Ministry of Health, Government of Alberta
June 2021
Coronavirus, Novel Public Health Disease Management Guideline
All rights reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without written permission of Alberta Health, Government of Alberta.
© Copyright of this document and its contents belongs to the Government of Alberta.

For further information on the use of this protocol contact:
Health.CD@gov.ab.ca
Health and Wellness Promotion Branch
Public Health and Compliance Branch
Alberta Health

View the current version of this publication at https://open.alberta.ca/publications/coronavirus-covid-19

Subseded
Table of Contents

Case Definition .................................................................................................................. 6
Confirmed Case ................................................................................................................. 6
Probable Case ................................................................................................................... 7

Reporting Requirements ................................................................................................... 8
1. Physicians ....................................................................................................................... 8
2. Laboratories .................................................................................................................. 8
3. Alberta Health Services (AHS) and First Nations Inuit Health Branch (FNIHB) ....... 8

Epidemiology ....................................................................................................................... 9
Etiology ................................................................................................................................. 9
Clinical Presentation ........................................................................................................... 9
Reservoir ............................................................................................................................... 10
Transmission ......................................................................................................................... 10
Incubation Period ............................................................................................................... 10
Period of Communicability ................................................................................................. 10
Host Susceptibility .............................................................................................................. 11
Incidence .............................................................................................................................. 11

Public Health Management ............................................................................................... 12
Section 1: Diagnosis ........................................................................................................... 13
Section 2: Testing Modality, Recommendations, Interpretation and Management .......... 14
  Testing Recommendations ............................................................................................... 14
  Table 2a: Symptom List for COVID-19 Testing ............................................................... 14
  Testing in Alberta: ........................................................................................................... 15
  Table 2b: Management of Tested Individuals who are NOT Previous Cases .......... 15
  Testing and Management of Resolved Cases ............................................................... 16
  Table 2c: Testing and Management of Resolved Cases ............................................... 17
  Indications to Re-Test Resolved Cases within 90 days ............................................... 18
  Management of Resolved Cases with New Exposure .................................................... 18
  Testing Recommendations for Residents Admitted to a Facility .............................. 19
  Table 2d: Testing Recommendations for Residents Admitted to a Facility ............... 19
Section 3: Key Investigation ............................................................................................... 20
  Table 3a: Definition of Close Contacts ......................................................................... 21
Section 4: Management of Cases ...................................................................................... 22
  Management of Hospitalized Cases .............................................................................. 22
  Discharge/Transfer of a Hospitalized Case ................................................................... 22
Annex C: Management of COVID-19 Outbreaks

Outbreak-related Definitions

Management of Community Outbreaks

Table C1: Outbreak Definitions of COVID-19

Management of COVID-19 Outbreaks in Facility/Other Congregate Settings

Testing of Staff/Residents/Children

Table C2: Symptoms to Initiate Testing

Table C3: Management of COVID-19 Outbreaks in Facility/Other Congregate Settings

Other COVID-19 Outbreak Management Recommendations for Facilities

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

Management of COVID-19 Outbreaks in Child Care Settings

Table C4: Management of COVID-19 Outbreaks in a Child Care Setting
Management of COVID-19 Outbreaks in Schools (K-12) ................................................................. 42
Table C5: Management of COVID-19 Outbreaks in Schools (K-12) ........................................ 42
Management of COVID-19 Outbreaks in Post-Secondary Institutions (PSI) .......................... 43
Table C6: Management of COVID-19 Outbreaks in PSI ......................................................... 43
Management of COVID-19 Outbreaks in a Workplace ............................................................ 44
Notifications of Public Exposures of COVID-19 ................................................................. 44
Annex D: Management of Travelers ..................................................................................... 45
Annex E: Preventative Measures ......................................................................................... 48
Annex F: Revision History ................................................................................................. 49
References ......................................................................................................................... 52
Case Definition

NOTE: Alberta Health will update this guideline as new information becomes available on the situation.

Confirmed Case

A person with confirmation of infection with the virus (SARS-CoV-2) that causes COVID-19 by:

- Detection of at least one specific gene target by a validated nucleic acid amplification tests (NAAT) (e.g. real-time PCR or nucleic acid sequencing) performed at a community, hospital or reference laboratory (NML or a provincial public health laboratory)

OR

- A positive result on a validated rapid/point-of-care (POC) NAAT-based assay or antigen test(A) that has been deemed acceptable to provide a final result (i.e. does not require confirmatory testing)

(A) The performance characteristics of commercial testing kits such as the Simplexa®, GeneXpert®, Aptima or BD Max™ NAT are similar to the COVID-19 lab-developed test being used at Alberta Precision Laboratories (APL) therefore additional confirmatory testing is not necessary. For more information refer to Rapid COVID-19 Tests. Positive results by the Abbott ID NOW COVID-19 molecular test or the Rapid Antigen tests such as the Abbott PanBio are considered valid and additional confirmatory testing is not required if completed under the conditions outlined by Health Canada and in accordance with the manufacturer’s instructions. (See Section 2: Testing Modality, Recommendations, Interpretation and Management and the Guidance For Employer-Initiated Covid-19 Testing)
Probable Case\(^{\text{(B)}}\)

A person with clinical illness\(^{\text{(C)}}\) who in the last 14 days\(^{\text{(D)}}\):

- Had close contact with a confirmed COVID-19 case OR was exposed to a known outbreak of COVID-19 OR had laboratory exposure to biological material (e.g., primary clinical specimens, virus culture isolates) known to contain COVID-19

AND

- Has not had a laboratory-based NAAT assay for SARS-CoV-2 completed or the result is inconclusive\(^{\text{(E)}}\)

\(^{\text{(B)}}\) All symptomatic contacts should be tested where feasible to confirm diagnosis. The probable case definition should only be used in the rare circumstances when the laboratory testing cannot be done or is inconclusive but clinical suspicion is high.

\(^{\text{(C)}}\) Clinical illness: Any one or more of the following: fever (over 38 degrees Celsius), new onset/exacerbation of following symptoms: cough, shortness of breath (SOB)/difficulty breathing, sore throat, loss of sense of taste and/or smell or runny nose. NOTE: Individuals may present with other symptoms that qualify them to be tested. Refer to Section 2: Testing Modality, Recommendations, Interpretation and Management and Table 2a: Symptom List for COVID-19 Testing for more information.

\(^{\text{(D)}}\) The incubation period is up to 14 days between infection and the onset of clinical symptoms of the disease; therefore exposure history based on the previous 14 days is recommended.

\(^{\text{(E)}}\) An inconclusive result on a real-time PCR assay is defined as: an indeterminate result on a single or multiple real-time PCR target(s) without sequencing confirmation or a positive result from an assay that has limited performance data available or performed by a laboratory that lacks/has not demonstrated accredited status by the College of Physicians and Surgeons of Alberta.
Reporting Requirements

1. Physicians
Physicians shall notify the Medical Officer of Health (MOH) (or designate) of the zone, of all probable and confirmed cases by the Fastest Means Possible (FMP).

2. Laboratories
All laboratories shall provide all reportable positive laboratory results, including results from rapid diagnostic tests, by FMP (e.g., secure electronic notification) to
- the MOH (or designate) of the zone and
- the Chief Medical Officer of Health (CMOH) (or designate)

The minimum client information required for reporting on the positive laboratory report must include:
- name,
- date of birth,
- health care number,
- address and
- phone number
- symptomatic, or asymptomatic and
- Exposure Investigation (EI) number if linked to an outbreak site

• NOTE: Employer initiated COVID-19 testing results must be reported using the minimum data set outlined in Appendix B: Positive Result Reporting of the Guidance For Employer-Initiated COVID-19 Testing document.

3. Alberta Health Services (AHS) and First Nations Inuit Health Branch (FNIHB)
- The MOH (or designate) of the zone where the case currently resides shall forward the Public Health Agency of Canada’s Coronavirus Disease (COVID-19) Case Report Form or use another mutually agreed upon reporting system, to report all probable and confirmed cases to the CMOH (or designate) within 24 hours of initial laboratory FMP notification.
- All out-of-province and out-of-country case and contact reports shall be forwarded to the CMOH (or designate) within 24 hours, using existing protocols i.e., AHS enters information into CDOM if investigation initiated in AB; FNIHB emails information to CD.Data@gov.ab.ca:
  - name,
  - date of birth,
  - out-of-province health care number,
  - out-of-province address and phone number,
  - positive laboratory report, and
  - other relevant clinical / epidemiological information.

• Any new confirmed COVID-19 outbreaks shall be reported to Alberta Health via email as soon as possible using HEALTH-AHSCOVIDReporting@gov.ab.ca. In addition, the Alberta Outbreak Report Form (AORF) is still required and should be submitted as soon as possible using existing processes (e.g., CDOM or fax) for reporting and surveillance purposes.

4. Rapid/Point Of Care Testing (POCT) Reporting
- All positive rapid/POCT test results (antigen or molecular) used for diagnosis of COVID-19 in symptomatic individuals must be reported to Alberta Health as outlined in the Guidance For Employer-Initiated COVID-19 Testing document.
Epidemiology

Etiology

Human coronaviruses are enveloped, ribonucleic acid (RNA) viruses that are part of the Coronaviridae Family. There are 7 known human coronaviruses at present:

- Four types that cause generally mild illness: 229E, OC43, NL63 and HKU; and
- Two types that can cause severe illness: Middle East respiratory syndrome coronavirus (MERS-CoV) and severe acute respiratory syndrome coronavirus (SARS-CoV). Refer to the Public Health Disease Management Guideline for Coronavirus – MERS/SARS for more information.
- COVID-19 is an illness caused by a coronavirus (SARS-CoV-2) first identified in December 2019, in Wuhan, China as having caused an outbreak of respiratory infections, including pneumonia.

Viruses constantly change through mutation, and new variants of a virus are expected to occur. A variant of concern (VOC) is a variant that has one or more of the following characteristics:

- increased transmissibility,
- evades natural or vaccine-related immunity,
- increased virulence,
- evades detection by available diagnostic tests, or
- is less responsive to treatment.

For more information including designated VOCs in Canada, refer to the SARS-CoV-2 variants: National definitions, classifications and public health actions.

SARS-CoV-2 VOCs have been reported globally since December 2020. The B.1.1.7 (Alpha) variant was first identified in the United Kingdom, B.1.351 (Beta) in South Africa, P.1 (Gamma) in Brazil and B.1.617.2 (Delta) in India. These VOCs have also been identified in Alberta and Alberta Health is continuously monitoring and assessing their impact on viral transmission, disease severity, diagnostic testing, therapeutics, and vaccine effectiveness in the province. For more information refer to the Alberta Health website on COVID-19 variants of concern.

Clinical Presentation

Individuals infected with the virus that causes COVID-19 may have few or no symptoms and symptoms may range from mild to severe. COVID-19 symptoms include cough, fever, headache, sore throat, shortness of breath, nasal congestion and new loss of sense of taste or smell, fatigue, muscle aches, vomiting or diarrhea. For some of the other symptoms that can be associated with COVID-19 infection, refer to Table 2a: Symptom List for COVID-19 Testing. Current evidence suggests that vaccinated individuals infected with COVID-19 may present with milder symptoms. Complications of COVID-19 include severe pneumonia, acute respiratory distress syndrome, sepsis, septic shock, multi-organ failure or death.

Generally, the duration of illness is about two weeks for cases with mild infection but can be up to six weeks for critical cases and in immunocompromised individuals. Post COVID-19 condition is a term used for a wide range of new, returning, or ongoing health problems people can experience more than four weeks after their COVID-19 infection. Research is ongoing to better understand all the health impacts associated with COVID-19. For more information refer to Post-COVID Conditions.

Children and adolescents infected with SARS-CoV-2 typically have mild or no symptoms and in Canada, account for approximately 19% of reported cases. Although rare, severe illness and death have been reported. Since April 2020, there have been reports of children and adolescents presenting with acute illness with a hyper inflammatory syndrome, leading to shock and multi-organ failure. This has been termed Multi-System Inflammatory Syndrome in children and adolescents (MIS-C). Some cases have been associated with COVID-19 (often several weeks following a SARS-CoV-2 infection), but a causal link with COVID-19 has not...
been definitively established. The risk factors associated with developing MIS-C are currently unknown.\(^{(13)}\) Research to further understand MIS-C is ongoing.\(^{(14-16)}\) For more information refer to the [WHO Multisystem inflammatory syndrome in children and adolescents temporally related to COVID-19](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/mis-c) and the [Alberta Health MIS-C Public Health Disease Management Guideline](https://open.alberta.ca/publications/coronavirus-covid-19).

