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Case Definition

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

Confirmed Case

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

- Detection of at least one specific gene target by nucleic acid amplification tests (NAAT) at a Provincial Public Health Laboratory where NAAT tests have been validated\(^{(A)}\);

OR

- Confirmed positive result by National Microbiology Lab (NML) by NAAT.

Probable Case\(^{(B)}\)

- A person (with NO laboratory testing done) with clinical illness\(^{(C)}\) who had close contact to a lab-confirmed COVID-19 case

OR

- A person (with laboratory testing done) with clinical illness\(^{(C)}\) who meets the COVID-19 exposure criteria;

AND

- in whom laboratory diagnosis of COVID-19 is inconclusive\(^{(D)}\)

\(^{(A)}\) As of March 9, 2020 this applies to Alberta Precision Laboratories (APL), where NAAT has been validated for detection of the virus that causes COVID-19.

\(^{(B)}\) All probable cases 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.

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

\(^{(D)}\) Inconclusive is defined as an indeterminate test on a single or multiple real-time PCR target(s) without sequencing confirmation or a positive test with an assay that has limited performance data available.
Suspect case\(^{(E)}\)

A person with clinical illness\(^{(C)}\) AND

- who meets the exposure criteria;
  
  OR

- had close contact with a probable case of COVID-19.

Exposure Criteria

In the 14 days\(^{(F)}\) before onset of illness, a person who:

- Returned to Canada from outside the country;
  
  OR

- Is a close contact of a person who had acute respiratory illness who returned from travel outside Canada in the previous 14 days before they became sick;
  
  OR

- Was involved in a COVID-19 outbreak or cluster
  
  OR

- Had laboratory exposure to biological material (e.g., primary clinical specimens, virus culture isolates) known to contain COVID-19.

\(^{(E)}\) Suspect cases are NOT reportable and should be tested to confirm diagnosis. Suspect cases (because they are symptomatic) shall by order, be in isolation for 10 days from onset of the following symptoms: fever (over 38 degrees Celsius), new onset/exacerbation of: cough, shortness of breath (SOB)/difficulty breathing, sore throat or runny nose or until symptoms have resolved, whichever is longer. Suspect cases who meet criteria for quarantine as per CMOH Order 05-2020 shall remain in quarantine for entire 14 days even if they test negative.

\(^{(F)}\) Current estimates of the incubation period range from 0-14 days with median estimates of 5-6 days between infection and the onset of clinical symptoms of the disease. Allowing for variability and recall error and to establish consistency with the World Health Organization's COVID-19 case definition, exposure history based on the prior 14 days is recommended at this time.
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 report all positive laboratory results by FMP (i.e., direct voice communication or secure electronic email) to:
- the MOH (or designate) of the zone,
- the Chief Medical Officer of Health (CMOH) (or designate).

3. Alberta Health Services and First Nations Inuit Health Branch
- The MOH (or designate) of the zone where the case currently resides shall forward the Public Health Agency of Canada’s Interim Novel Coronavirus (2019-nCoV) Case Report Form or use other 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.
- For out-of-province and out-of-country reports, the following information should be forwarded to the CMOH (or designate) via health.cd@gov.ab.ca within 24 hours:
  - 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.
- All confirmed outbreaks are to be reported to Alberta Health within 24 hours via the Alberta Outbreak Report Form (AORF) using existing processes (e.g., CDOM or fax).
Epidemiology

Etiology

Human coronaviruses are enveloped, ribonucleic acid (RNA) viruses that are part of the Coronaviridae Family.\(^{(1)}\) 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).\(^{(1)}\) Refer to the Public Health Disease Management Guideline for Coronavirus – MERS/SARS for more information.
- COVID-19 is an illness caused by a new coronavirus (SARS-CoV-2) first identified in December 2019, in Wuhan, China as having caused an outbreak of respiratory infections, including pneumonia.\(^{(2,3)}\)

Clinical Presentation

Individuals infected with the virus that causes COVID-19 may have few or no symptoms and these symptoms may range from mild to severe with manifestations such as fever (>90% of cases), dry cough (80%) or shortness of breath (20%). In Canada, commonly reported symptoms among reported cases include cough (74%), headaches (56%) and weakness (54%).\(^{(3,4)}\) For some of the other symptoms that can be associated with COVID-19 infection, refer to Table 2a: Symptom List for COVID-19 Testing. Complications include severe pneumonia, acute respiratory distress syndrome, sepsis, septic shock, multi-organ failure or death.\(^{(5)}\)

Reservoir

Most coronaviruses are considered zoonotic. COVID-19 is thought to have emerged from an animal source although this has not yet been confirmed.

Transmission

COVID-19 is transmitted person-to-person via droplet (i.e. coughing and or sneezing) or close contact via contaminated objects or surfaces and then touching one’s own mouth, nose, or possibly eyes.\(^{(7)}\) There is emerging evidence of transmission occurring up to 48 hours before symptom onset or even from individuals who are asymptomatic and never develop symptoms or whose symptoms went unnoticed.\(^{(6,9)}\) The highest risk of virus spread would be from a person who has symptoms like fever or cough. Human coronaviruses are rarely spread via fecal contamination.\(^{(6)}\) Airborne spread has not been documented for COVID-19.

