2019 Novel Coronavirus (COVID-19)
Public Health Management of cases and contacts
Yukon Communicable Disease Control
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# Interim Guidance: Public Health Management of Cases and Contacts Associated with Novel Coronavirus (COVID-19) in the Community

## Contents

## Background

*Yukon Communicable Disease Control (YCDC) has adapted this interim guidance document from the Public Health Agency of Canada (PHAC) for the public health management of human illness cause by the novel coronavirus (COVID-19) and BC Centre for Disease Control (BCCDC)* Interim Guidance: Public Health Management of cases and contacts associated with novel coronavirus (COVID-19) in the community.

*The strategy outlined in the guidance is aligned with a containment goal (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 the clinical spectrum, transmissibility, and epidemiology becomes available. This guidance builds upon relevant Canadian guidance developed for the current and previous coronavirus outbreaks (e.g. MERS CoV and SARS-CoV), in addition to available guidance from the World Health Organization (WHO)*[i].

*This guidance is also based upon current knowledge and it should be understood that guidance is subject to change as new data become available and new developments arise with this new virus; furthermore, unique situations may require some discretion in adjusting these guidelines which are meant to be supportive, not prescriptive.*

*This guidance should be read in conjunction with relevant territorial legislation, regulations, organizational polices as well as provider scope practice.* In Yukon, all aspects of management related to COVID-19 are coordinated by YCDC and Yukon's Chief Medical Officer of Health (CMOH) and/or the Deputy Chief Medical Officer of Health (DCMOH). For the purpose of this document Medical Officer of Health (MOH) will be used for either CMOH or DCMOH.

## Epidemiological Characteristics

| | |
|---|---|
| Clinical Characteristics | • Reported illnesses have ranged from infected people with mild to no symptoms, to severe illness, including death.<br>• At this time the progression seems to include initial symptoms that may be quite mild with worsening symptoms during the second week<br>• Common symptoms include:<br>o Fever, chills, cough, shortness of breath/difficulty breathing, sore throat, runny nose/congestion, loss of smell or taste, headache, muscle aches, fatigue, diarrhea, nausea and vomiting.<br>• Less common symptoms include:<br>o Dizziness, conjunctivitis, confusion, abdominal pain, rash on skin or discoloration of fingers or toes.<br>• WHO estimates that of all cases 82% will experience mild illness, 15% severe illness, and 3% critical illness. This is similar to the data that has been compiled from Canadian cases. |
| Treatment | • See Clinical management of patients with COVID-19: Second interim guidance |
| Period of Incubation | • Mean: 5 days<br>• Range: 2-14 days<br>• 14 days for clinical/public health purposes |
| Human to Human Transmission | • Contact & droplet<br>• Fomites (duration of virus survival could be days).<br>• Consider potential Fecal-oral transmission |
| Zoonotic Transmission | • Transmission from mink to humans has been reported in the Netherlands. The two identified human cases were mink farm workers and their infections were linked to mink cases through phylogenetic analysis and their exposure history. Outbreaks of SARS-CoV-2 in mink have been detected on mink farms in Europe (Denmark, the Netherlands, Spain) and in the United States (Utah).<br>• There is currently no evidence that other domestic animals (livestock or pets) are a source of transmission.<br>• At this time, there is evidence that bats, cats, dogs, mink, ferrets, hamsters, mink, non-human primates and rabbits have some level of susceptibility to infection with SARS-CoV-2 and may develop illness. |
| Period of Communicability | • Period of communicability is considered to be 72 to 48 hours prior to onset of symptoms and at least 10 days after onset of symptoms. Contact tracing efforts should consider all individuals with whom a case had contact prior to isolation, beginning up to 72 hours prior to the case developing initial symptoms of COVID-19.<br>• Prior of communicability and discontinuation of isolation depends on the patient and setting. See text for further discussion.<br>• Coughing may persist for several weeks and does not mean the individual is infectious and must self-isolate. |
| Diagnostics | • See Surveillance Case Definitions |

## Surveillance Case Definitions

| Surveillance Case Definitions[ii] | | Reportable YCDC |
|---|---|---|
| **PUI (person under investigation)** | A person for whom a laboratory test for COVID-19 has been ordered or is expected to be ordered. | Yes |
| **Probable** | A person who:<br>Has symptoms compatible with COVID-19 (See clinical characteristics)<br>**AND**<br>• Had a high-risk exposure with a confirmed COVID-19 case (i.e. close contact) OR was exposed to a known cluster or outbreak of COVID-19<br>**AND**<br>• Has not had a laboratory-based NAAT assay for SARS-CoV-2 completed or the result is inconclusive<br>**OR**<br>Had SARS-CoV-2 antibodies detected in a single serum, plasma, or whole blood sample using a validated laboratory-based serological assay for SARS-CoV-2 collected within 4 weeks of symptom onset<br>**OR**<br>Had a POC NAAT or POC antigen test for SARS-CoV-2 completed and the result is preliminary (presumptive) positive<br>**OR**<br>• Had a validated POC antigen test for SARS-CoV-2 completed and the result is positive | Yes |
| **Confirmed** | A person with confirmation of infection with SARS-CoV-2 documented by:<br>• The detection of at least one specific gene target by a validated laboratory-based nucleic acid amplification test (NAAT) assay (e.g. real-time PCR or nucleic acid sequencing) performed at a community, hospital, | Yes |

| | | |
|---|---|---|
| continued.. | or reference laboratory (the National Microbiology Laboratory or a provincial public health laboratory)<br>**OR**<br>• The detection of at least one specific gene target by a validated point-of-care (POC) nucleic acid amplification test (NAAT) that has been deemed acceptable to provide a final result (i.e. does not require confirmatory testing)<br>**OR**<br>Seroconversion or diagnostic rise (at least four-fold or greater from baseline) in viral specific antibody titre in serum or plasma using a validated laboratory-based serological assay for SARS- CoV-2 | continued.. |
| **Confirmed** | | Yes |

**Note:** Definitions above reflect surveillance criteria and does not reflect clinical criteria where testing for COVID-19 is recommended and reporting to MOH/YCDC is required, as soon as possible.