Analyses so far indicate that B.1.1.7, B.1.351, P.1 and B.1.617.2 variants are possibly associated with increased risk of severe disease and hospitalization, but this has not been confirmed yet.\(^{(17)}\) Research is ongoing regarding the spectrum of COVID-19 illness and severity of outcomes associated with all the circulating VOCs.

**Reservoir**

SARS-CoV-2 is thought to have emerged from an animal source although this has not yet been confirmed.

**Transmission**

SARS-CoV-2 virus (non-VOC and VOCs) is transmitted person-to-person primarily via respiratory droplets that are generated when a person coughs, sneezes, talks, shouts or sings. The droplets range in size from large droplets (defined as >5-10 μm in diameter) that spread at close range (i.e., less than two metres) to smaller droplets (or aerosols) that in certain circumstances, have the potential to be infectious over longer distances and may be suspended for longer periods of time and can play a role in COVID-19 transmission. These circumstances include aerosol-generating medical procedures (AGMP) or specific settings such as indoor locations that may be poorly ventilated, crowded, where gatherings are taking place for prolonged periods or where heavy breathing or exertion is occurring. For more information refer to the [Transmission of SARS CoV-2](https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care-transmission.html) and [Considerations for aerosol transmission](https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care-transmission.html). Current evidence shows there is an increase in transmissibility with currently known VOCs.\(^{(18)}\)

COVID-19 can also spread via direct physical contact with another person (e.g., hand shake) or by touching contaminated objects or surfaces and then touching one’s own mouth, nose, or possibly eyes.\(^{(7)}\) However, fomites do not appear to be a major source of transmission.\(^{(19)}\) Infected individuals can transmit the virus 48 hours before symptom onset (i.e., pre-symptomatic) or even if they have an asymptomatic infection (i.e., never developed symptoms) or when their symptoms went unnoticed.\(^{(20,21)}\)

**Incubation Period**

The incubation period ranges from 1-14 days with median estimates of 5-6 days between infection and the onset of clinical symptoms of the disease.\(^{(5)}\)

**Period of Communicability**

The period of communicability may begin up to 48 hours before symptom onset and throughout the symptomatic period, even if symptoms are mild or very non-specific. Studies have shown that after day eight of illness/symptoms no live virus was recovered from patients with upper respiratory tract disease or limited lower respiratory tract disease. People with more severe disease are likely to be infectious for a few days longer.\(^{(22,23)}\) NAAT positivity from respiratory samples can be prolonged to 3-4 weeks after symptom onset even when no viable virus was detected.\(^{(24)}\) There have been case reports of persistent RT-PCR results for up to 82 days after symptom onset.\(^{(25,26)}\) Experience from other respiratory viral infections suggests that immunocompromised patients with COVID-19 may shed detectable SARS-CoV-2 viral material and potentially infectious virus longer.\(^{(27)}\) Research is ongoing to determine if there is a difference in the period of communicability of VOC compared to non-VOC.
Host Susceptibility

Susceptibility is assumed to be universal. Knowledge about COVID-19 disease continues to evolve and this includes evidence on individuals who are most susceptible to infection and severe outcomes.\(^\text{(13)}\) To date, studies\(^{(9,13,21)}\) have found the following:

- Older adults (>60 years) and people with existing chronic medical conditions (e.g., cardiovascular and liver disorders, lung disease, diabetes, high blood pressure, kidney disease, sickle cell disease, dementia or stroke) or immune compromising conditions are more vulnerable to severe COVID-19 illness. The list of chronic conditions above only includes those for which there is sufficient evidence available to conclude a higher level of risk.\(^{(13)}\)
- Even though obesity is not well defined in the literature, individuals with a body mass index (BMI) ≥35 have a higher risk of ICU admission/intubation.
- There is no clear evidence on the role that race/ethnicity plays in outcomes of COVID-19 i.e., it is unclear whether any differences in outcomes are due to social determinants of health or biological factors.
- Pregnant women have a higher risk of severe illness compared to non-pregnant women and may also be at an increased for adverse pregnancy outcomes (e.g. preterm birth).
- Generally, children (under 18 years of age) are less susceptible to severe clinical disease than older people.\(^{(28)}\) However, some children do have severe outcomes and those with underlying medical conditions are at increased risk for severe illness compared to children with no underlying medical conditions.\(^{(13)}\)

Understanding of the immune response in COVID-19 disease is evolving. There are increasing reports of individuals who were infected a second time with a VOC or non-VOC after having recovered from a first infection.\(^{(29)}\) Ongoing COVID-19 studies are working to help establish the frequency and severity of reinfection with VOC and non-VOC and who might be at higher risk.

Incidence

For cases reported in Alberta refer to the following link:

For cases reported in Canada refer to the following link:

World Health Organization provides daily updates on global case counts and situation reports:
www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports

Johns Hopkins COVID-19 Case Map
gisanddata.maps.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6
Public Health Management

NOTE: This guidance is based on current available scientific evidence and expert opinion and is subject to change as new information on transmissibility and epidemiology becomes available. (30)

Public Health Management of VOC and non-VOC

VOCs now make up a significant proportion of COVID-19 cases in Alberta. The following public health guidance applies for both VOC and non-VOC cases and their close contacts.

Since the COVID-19 pandemic began, Alberta Precision Labs (APL) has been performing surveillance for variants using whole-genome sequencing (WGS) on select samples. High-throughput nucleic acid screening tests that are faster than WGS were subsequently developed to detect VOCs in samples soon after they test positive for COVID-19. Variant screening may not be possible in samples with low viral loads. (31) Screening and sequencing strategy is constantly reviewed and adjusted to meet surveillance needs and maintain laboratory capacity and turnaround times. For more information, refer to the lab bulletins on the APL website.
Section 1: Diagnosis

A diagnosis of SARS-CoV-2 infection is based on testing. Acceptable specimen types for COVID-19 testing include nasopharyngeal (NP) swab, throat swab, NP aspirate, endotracheal tube (ETT) suction/sputum, or bronchoalveolar lavage/bronchial wash (BAL/BW). NP and throat swabs are recommended over nasal swabs for COVID-19 testing. If unable to collect a NP swab or throat swab, a deep nasal swab can be collected instead, though sensitivity may be reduced. It is recommended that hospitalized patients with COVID-19 symptoms be tested with an NP swab. For patients who have a lower respiratory tract infection and are intubated, also submit an ETT suction or BAL/BW.\(^{(32)}\)
Section 2: Testing Modality, Recommendations, Interpretation and Management

Molecular, antigen and serology tests have been developed and continue to be developed and approved to test for COVID-19. Molecular tests detect the unique genetic sequence of the SARS-CoV-2 virus and antigen tests detect proteins of the virus. Both can be used to diagnose acute infection. For more information on molecular and rapid antigen test performance, refer to Annex A: Testing Performance.

Serology tests do not directly detect the virus but measure antibodies the body produces after infection with the virus. These antibodies can provide evidence of previous or current infection. Since it can take more than a week for antibodies to be produced following infection, serology tests are generally not recommended for use as a diagnostic tool to confirm acute infection. (33) Currently in Alberta, serology tests are mainly used for population serosurveys. Serology testing is available for clinical use for certain situations (e.g., to assist in the diagnosis of children with MIS-C) in consultation with APL microbiologists/virologists. Serology testing is not needed before receiving a COVID-19 vaccine to assess susceptibility to SARS-CoV-2 or after receiving the vaccination to assess immune response to the vaccine.

Testing Recommendations

Testing is recommended for the diagnosis of individuals with COVID-19 compatible symptoms as listed in Table 2a: Symptom List for COVID-19 Testing. Individuals with these symptoms who are working in high risk settings, including HCWs as well as residents/clients in congregate settings, should always be offered testing to confirm the diagnosis. An individual with symptoms not listed in Table 2a such as “COVID toes” or altered mental status may also be considered for testing at the discretion of the individual’s clinician.

Table 2a: Symptom List for COVID-19 Testing

<table>
<thead>
<tr>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Fever</td>
</tr>
<tr>
<td>- Cough (new cough or worsening chronic cough)</td>
</tr>
<tr>
<td>- Shortness of breath/difficulty breathing (new or worsening)</td>
</tr>
<tr>
<td>- Runny nose</td>
</tr>
<tr>
<td>- Sore throat</td>
</tr>
<tr>
<td>- Stuffy nose</td>
</tr>
<tr>
<td>- Painful swallowing</td>
</tr>
<tr>
<td>- Headache</td>
</tr>
<tr>
<td>- Chills</td>
</tr>
<tr>
<td>- Muscle/joint ache</td>
</tr>
<tr>
<td>- Feeling unwell/tired/severe exhaustion</td>
</tr>
<tr>
<td>- Nausea/Vomiting/Diarrhea/Unexplained loss of appetite</td>
</tr>
<tr>
<td>- Loss of sense of smell or taste</td>
</tr>
<tr>
<td>- Conjunctivitis</td>
</tr>
</tbody>
</table>

Superseded
View the current version of this publication at https://open.alberta.ca/publications/coronavirus-covid-19
Testing in Alberta:

- The following individuals are eligible for testing:
  - any person exhibiting symptoms listed in Table 2a: Symptom List for COVID-19 Testing.
  - close contacts of confirmed and probable COVID-19 cases.
    - NOTE: Testing is not recommended for close contacts who are fully immunized and are asymptomatic. For more information refer to Section 7: Management of Close Contacts Immunized Against COVID-19.
  - Workers and/or residents at specific outbreak sites including:
    - staff/residents in supportive living (including group homes and lodges), long-term care facilities (nursing homes and auxiliary hospital), hospices, shelters and correctional facilities when a NEW COVID-19 outbreak has been declared,
    - residents/staff in an existing COVID-19 outbreak if transmission appears to still be occurring.
  - New admissions to a congregate living facility e.g. supportive living (including lodges and group homes), long-term care (nursing homes and auxiliary hospital), hospices and correctional facilities. For more information refer to Testing Recommendations for Residents Admitted to a Facility.
  - NOTE: Albertans can access private testing for COVID-19 if they are asymptomatic and do not meet the eligibility criteria for testing in the public testing system.
- For more information on management refer to Table 2b: Management of Tested Individuals.

Table 2b: Management of Tested Individuals who are NOT Previous Cases

<table>
<thead>
<tr>
<th>Symptoms**</th>
<th>COVID-19 Test</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatic</td>
<td>Positive</td>
<td>- Manage as a lab-confirmed symptomatic case.</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>- <strong>Who is a close contact:</strong> Quarantine for 14 days since the last exposure or isolate until symptoms resolve, whichever is longer.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- <strong>NOTE:</strong> For quarantine requirements for fully and partially immunized close contacts refer to Table 7a. Management of Immunized Close Contacts.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- <strong>Who is NOT a close contact:</strong> Strongly recommended to stay at home and limit contact with others until symptoms resolve. Retesting may be considered.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asymptomatic</td>
<td>Positive</td>
<td>- Manage as a lab confirmed asymptomatic case.</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>- <strong>Who is a close contact:</strong> Quarantine for 14 days since the last exposure and monitor for symptoms.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- <strong>NOTE:</strong> For quarantine requirements for fully and partially immunized close contacts refer to Table 7a. Management of Immunized Close Contacts.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- <strong>Who is NOT a close contact:</strong> NO quarantine required. Continue with normal activities.</td>
</tr>
</tbody>
</table>

**See symptoms listed in Table 2a: Symptom List for COVID-19 Testing

**This also applies to resolved cases after 90 days of the initial positive test

Rapid Screening Program

In an effort to reduce spread of COVID-19 from pre-symptomatic and asymptomatic cases, rapid testing can be used to screen for infection in individuals who are not exhibiting COVID-19 symptoms. A number of screening programs have been initiated in Alberta in a variety of settings such as continuing care facilities, workplaces, schools etc. Individuals screening positive must isolate and their positive screen results must be confirmed by follow-up PCR test. For more information on the rapid screening program refer to the Alberta Health Rapid testing program website.
Testing and Management of Resolved Cases (F)

- Studies have demonstrated prolonged detection of SARS-CoV-2 RNA in COVID-19 cases even after symptoms have resolved; however in most cases, prolonged RNA detection does not reflect infectious virus. The median range of viral shedding has been reported to be 3-4 weeks after symptom onset, with case reports of persistent RT-PCR results for up to 82 days after symptom onset.\(^{(25,26)}\)
- Due to uncertainty regarding immunity after infection and the possible risk of re-infection,\(^{(34,35)}\) resolved cases should be advised to take the same precautions to avoid exposure as an individual who has never had COVID-19, including wearing a mask, physical distancing, practicing proper hand hygiene and respiratory etiquette and if they are a HCW to follow IPC recommendations regarding PPE.\(^{(36)}\)
- Generally, asymptomatic resolved cases should NOT be re-tested for COVID-19 within 90 days of the initial positive test result. However if the resolved case develops NEW COVID-19 symptoms within the 90 days, screening for VOC and testing for other pathogens should be considered depending on symptoms and the setting, and management of these individuals is based on symptoms and diagnosis.
- It may be possible for a few individuals to shed detectable SARS-CoV-2 viral material longer than 90 days. If suspected to be the case, consultation with the local MOH and other specialists including microbiologists/virologists and infectious disease physicians can help with the management decision. For more information refer to Table 2c: Testing and Management of Resolved Cases.

