



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

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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.

Coronaviruses were first identified as human pathogens in the 1960's, with seven now known to infection humans including SAR-CoV-2 (commonly known as COVID-19) (1). Common coronaviruses include OC-43, HKU1, 229E, NL63; these cause illnesses ranging from common colds to severe respiratory illnesses. Other coronaviruses have emerged in recent years: SARS-CoV (2002) and MERS-CoV (2012). COVID-19 initially seen in Wuhan, China in late 2019 and was declared a global pandemic in January 2020 by the World Health Organization. There have been recognized mutations leading to variants of the virus which may possible implicate transmission and case management. Information on new SARS-CoV-2 variants of public health concern is constantly emerging. Further information on variants can be found from these sources:

BC Centre for Disease Control: <http://www.bccdc.ca/health-info/diseases-conditions/covid-19/about-covid19/variants>

Centers for Disease Control and Prevention: <https://www.cdc.gov/coronavirus/2019ncov/transmission/variant.html>

PHAC: <https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html#VOC>

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. It 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) (2).

This guidance is based upon current knowledge and it should be understood that it is subject to change as new data become available and new developments arise with this new virus. SARS-CoV-2 has and will continue to develop mutations; after many significant mutations the virus becomes a variant. A variant of concern (VOC) is identified when it escalates disease transmission or severity; becomes undetectable by tests; or impacts the effectiveness of vaccines or treatments" (3).

This guidance is set in the Yukon context and is based on the available scientific evidence and expert opinion. In interpreting and applying this guidance, it is important to recognize that the health, disability, economic, social, or other circumstances faced by some individuals and households may limit their ability to follow the recommended measures (3). Furthermore, unique situations may require some discretion in adjusting these

guidelines which are meant to be supportive, not prescriptive. This may necessitate adapted case management and contact responses by YCDC.

This guidance should be read in conjunction with relevant territorial legislation, regulations, organizational policies 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 all MOHs practicing in Yukon.

Goals

The objectives of this guideline are:

- Promote prompt identification and reporting of probable and confirmed cases of COVID-19 and contacts
- Management of cases and contacts
- Supplement existing guidelines provided by the Public Health Agency of Canada related to case and contact management in the community.

Epidemiological Characteristics

Clinical Characteristics	<ul style="list-style-type: none"> Reported illnesses have ranged from infected people with mild to no symptoms, to severe illness, including death. Symptoms absent at the onset of illness may develop over time with disease progression. Based on available data, neither the absence nor presence of signs or symptoms are accurate enough to rule disease in or out (3). As such people suspected of having COVID-19 should be tested to rule in or out this diagnosis (4) At this time the progression seems to include initial symptoms that may be quite mild with worsening symptoms during the second week <u>Common symptoms</u> (5) (>50%) include: Fever, chills, cough, shortness of breath/difficulty breathing, fatigue, loss of appetite, loss of taste and/or smell. <u>Less common symptoms</u> (5) (<50%) include: sputum production, muscle aches, chest pain, diarrhea, nausea/vomiting, headache, dizziness, sore throat <u>Rare</u> (5) (<10%): confusion, runny nose, fainting, skin manifestations. 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. 15% of infected people are asymptomatic (6) (7) (8) (9) (10), up to 36% of children are asymptomatic (11), and those over the age or 65 and/or with medical conditions (5) may have atypical presentations.
Treatment	See Clinical management of patients with COVID-19: Second interim guidance
Period of Incubation	Mean: 5 days, Median: 5-7 days, Range: 2-14 days days for public health purposes. The Omicron variant of concern, which is the dominant strain in YT at this time, has a shorter median incubation period of 3 days (range 0-8 days)(48-51). A very small proportion of individuals would still be incubating at 14 days, likely about 1%, perhaps up to 6.7% (52). Some individuals could develop their infection after the end of their quarantine. Some individuals can be infectious even at the end of their quarantine without knowing it because they are asymptomatic, pre-symptomatic or very mildly symptomatic.
Human to Human Transmission	<ul style="list-style-type: none"> Contact & droplet which vary in size from large droplets that fall to the ground rapidly [within seconds or minutes], to smaller droplets [i.e., aerosols] which linger in the air under some circumstances, such as within settings with poor ventilation (3) Fomites (duration of virus survival could be days). Consider potential Fecal-oral transmission
Zoonotic Transmission	<ul style="list-style-type: none"> Reported transmission from mink to humans in the Netherlands. There is currently no evidence that other domestic animals are a source of transmission. At this time, there is evidence that bats, cats, dogs, mink, ferrets, hamsters, mink, non-human primates, tree shrews and rabbits have some level of susceptibility to infection with SARS-CoV-2 and may develop illness.
Period of Communicability	<ul style="list-style-type: none"> Period of communicability is considered 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 48 hours prior to the case developing initial symptoms. Period of communicability and discontinuation of isolation depends on the patient and setting. See text for further discussion. Coughing may persist for weeks, this does not mean the individual is infectious, nor is self-isolation needed.
Diagnostics	See Surveillance Case Definitions
Immune response and reinfection	Following infection, more than 90% of individuals will develop IgM and IgG antibodies within weeks of symptom onset (12). As stated by the Public Health Agency of Canada guidelines, the relationship between antibody levels and the level of protection against reinfection remains undetermined, as well as the role of cellular immunity in preventing reinfection (including cross-protective immunity) following exposure to common coronaviruses. See section on reinfection .