**Note:** Case definitions and exposure criteria are subject to change. YCDC assigns classification using the most recent PHAC definitions for affected area, exposure criteria as well as confirmed, probable, and suspect. Published case definitions can be found at www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/national-case-definition.html.

Front line health care providers must notify YCDC of any possible cases where further follow up, including testing, may be clinically warranted (as well as all, PUI, suspect, probable or confirmed) in accordance with territorial reporting requirements under Yukon's Reportable Disease List & the Public Health and Safety Act. See Contact section for contact numbers.

YCDC/MOH will provide overall coordination with health care providers for the management of the case and establish communication links with all involved health care providers. Based on clinical need, hospital admission may be recommended for any suspected, probable or confirmed cases whose clinical condition requires acute care to ensure effective isolation and appropriate monitoring of illness. On a case by case basis, MOH may recommend hospitalization based on additional factors such as anticipated disease trajectory, co-morbidities, access to health care services in one's home community and logistics associated with transportation to acute care services.

YCDC will document all investigations in Panorama, using the UDF and existing core functionality (i.e., risk factors, signs/symptoms). YCDC will report all confirmed cases of COVID-19 nationally to the PHAC using defined PHAC processes and case report forms, available at www.canada.ca/content/dam/phac-aspc/documents/services/diseases/2019-novel-coronavirus-infection/health-professionals/2019-nCoV-case-report-form-en.pdf

## Clinical Management

At this time, there is no specific treatment for cases of COVID-19 infection. However, supportive treatment should be based on the patient's clinical condition at the discretion of the primary health care provider. Guidance on the clinical management of severe acute respiratory infection when a case of COVID-19 is suspected is available from the WHO[iii].

### Case Management in the Community (Confirmed, Probable, PUIs)

Persons can be safety and effectively managed in the community setting providing the patient is clinically stable. Care in the community will be supported by YCDC (Whitehorse) or Community Nursing (rural Yukon) to actively follow cases. Although this purpose of this document is the public health management, it is important to note the importance of a collaborative approach to care, including that of primary care providers, who will continue to lead the care of chronic and acute illnesses within the isolation period that may or may not be exacerbated by COVID-19 infection.

If a case has not been assessed by a HCP prior to identification a thorough assessment should be undertaken at baseline or if symptoms progress, see Appendix A. Abnormal findings should be communicated to the primary health care provider or MOH based on the concern identified. For 8instance, clients experiencing changes in pre-existing chronic conditions while on self-isolation should have this communicated to their primary health care provider for further discussion and management, while changes in respiratory status assumed to be related to COVID-19 should be communicated to the primary care provider and MOH for further discussion including possible diagnostic imaging.

The following measures and activities are recommended for all persons investigated for COVID-19:

- should remain isolated at home
- will routinely be followed by passive surveillance; however, active surveillance may be considered at the discretion of the MOH. Cases must be followed by active daily monitoring of the case's health status for the duration of illness.
- should be provided standardized information included in the client hand out: *Information about the novel coronavirus (COVID-19) Self-isolating at home* and *Information about the novel coronavirus (COVID-19) for caregivers* *(if appropriate)* reviewed in detail by the HCP allowing for questions and demonstrated comprehension. *When possible* education should involve other household members. Standardizing information includes:
    - What is novel coronavirus (COVID-19)
    - How to self-isolate
    - Daily monitoring
    - Personal hygiene

- How to prevent the spread of infection to household contacts or the community
- How to care for the case as safely as possible
- Where and when to seek medical attention

See current testing recommendations for Whitehorse, rural Yukon as well as enhanced testing recommendations for long term care facilitates and Whitehorse emergency shelter for current recommendations and processes. Include exposure/travel history with specimens being sent. Refer to Laboratory guidance for specimen collection found on the Yukon Government website novel coronavirus information for health professionals page.

**How to care for the case as safely as possible**

**Healthcare workers**

For healthcare workers providing health care services in the home, virus-specific guidance for acute health care settings is applicable.[iv, xi]

- In addition to Routine Practices, healthcare workers should follow Contact and Droplet precautions, including eye protection, when within two meters of the case. Toilets should be flushed with the lid down. See Appendix B for further discussion.
- Aerosol-generating medical procedures should be avoided in the home as much as possible.
- If aerosol-generating medical procedures (e.g., case is receiving nebulized therapy) are necessary, the use of Additional Precautions, including using a fit-tested N95 respirator with eye protection, is recommended. Healthcare providers should follow existing facility/organizational direction on aerosol-generating medical procedures. PICNet IPC guidance has developed updated information for AGMP in health care settings specific to COVID-19. This can also be found on the BCCDC website on the Novel coronavirus (2019-nCoV) page for reference.
- Medical equipment should be cleaned, disinfected or sterilized in accordance with Routine Practices (such as Accel InterVention™ wipes, one step surface cleaner and disinfectant).

**For caregivers and others sharing the living environment**

- If direct contact care must be provided, the case should wear a surgical/procedure mask, or if not available, use a non-medical mask or facial covering (e.g., cloth mask, dust mask) or cover nose and mouth with a tissue at all times and follow respiratory etiquette.
- The caregiver providing direct contact care to the case should also wear a procedure/surgical mask and eye protection when within two metres of the case and

perform hand hygiene after contact.

- Anyone who is at higher risk of developing complications from infection should avoid caring for or come in close contact with the case. This includes people with underlying chronic or immunocompromising conditions[v].

