPH: EDM.SHE.EdmontonOnCall@albertahealthservices.ca IF cases meet escalation criteria.
        - When applicable, please ensure that the workplace/sites have been contacted prior to sending initial summary.

OR

- North MOH: **MOH.North@albertahealthservices.ca and**
    - Cc AHS.NZ.CDOMUsers@albertahealthservices.ca and North Zone EPH NLH.EPHOps@albertahealthservices.ca IF cases meet escalation criteria.
        - When applicable, please ensure that the workplace/sites have been contacted prior to sending initial summary.

OR

- Central MOH: **MOH.Central@albertahealthservices.ca**

Also, include the following groups in the emailed case summary as needed – see 'contact info' tab in SharePoint:

- **Outbreaks @ Congregate Living** (LTC/Assisted Living/group homes): CDOutbreak@albertahealthservices.ca
- **Workplace exposure**: see 'community outbreak' and 'contact list' tabs on the ACeRT SharePoint site for specific contact groups.

Appendix H: Process for follow up of COVID-19 Outbreaks in Community Settings

✓ The *Alberta Outbreak Reporting Form (AORF)* ***must*** be completed and sent to Alberta Health when an outbreak is declared as described above.

✓ CD Nurse Investigator is responsible for the following management in community settings:

- Obtain ProvLab EI number for the outbreak
- Open outbreak in CDOM and obtain necessary reporting criteria including:
  - Site Name
  - Site address
  - Site Contact Name and phone number
  - Onset date of first case
  - All current cases requiring linking
  - Total number of staff at site
  - Total number of people currently symptomatic
  - Date outbreak opened/declared
- Consult with Zone MOH to determine if swabbing of all employees from the site will be referred for testing, both symptomatic and asymptomatic. This testing can be arranged through Health Link. To arrange for testing:
  - obtain complete staffing list from site as noted below,
  - advise site OHS/Manager to advise their employees that Health Link will be calling them to arrange their testing,
  - send staffing list along with EI number to: Patricia Chambers @ Patricia.Chambers@albertahealthservices.ca
    - SUBJECT LINE: Please arrange for testing for workplace with outbreak EI <INSERT NUMBER>, include who from CDC Health Link should connect back with regarding outcomes of calls.
    - Health Link will make 2 contact attempts/day over a 3 day period on different shifts to get the testing referrals made.
    - Depending on the size of the staff list sent and current workload, this may take anywhere from 2-5 days to complete.
    - Health Link will follow up with CDC once they have completed the list to advise around those that were unable to be contacted.
- Connect with site and determine the following:
  - Does site have their own OHS? If yes, will they be able to help with contact tracing for employees? Or will Public Health need to do contact tracing?
  - Confirm the total number of staff members and would it be possible to obtain a complete staffing list? Staff list is required for arranging testing, please ensure list has:
    - Staff first and last names
    - Staff contact phone numbers
    - Staff DOBs if possible
  - What is the breakdown of staff – how many different positions are there and how many staff work at each position?
  - What shifts do the staff work (Mon-Fri? 6am-3pm, 7am-5:30pm….?)
  - Out of the confirmed cases, how many are from each position? Does it seem to be a particular shift or area of the worksite that has been most affected?
  - What measures are currently in place at the site to maintain physical distancing? Are they masking? Able to maintain two metre distances from each other at all time? Limits to number of people in same spaces at same time? Health screenings/temperature checks daily?
  - What is being done at the site in terms of environmental cleaning?
  - Are there hand sanitizer stations/handwashing stations on-site?
  - Do the site have a lunchroom/common area? What is the maximum capacity of the

lunchroom? How big is it? How many tables? How many people are in there at one time?
    - What other areas are in the building or on the site aside from the areas where job tasks are performed? Are there public areas? Smoking areas? What measures for social distancing are in place?
    - Does the site require PPE?
    - What is the make-up of the workforce? Are there many temporary foreign workers or workers that might require social supports and assistance to prevent spread of COVID in home environments? Do many staff carpool to and from work?
    - If testing is being completed for all staff, advise the manager/OHS that both symptomatic staff and known close contacts of confirmed cases must be quarantined, however asymptomatic staff that do not meet close contact criteria can continue to work while awaiting test results.

- In consultation with the Zone MOH, facilitate notification of EPH or occupational health and safety department (OHS).
    - EPH notification would be to Zone EPH should occur and would proceed for restaurants, daycares, schools, hotels/accommodations, food portions of stores, clinics, personal services businesses. Businesses with public access may also require EPH referral.
    - OHS referral should be made by completing a referral/complaint using the OHS provincial hotline online form at: https://www.alberta.ca/file-complaint-online.aspx, complete an online referral/complaint form requesting follow up for the workplace (that falls under the jurisdiction of OHS). Do not disclose any private health information on the form. This would be for occupations including manufacturing, trucking, non-food retail, power generation and distribution, etc., which fall under Alberta Labor Department of OHS, as well as for all worker safety issues within any workplace. Businesses with no public access (only workers are at the site) would be strictly OHS.
- Consult with Zone MOH to discuss whether any particular extra measures need to be put in place at the site.
    - Exclusion of individuals other than close contacts,
    - Assistance with PPE if needed,
    - Social supports and other measures to support isolation and quarantine
- Manage outbreak in CDOM daily to determine if new cases have been added, ensure all linked cases are appropriate and complete data quality for same.
- Liaise with the site to advise of new cases identified through testing, monitor status of outbreak, including any newly symptomatic individuals and ensure any issues on site are addressed.
- Provide daily update email to MOH with number of new cases, number of individuals tested (as applicable), any hospitalizations or deaths, notify of any issues arising.

Appendix I: Process and Documentation for follow up of COVID-19 Outbreaks in Work Sites/Camps

This appendix is designed to be used in conjunction with the following resources:

1) Guidelines for COVID-19 Outbreak Prevention, Control and Management in Work Camps and Work Sites https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-guidelines-work-camps-and-work-sites.pdf
2) Work site/camp specific tracking sheets provided by Alberta Health (AH) which are posted in the AHS_Provincial Drive: ND and Outbreaks\Provincial ND OB Team\Outbreaks\Work SiteCamp Resources folder
3) Alberta Health Document: Work Camp Outbreaks: Data/Information Requirements To Be Provided To Alberta Health Via Alberta Health Services which is posted in the AHS_Provincial Drive: ND and Outbreaks\Provincial ND OB Team\Outbreaks\Work SiteCamp Resources folder

Outbreaks in Work Sites/Camps require specific management and reporting that is unique to these settings due to the make-up, movement, housing and work duties of the population onsite.

The workforce in most of these settings is comprised of those who's permanent residence is Alberta but also many individuals who reside in the other provinces and territories in Canada. In addition, the accommodations provided (camp sites) are often located at a distance from the actual work site. Because of this, there are often multiple conveyances (e.g., inter-provincial flights, chartered flights to the North Zone from Edmonton or Calgary, bussing or car-pooling from within the province and between the camp site and the work site, etc.).

The camp accommodations are typically individual lodges/hotels that are managed globally by a management company (e.g., Civeo) who rents the lodges/hotels out to the companies who run the work sites (e.g., Imperial Oil, Suncor, Husky, Syncrude, Canadian Natural Resources Limited (CNRL) etc.).

There are many contracted agencies/companies who employ the actual workforce at the sites (e.g., Bee Clean, International SOS, electrical companies, mechanical companies, catering companies, etc.). The actual duties performed often require the individuals to work in close groups, within 6 feet of each other. Often the workforce is organized in teams or units that always work the same shifts together. Shift schedules vary, with individuals working from several days to several weeks onsite and then travelling home for several days to several weeks offsite.