(F) Resolved cases refers to previously lab-confirmed COVID-19 cases that have completed isolation – see Section 4: Management of Cases for more detail.
### Table 2c: Testing and Management of Resolved Cases

<table>
<thead>
<tr>
<th>Timing of test from previous positive result</th>
<th>New onset of COVID-19 Symptoms</th>
<th>Testing Recommendations</th>
<th>Management Recommendations</th>
</tr>
</thead>
</table>
| Less than 90 days                          | Not applicable (Asymptomatic) | No testing recommended  | If inadvertently tested for COVID-19 less than 90 days & result positive:  
- No repeat isolation  
- No contact follow-up  
**Note:** positive test result generally indicates residual non-viable virus and this person is considered not infectious and NOT a new case |
| 90 days or more                            | Not applicable (Asymptomatic) | Testing indications are the same as for people who have never had COVID-19 | - If tested for COVID-19 refer to [Table 2b: Management of Tested Individuals](https://open.alberta.ca/publications/coronavirus-covid-19) and manage according to lab results and exposure.  
- If concerned about the risk of re-infection, the individual should isolate while waiting for test results.  
- Exceptions may be made to this management requirement in consultation with the local MOH and other specialists including microbiologists/virologists and infectious disease physicians. |
| Less than 90 days                          | Symptomatic                   | - Generally do not re-test  
- If re-testing is considered refer to the section on [Indications to Re-Test Resolved Cases within 90 days](https://open.alberta.ca/publications/coronavirus-covid-19) | - Depending on symptoms & setting, consider testing for other pathogens (e.g. RPP).  
- If re-tested for COVID-19 and result is positive, request screening for VOC if not done automatically by the lab  
- Manage according to symptoms and diagnosis.  
- If concerned about the risk of re-infection, the individual should isolate while waiting for test results.  
- Further management is based on lab results and assessment. |
| 90 days or more                            | Symptomatic                   | - COVID-19  
- With or without Respiratory Pathogen Panel (RPP) | - Isolate while laboratory and epidemiological investigation is being conducted.  
- If only COVID-19 testing is done, refer to [Table 2b: Management of Tested Individuals](https://open.alberta.ca/publications/coronavirus-covid-19) and manage according to lab results and exposure.  
- Exceptions may be made to this management requirement in consultation with the local MOH and other specialists including microbiologists/virologists and infectious disease physicians. |

**This is 90 days from test date which yielded the initial positive result. ¥ Refer to [Table 2a: Symptom List for COVID-19 testing](https://open.alberta.ca/publications/coronavirus-covid-19)**
Indications to Re-Test Resolved Cases within 90 days

- Re-testing for COVID-19 within 90 days from a previous positive test can be considered if a clinician has concerns about the risk of re-infection (i.e., NEW COVID-19 symptoms develop after the person’s isolation period) in the following situations:
  - new symptoms develop within 14 days after they are identified as a close contact
  - severe COVID-19-like illness or hospitalized
  - anyone with a high degree of interaction with populations who are at high risk of more severe disease or outbreaks (e.g., HCWs, staff and residents in LTC facilities, prisons, shelters, work camps)
  - immunocompromised person.

Management of Resolved Cases with New Exposure

- There is growing evidence to support that resolved cases do not need to undergo repeat quarantine if they are identified as a close contact within 90 days of their initial diagnosis.
- Despite millions of COVID-19 cases worldwide, surveillance and investigations have only identified few confirmed cases of re-infection with non-VOC or VOC within 90 days of the initial diagnosis. Available evidence suggests that most individuals would have a certain degree of immunity for at least 90 days after initial diagnosis of COVID-19. However, the risk for reinfection is likely to increase due to waning immunity after initial infection and exposure to variants that cause immune escape.
- Therefore, if a resolved case is identified as a close contact (unrelated to their previous infection), no repeat quarantine is required if the exposure is within 90 days of their previous positive test result AND they are asymptomatic.
  - They should closely monitor for COVID-19 symptoms for 14 days after the last exposure.
  - If any COVID-19 symptoms develop, they should isolate immediately and be re-tested for COVID-19.
  - Refer to the section above for other testing and management recommendations.

If a resolved case is identified as a close contact 90 days or more from their previous positive test result, manage as any other close contact and quarantine for 14 days from last exposure. Refer to Section 5: Management of Close Contacts.

(G) The individual is identified as a close contact after exposure to a COVID-19 case unrelated to their previous infection.
Testing Recommendations for Residents Admitted to a Facility

- Testing is recommended for all new residents admitted to a congregate living facility e.g., licensed supportive living (including lodges and group homes), long-term care (nursing homes and auxiliary hospital) and hospices, regardless of symptoms upon admission.
- Residents who return to these settings post-hospitalization for non-COVID-19 illnesses are also recommended to be tested whether they have symptoms or not.
- Refer to Table 2d below for more information.

<table>
<thead>
<tr>
<th>Previous COVID-19 Test Result</th>
<th>Timing of Previous Test</th>
<th>Testing Recommendations on Admission to Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>Less than 90 days</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>90 days or more</td>
<td>Yes</td>
</tr>
<tr>
<td>Negative</td>
<td>Less than 90 days</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>90 days or more</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Table 2d: Testing Recommendations for Residents Admitted to a Facility
Section 3: Key Investigation

- Confirm the diagnosis and that individual meets case definition.
- Ensure appropriate clinical specimen(s) have been collected (see Diagnosis Section).
- Obtain history of illness including date of onset of signs and symptoms. See **Table 2a: Symptom List for COVID-19 Testing**.
- Determine immunization status.
- Determine previous COVID-19 infection. Refer to **Testing and Management of Resolved Cases**
- Determine spectrum of illness and if case requires hospitalization or if they can be managed at home.
- Determine any underlying chronic or immunocompromising condition. Determine possible source of infection:
  - Identify recent travel/residence history inside and outside Canada, or contact with a recent traveler outside Canada, including dates of travel, itineraries and mode of transportation (e.g., airplane, train, etc.);
  - Identify type of contact within health care settings with known COVID-19 cases (e.g., work, visiting patient, etc.), if applicable;
  - Recent contact with a known COVID-19 case or a person with COVID-19-like illness
  - Assess if other members in the household have similar symptoms or have had any contact with a known COVID-19 case/person with COVID-19 symptoms.
- Determine occupation (e.g., healthcare worker(H)) or works with vulnerable individuals i.e., long-term care facilities/continuing care/group homes/shelters)
- Determine possible transmission settings (e.g., household, healthcare setting, community setting, workplace, school, flight etc.).
- Identify close contacts that may have had exposure to the **confirmed/probable case** 48 hours prior to onset of symptoms in the confirmed/probable case and/or while the confirmed/probable case was symptomatic and not isolating. Refer to **Table 3a: Definition of Close Contacts**.
- Determine if a **laboratory confirmed case asymptomatic at testing** had two or more of the symptoms listed in clinical illness(B) for at least 24 hours in the **seven** days prior to specimen collection date. (For more information refer to the **Management of a Laboratory Confirmed Case Asymptomatic at Testing**).
- For public health management of a **laboratory confirmed case asymptomatic at testing** not meeting the criteria of having two or more of the symptoms listed in clinical illness(B) for at least 24 hours in the **seven** days prior to specimen collection, the period of communicability that may be used is 48 hours before laboratory specimen was collected to 10 days after the date of specimen collection. (**NOTE**: The period of communicability may be longer if they develop symptoms during the 10 days after lab specimen collection date).
- Identify close contacts that may have had exposure to a **laboratory confirmed case asymptomatic at testing**(H) between 48 hours before the laboratory specimen collection date and isolation date of that case. Refer to **Table 3a: Definition of Close Contacts**.

---

(H) Health Care Workers (HCW) are individuals who provide service in a clinical care setting, including hospitals, clinics, continuing care facilities, licensed supportive living sites (including group homes), public health centers, community assessment centers, and any other settings where face-to-face patient care is provided (including fire fighters and EMS)

(H) Where feasible, contact tracing for asymptomatic cases should include close contacts that were exposed to the case 48 hours before the specimen collection date. If not feasible, the specimen collection date can be used as the starting point for contact tracing.
### Table 3a: Definition of Close Contacts[^3^–^4^1^]

<table>
<thead>
<tr>
<th>DEFINITION OF CLOSE CONTACTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals that:</td>
</tr>
<tr>
<td>• provided direct care for the case, (including HCW[^h^], family members or other caregivers), or who had other similar close physical contact (e.g., intimate partner, hug, kiss, handshake) without consistent and appropriate use of personal protective equipment (PPE), OR</td>
</tr>
<tr>
<td>• lived with or otherwise had close prolonged[^j^] contact which may be cumulative, i.e., multiple interactions for a total of 15 min or more over a 24-hour period and within two metres with a case without consistent and appropriate use of PPE and not isolating OR</td>
</tr>
<tr>
<td>• had direct contact with infectious body fluids of a case (e.g., shared cigarettes, glasses/bottles, eating utensils) or was coughed or sneezed on while not wearing recommended PPE.</td>
</tr>
</tbody>
</table>

- For definition of close contacts in sports teams and schools, refer to the AHS website on Information for Close Contacts of a COVID-19 Case.

[^3^] As part of the individual risk assessment, consider 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.
Section 4: Management of Cases

Management of Hospitalized Cases

- Isolation precautions apply for hospitalized cases. Consult with hospital Infection Prevention and Control (IPC) for recommendations for lifting isolation.
- Provide information about disease transmission and measures to minimize transmission, including wearing a mask, practicing proper hand hygiene, physical distancing and respiratory etiquette.
- Provide information on immunization as applicable.
- For information on infection prevention and control precautions refer to the following:
  - AHS IPC Resources
  - Infection prevention and control for COVID-19: Second interim guidance for acute healthcare settings

Discharge/Transfer of a Hospitalized Case(K)

- Hospitalized cases that are discharged to their own home before hospital isolation is complete should remain on home isolation for 10 days from onset of symptoms or until symptoms have improved AND they are afebrile for 24 hours, without the use of fever-reducing medications, whichever is longer, after arrival at home.
- **NOTE:** The attending physician may have ordered a different isolation period for a patient based on their specific circumstances when they are discharged to the community (home or continuing care facility).
  - If a patient has been advised by their physician to isolate for longer than the minimum 10 days, they should follow the instructions of their physician.
- Hospitalized cases being discharged/transferred to long-term care facilities/continuing care/group homes/shelters etc. before their isolation period is complete should remain on isolation for 14 days from onset of symptoms or until symptoms have improved AND they are afebrile for 24 hours, without the use of fever-reducing medications, whichever is longer.
  - This additional length of time (four more days from the 10 days) is recommended as the case had severe disease (i.e., hospitalized) and will be re-entering a facility with other vulnerable persons (i.e., long-term care facilities/continuing care/group homes/shelters).