Caregivers of cases and PUI should have the standardized information included in the client hand out: *Information about the novel coronavirus (COVID-19) for caregivers* and reviewed in detail by the HCP allowing for questions and demonstrated comprehension.

**Self-isolation considerations for cases and contacts**
The location where a person will self-isolate will be determined by YCDC or their rural health care provider in conjunction with the case/contact. 'Case' refers to confirmed and probable cases. When determining the location, several factors to determine the suitability of the home setting:

**Severity of illness**
Mild symptoms that do not require hospitalization, taking into consideration their baseline health status including older age groups, or chronic underlying or immunocompromising conditions that may put them at increased risk of complications from COVID-19. The ill person should be able to monitor their own symptoms and maintain respiratory etiquette and hand hygiene. Cases with underlying co-morbidities associated with risks for severe COVID-19 disease may require additional or ongoing management. As such, engagement with the most responsible care provider should occur to support holistic management of cases within the isolation period.

**Suitable home care environment**
In the home, the case should stay in a room of their own so that they can be isolated from other household members. If residing in a dormitory, such as at a post-secondary institution or where there is overcrowded housing, efforts should be made to provide the case with a single room (e.g., relocate any other roommates to another location) with a private bathroom. Access to the Self-isolation facility either in Whitehorse or within rural Yukon should also be explored when needed. Contact the self-isolation facility assistance team at 867-332-4587. Consult YCDC for any concerns or problem solving surrounding appropriate self-isolation as soon as possible.

**Cohorting cases in co-living settings (e.g., those living in university dormitories, work camps, shelters, overcrowded housing)**
Special consideration is needed to support cases in these settings when self-isolating. Access to the self-isolation facility either in Whitehorse or within rural Yukon should also be explored

when needed. Contact the self-isolation facility assistance team at 867-332-4587. Consult YCDC, for support. If it is not possible to provide the case with a single room and a private bathroom, efforts should be made to cohort ill persons together. If there are two cases who reside in a co-living setting and single rooms are not available, they could share a double room.

**Access to supplies and necessities**

There should be access to food, running water, heating fuel, and supplies (ie medication) for the duration of the period of self-isolation. Ideally, there should have access to running water for both drinking and sanitation, however within the context of rural and remote Yukon this may not be feasible or appropriate. Those residing in remote and isolated communities may wish to consider having additional supplies, as well as food and medications usually taken, if it is likely that the supply chain may be interrupted or unreliable. Special consideration is needed to support persons within these contexts.

**Risk to others in the home**

Household members with conditions that put them at greater risk of complications of COVID-19 (e.g., underlying chronic or immunocompromising conditions, or the elderly) should not provide care for the case 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 medical mask, or if not available, a non-medical mask or facial covering (e.g., homemade cloth mask, dust mask, bandana), when near the infant, practice respiratory etiquette, and perform hand hygiene before and after close contact with the infant.

- Other cases in the home, e.g., non-breastfeeding parent or other caregiver should refrain from contact with the infant with the breastfeeding mother and infant isolating as a unit.

**Psychosocial Considerations**

HCPs should encourage individuals, families and communities to create a supportive environment for people who are self-isolating to minimize stress and hardship associated with self-isolation as the financial, social, and psychological impact can be substantial. Obtaining and maintaining public trust are key to successful implementation of these measures; clear messages about the criteria and justification for and the role and duration of self-isolation and ways in which persons will be supported during the self-isolation period will help generate public trust.

**Access to care**

While it is expected that persons isolating at home will be able to provide self-care and follow the recommended preventative measures, some circumstances may require care from a household member (e.g., the case is a child). The caregiver should be willing and able to provide the necessary care and monitoring for the case with appropriate precautions in place. See Information for caregivers about self-isolation for further information.

**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 as per the guidelines. 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. Providers can encourage people who are isolating themselves at home to connect with family and friends by phone or computer.

**Period of communicability and discontinuation of isolation**

Period of communicability is considered to be from 72 hours prior to onset of symptoms to 10 days after onset of symptoms. Live viral shedding may occur for longer in those with illness of greater severity (e.g., admitted to hospital directly due to COVID-19) and those who are severely immunocompromised, and the period of communicability may extend to 20 days after onset of symptoms in these groups. For a small number of individuals within these groups (~ 2%), live viral shedding may extend beyond 20 days, with the maximum known duration being

32 days. [vi, vii, ix, x, xi]

Discontinuation of isolation for confirmed cases can be complex depending on the clinical scenario.

Factors that are considered include:

- severity and length of disease[1]
- individual factors (e.g. severely immunocompromised[2] individuals may shed for longer)
- infection or possible infection with a variant of concern (VOC)
- activities of the recovering individual
- close contact with vulnerable populations (e.g., infants, seniors, immunocompromised etc.)
- ability to follow infection prevention measures (e.g., hand hygiene etc.)
- feasibility of obtaining negative NP swabs
- individual factors (e.g. immunocompromised individuals may shed for longer)
- potential risk of understaffing in health care facilities
- other individual and situation-specific factor

Those with more severe illness[1] (e.g. admitted to hospital directly due to COVID-19) or who are severely immunocompromised[2] can discontinue isolation at the direction of the MOH. Generally, the following criteria will be reviewed by MOH in relation to the clinical decision making, for the patent to return to their routine activities once the following criteria are met:

a. 20 days have passed since onset of symptoms[3]; AND
b. Fever has resolved without use of fever-reducing medication; AND
c. Symptoms (respiratory, gastrointestinal, and systemic) have improved; AND

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[1] A longer period of isolation should be considered for patients with markers of more severe illness Markers of severe illness include tachypnea, hypoxemia, reduced PaO2/FiO2, lung infiltratres > 50%, or admission to the ICU. Determination of severity and the minimum period of isolation is determined by the Medical Officer of Health.