Because of the potential of spread from a site/camp outbreak through several agencies and provinces, Alberta Health has provided specific line lists and questionnaires for work site/camp outbreaks that must be initiated at the beginning of an outbreak for case and contact data collection and reporting as well as contact tracing. AHS is responsible to provide these line lists and contact tracing questionnaires to the occupational health and safety (OHS) teams at the sites/camps in order to ensure that all required information is being collected and all required follow up for both onsite and offsite cases and contacts is being completed, documented and reported to AH daily.

Expectations for management and documentation of cases and close contacts in CDOM:

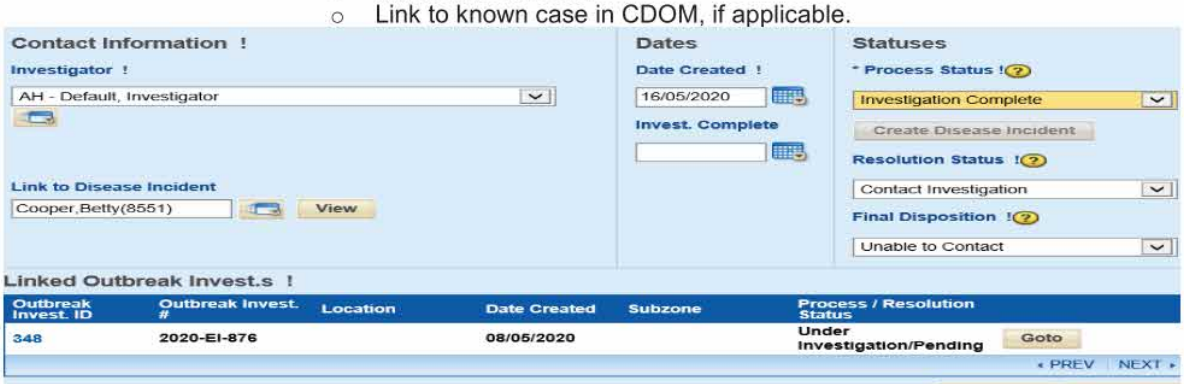
- ✓ Alberta residents and out of province (OOP) residents who are part of the outbreak (including those that are currently out of province) are documented as individual CIs and DIs in CDOM and linked to the outbreak.
    - For Alberta residents, case and contact management will be completed by Alberta and documented as per normal process with the additional details required for work site/camp cases as per this appendix.
    - For OOP residents that are currently in their home province, case and contact management of any OOP individuals will be the responsibility of the P/T where the individuals currently are. Any Alberta contacts of these cases will be transferred to AHS from AH for management.
        - For cases created a DI and complete minimum documentation as follows:
            - Demographics tab: All demographic information available, including OOP address, phone number and OOP health number.

- Assessment tab: Assigned Zone = Alberta Health and Service Area = Out of Province

- Interpretation tab: Outbreak associated = Yes
- Summary tab:
  - Process status = Investigation complete
  - Investigator = AH – Default Investigator
  - Resolution status = set as appropriate for case
  - Final Disposition = Unable to Contact
  - Link to the outbreak

- For contacts create a CI and complete minimum documentation as follows:
  - Demographics tab: All demographic information available, including OOP address, phone number and OOP health number.
  - Assessment tab: Assigned Zone = Alberta Health and Service Area = Out of Province

  - Summary tab:
    - Process status = Investigation complete
    - Investigator = AH – Default Investigator
    - Resolution status = set as appropriate for case
    - Final Disposition = Unable to Contact
    - Link to the outbreak
    - Link to known case in CDOM, if applicable.



- ✓ OOP cases that likely acquired disease in Alberta and who are currently in Alberta will NOT be reported as Alberta cases, these will be transferred to Alberta Health for reporting in their own Province or Territory (P/T) of residence.
    - Email all details to health.cd@gov.ab.ca with cc to MOH.North@albertahealthservices.ca and AHS CD OB lead(s) for that OB:
        - Subject line: DI # OOP Case associated with <insert OI #>, request that AH look to DI in CDOM for case details. No summary is required.
    - The responsibility for case and contact management for these individuals will remain with Alberta investigators. If any OOP contacts are identified by the Alberta investigators, this information will be communicated to Alberta Health for transfer to the responsible P/T (See next section for details).
    - CDOM Documentation: Document all case follow up as per usual and as per additional requirements in this appendix. However for all of these cases set:
        - Assessment tab > Zone = Alberta Health and Service area = Out of Province
        - Summary tab > DO NOT SUBMIT AN ESR FOR THESE CASES.

AHS CDC, Site/Camp OHS and AH Roles and Processes for management of cases and contacts:

- ✓ AHS CDC investigator will send the required line lists to the designated OHS contacts for the sites/camps involved in the outbreak.
    - AHS CDC investigator will instruct the OHS contacts for the sites/camps that they will be responsible for collection of all required information for suspect, confirmed and probable cases and close contacts daily.
    - The line lists must be submitted to AHS CDC daily by 1100.
        - Line lists are submitted via a template that the site should already have from NZ EPH. The template must be completed daily for known/suspect cases as well as close contacts. The sites submit using the excel spreadsheet. The submitted template goes to a work camp outbreak SharePoint site: https://private.albertahealthservices.ca/teams/Covid19/NZWorkCamp/SitePages/Home.aspx
        - AHS CDC will ensure line lists are accurate and do not contain duplicate information and send to AH daily to health.cd@gov.ab.ca
            - An excel spreadsheet is pulled from the SharePoint Site once it is cleaned and that is sent to AH.
    - AHS CDC investigator must ensure that all cases and contacts are appropriately documented in CDOM and that any probable or confirmed cases requiring investigation and follow up are either:
        - OHS will be responsible for onsite contact tracing and must provide AHS CDC with details of all onsite close contacts. If OHS identifies offsite employees requiring follow-up, the information must be provided to AHS CDC who will email details to CDCCOVID for contact follow up.
        - For cases/close contacts requiring management by Alberta, communicated by email to the CDCCOVID team for assignment to a case investigator/contact tracer.
            - Case investigators /contact tracers will provide the details of their investigation to the AHS CDC OB lead OR directly to the company OHS with a cc to the AHS CDC OB lead, according to the communication arrangements made for the OB.
                - Onsite contact tracing will be the responsibility of OHS who must provide AHS CDC with details of all onsite close contacts identified.

      OR
        - For cases/close contacts that are currently OOP, transferred to AH for follow up and management by responsible P/T:
            - email all details to health.cd@gov.ab.ca with cc to MOH.North@albertahealthservices.ca and AHS CD OB lead(s) for that OB,
                - subject line: DI # OOP Case associated with <insert OI #> (the line list cells copied and pasted into the email is acceptable if transferring multiple cases) OR
                - subject line: OOP contacts associated with <insert OI #> (the line list cells

copied and pasted into the email is acceptable if transferring multiple contacts)

- If a chartered flight or any chartered bussing (to and from North Zone or between camp and site) is identified where a case was present within the period of communicability:
  - Assessment of measures in place to reduce transmission should be completed and documented in the case DI, site OHS would be responsible to provide details:
    - Was there continuous masking by all passengers and crew?
    - Was there physical distancing in place between passengers and crew?
    - Was there health assessment prior to boarding?
    - Was in-flight service provided by the crew?
    - What seat and row did the case occupy for the flight?
  - If all measures are in place, the individuals on these conveyances are not considered close contacts that require follow up. However, a flight manifest for the chartered flights or a list of bus passengers, must be obtained and provided to Alberta Health (with a copy saved in the OI EFC in CDOM, file save name should include DI number of associated case and flight number and date or bussing date). If there are any OOP individuals who are currently offsite listed, the lists obtained must be provided to AH by email to health.cd@gov.ab.ca with a cc to MOH.North@albertahealthservices.ca and AHS CD OB lead(s) for that OB. Information required for each individual is:
    - name, contact information, seat and row number (if available), home province of residence and whether each individual is currently onsite or offsite.
    - subject line: DI # OOP individuals on flight/bus associated with <insert OI #>, include in the email:
      - description of measures in place,
      - seat and row of case,
      - whether AHS or OHS have identified that anyone meets close contact criteria.
  - Typically Canadian North is the airline that provides the chartered flights. Chartered flight numbers for the companies are always a 1200, 1400 or 1700 series number. Notify the airline contact for any flights where a case was present while communicable, advise in the email whether case followed all recommended measures or if there were breeches. Airline will provide follow up for their crew.
    - Contact for Canadian North chartered flights is Steve Boone @ sboone@canadiannorth.com