Surveillance Case Definitions

Surveillance Case Definitions (13)		Reportable to YCDC
PUI (person under investigation)	A person for whom a laboratory test for COVID-19 has been ordered or is expected to be ordered.	No
Probable	<p>A person who:</p> <p>Has symptoms compatible with COVID-19 (See clinical characteristics)</p> <p>AND</p> <p>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</p> <p>AND</p> <p>Has not had a laboratory-based NAAT assay for SARS-CoV-2 completed or the result is inconclusive</p> <p>OR</p> <p>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</p> <p>OR</p> <p>Had a POC NAAT for SARS-CoV-2 and the result is preliminary (presumptive) positive</p> <p>OR</p> <p>Had a POC antigen test for SARS-CoV-2 and the result is positive preliminary (presumptive) positive, however the individual met the current testing recommendations for a PCR or accessed a high risk setting during their POC.</p>	Yes
Confirmed	<p>A person with confirmation of infection with SARS-CoV-2 documented by:</p> <p>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, or reference laboratory (the National Microbiology Laboratory or a provincial public health laboratory)</p> <p>OR</p> <p>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)</p> <p>OR</p> <p>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</p>	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.

Case definitions and exposure criteria are subject to change. YCDC assigns classification using the most recent PHAC definitions for affected area. Published case definitions can be found at: www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/healthprofessionals/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. In circumstances where coordination is required with other provincial or territorial jurisdictions for contact tracing or case management, YCDC will coordinate with all other CDC offices.

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-coronavirusinfection/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 (14).

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.

Epidemiology Management Definitions

Covid-19 Illness Severity Criteria (applies to children and adults)

Asymptomatic illness: Cases with no COVID-19 compatible symptoms at the time of testing, and who do not develop symptoms during their isolation (if they develop compatible symptoms, they should be reclassified in the appropriate category based on severity of illness)

Mild to moderately severe illness: Cases that do not reach the threshold for severe illness. If a patient was admitted to the hospital for reasons unrelated to their COVID-19 illness, they should not automatically be considered as having severe COVID-19 illness.

Severe to critical illness: Individuals for whom COVID-19 causes any one of the following: experienced oxygen saturation below 94% on room air, pneumonia, hypoxemic respiratory failure, multiple organ dysfunction, or septic shock (15) (16) hospitalized because of the severity of COVID-19 illness (hospitalization in those who have COVID-19 can be for other reasons than COVID-19 severity of illness, e.g. for a surgical procedure, for relief of LTC capacity, for another medical condition...).

Level of Immune Compromise

Mildly immune compromised: Those with mild immune compromising conditions, such as diabetes, are treated the same as those without immune compromising conditions.

Moderately immune compromised (15) (17) individual with one or more of the following:

- Persons on chemotherapy for solid organ cancer (as determined by the most responsible physician (MRP))
- Human Immunodeficiency Virus (HIV) with a CD4 count of 50 - ≤200 cells/mm³ (inclusive)
- Combined primary immunodeficiency disorder

- Any person taking a biologic/immunomodulatory therapy, prednisone of >20 mg/day (or equivalent dose) for ≥14 days, tacrolimus, sirolimus, mycophenylate, methotrexate, or azathioprine.

Based on their clinical judgement, MRPs may determine that there are other diagnoses and/or medications not listed above that support considering patients as moderately immune compromised. Consult an infectious disease specialist as needed.

Severely immune compromised (17) (18) (19) (20) (21) individuals with one or more of the following (in consultation with the most appropriate care provided if needed):

- Bone marrow transplant
- Chronic lymphocytic leukemia
- Lymphoma
- Hypogammaglobulinemia
- Human Immunodeficiency Virus (HIV) with a CD4 count of < 50 or AIDS
- ○ Chimeric antigen receptor T-cell therapy
- Use of rituximab

There may be other diagnoses or a combination of diagnoses and/or medications that support considering patients as severely immune compromised. Current evidence may not have demonstrated prolonged live viral shedding with such diagnoses and/or medications yet. Thus, clinical judgement remains important to determine if these patients should be considered as severely immune compromised to determine their communicability period.

Period of communicability

The period of communicability is dependant on the level of immune compromise and severity of symptoms. It considered as 48 hours prior to onset of symptoms up 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 (22) (23) (24) (25) (15).