(K) This refers to cases hospitalized due to COVID-19.
Management of Non-Hospitalized Case

- It is highly recommended that ALL cases of COVID-19 (VOC or non-VOC) isolate completely away from their household members to prevent ongoing exposure. If this cannot be accomplished at home, use of an isolation hotel or a different dwelling should be considered.
- Provide information about disease transmission and measures to minimize transmission, including wearing a mask, physical distancing, practicing proper hand hygiene and respiratory etiquette.
- A non-test based approach to clearance for COVID-19 is recommended for cases with mild and moderate illness. Since NAAT positivity from respiratory samples can be prolonged and generally does not reflect infectious virus, a “test of cure” is often misleading.
- Symptomatic confirmed and probable cases are required to isolate for 10 days from onset of symptoms or until symptoms have improved AND they are afebrile for 24 hours, without the use of fever-reducing medications, whichever is longer.
  - Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post-infection.
  - Symptoms such as loss of sense of taste/smell or fatigue may last longer than 10 days, but do not require a longer isolation period.
- Residents of licensed supportive living (including group homes and lodges), long-term care (nursing homes and auxiliary hospitals) and hospices should be isolated with contact and droplet precautions for a minimum 10 days or until symptoms improve AND they are afebrile for 24 hours without the use of fever reducing medications, whichever is longer. Isolation may be extended to 14 days at the discretion of the MOH/Site IPC.
- Active daily surveillance by Public Health is not required.
- NOTE: If a person is determined to be at high risk of clinical decompensation and without necessary supports (e.g., elderly with comorbidities who lives alone), their primary care physician should provide active daily surveillance if feasible, or the case should be encouraged to arrange for family/friends/community organizations to provide wellness checks.
- COVID-19 virus RNA has been detected in the stool of some infected patients\(^{42}\), so there may be a risk of spread through stool. For these reasons, the case should be instructed of the following:
  - effective infection prevention control such as hand hygiene.
  - safe food handling practices.
  - refrain from preparing foods for others in the household until isolation is lifted.
Management of an Immunocompromised Case

- There is currently little information on viral shedding in confirmed COVID-19 cases who are immunocompromised.
- However based on experience from other respiratory viruses, especially influenza virus, immunocompromised confirmed cases may shed SARS-CoV2 for a longer period of time.\(^{(27)}\)
  - These cases should be isolated for 14 days from onset of symptoms or until symptoms have improved and they are afebrile for 24 hours, without the use of fever-reducing medications, whichever is longer.
    - Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post-infection.
    - Symptoms such as loss of sense of taste/smell or fatigue may last longer than 14 days, but do not require a longer isolation period.
  - Duration of isolation for those hospitalized should be decided in consultation with hospital IPC.

Management of a Laboratory Confirmed Case Asymptomatic at Testing

- Provide information about disease transmission and measures to minimize transmission, including wearing a mask, physical distancing, practicing proper hand hygiene and respiratory etiquette.
- Determine if the case had two or more of the following symptoms that lasted at least 24 hours in the seven days before laboratory specimen collection date:
  - fever (over 38 degrees Celsius),
  - new onset/exacerbation of following symptoms: cough, shortness of breath (SOB)/difficulty breathing, loss of sense of taste or smell, sore throat or runny nose.
    - If the case had two or more symptoms as outlined above, the positive result may indicate that the symptoms were due to COVID-19 and that date of symptom onset should be used for public health investigation and management purposes.
    - However, it is possible that the previous symptoms were due to another respiratory pathogen, so the case should be instructed to monitor for COVID-19 symptoms for the 10 days following lab specimen collection date.
    - For a case that had two or more of the symptoms listed above, for at least 24 hours in the seven days prior to specimen collection date, the period of communicability is 48 hours prior to onset of symptoms to 10 days after symptom onset.
- A hospitalized asymptomatic case should be isolated and placed on contact and droplet precautions. Consult with hospital IPC for recommendations for lifting isolation/discharge.
- A non-hospitalized asymptomatic case should be isolated for at least 10 days from the laboratory specimen collection date.
  - Instruct the case to monitor for symptoms in Table 2a: Symptoms for COVID-19 Testing and if symptoms develop during the isolation period, the (hospitalized/non-hospitalized) case must remain in isolation for 10 days after onset of symptoms, or until symptoms have improved AND they are afebrile for 24 hours, without the use of fever-reducing medications, whichever is longer.

Return to Work for Cases

- Proof of a negative COVID-19 test and/or a medical note is not required for cases to return to school/work/activities once the isolation period is complete.

Treatment of Cases

- For information on treatment of COVID-19 Cases refer to the following sources:
  - PHAC guidance on Clinical Management of Patients with COVID-19.
  - The World Health Organization’s Clinical Management of COVID-19 Patients
Section 5: Management of Close Contacts

Management of Close Contact of Confirmed or Probable Case

- Determine the type of exposure, the setting, and the time since last exposure.\(^{(L)}\)
- Provide information about COVID-19 disease including signs and symptoms.
- Determine immunization status. If immunized, refer to Section 7: Management of Close Contacts Immunized Against COVID-19 for information on quarantine and testing.
- If not immunized the following apply:
  - Close contacts of confirmed cases require mandatory quarantine for 14 days from last day of exposure and should be offered testing. Refer to Section 2: Testing Modality, Recommendations, Interpretation and Management. Quarantine must be maintained even if test is negative.
  - Close contacts of probable cases should also be quarantined for 14 days.
  - Close contacts of laboratory confirmed cases asymptomatic at testing, require mandatory quarantine for 14 days from last day of exposure and should be offered testing. Quarantine must be maintained even if test is negative.
  - Refer to Section 2: Testing Modality, Recommendations, Interpretation and Management.
  - For more information refer to Annex B: Isolation and Quarantine.
  - NOTE: Where feasible, contact tracing for any tested individual (symptomatic or asymptomatic) should be initiated once lab results have been received and the person has been determined to be a confirmed/probable case.
    - For more information on contact tracing notification process refer to the AHS website.

Guidance on the Use of Masks

- Non-medical masks and face coverings used in the community may reduce the risk of transmission of COVID-19 on the individual and population level.
- However, non-medical masks and face coverings are not considered to be sufficient PPE in an exposure to a confirmed COVID-19 case when assessing whether an individual is a close contact (i.e., wearing a non-medical mask or face covering does not preclude the individual who was exposed from being considered a close contact. See rationale below).
  - This includes self-reporting of use of medical masks by non-HCW in situations where the case is asymptomatic/pre-symptomatic, and where both persons involved in the exposure event are masked.
- Continuous masking (medical/surgical masks) and proper hand hygiene is considered to offer sufficient protection for HCWs\(^{(L)}\) who have cared for patients with pre-symptomatic/asymptomatic COVID-19 infection. This is NOT considered sufficient PPE for HCWs who work with symptomatic patients or confirmed/probable cases. For more information on appropriate PPE for HCW refer to the AHS COVID-19 Personal Protective Equipment website.

\(^{(L)}\) For close contacts with on-going exposure, the last date of exposure is the date the case is determined to be non-infectious i.e., 10 days after onset of symptoms or until symptoms have improved AND afebrile for 24 hours, without the use of fever-reducing medications, whichever is longer.
Rationale:

- HCWs have direct access to professional IPC/WHS support to ensure/evaluate appropriate practice standards. They are also trained in donning/doffing/using appropriate hand hygiene, are able to implement risk assessment practices, and are more aware of the types of interactions they are having with patients. For more information refer to Section 6: Management of Health Care Workers (HCW).
- In addition, mask quality specifications, fit and appropriate use are difficult to assess for members of the general public, and self-reports may not be accurate.

Assessment of PPE in Workplaces

- In general, employers will be contacted by Public Health if there is a case of COVID-19 who is identified as having been at the worksite while infectious.
  - Public Health will work with the case, employer and their occupational health and safety (OH&S) practitioner (if available) to identify persons who may have been exposed at work (close contacts).
  - Public Health will ask employers to identify and notify workplace close contacts.
- Workplaces that meet specific criteria listed below may consider PPE use in their assessment of close contacts if all of the following applies:
  - There needs to be a formal OH&S or an IPC professional/practitioner(M) that has knowledge of what constitutes adequate PPE for that particular work setting in the context of COVID-19.
  - The professional/practitioner must provide oversight of PPE use and provide PPE training to workers in that work setting.
  - In the event of an exposure to COVID-19 in the work setting, the OH&S or IPC professional/practitioner should be able to conduct an assessment to determine if the exposed worker was wearing the appropriate PPE as per work site guidance and training.
  - This assessment should be documented and made available, if requested by AHS.
- If the assessment determines the worker was following all PPE guidance and there were no breaches, the worker would be considered protected and would NOT be considered a close contact and quarantine would not be required.
- If workplaces do not meet the criteria outlined above, workers exposed to COVID-19 will follow the same direction that applies to members of public (i.e. mask use is not considered in the close contacts assessment).

(M) OH&S or IPC team/program includes any one of the following:
- A certified Occupational Health and Safety (OH&S) professional/practitioner (as defined by the Canadian Society of Safety Engineering),
- A health professional certified in Infection Prevention and Control (by CHICA-Canada)
- An individual who holds a certificate or other credential in Occupational Health and Safety from a recognized post-secondary institution in Canada
Section 6: Management of Health Care Workers (HCW) (H)

Recommendations on Return to Work

- Refer to COVID-19 Return to Work Guide for AHS Healthcare Workers
- HCW who may have been exposed to COVID-19 should refer to the COVID-19 Self-Assessment Tool for Healthcare Workers and the COVID-19 Testing / Online Booking for more information.
- The following applies for HCW who tested positive for COVID-19:
  - They require mandatory isolation for 10 days from onset of symptoms or until symptoms have improved AND afebrile for 24 hours, without the use of fever-reducing medications, whichever is longer.
  - If symptoms such as a lingering cough, loss of sense of taste/smell or fatigue persist beyond 10 days, the HCW may return to work as long as other symptoms have improved and they are well enough to go back to work.
  - If they are asymptomatic and remain asymptomatic, the HCW may return to work 10 days after the lab specimen date.
  - If the HCW is immunocompromised or has other health conditions (e.g. cardiovascular and liver disorders, lung disease, diabetes, high blood pressure, kidney disease, sickle cell disease, dementia or stroke (see Host Susceptibility section for more information), they should consult with WHS/OHS/MOH/designate for further direction about returning to work.

Recommendations on Mask Use for HCWs

- A surgical/procedure mask and good hand hygiene is considered sufficient PPE for asymptomatic HCW working with asymptomatic patients, including within the 48 hours prior to developing symptoms.
  - If HCW becomes symptomatic, all the patients who they cared for (or co-workers) in the 48 hours prior to symptom onset in that HCW will NOT be considered close contacts if the HCW wore a surgical/procedure mask and practiced routine, frequent hand hygiene.
  - If a patient becomes symptomatic, all HCW that cared for the patient in the 48 hours prior to symptom onset in that patient, would NOT be considered close contacts if they were wearing a surgical/procedure mask and practiced good hand hygiene i.e., sufficient PPE.
    - If the time of symptom onset for the patient cannot be reliably ascertained (e.g., patient with cognitive impairment), WHS/OHS/MOH/designate should be consulted regarding period of communicability and its relationship to appropriate PPE use.
- A surgical/procedure mask and good hand hygiene is NOT appropriate PPE for HCW caring for symptomatic patients or when identified as a close contact of a symptomatic co-worker.
- Appropriate PPE for HCW caring for symptomatic patients or confirmed/probable cases of COVID-19 includes: medical masks (or N95 respirators when AGMP is performed), eye protection (e.g., goggles, visor, and face shield), gloves and gown, which means full contact and droplet precautions. For more information, refer to the AHS COVID-19 Personal Protective Equipment website.
- At this time, immunized HCW should continue to use recommended PPE when caring for patients.
  - Immunized HCW who are determined to be a close contacts should follow recommendations outlined in Section 7: Management of Close Contacts Immunized Against COVID-19.

Additional PPE Recommendations for HCWs

- NOTE: Eye protection is recommended as an additional layer of protection for all patient interactions within two metres in areas where there are ongoing high levels of community transmission.
  - If a HCW was wearing a surgical/procedure mask, eye protection and was practicing good hand hygiene and had brief/transient contact with a patient who had symptoms that were not recognized to be COVID-19 at the time (e.g. confusion), it’s possible that HCW may not be considered a close contact but this assessment would have to be done on a case by case basis by WHS/OHS/MOH/designate.
Regulated Health Professionals\(^{(N)}\) in Community Healthcare Settings

- In private community healthcare settings, some health professionals are accountable to their regulatory body/colleges and some may have received professional guidance and training on PPE. These professionals are accountable to their college/regulatory body to follow guidance on the appropriate PPE products to use in their practice settings.
- **NOTE:** All regulated health professionals will be assessed by the MOH/designate regarding their IPC practices to determine if those offered sufficient protection while caring for COVID-19 patients. Quarantine recommendations based on this assessment are at the discretion of the MOH.

