Ontario

Ministry of Health

COVID-19 Provincial Testing Guidance Update

V. 9.0 November 20, 2020

This document is an update to the COVID-19 Provincial Testing Guidance Update issued September 24, 2020. This document also adds to the Quick Reference Public Health Guidance on Testing and Clearance. This information is current as of November 20, 2020 and may be updated as the situation on COVID-19 continues to evolve. The following updated testing guidance should be used as appropriate.

It is expected that this guidance will be consistently applied across all regions in Ontario to help guide decision making regarding COVID-19 testing of further priority population groups, in conjunction with other setting-specific guidance as appropriate.

Updates to this document include:

- New information on PCR and serology testing under the Laboratory and Specimen Collection Centre Licensing Act (page 2/3)
- Information on rapid testing (page 3)
- New guidance on the appropriate technologies for testing and ensuring all test results performed by a licensed laboratory are entered into OLIS (page 4)
- Updated information on targeted testing initiatives and rapid antigen pilot (page 6)
- Clarify that testing prior to surgery in high transmission regions applies to settings beyond hospitals (page 8)
- Guidance for Priority Populations section removed and embedded throughout document

Types of tests available

There are three types of tests available in the province of Ontario:

1. **Molecular testing: nucleic acid amplification test (e.g., polymerase chain reaction (PCR) test) detects virus or viral fragments**
    a. Purpose: Molecular testing is used for diagnostic purposes only.
    b. Preferred and Acceptable Specimen types: nasopharyngeal swab (NPS) is the preferred specimen due to its high sensitivity. Although less sensitive, acceptable specimens (in descending order) when an NPS is contraindicated or unavailable, include a combined swab of throat and both nares or deep nasal swab, followed by anterior nares (both nostrils) or oropharyngeal (throat) swab. Saliva samples are also acceptable in non-hospitalized patients. A lower respiratory tract specimen (e.g. sputum, tracheal aspirate) is the preferred specimen in seriously ill patients.
2. **Serology testing: detects antibodies to SARS-CoV-2**
    a. Purpose: Serology testing is available for clinical use under specific clinical indications. **Serology should NOT be used for screening and diagnosis of acute COVID-19 infection or determining immune status.** A positive serology test does NOT mean a patient is immune to COVID-19. Diagnostic testing for acute COVID-19 infection should be done using a validated PCR assay.
    b. Clinical indications for serology testing:
        i. Patients presenting with symptoms compatible with Multisystem Inflammatory Syndrome in Children (MIS-C) who do not have laboratory confirmation of COVID-19 by PCR.
        ii. Testing may be considered for patients with severe illness who have tested negative for COVID-19 by PCR and where serology testing would help inform clinical management and/or public

health action. Serology testing for these patients requires consultation and approval by the testing laboratory.

3. **Point of Care Testing**

A positive result on a rapid test is considered a preliminary positive and should also have a parallel sample taken for a laboratory-PCR test to act as a confirmatory test. In some circumstances, confirmatory laboratory-based molecular testing and/or repeated antigen testing may be advised for negative antigen tests due to the risk of false negatives.

   a. **Rapid Molecular**

      i. Purpose: Molecular testing is for diagnostic testing purposes only.

      ii. Specimen types: Upper respiratory tract specimen, which can be collected using a nasopharyngeal (NP) or other swabs approved by Health Canada and validated by PHO. (Refer to 1b above for preferred specimen types).

   b. **Rapid Antigen**

      i. Purpose: Antigen testing is used for screening purposes only. **Antigen testing should NOT be used for diagnosis of acute COVID-19 infection.**

      ii. Specimen types: Upper respiratory tract specimen, which can be collected using a nasopharyngeal (NP) or other swabs approved by Health Canada and validated by PHO. (Refer to 1b above for preferred specimen types).

For all test types:

All testing must be performed on technologies approved by Health Canada (HC) or otherwise validated by the licensed laboratory (i.e., laboratory-developed test or research use only test), and must be used, processed, and interpreted in compliance

with the manufacturer's instructions or laboratory-established protocol. Laboratories used to collect specimens and conduct testing must be licensed under the *Laboratory and Specimen Collection Centre Licensing Act* LSCCLA.

All test results performed by a licensed laboratory must be uploaded as per Ontario Health guidelines accompanied with minimum data elements required for laboratory results and uploaded into the Ontario Laboratory Information System (OLIS) as per Ontario Health guidelines. All positive and preliminary positive COVID-19 tests performed using a Health Canada approved test or an assay validated by the laboratory must be reported to the local public health unit as per the LSCCLA's Reg 682 and Health Protection and Promotion Act. Reporting of positive results must be in accordance with CMOH guidance.

All rapid tests must be performed by a licensed specimen collection centre or a laboratory licensed under the LSCCLA. All clinical testing in Ontario must be performed at a laboratory licensed under the LSCCLA or by certain regulated health professionals that are specifically exempt from the licensing requirements of the LSCCLA.

Guidance for Symptomatic Individuals

Any Ontarian presenting with at least one symptom or sign from the COVID-19 Reference Document for Symptoms should be considered for PCR testing for COVID-19. Clinicians should continue to use their clinical judgement during patient assessment and test facilitation, considering local epidemiology and exposure risks.

Influenza testing

The following populations who are symptomatic with acute respiratory infection (ARI) are eligible for molecular testing for influenza:

- Symptomatic hospitalized patients
- Outbreak investigations (up to 4 specimens from symptomatic patients only). This includes symptomatic residents, staff and/or essential visitors in an

institutional/congregate living setting (e.g., long-term care homes, retirement homes, correctional facilities, shelters, group homes) with ARI. For additional testing in outbreak settings, contact PHO's Laboratory Customer Service Centre and reference PHOs Respiratory Virus Testing Update.

- Persons residing in remote communities

When completing the PHO Laboratory COVID-19 Virus Test Requisition Form, the appropriate test should be selected in the "Test(s) Requested" (box 5) – either COVID-19 virus alone or also including other respiratory viruses (if influenza and/or other respiratory virus testing is also requested).

Guidance for Asymptomatic Individuals

Only high-risk asymptomatic individuals or individuals from targeted testing groups or participating in a workplace rapid antigen screening pilot should be considered for testing as follows:

1. Contacts of confirmed positive cases:

Asymptomatic contacts of a confirmed case should be considered for testing at an assessment centre within 14 days from their last exposure or notification from the COVID Alert app.

- Contacts who have had ongoing exposure to the case while they have been infectious, or who had similar acquisition exposures as the case, should be tested as soon as possible
- Contacts who are part of an outbreak investigation should be tested as soon as possible
- Contacts who were only exposed to the case and who do not share acquisition exposures should be tested at least 5-7 days after their exposure to the case (median incubation period). Testing at day 10-14 is more likely to yield whether the contact has become an asymptomatic case.

If the test result is negative, asymptomatic contacts must remain in self-isolation for 14 days from their last exposure to the case. If an asymptomatic contact tests negative and then subsequently becomes symptomatic, they should be re-tested.

2. Outbreak Investigations:

Asymptomatic workers and residents at specific outbreak sites may be considered for testing at the direction of public health. These individuals should be directed to seek testing at an assessment centre.

3. Targeted Testing Groups:

Asymptomatic individuals without known high-risk exposures or part of outbreak investigations, but from certain populations may be considered for testing. These individuals should be directed to seek testing at an approved specimen collection location.

This includes any individual identified as part of a targeted testing campaign as directed by the Ministry of Health, Ministry of Long-Term Care, Ministry of Seniors and Accessibility or by local public health as listed:

1. Workers or visitors of long-term care homes
2. Workers of retirement homes
3. Residents or workers in homeless shelters or other congregate settings
4. International students that have passed their 14-day quarantine period
5. Farm workers
6. Individuals who identify as Indigenous
7. Patients with preliminary positive results obtained through rapid antigen testing

4. Rapid Antigen Pilot

Asymptomatic individuals who are part of a workplace that are participating in a rapid antigen screening pilot are eligible for testing.

Guidance for Specific Settings

1. Facility Transfers

Any patient transferred between facilities (i.e. leaving one facility and entering another, even within same multi-site organization, regardless of symptomology), should be tested upon admission to the destination facility. For patients entering a residential treatment facility (e.g. a mental health or addiction program), testing should also be conducted prior to admission into the program.

Examples include, but are not limited to:

- Admission to hospital from another hospital, long-term care home, retirement home or other congregate living setting/institution (including group homes and equivalent higher-risk settings)
- Transfers from, or repatriation to community hospitals and regional tertiary/quaternary centres; or
- Transfers from an acute site to a post-acute site (e.g. patient transferred to complex continuing care/rehab) within a multi-site organization

There are two exclusions to the above guidance:

1. The first in relation to Directive #3, outlining that tests and results should be reported prior to transfers from hospitals to long-term care, retirement homes and hospices

2. The second in relation to newborn infants (<48 hours old at time of transfer) born to women who are asymptomatic and screen negative. Such newborns should be considered exempt from routine COVID-19 testing on admission to the destination facility. See Appendix A on newborn testing.

Any individuals who have previously tested positive for COVID-19 and have since recovered do NOT need to be tested prior to or after transfer between facilities, unless they have had a new high-risk exposure and symptoms. The decision to test should use clinical judgment and/or be at the discretion of public health.

2. Hospitals

Testing prior to a scheduled (non-urgent/emergent) surgery in a hospital or other surgical setting:

- A regional approach to testing prior to scheduled surgery should be adopted, after review of local epidemiology and risk assessment by COVID-19 Regional Steering Committee/Response Table.
- For areas with low community transmission of COVID-19, testing prior to a scheduled surgical procedure is not required.
- In areas where community transmission of COVID-19 is not low, any patient with a scheduled surgical procedure requiring a general anaesthetic should be tested 24-48 hours prior to procedure date. This includes any setting where a surgical procedure is taking place (e.g., hospital, independent health facility, etc.).
- Patients should self-isolate for a period of at least 14 days prior to a scheduled procedure.
- In the event of a positive test result, the scheduled non-urgent/emergent procedure should be delayed for a period of at least 10 days and until cleared by public health.

Testing of hospitalized patients:

In the event a patient develops **laboratory-confirmed COVID-19**, within a 14-day period where the case could have reasonably acquired their infection in the hospital, and the patient was not cared for on Droplet/Contact Precautions, asymptomatic contacts of the confirmed patient, determined in consultation with the hospital's Infection Prevention and Control and Occupational Health, should be tested including:

- All patients on the unit/care hub
- All staff working on the unit/care hub while the patient was not on Droplet/Contact Precautions
- All essential visitors that attended the unit/care hub

- Any other contacts deemed appropriate for testing based on a risk assessment by infection prevention and control

Infection Prevention and Control/Occupational Health may also, based on a risk assessment, determine if any additional testing is required, or whether any of the above-mentioned individuals do not require testing.[1]

In asymptomatic persons, a negative result should not change infection control management as the individual may still be in the 14-day incubation period.

In the event a hospitalized patient is diagnosed with community acquired **laboratory-confirmed COVID-19**, and the patient was not cared for on Droplet/Contact Precautions, asymptomatic contacts of the confirmed patient, while the confirmed patient was infectious, should be tested, determined in consultation with Infection Prevention and Control and Occupational Health:

- Any patient in the same patient care area when the case was not under Droplet and Contact precautions
- Any staff who cared for the patient who had close prolonged contact within 2 meters not wearing appropriate personal protective equipment, and the case was not wearing a mask

Infection Prevention and Control/Occupational Health may also, based on a risk assessment, determine if any additional testing is required, or whether any of the above-mentioned individuals do not require testing.

In asymptomatic persons, a negative result should not change infection control management, as the individual may still be in the 14-day incubation period.

[1] Note: Testing recommendations based on a single case are at the direction of the acute care Infection Prevention and Control and Occupational Health. If an outbreak is declared, additional testing recommendations are determined by the Outbreak Management Team including the local public health unit.

3. Long-Term Care and Retirement Homes

Definitions:

- **Long-term care/nursing homes**: Health care homes designed for adults who need access to on-site 24-hour nursing care and frequent assistance with activities of daily living
- **Retirement homes**: Privately-owned, self-funded residences that provide rental accommodation with care and services for seniors who can live independently with minimal to moderate support

In the event a resident living in a long-term care or retirement home develops symptoms compatible with COVID-19, asymptomatic residents living in the same room should be tested immediately along with the symptomatic resident under the direction of local public health.

In the event an outbreak of COVID-19 is declared in the home, all staff in the entire home **and** all residents in the LTCH must be tested. Any exception to this must be approved by the Chief Medical Officer of Health.

In asymptomatic persons who have been identified as a close contact of a known case, a negative result should not change public health management as the individual may still be in the 14-day incubation period.

Re-testing of asymptomatic individuals who initially test negative, is recommended if they develop symptoms.

In general, asymptomatic persons who have previously had a laboratory-confirmed case of COVID-19 and have since recovered do NOT require testing, unless otherwise directed by local public health. Testing is recommended if they become symptomatic.

In the event of ongoing transmission in an outbreak, repeating testing of asymptomatic residents and staff who initially tested negative in the outbreak may be advised by the local public health unit to assess for additional asymptomatic/pre-symptomatic cases in an outbreak.

4. Other Congregate Living Settings and Institutions

Definition: Other congregate living settings and institutions include homeless shelters, group homes, community supported living, disability-specific communities/congregate settings, short-term rehab, hospices, and other shelters.

Note: correctional facilities should follow sector-specific guidance on testing.

In the event of an outbreak declared in the setting, all staff in the facility AND all residents/attendees in the facility should be tested under the direction of local public health. Local public health may also, based on a risk assessment, determine if any additional testing is required or, whether any of the above-mentioned individuals do not require testing.

In asymptomatic persons, a negative result should not change public health management as the individual may still be in the 14-day incubation period.

Re-testing of asymptomatic individuals who initially test negative, is recommended if they develop symptoms.

In general, asymptomatic persons who have previously had a laboratory-confirmed case of COVID-19 and have since recovered do NOT require testing, unless otherwise directed by local public health. Testing is recommended if they become symptomatic.

In the event of ongoing transmission in an outbreak, repeating testing of asymptomatic persons who initially tested negative in the outbreak may be advised by the local public health unit to assess for additional asymptomatic/pre-symptomatic cases in an outbreak.

Asymptomatic patients transferred from a hospital to a hospice setting must be tested and results received prior to transfer, unless previously positive.

5. Remote/Isolated/Rural/Indigenous Communities

In the event of a confirmed case of COVID-19 in a remote, isolated, rural or Indigenous community testing of contacts at low-risk of exposure, in addition to contacts at high-risk of exposure, should be considered in consultation with the local public health unit.

6. Workplaces and Community Settings – Enhanced Contact-Based Testing

In the event of **one laboratory-confirmed case of COVID-19** identified in a workplace or community setting (e.g. religious gathering, recreational centre) during their period of communicability, exposed individuals in the workplace or community setting, determined in consultation with local public health, should be tested including:

- Any close contacts of the case
- In settings where contacts are difficult to determine, broader testing may be considered at the discretion of local public health

In the event of an **outbreak in a workplace or community setting**, as determined by local public health, all individuals associated with the outbreak area should be considered for testing.

In asymptomatic persons, a negative result should not change public health management as the individual may still be in the 14-day incubation period.

In general, asymptomatic persons who have previously had a laboratory-confirmed case of COVID-19 and have since recovered do NOT require testing, unless otherwise directed by local public health.

In the event of ongoing transmission in an outbreak, repeating testing of asymptomatic persons who initially tested negative in the outbreak may be advised by the local public health unit to assess for additional asymptomatic/pre-symptomatic cases in an outbreak.

7. Other Populations

Definition: Patients requiring frequent contact with the healthcare system due to the nature of their current course of treatment for an underlying condition (e.g. patients undergoing chemotherapy/cancer treatment, dialysis, pre-/post-transplant, pregnant persons, neonates).

Specific guidance (including asymptomatic groups) has been developed for the following populations:

- Newborn testing – See Appendix A
- Testing for Cancer Patients- See Appendix B
- Testing for Hemodialysis Patients – See Appendix C

Appendix A:

Testing Newborns

Newborns born to mothers with confirmed COVID-19 at the time of birth should be tested for COVID-19 within 24 hours of delivery, regardless of symptoms.

If maternal testing is pending at the time of mother-baby dyad discharge, then follow-up must be ensured such that if maternal testing is positive the baby is tested in a timely manner. If bringing the baby back for testing is impractical, the baby should be tested prior to discharge.

Newborns currently in the NICU/SCN born to mothers with confirmed COVID-19 at the time of birth should be tested within the first 24 hours of life and, if the initial test is negative, again at 48 hours of life, regardless of symptoms.

Appendix B:

Testing Asymptomatic Cancer Patients

Routine testing of all patients prior to Radiation or Systemic treatment is not recommended but instead a regional approach should be adopted after reviewing local epidemiology by regional COVID response committees. In regions with low community transmission of COVID-19, routine testing prior to treatment is not required but should be done at the discretion of the treating physician if he/she feels it is necessary or indicated, in particular when:

- High dose multidrug chemotherapy is planned
- Radiation treatment will involve treatment of lung tissue
- Treatment is planned in patients with a new ground glass lung opacity

- Treatment (Radiation or Systemic) is planned in patients who are significantly immunosuppressed)

Recommendations for Hematopoietic Cell Therapy (HCT)

1) All patients booked for hematopoietic cell therapy should be tested 24-48 hours before their appointment apart from exceptional circumstances (e.g., Priority A case requiring urgent same day treatment).

Appendix C:

Testing for Hemodialysis Patients

1. **Testing for symptomatic in-centre hemodialysis patients**
    - Test symptomatic patients using a low-threshold approach, incorporating "atypical symptoms"
    - Patients with persistent respiratory symptoms or fever despite a negative test should be managed on Droplet and Contact Precautions and be tested as appropriate, based on clinical judgement.
2. **Testing for in-centre hemodialysis patients who reside in LTC/retirement homes (~450 patients total) or other congregate living settings**
    - Given that there have been no new cases of COVID-19 detected in in-centre hemodialysis patients residing in LTC homes since the first week of June 2020, periodic testing of asymptomatic patients from LTC or retirement homes is not at present recommended where the patient's home does not have known cases.
    - Surveillance testing of hemodialysis patients from LTC/retirement homes with known cases or outbreaks should continue regularly until the outbreak is considered cleared.
    - If a LTC/retirement home patient comes from a home where there is or subsequently has a declared COVID-19 outbreak and the patient becomes a laboratory-confirmed case, decisions around additional testing of asymptomatic patients and staff should be left to the discretion of local infection prevention and control as testing decisions will be informed by the size and layout of the unit.
    - Testing for in-centre hemodialysis patients who reside in LTC or retirement homes to be conducted in the hemodialysis unit, or in accordance with hospital and local Public Health protocols, if not already done in in the home.

There may be consideration given to periodic testing of staff not known to be positive, however, this should be coordinated with the ongoing active testing occurring in the homes. However, this should not be used as a basis for additional precautions in the homes, such as isolation and droplet precautions for these patients in a facility upon their return (e.g. long-term care homes).

3. **Testing for in-centre hemodialysis patients in hemodialysis unit where outbreak declared**
    - If an outbreak is declared in a hemodialysis unit, test all patients in that unit regardless of whether they are symptomatic. In addition, all staff working in that hemodialysis unit must be tested.
    - Retesting should be directed by the outbreak management team overseeing the outbreak, in collaboration with local public health.