Cases with asymptomatic illness. In general, the duration of infectiousness is from 48 hours before a COVID-19 positive sample was taken until 10 days¹ after the sample was taken. Since the exact start

¹ Case isolation is reduced to 7 days for those who are up to date in their COVID-19 immunization (i.e., completion of a 2-dose primary COVID-19 vaccine series in the last 6 months or 2 doses primary and 1 booster dose and > 14 days prior to onset of symptoms, provided the criteria outlined in Table 2 has been met

of the infection is difficult to establish in asymptomatic cases, some case-by-case assessment is warranted. Sometimes, an earlier onset of infectiousness date may be considered to identify further potential exposures, especially if someone has been in a high-risk setting. If the case is immune compromised, the infectious period is longer and extends generally to 20 days after testing.

Cases with mild to moderately severe illness, and who are not immune compromised, or only mildly immune compromised: From 48 hours prior to onset of symptoms up to 10 days after onset of symptoms (see Clinical Illness). All possible symptoms should be considered, with particular attention to those that may be mild and/or nonspecific (e.g., fatigue, muscle pain) and those less common.

Cases with severe or critical illness, or moderately immune compromised: From 48 hours prior to onset of symptoms to 20 days after onset of symptoms (see Clinical Illness). All possible symptoms should be considered, with particular attention to those that may be mild and/or nonspecific (e.g., fatigue, muscle pain) and those less common.

Cases who are severely immune compromise: From 48 hours prior to onset of symptoms to potentially more than 20 days after onset of symptoms. In those individuals, it is recommended to consult with a Medical Health Officer and a test based strategy might be recommended to determine the most likely end to the infectious period.

Based on the individual patient settings, most responsible provider in consultation with Infectious Disease Specialist or MOH may determine that there are other diagnoses and/or medications not listed above that warrant considering patients as moderately or severely immune compromised. In those cases, in acute care settings, a test-based strategy may be used to cease the use of additional precaution, on recommendation of MOH.

Reinfection

Following infection, more than 90% of individuals will develop IgM and IgG antibodies within weeks of symptom onset (12). As stated by the Public Health Agency of Canada guidelines, the relationship between antibody levels and the level of protection against reinfection remains undetermined, as well as the role of cellular immunity in preventing reinfection (including cross-protective immunity following exposure to common coronaviruses). However, this might be affected by the emergence of variants of concern with mutation enabling immune escape. As explained by the US CDC (26) "Reinfection with a SARS-CoV-2 variant virus has been reported in Brazil, the U.K., and South Africa. The risk of reinfection may be increased in the future with exposure to SARS-CoV-2 variant virus strains that are not neutralized by immune antisera, such as one recently described in South Africa." The risk of reinfection also depends on the nature of exposure to an infectious case of COVID-19. The use of prevention strategies can lower the risk of transmission and reinfection.

A recent PHAC review indicates that the time to reinfection can vary from 15 days to more than 220 days, with a median time to reinfection below between approximately 60 to 80 days (27). For

confirmed reinfection, studies suggest the risk is decreased by more than 95%, while studies of suspected reinfection suggest 83 to 94% protection. Most studies conclude that the vast majority of individuals with prior infection are at very low risk of reinfection in the first 6 months, and likely protected for longer.

Some studies indicate the relative risk of reinfection is significantly lower in those with detectable antibodies, even several months after infection (28) (29). Those who did not seroconvert may not have the same degree of protection from reinfection as those with high titers of antibodies; older age, duration of symptoms, and the number of symptoms correlate with higher IgG responses after primary infection, while an immune-compromised status, and older age in some studies, is correlated with a lower antibodies response.

There are too few cases to determine the clinical presentation in a second infection and how it may differ. To date, there has not been any evidence of antibody-dependent disease enhancement observed.

As serological testing for the detection of SARS-CoV-2 antibodies becomes more widely available, the results are expected to provide further insight into the questions on reinfection and the duration of immunity

A repeat test resulting as positive is highly unlikely to indicate a new infection (30) in the first 45 days since recovery and is unlikely in the first 90 days following recovering. For clients who continue to be symptomatic, or have new symptoms with a positive test it is important to consider other differential diagnoses such as long COVID-19 or underlying immune compromise.

Diagnostic Testing

Yukon is conducting COVID-19 diagnostic testing for certain groups of individuals with compatible symptoms, however mild. Up to date laboratory testing guidelines for clinical purposes can be found on the [Yukon Health Professionals](#) page. For those who have had close contact with a COVID-19 case, and have even a single of the symptom included in the testing guidelines, isolation and/or testing is strongly recommended.

Asymptomatic testing is not routinely recommended, but can be useful in specific circumstances as determined by YCDC/MOH. Canadian guidelines suggest that asymptomatic testing of close contacts may be warranted to interrupt more chains of transmission. YCDC/MOH may recommend testing for individuals who are part of a public health investigation of a case, cluster or an outbreak, regardless of symptom profile.

Point-of-care (POC) testing may assist in addressing the gaps in access to timely COVID-19 testing. Use of POC testing such as Abbott ID Now™ continues to be evaluated in the COVID19 response, as well as the role of serology and genomic testing. **POC testing has different sensitivity and specificity compared to the gold standard PCR tests**, including a potential to miss early or late infections. Some may need confirmatory testing. As always, the COVID-19 test result must be interpreted in the clinical

context of the patient and exposure history. If a POC test results negative but the client is symptomatic, client should isolate and retest in 2-3 days if signs and symptoms persist or have a PCR collected after the POC test. Refer to Yukon guidelines on use the use of Abbott ID testing.

At this time, PCR lab-based testing is recommended for certain populations of individuals (based upon health risk, age, vaccination status and working/living environment), see current Yukon COVID-19 PCR testing recommendations available at <https://yukon.ca/en/health-and-wellness/health-concerns-diseases-and-conditions/find-information-health-professionals>. Individuals who do not meet criteria for lab-based testing are recommended to self-test with an at-home test. Specific information regarding the use of at-home antigen tests, interpretation of results and additional recommendations can be found at [Yukon.ca/covid19](https://yukon.ca/covid19).

Discontinuation of isolation

International travelers must adhere to the requirements of the [Canadian Quarantine Act](#). Note: this may include self-isolation recommendations that extend beyond 14 days for certain circumstances, including a case diagnosed after their first day of quarantine, as outlined in the Act.

Cases are considered 'recovered' when they have met the criteria for removal of isolation. Discontinuation of isolation for confirmed cases can be complex depending on the clinical scenario but it ultimately based on the potential risk of transmission to others. When multiple isolation requirements apply for one individual, for example: needing to isolate due to international travel while being a high-risk contact or a positive case, the longest isolation period will always apply.

Table 2. Criteria for ceasing isolation of cases that are not under a federal quarantine order to use in conjunction with definitions in infectious period section.

<p>Individuals who are "UP TO DATE" for COVID-19 vaccine as defined as:</p> <ul style="list-style-type: none"> • 2 doses with 2nd dose received within 6 months and at least 14 days before symptom onset; OR • 3 doses (2 primary series + 1 booster) with 3rd dose received at least 14 days before symptom onset <p>with asymptomatic, mild or moderate illness who are managed at home and are not moderately nor severely immune compromised can cease isolation once the following criteria are met:</p> <ol style="list-style-type: none"> a. At least 7 days have passed since onset of symptoms (or test date for asymptomatic cases); AND b. Fever has resolved for 24 hours without use of fever-reducing medication; AND c. Symptoms (respiratory, gastrointestinal, and systemic) have improved
<p>Individuals who are UNVACCINATED, PARTIALLY VACCINATED or VACCINATED but >6 months from most recent dose, with asymptomatic, mild or moderate illness who are managed at home and are not moderately nor severely immune compromised can cease isolation once the following criteria are met:</p> <ol style="list-style-type: none"> a. At least 10 days have passed since onset of symptoms (or test date for asymptomatic cases); AND b. Fever has resolved for 24 hours without use of fever-reducing medication; AND c. Symptoms (respiratory, gastrointestinal, and systemic) have improved

Irrespective of vaccination status, all persons with **severe or critical illness, and those who are moderately immune compromised** can cease isolation once the following criteria are met:

- a. Twenty days have passed since onset of symptoms (or test date for asymptomatic cases; **AND**
- b. Fever has resolved for **24 hours without use of fever-reducing medication; AND**
- c. Symptoms (respiratory, gastrointestinal, and systemic) have improved

Irrespective of vaccination status, all persons who are **severely immune compromised** can cease isolation when determined by the MOH, at least 20 days, potentially longer; consider a test-based strategy.

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

Additions factors that are considered when determining end of isolation include:

- 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
- potential risk of understaffing in health care facilities
- other individual and situation-specific factor

Test-based cessation of isolation

In general, repeat laboratory testing (e.g., a negative test result) as the basis for discontinuing home isolation is not recommended. In exceptional circumstances, a test-based strategy might be considered, at the discretion of the MOH. In health care settings, the decision would be based on clinical judgement, including most responsible physicians in consultation with Infectious Disease and MOH, may determine that there are other diagnoses and/or medications that warrant considering a test-based strategy to cease the use of additional precaution. When this occurs, consultation with an MOH is recommended.

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

Persons can be safely 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 certain cases. Although the 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. When appropriate, respective First Nations Governments may also be involved for supports.

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 instance, 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:

- Individuals should remain isolated at home or a suitable alternative environment if isolating at home is not possible. It is important that cases who do not require hospital-level care convalesce in a suitable environment where effective isolation can be maintained and appropriate monitoring (e.g., for worsening of illness) can be provided. Considerations for a suitable environment will depend on the individual and their living situation; and may vary depending on the sex, gender, or other socioeconomic or identity factors of the case.
- Individuals will routinely be followed by passive surveillance; however, active surveillance may be considered at the discretion of the MOH. Cases may be followed by active daily monitoring of the case's health status for the duration of illness. Active daily monitoring will be completed primarily by YCDC staff as well as by Primary Care Nurses and/or Community Health Nurses if cases are in rural communities.
- Individuals 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 facilities 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.

Home based COVID-19 tests

Yukon government as well as other local agencies provide access to free home based COVID-19 tests in addition to those accessed through a private market, at this time many of these are rapid antigen tests (RAT) however, the use of rapid molecular tests may also be available. It is important to note that the sensitivity, specificity of these test differ from that of lab based molecular tests and can vary widely from product to product. **Within the context of widespread community transmission of COVID-19 within a community setting the likelihood of a positive test reflecting true infection is high, while the utility of a negative results, specifically in the presence of symptoms or repeat testing is suboptimal and should be interpreted with caution. Persons meeting this criteria, specifically HCPs or those working in vulnerable settings SHOULD NOT use a negative RAT in the context of symptoms and widespread community transmission to continue to present within the workplace.**

Persons who report a positive home based test who meet the Yukon criteria for a lab based PCR who meet existing criteria for a PCR test, should be routed to access GeneXpert for confirmation.

Persons reporting a positive home-based RAT, cases are strongly encouraged to follow up with their family doctor, emergency department or community health centre if there are any pre-existing health concerns that may be exacerbated or result in a high risk of morbidity and mortality or any medical emergency.

In conjunction with the surveillance definitions, patient reported positive RAT within the context of not meeting the [high priority setting](#) does not need to be reported to YCDC.

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 (31) (32).
- 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 \(2019nCoV\)](#) page for reference.
- When possible, allow for adequate ventilation.
- Medical equipment should be cleaned, disinfected or sterilized in accordance with [Routine Practices](#) (such as Accel InterVention™ wipes, one step surface cleaner and disinfectant).
- Wherever possible, only household members who are essential for communication with staff should be present during visit (33). They should remain 2m from staff and wear a medical mask. As household member is a contact to client, staff should wear appropriate PPE if a 2m distance cannot be ensured. Depending on household situation, may be recommended for entire household to wear a mask and remain 2m away from staff during visit (if tolerated).

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 (2). 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.
- When possible, allow for adequate ventilation.

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. Children's psychological needs still need to be tended to, including physical contact and comfort from a caregiver. It might also be impossible to prevent interaction between young siblings. See and [Information about the novel coronavirus \(COVID19\) for caregivers](#). 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, 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 COVID19 (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. For Indigenous Peoples, mandatory isolation away from home due to COVID-19 may trigger re-traumatization based on the history of forced removals. There is also the potential for new trauma if their ability to practice cultural and/or spiritual activities is limited.

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.

Contact identification and management

Objectives of contact tracing

Contact tracing and management is the cornerstone for rapid case identification and transmission 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 YCDC/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).

Forward, or traditional, contact tracing methods are when there is a known acquisition for a case. Backward contact tracing may be used during outbreak investigations. **For the purpose of contact tracing, the trace back period should be 48 hours 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 federal requirements for travellers. In such cases the highest level of protection (ie self-isolation versus self-monitoring) and longest duration will supersede.

For the purpose of this section, a case refers to a confirmed or probable case. It is important to identify and manage the contacts of a COVID-19 case as soon as possible, as this underpins the effectiveness of contact tracing (34).

Several objectives may be achieved through contact management activities by regional health authorities, including:

1. To facilitate rapid identification of new cases and reduce community transmission by:
 - Identifying contacts of the case;
 - Testing contacts as per jurisdictional parameters;
 - Isolating any secondary confirmed, or probable cases as quickly as possible;

- Advising all contacts at high risk of exposure to quarantine (self-isolate) if applicable, and providing them with information regarding infection prevention and control measures they should follow; and
 - Providing contacts with the information about what symptoms to self monitor for and what to do if they develop symptoms, as well as any other relevant instructions specific to their situation.
2. To identify additional individuals or events as potential exposure sources and subsequently additional cases and/or chains of transmission (see Backward Contact Tracing below).
 3. To gain a better understanding of the epidemiology of this coronavirus

Contact management

Contacts of a case should be identified and managed as per the recommendations in this document, where feasible based on public health resources. The level and intensity of public health actions by YCDC/MOH and may vary according to the local epidemiology of COVID-19 at a given time. Currently, the level of YCDC follow-up with regard to contact tracing/notification is dependent on the setting:

- **High priority setting:** YCDC facilitates direct contact tracing/notification in high-priority settings, including long-term care/assisted living facilities, acute care and community based health services (ie health centres, medical and dental clinics, and allied health care clinics), correctional facilities, shelters, group homes, work camps and aggregate addiction services.
- **All other settings:**
 - Cases are empowered to self-manage the identification and notification of their close contacts. Information is available for cases to identify those with whom they had close contact in the two days prior to symptom onset (or two days prior to testing positive if asymptomatic) up until the start of self-isolation. The following resources are available on the Yukon.ca website to support this process:
 - [What to do if you get a positive COVID-19 test result](#)
 - [How to notify your close contacts if you've tested positive for COVID-19](#)
 - [What to do if you're told you're a close contact](#)
 - [How to manage a report of COVID-19 in your business or organized event](#)

All the above links as well as quick links to other supports can be accessed from the following landing page: [What to do if you test positive or are a contact: COVID-19](#).

Contacts are mostly managed by the level of risk of the COVID-19 exposure and their immunity against infection. Since quarantine has negative social and economic impacts, we must ensure that self-isolation requirements are necessary and that the benefits outweigh the harms. The recommendations for the isolation of contacts varies based on immunization status, recent prior COVID-19 infection, and the potential for breakthrough infection related to emerging variants (e.g. Omicron). For complete guidance of recommendations for contacts see [Appendix D & E](#)

Additional factors YCDC/MOH use to consider that may influence the risk stratification and public health management of contacts include:

- Use of PPE by the contact at the time of exposure
- Duration of the contact's exposure (e.g., a longer exposure time likely increases the risk)
- Household-like type of exposure versus other types of high risk exposure
- The case's symptom severity (coughing or severe illness likely increases transmission risk)
- Persons who engage in high-risk settings, e.g. daycares and health care, or situation where there is interaction with those at the extremes of age, who are immune compromised, medically extremely vulnerable or at risk of severe COVID-19 illness, etc.
- Whether the contact had exposure to a case infected with a variant of concern

Contacts who are asymptomatic will be advised to self-isolate or self-monitor depending on the exposure risk, see [Appendix E](#). If the contact is/becomes symptomatic they will be required to self-isolate. Testing of high risk close contacts may be recommended even if they are asymptomatic under the direction of YCDC/MOH. **In this scenario, persons who have a COVID-19 testing during this incubation period, will be required to complete the self-isolation period irrespective of negative test results.** This is due to the high rates of false negative tests, specifically within the early contact period.

Information about COVID-19 disease in children is limited, but children appear to have reduced severity of illness compared to adults (14). 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, may be recommended.

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 placed 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.

Appendix E 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.

For personal protective equipment (PPE) to be considered sufficient, at least a medical-grade mask and eye protection need to be worn by someone who has received appropriate training in the use of PPE and associated infection prevention and control practices. Wearing nonmedical masks by either or both of the case and contact, in most situations, would not nullify an exposure. It is difficult to assess adequacy of mask's fit, material, and how consistently individuals wore masks.

Although outdoor settings are not generally considered high risk, the potential for transmission still exists under certain circumstances, such as close conversations or rigorous exercise when participants are in close proximity and are not wearing masks, case-by-case risk-assessment should be carried of outdoor exposure.

Contact tracing immune competent individuals with a prior COVID-19 infection

Lab-confirmed cases with a subsequent exposure in the 90 days after recovery are recommended to self-monitor for 14 days after a high-risk exposure rather than to isolate (see [Appendix D](#)). A case-by-case assessment of risk can lead to a different decision on self-isolation requirement or appropriate additional actions. Lab-confirmed cases with a subsequent exposure more than 90 days after recovery are managed in a similar manner to those without prior infection.

In some circumstances, reinfection is suspected and can lead to more diagnostic testing and isolation. Exposure to variant of concern strain associated with a higher risk of reinfection (35). Reinfection can be more common with immune escape variants of concerns such as P.1, B.1.351, and B.1.1.529 (Omicron). Against those variants, natural immunity might not be as good as immunity provided by some vaccine (35).

For those this prior documented infection, who develop symptoms within 14 days after a high risk exposure to COVID-19, if another etiology cannot be identified for the symptoms, retesting is recommended (36). However, clinicians should consider the likelihood of long-COVID-19 as a likely possibility when cases continue to be symptomatic. Consideration should also include local epidemiology and possible exposure to a different VOC. The testing results should be interpreted in consultation with the appropriate expert.

[See Appendix D](#)

Contact tracing for those with partial or fully immunization

See [Appendix D](#) and [E](#)

Contact tracing in outbreak situations

In an outbreak context, contact tracing and management also serves the purpose of active case finding during an investigation. Where an outbreak is suspected, YCDC may adopt a situation specific definition for those at high risk of exposure (i.e., "close contact") to help efficiently target their contact investigation and case finding efforts.

Outbreaks may have a significantly higher impact in some populations due to their vulnerabilities or their potential for widespread transmission (37)

Guidelines for outbreaks in school and daycare settings can be found in [Appendix C](#).

Contact tracing for airplane passengers

Contact tracing for all airplane passengers will be co-ordinated by YCDC at the direction of MOH and is not routinely used at this stage of the pandemic.

Decisions related to contact tracing air travellers who may have been exposed to a case of COVID19 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.

When employed, 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, however broad exposure notification may also be utilized by YCDC/MOH.

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.

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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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.

Different populations will present with different clinical presentations. 36% of children present asymptotically and the elderly and those with medical conditions may have atypical presentations (11).

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

For the most up to date recommendations see PPE information at yukon.ca/en/health-and-wellness/health-concerns-diseases-and-conditions/find-information-health-professionals

Depending upon the intake process for new clients there may be two opportunities to perform a risk assessment (23) (24) (25)

- 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.
- 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 (33) (31)

- Hand hygiene (i.e., using alcohol-based hand rub (ABHR) of at least 70%)
 - 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).
- Client/patient/resident should be provided a mask or if unable to tolerate one, be advised to practice respiratory etiquette when coughing or sneezing.

Droplet/Contact Precautions include (33) (31)

- At a minimum: gloves, gown, medical mask and eye protection with any contact to a suspect or confirmed case or high risk contact. Use of N95 mask may be used based on a staff point-of-care risk assessment (PCRA).
- Facial protection covering the nose and mouth including eye protection when within **two**

metres of the client/patient/resident. 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.



- 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**. 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. 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.
- Wear contact/droplet PPE for the duration of the visit if there are household contact present or if the client is not confined to an enclosed room.
- See guidelines for Contact and Droplet precautions- personal protective equipment - Donning & Doffing available at yukon.ca/en/health-and-wellness/health-concerns-diseases-and-conditions/find-information-health-professionals

Additional considerations:

- Only bring in essential equipment for visits. Staff bags for professional purposes can be brought in the home (38), placed on a solid elevated surface (i.e. those containing important paperwork and tools). 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 placed back into the homecare bags after use. 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 returning to the facility. (39)

- 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 (38). If visibly soiled and running water is available, the sink may be used, provided it is followed immediately by use of ABHR (39) (38).
- 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

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.

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.

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 including testing for COVID-19.

Outbreak Management

Throughout Yukon, outbreak management is led by MOH/YCDC, with the authority to call an outbreak, belonging to MOH. 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, 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 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.
 - The wearing of masks or other face coverings **should not** be taken into account when assessing the risk of exposure.

Close contacts will be excluded from the school/daycare and directed to self-isolate for 10 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 direction 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, depending on the scenario it may be one (14days) or 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.

Appendix D – Primary guidance for high risk contacts of COVID-19 who have been vaccinated or have a prior history of infection

COVID-19 immunization/disease history ²	Assessment of susceptibility of all contacts ¹ (including household)	Clinical direction for person who would normally be recommended self-isolation
Immunocompetent and immunized with mRNA vaccine as follows: <ul style="list-style-type: none"> • 2 doses with 2nd dose received within 6 months and at least 14 days before the contact; OR • 3 doses (2 primary series + 1 booster) with 3rd dose received at least 14 days before the contact. 	Consider immune ³	If asymptomatic: <ul style="list-style-type: none"> • Self-monitor • COVID-19 testing at low threshold, if s/s develop • Safe 6 + 1 If symptomatic: <ul style="list-style-type: none"> • Isolation until COVID-19 ruled out by testing
Lab confirmed COVID-19 infection within 90 days prior to contact	Consider immune ³	If asymptomatic: <ul style="list-style-type: none"> • Self-monitor • COVID-19 testing at low threshold, if s/s develop • Safe 6 + 1 If symptomatic: <ul style="list-style-type: none"> • Isolation until COVID-19 ruled out
<ul style="list-style-type: none"> • Not immunized or incomplete immunization series (as above); OR • No documented history of lab confirmed infection; OR • Moderately to severe immunosuppression¹; OR • Individual is remaining in close contact with COVID-19 positive case during their POC³. 	Susceptible	If asymptomatic: <ul style="list-style-type: none"> • Self-isolation • Arrange for vaccination if series not complete • COVID-19 testing at low threshold If symptomatic: <ul style="list-style-type: none"> • Test for COVID-19 and continue self-isolation

Persons considered immune should be advised to limit their e. In rare occurrences, an employer may choose alternate approaches. Persons should adhere to workplace specific recommendations, where they exist. Adherence to the safe 6 + 1 and workplace COVID-19 protocols are critical. As per routine, avoiding the Three Cs: Crowded places with many people nearby, Close-contact settings, especially where people have conversations very near each other, Confined and enclosed spaces with poor ventilation.

¹ Individuals must not be significantly immune suppressed, by disease or medication that would influence immunity. See page 8 and 9 for definitions on [moderate and severe immunosuppression](#).

² Immunization/disease history should be documented and reviewed (ie Panorama or paper records). When records are from out of YT, an assessment should occur on the quality/comprehensiveness of the documentation. Where there is uncertainty, clinical confirmation should occur with the administering P/T. **Verbal communication of immunization/disease history is not sufficient.**

³ This guidance is under the assumption that ongoing contact does not continue and the case is isolating away from others. There is a higher likelihood of breakthrough infection with continued exposure. Contacts who remain in ongoing close contact with a positive case should isolate with the case during the cases' period of communicability. Provided no signs/symptoms develop in the contact, they can then follow the direction above.

This guidance, may not apply to persons who are living in aggregate settings where clusters/outbreaks are occurring. Follow outbreak management direction provided by MOH/YCDC.

Appendix E – Primary guidance for individuals exposed to COVID-19

Risk level	Description	Management - 14 days post last exposure	
		Isolation level / contact responsibilities	Public health responsibilities
High risk	<ul style="list-style-type: none"> Close contacts ¹ 	<ul style="list-style-type: none"> Based on immunization status. See appendix D Follow recommended personal preventive practices. If living with the case, avoid further exposure to the case; if in a shared space (e.g., same room) with the case, wear a well-constructed and well-fitting, nonmedical mask and stay at least 2 meters apart. Take & record temperature avoid the use of fever-reducing medications (e.g., acetaminophen, ibuprofen) as much as possible. These medications could mask an early symptom of COVID-19; if these medications must be taken, advise public health Follow health authority directions related to testing requirements. 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. Avoid contact with those who are at risk for developing more severe disease or outcomes from COVID-19 (e.g. avoid getting a ride from them to a testing site) Contacts at risk for developing more severe disease or outcomes should not provide care for the case and should stay elsewhere if feasible. 	<ul style="list-style-type: none"> Consider active daily monitoring of contacts, if resources permit⁴ Manage as probable or suspect case if symptomatic⁵ If testing for COVID-19 is negative, continue self-isolation for 10 days, and self-monitoring for 14 days since the last exposure
Medium risk ⁶	<ul style="list-style-type: none"> Non-close contacts- Incoming travellers, where self-isolate is required under law (federal and/or territorial). Airline contacts (see p 18) 	<ul style="list-style-type: none"> Non-close contacts → daily self-monitoring for 14 days⁶ If symptoms occur, isolate away from others as quickly as possible, put on a medical mask if available (preferred), or well-constructed and will-fitting nonmedical mask, and contact public health for further direction, which will include: where to go for care, appropriate mode of transportation to use, and infection and prevention control precautions to be followed. Where possible, avoid interactions with individuals at higher risk for severe illness Follow PHA directions related to testing requirements Follow recommended personal preventive practices Incoming travelers who are required under law → self-isolation² and self-monitoring³ Airline contacts → daily self-monitoring³ or self-isolation² and self-monitoring³ depending on flight plan If symptomatic, start to self-isolate and arrange for testing. 	<p>Active daily monitoring generally not required, may be considered at the discretion of the MOH</p> <ul style="list-style-type: none"> Manage as probable or suspect case if symptomatic⁵ If testing for COVID-19 is negative, continue self-isolation for the duration of the 14 days post exposure/landing
Low / No risk	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Follow action recommended for the entire population 	<ul style="list-style-type: none"> Community level information Individual advice if required

See definitions for all footnotes on following pages

¹Definition of a high risk close contact

- Anyone who has been within 2 meters of a case for more than 15 minutes cumulatively in a day
- Anyone who is exposed to the infectious body fluids of a case
- Anyone who is a household-like contact, such as
- Anyone who lived with a case before the case started isolation, or if the case is unable to isolate adequately in the household setting anyone who lives with the case during his or her isolation period; or
- Anyone who has direct physical contact with a case, including the case's caregiver, an intimate partner or a child receiving care from the case even if not residing in the same household as the case.
 - The caregiver should reduce their risk of COVID-19 infection by wearing a medical mask if available (preferred), or a well-constructed and well-fitting non-medical mask, when providing direct care, or within 2m of the case. They should also use appropriate eye protection. However, in most cases, this will not be sufficient to avoid the classification of the exposure as high-risk.
 - There are scenarios where someone with COVID-19 has to take care of dependents, or dependents with COVID-19 need care from someone without it. Psychological needs of children need to be attended too, frequently including physical contact and comfort from a caregiver. It might be impossible to prevent all interaction between young siblings.
- Others, as determined by the MHO/YCDC.
- Factors to consider in determining if someone is a household-like contact include the number of hours or days spent with the case, sleeping arrangement, etc.
- A healthcare worker who provided direct physical care to a case, or a laboratory worker handling COVID-19 specimens, without consistent and appropriate use of recommended PPE and infection prevention and control practices.
- Anyone who has been identified by the local MOH/YCDC as a possible high-risk 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.

²Self-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 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.

³Daily self-monitoring means:

- Self-monitor for the appearance of symptoms, particularly fever and respiratory symptoms like 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.

⁴Active daily monitoring

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

⁵Manage 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.

⁶Essential service workers

- 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 the YCDC/MOH workers who are deemed essential may return to work if their organizational management team has identified the individual as a critical essential worker needed to support minimum staffing thresholds to support overall public safety. **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-isolate as per existing clinical direction while not at work, and if they develop symptoms, should self-isolate immediately, contact 811 and their employer.