\(^{(N)}\) This includes professionals regulated under the *Health Professions Act* and the *Veterinary Profession Act*. 
Section 7: Management of Close Contacts Immunized Against COVID-19

- Vaccines against COVID-19 have been developed and approved for use in Alberta. For more information refer to [COVID-19 Vaccines](https://open.alberta.ca/publications/coronavirus-covid-19) and the Alberta Health website on Vaccine Distribution.
- Current evidence suggests one dose of COVID-19 vaccines can offer very good protection against symptomatic COVID-19 infection and severe outcomes including hospitalization and death. A complete vaccine series offers even greater protection.[43]
- Due to the lower risk of infection in immunized persons and reduced transmission from them, the following quarantine requirements outlined in [CMOH Order 26-2021](https://open.alberta.ca/publications/coronavirus-covid-19) apply for Albertans who have received COVID-19 vaccine. Refer to Table 7a below for more information:

Table 7a: Management of Immunized Close Contacts

<table>
<thead>
<tr>
<th>Immunization Status on First Day of Exposure</th>
<th>Symptoms</th>
<th>COVID-19 Testing Recommendations</th>
<th>COVID-19 Test Results</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Immunized - more than 14 days after receiving the second dose of a two-dose vaccine series OR one dose in a one-dose vaccine series</td>
<td>No</td>
<td>No</td>
<td>If NO test done OR if tested &amp; result is negative</td>
<td>NO quarantine required</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>If NO test done</td>
<td>Manage as a confirmed case of COVID-19</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If tested &amp; result is positive</td>
<td>Manage as a probable case, Continue to isolate**</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Result is negative</td>
<td>Strongly recommended to stay at home and limit contact with others until symptoms resolve. NO quarantine required</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Result is positive</td>
<td>Manage as a confirmed case of COVID-19</td>
</tr>
<tr>
<td>Partially Immunized - more than 14 days after receiving one dose in a two-dose vaccine series</td>
<td>No</td>
<td>Yes</td>
<td>Test immediately after symptom onset</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>Test on day 7 or later after exposure</td>
<td>If NO test done</td>
<td>Complete quarantine for 10 days from last day of exposure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If tested BEFORE day 7 &amp; result is negative</td>
<td>Quarantine lifted after negative test result received</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If tested on day 7 or later &amp; result is negative</td>
<td>Manage as a confirmed case of COVID-19</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If tested at any time and result is positive</td>
<td>Manage as a probable case, Continue to isolate**</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>IF tested BEFORE day 7 &amp; result is negative</td>
<td>Complete quarantine for 10 days from last day of exposure***</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If tested on day 7 or later &amp; result is negative</td>
<td>Quarantine lifted after negative test result received AND</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Strongly recommended to stay at home and limit contact with others until symptoms resolve.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If tested at any time &amp; result is positive</td>
<td>Manage as a confirmed case of COVID-19</td>
</tr>
</tbody>
</table>

*This includes symptoms outlined in Table 2a: Symptom List for COVID-19 Testing

**Isolate for 10 days from onset of symptoms or until symptoms have improved AND afebrile for 24 hours, without the use of fever-reducing medications, whichever is longer

***If tested again on day 7 or later, quarantine can be lifted after receipt of negative result.
Other Considerations:
- There may be circumstances where it is operationally or medically necessary to exceed the above recommendations.
  - The Medical Officer of Health, their designate or IPC team responsible for a public health investigation, having conducted a clinical assessment, may require individuals to quarantine for periods longer than the timeframes included above.
  - Organizations (including Alberta Health Services) may require more stringent/longer exclusions for higher risk clinical settings or for vulnerable populations.
- Quarantine outlined in Table 7a does not apply to international travelers returning to Canada. International travelers must comply with federal quarantine required by the federal Quarantine Act.
- NOTE: Individuals who are immunocompromised and immunized should discuss testing recommendations with their primary care physician. Profoundly immunocompromised individuals who are fully or partially immunized may have a reduced immune response to immunization. Although there are no different legal quarantine requirements if they are exposed to a COVID-19 case, it is recommended that those in this category exercise extra caution knowing that they may be at higher risk of becoming infected and exposing others.

Additional Recommendations
- During the 14 days post-exposure, the following apply for fully or partially immunized individuals when not required to quarantine:
  - may return to work, school, childcare, and other activities,
  - they must adhere to all public health measures to minimize transmission, including wearing a mask, physical distancing, practicing proper hand hygiene and respiratory etiquette
  - reduce their number of contacts when possible (especially avoiding non-essential visits to continuing care or acute care settings),
  - self-monitor for symptoms and isolate immediately and get tested if develop symptoms.
  - Immunized HCWs are still required to adhere to existing PPE guidance. Refer to AHS Personal Protective Equipment (PPE) website.
Annex A: Testing Performance

Testing Performance:

Real-time Reverse Transcriptase-PCR Tests

The overall performance of COVID-19 molecular tests to determine or rule out lab-confirmed COVID-19 cases depends on sensitivity/specificity of the test, stage of illness and the epidemiology of COVID-19 in the population.\(^{44,45}\)

False negative rates of molecular tests used to test for SARS Co-V-2 ranges from 1 to 30%. The following may lead to false negative results:

- Low viral load,
- insufficient virus at the time of specimen collection (i.e., early in the incubation period or later in the course of illness),
- low analytic sensitivity,
- variability in viral shedding or
- inappropriate specimen type.\(^{46}\)

False negative results pose a challenge in public health management of COVID-19 cases as an individual may still be infected and be infectious to others. If the clinical index of suspicion is high, a negative result should not rule out disease and the test should be repeated.\(^{(0)}\)

Although considered extremely rare, false positive results can happen because of non-specific PCR reactions, contamination, or specimen mislabeling or mix-up. The proportion of false positive results increases as the prevalence of COVID-19 in the population decreases.\(^{45}\) If a test is thought to be a false positive, the test should be repeated. For more information refer to the COVID-19 Scientific Advisory Group Rapid Response Report.

COVID-19 rapid nucleic acid tests (NAT) such as Simplexa®, GeneXpert®, or BD Max™ are now available in Alberta and provide test results within six hours of receipt at the hospital laboratory. These kits are considered Rapid COVID-19 Tests and are referred to as such in the current reporting scheme used by APL and Dynalife. The performance characteristics of these rapid tests are similar to the COVID-19 lab-developed test being used at the APL and additional confirmatory testing is not necessary.\(^{47}\)

CT Values

There is considerable interest in using cycle threshold (CT) values produced by real-time PCR assays to help guide interpretation of tests and patient management. While CT values provide a general sense of the level of viral nucleic acid in a given sample, they are raw values generated by the testing instruments and are not meant to be interpreted in a quantitative manner. CT values are not routinely reported by the laboratory and caution must be exercised in their interpretation if they are disclosed. APL discourages the use of CT values to guide patient management. Any interpretation of CT values must take the following into account:

- CT values are not viral loads – all tests used in Alberta are qualitative tests and therefore do not provide viral loads.
- No COVID-19 PCR assays are FDA or Health Canada authorized as quantitative tests.
- CT values are imprecise measurements due to the heterogeneous nature of respiratory specimens.
- CT values are also dependent on collection quality, sample type, transport medium, transport conditions, and shipping time.

\(^{(0)}\) While waiting for results of the repeat test, the suspect case should continue to isolate or if hospitalized, continue to be on droplet and contact precautions.
• CT values are not suitable predictors of transmissibility, which is dependent on numerous clinical factors as well. CT values for the same samples will vary widely depending on the instrument and assay used – they are not comparable from assay-to-assay.\textsuperscript{(48)}

**Serology Testing**

Limitations of serology tests include the following:

• They are not useful in the diagnosis of acute COVID-19 infection (see above for more information).
• The relationship of various antibody types, amounts and timing of appearance to immunity is currently unknown.
• The sensitivity of serology testing in immunocompromised individuals or the elderly is currently not known.

Serological assays may be useful in targeted sampling studies in the population to model the spread of the virus and the immune response dynamics to inform the risk of further epidemic waves. They may also be used for retrospective case identification, diagnosing post-infectious complications, and to more accurately determine the prevalence of COVID-19 infection.\textsuperscript{(45)}

**Rapid COVID-19 Tests**

Health Canada has approved a number of rapid tests for diagnostic use in symptomatic individuals, including the ID NOW\textsuperscript{™}, PanBio\textsuperscript{™} manufactured by Abbott which are available in certain sites in Alberta. The ID NOW\textsuperscript{™} is a molecular test which detects SARS-CoV-2 from throat swab specimens and approaches the sensitivity and specificity of lab-based molecular testing done by APL. The PanBio\textsuperscript{™} is an antigen test which has high specificity but reduced sensitivity (higher rate of false negative results) that detects SARS-Co-V2 from nasopharyngeal or nasal specimens. The BD Veritor\textsuperscript{™} is another point-of-care antigen test recently introduced in Alberta. In situations where pre-test probability for COVID-19 infection is high, referral for RT-PCR testing at APL is necessary to confirm negative results from antigen tests.\textsuperscript{(33,47,49)}

The ID NOW\textsuperscript{™}, PanBio\textsuperscript{™} and BD Veritor\textsuperscript{™} provide results in approximately 15 minutes. For best performance, it is recommended these tests be used in individuals who have been symptomatic for less than seven days and are not recommended for use in those who are asymptomatic or who have been symptomatic for more than seven days.\textsuperscript{(49,50)} However, the ID NOW may be used in asymptomatic close contacts of a confirmed case of COVID-19.\textsuperscript{(51)}
Annex B: Isolation and Quarantine

**Isolation is required for the following:**

- It is highly recommended that ALL cases of COVID-19 (VOC or non-VOC) isolate completely away from their household members to prevent ongoing exposure. If this cannot be accomplished at home, use of an isolation hotel or a different dwelling should be considered.
  - If the case isolates at home, the following would apply:
    - the case must remain completely away from others, in a separate room with access to their own bathroom.
    - if the case must use a shared space, even temporarily when others are not present (such as a hallway to the bathroom), the case must wear a mask.
    - if there are multiple individuals in the household, these individuals should also remain separate from each other as much as possible.
    - If any household contacts become a COVID-19 case, the remainder of the household contacts will have to restart their quarantine period based on their last date of exposure to the most recent case.

- Individuals with new onset of any of the following symptoms: fever (over 38 degrees Celsius) and/or new onset of (or exacerbation of chronic) cough, SOB/difficulty breathing, sore throat or runny nose, loss of sense of taste or smell must isolate for 10 days from onset of symptoms or until symptoms have improved AND afebrile for 24 hours, without the use of fever-reducing medications, whichever is longer.

**NOTE:** Exemption applies for children with runny nose or sore throat. See Exemptions to Mandatory Isolation/Quarantine.

- Individuals with any of these symptoms and others listed in Table 2a: Symptom List for COVID-19 Testing should complete the online COVID-19 self-assessment or call 811 to arrange for testing, and remain isolated until test results are available:
  - If COVID-19 test result is positive, manage as a confirmed case and continue isolation for 10 days from onset of symptoms or until symptoms have improved AND afebrile for 24 hours, without the use of fever-reducing medications, whichever is longer.
  - If person was NOT a close contact and if COVID-19 test result is negative, they are strongly recommended to stay at home and limit contact with others until symptoms resolve.
  - If person was a close contact to COVID-19 and if COVID-19 test result is negative, they still MUST complete the 14-day quarantine since their last exposure.

- For more information on isolation requirements refer to the COVID-19 Alberta website.
Quarantine is required for the following:

- Returning international travelers must follow federal quarantine requirements after arrival in Canada (unless exempted by Federal/Provincial Government) and should monitor for symptoms. Refer to Table 2a: Symptom List for COVID-19 Testing.
  - If at any time during the quarantine period they develop symptoms, they should follow instructions provided by Government of Canada upon arrival in Canada. This may include accessing provincial COVID-19 testing by completing the online COVID-19 self-assessment or call 811 to arrange testing for COVID-19:
    ▪ If COVID-19 test result is negative, continue quarantine for full 14 days.
    ▪ If COVID-19 test result is positive, isolation is required for 14 days from onset of symptoms or until symptoms have improved AND afebrile for 24 hours, without the use of fever-reducing medications, whichever is longer.