[2] Some conditions, such as being treated with chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone > 20 mg/day for more than 14 days, may cause a higher degree of immunocompromise. Other factors, such as advanced age, diabetes, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of isolation.

[3] May be modified by the Medical Officer of Health with the health care provider most familiar with the client's medical status. It is estimated that the likelihood of live viral isolation in this population is 12% on day 10 post symptom onset, 5% on day 15, and 2% on day 20.

Upon direction of YCDC/MOH, persons who are **not** severely immunocompromised[2] with mild to moderate symptoms that can be managed at home can return to their routine activities once the following criteria are met:

a. At least 10 days have passed since onset of symptoms; AND
b. Fever has resolved without use of fever-reducing medication; AND
c. Symptoms (respiratory, gastrointestinal, and systemic) have improved; AND

Coughing may persist for several weeks, so a cough alone does **not** mean the individual is infectious.

As transmission can occur from asymptomatic laboratory confirmed cases, tracing should occur contacts from 3 days before through the 10 days after the date on which the sample was taken which led to confirmation of the asymptomatic case. For asymptomatic cases who are severely immunocompromised[2], MOH consultation is required and consideration of tracing contacts from 3 days before through 20 days after the date on which the sample was taken.

At this time, there is no evidence to suggest that the period of communicability is different in the pediatric population compared to the adult population. Therefore, public health follow-up in pediatric cases mirrors that of adult cases.

At this time there is limited understanding of the period of communicability for persons infected with VOCs. Decisions surrounding removal of isolation will occur on a case-by-case based at the direction of the MOH.

Cases are considered 'recovered' when they have met the criteria for removal of isolation.

The following table describes a suggested approach for various groups of COVID-19 cases and the strategies are further defined below. If an individual falls into more than one category, then the more stringent strategy should be applied.

| Group of COVID-19 cases | Preferred strategy | Alternate strategy |
|---|---|---|
| Mild disease | Non-test-based strategy | n/a |
| Severe disease, e.g., ICU | Non-Test-based strategy | Test based strategy |
| Immunocompromised | Non-Test-based strategy | Test based strategy |
| Risk of exposure to vulnerable populations (e.g. LTC facility) except health care workers | Non-Test-based strategy | Test based strategy |
| Health care workers | As directed by the MOH | |

Description of the strategies:

1. Test based strategy:
    a. Resolution of fever without use of fever-reducing medication; AND
    b. Improvement in symptoms (respiratory, gastrointestinal, and systemic); AND
    c. Two negative NP swabs collected at least 24 hours apart

2. Non-test-based strategy:

    a. Those who are not severely immunocompromised[2] with non-severe illness[1]:
        i. At least 10 days have passed since onset of symptoms; AND
        ii. Fever has resolved without use of fever-reducing medication; AND
        iii. Symptoms (respiratory, gastrointestinal, and systemic) have improved;

    b. Those with more severe illness[1] or who are severely immunocompromised[2]:
        i. 20 days have passed since onset of symptoms; AND
        ii. Fever has resolved without use of fever-reducing medication; AND
        iii. Symptoms (respiratory, gastrointestinal, and systemic) have improved;

## Contact identification and management

Close contacts of confirmed and probable cases should be identified and managed as per the recommendations in this document and an individual risk assessment by the MOH, until the containment objective is achieved or a new objective becomes necessary (e.g., if sustained person to person transmission is occurring in the community).

**For the purpose of contact tracing, the trace back period should be 3 days prior to onset of sign/symptoms consistent with COVID-19 infection.**

Contact isolation can be difficult to manage with multiple exposures and when overlaid with additional direction such as 14-day self-isolation for travellers. In such cases the highest level of protection (ie self-isolation versus self-monitoring) and longest duration will supersede.

Contacts who are asymptomatic will be advised to self-isolate or self-monitor depending on the exposure risk see following table. If the contact is/becomes symptomatic they will be required to self-isolate along with all members of their immediate household. In this scenario, persons who have a negative COVID-19 testing during this incubation period, will be required to complete the 14-day self-isolation period irrespective of negative test results.

Information about COVID-19 disease in children is limited, but children appear to have reduced severity of illness compared to adults[xvii]. This, coupled with challenges in eliciting mild sign/symptoms in a pediatric population, lends itself to aggressive self-isolation and contact management within a

household setting. In scenarios where the child and not the caregiver was exposed, testing of symptomatic adults within the household, in the absence of symptoms in the child is recommended.

As transmission may occur from asymptomatic laboratory confirmed cases, consider tracing contacts from 2 days before through the 14 days after the date on which the sample was taken which led to confirmation of the asymptomatic case.

Within the context of a transmission in a household setting, individuals may be identified as contact multiple times. Often, in such scenarios the whole home will be place on isolation and removed from isolation as a group. Outside of this context, lab-confirmed cases with a subsequent exposure after recovery will be assessed on a case-by-case for the requirement to self-isolate.

The following table provides guidance on risk assessment of contacts and corresponding public health management. If a contact belongs to more than one risk category, the highest risk category should apply. Risk categories are not absolute and may be modified by the MOH in consideration of other factors including but not limited to, use of Personal Protective Equipment (PPE), duration of the contact's exposure (e.g., a longer exposure time likely increases the risk), the case's symptom severity (coughing or severe illness likely increases transmission risk), as well as persons who engage in high-risk settings or situations, e.g. daycares, health care, extremes of age, immunocompromised etc.