An aerosol-generating medical procedure (AGMP) has the potential to cause airborne transmission.
Incubation Period

Current estimates of the incubation period range from 0-14 days with median estimates of 5-6 days between infection and the onset of clinical symptoms of the disease. Allowing for variability and recall error and to establish consistency with the World Health Organization's COVID-19 case definition, exposure history based on the prior 14 days is recommended at this time.(6)

Period of Communicability

The period of communicability may begin one to two days before symptoms appear, but people are likely most infectious during the symptomatic period, even if symptoms are mild or very non-specific. Evidence shows that after day 8 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.(7,8) NAAT positivity from respiratory samples can be prolonged (3-4 weeks after symptom onset) even when no viable virus was detected.(9) 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.(10)

Host Susceptibility

Susceptibility is assumed to be universal. Older adults (>age 60 years) and people with existing chronic medical conditions (e.g., cardiovascular and liver disorders, diabetes and other respiratory diseases) or immune compromising conditions are likely more vulnerable to severe COVID-19 illness.(7) There is an evolving understanding of the immune response in COVID-19 disease, and the possibility of reinfection with SARS-CoV-2 has not been excluded. However, there have been no well substantiated cases of reinfection to date and most such reported cases are likely related to testing methodologies.(11)

Incidence

For cases reported in Alberta refer to the following link: https://www.alberta.ca/covid-19-alberta-data.aspx

For cases reported in Canada refer to the following link: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html

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: The strategy outlined in this guidance is containment (i.e., to reduce opportunities for transmission to contacts in the community) and is based on the assumption that the virus is primarily spread while the case is symptomatic. This guidance is based on current available scientific evidence and expert opinion and is subject to change as new information on transmissibility and epidemiology becomes available.\(^{(12)}\)

Section 1: Diagnosis

A diagnosis of SARS-CoV-2 infection is usually based on testing. Acceptable specimen types for COVID-19 testing include NP swab, throat swab, NP aspirate, endotracheal tube (ETT) suction/sputum, or bronchoalveolar lavage/bronchial wash (BAL/BW). Nasopharyngeal (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. 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.\(^{(13)}\) For more information, refer to the lab bulletins on Public Health Laboratories (formerly ProvLab) website.
Section 2: Testing Recommendations, Interpretation and Management

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, should always be offered testing to confirm the diagnosis as well as residents/clients in congregate settings. 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/fatigue/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>

*NOTE: individuals with fever, cough, shortness of breath, runny nose or sore throat, require 10 day mandatory isolation according to CMOH Order 05-2020. Refer to Section 6: Mandatory Quarantine and Isolation CMOH Order 05-2020
Testing of Symptomatic Individuals:

- In Alberta, testing is being done to confirm the diagnosis and to track the spread of COVID-19 in the population. Testing is recommended for the following:
  - any person exhibiting symptoms listed in Table 2a: Symptom List for COVID-19 Testing.
  - individuals with fever, cough, shortness of breath, runny nose or sore throat, require 10 day mandatory isolation according to CMOH order 05-2020.
  - mandatory isolation is NOT required for individuals with only italicized symptoms in the list in Table 2a if not tested or while waiting for the testing result; however, it is strongly recommended that individuals with these symptoms stay home and minimize contact with others.
  - any person with any of the symptoms in Table 2a: Symptom List for COVID-19 Testing should complete the online self assessment tool or call 811 to arrange for testing.
  - any person that is unwell with any new onset of any COVID-19 symptoms, should not be at work.
- For more information on management refer to Table 2b: Management of Tested Individuals.

Testing of Asymptomatic Individuals:

- Asymptomatic individuals should be offered testing if they are:
  - close contacts of confirmed or probable COVID-19 cases,
  - staff/residents in licensed supportive living (including lodges BUT NOT group homes), long-term care (nursing homes and auxiliary hospital) when a NEW COVID-19 outbreak has been declared
    - residents/staff in an existing COVID-19 outbreak if transmission appears to still be occurring
  - staff, residents, workers etc during an outbreak in other settings (e.g. shelters, workplaces, workcamps, corrections etc.)
  - residents admitted to licensed supportive living (including lodges and group homes) and long-term care (nursing homes and auxiliary hospital) from community or hospital settings or returning to these settings post-hospitalization for non-COVID-19 illnesses.
- For more information on management refer to Table 2b: Management of Tested Individuals.
Table 2b: Management of Tested Individuals

<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 case.</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>With known exposure: Quarantine for 14 days since the last exposure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>With no exposure: lift isolation</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>With known exposure: Quarantine for 14 days since the last exposure and monitor for symptoms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>With no exposure: Lift isolation</td>
</tr>
</tbody>
</table>

Testing and Management of Previously Lab-Confirmed Case (HCW)

- Refer to COVID-19 Return to Work Guide for AHS Healthcare Workers
- HCW who is a previously confirmed COVID-19 case and has recovered from illness, should NOT be re-tested for COVID-19 if they are asymptomatic.
- A detailed symptom inquiry should be performed to determine whether the person is symptomatic before re-testing.
- It is recommended that a HCW who has recovered from previous infection should ONLY be re-tested if they have new onset of COVID-19 compatible symptoms (Refer to Table 2a: Symptom List for COVID-19 Testing).
- If deciding to re-test, testing for both COVID-19 and respiratory pathogen panel (RPP) should be done. Follow management recommendations in Table 2c: Testing and Management of previously Lab Confirmed Case (HCW).
Table 2c: Testing and Management of Previously Lab Confirmed Case (HCW)