- The following quarantine requirements apply for unimmunized close contacts. For close contacts who are immunized, refer to Section 7: Management of Close Contacts Immunized Against COVID-19
  - Close contacts of confirmed cases must quarantine for 14 days since last exposure and should monitor for symptoms. Refer to Table 2a: Symptom List for COVID-19 Testing.
  - Close contacts of probable cases should also be quarantined for 14 days since last exposure and monitor for symptoms.
  - Quarantine requirements for household contacts: The last day of exposure for household contacts depends on whether the case is able to isolate adequately away from the household or not:
    ▪ A case is considered to be adequately isolated from their household members at home if they are able to remain completely away from others (i.e. in a separate room with access to their own bathroom and no interaction with the rest of their household or if they are isolating in an isolation hotel).
    ▪ The last day of exposure for household contacts of cases who CAN adequately isolate away from their household members would be the day the case went into an adequate isolation location e.g. went to an isolation hotel.
    ▪ All household contacts of cases who CANNOT adequately isolate away from their household members are required to quarantine every day they are exposed to the case during the case’s isolation period, and continue their quarantine for 14 days after the last day of exposure (i.e., the last day of isolation for the case).
  - Close contacts of confirmed/probable cases should be offered testing and instructed to complete the online COVID-19 self-assessment or call 811 to arrange testing for COVID-19. For more information refer to Table 2b: Management of Tested Individuals. As of April 28, 2021, one test is recommended for all close contacts during their quarantine period:
    ▪ Arrangements for the test should occur when they are first notified they are a close contact.
    ▪ If at any time during the quarantine period, the close contact becomes symptomatic they should be re-tested.
    ▪ NOTE: Under certain circumstances, and in certain settings such as acute care facilities and long-term care facilities, additional testing recommendations are at the discretion of the MOH.

- For more information on quarantine refer to difference between quarantine and isolation
Exemptions to Mandatory Isolation/Quarantine

Children Under the Age of 18

- Runny nose and sore throat were removed from the core symptom list on the Alberta Health daily checklist for children and youth under the age of 18 years, as well as all students who attend kindergarten to grade 12, including high school students over 18 years, in October 2020.
- Any child with a single symptom of runny nose or sore throat but no fever, cough, SOB/difficulty breathing and who has NO KNOWN EXPOSURE is exempt from the 10 day isolation requirement as outlined in the exemption for individuals under 18 years of age.
- For more information refer to the COVID-19 Alberta Health Daily Checklist and the Alberta Health website on changes to the daily symptoms checklist for children under 18.

Immunized Individuals (P)

- Following the administration of any vaccine, an immunized person should be counseled about the risk of short-term self-limited side effects, including local reactions and systemic reactions.
- Because some side effects following immunization such as fever, fatigue, headache, muscle/joint ache, vomiting/diarrhea are similar to symptoms for COVID-19, if a vaccine recipient develops these symptoms after vaccination in the expected timeframe for that vaccine (for most vaccines: within 24 hours; for MMR, Varicella and MMRV, usually within five to 12 days; COVID-19 vaccines, usually within a few hours to a few days), they should stay home and away from others.
- If the symptoms resolve within **two** days (48 hours), they can resume normal activities, unless they have been instructed to quarantine or isolate for other reasons.
- If the symptoms do not resolve within **two** days (48 hours) of symptom onset, they should continue to stay home and complete the online COVID-19 self-assessment or call 811 to arrange testing.
- If testing is not done, anyone 18 years of age and older should remain at home for 10 days after onset of symptoms if they exhibit any of the following symptoms - fever, cough, runny nose, sore throat, shortness of breath, loss of sense of taste or smell until symptoms have improved AND afebrile for 24 hours, without the use of fever-reducing medications, whichever is longer. For information about children under 18 years old or about students who attend kindergarten to Grade 12, including high school students over 18, refer to the COVID-19 Alberta Health Daily Checklist.
- Anyone (adult/child) with other COVID-19 symptom list outlined in Table 2a: Symptom List for COVID-19 Testing but not included in CMOH Order 26-2021 or exempted as outlined in the COVID-19 Alberta Health Daily Checklist should stay at home until symptoms resolve.

(P) Exemptions are outlined in Clarification of CMOH Order 05-2020 posted on the Alberta Health website August 27, 2020.
Annex C: Management of COVID-19 Outbreaks

Outbreak-related Definitions

- **Outbreak:** “The occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season” (World Health Organization, 2018). **NOTE:** A common source of infection or the identification of transmission between cases are not requirements for an outbreak. The epidemiologic features of an outbreak and subsequent public health actions are assessed through the outbreak investigation process.

- **Alert:** A warning sign that the situation may evolve into an outbreak. The threshold for triggering an alert is dependent on the specific setting. For more information, refer to Table C1: Outbreak Definitions of COVID-19.

- **Public Reporting:** The minimum number of cases marking the threshold for public reporting of COVID-19 outbreaks.

Management of Community Outbreaks

- A COVID-19 outbreak may be declared for community settings based on outbreak definitions listed in Table C1: Outbreak Definition of COVID-19. The Alberta Outbreak Reporting Form (AORF) **must** be completed and sent to Alberta Health when an outbreak is declared as described in Table C1.

- An outbreak in the community or workplace/work camp may be declared over 28 days (i.e., two incubation periods) from date of onset of symptoms in the last case.
Table C1: Outbreak Definitions of COVID-19

- **NOTE:** Different alert and outbreak definitions are developed for different settings according to the risk level of that specific setting.
- The risk level is based on the combination of vulnerability of the population to severe illness and ease of transmission within the setting. It is critical to take early action to investigate and institute control measures.

<table>
<thead>
<tr>
<th>Type of Setting</th>
<th>Risk</th>
<th>Example</th>
<th>Alert</th>
<th>Outbreak**</th>
<th>Public Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congregate Settings</td>
<td>Very High Risk</td>
<td>Continuing Care, Long-term Care, DSL</td>
<td>1 symptomatic person (see Table A3)</td>
<td>1 confirmed case</td>
<td>2 confirmed cases</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acute care</td>
<td>See AHS Acute Care Outbreak document</td>
<td>See AHS Acute Care Outbreak document</td>
<td></td>
</tr>
<tr>
<td></td>
<td>High Risk</td>
<td>Prisons/Correctional Facilities</td>
<td>1 symptomatic person (see Table A3)</td>
<td>1 confirmed case</td>
<td>5 confirmed cases</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Homeless Shelters or Temporary Housing</td>
<td>1 symptomatic person (see Table A3)</td>
<td>1 confirmed case</td>
<td>5 confirmed cases</td>
</tr>
<tr>
<td></td>
<td>High Risk Workplaces</td>
<td>Standalone work camps OR work sites with ≥ 1 work camp</td>
<td>2 confirmed case</td>
<td>5 confirmed cases €</td>
<td>10 confirmed cases</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Workplaces where individuals work in close proximity indoors for extended periods of time e.g. Food Processing Facilities, Warehouses, Distribution, or Manufacturing Facilities etc.</td>
<td>1 confirmed case</td>
<td>2 confirmed cases €</td>
<td>10 confirmed cases</td>
</tr>
<tr>
<td></td>
<td>Medium Risk</td>
<td>Schools</td>
<td>See Table C5: Management of Outbreaks in Schools (K-12)</td>
<td>See AHS Acute Care Outbreak document</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child care setting: includes daycares, after school care, day homes and preschools</td>
<td>2 symptomatic individuals within 48 hours OR 1 confirmed case (see Table A4)</td>
<td>2 confirmed cases €</td>
<td>5 confirmed cases</td>
</tr>
<tr>
<td></td>
<td>Events</td>
<td>Including but not limited to weddings, funerals, religious gatherings, community events and small gatherings with more than one household</td>
<td>N/A</td>
<td>5 confirmed cases*</td>
<td>10 confirmed cases associated with at least 3 households</td>
</tr>
<tr>
<td>Public Settings</td>
<td>Medium-Low Risk</td>
<td>Including but not limited to hair salons, restaurants, retail spaces, indoor or outdoor recreation facilities, etc.</td>
<td>N/A</td>
<td>5 confirmed cases*</td>
<td>10 confirmed cases</td>
</tr>
<tr>
<td></td>
<td>Post-Secondary Institutions (i.e., classes, cafeteria/restaurant, residences)</td>
<td>See Table C6: Management of Outbreaks in PSI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other workplaces</td>
<td>Medium-Low Risk</td>
<td>Workplaces that do not fit into the categories above (e.g. office buildings, group homes, work sites with no association with a work camp)</td>
<td>N/A</td>
<td>5 confirmed cases*</td>
<td></td>
</tr>
</tbody>
</table>

*Confirmed case(s) needs to have been in the setting during their incubation period or infectious period

¥ Work camps and other facilities: Consider involvement of Environmental Public Health to ensure knowledge of the worksite and workforce.

For schools refer to the Resource Guide for COVID-19 Outbreaks in Schools.

Case numbers within a 14 day period, OR cases with an epi link (i.e. an exposure at a common setting, presence at a gathering, or time spent in a common location or venue, where there is reasonable evidence that transmission could have occurred)

*Case numbers within a 14 day period, OR cases with an epi link (see above) AND at least two or more households are involved.

Ω These are group homes not covered by CMOH Order 23-2021.

*** Work sites where all workers leave site using own transportation or charter/shuttle bus and go to nearest municipality (e.g., Fort McMurray) to their own private accommodations at the end of each shift.

---

Public Health Disease Management Guidelines | Coronavirus, COVID-19
© 2021 Government of Alberta

Classification: Public
Management of COVID-19 Outbreaks in Facility/Other Congregate Settings

Testing of Staff/Residents/Children
- Testing should be done for the following symptomatic individuals:
  - Residents/staff in facilities as per CMOH Order 23-2021 (i.e., licensed supportive living (including group homes and lodges), long-term care (nursing homes and auxiliary hospitals), and hospice services,
  - Residents/staff in other congregate settings* not covered by CMOH Order 23-2021 (e.g., corrections, shelters)
- Refer to Table C2: Symptoms to Initiate Testing.
- For more information on testing refer to Section 2: Testing Modality, Recommendations, Interpretation and Management.

Table C2: Symptoms to Initiate Testing

<table>
<thead>
<tr>
<th>Staff in Facility</th>
<th>Residents in Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff/Resident in Other Congregate Setting(U)</td>
<td>Fever (37.8°C or higher)</td>
</tr>
<tr>
<td>Staff/Children in Childcare Setting/School</td>
<td>- Cough (new cough or worsening chronic cough)</td>
</tr>
<tr>
<td>- Fever</td>
<td>- Shortness of breath/difficulty breathing (new or worsening)</td>
</tr>
<tr>
<td>- Cough (new cough or worsening chronic cough)</td>
<td>- Runny nose</td>
</tr>
<tr>
<td>- Shortness of breath/difficulty breathing (new or worsening)</td>
<td>- Sore throat</td>
</tr>
<tr>
<td>- Runny nose</td>
<td>NEW ONSET of any of the following:</td>
</tr>
<tr>
<td>- Sore throat</td>
<td>- Stuffy nose/Sneezing</td>
</tr>
<tr>
<td>New/unusual onset of any of the following:</td>
<td>- Hoarse Voice/Difficulty or Painful swallowing</td>
</tr>
<tr>
<td>- Stuffy nose</td>
<td>- Headache</td>
</tr>
<tr>
<td>- Painful swallowing</td>
<td>- Chills</td>
</tr>
<tr>
<td>- Headache</td>
<td>- Muscle/joint ache</td>
</tr>
<tr>
<td>- Chills</td>
<td>- Feeling unwell/fatigue/severe exhaustion</td>
</tr>
<tr>
<td>- Muscle/joint ache</td>
<td>- Nausea/Vomiting/Diarrhea/Unexplained loss of appetite</td>
</tr>
<tr>
<td>- Feeling unwell/fatigue/severe exhaustion</td>
<td>- Loss of sense of smell or taste</td>
</tr>
<tr>
<td>- Nausea/Vomiting/Diarrhea/Unexplained loss of appetite</td>
<td>- Conjunctivitis</td>
</tr>
<tr>
<td>- Loss of sense of smell or taste</td>
<td>- Altered/change in mental status</td>
</tr>
<tr>
<td>- Conjunctivitis</td>
<td></td>
</tr>
</tbody>
</table>

For recommendations on management of outbreaks in facilities and other congregate settings refer to Table C3: Management of COVID-19 Outbreaks in Facility/Other Congregate Settings