**Risk stratification and management for contacts (of confirmed cases)**

| Risk level | Description | Management - 14 days post last exposure | |
|---|---|---|---|
| | | **Isolation level / contact responsibilities** | **Public health responsibilities** |
| **High risk** | • Close contacts [4] | • Self-isolation[5] at home for 14 days post last exposure<br>• Daily self-monitoring[6]<br>• Take & record temperature<br>• If symptomatic, continue isolation and report to public health. If symptoms are severe, e.g. shortness of breath, call ahead and go to the nearest emergency department. | • Active daily monitoring of contacts[7]<br>• Manage as probable or suspect case if symptomatic[8]<br>• If testing for COVID-19 is negative, continue self-isolation for 14 days post contact |
| **Medium risk[10]** | • Non-close contacts- those who do not meet a high-risk definition; e.g. household contacts who consistently use PPE or who were not within 2 metres of the case<br>• Incoming travellers, where self-isolate is required under law (federal and/or territorial).<br>• Airline contacts (see p 18) | • Non-close contacts –> daily self-monitoring[6]<br>• Incoming travelers who are required under law –> self-isolation[5] and self-monitoring[6]<br>• Airline contacts-> daily self-monitoring[6] or self-isolation[5] and self-monitoring[6] depending on flight plan<br>• If symptomatic, continue to self-isolate and contact YCDC (Whitehorse) or the rural community health center | • If tested in acute care or medical clinic: YCDC (Whitehorse) or health center (rural) will contact client to confirm self-isolation is in place and again when lab results available.<br>• Active daily monitoring generally not required, may be considered at the discretion of the MOH<br>• Manage as probable or suspect case if symptomatic[8]<br>• If testing for COVID-19 is negative, continue self-isolation for the duration of the 14 days post contact/landing |
| **Low / No risk** | • Interactions with a case that do not meet any of the high, medium, categories such as walking by the person or briefly being in the same room | • Follow action recommended for the entire population | • Community level information<br>• Individual advice if required |

**See definitions for all footnotes on following pages**

**[4]Definition of a high risk close contact**

For the purpose of identifying the appropriate individuals for public health monitoring, a high risk close contact is defined as a person who:

- provided care for the case, including healthcare workers, family members or other caregivers, or who had other similar close physical contact (e.g., intimate partner) without consistent and appropriate use of personal protective equipment, OR
- who lived with or otherwise had close face to face contact (within 2 metres) with a probable or confirmed case for more than 15 minutes (may be cumulative) up to 48 hours prior to symptom onset, OR
- had direct contact with infectious body fluids of a probable or confirmed case (e.g., was coughed or sneezed on) while not wearing recommended PPE, OR
- has been identified by MOH/YCDC as a possible contact.

*As part of the individual risk assessment, consideration is given to the duration of the contact's exposure (e.g., a longer exposure time likely increases the risk), the case's symptoms (coughing or severe illness likely increases exposure risk) and whether exposure occurred in a health care setting when determining implementation of level of contact as well as active daily monitoring.

**[5]Self-isolation within the home/community setting means:**

- Avoiding situations where the person could infect other people. This means all situations where the person may come in contact with others, such as social gatherings, work, school, child care, athletic events, university, faith-based gatherings, healthcare facilities, grocery stores, restaurants, shopping malls, and all public gatherings.
- The person should not use public transportation including buses or taxis.
- As much as possible, the person should limit contact with people other people, other than the family members/companions that they travelled with. They should avoid having any visitors to their home, but it is okay for friends, family or delivery drivers to drop off food. The person can also use delivery or pick up services for errands such as grocery shopping.
- See client hand out *Information about the novel coronavirus (COVID-19) Self-isolating at home,* and *Information about the novel coronavirus (COVID-19) for caregivers* *(if appropriate)* for more details.

**[6]Daily self-monitoring means:**

- Self-monitor for the appearance of symptoms, particularly fever and respiratory symptoms such as coughing or shortness of breath. Reinforce the importance of reporting "mild" symptoms.

- Take and record temperature daily and **avoid the use of fever reducing medications** (e.g., acetaminophen, ibuprofen). These medications could mask an early symptom of COVID-19; if these medications must be taken, advise MOH.
- Stay in an area where health care is readily accessible in case symptoms develop.
- Self-isolate within the home as quickly as possible should symptoms develop, and contact the health care provider indicated. If symptoms are severe, (e.g., shortness of breath), call ahead and go to the nearest emergency department. When presenting to a health care facility, wear a mask or if that is not readily available, cover nose and mouth with a tissue. Inform the facility that you are being investigated for COVID-19.

**[7]Active daily monitoring**

- Daily contact with client for ongoing assessment of signs or symptoms. See UDF in panorama or internal active daily monitoring form.

**[8]Manage as probable or suspect case if symptomatic**

- From an infection prevention and control perspective, such individuals should be managed as a case. If transferring from the community to an acute care facility, it will be important to notify EMS services (if appropriate) and the receiving facility prior to arrival to ensure appropriate measures are in place.

**[10]Exemptions for essential service workers in medium risk category**

- Several groups are considered essential for the continued functioning of the health care system, public safety and the transportation of essential goods. Generally, essential services are those considered critical to preserving life, health and basic societal functioning. For example, this includes first responders to life threatening events, health care workers who are essential to delivering patient care and life-saving services, critical infrastructure workers such as drinking water, hydro, internet and natural gas and workers who are essential to supply society with critical goods such as food and medicines.

  After a discussion with their manager and a risk assessment, those workers who *have returned from travel* and are deemed *essential* may return to work. **However**, they are required to take additional precautions to reduce the risk to their patients, colleagues and public. Precautions within in the workplace include:

  - Daily self-monitoring for the development of signs or symptoms (as per YT testing recommendations)
  - Wear a surgical mask at all times and in all areas of your workplace
  - Follow closely infection prevention and control protocols including attentive hand hygiene and use of personal protective equipment when providing patient care

- Limit close contact with other health care workers and avoid sharing same spaces
- Avoid close contact with others when traveling to/from work and between shifts
- Self-isolate at home when not required at the workplace.

They must self-monitor for 14 days, and if they develop symptoms, should self-isolate immediately, contact 811 and their employer.

**Contact tracing for airplane passengers**
Contact tracing for all airplane passengers will be co-ordinated by YCDC at the direction of MOH.

At this time there is no specific PHAC recommendation for contact tracing for airline passengers. The European Centre for Disease Prevention and Control (ECDC) has recommended the ECDC Risk assessment guidelines for infectious diseases transmitted on aircraft (RAGIDA): Middle East Respiratory Coronavirus (MERS-CoV) be used in response to the current 2019-nCoV outbreak, until new evidence becomes available.

Decisions related to contact tracing air travellers who may have been exposed to a case of COVID-19 are multifactorial, and may require case-by-case review by the MOH, specifically with considerations related to VOCs. Contacts will be notified, at the direction of the MOH, based on the case's classification (e.g., confirmed), the type and severity of symptoms during the flight, mask use and possible VOC risk. As there is no direct evidence at present regarding transmission risk in relation to flight duration, these recommendations apply regardless of the length of the flight.

Contact tracing efforts should focus on those seated within a 2 metre radius of the case, as this is the accepted exposure risk area for droplet transmission. Where possible an aircraft seat map will be requested by YCDC to best target contact tracing efforts.

**Contact tracing in order to identify passengers in the exposure risk area should occur if a COVID-19 confirmed case was symptomatic during the flight, and if it can be conducted within 14 days of the flight.**

Contact tracing efforts should focus on:

- passengers seated in the same row and three rows in front of and behind the index case's row AND
- crew members serving the section of the aircraft where the index case was seated AND
- persons who had close contact with the index case, e.g., travel companions or persons providing care.

See BCCDC Interim Guidance: Public Health Management of cases and contacts associated with novel coronavirus (2019-nCoV) in the community for further discussion.

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## Community Based Measures

A number of community-based measures can and will be implemented to minimize the risk of community transmission of COVID-19. These measures can be found on the PHAC website: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/public-health-measures-mitigate-covid-19.html

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## References

[i] WHO. Home care for patients with COVID-19 presenting with mild symptoms and management of their contacts. [Online] 17 March 2020. [Accessed on 1 April 2020] https://www.who.int/publications- detail/home-care-for-patients-with-suspected-novel-coronavirus-(ncov)-infection-presenting-with-mild- symptoms-and-management-of-contacts

[ii] Public Health Agency of Canada (PHAC).Interim national case definition: Coronavirus disease (COVID-19) [Online] February 17, 2021. [Accessed 17 Feb 2021]. https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/national-case-definition.html

[iii] WHO. Clinical management of severe acute respiratory infection when novel coronavirus (nCoV) infection is suspected. [Online] 28 January 2020. [Accessed on 21 February 2020]. https://www.who.int/publications-detail/clinical-management-of-severe-acute-respiratory-infection-when-novel-coronavirus-(ncov)-infection-is-suspected

[iv] PHAC. Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings. [online] September 2017. [Accessed 20 January 2020] https://www.canada.ca/en/public-health/services/infectious-diseases/nosocomial-occupational-infections/routine-practices-additional-precautions-preventing-transmission-infection-healthcare-settings.html

[v] WHO. Home care for patients with COVID-19 presenting with mild symptoms and management of their contacts. [Online] 17 March 2020. [Accessed on 18 March 2020] https://www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-(ncov)-infection-presenting-with-mild-symptoms-and-management-of-contacts

[vi] Folgueira, M.D. et al. Persistent SARS-CoV-2 replication in severe COVID-19. MEDRxiv. [Online] 12 June 2020. [Accessed on 23 June 2020] https://doi.org/10.1101/2020.06.10.20127837

[vii] Van Kampen, J.J.A. et al. Shedding of infectious virus in hospitalized patients with coronavirus disease- 2019 (COVID-19): duration and key determinants. [Online] 9 June 2020. [Accessed on 23 June 2020] https://doi.org/10.1101/2020.06.08.20125310 .

[ix] Cheng, H-Y et al. Contact tracing assessment of COVID-19 transmission dynamics in Taiwan and risk at different exposure periods before and after symptom onset. JAMA Intern Med. [Online] 1 May 2020. [Accessed on 23 June 2020] https://doi.org/10.1001/jamainternmed.2020.2020

[x] Decker, A. et al. Prolonged SARS-CoV-2 shedding and mild course of COVID-19 in a patient after recent heart transplantation. [Online] 9 June 2020. [Accessed on 23 July 2020]

https://doi.org/10.1111/ajt.16133

[xi] CDC. Duration of isolation and precautions for adults with COVID-19. [Online] 22 July 2020. [Accessed on 23 June 2020] https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html

[xii] WHO. Clinical management of COVID-19. [Online] 27 May 2020. [Accessed on 18 June 2020] https://www.who.int/publications/i/item/clinical-management-of-severe-acute-respiratory-infection-when-novel-coronavirus-(ncov)-infection-is-suspected

[xiii] PHAC. Infection prevention and control for COVID-19: Second interim guidance for acute healthcare settings. [Online] 4 April 2020. [Accessed 8 May 2020] https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/infection-prevention-control-covid-19-second-interim-guidance.html

[xiv] Provincial Infectious Diseases Advisory Committee (PIDAC), Routine Practices and Additional Precautions In All Health Care Settings, 3rd edition, Provincial Infectious Diseases Advisory Committee (PIDAC), [Online] 3rd Revision: November 2012. [Accessed on 18 February 2020] https://www.publichealthontario.ca/-/media/documents/bp-rpap-healthcare-settings.pdf?la=en

[xvi]Regina Qu'Appelle Health Region, Quick guide to infection Prevention and Control in Home Care, August 2013

[xvii] Provincial Infection Control Network of British Columbia (PICNet), Infection Prevention and Control Guidelines for Providing Healthcare to Clients Living in the Community, [Online] July 2014. [Accessed on 20 February 2020] https://www.picnet.ca/wp-content/uploads/PICNet_Home_and_Community_Care_Guidelines_2014_.pdf

[xv]Canadian Paediatric Society. Current epidemiology and guidance for COVID-19 caused by SARS-CoV-2 virus, in children: March 2020, [Online] March 2020. [Accessed on 31 March 2020] https://www.cps.ca/en/documents/position/current-epidemiology-and-guidance-for-covid-19-march-2020

## Appendix A – Clinical Assessment

Initial assessment should include:

Detailed information specific to COVID-19 including: signs/symptoms severity and onset, travel history, work/school/community involvement, contacts (if appropriate).

General health history including previous medical history, current HCP, treatment, allergies, current medications (OTC, traditional/herbal and prescribed), alcohol/drug use.

1. Focused interview
    - Ask relevant questions related to dyspnea, cough/sputum, fever, chills, chest pain with breathing (see Active daily monitoring for full list).
2. Vital signs including O2 saturation with a pulse oximeter
3. Detailed respiratory assessment (initial assessment or change in symptoms)
    - Inspect
        - For use of accessory muscles and work of breathing
        - Configuration and symmetry of the chest
        - Respirations for rate (1 minute), depth, rhythm pattern
        - Skin colour of lips, face, hands, feet
    - Auscultate (anterior and posterior) lungs for breath sounds and adventitious sounds
        - Fine crackles (rales) may indicate asthma and chronic obstructive pulmonary disease (COPD).
        - Coarse crackles may indicate pulmonary edema.
        - Wheezing may indicate asthma, bronchitis, or emphysema.
        - Low-pitched wheezing (rhonchi) may indicate pneumonia.
        - Pleural friction rub (creaking)
4. Assess adherence to self-isolation.
5. Report and document assessment findings, immediately upon return to the facility

See https://opentextbc.ca/clinicalskills/chapter/2-5-focussed-respiratory-assessment/ for more information including stethoscope placement and adult reference ranges.

## Appendix B - PPE

Depending upon the intake process for new clients there may be two opportunities to perform a risk assessment[8,9,10]

1. While booking an appointment, questions regarding potential infectiousness should be asked, such as whether the individual has symptom compatible with COVID infection. Include questions on home environment including other occupants. Consider eliciting information to support effective donning & doffing of PPE as well as alerting patient/family that PPE will be in use by the HCP. This risk assessment should be ongoing for all interactions.
2. Upon arriving within the home the initial risk assessment should be confirmed or adapted. During a home visit, a more complete health history is usually performed by using information as well as interviewing the client.

Routine Practices include [i,v, viv, xv, xvi, xvii]

- Hand hygiene (i.e., using alcohol-based hand rub (ABHR) of at least 70%) [i,v, viv, xv, xvi, xvii]
  - before entering the client/patient/resident's room
  - after exiting the client/patient/resident's room
  - after taking off and disposing of personal protective equipment.
- Examination procedures that minimize contact with droplets/aerosols (e.g., sitting 2 metres away and next to rather than in front of a coughing client/patient/resident when taking a history or conducting an examination).[i, xiv, xv]
- Client/patient/resident should be provided a mask or if unable to tolerate one, be advised to practice respiratory etiquette when coughing or sneezing. [i, v, xiv, xv]

Droplet/Contact Precautions include [i,v, viv, xv, xvi, xvii]

- Facial protection covering the nose and mouth including eye protection when within **two metres of the client/patient/resident.**[i, v, xiv, xv] Regular glasses are insufficient and do not meet the requirement of eye protection. Goggles or a face shield is required. Personally-owned and non-single use eyewear may be cleaned by the individual after each use [xiv]


- In non-acute settings, gloves and gown are **required** for activities that involve direct care where the health care provider's skin or clothing may come in direct contact with the clients or items in the client's room or bed space or when within **two metres of the client/patient/resident**. [i,v, viv, xv, xvi, xvii] Gloves and gown, if worn, must be removed and hands

cleaned immediately following the activity for which they were used. In the context of COVID-19 consideration can be given to donning contact precautions in the home, outside of the 2 metre area based on point of care risk assessment. This includes the capacity to implement and adherence to self-isolation at home, number of persons in the home, size of the home, symptoms and age of the client.

- After the health care provider has completed care **and is greater than two metres distance** from the client/patient/resident, must remove PPE in a manner that does not contaminate themselves or the environment.[iv] Removed PPE and other waste generated during the health care of the patient at home should be placed in a waste bin with a lid and remain in the home for routine disposal.[i, xiv, xv, xvii]
- See guidelines for Contact and droplet precautions- personal protective equipment - Donning & Doffing available at https://yukon.ca/en/novel-coronavirus-hp

Additional considerations:

- Staff bags for professional purposes can be brought in the home[xvii], placed on a solid elevated surface (i.e. those containing important paperwork and tools).[xvi] We recommend following droplet precautions: keep bag outside 2 metre range and remove items that will be required for direct client care (e.g. stethoscope).
- Communal or shared equipment should be cleaned and disinfected after use and can be place back into the homecare bags after use.[iv, xiv, xvi, xvii] If additional cleaning is required, consider initial clean within the home and placing objects into a plastic bag within the home care bag for secondary cleaning (if required) upon retuning to the facility.[xvii]
- If a health care provider believes that his/her hands have become contaminated during any stage of PPE removal, hand hygiene must be performed before proceeding further. Sinks that patients/residents use may be heavily contaminated and should not be used by health care providers for hand hygiene.[xiv] If visibly soiled and running water is available, the sink may be used, provided it is followed immediately by use of ABHR.[xiv, xvii]
- Gloves are not a substitute for hand hygiene; caregivers must perform hand hygiene before and after putting on and taking off gloves. Reusable utility gloves may be used; however, they must be cleaned with soap and water and decontaminated after each use with a diluted bleach solution (100 ml bleach to 900 ml of water).
- Face masks (surgical/procedure masks) provide a physical barrier that help prevent the transmission of the virus from an ill person to a well person by blocking large particle respiratory droplets propelled by coughing or sneezing. However, using a mask alone is not guaranteed to stop infections and should be combined with other prevention measures including respiratory etiquette and hand hygiene.