<table>
<thead>
<tr>
<th>Testing</th>
<th>Result of symptom® Test</th>
<th>COVID-19 Test</th>
<th>RPP test</th>
<th>Management</th>
</tr>
</thead>
</table>
| If re-testing is inadvertently done | Asymptomatic            | Negative      | No test          | - Continue to work  
- Follow existing workplace protocols                                             |
|                                 | Positive                | No test/negative |                 | - Consult with MOH on a case by case basis for management and return to work |
| Recommended Re-testing          | Symptomatic             | Positive      | Negative         | - Manage as a lab-confirmed case i.e. isolate for 10 days after onset of symptoms or until symptoms resolve, whichever is longer with an additional 4 days not to work in a healthcare setting. |
|                                 | Negative                | Positive/Negative |                 | - Stay at home and limit contact with others until symptoms resolve          |
|                                 | Positive                | Positive      |                 | - Isolation requirements and return to work considerations must be decided on a case by case basis in consultation with the Medical Officer of Health. |

@ Refer to Table 2a: Symptom List for COVID-19 Testing

- **NOTE**: No additional isolation requirements are required for a previously confirmed COVID-19 case (HCW) who has recovered from their illness and completed their isolation period, AND who during their isolation period had continuous/ongoing close contact with a lab-confirmed case of COVID-19 (e.g., household contact).
- Out of an abundance of caution, if a previously lab-confirmed COVID-19 case (HCW) who has recovered from illness and completed their period of isolation is exposed to a lab-confirmed COVID-19 case AFTER isolation, they must observe the appropriate isolation requirements related to being a close contact with a lab-confirmed COVID-19 case.
Testing and Management of Previously Lab-Confirmed Cases (non-HCW)

- It is recommended that any previously lab-confirmed COVID-19 case who has recovered from illness should **NOT** be re-tested if they are asymptomatic.
- However, if the person is re-tested, a detailed symptom inquiry should be performed to determine whether the person is truly asymptomatic. Management of these individuals is outlined in Table 2d: Testing and Management of Previously Lab Confirmed Case (non-HCW):

### Table 2d: Testing and Management of Previously Lab Confirmed Case (non-HCW)

<table>
<thead>
<tr>
<th>Timing of test from previous positive result</th>
<th>COVID-19 Test Result</th>
<th>Result of symptom inquiry</th>
<th>Management</th>
</tr>
</thead>
</table>
| Less than 30 days                           | Positive             | Asymptomatic             | - No repeat isolation  
|                                              |                      |                          | - No contact follow-up  
|                                              |                      |                          | Note: test result probably indicates residual non-viable virus and this person is considered NOT a new case |
| More than 30 days                           | Positive             | Asymptomatic             | Manage as new lab confirmed asymptomatic case |
| Less than 30 days                           | Positive             | Symptomatic              | - Management is on a case by case basis  
|                                              |                      |                          | - Consider potential risk to others and risk of this being a new case based on exposure history and time since last infection. |
| More than 30 days                           | Positive             | Symptomatic              | Manage as a new lab confirmed case |

*NOTE: Any individual who is symptomatic and whose test result is COVID-19 is negative it is recommended that the individual should stay at home and limit contact with others until their symptoms resolve.

@ Refer to Table 2a: Symptom List for COVID-19 testing
Testing Recommendations for Residents Admitted to a Facility

- All new residents admitted to a facility as per CMOH Order 12-2020 i.e. licensed supportive living (including lodges and group homes) and long-term care (nursing homes and auxiliary hospital) from community or hospital settings are recommended to be tested and should be offered testing 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 2e below for more information.

Table 2e: Testing Recommendations for Residents Admitted to a Facility

<table>
<thead>
<tr>
<th>Previous COVID-19 Test Result</th>
<th>Previous Test done &lt; or &gt; 30 days</th>
<th>Testing Recommendations on Admission to Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>Less than 30 days</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>More than 30 days</td>
<td>Yes</td>
</tr>
<tr>
<td>Negative</td>
<td>Less than 30 days</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>More than 30 days</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Section 3: Key Investigation

- Confirm the diagnosis and that individual meets case definition.
- Ensure appropriate clinical specimen(s) have been collected (see Diagnosis section for more information on specimen collection).
- Obtain history of illness including date of onset of signs and symptoms. See Table 2a: Symptom List for COVID-19 Testing.
- Determine spectrum of illness and if case requires hospitalization or if they can be managed at home.
- Determine any underlying chronic or immunocompromising conditions.
- Determine possible source of infection:
  - Identify recent travel/residence history 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;
  - Direct contact with animals (e.g., visited a live animal market or other animal contact while travelling outside Canada);
  - Recent contact with a known COVID-19 case or a person with COVID-19-like illness i.e. Clinical illness: fever (over 38 degrees Celsius), new onset/exacerbation of following symptoms: cough, shortness of breath (SOB)/difficulty breathing, sore throat or runny nose.
  - Assess if other members in the household have similar symptoms or if there has been any contact with a known COVID-19 case/person with COVID-19-like illness.
- Determine occupation (e.g., healthcare worker(G) or works with vulnerable individuals i.e., long-term care facilities/continuing care/group homes/shelters)
- Determine possible transmission settings (e.g., flight, household, healthcare setting, community setting).
- 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 or while the confirmed/probable case was symptomatic. 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 for at least 24 hours in the 7 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 for at least 24 hours in the 7 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

(G) 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 centres, community assessment centres, and any other settings where face-to-face patient care is provided (including fire fighters and EMS)
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\(^\text{(H)}\) between 48 hours before the laboratory specimen collection date and isolation date of that case. Refer to Table 3a: Definition of Close Contacts.

### Table 3a: Definition of Close Contacts

<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(^\text{(G)}), family members or other caregivers, or who had other similar close physical contact without consistent and appropriate use of personal protective equipment (PPE), OR</td>
</tr>
<tr>
<td>- lived with or otherwise had close prolonged(^\text{(I)}) contact (i.e., for more than 15 min 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., was coughed or sneezed on) while not wearing recommended PPE.</td>
</tr>
</tbody>
</table>

\(^\text{(H)}\) 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.

\(^\text{(I)}\) 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 IPC for recommendations for lifting isolation.
- Provide information about disease transmission and measures to minimize transmission, including practicing proper hand hygiene and respiratory etiquette.
- For information on infection prevention and control precautions refer to the following:
  - AHS IPC Resources

Discharge/Transfer of a Hospitalized Case

- 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 resolved, whichever is longer, after arrival at home.
- 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 resolved, whichever is longer.
  - This additional length of time (4 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).

Management of Non-Hospitalized Case

- Provide information about disease transmission and measures to minimize transmission, including practicing proper hand hygiene and respiratory etiquette.
- Symptomatic confirmed and probable cases should be isolated for 10 days from onset of COVID-19 compatible symptoms or until these symptoms have resolved, whichever is longer.
  - Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post-infection
  - Isolation may be lifted at the discretion of the MOH for cases with prolonged loss of sense of taste/smell.
- 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.
- If the case requires non-urgent medical attention, advise to contact public health for further direction on where to go for care, the appropriate mode of transportation to use, and Infection Prevention Control (IPC) precautions to be followed. If they require urgent attention, advise

(J) This refers to cases hospitalized due to COVID-19
them to call 911 and to let 911 know they have COVID-19 so that appropriate precautions can be taken to care for the case safely.

- **NOTE:** Non-hospitalized cases who were isolated for example in an isolation centre and are returning to congregate settings (e.g., long-term care facilities/continuing care/group homes/shelters etc.) shall be in isolation for at least 10 days from onset of symptoms or until symptoms have resolved whichever is longer.

- Due to the theoretical possibility that animals in the home could be affected by COVID-19, it is recommended that cases also refrain from contact with pets.

- COVID-19 virus RNA has been detected in the stool of some infected patients\(^{(14)}\), 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 Immunocompromised Case

- There is currently no information on viral shedding in immunocompromised confirmed COVID-19 cases.
  - However based on experience from other respiratory viruses, especially influenza virus, immunocompromised confirmed cases may shed SARS-CoV2 for a longer period of time\(^{(10)}\)
  - These cases should be isolated for 14 days from onset of symptoms or until symptoms have resolved, whichever is longer.\(^{(10)}\)

### Management of a Laboratory Confirmed Case Asymptomatic at Testing

- Provide information about disease transmission and measures to minimize transmission, including 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 7 days before laboratory specimen collection date:
  - fever (over 38 degrees Celsius)
  - new onset/exacerbation of following symptoms: cough, shortness of breath (SOB)/difficulty breathing, sore throat or runny nose.
    - If the case had two or more symptoms that lasted at least 24 hours in the 7 days before laboratory specimen collection date, the positive result may indicate that the symptoms were due to COVID-19 and that date of symptom onset could 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 next 10 days since lab specimen collection date.
    - For a case that had two or more of the symptoms listed above, for at least 24 hours in the 7 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 resolve, whichever is longer.

Treatment of Cases

• Currently, there is no specific treatment or vaccine to prevent infection.
• Supportive treatment is recommended based on condition of the case.
• For more information refer to WHO guidance on the clinical management of severe acute respiratory infection when novel coronavirus infection is suspected.
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.\(^{(K)}\)
- Provide information about COVID-19 disease including signs and symptoms.
- Close contacts of confirmed cases shall by order (CMOH Order 05-2020) be in quarantine for 14 days from last day of exposure and should be offered testing with consent. Refer to Section 2: Testing Recommendations, Interpretation and Management.
- Close contacts of probable cases should also be quarantined for 14 days.
- Close contacts of laboratory confirmed cases asymptomatic at testing, shall by order (CMOH Order 05-2020) be in quarantine for 14 days from last day of exposure and should be offered testing with consent. Refer to Section 2: Testing Recommendations, Interpretation and Management.
- For more information refer to Section 6: Mandatory Quarantine and Isolation CMOH Order 05-2020 section.
- NOTE: 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.
  - however if lab results will not be received within 48 hours for a symptomatic individual, contact tracing should be initiated pending lab results.

\(^{(K)}\) 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. from 10 days since symptom onset.
Section 6: Mandatory Quarantine and Isolation: CMOH Order 05-2020

- **Quarantine** is legally enforced for the following individuals:
  - All returning international travelers **shall by order** be in quarantine for 14 days after arrival in Canada and monitor for symptoms. Refer to Table 2a: Symptom List for COVID-19 Testing.
    - If symptoms develop, complete the Online self assessment tool 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, shall be in isolation for 10 days from onset of symptoms or until symptoms have resolved, whichever is longer.
  - Close contacts of confirmed cases **shall by order** be quarantined for 14 days since last exposure and 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.
  - Close contacts of confirmed and probable cases should be offered testing. For more information refer to Table 2b: Management of Tested Individuals.
  - For more information on quarantine refer to difference between quarantine and isolation.

- **Isolation** is legally enforced for individuals with new onset 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 **shall by order** in isolation for 10 days from onset of symptoms or until symptoms resolve, whichever takes longer.
  - Individuals with any of these symptoms and others listed in Table 2a: Symptom List for COVID-19 Testing should complete the Online self assessment tool or call 811 to arrange for testing.
    - If person had NO known exposure to COVID-19 and if COVID-19 test result is negative, isolation may be lifted.
    - If person had known exposure to COVID-19 and if COVID-19 test result is negative, complete the 14-day quarantine since the last exposure.
    - 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 resolved whichever is longer.
    - For more information on isolation requirements refer to the COVID-19 Alberta website.
Section 7: Management of Health Care Workers (HCW)

- Refer to COVID-19 Return to Work Guide for AHS Healthcare Workers
- HCW\(^{(G)}\) who may have been exposed to COVID-19 should refer to the COVID-19 Self-Assessment Tool for Healthcare Workers for more information.
- HCW\(^{(G)}\) tested positive for COVID-19 shall by order be isolated for 10 days from onset of symptoms or until symptoms have resolved, whichever is longer.
  - **NOTE:** HCW should NOT go back to work in a health care setting for 14 days from the onset of symptoms or until symptoms resolve, whichever is longer.
- 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 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.
Section 8: Preventative Measures

- Avoid close contact with people that have acute respiratory infections.
- Maintain physical distancing (i.e., 2 metres/6 feet).
- Practice proper respiratory etiquette (i.e., cover coughs and sneezes with disposable tissues or clothing).
- Wash hands often with soap and water for at least 20 seconds.
- Avoid touching your face with unwashed hands.
- Stay at home as much as possible. Avoid non-essential travel.
- Monitor for COVID-19 symptoms.
- Where physical distancing (i.e., 2 metres/6 feet) cannot be maintained, wearing a non-medical mask or face covering while out in public may be helpful in protecting others around you. For more information on wearing a mask refer to the COVID-19 website.
- Health care workers should follow guidelines for personal protective equipment when caring for individuals who may have COVID-19.
- Enhance standard infection prevention and control practices in health care facilities especially in hospitals and emergency departments.
- Resources on COVID-19:
  - Alberta Health Services [www.albertahealthservices.ca/topics/Page16944.aspx](http://www.albertahealthservices.ca/topics/Page16944.aspx)
Annex A: Interpretation of Lab results and Management

<table>
<thead>
<tr>
<th>RPP*</th>
<th>COVID-19 (ProvLab)</th>
<th>Management of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>Negative</td>
<td>Lift isolation(^y)</td>
</tr>
<tr>
<td>Positive(^e)</td>
<td>Negative</td>
<td>Isolate as appropriate to RPP results</td>
</tr>
<tr>
<td>Negative</td>
<td>Positive</td>
<td>- Maintain isolation for at least 10 days from symptom onset.(^e)</td>
</tr>
</tbody>
</table>

\(^y\) Respiratory Pathogen Panel Results
\(^e\) Individuals who are self-isolated due to exposure risk (e.g., travel/residence outside of Canada, close contact of a confirmed case) and who have negative RPP and COVID-19 results, should remain self-isolated for the full 14 days. If during the 14 days they are hospitalized, they should be placed on contact and droplet precautions.
\(^e\) Positive result for anything that explains symptoms. This may also include positive tests results outside of RPP.
\(^e\) For hospitalized cases consult with hospital IPC for recommendations for lifting isolation/discharge. Release from isolation of non-hospitalized cases with mild symptoms should be 10 days after symptom onset or until symptoms resolve, whichever is longer.
Annex B: Management of Outbreaks

- In order to effectively manage COVID-19 outbreaks in settings where infection can be transmitted quickly or where individuals in that setting may be at increased risk of severe outcomes, early recognition and management of symptomatic individuals is critical.

**Testing of Staff/Residents/Children**
- Testing should be done for the following symptomatic:
  - Residents/staff in facilities as per [CMOH Order 12-2020](#) (i.e. licensed supportive living (including group homes and lodges), long-term care, nursing homes and auxiliary hospitals),
  - residents/staff in other congregate settings not covered by [CMOH Order 12-2020](#) (e.g. corrections, shelters) and
  - staff/children in child care settings.
- Refer to Table B1: Symptoms to Initiate Testing.
- For more information on testing refer to Section 2: Testing Recommendations, Interpretation and Management.

**Table B1: Symptoms to Initiate Testing**

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

**NOTE:** individuals with fever, cough, shortness of breath, runny nose or sore throat, require 10 day mandatory isolation or until symptoms resolve, whichever is longer according to [CMOH order 05-2020](#).
For recommendations on management of outbreaks in facilities, other congregate settings and child care settings, refer to Table B2: Management of COVID-19 Outbreaks.

**Table B2: Management of COVID-19 Outbreaks**

<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 facilities) | • For any staff/resident/child with symptoms listed in Table B1 above, the following actions apply:  
  - Resident must be isolated, placed on contact and droplet precautions and tested for COVID-19.  
  - Child must be sent home and isolated. Instruct parents to complete online self assessment screening tool or call 811 to arrange testing.  
  - Any symptomatic 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/child who is confirmed to have COVID-19 and/or  
  - Any staff member who is confirmed to have COVID-19\(^{(1)}\) | - All confirmed outbreaks that meet the COVID-19 outbreak definition should be investigated and reported |
| Other Congregate Setting (e.g., corrections, shelters) | | |  
| Child Care Setting | | | |

\(^{(1)}\) This refers to staff in facilities as per CMOH Order 12-2020 and in other congregate settings (excludes staff in child care setting) who **worked** at the site/s during the communicable period **WITHOUT** appropriate PPE. (See section on Management of HCW).

- 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.
- 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.  
- **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 Outbreak Management Recommendations

- For more information refer to the AHS Guidelines for COVID-19 Outbreak Prevention, Control and Management in Congregate Living Sites and the CMOH Order 12-2020.
- An outbreak can be declared over in any setting 14 days after isolation is completed in the last reported case. **NOTE:** If a staff member is the only confirmed case at the outbreak site, the outbreak can be declared over 14 days from their last day of work.
  - **NOTE:** Asymptomatic staff who are not considered HCW should **NOT** be retested during a site outbreak if they were a lab confirmed COVID-19 case within the past 30 days. For more information, refer to the Management of Previously Lab-Confirmed Case (non-HCW) section.

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

- Where there is evidence of continued transmission (defined as 2 or more lab-confirmed COVID-19 cases), continuous use of surgical/procedure mask and eye protection (e.g. goggles, visor, 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 determined by IPC (where available) or the MOH/designate to be non-infectious.
- **NOTE:** Continuous use of surgical/procedure mask and proper hand-hygiene is recommended for all other patient care areas in AHS and community settings with NO COVID-19 outbreak.

Management of Community Outbreaks

- A COVID-19 outbreak may be declared if there is evidence of epidemiologically linked transmission of 5 or more COVID-19 cases with a common exposure e.g., attended the same facility/event/gathering (e.g., community events, churches, dinner party, workplace etc.)
  - **NOTE:** this does not include cases epi-linked within the same household.
- The Alberta Outbreak Reporting Form (AORF) **must** be completed and sent to Alberta Health when an outbreak is declared as described above.
- For other outbreak guidance information refer to Guidelines for COVID-19 Outbreak Prevention, Control and Management in Work Camps and Work Sites.
Annex C: Management of Travellers

- An official global travel advisory is in effect and non-essential travel is NOT recommended.
- Any returning travellers to Canada, must follow mandatory requirements as laid out in the Federal Emergency Order under the Quarantine Act and CMOH Order 05-2020.
- Some individuals may be exempt from travel restrictions if they provide critical services and have no symptoms. For more information refer to Public Health Agency Canada website on Exemptions to travel restrictions.

National/International Flights

- Flight manifests are not being requested for national/international flights.
- Flight numbers and dates of travel for national/international flights with symptomatic cases will be sent to the Public Health Agency of Canada by Alberta Health to be posted on the Government of Canada Coronavirus disease (COVID-19): Locations where you may have been exposed.
- Alberta Health must be notified of any cases that travelled on while infectious, including those who reside outside Alberta (regardless of whether the case is being counted here) and include the following information:
  - ULI or CDOM DI#,
  - Contact information (address, phone #)
  - Onset date,
  - Dates of travel,
  - Airline(s), and
  - Seat number(s) (if known).

Provincial Chartered Flights

- Flight manifests, especially those relating to work camps, should be requested by local Public Health as part of the case/contact investigation and followed up with as per guidance below. (M) (To request a flight manifest for a chartered flight refer to local DSOP).

(M) 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, and
  - movement of case around the plane cabin.
- 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
• Alberta Health should be notified of any cases that reside outside Alberta, and that travelled **while infectious**, regardless of whether or not Alberta is counting the case. The following information should be included:
  - ULI or CDOM DI#
  - Contact information (address, phone #)
  - Onset date,
  - Dates of travel,
  - Airline(s), and
  - Seat number(s) (if known).

• Alberta Health should be notified 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).

- 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 D: Revision History

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Document Section</th>
<th>Description of Revision</th>
</tr>
</thead>
</table>
| 2020-01-29    | Case Definition   | - Probable Case definition – Clinical illness moved into Footnote section.  
- Changed from “fever AND…” to “fever and/or…”  
- Removal of “breathing difficulty” and “Evidence of severe illness…” from clinical illness criteria.  
- Person Under Investigation – “fever and acute respiratory illness, or pneumonia” changed to “fever and/or cough”.  
- Exposure criteria expanded from city of Wuhan to include all of Hubei Province, China. |
| 2020-02-07    | Case definition   | - The affected area in the exposure criteria has been expanded to mainland China. |
| 2020-02-11    | Epidemiology/PH Management | - Added full guideline. |
| 2020-02-20    | Case definition   | - Close contact definition changed from “had direct contact with infectious bodily fluids of a probable or confirmed case…” to “had direct contact with infectious bodily fluids of a person…” |
|               | Management of non-hospitalized case/PUI | - Added a note regarding transmission of COVID-19 in stool and management of case/PUI |
|               | Management of HCW | - Updated in consultation with AHS.  
- Risk assessment table included and public health actions based on risk assessment |
|               | Management of contacts on airplane | - Added criteria on when PH may consider expanding contact tracing on an airplane. |
| 2020-02-27    | Case definition   | - “Testing not available” removed from probable case definition.  
- “Affected areas” expanded beyond China to Hong Kong, Iran, Italy, Japan, Singapore and South Korea.  
- Added “Or a provincial public health laboratory where nucleic acid amplification tests has been validated for detection of the virus that causes COVID-19.” to footnote for confirmed and probably case definitions.  
- Footnote G – add two more examples of other possible scenarios.
<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Zone MOH approval no longer required for specimen collection.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of Non-Hospitalized Case/PUI</td>
<td>Active daily surveillance is no longer required for PUIs only.</td>
</tr>
</tbody>
</table>
| Management of Asymptomatic Returning Travelers | Updated to include expanded affected areas.  
| | Active daily surveillance is no longer required for self-isolated contacts.  
| | Separated returning travelers from mainland China (given info at airport) from other affected areas (not given info at airport) but who should all self-monitor none-the-less. |
| Management of Asymptomatic HCW | Table updated to include expanded affected areas.  
| | Active daily isolation is no longer required for self-isolated contacts. |
| Management of Contacts on Airplane | Added “movement of case around the cabin” as a consideration. |
| Additional Annexes | Removed text from main guidance and put into Annexes:  
| | Annex B: Home Isolation Recommendations  
| | Annex C: Self-Isolation Recommendations  
| | Annex D: Self Monitoring Recommendations |
| Home Isolation Recommendations | Updated based on new recommendations in PHAC Public Health Management of Cases and Contacts Associated with COVID-19 document (soon to be posted). |
| 2020-03-02 | Close contacts  
| | A footnote was added for close contacts with ongoing exposure to help with determination of “last date of exposure”. |
| Management of Asymptomatic Returning Travelers (non-HCW and HCW) | Iran was added to Hubei province with recommendations to self-isolate x 14 days. |
| Management of Contacts on an Airplane | Added info on requesting a flight manifest. |
| Annex A | Added a footnote for symptomatic PUls to remain on isolation, depending on their exposure risk, even if lab result returns as negative. |
| 2020-03-09 | Case definition  
| | Confirmed Case:  
| | Added APL testing is now validated  
| | Changed the AND to OR  
| | Probable Case  
<p>| | Deleted: positive but not confirmed by the NML by NAAT |</p>
<table>
<thead>
<tr>
<th>Case Definition–Exposure criteria</th>
<th>• “Affected area” changed to “any travel outside of Canada”.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidemiology/PH management</td>
<td>• “Affected area has been changed to any travel outside Canada”.</td>
</tr>
<tr>
<td></td>
<td>• Diagnosis - Updated recommendations for specimens.</td>
</tr>
<tr>
<td></td>
<td>• Updated close contacts exposure should be while case was communicable (not after the onset of symptoms).</td>
</tr>
<tr>
<td></td>
<td>• Added exclusion section for cases, PUIs, close contacts.</td>
</tr>
<tr>
<td>2020-03-17 Case Definition</td>
<td>• Probable Case: added “person with clinical illness who is epi-linked to a lab-confirmed COVID-19 case”.</td>
</tr>
<tr>
<td></td>
<td>• Clinical illness changed to: fever (over 38oC) or new onset of (or exacerbation of chronic) cough or shortness of breath or pneumonia</td>
</tr>
<tr>
<td></td>
<td>• PUI – clinical illness changed to match Confirmed and Probable cases.</td>
</tr>
<tr>
<td></td>
<td>• Exposure criteria: removed “Had close contact with a confirmed or probable case of COVID-19” as this is now probable case.</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>• Added “Symptomatic close contacts of cases do not require testing and should be considered probable cases.”</td>
</tr>
<tr>
<td>Management of Non-Hospitalized PUI/Cases</td>
<td>• Added bullet that PUI should be isolated for 14 days even if COVID-19 testing comes back negative</td>
</tr>
<tr>
<td></td>
<td>• Changed viral clearance of 2 negative tests 24 hrs apart to ‘from 10 days after symptom onset’</td>
</tr>
<tr>
<td></td>
<td>• Changed that PUI’s may be excluded for 14 days</td>
</tr>
<tr>
<td>Management of Close Contacts of Confirmed and Probable Cases</td>
<td>• Changed bullet to “A close contact who develops symptoms should be managed as a probable case”.</td>
</tr>
<tr>
<td>Management of Asymptomatic Returning Travelers (Non-HCW) from Abroad</td>
<td>• Changed recommendation to: all travelers returning from Italy should self-isolate for 14 days after arrival in Canada</td>
</tr>
<tr>
<td>Management of Asymptomatic HCW</td>
<td>• Removed lower risk exposure row as all travel is now considered high risk.</td>
</tr>
<tr>
<td>Management of Contacts on an Airplane</td>
<td>• Updated to indicate that flight manifests will no longer be requested but flights with known symptomatic travelers will be posted on AH website.</td>
</tr>
<tr>
<td>Date</td>
<td>Section</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------</td>
</tr>
</tbody>
</table>
| 2020-03-28   | Case definition             | • Definition of clinical illness changed to: New onset of Fever, Cough, Shortness of breath/Difficulty breathing, Sore throat, Runny nose.  
• PUI title changed to Persons with clinical illness and exposure criteria |
|              | Epidemiology                | • Updated transmission, incubation and communicability sections based on current evidence.        |
|              | Close Contacts              | • Prolonged case definition has been included.                                                    |
|              | Discharge/Transfer of hospital cases | • New section added                                                                             |
|              | Mandatory Quarantine        | • New section added to account for legal requirement for Quarantine and Isolation                |
|              | Isolation                   | • Deleted                                                                                       |
|              | Management of returning travelers | • Table 2 deleted as a Self-assessment tool for HCW has been developed. Hyperlink to self assessment tool included  
• Included definition for HCW |
|              | Management of HCW           | • Deleted column regarding tests results from NML as all confirmatory results are being done at Provlab  
• Removed information on viral clearance for hospitalized cases. These should follow hospital IPC recommendations. |
<p>|              | Annex A                     | • Updated home isolation and information so that it's consistent with what is posted on the Alberta COVID-19 website |
|              | Annex B                     | • Title changed to Quarantine Requirements                                                        |
| 2020-04-02   | Case definition             | • Added footnote that HCW and residents in congregate settings who are probable cases should be tested. |
|              | Hospitalized Cases          | • No testing for clearance is required                                                             |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge/Transfer of Hospitalized cases</td>
<td>Updated to 14 days isolation and no testing for clearance</td>
</tr>
<tr>
<td>Management of HCW</td>
<td>Updated to 14 days isolation and no testing for clearance</td>
</tr>
<tr>
<td>Management of Facility Outbreaks</td>
<td>Updated with new outbreak case definition</td>
</tr>
<tr>
<td>Management of Contacts on Airplane</td>
<td>Updated website to Government of Canada for airline travel info.</td>
</tr>
<tr>
<td>2020-04-10 Case definition</td>
<td>The following have been changed based on updated PHAC case definition</td>
</tr>
<tr>
<td></td>
<td>- Suspect case definition added</td>
</tr>
<tr>
<td></td>
<td>- Confirmed case definition updated</td>
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<tr>
<td></td>
<td>- Exposure criteria updated</td>
</tr>
<tr>
<td>Epidemiology</td>
<td>Transmission, incubation period and period of communicability updated</td>
</tr>
<tr>
<td></td>
<td>to include possible asymptomatic transmission 48 hours prior to symptom</td>
</tr>
<tr>
<td>Public Health management</td>
<td>Updated key investigation section to include identifying close contacts</td>
</tr>
<tr>
<td></td>
<td>that may have been exposed to the case 48 hours before onset of symptoms</td>
</tr>
<tr>
<td></td>
<td>in the case or 48 hours before lab specimen collection for asymptomatic</td>
</tr>
<tr>
<td>Management of Laboratory Confirmed Asymptomatic Case</td>
<td>New section added</td>
</tr>
<tr>
<td>Management of HCW</td>
<td>Updated to include information on sufficient PPE</td>
</tr>
<tr>
<td>2020-04-24 Diagnosis</td>
<td>Updated to include specimens that can be submitted for testing for</td>
</tr>
<tr>
<td></td>
<td>COVID-19.</td>
</tr>
<tr>
<td></td>
<td>Added section on testing of asymptomatic individuals</td>
</tr>
<tr>
<td>Management of non-hospitalized cases</td>
<td>Added a bullet that cases active daily surveillance should ideally be</td>
</tr>
<tr>
<td></td>
<td>done by primary health care provider for cases at risk for complications.</td>
</tr>
<tr>
<td>Management of Asymptomatic cases</td>
<td>Added information on determining if the case may have had symptoms in</td>
</tr>
<tr>
<td></td>
<td>the 7 days prior to lab specimen collection date.</td>
</tr>
<tr>
<td>Management of Facility Outbreaks</td>
<td>Section moved to Annex B and C</td>
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<tr>
<td></td>
<td>Included information on PPE recommendations for staff during an</td>
</tr>
<tr>
<td></td>
<td>outbreak.</td>
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<tr>
<td></td>
<td>- Annex C: Management of Congregate Settings Outbreaks</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>Added</td>
</tr>
<tr>
<td>-------------------</td>
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</tr>
</tbody>
</table>
| Case Definition   | • Suspect case definition updated to: “…had close contact with a probable case of COVID-19”  
|                   | • Exposure criteria: added the following: Was involved in a COVID-19 outbreak or cluster |
| Period of communicability | • Added: NAAT can be prolonged for 3-4 weeks after symptom onset even when no viable virus is detected. |
| Host susceptibility | • Added: There is an evolving understanding of the immune response in COVID-19 disease, and the possibility of reinfection with SARS-CoV-2 has not been excluded. However, there have been no well substantiated cases of reinfection to date and most such suspect cases are likely related to testing methodologies. |
| Resources for COVID | • Added to preventative measures. |
| Public Health Management | • Divided into sections that align with the the table of contents |
| Testing Recommendations, Interpretation and Management | • New section added  
|                   | • Includes the expanded symptom list for testing  
|                   | • Includes testing of different individuals e.g. asymptomatic/ symptomatic/ previously tested cases. |
| Management of Immunocompromised Cases | • New section added |
| Annex B | • New section Management of Outbreaks  
|                   | • All the outbreak information is now in one section i.e. facility, congregate and childcare outbreaks. |
| Annex C | • Management of Travellers put into an annex and updated with new processes for management of travelers and flights |
| Annex E- Isolation Requirements and Annex F-Quarantine Requirements | • Annex E and F that had detailed information on isolation and requirements removed. Links to the information added to Section 6: Mandatory Quarantine and Isolation: CMOH Order 05-2020. |
References


13. Laboratory Bulletins | Alberta Health Services [Internet]. [cited 2020 Apr 19]. Available