*Congregate settings are defined as locations where individuals live, work or are cared for within close quarters in a communal environment.
### Table C3: Management of COVID-19 Outbreaks in Facility/Other Congregate Settings

<table>
<thead>
<tr>
<th>Setting</th>
<th>Management of a Single Symptomatic Person</th>
<th>Definition of COVID-19 Outbreak</th>
<th>Management of Confirmed COVID-19 Outbreak</th>
</tr>
</thead>
</table>
| Facility (e.g., long term care facility) | - For any staff/resident with symptoms listed in Table C2 above, the following actions apply:  
  - Resident must be isolated, placed on contact and droplet precautions and tested for COVID-19.  
  - Any asymptomatic staff MUST NOT work. They must self-isolate at home and arrange for COVID-19 testing on site or via the HCW screening online tool.  
  - Determine any urgent issues for the site/facility e.g., access to testing, personal protective equipment (PPE) etc.  
  - No reporting to Alberta Health (AH) required.  
  - If test results are negative for COVID-19, usual influenza like-illness (ILI) or gastrointestinal illness (GI) outbreak protocols (e.g., daily line lists, enhanced IPC and other control measures) should be followed, as appropriate to the identified organism causing the outbreak and report to AH as per usual processes. | A COVID-19 Outbreak is defined as:  
- Any resident who is confirmed to have COVID-19 and/or  
- Any staff member who is confirmed to have COVID-19 (R) AND worked at the site during the period of communicability OR likely acquired infection at work | - All confirmed COVID-19 outbreaks should be investigated and reported |
| Other Congregate Setting (U) (e.g., corrections, shelters) | - The communicable period is defined as 48 hours before symptom onset to isolation date in symptomatic cases, OR 48 hours before lab specimen collection date to isolation date in asymptomatic cases.  
  - **NOTE:** If staff worked at multiple sites in the 48 hours prior to symptom onset/lab test **WITHOUT** appropriate PPE, outbreak should be declared at those sites. | |

(R) This refers to staff in facilities as per CMOH Order 23-2021 and in other congregate settings who **worked** at the site/s during the incubation period or during the communicable period **WITHOUT** appropriate PPE. (See section on Management of HCW). This also includes any staff who may have been symptomatic even while using continuous masking, eye protection and practicing good hand hygiene.

- The communicable period is defined as 48 hours before symptom onset to isolation date in symptomatic cases, OR 48 hours before lab specimen collection date to isolation date in asymptomatic cases.
- **NOTE:** If staff worked at multiple sites in the 48 hours prior to symptom onset/lab test **WITHOUT** appropriate PPE, outbreak should be declared at those sites.
Other COVID-19 Outbreak Management Recommendations for Facilities

- For more information refer to the AHS Guidelines for COVID-19 Outbreak Prevention, Control and Management in Congregate Living Sites and the CMOH Order 23-2021.
- An outbreak in licensed supportive living (including group homes and lodges), long-term care (nursing home and auxiliary hospitals) and hospice services may be declared over after 28 days (two incubation periods) from date of onset of symptoms in the last case, with the following exception:
  - If a staff member is the only confirmed case at the outbreak site, the outbreak can be declared over after 14 days from their last day of work.
  - **NOTE:** Asymptomatic staff and residents should NOT be retested during a site outbreak if they were a lab confirmed COVID-19 case within the past 90 days. For more information, refer to the Testing and Management of Resolved Cases section.

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

- Where there is evidence of transmission (defined as two or more lab-confirmed COVID-19 cases), continuous use of surgical/procedure mask and eye protection (e.g., goggles, visor, or face shield) is recommended for all staff providing direct face-to-face care of residents/patients.
- Full contact and droplet precautions should be applied when providing care to any symptomatic person (including any lab-confirmed case of COVID-19) until that person is determined by IPC (where available) or the MOH/designate to be non-infectious.
- **NOTE:** For PPE recommendations for all other patient care areas in AHS and community settings with NO COVID-19 outbreak, refer to the AHS website on Personal Protective Equipment (PPE).
Management of COVID-19 Outbreaks in Child Care Settings

- Child care settings includes daycares, after school care, preschools, and day homes.
- Parents/students should be instructed to complete the COVID-19 Alberta Daily Checklist (for Children under 18) before going to childcare and follow instructions as outlined in the checklist.
- Childcare staff should complete the COVID-19 Alberta Daily Checklist for adults before going to a childcare setting.
- For staff with COVID-19 symptoms listed in Table C2: Symptoms to Initiate Testing the following actions apply:
  - Any symptomatic staff MUST NOT work. They must isolate at home and arrange testing via the online COVID-19 self assessment or call 811.
  - Refer to Table C4: Management of COVID-19 Outbreaks in Child Care Setting for more information.
  - An outbreak in a child care setting can be declared over 28 days (two incubation periods) after date of onset of symptoms in the last case.
- Asymptomatic staff and children should NOT be retested during a childcare setting outbreak if they were a lab confirmed COVID-19 case within the past 90 days. For more information, refer to the Testing and Management of Resolved Cases section.
- **NOTE:** For any child with a rash illness, follow usual notification/management process as outlined by AHS.

### Table C4: Management of COVID-19 Outbreaks in a Child Care Setting

<table>
<thead>
<tr>
<th>Setting</th>
<th>COVID-19 Alert</th>
<th>One Confirmed Case</th>
<th>COVID-19 Outbreak</th>
<th>Management of Confirmed COVID-19 Outbreak</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child Care Setting</strong></td>
<td>Two Symptomatic Individuals (child/staff) within 48 hours</td>
<td>When there is one confirmed case (staff/child) in a child care setting, actions include but not limited to the following:</td>
<td>A COVID-19 Outbreak is defined as:</td>
<td>All confirmed COVID-19 outbreaks should be investigated and reported</td>
</tr>
<tr>
<td></td>
<td>The child care setting must call the Coordinated Early Identification and Response (CEIR) Team at 1-844-343-0971 to connect with public health who will:</td>
<td>- Case investigation and contact follow-up</td>
<td>- Two confirmed cases (staff/child) within 14 days (one incubation period) OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- advise on additional IPC measures,</td>
<td>- Engagement with the child care setting as appropriate to ensure measures are in place to prevent spread, identify additional cases early and communicate with parents in a timely manner</td>
<td>- Two confirmed cases (staff/child) that are epidemiologically linked AND who were at the child care setting during the period of communicability OR likely acquired infection at that setting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- recommend testing for symptomatic persons via the online COVID-19 self assessment tool or call 811</td>
<td>- Report to AH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- refer to EPH or CDC if investigation determines symptoms may be due to another pathogen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No reporting to Alberta Health (AH) required.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If test results are negative for COVID-19, usual influenza like illness (ILI) or gastrointestinal illness (GI) outbreak protocols (e.g., daily line lists, enhanced IPC and other control measures) should be followed, as appropriate to the identified organism causing the outbreak and report to AH as per usual processes.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Management of COVID-19 Outbreaks in Schools (K-12)

- Parents/students should be instructed to complete the COVID-19 Alberta Daily Checklist (for Children under 18) before going to school and follow instructions as outlined in the checklist.
- School staff/teachers should complete the COVID-19 Alberta Daily Checklist for adults before going to school.
- For one staff with COVID-19 symptoms listed in Table C2: Symptoms to Initiate Testing, the following actions apply:
  - Any symptomatic staff MUST NOT work. They must isolate at home and arrange testing via the online COVID-19 self assessment or call 811.
- Refer to Table C5: Management of COVID-19 Outbreaks in Schools for more information. For full guidance, please refer to the COVID-19 guidance and health measures for K-12 schools website.
- An outbreak in a school can be declared over 28 days (two incubation periods) after date of onset of symptoms in the last case.
- NOTE: Asymptomatic staff and children should NOT be retested or quarantined during a school outbreak if they were a lab confirmed COVID-19 case within the past 90 days. For more information, refer to the Testing and Management ofResolved Cases section.

Table C5: Management of COVID-19 Outbreaks in Schools (K-12)

<table>
<thead>
<tr>
<th>Setting</th>
<th>COVID-19 Alert</th>
<th>COVID-19 Outbreak</th>
<th>Management of Confirmed COVID-19 Outbreak</th>
</tr>
</thead>
</table>
| School  | One confirmed case (i.e., staff, student and/or visitor) in the school setting who was present at the school while infectious and/or most likely became infected at the school. | A COVID-19 outbreak investigation will begin when:  
  - Two confirmed cases (i.e., staff, student and/or visitor) within 14 days (one incubation period) who were present at the school while infectious and/or most likely became infected at the school  
  - Two confirmed cases (staff, student and/or visitor) that are epidemiologically linked who were present at the school while infectious and/or most likely became infected at the school. | All confirmed COVID-19 outbreak investigations should be investigated and reported |

Outbreak investigations in schools will be publicly reported as follows:
- A school with 2-4 confirmed cases will be publicly reported as an “Alert (2-4 cases)”
- A school with 5-9 confirmed cases will be publicly reported as an “Outbreak (5-9 cases)”
- A school with 10+ confirmed cases will be publicly reported as an “Outbreak (10+ cases)”
Management of COVID-19 Outbreaks in Post-Secondary Institutions (PSI)

- PSI should follow recommendations as outlined in the Post-Secondary Institution Guidance document posted on the BizConnect website.
- Refer to Table C6: Management of COVID-19 Outbreaks in PSI for more information.
- An outbreak in PSI can be declared over 28 days (two incubation periods) after date of onset of symptoms in the last case.

Table C6: Management of COVID-19 Outbreaks in PSI

<table>
<thead>
<tr>
<th>Setting</th>
<th>COVID-19 Alert</th>
<th>COVID-19 Outbreak</th>
<th>Management of Confirmed COVID-19 Outbreak</th>
</tr>
</thead>
</table>
| Class Setting or Other Program in which students/faculty are attending in person | N/A | A COVID-19 Outbreak is defined as:  
- Five confirmed cases (staff/student) within 14 days (one incubation period) | All confirmed COVID-19 outbreaks should be investigated and reported |
| Residence (operated/contracted by PSI to cater for PSI students in which students share dormitory rooms, bathrooms, food preparation/in residence food services) | Two confirmed COVID-19 cases (staff/student) within 14 days (one incubation period) | |
| Restaurant/Cafeteria located on PSI | N/A | | |

View the current version of this publication at https://open.alberta.ca/publications/coronavirus-covid-19
Management of COVID-19 Outbreaks in a Workplace

- Any staff/client with COVID-19 symptoms listed in Table C2: Symptoms to Initiate Testing, MUST NOT work and testing should be arranged by completing the online COVID-19 self assessment or by calling 811.
- Refer to Table C1: Outbreak Definitions of COVID-19 for information on COVID-19 alerts and confirmed outbreaks.

Notifications of Public Exposures of COVID-19

- In instances where it is determined that a known COVID-19 positive case attended a public space/event while infectious, every effort should be made by public health to identify close contacts and notify them individually of their exposure.
- However, in the following circumstances, notification of public exposures using communication tools such as distribution of letters or a media announcement may be considered to notify potentially exposed individuals of their risk and actions they should take:
  - If there is a significant exposure risk (e.g., case attended the public space/event two days before and/or within 5 days of their symptom onset with respiratory symptoms, multiple exposures or prolonged close contact, i.e., cumulative for a total of 15 minutes or more over a 24-hour period and within two metres with a case, crowded setting, confined and enclosed spaces with poor ventilation) AND there is no ability to identify close contacts AND it has been a short time since exposure occurred,
  - Site/event organizer not willing or able to provide contact lists,
  - Vulnerability of individuals in that setting e.g., seniors’ coffee space
  - Other situations as determined by the MOH.
- These tools should be utilized on the recommendation of the Zone MOH and in collaboration with public health teams, impacted stakeholders, and Alberta Health.
Annex D: Management of Travelers

- An official global travel advisory is in effect and non-essential travel is NOT recommended.
- Any returning travelers to Canada, must follow mandatory requirements as laid out in the Federal Emergency Order under the Quarantine Act and CMOH Order 26-2021.
- Some individuals may be exempt from travel restrictions (e.g., if they provide critical services and have no symptoms, or meet other exemption criteria). For more information refer to the PHAC website on Exemptions to travel restrictions.