Additional Case Investigation Questions Required for Management of cases and contacts and Related CDOM documentation:

All routine case investigation questions must be asked and documented in CDOM, however there are specific additional details required to be entered into CDOM for cases associated with work sites/camps. Investigators must ensure to ask the following questions and document in CDOM as follows:

Definitions:

- **Work site** = is where the work occurs e.g., in an office, maintenance, lab, surveying a site, etc. When asking the question of where they work (even as a contractor) it should include a company name and site for example:

Company:	**Site:**
Imperial Oil	Kearl Lake
Syncrude	Mildred Lake
Suncor	Baseplant and they may add a name of a mine

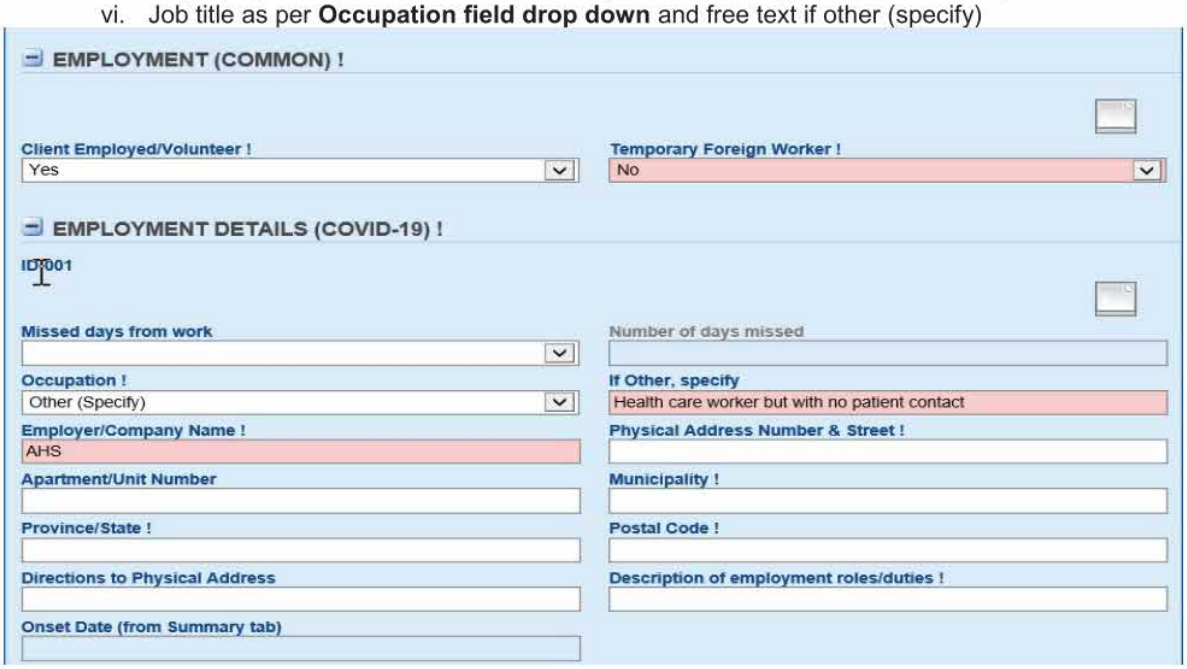
- **Work camp** = is related to where the case/contact lives while on site during their work rotation e.g. eat, sleep, activity room
  When asking the question of where they stay it should include a company name and site for example:

Company:	**Site:**
Civeo	Wolverine
Civeo	Ruth Lake
CNRL	Albian Village
CNRL	Richardson

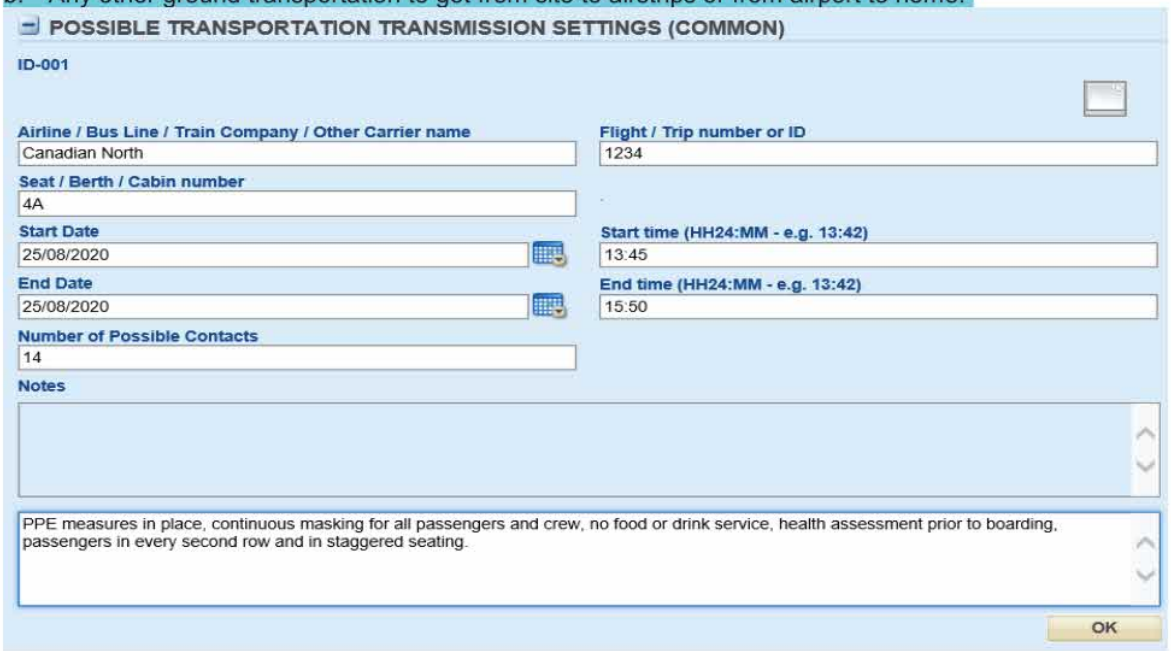
- If employee indicates that they don't stay in camp while on rotation, ask where do they stay? e.g., rent an apartment in town, live in the nearest town, or camps elsewhere in the Zone?

1) Demographic Information: Ensure to ask about home, work and cell phone numbers and an email address. Document in DI **Demographics Tab**.

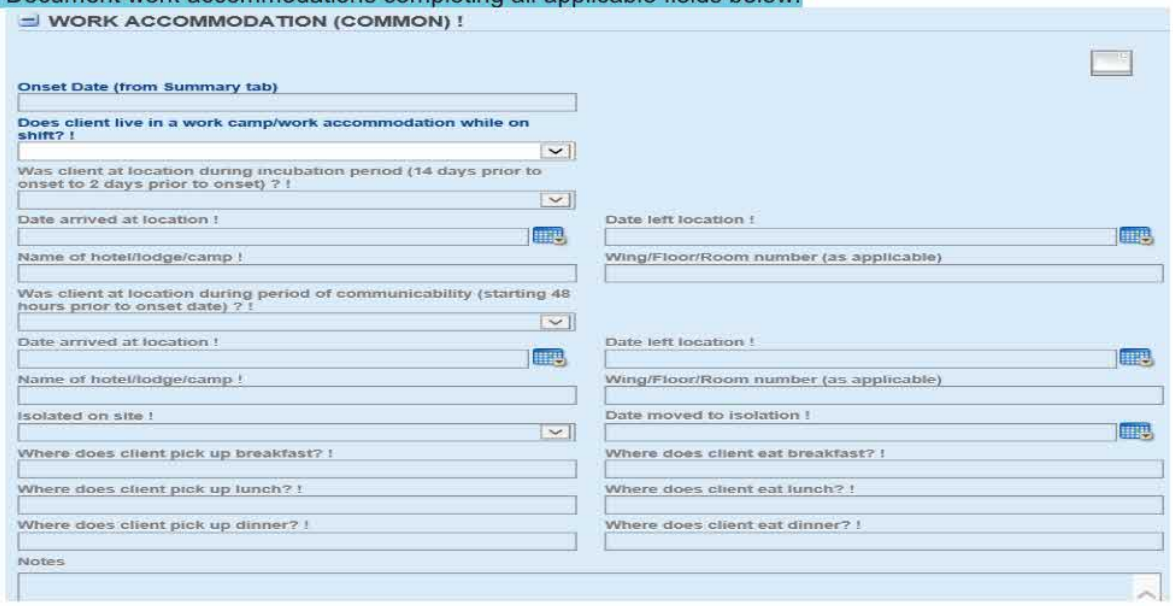
2) Employment Details for those who worked while infectious –
   a. **DI Assessment Tab > Employment (Common)! and Employment Details (COVID-19)!**
      i. Complete as much as possible including a physical address with postal code if possible.
      ii. Note supervisor contact name and phone number in the Notes field.
      iii. Ensure to complete sections for worked during incubation period and/or worked during infectious period if case worked during these times frames.
      iv. Description of shift cycle (days/evenings, length of shift, duration of rotation number of days onsite and number of days offsite
      v. Employer, description of roles and duties, entire date range for current shift cycle worked
      vi. Job title as per **Occupation field drop down** and free text if other (specify)



3) Did case travel by Airline (chartered or otherwise) and/or chartered bus Travel to and from location in Alberta for current rotation **during infectious period**, document in **Assessment Tab > Possible Transportation Transmission Settings (Common) !** field:
   a. Flight details for both incoming and leaving flights (chartered and interprovincial), including dates, row and seat numbers
   b. Any other ground transportation to get from site to airstrips or from airport to home.

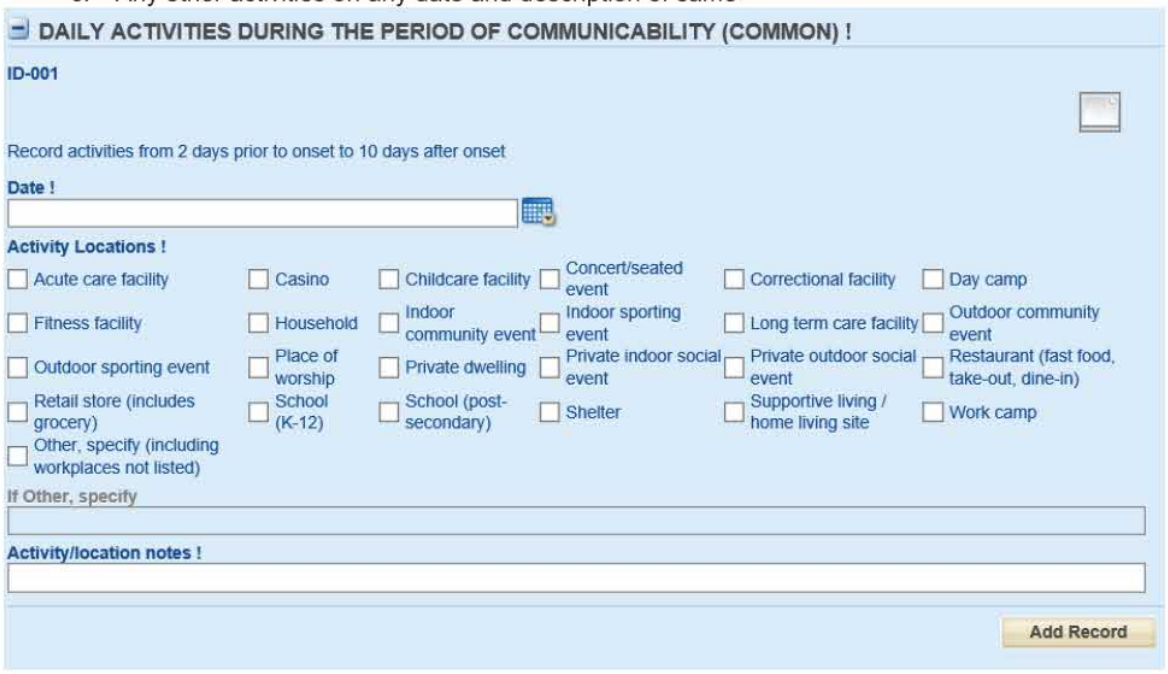


4) Document work accommodations completing all applicable fields below:

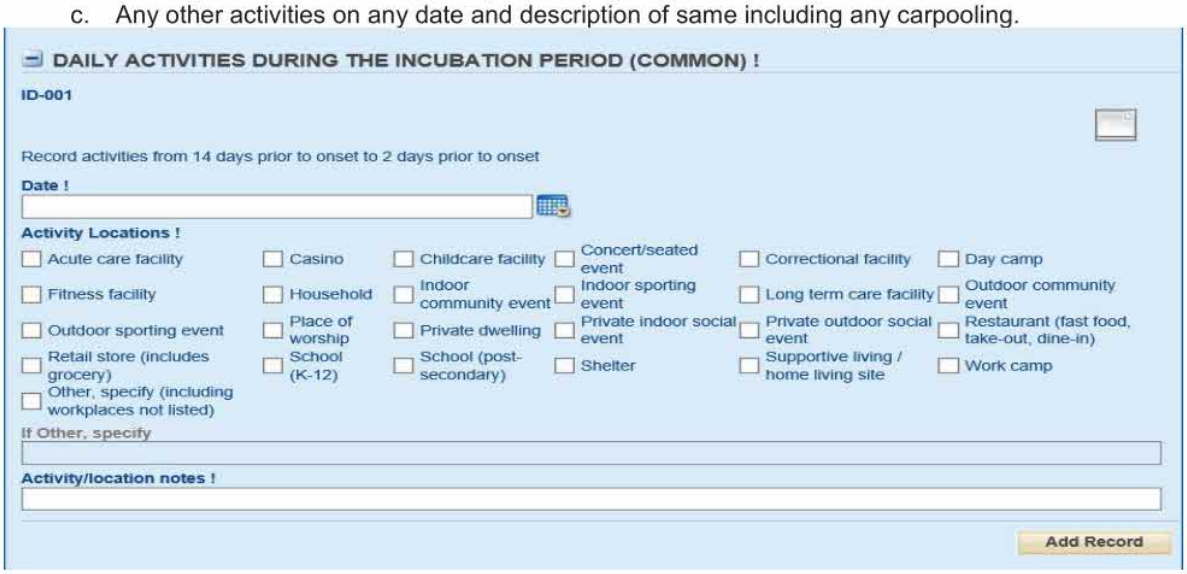


5) Document any conveyances that the employer has arranged for transportation from accommodation to job site(s) or between job sites during both the incubation and infectious period. These sections are able to document multiple instance of transport.
   a. Include any ground transportation that employer arranged to and from airstrips.

6) Document all daily activities during the period of communicability in the **Assessment Tab > Daily Activities During the Period of Communicability (Common)** section including:
   a. Daily work locations and workgroup/work crew names for each day.
   b. Where picked up breakfast, lunch, dinner and where ate same
   c. Any other activities on any date and description of same

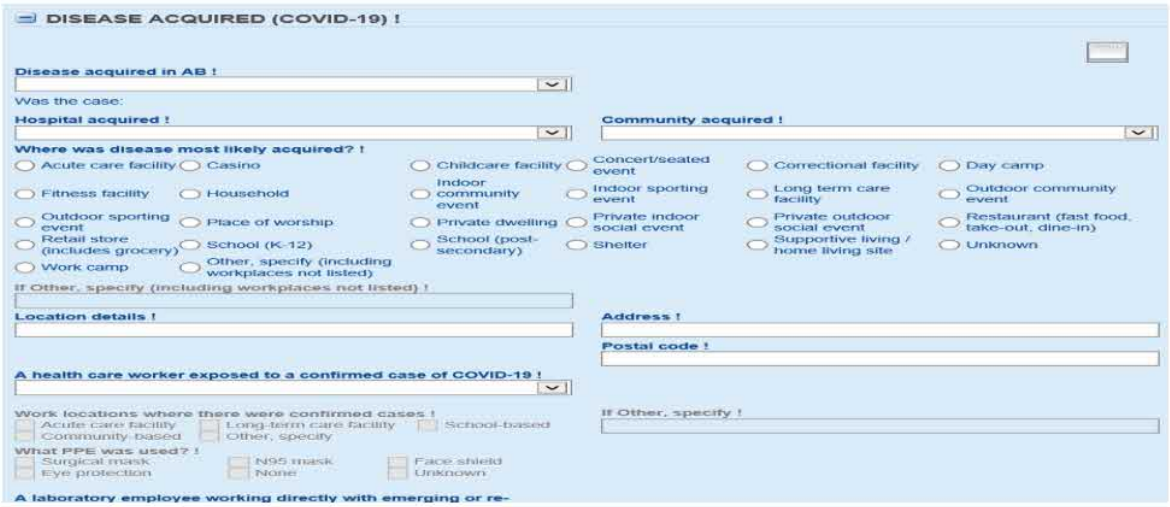


7) Document all daily activities during the incubation period in the **Assessment Tab > Daily Activities During the Incubation Period (Common) section**, including (same type of format as above):
   a. Daily work locations and workgroup/work crew names for each day.
   b. Where picked up breakfast, lunch, dinner and where ate same
   c. Any other activities on any date and description of same including any carpooling.



8) Exposures in the 14 days prior to onset: Document in **Assessment Tab > Exposures (Common) !**
   a. Contact with known case? If yes, ensure to obtain case name and link to DI in CDOM (if case is out of province and not associated with OB, it will not be in CDOM) in **Interpretation Tab > Epidemiological Linkage > Epi-Linked to Known CDOM record** field.
      i. If the case is also associated with the outbreak site document details in the **Assessment Tab > Notes Assessment (Common)** section at the bottom of the tab:
         - Name of case, date(s) of contact, workgroup/team name, frequency of contact and whether measures such as PPE and physical distancing were used during contacts.
   b. Contact with someone who was symptomatic, even if not a known case? If yes, ensure to obtain name.
      i. Document details in the **Assessment Tab > Notes Assessment (Common)** section at the bottom of the tab including name of individual, date(s) of contact, whether it is someone from the OB site or not.
         - If it was someone from outbreak site, workgroup/team name, frequency of contact and whether measures such as PPE and physical distancing were used during contacts.

9) Document Where Disease was acquired in the **Disease Acquired (COVID-19)!** Field.
   a. Ensure to capture if disease was acquired in Alberta or not.



Appendix J: Call Scripts for Contact Tracing

The most up to date versions of these scripts should be accessed from the Alberta COVID-19 Exposure Response team SharePoint Site under the heading “Scripts”.

https://private.albertahealthservices.ca/teams/contacttracing/SitePages/Home.aspx

Appendix K: Unable to Contact and Lost to Follow up Process for COVID Cases

Case investigator is responsible to submit request for unable to contact letter, by email, to CDC clerical support for mailing. CDC Clerical will mail out letters by next business day. Letters go out via routine mail. Letters that are returned will be uploaded into the Electronic Filing Cabinet (EFC) in the case Disease Incident Record (DI) in CDOM.

Case Investigator:

If unable to contact client/parent/guardian to complete initial case investigation:

- ✓ Ensure that all CDOM documentation is complete and final enhanced surveillance report (ESR) has been transmitted to Alberta Health.
  - All ESR required fields marked by (!) must be complete, even though client is unable to be contacted. Chose unknown when unable to determine answers to fields, Netcare should be checked to see if any additional information can be obtained for completing ESR.
- ✓ Set CDOM DI Summary Tab >
  - Process Status = Investigation complete
  - Resolution Status = Confirmed
  - Final Disposition Status = Unable to Contact
- ✓ Email CDC clerical at CDCAdmin@albertahealthservices.ca and cc:CDCCOVID@albertahealthservices.ca
  - Subject line: COVID Unable to Contact Letter Request
  - Email Body:

    Hello,

    Please send unable to contact letter to the following client:
    Client Name:
    Client DI #:
    Client PHN:

    Thank you,
- ✓ Document in the Intervention Tab > Communications/Referrals section of the DI that a request for unable to contact letter has been sent to CDC Clerical.
- ✓ Delete from ACeRT Surveillance list for the Unable to Contact cases after the letter has been requested from clerical.

If case is unable to be contacted to lift isolation, they are considered lost to follow up to:

- ✓ Set Assessment Tab > Disposition status = Recovered and the date.
- ✓ Run ESR check and ensure all mandatory fields are complete.
- ✓ Send Final ESR to AH.
- ✓ Set CDOM DI Summary Tab >
  - Process Status = Investigation complete
  - Resolution Status = Confirmed
  - Final Disposition Status = Lost to Follow up.
- ✓ No letter is sent for Lost to Follow up

CDC Clerical:

- ✓ Retrieve emails from CDC Admin inbox.
- ✓ Enter CDOM DI and populate required fields on letter.
- ✓ Document that Unable to Contact letter has been sent in the CDOM DI Intervention Tab > Unable to Contact Letter section. Check box that says “unable to contact letter sent” and populate date letter sent.
- ✓ Mail letters by next business day.
- ✓ If letters are returned as not deliverable, upload returned letter to the EFC in the client’s CDOM DI.

Appendix L: Single Case of COVID-19 in a Childcare Setting

One case of COVID-19 in a childcare facility is not an outbreak. Two or more cases of COVID-19 within a childcare facility within 14 days is considered an outbreak and a notification must be sent to the outbreak team. This does not apply to day homes. Day homes are managed as a private residence.

Investigator:

- ✓ Zone MOH MUST be notified of new cases in childcare facilities through the MOH case summary email template. Cases in childcare facility attendees/staff meet escalation criteria.
- ✓ Assess if there have been any other confirmed cases at the childcare facility within the past 14 days. 2 cases at the site within 14 days would mean that the outbreak team would need to be notified.
    1) If the case is the second case of COVID-19 in a 14 day period that has been present at the childcare facility
    OR
    2) If there is a new case and contacts that are being added to a current outbreak and whether this new case will change the currently impacted classes.
        - Send email with case details to CD_Outbreak with the subject line: DI # NEW COVID CASE [insert childcare facility name] [insert municipality name]. Include the following details in the email:
            - Full school name,
            - School contact person names and phone numbers and an after-hours contact phone number in the email.
            - DI number of case,
            - Full name of case,
            - Dates at school while communicable,
            - If close contact lists are in progress or have been obtained.
            - Cohorts identified as close contacts
- ✓ Assess what cohort the case belongs to at the site. The entire cohort is considered to be close contacts of the case and all cohort individuals must be quarantined for 14 days from last contact with case.
- ✓ If needed, the impacted cohort may be entirely closed for a minimum of 72 hours to allow contact tracing to determine who was and was not present from the cohort on the dates that the case was present and communicable.
    - Communicate to the childcare facility operator that any individuals (staff or attendees) from the cohort that were **not** present on the days that the case was present, are not required to be quarantined from the facility. Operationally the facility can either accommodate these individuals in another cohort OR can continue to run the cohort they belong to, as long as there is staff available that are NOT requiring quarantine from this case.
- ✓ Staff that provide coverage/short-term services for the impacted cohort and children outside of the impacted cohort would only be recommended to quarantine if they are otherwise considered close contacts of the case.
    - "Close contact" means: having direct physical contact with the case during the period of communicability OR being within 2m of the case within the period of communicability for more than 15 minutes even if utilizing masking. If staff is unsure about the contact with the case, if they were applying physical distancing, appropriate hand hygiene and wearing a mask – they would not require quarantine but can be advised to monitor for symptoms and may be tested.
- ✓ Routine swabbing of all asymptomatic and symptomatic close contacts (i.e.; the entire cohort) is recommended.
- ✓ Typically swabbing of those outside of the case cohort (s) is not required. Swabbing of those outside of the case cohort (s) would only happen in consultation with Zone MOH.
- ✓ Case investigators please work with daycare to obtain complete list of staff/children to be tested from daycare including:
    - First and Last Name,
    - DOB,
    - Accurate phone number of contact or parent/guardian for minor children
    - Last date of exposure to the case

- Original PDF or excel line list is preferred, scanned documents are very difficult to work with electronically for the teams that need to use the lists for follow up of contacts.
- List must ONLY include those who meet close contact definition, please ask daycare not to include anyone on the lists that are not close contacts. For example, if a child was absent on the day/or days that the case was present and was therefore not exposed, those individuals should NOT be included on the list from the daycare.
- There is a template excel line list document located on the SharePoint site > Templates Library > Daycare Close Contact List Template which can be sent to the childcare facility by encrypted email for their team to use to put together the close contact list with the minimum information that we require.
  - Send the template to the facility in an email using !Private in the subject line to encrypt the email (alternatively, the spreadsheet can be password protected if the encrypted email is not a viable option). If the case investigator sending the email is NOT going to be on shift when the facility will be sending the list back, ensure that the facility is aware that an investigator will connect with them to let them know who to email the list to.
    - **Case investigator is responsible to ensure that facility follow up is handed off for the next shift for any outstanding line lists.**
  - The childcare facility staff would only need to complete the yellow highlighted columns of the list. When the line list is ready, please have the facility email the list back as an attachment and "reply" to the encrypted email that was sent. Replying to the encrypted email that the case investigator has sent will automatically encrypt the information in the reply.
  - If the school sends the information and it is not in an editable Word or Excel document version, it must be transposed into the Template by the School Close Contact team BEFORE sending to Health Link for calls OR clerical for data entry into CDOM.

✓ Case Investigator send email to CDCCOVID with completed list from daycare.
- SUBJECT LINE: FOR SUBMISSION TO HEALTH LINK
- Include in body of email:
  - exposure dates and corresponding lift dates
  - Settings of exposure (name of room/rooms at daycare)
  - Full name and municipality of daycare
- advise the daycare contact that Health Link will be calling the close contacts to arrange their testing,
- REMOVE ANY POSITIVE CASES FROM THE LIST BEFORE SENDING.

✓ CDCCOVID will send list of those to be swabbed to: Patricia Chambers @ Patricia.Chambers@albertahealthservices.ca and Stephanie.Schwartz@albertahealthservices.ca
- SUBJECT LINE: Please arrange for testing for [Insert Name of Daycare] close contacts.
- Include in body of email:
  - Health Link is to connect back with CDCCOVID regarding outcomes of calls.
  - Dates of exposures at the site and quarantine lift dates for those exposures
  - Settings of exposure (name of room/rooms at daycare)
  - Full name and municipality of the daycare
  - Request that Health Link also give close contact quarantine messaging, Health Link has their own script for this.

✓ Zone EPH is included on case summaries for children and staff from childcare facilities. EPH site assessment is not required for a single case, however Zone EPH can be engaged if there is uncertainty about who should be considered as part of the cohort based on the site set-up and flow.

Appendix M: Single Case of COVID-19 in a School

One case of COVID-19 in a school is not an outbreak.

Two or more confirmed cases of COVID-19 in a student/staff who attended the site while communicable within a 14 day period (this includes 2 individuals from the same household) OR two or more confirmed cases of COVID-19 in a student/staff that are epidemiologically linked to the school are considered an outbreak and a notification must be sent to the outbreak team.

Non-medical masks (NMM) are used as a measure to decrease the possibility of transmission from an infectious case to others. NMM are not considered sufficient personal protective equipment for a student or teacher who has spent time in a classroom with an infectious COVID case, therefore, even if a student or teacher was masked, they would still be considered to be a close contact.

NOTE:

- Cases must be related to physical attendance at school for school based programming.
  - Includes:
    - staff meetings and other education or academic programs
    - Parent volunteers that are at school or support persons providing services in schools if the services are related to educational programs or supports needed for students in class
  - Does not include
    - cases attending community programs using the school space (indoor or outdoor)
    - students attending at home learning
    - students only attending after school/daycare at the school
    - bus drivers who do not enter the school grounds
    - if the ONLY potential transmission of disease between students or the bus driver is thought to have occurred on the bus and NOT in the school, none of those cases should be considered school acquired.

✓ If a student/staff is not at school while infectious and disease is determined to have not been acquired at school, the case would not be included in the outbreak numbers
  - E.g., if the case acquired disease from a social exposure, if they also attended the school, they would ONLY be included in the numbers if they also attended the school while infectious

✓ If a school is on alert, the school's alert status would typically end 14 days from the *onset* date of the single case
  - If there is a subsequent case within 14 days of a school exposure (case 2 onset date within 14 days of case 1 being at school while communicable) that would trigger an outbreak and both cases would be included only if case 1 is believed to be the source of infection in case 2

Otherwise, the case count would start over and the school would be back on alert but not outbreak.

Case Investigators:

When there is an outbreak at a school, the case investigation team should still complete the single cases associated with that outbreak and communicate back to the CD Outbreak teams with the newly identified cases and if the case was on site at the school while communicable.

✓ Assess if the case was at the school during both the communicability and incubation periods.

✓ In order to determine if the school is "where disease was likely acquired" consider the following:
  - Was the case identified as a classroom or other school contact of a case that was infectious at school?
    - Did the case have an onset date within 14 days of exposure at school?
      - While the incubation period of COVID-19 extends from 1 to 14 days, the most common is 5-6 days. Disease onset approx. 5 days after a school exposure would increase the index of suspicion that transmission occurred at school.
  - Does the case have another more likely source of transmission such as:
    - Do they have a close contact outside of school with an onset day prior to theirs? This could include household contacts who also attend the school.
      - Do they have another potential source of infection? E.g., symptomatic family member with earlier symptom onset date who has not been tested/pending results
    - Are they linked to another exposure setting? E.g., attendance at a daycare that is on Outbreak

- Is the case symptomatic or asymptomatic?
  - A case with symptoms and a definitive onset date can be more clearly linked to an exposure source vs. an asymptomatic cases which may be related to prolonged viral shedding.

✓ Zone MOH MUST be notified of new cases in schools through the MOH Case Summary Email template. Cases in school attendees/staff meet escalation criteria.
- Consult Zone MOH as needed regarding any questionable close contact determinations that do not meet criteria listed below.

✓ If the case was at the school while communicable AND/OR disease was likely acquired at school, ensure to cc the CD_Outbreak inbox on the Zone MOH Case Summary email.

✓ Assess if the case took a yellow school bus while communicable. If they did, ensure that the dates that the case rode the bus while communicable, name of the school bus company (if case parent/guardian is aware) and what measures were in place (masking, assigned seating, distancing) (if parent/guardian is aware) are documented.
- Refer Yellow school bus follow up to the appropriate team following internal AHS processes.
- If the case is a bus driver, ensure that the bus company name and route number/information are documented in the CDOM DI Employment details section.

✓ If case was present in the school while communicable OR on the school bus while communicable, the school notification and school/yellow school bus close contacts will occur through the school close contact team. Notify the School Close Contact Team of need to follow up with the school **as soon as possible** by adding the following information to the ACeRT SharePoint Site: School Close Contact Handover list.
- Case DI
- Case first and last name
- Name of school
- Municipality of school
- Name of school board/district that the school belongs to
- Whether school bus follow up is required
- Exposure date(s)
- School principal name and school phone number (if case knows same)

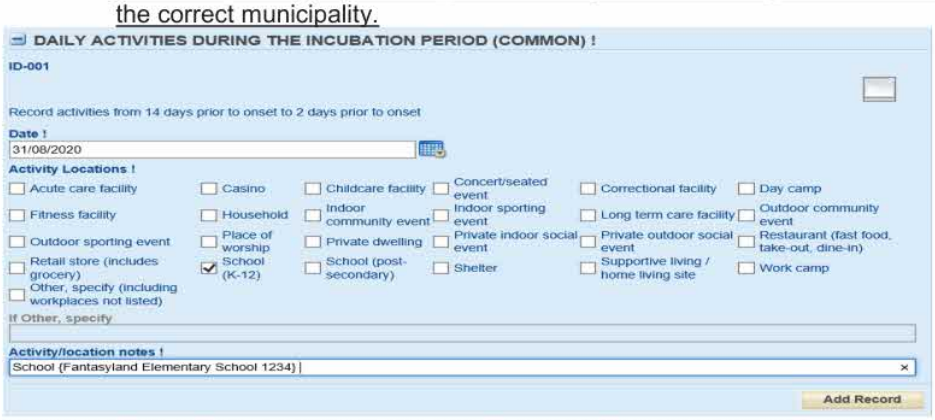
✓ Outside of the school class schedule and the school bus contacts, it is up to the student/guardian to provide a list of all other close contacts. Assess for:
- Where they eat snacks or lunch?
- Do they leave the school during breaks and any associated transportation?
- Any extra-curricular activities?
- All other activities

✓ **Complete the rest of the case investigation as per usual processes**. All close contacts outside of school class and yellow bus lists should be followed by the case investigator or contact follow up team, as per current processes.

✓ Investigators should ensure correct school documentation in the following CDOM fields:
- Daily activities during the incubation period
- Daily activities during the communicability period
  **Each separate day must have its own separate school activity added (no date ranges).
- Employment details section
- Disease Acquired section

✓ Ensure to document school information appropriately in CDOM. The school name in the case DI must be captured in CDOM as follows:
- For students/visitors/volunteers:
  - Assessment Tab > Daily Activities During the Incubation period (Common)!
    - Date = date attended
    - Activity locations = choose School (K-12)
    - Activity/location notes ! = Document exactly as follows:
      - School (School Name 4 digit School code)
        - e.g. School (Fantasyland Elementary School 1234)
        - School code is found on the ACeRT SharePoint website in the School and Daycare Library in the document called “School Code Look-up”. Use the Excel “Find” function to easily find the name of the school. There may be multiple schools in the

province with the same name, ensure that you are choosing the correct school in the correct municipality.



- Assessment Tab > Daily Activities During the Period of Communicability (Common)!
  - Date = date attended
  - Activity locations = choose School (K-12)
  - Activity/location notes ! = Document exactly as follows:
    - School (School Name 4 digit School code)
      - e.g. School (Fantasyland Elementary School 1234)
      - School code is found on the ACeRT SharePoint website in the School and Daycare Library in the document called “School Code Look-up”. Use the Excel “Find” function to easily find the name of the school. There may be multiple schools in the province with the same name, ensure that you are choosing the correct school in the correct municipality.

- For Staff:
  - Assessment Tab > Employment Details (COVID-19)!
    - Occupation = As reported by case
    - Employer/Company Name = School (School Name 4 digit School code)
      - e.g. School (Fantasyland Elementary School 1234)
    - Complete all other fields as applicable for case including whether the case worked during the incubation and communicability periods.
      - School code is found on the ACeRT SharePoint website in the School and Daycare Library in the document called “School Code Look-up”. Use the Excel “Find” function to easily find the name of the school. There may be multiple schools in the province with the same name, ensure that you are choosing the correct school in the correct municipality.
  - Complete all other fields as applicable for case including whether the case worked during the incubation and communicability periods.

- Disease Acquired – while awaiting MOH consultation for those cases where the disease most likely acquired is the school choose "unknown", after MOH consultation/agreement is obtained change unknown to School (K-12) for where the disease was likely acquired and complete the location details School (Name of school School 4 digit code), address and postal code.
- If the school bus is where the disease is most likely acquired – enter other – school bus.
    - School code is found on the ACeRT SharePoint website in the School and Daycare Library in the document called "School Code Look-up". Use the Excel "Find" function to easily find the name of the school. There may be multiple schools in the province with the same name, ensure that you are choosing the correct school in the correct municipality.

If there is need to connect with the School Close Contact Team, email the team at CDC-Schools-Daycare@albertahealthservices.ca

School Investigation Team for School Notifications and School Close Contact Follow Up

School Notifications

The Assessment details below are designed to be used in conjunction with the *School Close Contact Follow up Script* located on the ACeRT SharePoint Site in the School and Daycare library.

The school superintendent is typically the school contact to start the investigation process with.

- See Contact Info List on ACeRT for contact information for superintendents and/or school boards. Use the school board/district after hours number, if available for the school board/district you are trying to reach, BEFORE trying a Superintendent after hours.
    - There is a list of all school board superintendent contact info located here as well as in the Schools and Daycares Library.
- School and school board contact information can also be found on the ACeRT SharePoint website in the School and Daycare Library in the document called "School Code Look-up". Use the Excel "Find" function to easily find the name of the school. There may be multiple schools in the province with the same name, ensure that you are choosing the correct school in the correct municipality.
- All email communications with schools are considered outside of the AHS firewall and must be encrypted by adding !Private to the subject line.

There is a School Close Contact Follow up team Checklist in the Schools and Daycares Library on the SharePoint site that outlines the roles of the various team members and how daily assignments for case work proceed. This checklist is to be used in conjunction with this Appendix and the *School Close Contact Follow up Script*.

- ✓ Pick up assignments daily as per internal AHS team process.
- ✓ Check case DI in CDOM to ensure that case was at school while communicable PRIOR to initiating follow up with the school.
- ✓ Check to see how many cases the school has had in the past 14 days OR if there is an outbreak:
    - To determine if a school has had a case in the past 14 days, check the "New School Alerts" file for the most current date in the School and Daycare library. This is a list of all schools that have been reported through CDOM as having a single case in the previous 14 days. It will also list if there is an outbreak at a school.
    - If the school has an outbreak, check the Outbreak List on the SharePoint site to look for any special instructions for who/how to contact the school for contact tracing.
- ✓ Notify the outbreak team if there are 2 or more cases physically present at the school within the last 14 days.
- ✓ **Communication with Zone outbreak team**: Communicating with the Zone outbreak teams must happen as soon as possible. Zone outbreak team must be advised:
    3) If the case is the second case of COVID-19 in a 14 day period that has been present at the school OR
    4) If there is a new case and contacts that are being added to a current outbreak and whether this new case will change the currently impacted classes.

  - Send email with case details to CD_Outbreak with the subject line: DI # NEW COVID CASE [insert school name] [insert municipality name]. Include the following details in the email:
    - Full school name,
    - School contact person names and phone numbers and an after-hours contact phone number in the email.
    - DI number of case,
    - Full name of case,
    - Dates at school while communicable,
    - If close contact lists are in progress or have been obtained.
    - Classrooms/cohorts identified as close contacts

- ✓ If the case only attended school during incubation period (not communicability period) AND it is confirmed the case acquired the disease at school, the investigator is to search Outbreak Tracking for an outbreak ID for the school, epi-link the case to the outbreak, send outbreak notification email, and ensure attendance at school is documented appropriately in CDOM.
- ✓ If a student/staff is not at school while infectious and disease is determined to have not been acquired at school, the case would not be included in the outbreak numbers
  - E.g., if the case acquired disease from a social exposure, if they also attended the school, they would ONLY be included in the numbers if they also attended the school while infectious
- ✓ Follow *School Close Contact Follow up Script* located in ACeRT SharePoint to walk through close contact assessment and obtaining close contacts line lists. *Note: Do not collect close contact information from the school IF quarantine period for close contacts has already passed at the time of the call.*
- ✓ Send email to identified school contact using Email Template for Notifications (located in schools-daycares tab on ACERT SharePoint). Attach to email: 1. ***Blank School Close Contact Excel Line List Template***; 2. ***Covid-19_Generic Letter for School Notification***. Ensure that email is Cc'd to: CDC-Schools-Daycare@albertahealthservices.ca
- ✓ Ensure follow up is done with the yellow school bus company if case rode bus while communicable to determine the practices and procedures being follow on the buses.
  - Typically close contacts are individuals seated within 2 rows behind, in front of or beside the case, regardless of mask use.
  - The schools should be able to provide the list of close contact for the yellow buses.
  - For bus drivers, only the route and days impacted should be disclosed to the school, the name of the bus driver should not and does not need to be shared with the school.
- ✓ Routine swabbing of all asymptomatic and symptomatic close contacts (i.e.; the entire cohort and all close contacts) is recommended.
- ✓ Typically swabbing of those outside of the case classroom(s) and close contacts, is not required.
- ✓ Testing and isolation recommendations for the identified school close contacts will be arranged through Health Link (see process for sending lists below).
  - Note, in the case that Health Link is no longer able to accept school close contact lists for follow up, these lists will be called by the School Close Contact team. If the School Close Contact Team is calling the close contacts, individual CIs should be created by the team for each close contact.
  - If Health Link is calling the close contacts, clerical can assist in creating the CIs, see process below to send.
- ✓ Zone EPH is Cc'd on all case summaries for students and staff from schools by the case investigators. EPH site assessment is not required for a single case, however Zone EPH can be engaged if there is uncertainty about who should be considered as part of the cohort based on the site set-up and flow.
  - Consult Zone MOH if school identifies that they require infection control and cleaning support OR if school is having difficulty determining who is part of the close contact cohort based on site set-up and flow of people in the school.
- ✓ See script for how to instruct school administration (generally the school principal) to send communication out for alert of one case, detailed in Appendix B of the COVID-19 In School Settings: A Resource Guide for Schools Before, During and After a COVID-19 Outbreak document on the Alberta Health website.
  - If school administrator does not know that this is their responsibility, please refer them to their school superintendent for guidance.
- ✓ No outbreak is opened for a single case.

- ✓ Double check that the school name in the case DI is captured in CDOM appropriately as noted above in the case investigator section. Check for and correct school documentation in the following fields:
    - Daily activities during the incubation period
    - Daily activities during the communicability period
    - Employment details section
    - Disease Acquired section
- ✓ Double check that the employment details are capturing the staff titles correctly in the Occupation field.
- ✓ Send Zone MOH summary email of contact follow up with school and cc CD_Outbreak and CDCCOVID. This communication can be sent if close contact lists are pending, investigator does not need to wait for the close contact lists from the school to send the MOH summary. Include the following information:

    SUBJECT LINE: DI# School Close Contact Follow up [school name] [school municipality]

    NOTE: *Please be advised this summary is for school close contact follow up only. The case investigator will send the full case summary for this DI with attached ESR, addressing likely exposure once the case investigation is complete.*
        - School contact name and phone number
        - DI of case
        - Dates that the case was at the school while communicable
        - List the impacted classrooms and/or the approximate number of close contacts identified
        - Was yellow school bus follow up required?
            - If so, have lists been obtained?
        - Is this the only case at the school within the past 14 days OR is this the second case within the past 14 days?
        - If more than one case in 14 days, has CD Outbreak team been notified?
        - Is this school currently on outbreak?
        - Any outstanding issues or concerns for MOH consultation OR No MOH consultation required at this time.

School Close Contact Follow Up:

Depending on operational needs, how close contacts are followed up may involve direct voice communication or be done through mail or email notification. **See internal AHS processes for which method of communication and process for follow up of close contacts is being used.**

Process for Sending School Close Contact Letters

- ✓ School Close Contact Follow up Team receive completed ***Close Contact Excel Line List*** from school via encrypted email.
- ✓ Line lists are reviewed for completion and accuracy (i.e., ensure DI is not included on list, parent/guardian/staff emails are included on list, bus contacts are included if applicable, exposure dates are clear). If errors are present, communicate back to the school requesting corrected list.
- ✓ Prepare close contact letters using ***Covid-19_student close contacts letter template*** and ***Covid-19_staff close contacts letter template*** (may require preparation of multiple letters to capture more than one exposure date or classroom).
- ✓ Close contact letter information to be emailed to parent/guardian/staff close contacts from Covid19_contact@albertahealthservices.ca. If email is unavailable/not provided, or line list indicates an interpreter is required - phone calls to close contacts should be made instead using ***Covid Script for School Contacts***.
- ✓ Excel line list should be populated with successful/unsuccessful contact attempts.
- ✓ Send encrypted email to identify school contact using the ***Email Template Unable to Contact*** (located in schools-daycares ACERT SharePoint tab).
- ✓ Attach the close contact letter(s) with the correct exposure/isolation lift dates for any staff/student close contacts who were unable to be successfully contacted.
- ✓ Ensure all communications were documented in CDOM.
- ✓ Mark as status completed in ACERT SharePoint.

Appendix N: Assessment of Close Contacts Related to Sports

Assessment and Management of Sports Contacts

Who are considered close contacts of cases who have participated in team sports while communicable?

Generally all individuals in the same cohort as the case will be considered close contacts if the case was participating in the team sport/practice during their infectious period.

- As part of Alberta's relaunch strategy, team sports organizations are required to maintain team sports cohorts of no more than 50 individuals. The 50-person maximum includes any coaches/staff, instructors, participants, officials, and volunteers who consistently and routinely engage with participants at a distance of less than two metres.
- When playing a contact sport or engaging in a physical activity that involves multiple participants/players and where it is not possible to maintain a physical distance of two metres from other participants/players at all times, all the individuals in the group will be considered the cohort. (e.g., hockey, soccer, ringette, football, basketball, volleyball, etc.)
- The cohort will include both the team the case is playing on and the team(s) they are playing against.
- While cohorts limit the risk of extensive disease transmission because they reduce the number of people with whom players/participants have close contact, cohorts do NOT eliminate the risk of transmission and everyone in the cohort will therefore be considered close contacts.
- Cohorts will be considered close contacts regardless of mask use, duration and degree of close proximity to each other as assessment of these risks is not possible in these activities.

Who is NOT considered a close contact of cases involved in team sports?

- Members of the cohort who were not present at the games or practices where the exposure occurred would be considered to have no exposure risk and deemed not to be a close contact.
- Cohorts would not be considered close contacts if the case was not present for games or practice during the communicability period.
- Coaches, staff and officials who primarily interact with individuals or teams at a distance of two metres or greater do not need to be counted as part of the exposed cohort. These individuals are required to wear a mask and perform proper hand hygiene if it becomes necessary to temporarily interact with cohorting participants at a distance of less than two metres.
- For sports where the whole cohort may not have had exposure to the case (e.g. wrestling), close contacts would need to be identified based on direct contact or proximity to the case during play/activity.
- Spectators who are able to maintain a distance of two metres would not be considered close contacts.

Assessment Considerations:

- Remember to also assess transportation to and from activities to identify close contacts who may be sharing rides between activities and have increased risk of transmission.
- For contact management of sports related close contacts, obtain lists of the exposed individuals, including exposure times and locations as well as details on the use of PPE.
- For identified close contacts, follow current internal AHS process for follow up.