Applying a consistent approach to putting on and taking off a mask are key in providing overall protective benefits.

# Appendix C - COVID-19 Outbreak Management in School and Daycare Settings

## Outbreak Detection and Confirmation

**Outbreak definition:** Two or more cases of COVID-19 diagnosed within a 14-day period in a common or closed location, with evidence of transmission occurring within the setting.

Early detection of COVID-19 symptoms and laboratory testing of symptomatic clients will facilitate the immediate implementation of effective control measures. In addition, the early detection and immediate implementation of control measures are two of the most important factors in limiting the size and length of an outbreak.

A COVID-19 cluster or outbreak may be in effect when there are multiple children or staff within the same classroom or same age group within a school or daycare that have symptoms compatible with COVID-19 (see Clinical Illness for a list of symptoms). An early signal for a cluster or outbreak may be an increase in the number of ill staff/children that exceeds what is normal in the school/daycare within a short period of time and ensuring we have the earliest possible signal of any illness.

All children and staff, with symptoms compatible with COVID-19, will be referred for testing as soon as possible. Any symptomatic children or staff within the school/daycare setting should be isolated and sent home immediately, and parents should be referred to a healthcare provider or 8-1-1 as necessary.

## Outbreak Management

Throughout Yukon, outbreak management is led by MOH/YCDC. In Whitehorse, YCDC is also the lead agency for all direct follow-up care. In rural YT, YCDC will guide the direct care and management with the local community health centre.

Steps for outbreak management:

1. **Request** a list from the school/daycare to identify all of the children, staff, volunteers and students within the affected common or closed location (e.g., classroom) who may have been exposed during the case's communicable period.
2. **Identify** all high risk close contacts[10], as defined in Contact identification and management. This includes any child or staff who:
    - assisted, gave care, calmed or played with the case during the communicable period
    - had direct contact with infectious body fluids of the case during the communicable

[10] The wearing of masks or other face coverings **should not** be taken into account when assessing the risk of exposure.

period (e.g., was coughed or sneezed on)
- had close face to face contact (within 2 metres) with the case for at least 15 cumulative minutes during the communicable period, including (but not limited to) settings such as on the school bus, in the classroom, in the schoolyard and during recess/lunch etc.

**Close contacts will be excluded** from the school/daycare and directed to self-isolate for 14 days from the last contact with the case and managed as per Risk stratification and management for contacts (of confirmed cases). Testing and isolation is recommended for all children and staff with symptoms compatible with COVID-19 as soon as possible.

3. An ongoing **notification** process will be implemented in collaboration with YCDC for school/daycare to communicate any children, staff, volunteers and students reporting as absent and with symptoms compatible with COVID-19.
4. **Exclude** symptomatic children and staff as per the self-isolation recommendations in Period of Communicability before returning to school/daycare.
5. **Provide communication** to parents/caregivers, will be developed under the diction of YCDC/MOH. This communication will include the nature of the exposure, the recommendation to monitor their children for symptoms for 14 days and what to do should symptoms occur. Dissemination of this communication will be in conjunction with the Department of Education.
    - Students and staff who are immunocompromised due to a medical condition or treatment, should be advised to speak with their primary healthcare provider regarding their risk of exposure to COVID-19. Consideration may be given to removing such individuals from the outbreak setting until the outbreak is declared over, as appropriate.
    - In certain circumstances, consideration may be given to providing communication to all parents/caregivers of the school/daycare (e.g., outside of the outbreak setting) to inform them of the situation at the direction of YCDC/MOH.
6. **Implement outbreak control measures under the guidance of YCDC**, such as:
    - Post outbreak signs at entrances and affected area
    - Inform outside agencies that use the school/daycare of the outbreak
    - Minimize the movement of children and staff between age groups and rooms
    - Staff, volunteers and students should only work at the outbreak facility, and not other daycares or schools
    - Reinforce the importance of hand hygiene with staff, volunteers, students and children
    - Daily symptom screening for staff and children
    - Initiate enhanced environmental cleaning and disinfection:
        - All toys and high contact surfaces should be cleaned and disinfected daily

- Use of a broad spectrum disinfecting agent is recommended for the disinfection of toys, change tables and high contact surfaces
- Inform outside cleaning companies who work in the setting about the outbreak and review cleaning/disinfecting products

- Suspension of activities:
  - Activities between children should be limited to same age group/room
  - Visitation from outside groups should not be permitted
  - Discontinue group outings, including field trips
  - Suspend sensory play, such as wet/dry sensory tables, sand boxes and play dough
- Inform parent(s)/caregiver(s) with new child enrolments of the outbreak
- The MOH will consider the need for closure of the school/daycare, if appropriate.

7. If new cases continue to be reported despite implementation of case and contact management measures and outbreak control measures, YCDC in collaboration with MOH, may consider further measures including screening of children and staff within the outbreak setting whether symptomatic or not.

**Declaring Outbreak Over**

Control measures will continue until the outbreak is declared over by the MOH. Generally, an outbreak is declared over after two full incubation periods after the last date of exposure, without any new cases. For COVID-19, two incubation periods (28 days) after the last date of exposure. The length of time to conclude an outbreak may be reduced or extended at the direction of the MOH.