Flight Notification to PHAC for Posting on Their Website: Known COVID-19 + (VOC or non-VOC) Passenger on Board While Infectious

- Information for domestic/international flights with infectious cases are sent to PHAC to be posted on the Government of Canada Coronavirus disease (COVID-19): Locations where you may have been exposed.
- Local public health (AHS/FNIHB) will notify PHAC directly (and cc airline) of flights with known COVID-19 case that flew while infectious. Reporting criteria includes:
  - Cases who were symptomatic during travel, or
  - Cases with symptom onset/lab specimen collection date no more than 10 days BEFORE the date of travel, or
  - Cases with symptom onset no more than 48 hours AFTER the date of travel.
  - Flight has occurred within past 14 days.
- **NOTE:** since pre-symptomatic/asymptomatic transmission of COVID-19 can occur, individuals do not have to have been symptomatic while on the flight in order to post flight information on the website.
- Minimum information needed to post flight information:
  - Includes travel within Canada OR travel into Canada as a final destination (this may involve more than 1 flight for 1 person);
  - Flight date;
  - Airline and Flight Number;
  - Departure location and Arrival destination;
  - Seat/row information (if known);
  - Case Onset date (as per notifiable disease guideline for symptomatic/asymptomatic cases); and
  - DI (or NDR#) number & DI Initials (First Name Initial, Last Name Initial).

Flight Notification to Airline to Request Flight Manifest for Domestic Flights: Known VOC(S) Case on Board while Infectious

At this time flight manifests are only being requested for domestic flights (flights within Canada).

- Local public health (AHS/FNIHB) will request flight manifest from airline (and cc PHAC IJN) for flights with a confirmed/presumptive VOC case that flew while infectious within the last 21 days.
  - The same fields required here as for flight notification with addition of VOC identified or presumptive status.
- Once manifest is received, local public health team reviews the list as outlined in the table.

---

(S) Public Health will request flight manifests for flights that had B.1.351 (Beta), P.1 (Gamma) and B.1.617.2 (Delta) variant case on board.
### Table D1: Flight Notification Domestic Flights

<table>
<thead>
<tr>
<th>Domestic VOC Flights that have landed in Alberta</th>
<th>Alberta Health Services</th>
<th>Alberta Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>- All flight contacts in affected rows will be followed-up by local PH.</td>
<td>- Alberta Health will obtain OOP/OOC flight contacts from local PH and transfer to appropriate P/T if in Canada and to PHAC if out-of-country (OOC).</td>
<td></td>
</tr>
<tr>
<td>- Flight contacts that are currently in AB (i.e., both residents and non-residents) will be managed by local PH.</td>
<td>- If OOP/OOC notification has already occurred, AH will send updated VOC information to appropriate OOP/OOC jurisdiction.</td>
<td></td>
</tr>
<tr>
<td>- Flight contacts that are not currently in AB, are to be transferred to Alberta Health via established processes (e.g., CDOM).</td>
<td>- Flight contacts that are not currently in AB, are to be transferred to Alberta Health via established processes (e.g., CDOM).</td>
<td></td>
</tr>
<tr>
<td>- If unable to reach a flight contact the file should be closed as “Unable to Contact” or “Lost to Follow up”; do not transfer to AH.</td>
<td>- If unable to reach a flight contact the file should be closed as “Unable to Contact” or “Lost to Follow up”; do not transfer to AH.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>International VOC Flights that have landed in Canada or Alberta</th>
<th>Alberta Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Do NOT request flight manifests due to the new federal quarantine requirements.(^{(1)})</td>
<td>- Not applicable.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AB VOC cases identified by another P/T and transferred to AB for reporting and management</th>
<th>Alberta Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>- AB public health to follow-up and manage these cases for reporting and surveillance purposes.</td>
<td>- OOP/OOC notifications as outlined above.</td>
</tr>
<tr>
<td>- Flight notifications and manifests should be made/requested as outlined above.</td>
<td>- Flight notifications and manifests should be made/requested as outlined above.</td>
</tr>
</tbody>
</table>

Provincial Chartered Flights

- Flight manifests, especially those relating to work camps, should be requested from the airline by the company’s Occupation Health and Safety team as part of the case/contact investigation, and follow up as per guidance below. AHS should ensure that this has been completed and assist in the notification of out-of-province cases and contacts as per below.
- AHS/FNIHB will notify AH via established processes (e.g., CDOM) of any cases that reside outside Alberta, and that travelled while infectious. The following information should be included:
  - ULI or CDOM DI#,
  - Contact information (address, phone #)
  - Onset date of source case,
  - Dates of travel,
  - Airline(s), and
  - Seat number(s) (if known).
- AHS/FNIHB will notify Alberta Health via established processes (e.g., CDOM) of any close contacts that reside outside of Alberta and that travelled on the same flight as a confirmed case that require notification.
  - ULI or CDOM DI# (if available)
  - Contact information (address, phone #)
  - Dates of travel,
  - Airline(s), and
  - Seat number(s) (if known).
- Contact tracing of travelers on a chartered airplane who may have been exposed to case of COVID-19 during a flight should be made on a case-by-case basis based on the following:
  - case’s classification (e.g., confirmed),
  - the type and severity of symptoms of the case during the flight,
  - movement of case around the plane cabin, and
  - distancing and preventive measures during flight.
- There is currently no evidence of transmission risk related to flight duration. The following recommendations apply regardless of length of flight.
- When a case(passenger) was symptomatic on the flight contact tracing should focus on the following:
  - passengers seated within two meters of the index case, AND
  - crew members serving the section of the aircraft where the index case was seated, AND
  - persons who had close contact with the index case, e.g., travel companions or persons providing care.
- Expanding the scope of contact tracing may be considered based on the severity of symptoms of the case (passenger) during the flight e.g., persistent coughing, sneezing, diarrhea or vomiting.
- If the case on the flight was a symptomatic crew member, contact tracing may also be considered for all passengers seated in the area where the crew member provided service and all other crew members.
- Refer to Management of Close Contacts of Confirmed/Probable Cases section for further management of these contacts.
Annex E: Preventative Measures

- For more information on prevention of COVID-19 refer to the following websites:
  - COVID-19 info for Albertans
  - Help prevent the spread
  - Information for Albertans
  - Measures to reduce COVID-19

Resources on COVID-19

- Alberta Health Services [www.albertahealthservices.ca/topics/Page16944.aspx](http://www.albertahealthservices.ca/topics/Page16944.aspx)
### Annex F: Revision History


<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Document Section</th>
<th>Description of Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020-08-25</td>
<td>Case definition</td>
<td>Under footnote A added information on the performance characteristics of the Simplexa®, GeneXpert®, or BD Max™ NAT</td>
</tr>
<tr>
<td></td>
<td>Clinical presentation</td>
<td>Added information on Multi-system inflammatory Syndrome in Children (MIS-C)</td>
</tr>
<tr>
<td></td>
<td>Diagnosis</td>
<td>Added information on Simplexa®, GeneXpert®, and BD Max™ NAT test results are considered confirmatory</td>
</tr>
<tr>
<td></td>
<td>Section 2: Testing Modality, Recommendations, Interpretation and Management</td>
<td>Added information on COVID-19 testing performance for molecular tests and serology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Added new section on management of resolved cases</td>
</tr>
<tr>
<td></td>
<td>Section 3: Key Investigation</td>
<td>Expanded close contact definition</td>
</tr>
<tr>
<td></td>
<td>Section 5: Management of Close Contacts</td>
<td>Added information on Guidance on the use of masks</td>
</tr>
<tr>
<td></td>
<td>Section 6: Mandatory Quarantine &amp; Isolation</td>
<td>Added new information regarding immunized individuals with COVID-19 symptoms post immunization</td>
</tr>
<tr>
<td></td>
<td>Annex A- Management of Outbreaks</td>
<td>Expanded section to include outbreak definitions, management of COVID-19 outbreaks in childcare settings, schools and workplaces</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Added section on notification of COVID-19 in public exposures</td>
</tr>
<tr>
<td></td>
<td>Annex B: Management of Travelers</td>
<td>Updated section on national and international flights</td>
</tr>
<tr>
<td>2020-01-03</td>
<td>Case Definition</td>
<td>Added rapid/POC NAAT and antigen tests to the confirmed case definition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Footnote A updated to include info on the ID NOW and PanBio tests from Abbott</td>
</tr>
<tr>
<td></td>
<td>General</td>
<td>Order 23-2020 has been updated to Order 32-2020</td>
</tr>
<tr>
<td></td>
<td>Clinical presentation</td>
<td>Updated information to include symptoms most frequently observed in Canada</td>
</tr>
<tr>
<td></td>
<td>Transmission</td>
<td>Updated to include information on aerosol/airborne transmission</td>
</tr>
<tr>
<td></td>
<td>Host Susceptibility</td>
<td>Updated with conditions/individuals most susceptible to COVID-19</td>
</tr>
<tr>
<td></td>
<td>Section 1: Diagnosis</td>
<td>Information on rapid nucleic acid tests moved to Section 2: Testing Modality, Recommendations, Interpretation and Management</td>
</tr>
<tr>
<td>Section</td>
<td>Changes</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td></td>
</tr>
</tbody>
</table>
| **Section 2: Testing Modality, Recommendations, Interpretation and Management** | • Updated information on individuals eligible for testing in AB  
• Added section on Rapid COVID-19 Tests  
• Reworded section on Testing and Management of Resolved Cases |
| **Section 5: Management of Close Contacts** | • Updated section on Guidance on the use of Masks  
• Added new section on Assessment of PPE in Workplaces |
| **Section 6: Mandatory Isolation and Quarantine** | • Added section on Exemptions to Isolation/Quarantine |
| **Section 7: Management of HCW** | • Added information on when HCW who are cases can return to work  
• Added that eye protection is recommended during patient interactions in places where community transmission is high  
• Added section on recommendations for regulated HCW |
| **Section 9: Management of Individuals Immunized Against COVID-19** | • New section added |
| **Section 9: Preventative Measures** | • Updated to include links to AH, AHS, PHAC websites |
| **Annex A: Management of COVID-19 Outbreaks** | • Updated some of the reporting thresholds in Table A1: Outbreak Definitions for COVID-19 |
| **Annex C: Management of COVID-19 Variants of Concern** | • New Annex added |
| **Annex D: Revision History** | • This used to be the old Annex C |

*Case Definition:*  
• Probable Case definition updated to align with PHAC case definition  
• Suspect Case definition and Exposure criteria retired.  

*Reporting Requirements:*  
• Added reporting requirements for POCT (antigen & molecular) tests  

*Epidemiology:*  
• Sections updated to include information on variants of concern
<table>
<thead>
<tr>
<th>Public Health Management</th>
<th>• Added information that following sections on public health management apply to VOC and non-VOC cases and their close contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 2: Testing Modality, Recommendations, Interpretation and Management</td>
<td>• Added information on rapid screening program</td>
</tr>
<tr>
<td>Treatment of Cases</td>
<td>• Section updated</td>
</tr>
<tr>
<td>Section 7: Management of Close Contacts Immunized Against COVID-19</td>
<td>• Updated to include new quarantine recommendations for fully and partially immunized individuals</td>
</tr>
<tr>
<td>Annex A: Testing Performance</td>
<td>• This is a new annex and includes information from Section 2: Testing Modality, Recommendations, Interpretation and Management</td>
</tr>
<tr>
<td>Annex B: Isolation and Quarantine</td>
<td>• New annex that includes information on isolation and quarantine from the previous Annex C: Management of VOC</td>
</tr>
<tr>
<td>Annex C: Management of COVID-19 Outbreaks</td>
<td>• This was the previous Annex A</td>
</tr>
<tr>
<td>Annex E: Preventative Measures</td>
<td>• New Annex. Information was in the epidemiology section</td>
</tr>
</tbody>
</table>
References


9. AHS-Scientific Advisory Group. What risk factors (such as age, medical conditions, or lifestyle factors) are associated with the development of severe outcomes in COVID-19? 2020 Aug.


32. Laboratory Bulletins | Alberta Health Services [Internet]. [cited 2020 Apr 19]. Available from: https://www.albertahealthservices.ca/lab/Page3290.aspx


35. Government of Canada. COVID-19 signs, symptoms and severity of disease: A clinician guide -
36. PHAC. Re-testing guidance for COVID-19 - Nov 26 post SGBA clean EN. 2020;


51. Alberta Precision Laboratories (APL). COVID-19 POCT with ID NOW or Panbio Availability in Assessment Centres Across Alberta [Internet]. 2021 [cited 2021 Jun 6]. Available from: