Public health management of cases and contacts of COVID-19 in Ontario

March 25, 2020 (version 6.0)

Document History

Revision Date	Document Section	Description of Revisions
January 30 2020		Document was created.
February 5 2020	Contact Management – Public Health Advice	Language included to reflect policy change: self-isolation of 14 days for those returning from Hubei province and for close contacts of cases.
February 7, 2020	Throughout Document	Updates to reflect changes to case definition and self-isolation
February 12 2020	Case and Contact Management Travelers from Affected Areas	Updates to language around risk level and corresponding level of self isolation/ self monitoring Addition of Table 3
March 3 2020	Updates throughout document	Updates based on new case definition and evolving advice based on travel history of patient
March 25 2020	Updates throughout document	Change in Purpose section; guidance on testing, explanation on case definition, assessment and management of persons suspected of COVID-19, Information on pets

Version 6 – Significant Updates:

Page 5 – Updates to Purpose section

Page 6 – Assessment and Management of Persons Suspected to Have COVID-19

Page 11 – Case Management; Changes on when to discharge from self-isolation

Page 12 – Self Isolation Guidelines updates

Page 14 – Self Care While Convalescing

Page 15-16 – OHS & IPAC for Acute Care Settings

Page 17-20 – Updates to Contact Management. Significant updates to Table 1

Ministry of Health. Health System Emergency Management Branch

1075 Bay Street, Suite 810. Toronto, Ontario. Canada, M5S 2B1

416-212-8022 (local); 1-866-212-2272 (long distance).

Emergencymanagement.moh@ontario.ca

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Public health management of cases and contacts of novel coronavirus (COVID-19)

This document provides information for the public health sector in Ontario. The Ministry of Health has developed this document with contributions from Public Health Ontario (PHO) based on current available scientific evidence and expert opinion. This document is subject to change as new information about the novel coronavirus (COVID-19) initially identified in Wuhan, China, is identified and understood.

Nothing in this document is intended to restrict or affect the discretion of local medical officers of health to exercise their statutory powers under the *Health Protection and Promotion Act*. This document is intended for information and guidance purposes only.

Purpose

The Ministry of Health (ministry) has developed this guidance for public health units (PHUs) to use to assess and manage probable and confirmed cases and persons undergoing testing, and conduct case and contact management activities for COVID-19. This document also contains information on the guidance for individuals with travel history outside of Canada within the past 14 days.

This document outlines a strategy to initially contain and then mitigate the spread of COVID-19 in Ontario. PHUs should use this document when there are low to moderate levels of importation or community transmission.

PHUs should conduct case and contact management for all probable and confirmed COVID-19 cases. PHUs should also consider conducting case and contact management for individuals with a high index of suspicion for becoming a case, specifically where the individual has travelled outside of Canada or is a contact of a case, in the 14 days prior to onset of symptoms. Case definitions are shared in daily situation reports as they are updated and are also available in the ministry's Guidance for Health Care Workers and Health Sector Employers posted on the COVID-19 website.

Public Health Ontario (PHO) Laboratory conducts testing and shares laboratory results with the requesting health care provider and the relevant PHU; significant results are also shared with the ministry. Some hospital and community laboratories have implemented COVID-19 testing in-house and report final positive results, which is sufficient for case confirmation. Other hospital and community laboratories report positives as preliminary positives during the early phase of implementation and will require confirmatory testing at a reference laboratory (e.g., PHO or National Microbiology Laboratory (NML).

The identification of the first probable case or confirmed case triggers a number of actions, including activation of the Ministry's Emergency Operations Centre (MEOC)[1], at which PHO and relevant ministry divisions are represented. Once activated, the MEOC is the primary source of information, support and provincial coordination of health system response activities. The MEOC can be accessed through the Health Care Provider Hotline at 1-866-212-2272 on a 24/7 basis. Shortly after activation, the MEOC holds a Health Sector Coordination Teleconference with all relevant stakeholders to discuss next steps, including implementation of the guidance in this document. Once activated, the MEOC will continue to provide Health Sector Coordination for all new cases in Ontario.

[1] For more information on the MEOC, please view the Ministry of Health Emergency Response Plan.

Investigation Tools

PHUs can use the following tools to conduct case and contact management activities:

- Appendix 1: Ontario's Severe Acute Respiratory Infection (SARI) Case Report Form – PHUs can use this form to guide their collection of information from probable and confirmed cases or their proxies. PHUs should enter all cases in the integrated public health information system (iPHIS), as per iPHIS entry guidelines.
- Appendix 2: Routine Activities Prompt Worksheet for Cases – PHUs can use this sample worksheet to identify potential exposures that may have led to disease acquisition in a case. Along with the SARI Case Report Form in Appendix 1, this worksheet can also be used to interview the case or their proxy to collect detailed information and to investigate potential exposures in the 14 days before onset of symptoms.
- Appendix 3: Daily Clinical Update Form for a Case Managed in an Acute Care Setting and Appendix 4: Daily Clinical Update Form for a Case Managed in a Household Setting – PHUs can use these sample forms to monitor the health status of a probable or confirmed case for the duration of their illness and infectious period (which continues until documentation of two negative tests on respiratory specimens collected at least 24 hours apart), or until a probable case no longer meets the case definition (i.e., as a result of additional laboratory testing).
- Appendix 5: Close Contact Tracing Worksheet – PHUs can use this sample worksheet to identify close contacts of a probable or confirmed case
- Appendix 6: Daily Contact Clinical Update Form – PHUs can use this sample form to follow-up and monitor close contacts.

Assessment and Management of Persons Suspected to Have COVID-19

As of March 11, 2020, the World Health Organization (WHO) declared COVID-19 a pandemic. Ontario hospitals and the broader provincial healthcare system, including primary and community care, have been alerted to this pandemic associated with COVID-19 and advised to assess individuals presenting with acute respiratory symptoms for their travel history and other potential close contact exposures to the virus and triage their most appropriate level of care and need for testing. It is expected that as the pandemic progresses there will be community transmission and an increasing volume of patients suspected or confirmed to have COVID-19. Confirmatory testing for COVID-19 should be prioritized to those for whom testing impacts clinical management (e.g., hospitalized patients, health care workers) and for public health management purposes (e.g., outbreak management).

Case Definition Updates

- The case definition has been updated to **no longer include a 'person under investigation' definition (PUI)**. This is in response to evolving clinical risk criteria to prompt suspicion of COVID-19, and to align with other case definitions for Diseases of Public Health Significance in Ontario. Only Probable and Confirmed cases are reportable to Public Health Agency of Canada (PHAC) and WHO.
    - Clinicians who suspect COVID-19 are required to report the individual to their local public health unit.
    - PHU follow-up of individuals who would have previously met the PUI case definition (i.e. symptoms plus exposure risk through travel, contact with a case or contact with an ill person who has a travel risk) and who were not tested is at the discretion of the PHU
    - Data entry into iPHIS of individuals suspected to have COVID-19 is at the discretion of the PHU.
    - Individuals with fever and/or new onset cough or difficulty breathing, and an exposure risk who previously would have been classified as a PUI are not all probable cases.
    - **Probable cases** are symptomatic individuals with travel outside of Canada, or had close contact with a confirmed or probable case, or had close contact with a person with acute respiratory illness who has traveled outside of Canada and for whom laboratory specimen is not available (e.g., patient refused), inconclusive, or negative (if specimen quality or timing is suspect). Probable cases should be entered in iPHIS within 24 hours as per iPHIS entry guidelines.

  There is **no longer a 'presumptive positive'** case definition due to the short time interval to provide a confirmatory test result. Some individuals may still have a 'preliminary' result from a hospital or community laboratory, with confirmatory testing provided by a reference laboratory.

Management of Persons Being Tested for COVID-19

- Healthcare providers who identify individuals at risk of COVID-19 and who meet testing criteria for COVID-19 should inform the individual to self-isolate while test results are pending (if the individual does not require hospital care). Patient information on self-isolation is available on the PHO website.
- Healthcare providers should report the individual being tested to their local public health unit.
- In the hospital setting, clinicians should alert their hospital's Infection Prevention and Control (IPAC) department to ensure appropriate management of the individual.

Health Unit Role:

- When PHUs are aware of an individual being tested for COVID-19, they should provide direction on self-isolation to prevent potential transmission, and actively monitor while testing is pending particularly if the person is not in hospital.

    - For a symptomatic individual with a high risk exposure, PHUs should conduct daily active monitoring while testing is pending and consider initiating contact identification and/or contact follow-up
- All patients for whom testing for COVID-19 has been ordered should follow the same advice regarding self-isolation while testing is pending.
- Individuals for whom a negative result for COVID-19 is obtained should continue physical distancing, avoiding public spaces and self-monitoring for symptoms.

Management of Symptomatic Persons NOT Being Tested for COVID-19

- Due to testing prioritization by clinicians, not all individuals with respiratory symptoms compatible with COVID-19 and a risk of exposure will be tested for COVID-19.
- These individuals should have ready access to information on worsening signs and symptoms that should prompt urgent medical attention. Examples of worsening symptoms can include: 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, and/or lost consciousness.
- Provide information to individual to minimize risk for those living with vulnerable individuals in the home while self-isolating.
- Provide information to the individual for advising those who they had close contact with to also self-isolate for 14 days from last contact.
    - This applies to those in the same household and anyone else who had close contact when they were sick and not self-isolating, and up to 2 days (48 hours) before they were sick

Recovery Criteria for Persons NOT being Tested for COVID-19

- Where individuals can manage their symptoms at home and are not health care/essential services workers, it is currently recommended that they self-isolate for:
    - **14 days from symptom onset;**
    - After 14 days, if they are afebrile and their symptoms are improving, they may discontinue self-isolation. Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post-infection
    - If symptoms or fever are persisting, individuals should follow-up with their primary care provider or Telehealth
    - This is based on current evidence regarding viral shedding and viability after symptom onset in out-patients and will be updated as additional information on the period of infectiousness becomes available

Reporting of Cases to the Public Health Agency of Canada

Within 24 hours of the identification of a **probable or confirmed** case in Ontario, the ministry will report to PHAC as part of national notifiable disease reporting requirements, as well as in accordance with the International Health Regulations.

To meet this timeline, the PHU should enter the case in iPHIS as soon as possible (and within 24 hours) as per the instructions provided in the Enhanced Surveillance Directive (ESD) and the Quick Reference Guide for COVID-19. At a minimum, PHUs should enter the following for each probable or confirmed case:

- reporting PHU
- outbreak or cluster related within Ontario
- gender
- age
- date of symptom onset
- symptoms
- whether hospitalized/date of hospitalization
- whether in ICU/ date of ICU admission
- if deceased/ date of death
- laboratory test method and result (when or if available)
- travel history (i.e., dates and locations (city/country), travel conveyance used)
- other possible exposures (e.g., ill contact, live animal market or other animal contact, etc.)

Note: PHUs are no longer required to complete and submit the SARI case report form to PHO, however, this tool may still be used to guide data collection and iPHIS entry.

Case and Contact Management

The identification of a probable or confirmed case triggers an investigation by the PHU in order to assess potential exposures within the 14 days prior to symptom onset and to evaluate potential transmission among close contacts. These investigation results assist in preventing further transmission and improve knowledge about the epidemiology of COVID-19 (e.g., provide information about duration and type of exposures that facilitate virus transmission).

Case Management

Recommendations to support PHUs to manage a probable or confirmed case are outlined below.

Case follow-up and monitoring

- The PHU interviews the case and/or household contacts/family members (i.e., if the case is too ill to be interviewed, has died, or is a child) as soon as possible to collect the reporting information outlined above (see Reporting to the Public Health Agency of Canada) and identify close contacts (see Contact Management).
    - Most PHU investigators conduct these interviews by telephone.
    - For interviews conducted in person, the investigator follows Routine Practices and Contact, and Droplet Precautions when entering the case's environment (see the ministry's Guidance for Health Care Workers and Health Sector Employers for further information on occupational health & safety (OHS)[2] and infection IPAC measures).
- The PHU interviews the case to identify potential exposures that may have led to disease acquisition (see Appendix 2 for a sample template).
- The PHU monitors the probable and confirmed case's health status on a daily basis for the duration of illness (whether the case is in an acute care setting or household setting) and until resolution of their illness. (see Appendix 3 and Appendix 4 for sample templates to assist with this monitoring). The PHU monitors probable case's health status on a daily basis for the duration of illness.

Criteria for when to discharge a confirmed case from isolation

For each scenario, isolation after symptom onset should be for the duration specified, and provided that the individual is afebrile and symptoms are improving. Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post-infection. Once a case is discharged from isolation, their case status should be updated to 'resolved'.

- For individuals **at home**:
    - 14 days following symptom onset
- For **hospitalized** patients:
    - Isolate in hospital until 2 negative tests, obtained at least 24 hours apart
    - If discharged home within 14 days of symptom onset, follow advice for individuals at home
- For **health care workers**:
    - For return to work, 2 negative tests are required, obtained at least 24 hours apart
    - If critical for operations, health care workers may return to work 14 days after symptom onset while wearing appropriate PPE, and continuing use of appropriate PPE until 2 negative specimens at least 24 hours apart.

[2] Further information on legislated occupational health and safety requirements may be found on the Ministry of Labour, Training and Skills Development's Health and Safety website.

Self-isolation for cases/individuals in the household setting

The PHU should provide the following advice to a case in a household setting. This guidance can also be applied to individuals undergoing testing, or anyone being asked to self-isolate.

- The individual should self-isolate while ill and not go to work, school, or other public areas. This includes not using public transportation or taxis and limiting visitors. If they must take a taxi/ride share, they should wear a scarf or mask, sit in the backseat, and if possible open the window (weather permitting) to increase air exchange in the vehicle. If possible, the case should also note the taxi/ride share company name and operator number in case there is a need for contact tracing.
- If the case must go out for a medical appointment or urgent care, they should inform the PHU and wear a surgical or procedure mask over their nose and mouth, and travel in a private vehicle if possible.
- The individual or family members (and/or the PHU) should alert all health care workers about the case's status (exposure and illness) so that appropriate OHS & IPAC measures can be taken (including notifying Ambulance Communication Centres that have a direct link to paramedic services, should an ambulance be called to transport the case).
- The individual and household members should reduce opportunities for disease transmission within the household setting:
    - They should be separated from others in the household environment to the greatest extent possible (e.g., remain/ sleep in a separate room and have a dedicated bathroom; if these steps are not possible, maintain a distance of two metres from others).
    - If they cannot be separated from others, then they should wear a mask (if tolerated).
    - Shared rooms or areas (e.g., kitchen, bathroom, and the case's room) should be well ventilated (i.e., keep window open if possible and tolerated).
- The individual should be instructed about respiratory etiquette:
    - They should have tissues beside or with them to be able to cover coughs, sneezes or to wipe or blow their nose. If a tissue is not immediately available when coughing or sneezing they should cover their mouth and nose with the sleeve of their clothing, into the bend of their arm, to reduce droplets spread into the air.
    - They should cover their mouth and nose with tissues or wear a mask while receiving care (e.g., receiving medications, dressing, bathing, toileting, repositioning in bed).
    - They should discard tissues/disposable materials including masks in a plastic-lined, covered garbage can.
    - They should perform hand hygiene frequently by handwashing for at least 15-20 seconds. Handwashing with plain soap and water is preferred however, alcohol-based hand rub/sanitizers (ABHR) are acceptable if soap and water are not available. If hands are visibly soiled, clean them

with plain soap and water immediately after contamination with respiratory secretions and/or after disposing of used tissues or masks. They should avoid touching their eyes, nose and mouth with unwashed hands.
    - They should use a paper towel to dry hands. If that isn't an option, the case should use a dedicated cloth towel that is kept separate from everyone else's towels and replaced when it becomes wet.
- They should limit contact with household members as much as possible, recognizing that care may need to be provided by household members. Caregiving activities may include washing the case's face or hands and assisting with bathing, toileting, dressing, feeding or offering liquids, and taking medications.
- They may need to make arrangements to remain isolated, including having discussions with their employer, making alternate arrangements to support children/ other dependents and taking steps to ensure an adequate supply of groceries and other necessities.
- Individuals who have travelled to outside of Canada should not visit a farm or handle livestock for at least 14 days after returning to Canada, regardless of their personal health status.

The PHU should provide the following advice to **household caregivers and others** in the case's immediate household environment:

- The only people in the household should be those who are essential for providing care:
    - People who are not taking care of the individual should make arrangements to live somewhere else until they no longer need to self-isolate. If this is not possible, they should stay in another room or be separated from the person as much as possible.
    - Anyone who is at higher risk of developing complications from infection should avoid caring for or come in close contact with the individual. This includes anyone who is:
        - An older adult
        - At risk due to underlying medical conditions (e.g., heart disease, hypertension, diabetes, chronic respiratory diseases, cancer)
        - At risk due to a compromised immune system from a medical condition or treatment (e.g., chemotherapy)
- Household caregivers who have been living in the same household since the individual became symptomatic (and who have already had an exposure risk) may decide to use gloves, a mask and eye protection (goggles or a face shield) to reduce their risk of acquiring the virus while providing care and when in the same room as the case.
- A new caregiver coming into the household and who hasn't had previous contact with the individual while they were symptomatic (and therefore has not had a previous exposure) should wear gloves, a mask and eye protection while providing care to the case and when in the same room as the case.

- When they have left the individual's room, caregivers must remove personal protective equipment (PPE) in the appropriate sequence to reduce the risk of contamination of hands or face through inadvertent contact with contaminated PPE:
    - After gloves and the gown are removed, perform hand hygiene. Plain soap and water is preferred however, alcohol-based hand rub/sanitizers (ABHR) are acceptable if soap and water are not available. If hands are visibly soiled, clean them with plain soap and water.
    - Remove eye protection. Then remove the mask by holding only onto the ear loops or ties (do not touch the front of the mask that was over the face) and dispose of the mask immediately into a waste container or disposable bag. Clean eye protection with a cleaner/disinfectant as per manufacturer's instructions or place into a container for later cleaning/disinfection.
    - Perform hand hygiene again immediately after removing PPE. If hands are visibly dirty or have come into contact with respiratory secretions or other body fluids, clean them with plain soap and water to physically remove the soil.
- Caregivers should avoid other types of possible exposure to the individual or contaminated items. For example, they should avoid sharing toothbrushes, cigarettes, eating utensils, drinks, phones, computers, other electronic devices, towels, washcloths or bed linen. Dishes and eating utensils should be cleaned with dish soap and water after use. Use of a dishwasher with a drying cycle also provides a sufficient level of cleaning.
- High-touch areas such as toilets, sink tap handles, doorknobs and bedside tables should be cleaned daily using regular household cleaners and more often if visibly soiled. If they can withstand the use of liquids for disinfection, high-touch electronics such as phones, computers and other devices may be disinfected with 70% alcohol or alcohol wipes. The contact's clothes and bedclothes can be cleaned using regular laundry soap and water and do not require separation from other household laundry.
- All waste generated can be bagged in a regular plastic bag and disposed of in regular household waste.
- There is currently no evidence that pets can spread COVID-19. Due to the theoretical risk of animals within the household acting as a fomite for spread of the virus between people or becoming infected with the virus themselves, cases should limit their contact with household pets, if possible. The case should observe the same respiratory etiquette and hand hygiene with the pet as for another person. Caregivers may also decide to take the same precautions around pets that have already had close contact with a symptomatic case. These measures may decrease the risk of the pet acting as a fomite for the spread of the virus or from any possibility of disease transmission.
- While there is no current evidence that pets can become sick from COVID-19, pets that have been living in the same household since the case became symptomatic (and who have already had an exposure risk) should be monitored

for any signs of illness. If signs of fever or infection develop, the animal's caretaker should contact their local veterinarian and also notify the PHU.

Given the high degree of exposure, household contacts should be assessed for their level of contact with a case, and be provided information on self-isolation or self-monitoring by the PHU (see Contact Management) for 14 days from last exposure to the case. The ministry has developed a fact sheet on Preventing 2019-nCoV from Spreading to Others in Homes and Communities that PHUs can use to provide guidance and information for probable cases, presumptive confirmed cases and confirmed cases and their close household contacts when being cared for in household settings.

In the event the case lives in a congregate setting, with communal facilities such as dining areas and bathrooms, the PHU should assess the living situation for options to minimize interactions with others. This may include assessing bathroom and kitchen facilities or alternate living arrangements.

Occupational health & safety and infection prevention & control advice for acute care settings

- If the PHU refers the probable or confirmed case to an acute care setting for follow-up, the PHU should provide a procedure mask for the case to wear when in public and during transport (in a private vehicle or ambulance). The PHU should notify the acute care setting of the case's impending arrival and advise/remind the organization that at this time, in addition to Routine Practices, cases are to be placed on **Droplet and Contact Precautions**. Airborne, droplet and contact precautions should be used for aerosol-generating medical procedures, in an airborne infections isolation room, where available.
- Acute care settings should consult the ministry's website on COVID-19.

Self-care while convalescing

Treatment

At this time, there is no specific treatment for COVID-19. The case should rest, eat nutritious food, stay hydrated with fluids like water, and manage their symptoms. Over the counter medication can be used to reduce fever and aches. Vitamins and complementary and alternative medicines are not recommended unless they are being used in consultation with a licensed healthcare provider.

Monitor temperature regularly

The case should monitor their temperature daily, or more frequently if they have a fever (e.g., sweating, chills), or if their symptoms are changing. Temperatures should be recorded and reported to the PHU as per its instructions. If the case is taking acetaminophen (e.g. Tylenol) or ibuprofen (e.g. Advil), the temperature should be recorded at least 4 hours after the last dose of these fever-reducing medicines.

Maintain a suitable environment for recovery

The environment should be well ventilated and free of tobacco or other smoke. Airflow can be improved by opening windows and doors, as weather permits.

Stay connected

- Staying at home and not being able to do normal everyday activities outside of the home can be socially isolating. PHU's can encourage people who are isolating themselves at home to connect with family and friends by phone or computer.

Contact Management

Contact management may involve collaboration between PHUs and acute care settings:

- PHUs are responsible for monitoring close contacts of probable and confirmed cases in the community. This includes close contacts who were exposed in an acute care setting or other health care setting (e.g., primary health care setting, urgent care clinic) but live in the community. The responsibility for monitoring close contacts that were exposed during their hospital admission (i.e., inpatients) and subsequently discharged prior to completing 14 days should be transferred from the acute care setting to the PHU.
- Acute care settings are responsible for monitoring close contacts who were exposed in the hospital and are currently admitted (i.e., inpatients). This includes patients who were exposed in the emergency department and subsequently admitted. Acute care settings are also responsible for monitoring health care workers who were exposed at work. Acute care settings should refer to PIDAC Tools for Preparedness: Triage, Screening and Patient Management for Middle East Respiratory Syndrome Coronavirus (2019-nCoV) Infections in Acute Care Settings for additional information.

Tracing and categorization of Close Contacts

- A close contact is defined as:
    - A person who provided care for the patient, including healthcare workers, family member or other caregivers, or
    - who had other similar close physical contact or
    - who lived with or otherwise had close, prolonged contact with a probable or confirmed case while the case was ill.
- PHUs conduct contact tracing activities to identify close contacts of a probable, or confirmed case (see Appendix 5 for a sample worksheet to conduct close contact tracing activities).
- PHUs may also conduct contact identification and possibly contact follow-up activities for individuals undergoing testing and who have had a high risk exposure
- PHUs should assess each contact based on exposure setting and risk of exposure based on the interaction with the case.
- **Period of communicability:**
    - As early symptoms of COVID-19 may be mild and non-specific, and there have been early reports of potential asymptomatic transmission, contact tracing should extend from **48 hours** prior to symptom onset to **14 days** after symptom onset.
        - The period of communicability has been updated from previous guidance based on emerging information on infectiousness and transmission in the incubation period

- **Self-isolation of contacts:** While the isolation of asymptomatic contacts is technically termed “quarantine”, the common use of “self-isolation” to refer to both symptomatic and asymptomatic individuals means we have adopted the language of “self-isolation” for asymptomatic close contacts for ease of understanding. The purpose of self-isolation is to prevent the risk of spread in the event a contact becomes infected and prior to recognizing they are infectious. Due to varying degrees of risk posed by different exposures, contacts can be categorized into three levels of risk exposure and corresponding requirements for self-isolation:
    - **High-risk exposure** – self-isolation for high-risk exposure. If individual becomes symptomatic, consider testing if they meet the testing criteria
    - **Medium-risk exposure** – self-monitoring for medium-risk exposure. If individual becomes symptomatic, consider testing if they meet the testing criteria
    - **No/Low-risk exposure** – no monitoring required. Provide information and reassurance.
- **Table 1** details contacts by their exposure setting and exposure type, as well as their recommended level of self-isolation or self-monitoring.
- **Table 2** details description of self-isolation and self-monitoring and PHU follow-up.
- **Prioritization of contact follow-up:**
    - PHUs should prioritize contact follow-up for high risk exposure and then medium risk exposures as resources allow

Table 1: Contact management recommendations based on exposure setting and type

Exposure Setting	Exposure Type	Level of Self Isolation or self-monitoring
Household (includes other congregate settings)	• Anyone living in the same household, while the case **was not self-isolating**: o This may include members of an extended family, roommates, boarders, ‘couch surfers’ etc. o This may include people who provided care for the case (e.g., bathing, toileting, dressing, feeding etc.) o This may include congregate settings (e.g., dormitories, shelters, group homes, detention centres, child/daycare centres) where contacts are in direct contact through shared communal living areas (e.g., kitchen, bathroom, living room)	Self-isolation – High risk exposure

	• Household contacts as above who only had exposure to the case while the case **was self-isolating** and applying consistent and appropriate precautions as per the guidance "Self-isolation for cases/individuals in the household setting"	Self-monitoring – Medium risk exposure
Community	• Had direct contact with infectious body fluids of the case (e.g., coughed on or sneezed on) • Had close prolonged[1] contact while case **was not self-isolating**	Self-isolation – High risk exposure
	• Had prolonged[1] contact while the case **was self-isolating** as per the guidance "Self-isolation for cases/individuals in the household setting"	Self-monitoring – Medium risk exposure
	• Only transient interactions (e.g., walking by the case or being briefly in the same room)	No isolation required – No/low risk exposure
Healthcare	• Healthcare worker and/or support staff who provided care for the case, or who had other similar close physical contact **without** consistent and appropriate use of personal protective equipment[2]	Self-isolation – High risk exposure
	• Healthcare worker and/or support staff who provided care for the case, or who had other similar close physical contact **with** consistent and appropriate use of personal protective equipment[2]	Self-monitoring – Medium risk exposure
	• Laboratory worker processing COVID-19 specimens from case **without** appropriate PPE (including accidental exposures where appropriate PPE was breached).[2]	Self-isolation – High risk exposure
	• Laboratory worker processing COVID-19 specimens from case **with** appropriate PPE.[2]	Self-monitoring – Medium risk exposure
Conveyance (e.g., aircraft, train, bus)	• Passengers or airplane crew seated within 2 meters of the case (approximately two seats in all directions, depending on type of aircraft and seating) • Other passengers/crew with close prolonged[1] contact while case was not	Self-monitoring – Medium risk exposure

	wearing mask or direct contact with infectious body fluids	
	• Crew members who do not meet criteria above	No isolation required- No/low risk exposure
	• Other passengers seated elsewhere in cabin/car as case who do not meet above criteria.	No isolation required – No/low risk exposure
Travel to affected area	• Exposure to high risk location or setting and subject to an order under the federal *Quarantine Act*	Management at discretion of PHAC
	• Exposure by travelling outside of Canada in past 14 days[3]	Self-isolation – High risk exposure

[1] As part of the individual risk assessment, consider the duration and nature of the contact's exposure (e.g., a longer exposure time likely increases the risk), the case's symptoms (coughing or severe illness likely increases exposure risk) and whether personal protective equipment (e.g., procedure/surgical mask) was used.
[2] Refer to relevant guidance for health care professionals on what constitutes appropriate PPE for the type of interaction with the case. PHO IPAC guidance on PPE
[3] Health Care Workers returning from travel should not attend work if they are sick. If there are particular workers who are deemed critical, by all parties, to continued operations, these workers undergo regular screening, use appropriate Personal Protective Equipment (PPE) for the 14 days and undertake active self-monitoring. This includes taking their temperature twice daily to monitor for fever, and immediately self-isolate if symptoms develop and self-identify to their occupational health and safety department.

Contact tracing for airplane passengers

Decisions related to contact tracing individual air travelers who may have been exposed to a case of COVID-19 on a flight should be made based on a risk assessment conducted by the PHU to which the case is notified, considering the:

- case's classification (e.g. confirmed) and the type and severity of symptoms during the flight, and whether masked or not
- current messaging to all international travelers (e.g., to self-monitor, avoid crowds and public places etc.),
- timing of notification and likelihood of getting sufficient passenger contact information (i.e., within 14 days of flight),
- incremental benefit of individual communication to those seated within 2 metres of the case versus public communication of the flight number (with or without identification of the section of the plane where the case was seated).

There is no direct evidence at present that contacting individual air travelers/crew has facilitated early case finding. Nor is there evidence regarding transmission risk in relation to flight duration.

PHUs should send the following information to PHO (EPIR@oahpp.ca) if they identify a flight/cruise with a confirmed case:

- Flight number, date, departure location, arrival location, relevant rows
- Cruise line, dates of travel, departure port, arrival port

Table 2: Description of self-isolation and self-monitoring based on risk levels in Table 1.

Category	Actions for the individual	Public health monitoring/activities
Self-isolation – High risk exposure	• Do not attend school or work • Avoid close contact with others, including those within your home, as much as possible (see Preventing 2019-nCoV from spreading to others in homes and communities) • Have a supply of procedure/surgical masks available should close contact with others be unavoidable • Postpone elective health care until end of monitoring period • Use a private vehicle. Where a private vehicle is not available, private hired vehicle may be used while wearing a procedure/surgical mask and sitting in the rear passenger seat with the window open (weather permitting). Do not take public transportation. • Remain reachable for daily monitoring by local public health unit • Discuss any travel plans with local public health unit • If symptoms develop, ensure self-isolating immediately, and contact local public health unit and health care provider prior to visiting a health care facility	Intermittent monitoring for 14 days from last exposure (interval at discretion of PHU) Consider providing thermometer or assessing other needs/supports to facilitate self-isolation and monitoring of symptoms Provide handouts: Self-isolation "Preventing 2019-nCoV from spreading to others in homes and communities"

Self-monitoring – Medium risk exposure	• Self-monitor for fever and respiratory symptoms
	  ○ If symptoms develop, contact local public health unit and health care provider prior to visiting a health care facility
	  ○ Self-isolate immediately if symptoms develop
	• Avoid places where you cannot easily separate yourself from others if you become ill
	• Health care workers should inform their employer/institution of their exposure
	• Avoid social visits to areas with highly vulnerable individuals (e.g., visitors should not attend long-term care homes unless the resident is near end of life)
		Indicate they should self-monitor and contact local PHU if symptoms develop
		
		If symptoms develop consider for testing (if meet testing criteria) and/or refer to assessment centre or primary care physician
		
		Written information provided by public health unit on symptoms to watch for, timing of the self-monitoring period, and information on what to do if symptomatic
		
		Provide handouts: Self-monitoring

No/low risk exposure	None	No active follow-up required

Health care workers and self-isolation

- Health care workers who have been advised to self-isolate for a period of 14 days
  - If there are particular workers who are deemed critical, by all parties, to continued operations, it is recommended that these workers undergo regular screening, use appropriate PPE for the 14 days and undertake active self-monitoring, including taking their temperature twice daily to monitor for fever and any symptoms compatible with COVID-19, and immediately self-isolate if symptoms develop and self-identify to their occupational health and safety department
  - These workers should continue to follow self-isolation instructions outside of the workplace and in the home
  - These workers should not work in multiple locations

Contact follow-up and monitoring

- The period of monitoring is 14 days following last known exposure.
- The PHU can use the ***Daily Contact Clinical Update Form in*** Appendix 6 to monitor close contacts requiring active daily or intermittent monitoring
- All contacts should be informed of how to contact the PHU if they develop symptoms or have other questions.
    - A contact who becomes ill with any acute respiratory infection symptoms (e.g. cough) or fever within 14 days following last known exposure to the case should immediately self-isolate (if not already) and report their symptoms to the PHU. The PHU should consider testing for COVID-19 (if meet testing criteria) and advise the contact to self-isolate (until laboratory testing results are available). Detailed information on laboratory testing for COVID-19 is available at the PHO website and from local hospital and community laboratories providing COVID-19 testing.
        - For contacts with high risk exposures who become symptomatic, the PHU may initiate contact investigation and management (due to a high index of suspicion for becoming a case)
        - For contacts with high risk exposure who become symptomatic and their COVID-19 testing is negative, they should continue self-isolating until the end of their 14-day period in case their symptoms worsen and require reassessment/re-testing
        - For contacts with medium risk exposure who become symptomatic and their COVID-19 testing is negative, they should resume self-monitoring until the end of their 14-day period in case their symptoms worsen and require reassessment/re-testing
    - Contacts who become symptomatic and are not tested should follow the guidance above on isolation if they are isolating at home
    - Testing asymptomatic contacts for COVID-19 is not recommended at this time, but may be considered on a case-by-case basis.
        - In the event an asymptomatic contact tests positive for COVID-19, the PHU should manage this person as a presumptive confirmed/confirmed case (including the initiation of further case and contact management activities).
        - The contact tracing period for an asymptomatic case prior to their positive test result should be based on their likely date of exposure.
        - The PHU can remove an asymptomatic case from isolation after they have completed a 14-day isolation period without any symptoms or at the direction of the PHU if viral clearance specimens are required..
- The PHU should advise contacts to seek medical attention if symptoms develop and/ or call 911 if they require emergency care and inform paramedic services or health care provider(s) that they are a contact of a case.

- The PHU should advise contacts that if they develop symptoms, the PHU will ask them to follow self-isolation requirements
- For contacts who are self-isolating (high risk exposure), the PHU should ask about the contact's needs in order to be able to comply with these recommendations. This might include discussion with employers, making alternate arrangements to support children/dependents and ensuring an adequate supply of groceries and other necessities.
- All contacts should also consider these needs if they become symptomatic and need to isolate themselves

Travelers from outside of Canada

The Public Health Agency of Canada has advised travelers who have traveled outside of Canada in the past 14 days to limit contact with others, including self-isolation and staying at home, for 14 days from last exposure regardless of symptoms. Health Care Workers and Essential Service Workers returning from any destination outside of Canada are permitted to return to work upon their return from travel providing they are asymptomatic. These workers should self-monitor for symptoms and immediately self-isolate should symptoms develop.

Any returning traveler who presents with symptoms upon their arrival in Canada will be placed under federal Quarantine Orders.

Travelers under federal Quarantine Orders

Returning travelers who are under federal Quarantine Orders are subject to requirements of the Order.

Should an individual subject to a federal quarantine order require non-COVID related health care outside of a federal quarantine facility (e.g., if transfer from a federal quarantine facility to a local hospital is required, during the quarantine period), these individuals should be managed as having a high risk exposure requiring isolation, in consultation with local public health unit and local health care providers, including IPAC.

Table 3: Assessment and management of asymptomatic travelers

Travel outside of Canada in the past 14 days	Consider as 'High risk exposure'. Follow Table 2 – 'Self-isolation – High risk exposure' If the Government of Canada has gathered additional information on these individuals as they enter Canada and has forwarded that information to the province with

	contact information, this will be forwarded by PHO to the PHU where the individual is residing. Children who have travelled outside of Canada should self-isolate for 14 days and should not attend school/daycare
Travel within Canada	If individuals self-identify to their PHU with concern of risk of exposure within Canada: Determine based on the exposure history whether the individual should be recommended to self-monitor (medium risk exposure), self-isolate (high risk exposure), or no active follow-up (low/no risk exposure) as per Table 2.

Any returning travelers who develop symptoms should follow self-isolation guidance. If a returning traveler is tested and is negative, they should resume self-isolation for the remainder of their 14-day isolation period in case their symptoms worsen and require reassessment/re-testing.

Health Care Workers should not attend work if they are sick. If there are particular workers who are deemed critical, by all parties, to continued operations these workers should undergo regular screening, use appropriate Personal Protective Equipment (PPE) for the 14 days and undertake active self-monitoring. Active self-monitoring includes taking their temperature twice daily to monitor for fever, and immediately self-isolating if symptoms develop. Symptomatic health care workers should also self-identify to their occupational health and safety department.

Responsibilities

All PHUs:

- Keep updated on the COVID-19 case definitions (available on the ministry's Guidance for Health Care Workers and Health Sector Employers on 2019-nCoV website).
- Keep updated on the Government of Canada's COVID-19 Affected Areas list in order to inform decision making for patients who have travelled abroad
- Review the case and contact management guidance in this document.
- Ensure health care workers who may be engaged in case and contact management are aware of appropriate OHS & IPAC measures

PHUs with a probable or confirmed case within their jurisdiction:

- Enter case details in iPHIS as per iPHIS guidance. Conduct contact tracing to identify contacts of the case.
- Monitor case on a daily basis for the duration of illness and until cleared from self-isolation if viral clearance is required
- Provide information and monitoring of contacts based on their exposure level for 14 days following last known exposure to a case.
- Ensure close contacts of cases[3] are self-isolating for 14 days following the last exposure to the case.
- Ensure local health care workers are aware of appropriate screening, laboratory testing and IPAC & OHS measures.
- Support coordinated provincial communication activities.

PHO:

- Participate in the MEOC's response activities.
- Provide scientific and technical advice to stakeholders in areas such as laboratory testing, case and contact management information, reporting of case information using data entry in the integrated public health information system (iPHIS), outbreak management recommendations, and advice on clinical management and IPAC & OHS measures.
- Conduct provincial epidemiological surveillance and analyses.
- Provide laboratory testing for COVID-19.
- Transmit information received from PHAC to PHUs on returning travelers

Ministry of Health:

- Coordinate the response to COVID-19 in Ontario.
- Coordinate and participate in MEOC's response activities.
- Share information with the public.
- Receive notifications of PUIs.
- Report case details to PHAC.

Additional Resources

- Centers for Disease Control and Prevention's COVID-19 website
- European Centre for Disease Prevention and Control's COVID-19 website
- Ministry of Health's novel coronavirus website
- Provincial Infectious Diseases Advisory Committee's Tools for Preparedness: Triage, Screening and Patient Management of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) Infections in Acute Care Settings
- Public Health Agency of Canada's Emerging Respiratory Infection website
- Government of Canada's COVID-19 Affected Areas list

[3] This includes: probable and confirmed cases

- World Health Organization's Disease Outbreak News website
- World Health Organization's Global Alert and Response website
- World Health Organization's coronavirus

Appendix 1: Ontario's Severe Acute Respiratory Infection Case Report Form

iPHIS Case ID: _____

CLIENT RECORD

Last name: _____
First name: _____
Usual residential address: _____
_____
City: _____ Province/Territory: _____
Postal code: _____

Responsible Health Unit: _____
Branch office: _____

Diagnosing Health Unit: _____

Phone number(s): (_____) _____ - _____
(_____) _____ - _____

Date of Birth ____/____/_____ (dd/mm/yyyy)

PROXY Information

Is respondent a proxy? (e.g., for deceased patient, child)

☐No ☐ Yes (complete information below)

Last name:
_____
First name:
_____

Relationship to case:
_____

Phone number(s): (_____) _____ -
_____
(_____) _____ -
_____

Contact information for health unit person reporting

Name: _____
Telephone #: ( ) ____-_____
Email: _____

Emerging Pathogens and Severe Acute Respiratory Infection (SARI) Case Report Form

(2) ADMINISTRATIVE INFORMATION

□ Initial Report □ Updated Report	Report Date: ____/____/_____ (dd/mm/yyyy)
Outbreak or cluster related? □ Yes □ No If yes, local Outbreak #:_____ Number of ill persons associated with the outbreak: _____	**For Provincial Use Only** Has the outbreak been declared and made public? □Yes □ No If case is related to a provincial /territorial outbreak, P/T Outbreak ID:_____

(3) CASE DETAILS: DISEASE / AETIOLOGIC AGENT / SUBTYPE

□ Severe Acute Respiratory Infection □ Middle East respiratory syndrome coronavirus (MERS-CoV) □ COVID-19, Wuhan,China □ Other Novel Respiratory Pathogen *Specify:*_____ _____	□ Novel Influenza A □ H1__ □ H3__ □ H5__ □ H7__ □ Other: _____ □ Novel Influenza B _____

(4) CASE DETAILS: CASE CLASSIFICATION *(please refer to Ontario case definitions)*

□ Confirmed □ Presumptive Confirmed □ Probable

(5) CLIENT RECORD: DEMOGRAPHIC INFORMATION

Gender: □ Male □ Female □ Unk □ Other (sp): _____	Age:_____ years *If under 2 years* _____months □ Unk

Does the case identify as Aboriginal? □ Yes □ No □ Refused to answer □ Unk

If yes, please indicate which group: □ First Nations □ Metis □ Inuit

Does the case reside on a First Nations reserve most of the time? □ Yes □ No

□ Refused to answer □ Unk

(6) SYMPTOMS *(check all that apply)*

Date of onset of first symptom(s): ____/____/_____ (dd/mm/yyyy)

□ Fever (≥38°C)	□ Swollen lymph nodes	□ Shortness of breath/difficulty breathing	□ Nose bleed
□ Feverish (temp. not taken)	□ Sneezing	□ Chest pain	□ Rash
□ Cough	□ Conjunctivitis	□ Anorexia/decreased appetite	□ Seizures
□ Sputum production	□ Otitis	□ Nausea	□ Dizziness
□ Headache	□ Fatigue/prostration	□ Vomiting	□ Other, specify: _____
□ Rhinorrhea/nasal congestion	□ Malaise/chills	□ Diarrhea	□ No Symptoms
□ Sore throat	□ Myalgia/muscle pain	□ Abdominal pain	
	□ Arthralgia/joint pain		

(7) SYMPTOMS, INTERVENTIONS, and OUTCOME

Date of first presentation to medical care: ____/____/_____ (dd/mm/yyyy)

Clinical Evaluations *(check all that apply)*

□ Altered mental status
□ Arrhythmia
□ Clinical or radiological evidence of pneumonia
□ Diagnosed with Acute Respiratory Distress Syndrome
□ Encephalitis
□ Hypotension
□ Meningismus/nuchal rigidity
□ O2 saturation ≤95%
□ Renal Failure
□ Sepsis
□ Tachypnea (accelerated respiratory rate)
□ Other (specify): _____

Case Hospitalized? □ Yes □ No □ Unk
Diagnosis at time of admission: _____
Admission Date: ____/____/_____ (dd/mm/yyyy)
Re Admission Date: ____/____/_____ (dd/mm/yyyy)

Case admitted to Intensive Care Unit (ICU) □ Yes □ No □ Unk
ICU Admission Date: ____/____/_____ (dd/mm/yyyy)
ICU Discharge Date: ____/____/_____ (dd/mm/yyyy)

Patient isolated in hospital? □ Yes □ No □ Unk
If yes, specify type of isolation (e.g., respiratory droplet precaution, negative pressure):_____

Supplemental oxygen therapy □ Yes □ No □ Unk
Mechanical ventilation □ Yes □ No □ Unk
If yes, number of days on ventilation _____

Case Discharged from Hospital □ Yes □ No □ Unk
Discharge Date 1: ____/____/_____ (dd/mm/yyyy)

Case Transferred to another hospital □ Yes □ No □ Unk
Discharge Date 2: ____/____/_____ (dd/mm/yyyy)
Transfer Date: ____/____/_____ (dd/mm/yyyy)

Current Disposition □ Recovered □ Stable □ Deteriorating □ Deceased
____/____/_____ (dd/mm/yyyy)
If deceased, is post-mortem: □ Performed □ Pending □ None □ Unk
Respiratory illness contributed to the cause of death? □ Yes □ No □ Unk
Respiratory illness was the underlying cause of death? □ Yes □ No □ Unk
Cause of death *(as listed on death certificate)*: _____

(8) RISK FACTORS (check all that apply)

□None identified

Cardiac Disease □ Yes □ No □ Unk
If yes, please specify:

Hemoglobinopathy/Anemia □ Yes □ No □ Unk
If yes, please specify:

Hepatic Disease □ Yes □ No □ Unk
If yes, please specify:

Receiving immunosuppressing medications □ Yes □ No □ Unk
If yes, please specify:

Metabolic Disease □ Yes □ No □ Unk
If yes, please specify:

Substance use □ Yes □ No □ Unk
If yes, please specify:

□ Diabetes □ Obese (BMI > 30) □ Other:_____ _____		□ Smoker (current) □ Alcohol abuse □ Injection drug use □ Other:_____ _____	
Renal Disease *If yes, please specify:*	□ Yes □ No □ Unk	Malignancy *If yes, please specify:*	□ Yes □ No □ Unk
Respiratory Disease *If yes, please specify:* □Asthma □Tuberculosis □Other:_____ _____	□ Yes □ No □ Unk	Other Chronic Conditions *If yes, please specify:*	□ Yes □ No □ Unk
Neurologic Disorder *If yes, please specify:* □Neuromuscular Disorder □Epilepsy □Other:_____ _____	□ Yes □ No □ Unk	Pregnancy *If yes, week of gestation:*_____	□ Yes □ No □ Unk
Immunodeficiency disease / condition *If yes, please specify:*	□ Yes □ No □ Unk	Post-Partum (≤6 weeks)	□ Yes □ No □ Unk

(9) TREATMENT *(submit additional information on a separate page if required)*

Did the case receive prescribed prophylaxis prior to symptom onset? □ Yes □ No □ Unk	Specify name:_____ date of first dose*:* ____/____/_____ (dd/mm/yyyy) date of last dose*:* ____/____/_____ (dd/mm/yyyy)
In the treatment of this infection, is the case taking: □ Antiviral medication □ Antibiotic/antifungal medication □ Immunosuppressant/immunomodulating medication □ Unknown □ None □ Other	Specify name (1):_____ date of first dose (1)*:* ____/____/_____ (dd/mm/yyyy) date of last dose (1)*:* ____/____/_____ (dd/mm/yyyy) Specify name (2):_____ date of first dose (2)*:* ____/____/_____ (dd/mm/yyyy) date of last dose (2)*:* ____/____/_____ (dd/mm/yyyy)

(10) INTERVENTIONS: IMMUNIZATIONS

Did the case receive the <u>current</u> year's seasonal influenza vaccine? □ Yes □ No □ Unk □ Vaccine not yet available	*If yes,* date of vaccination: ____/____/_____ (dd/mm/yyyy)

Did the case receive the previous year's seasonal influenza vaccine? □ Yes □ No □ Unk

Did the case receive pneumococcal vaccine in the past? □ Yes □ No □ Unk
If yes, year of most recent dose: ____/____/_____ (dd/mm/yyyy)
If yes, type ☐ polysaccharide or ☐ conjugate: 7 or 13

(11) LABORATORY INFORMATION

Microbiology / Virology / Serology *(complete if applicable)*

Lab ID	Date Specimen Collected	Specimen Type & Source	Test Method	Test Result	Test Date

Antimicrobial Resistance of suspect etiological agent(s) *(complete if applicable)*

Lab ID	Name of Antimicrobial	Specimen Type & Source	Test Method	Test Result	Test Date

(12) EXPOSURES *(add additional details in the comments section as necessary)*

Travel

In the 14 days prior to symptom onset, did the case travel outside of their province/territory of residence or outside of Canada? ☐Yes ☐No ☐ Unk
If yes, please specify the following (submit additional information on a separate page if required)

	Country/City Visited	Hotel or Residence	Dates of Travel
Trip 1			
Trip 2			

In the 14 days prior to symptom onset, did the case travel on a plane or other public carrier(s)? □ Yes □ No □ Unk

If yes, please specify the following

Travel Type	Carrier Name	Flight / Carrier #	Seat #	City of Origin	Dates of Travel

Human

In the 14 days prior to symptom onset, was the case in close contact (*cared for, lived with, spent significant time within enclosed quarters (e.g., co-worker) or had direct contact with respiratory secretions)* with:

A confirmed case of the same disease? □ Yes □ No □ Unk
If yes, specify the Case ID:_____
A probable case of the same disease?

If yes, specify disease:_____ and specify the Case ID:_____ □ Yes □ No □ Unk

A person who had fever, respiratory symptoms like cough or sore throat, or respiratory illness like pneumonia? □ Yes □ No □ Unk

If yes, specify the type of contact:

□ Household member
□ Person who travelled outside of Canada
□ Person who works in a healthcare setting
□ Person who works in a laboratory
□ Other (specify):_____
□ Works with Patients
□ Person who works with animals

Where did exposure occur?

□ In a household setting
□ School/daycare
□ Farm
□ Other (please specify)
□ In a health care setting (e.g., hospital, long-term care home, community provider's office)
□ Other institutional setting (dormitory, shelter/group home, prison, etc.)
□ In means of travel (place, train, etc.)

Occupational / Residential

The case is a:

□ Health care worker or health care volunteer
If yes, with direct patient contact? □ Yes □ No □ Unk
□ Resident in an institutional facility *(dormitory, shelter/group home, prison, etc.)*
□ Laboratory worker handling biological specimens
□ Veterinary worker
□ School or daycare worker/ attendee
□ Farm worker
□ Resident of a retirement residence or long-term care facility
□ Other:

Animal

A. Direct Contact ***(touch or handle)***

In the 14 days prior to symptom onset, did the case have <u>direct contact</u> with any animals or animal products *(faeces, bedding/nests, carcass/fresh meat, fur/skins, camel milk, etc.)*? □ Yes □ No □ Unk

If yes, specify date of last direct contact: ____/____/_____ (dd/mm/yyyy)

What type of animals did the case have direct contact with? *(check all that apply)*

□ Cat(s) □ Dogs □ Horses □ Cows □ Poultry □ Sheep / Goat □ Wild Birds □ Rodents □ Swine □ Camel □ Snakes/ reptiles
□Wild game (eg. Deer) □ Bats □ Other:_____

Did the animal display any symptoms of illness or was the animal dead? □ Yes □ No □ Unk

Where did the direct contact occur? *(check all that apply)*

□ Home □ Work *(fill in occupational section)*□ Agricultural fair or event/petting zoo
□ Outdoor work/recreation (camping, hiking, hunting etc.) □ Other:_____

B. Indirect Contact ***(e.g., visit or walk through or work in an area where animals are present, etc.)***

In the 14 days prior to symptom onset, did the case have <u>indirect contact</u> with animals? □ Yes □ No □ Unk

If yes, specify date of last indirect contact: ____/____/_____ (dd/mm/yyyy)

Where did the indirect contact occur? *(check all that apply)*

□ Home □ Work *(fill in occupational section)* □ Agricultural fair or event/petting zoo

□ Outdoor work / recreation (camping, hiking, hunting, etc.)

□ Market where animals, meats and/or animal products are sold

□ Other:_____

(13) ADDITIONAL DETAILS/COMMENTS *(add as necessary)*

Appendix 2: Routine Activities Prompt Worksheet – Case[4]

When interviewing a case, ensure that the following activity prompts are considered to identify a possible source of infection within the 14 days prior to the onset of symptoms: work; school; visitors at home; volunteer activities; daycare; religious activities; social activities (restaurants, shopping); sports; visits to acute care settings, long-term care homes, retirement homes, medical labs, dentists, and other health care providers; contact with ill persons; and contact with birds/swine or other animals.

Date of Onset: _____ (Create an acquisition exposure for each activity)

Case Last Name: _____ Case First Name: _____ Date of Birth: _____ Gender: _____

PHU representative: _____

Date/Time (Start and End)	Activities/Contacts	Location of Activity	Contact Person (Name & Tel)	Comments

[4] Adapted with permission from Toronto Public Health

Date/Time (Start and End)	Activities/Contacts	Location of Activity	Contact Person (Name & Tel)	Comments

Appendix 3: Daily Clinical Update Form – Case Managed in an Acute Care Setting

Case Last Name: _____ Case First Name: _____ Date of Birth: _____ Gender: _____

(yy/mm/dd)

	Follow-up Date/ Time (YEAR/ MM/DD)	Purpose (1)	Admission Date (YEAR/ MM/DD)	Discharge Date (YEAR/ MM/DD)	Facility Name (Progression Recovery Location) (2)	Facility Type (3)	Class (4)	Progression (Clinical) (5)	Progression					PHU representative
									ICU (Y/N/DK)	Antiviral Drugs (Y/N/DK)	Oxygen Saturation	Temp	On Oxygen (Y/N/DK)	
Progression														

1) Purpose

C = Convalescing
D = Diagnostics
I = Isolation
T= Treatment

(2) Facility Name - Progression Recovery Location

Enter facility name or
DK = Don't know

(3) Facility Type

Hosp = Hospital
LTC = Long-term care
Home = person is at home
DK = Don't know

(4) Classification

C= Confirmed
P = Probable
PUI = Person Under Investigation
DNM = Does Not Meet case definition

5) Progression – Clinical

CC = Case Closed. Completed home isolation after discharged from hospital or no longer being followed.
D = Deceased
DC = Discharged
I = Improving
II = Improving (Intubated)
S = Stable
SI = Stable (Intubated)
W = Worsening
WI = Worsening (Intubated)
EX = Extubated

Notes:

Appendix 4: Daily Clinical Update Form – Case Managed in a Household Setting

Case Last Name: _____ Case First Name: _____ Date of Birth: _____ Gender: _____

(yy/mm/dd)

PHU representative: _____

Date	Symptoms (please indicate if present ☑ absent ⊗ or resolved (R))									Complications		Specimens/Diagnostics			Treatment/Supportive Therapy	
	No Symptoms	Fever > 38	Cough	Shortness of	Diarrhea	Runny nose	Malaise	Chest pain	Other	Pneumonia	Other (specify)	Nasopharyngeal swab	Chest xray	Other (specify)	Medication	Other (specify)

Appendix 5: Close Contact Tracing Worksheet[5]

When interviewing a case to identify potential close contacts, consider all individuals that could have had exposure since the case was symptomatic. See the Close Contact Tracing section for the definition of a close contact. Use the following activity prompts to help identify potential close contacts: work; school; visitors at home; volunteer activities; daycare; religious activities; social activities (restaurants, shopping); sports; visits to acute care settings, long-term care homes, retirement homes, medical labs, dentists, and other health care providers; contact with ill persons; and contact with birds/swine or other animals.

Date of Onset: _____

Case Last Name: _____ Case first Name: _____ Date of Birth: _____ Gender: _____ (yy/mm/dd)

PHU representative: _____

Date/Time (Start and End)	Activities	Location of Activity	Name & contact information of potential close contacts	Comments

[5] Adapted with permission from Toronto Public Health

Date/Time (Start and End)	Activities	Location of Activity	Name & contact information of potential close contacts	Comments

Appendix 6: Close Contact Daily Clinical Update Form

Contact Last Name: _____ Contact First Name: _____ Date of Birth: _____ Gender: _____ (yy/mm/dd)

PHU representative: _____

Follow-up Date/Time (YEAR/MM/DD and 24 Hour Clock)	Symptoms? (Y/N)	If yes, please specify (e.g., fever >38; cough, difficulty breathing, headache, fatigue, sore throat, chills, muscle pain, nasal congestion, nausea, vomiting, diarrhea, joint pain, decreased appetite)	Did contact seek medical attention for ARI symptoms? (Y/N)	If yes, please specify where contact went to seek attention (e.g., primary health care, home care, acute care, etc.)

Follow-up Date/Time (YEAR/MM/DD and 24 Hour Clock)	Symptoms? (Y/N)	If yes, please specify (e.g., fever >38; cough, difficulty breathing, headache, fatigue, sore throat, chills, muscle pain, nasal congestion, nausea, vomiting, diarrhea, joint pain, decreased appetite)	Did contact seek medical attention for ARI symptoms? (Y/N)	If yes, please specify where contact went to seek attention (e.g., primary health care, home care, acute care, etc.)