Interim Guidance Public Health Measures

Managing Novel Coronavirus (COVID-19) Cases and Contacts in Community
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Summary of Changes

October 22, 2021
• Updates to Appendix C
  o how to declare a school outbreak over (pg. 58)
  o Assessment Tool for Exposures in Schools and Child Care Settings (pg. 60 - 61)

September 13, 2021
• Updates to Appendix C ‘Process for investigating COVID-19 cases in school/ child care settings’ (pg. 55 – 58)
• Updates to Appendix I – Case & contact management (pg. 93 - 96)
  o Includes updates to Case & contact management guidance throughout document (pg. 16 – 20; 22 – 27).

July 22, 2021
• Updates to discontinuation of home isolation with clarification for hospitalized patients (pg. 13, 14)

June 16, 2021
• Updates to quarantine recommendations if fully immunized (travel and close contacts) (pg. 21, 33, 89)
• Updates to assessment of reinfection and alignment of assessment with IP&C (pg. 17 - 21)

June 4, 2021
• Updated definition of “fully vaccinated” (pg. 20)
• Addition of guidance on public posting of charter flights (pg. 36)
• Clarification of declaring outbreak in highly vulnerable setting, and updates to workplace clusters (pg. 50)
• Updates to VOC guidance and removal of VOC notification interview (pg. 85)
• Updates to Appendix H – Supports for Community Members (pg. 78)
• Process for PHI Isolation checks where VCC unsuccessful in reaching (pg. 103)
Situation

The strategy outlined in this guidance is intended to focus on case and contact management to mitigate the health impacts of COVID-19 on Manitobans. This guidance is set in the Canadian context and is based on the available scientific evidence and expert opinion. In interpreting and applying this guidance, it is important to recognize that the health, disability, economic, social, or other circumstances faced by some individuals and households may limit their ability to follow the recommended measures. This may necessitate adapted case management and contact responses in some situations.

This document is based on the Interim Guidance: Public Health Management of cases and contacts associated with novel coronavirus from the Public Health Agency of Canada.1 Information on the situation is evolving. This guidance will be updated as further information becomes available.

Background

First identified in the 1960s, there are now seven known coronaviruses that can infect people. While four of these cause mild-to-moderate illness in humans, recently discovered viruses such as SARS (severe acute respiratory syndrome) and MERS-CoV (Middle East Respiratory Syndrome Coronavirus) can cause severe illness. On January 12, 2020, the World Health Organization confirmed China’s detection of a novel coronavirus (COVID-19) with significant health impacts. Early information suggest that common symptoms include fever (> 90%), malaise, dry cough (80%), shortness of breath (20%) and respiratory distress (15%).2

Current case numbers can be found on the Johns Hopkins coronavirus website (www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ef6).

Surveillance Case Definitions

Surveillance case definitions are provided for the purpose of standardized case classification and reporting. They are based on the current level of epidemiological evidence and uncertainty, and public health response goals, and are subject to change as new information becomes available.

These surveillance case definitions are not intended to replace clinician or public health practitioner judgment in individual patient management or testing, or for the purpose of infection

1 PHAC. Interim Guidance: Public Health Management of cases and contacts associated with novel coronavirus (COVID-19) (February 6, 2020)

control triage. For current screening and testing advice, please refer to

**Suspect case** –
A person with symptoms compatible with COVID-19
AND
Had close contact with a probable case of COVID-19.

*Note: COVID-19 may present as a co-infection with other pathogens. At this time, the
identification of one causative agent should not exclude COVID-19 where the index of
suspicion may be high.*

**Probable case** –
A person who:
1. Has symptoms compatible with COVID-19
   AND
   • Had a high-risk exposure with a confirmed COVID-19 case (i.e. close contact) OR was
     exposed to a known cluster or outbreak of COVID-19**
   AND
   • Has not had a laboratory-based NAAT assay for SARS-CoV-2 completed or the result is
     inconclusive*
     OR
   • Had SARS-CoV-2 antibodies detected in a single serum, plasma, or whole blood sample
     using a validated laboratory-based serological assay for SARS-CoV-2 collected within 4
     weeks of symptom onset (note serological assays are not routinely done for diagnostic
     purposes)*
   OR

2. Had a POC NAAT or POC antigen test for SARS-CoV-2 completed and the result is preliminary
   (presumptive) positive*

   OR

3. Had a validated POC antigen test for SARS-CoV-2 completed and the result is positive*

*See Laboratory Comments for further details
**This includes clusters that are not considered reportable outbreaks.

**Confirmed case** –
A person with confirmation of infection with SARS-CoV-2 documented by:
• The detection of at least one specific gene target by a validated laboratory-based
  nucleic acid amplification test (NAAT) assay (e.g. real-time PCR or nucleic acid
  sequencing) performed at a community, hospital, or reference laboratory (the
  National Microbiology Laboratory or a provincial public health laboratory)

OR

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• The detection of at least one specific gene target by a validated point-of-care (POC) nucleic acid amplification test (NAAT) that has been deemed acceptable to provide a final result (i.e. does not require confirmatory testing)*

OR

• Seroconversion or diagnostic rise (at least four-fold or greater from baseline) in viral specific antibody titre in serum or plasma using a validated laboratory-based serological assay for SARS-CoV-2 (note serological assays are not routinely done for diagnostic purposes)*

*See Laboratory Comments for further detail

**Laboratory Testing**

Laboratory tests are evolving for this emerging pathogen, and laboratory testing recommendations will change as new assays are developed and validated. Assays that have been licenced by Health Canada are preferred.

Any case classified as probable based on an epidemiological link, which subsequently tests negative for the SARS-CoV-2 virus should no longer be classified as a case. Exceptions may be made for negative results from a compromised sample or if NAAT testing is delayed (e.g. >10-14 days following symptom onset), whereby such persons remain as probable cases.

Testing for COVID-19 requires a nasopharyngeal (NP) swab placed in viral transport medium for conventional laboratory nucleic acid, or performed in a community facility with approved point of care testing. If such a specimen is being collected for ILI or presumed viral RTI, then a second swab is not required. Note: There may be some clinical indications for the use of an oropharyngeal swab instead of a NP swab, but when possible, a NP swab is the preferred specimen as it is more sensitive compared to other specimen types. As well, some of the approved point of care tests require a different specimen type and the direction for that particular test should be followed (e.g. Abbott ID NOW requires a mid-nasal turbinate swab).

For samples being sent to CPL, include the following information on the CPL General Requisition: relevant symptoms, priority group/reason for test, outbreak code if applicable, and request for COVID-19.

More severely ill patients may also require deep lung specimens be submitted, such as sputum, ETT secretions or broncho-alveolar lavage specimens.

The Respiratory Virus Infections Working Group of the Canadian Public Health Laboratory Network has developed laboratory testing best practices for COVID-19 and has updated its
Laboratory-Based Tests

At present, a validated reverse transcription polymerase chain reaction (RT-PCR) test on a clinically appropriate sample collected by a trained health care provider is the gold standard for the diagnosis of SARS-CoV-2 infection.

NAATs must be validated for SARS-CoV-2 detection.

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 for which limited performance data are available.

An indeterminate result on a real-time PCR assay is defined as a late amplification signal in a real-time PCR reaction at a predetermined high cycle threshold value. This may be due to low viral target quantity in the clinical specimen approaching the limit of detection (LOD) of the assay, or may represent nonspecific reactivity (false signal) in the specimen. When clinically relevant, indeterminate samples should be investigated further in the laboratory (e.g. by testing for an alternate gene target using a validated real-time PCR or nucleic acid sequencing that is equally or more sensitive than the initial assay or method used) or by collection and testing of another sample from the patient.

Point-of-Care Tests

Validation and evaluation is required for all POC tests (molecular and/or antigen-based), with the reference testing done in a licenced/accredited laboratory. If validation is not completed prior to clinical use at an individual location, a simultaneous sample should be obtained from the individual and tested using a validated laboratory-based NAAT at a licenced/accredited laboratory until acceptable performance data are obtained. If discrepant results from simultaneous testing are obtained, a case should be re-classified based on the results from the laboratory-based NAAT testing.

If reporting occurs prior to completion of validation AND jurisdictional evaluation, or testing occurs in a non-licenced setting, a positive POC result should be considered a preliminary or

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presumptive positive and the case should be classified as a probable case while awaiting results of the validated laboratory-based NAAT.

If no laboratory-based NAAT test result is obtained (or repeat specimen collected >24 hours after the preliminary POC collection and laboratory-based result is negative), the case status should remain as probable.

Appendix F of this document contains a summary of various tests that are available through the Manitoba Health system and guides the interpretation of results. This does not include interpretation for tests completed outside of the Manitoba Health system. As stated above, if testing occurs in a non-licenced setting, a positive result should be considered a preliminary or presumptive positive and the case should be classified as a probable case while awaiting results of the validated laboratory-based NAAT.

This recommendation may change as more data are accumulated on POC antigen test performance in Canada.

**Serology Tests**

SARS-CoV-2 antibody testing must be conducted using a validated assay by a licenced/accredited laboratory. Currently, SARS-CoV-2 IgM and serology POC tests are not widely available and are not recommended for use at this time due to a lack of adequate performance data. A diagnostic rise in antibody titre can be established using paired acute and convalescent sera taken 2-4 weeks apart and tested by an end-point enzyme immunoassay (EIA), quantitative EIA, or neutralizing antibody titres (e.g., plaque reduction neutralization (PRN)); however, these assays are not yet widely available and are not currently recommended for routine diagnostic testing. Since an individual can have detectable antibody levels for many months, a single positive serology result (i.e., no documented seroconversion or diagnostic rise) may not reflect recent infection.

In populations with low disease prevalence (<5%) or in individuals with a low pre-test probability, there is a risk of false positive results, even with an assay with high performance characteristics. In such cases, an orthogonal testing algorithm may be considered to increase the positive predictive value (PPV). In an effective orthogonal algorithm, a specimen that tests positive initially is tested with a second unique assay (i.e., uses a different antigen).

At this time, serology testing should not be used for classification of cases who have been previously diagnosed with COVID-19 or who have received a SARS-CoV-2 vaccination. SARS-CoV-2 serology tests should not be used for screening or the routine diagnosis of acute infection. It may be considered as an adjunct to SARS-CoV-2 NAAT in individuals with compatible symptoms who present late and therefore may test negative, and in the diagnosis of multisystem inflammatory syndrome in children (MIS-C) and multisystem inflammatory syndrome in adults (MIS-A).
At present, a validated reverse transcription polymerase chain reaction (RT-PCR) test on a clinically appropriate sample collected by a trained health care provider is the gold standard for the diagnosis of SARS-CoV-2 infection.

Contact Definitions

*Period of communicability*⁵ - The period extending from 48 hours prior to the development of overt symptoms in the case until the case is classified as no longer infectious.

*Close contact* – A person who, within the period of communicability

- provided care for the case, including HCWs, family members or other caregivers, or who had other similar close physical contact without consistent and appropriate use of personal protective equipment, OR
- who lived with or otherwise had close prolonged* contact (within 2 metres) with a probable or confirmed case while the case was infectious, OR
- had direct contact with infectious body fluids of a probable or confirmed case (e.g., was coughed or sneezed on) while not wearing recommended personal protective equipment.

*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. Prolonged exposure is defined as lasting for more than 10 minutes, cumulative over 24 hours.

Public Health Management of Cases

*Suspect, probable and confirmed cases well enough to be managed at home*

Epidemiologic evidence suggests that the majority of people who develop COVID-19 will have mild illness and will not require care in a hospital. Cases whose clinical condition does not require hospital care may be cared for in the home environment as long as effective isolation and appropriate monitoring (i.e., for worsening of illness) can be provided. The location where a person will isolate will be determined by their healthcare provider and public health.

Considerations for a suitable environment will depend on individual or household living situations and may vary depending on the sex, gender, or other socioeconomic or identity factors of cases. Cases should be isolated away from others in the home or co-living setting, including household members (i.e. not to go out unless directed to do so to seek medical care, not to take public transportation to seek medical care and to avoid contact with others).

⁵ Evidence is limited on transmission of the infection during the incubation period or during asymptomatic infection. There are a small number of case reports suggesting asymptomatic transmission can occur.
When determining the location, several factors to determine the suitability of the home setting are described below.

- **Ability to self-manage:** Symptomatic and asymptomatic cases should be able to monitor themselves for symptoms, maintain proper personal hygiene practices (i.e., hand hygiene, respiratory etiquette, clean and disinfect high-touch surfaces) and isolate away from others (See Appendix 1), which will be impacted by:
  o Household social and economic circumstances such as insecurity, violence or abuse;
  o Inadequate housing conditions (e.g. lack of access to clean water and appropriate supplies), economic barriers (e.g., inability to purchase larger quantities of needed supplies at one time, unstable employment or inflexible working conditions);
  o Individual skills, abilities and vulnerabilities such as difficulty reading, speaking, understanding or communicating, physical or psychological difficulty undertaking preventive activities and using protective equipment, need for assistance with personal or medical care activities or supplies, or need for ongoing supervision.
  o Social or geographic isolation such as lacking family or community contacts for support or residing in an area with reduced access to services or supports;
  o The ability for the case to access plain-language instructions in the appropriate languages on: proper personal hygiene practices, how to self-isolate away from others, how to self-monitor symptoms, and when to seek help. Note that male gender cases are more likely to live alone and may be less likely to seek help.

- **Severity of illness.** The case is exhibiting mild symptoms that do not require hospitalization, taking into consideration their baseline health status and the presence of risk factors for severe disease or outcomes (i.e., older adults, chronic medical conditions, immunocompromised, or obesity (BMI of 40 or higher)). Instructions should be provided on self-monitoring of symptoms and when/how to seek medical care.

- **Household configuration.** Cases will be in varying household configurations that may hinder their ability to isolate themselves. This includes single-parent households, and multi-generational households with shared child care and elder care responsibilities. It also includes situations where child care is shared between two homes. In this context, the children should remain in the household that does not have a case for the duration of the isolation.

- **Suitable home care environment.** In the home, the case should stay in a room of their own so that they can be isolated from other household members. If a separate room is not feasible, ensure that shared spaces are well ventilated (e.g. windows open, as weather permits) and that there is sufficient room for other members of the home setting to maintain a two-metre distance from the case whenever possible. If the ill person is sleeping in the same room as other persons, it is important to maintain at least 2 meters of separation from others (e.g. separate beds and have people sleep head-to-toe, if possible). If a separate bathroom is not available, the bathroom should be cleaned and disinfected frequently.

- **Cohorting cases in co-living settings (e.g. those living in university dormitories, shelters, overcrowded housing).** Special consideration is needed to support cases in these settings when isolating. If residing in a dormitory, such as at a post-secondary
institution or where there is overcrowded housing, the preferred option is to provide the case with a single room (e.g. relocate any other roommates to another location) with a private bathroom. If it is not possible to provide the case with a single room and a private bathroom or to relocate the case outside of the home, ensure that shared spaces are well ventilated (e.g., windows open, as weather permits) and that there is sufficient room for other members of the home setting to maintain a two-metre distance from the case. If the case cannot be isolated in their own room, hanging a sheet from the ceiling to separate the ill person from others may be considered. If the ill person is sleeping in the same room as other persons, it is important to maintain at least 2 metres distance from others (e.g. separate beds and have people sleep head-to-toe). If a separate bathroom is not available, the bathroom should be cleaned and disinfected frequently. Efforts should be made to cohort ill persons together. If there are two cases who reside in a co-living setting and single rooms are not available, they could share a double room. Note that confirmed positives can be cohorted together. However, do not cohort confirmed positives with symptomatic individuals waiting for test results (or not being tested). Cases in these settings are a priority to move to alternate accommodations.

- **Access to supplies and necessities.** The case must have access to food, running water/hand hygiene supplies, drinking water, and supplies (see Supplies for the home when isolating in appendix A) for the duration of the period of isolation. Those residing in remote and isolated communities may wish to consider stockpiling the needed supplies, as well as food and medications usually taken, if it is likely that the supply chain may be interrupted or unreliable. Resources are available to assist individuals who require supports to isolate in the home, including access to food and supplies.

- **Risk to others in the home.** Household members with conditions that put them at greater risk of complications of COVID-19 (e.g. older adults, underlying chronic or immunocompromising conditions, or obesity (BMI of 40 or higher) should not provide care for the case, and alternative living arrangements for the household member(s) or case may be necessary. This could include temporarily relocating these individuals or the case outside of the home to a location determined by public health, such as a designated hotel. For breastfeeding mothers: considering the benefits of breastfeeding and that the virus has not been found in breastmilk, breastfeeding can continue. If the breastfeeding mother is a case, she should wear a medical/procedure mask when near the baby or if not available, a non-medical mask or facial covering (e.g., homemade cloth mask, dust mask, bandana) when in close contact with the baby, especially during feeding. The mother should adhere to respiratory etiquette, and perform hand hygiene as well as washing the mother’s chest/breast area before and after close contact with the baby\(^6\). **Never place a mask on a child under two years of age.**

- **Access to care.** While it is expected that the case/convalescing at home will be able to provide self-care and follow the recommended preventative measures, some

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circumstances may require care from a household member (e.g. the case/ is a child). The caregiver should be willing and able to provide the necessary care and monitoring of the case, and be prepared to self-isolate (quarantine) for 10 days from the last known contact with the case.

- **Psychosocial Considerations:** Public health should encourage individuals, families and communities to create a supportive environment for people who are isolating to minimize stress and hardship associated with isolation as the financial, social, and psychological impact can be substantial. Obtaining and maintaining public trust are key to successful implementation of these measures; clear messages about the criteria and justification for and the role and duration of isolation or self-isolation (quarantine) and ways in which persons will be supported during the isolation or self-isolation (quarantine) period will help generate public trust. Additional information on the psychological impacts of COVID-19 is available.

**Alternative Isolation Accommodations (AIA)** are available in Manitoba and recommended for cases and contacts that cannot be suitably isolated or self-isolated (quarantined) within their home or living arrangements. AIA should also be considered in situations where there are children/youth ineligible for immunization reside, to minimize any disruption to their in-class learning. Further information is available at [https://sharedhealthmb.ca/covid19/providers/alternative-isolation-accommodations/](https://sharedhealthmb.ca/covid19/providers/alternative-isolation-accommodations/).

For cases being cared for in the home environment, the following measures and activities are recommended. Refer to **Appendix A Instructions for Self-Isolating the home or co-living situation, and Appendix H Supports for Community Members**.

- Provide public health advice to the case and household (or co-living setting) contacts on individual measures including self-monitoring, infection prevention and control, and environmental cleaning of the home setting. See **Appendix A**
- The client should be instructed to cancel or notify any service providers that regularly come into the home.
- Public Health to conduct **active monitoring** of the case’s health status for duration of illness (and until they have met the criteria for discontinuing isolation) or until laboratory investigation has ruled out COVID-19 infection. Refer to the Temperature Self-Monitoring Form adapted from the Winnipeg Regional Health Authority for specific guidance. Suspect cases should be advised to isolate until results are known and advised to call Health Links if symptoms worsen. Active monitoring of suspect cases does not need to occur unless the individual becomes a case.
- Active monitoring should occur 2 - 3 times during the isolation period (on notification, during period of isolation (may be missed in short quarantine periods), and to remove from isolation), with SMS used where possible to supplement calls. Follow-up monitoring

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7 Quarantine is also referred to publicly as ‘self-isolation’. This document will use ‘self-isolation (quarantine)’ to refer to quarantine recommendations for people who are well but have been potentially exposed to COVID-19. The term ‘isolation’ will refer to recommendations for individuals with symptoms that are suspected of having, or known to have, COVID-19.

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should occur on notification (around day 4-5), at the end of isolation (day 10), and once around day 7-8 to monitor for severe symptoms and assist with isolation issues. Cases should be advised to call Health Links Info Santé if symptoms worsen between calls, or if they have additional questions.

**Discontinuation of home isolation**

An individual who has been placed on home isolation can stop home isolation 10\(^8\) days after the onset of their first symptom provided they are afebrile and have improved clinically. Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post-infection. As well, loss of taste or smell can persist after the period of communicability so on their own are not reasons for continuing isolation.

- Clients on home isolation with worsening symptoms should have a prompt clinical assessment. Note that clinical deterioration has more commonly occurred around 8 to 10 days post-symptom onset.
- Anyone with persistent symptoms at day 10 (e.g. fever, increasing shortness of breath, fatigue), aside from a reactive airway cough or loss of taste and/or smell, should have a prompt clinical assessment. Individuals who remain symptomatic at day 10 should also continue on active daily monitoring until symptoms have resolved for 24 hours.

For asymptomatic cases, isolation can be discontinued if at least 10 days have passed since the specimen collection date of the confirmatory laboratory sample. If an asymptomatic case subsequently develops symptoms of COVID-19, the period of isolation should be adjusted to 10 days after the onset of their first symptom provided they are afebrile and have improved clinically.

In general, repeat laboratory testing (i.e., a negative test result) as the basis for discontinuing home isolation is not recommended.

**This criteria does not apply to hospitalized patients.** Seriously ill patients can have prolonged shedding of infectious virus and thereby may have a longer period of communicability. Decisions on discontinuing isolation should be made in conjunction with the case’s health care providers and hospital IP&C, considering both the clinical and laboratory findings. Information on discontinuing precautions in hospitalized cases can be found in the COVID-19 Specific Disease Protocol (Provincial) – Acute and Community Settings - [https://sharedhealthmb.ca/files/IPC-acute-care-manual-provincial.pdf](https://sharedhealthmb.ca/files/IPC-acute-care-manual-provincial.pdf) This would also apply for cases who were seriously ill, but being discharged from the hospital prior to completing their isolation.

- For cases that are discharged from hospital, who are not immunocompromised and who did not require ICU admission or Optiflow (in and out of ICU) for COVID-19 management

\(^8\) Manitoba previously used 14 days of isolation post symptom onset. Evidence supports limiting to 10 days post-symptom onset, and is consistent with current national guidance.

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and/or treatment, and require ongoing isolation for COVID-19 in the community, they can discontinue home isolation following the same criteria as for individuals who never required hospitalization. This is regardless if the case required hospitalization for management and/or treatment of COVID-19 or for another reason.

**Health Care Workers (HCWs):** Those who work in health care settings may need to meet additional requirements before returning to their workplace. For cases that are HCWs, public health should notify and consult with regional occupational health at the end of the home isolation period to determine any additional requirements before the HCW returns to the workplace. In general, HCWs can return to work without laboratory testing 10 days after the onset of their first symptom provided they are afebrile and have improved clinically for at least 24 hours. If symptoms remain, consult Occupational Health on return to work guidance, which may include laboratory testing if symptoms continue to persist. Further information on return to work can be found at: [https://sharedhealthmb.ca/files/covid-19-screening-tool-hcw-symptomatic.pdf](https://sharedhealthmb.ca/files/covid-19-screening-tool-hcw-symptomatic.pdf)

**Infection Prevention and Control**

**Healthcare Workers**
- For healthcare workers providing health care services in the home, virus-specific IPC guidance for acute health care settings is applicable.
- In addition to **routine practices**, healthcare workers should follow Enhanced Contact and Droplet precautions when within two metres of the case. See provincial coronavirus resources for staff at [https://www.gov.mb.ca/covid19/restoring/industry-sectors.html](https://www.gov.mb.ca/covid19/restoring/industry-sectors.html) For aerosol-generating medical procedures⁹ (e.g., case is receiving nebulized therapy) the use of additional precautions, including using a N95 respirator, is recommended. See [https://sharedhealthmb.ca/files/N95-respirator-FAQ-for-managers.pdf](https://sharedhealthmb.ca/files/N95-respirator-FAQ-for-managers.pdf)
- Medical equipment should be cleaned, disinfected or sterilized in accordance with routine practices.

**Caregivers and others sharing the living environment**
- If possible caregivers should be vaccinated
- If direct contact care must be provided, the case should wear a surgical/procedure mask and follow respiratory etiquette.
- The caregiver providing direct contact care to the case should also wear a procedure/surgical mask and eye protection when within two metres of the case and perform hand hygiene after contact.

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⁹ Aerosol-generating medical procedures (AGMPs): AGMPs are medical procedures that can generate aerosols as a result of artificial manipulation of a person’s airway. There are several types of AGMPs which have been associated with a documented increased risk of tuberculosis (TB) or SARS transmission: Intubation and related procedures (e.g. manual ventilation, open endotracheal suctioning), Cardiopulmonary resuscitation, Bronchoscopy, Sputum induction, Nebulized therapy, Autopsy, Non-invasive positive pressure ventilation (CPAP, BiPAP). [https://sharedhealthmb.ca/files/N95-respirator-FAQ-for-managers.pdf](https://sharedhealthmb.ca/files/N95-respirator-FAQ-for-managers.pdf)
• Masks should not be touched or handled during use. If the mask gets wet or dirty with secretions, it should be changed immediately. After discarding the mask, hand hygiene should be performed.

• Direct contact with body fluids, particularly oral, and respiratory secretions should be avoided. Use disposable gloves to provide oral or respiratory care, and when handling stool, urine and waste, if possible. Perform hand hygiene following all contact.

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

• Persons caring for a case should limit their contact with other people as much as possible and monitor themselves for any signs of illness for 14 days from last close contact.

• Additional provincial Infection Prevention and Control guidance documents are available at https://sharedhealthmb.ca/covid19/providers/ipc-resources/

Clinical Management/Treatment
• The treating health care provider will provide clinical management of the case (whether in the home or in an acute care setting) based on their condition and at the discretion of the health care provider. Canadian guidance on the clinical management of patients with COVID-19 is available.

• HCWs providing care for a case should follow relevant guidance developed for infection prevention and control including Routine Practices and Additional Precautions, and COVID-19-specific infection prevention and control (IPC) guidance. Any aerosol-generating medical procedures (AGMP), such as nebulized medications, should be avoided in the home environment. If an AGMP is required, consideration should be given to transferring the case to hospital due to the need for Additional Precautions.

Testing Individuals After Death
In the interest of identifying all deaths related to COVID-19 and to better understand the burden of disease in Manitoba, collection of a post-mortem nasopharyngeal (NP) swab for COVID-19 testing should be considered if the following are true:
Part A: Prior testing
  1) The deceased did not have a NP swab positive for COVID-19 prior to death

OR

11 https://sharedhealthmb.ca/covid19/providers/

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2) The deceased did not have two or more NP swabs negative for COVID-19 in the past week

AND

Part B: Symptoms or cause of death
1) Death was preceded by influenza-like illness (ILI), upper or lower respiratory tract infection, or any symptoms compatible with COVID-19, even if very mild
OR
2) Cause of death is unclear
If a previous swab was positive, no further testing is required.

Process for acquiring the NP swab:
For deaths occurring in a health care facility:

- If the death is reportable to Office of the Chief Medical Examiner (OCME), the NP swab can be obtained without prior permission from the OCME, unless the death is a homicide or suspicious in nature with police involvement. It should be communicated to the OCME that the swab has been taken when the death is reported
- If the death is not reportable to the OCME, follow facility processes for post-mortem procedures.

For deaths occurring outside of a health care facility:

- Current process by OCME for deaths reportable to their office should continue. The OCME has been bringing in every decedent with any indication of ILI, respiratory difficulty, exposure to a known COVID-19 case, recent travel, etc. for an external examination and acquisition of NP swab.

To understand risk factors for severe outcomes, for all deaths related to COVID-19 ensure complete documentation of underlying illnesses (in risk factors), and, if known, the cause of death and any contributing factors. For deaths under the age of 65 years, when underlying illness is unknown, regional Medical Officers of Health should follow-up with the attending physician to obtain further information.

Public Health Management of a Contact Who was Previously a Case

There is limited evidence regarding duration of immunity following infection with SARS-CoV-2 and worldwide there have been a small number of reports of reinfection. The risk of reinfection may also be affected by the emergence of variants of concern with mutations enabling immune escape. Based on our understanding of other human coronaviruses and the evidence regarding SARS-CoV-2 to date, individuals appear to be susceptible to reinfection around 6 months after initial infection. Reinfection can occur within the 6 months of previous infection or afterwards, but appears to be uncommon. However, the frequency of occurrence remains uncertain. Some reports of reinfection have completed whole genome sequencing documenting two phylogenetically distinct strains of SARS-CoV-2. For some, milder illness or asymptomatic cases were reported, but for a few individuals, reinfection resulted in more severe disease. At this time, little can be concluded other than reinfection can occur. Nucleic acid amplification tests can continue to detect virus long after the period of communicability, so repeat testing needs to be

Individuals who have recovered from COVID-19 generally should not undergo testing for screening/surveillance purposes if they are asymptomatic. If a test is done in a recovered individual with no symptoms and no known exposure and the result is positive, it should generally not be considered a new infection and should not trigger public health actions unless there are additional factors, such as a new exposure or new symptoms. This may not be applicable to very high-risk situations such as outbreaks in long term care homes.

Laboratory consultation and additional testing:

PCR positivity is a necessary but not a sufficient condition for the diagnosis of reinfection due to evidence of prolonged detection that can last months after symptom resolution.

- PCR cycle threshold (Ct) values: the higher the Ct value required to detect a gene target, the lower the number of viral copies present in a sample. Higher Ct values in the setting of new acute symptom onset may be more suggestive of old/persistent viral shedding. However, Ct values may also be higher with early case detection, and re-testing 48 hours later may be considered to assist with interpretation. If the Ct value on a subsequent sample is lower, this would add support for a diagnosis of a new acute infection. Ct values and cut-offs vary dependent upon the assay used and should be reviewed with the laboratory that performed the testing.
- Genomic analysis: whole genome sequencing of virus from suspected separate episodes of infection can be used for comparative phylogenetic analysis to determine whether viruses are genetically distinct enough to support a diagnosis of reinfection. Results of VOC screening tests may also support this assessment, and are available earlier in the investigation. Current VOC's circulating in Manitoba were not known to be present prior to February 2021.

If the new investigation is determined to NOT be a reinfection, the case classification on the new investigation must be changed to “Not a case”. This will ensure the case is not counted as a reinfection.

If a new investigation is assessed to be a remote infection, and there is no previous documented investigation for COVID-19, the case classification should remain as lab confirmed. In this situation, an isolation intervention will not be required, and a status assessment of recovered should be documented. This will ensure the case is counted, but will not be considered an active case.

Individual (Previously a Case) With New Symptoms of COVID-19 but No New Exposure:
If an individual, who was previously a confirmed or probable case, has new onset of symptoms consistent with COVID-19, but no new exposure, the following should be considered:

- How long has passed since they were a confirmed or probable case?
- Are they requiring hospital admission because of their symptoms?
- Is there an alternative diagnosis?
- Do they work in a setting with high risk or vulnerable populations (e.g. long-term care, corrections, residential facilities, shelters, etc.)?

If it has been less than six months since they were determined to be a confirmed or probable case, they do not require hospitalization for their new symptoms, and there is an alternative diagnosis (either by clinical assessment or confirmed by investigation) then the individual should isolate until their symptoms have resolved for 24 hours. COVID-19 testing is not recommended. This recommendation stands even if there is no obvious alternative diagnosis because new symptoms in less than six months, in the setting of no exposure, makes it very unlikely to be COVID-19 re-infection. However, if they work in a setting with high risk or vulnerable populations, they should consult with their workplace’s occupational health and safety to determine whether additional precautions are warranted and testing should be considered.

If it has been less than six months since they were determined to be a confirmed or probable case and they require hospitalization for their new symptoms, testing for COVID-19 should be considered. COVID-19 testing should be done if they require admission to the intensive care unit for their symptoms. The laboratory requisition should say “possible reinfection” under testing indication.

If it has been six months or more since they were determined to be a confirmed or probable case, they should isolate and go for COVID-19 testing. They should advise the collection site that they are being tested for possible reinfection, which should be included on the requisition.

**Individual (Previously a Case) With a New Exposure:**

If an individual who was previously a confirmed or probable case, is now identified as a close contact of a confirmed or probable case the following should be considered:

- How long has passed since they were a confirmed or probable case?
- Are they symptomatic?
- What type of exposure did they have/what was the degree of exposure?
- Do they work in a setting with high risk or vulnerable populations (e.g. long-term care, corrections, residential facilities, shelters, etc.)?

If the individual is asymptomatic and it was less than six months since they were determined to be a confirmed or probable case, they do not need to self-isolate (quarantine), but should self-monitor for symptoms. Should they develop symptoms of COVID-19, the individual must isolate and should go for COVID-19 testing.
If the individual is asymptomatic and it was less than six months since they were determined to be a confirmed or probable case, but they work in a setting with high risk or vulnerable populations they do not need to self-isolate (quarantine), but they should consult with their workplace’s occupational health and safety to determine whether additional precautions are warranted.

If the individual is symptomatic and they fulfill criteria for COVID-19 testing, they must isolate and should go for testing.

If the individual is asymptomatic and it has been six months or more since they were determined to be a confirmed or probable case, they should self-isolate (quarantine) for 10 days, followed by 4 days of self-monitoring for symptoms, from their last exposure. Should they develop symptoms of COVID-19, the individual must isolate and should go for testing.

**Individual (Previously a Case) with no new symptoms or exposures, but tested for other reasons and COVID-19 is detected:**

If an individual who was previously a confirmed or probable case, is tested again for COVID-19 (e.g. prior to surgery or travel) and has a positive result, the following should be considered:

- How long has passed since they were a confirmed or probable case?
- Are they symptomatic (assess for mild symptoms?)
- Did they have any potential exposures?
- Do they work or live/reside in a setting with high risk or vulnerable populations (e.g. long-term care, corrections, residential facilities, shelters, etc.)?
- Is the CT value available for the lab test? If yes, does it suggest a more remote infection?

If the individual is asymptomatic and it was **less than six months** since they were determined to be a confirmed or probable case, and the review above does not suggest a new infection, they do not need to isolate, but should self-monitor for symptoms. Should they develop symptoms of COVID-19, the individual must isolate. If re-infection is not suspected and the client does not have any high risk exposures, the client could be advised that they do not need to isolate, but should self-monitor for symptoms and avoid contact with anyone at high risk of severe outcomes from COVID-19. Should they develop symptoms of COVID-19, the individual must isolate. If re-infection is suspected, the client should be managed as a new case of COVID-19 and should isolate. Genome sequencing should be requested from CPL.

If the individual **works or resides in a setting with high risk or vulnerable populations**, is asymptomatic and it was **less than six months** since they were determined to be a confirmed or probable case, they do not need to isolate outside the setting, but they should consult with their
workplace’s occupational health and safety and/or Infection Prevention and Control to determine whether additional precautions are warranted. If the individual is asymptomatic and does not have any new exposures, and it was more than six months since they were determined to be a confirmed or probable case, clinical review is required in these settings to determine whether any additional precautions are warranted. Individuals have been shown to test positive for COVID-19 longer than six months after the infection, so a risk assessment is required to inform whether isolation is required. If re-infection is not suspected, isolation may not be required, but additional precautions may be warranted in the high risk setting. If re-infection is suspected, the client should be managed as a new case of COVID-19 and should isolate. Genome sequencing should be requested from CPL.

In general, asymptomatic COVID-19 testing should not be performed on clients who were previous cases, unless clearly indicated. Since individuals have been shown to test positive for COVID-19 longer than six months after the infection, a decision cannot be made on reinfection strictly based on time frame.

If a client is assessed in an acute care or long term care facility by an Infection Prevention and Control (IP&C) physician and determined to be a previous COVID-19 infection and not infectious, this decision will be communicated by IP&C to Public Health (PH) through the regional CD coordinators to ensure public health follow-up is in alignment with this assessment (and vice versa). If the assessment by Public Health is different from IP&C, discussion between IP&C and PH physicians should occur to come to a consensus on the approach for the case to ensure consistent recommendations are provided to the client and their contacts.

If the new investigation is determined to NOT be a reinfection, the case classification on the new investigation must be changed to “Not a case”. This will ensure the case is not counted as a reinfection.

Public Health Management of Contacts

In an effort to help prevent or reduce the spread of COVID-19 in Canada, the entire population has been asked to:

- when outside of the home, practice physical distancing from others,
- wear a mask when physical distancing from others, is not possible (includes shared public spaces both indoors and outdoors),
- avoid crowded places,
- self-monitor for symptoms of COVID-19, and
- isolate themselves within the home-setting should symptoms develop and follow instructions provided by public health, including testing if symptomatic.

Close contacts of confirmed and probable cases occurring in Canada should be identified and managed as per the recommendations in this document, to the extent possible.

The purpose of contact management is:
1. to facilitate rapid identification of new cases and to reduce community spread by:
   - identifying and isolating any symptomatic contacts as quickly as possible; and
   - reducing the opportunity for transmission to others in the community from those with
     infection but without symptoms or with mild symptoms that may go unnoticed, and by
     providing contacts with information regarding infection prevention and control
     measures they should follow, and what to do if they develop symptoms.

2. to gain a better understanding of the epidemiology of this coronavirus.

Contact tracing should include:

- identifying people who were in contact with a symptomatic case starting 48 hours prior to
  the case developing a symptom consistent with COVID-19.
- identifying people who were in contact with a laboratory confirmed asymptomatic case
  starting 48 hours prior to the day their positive specimen was collected.

An individual risk assessment conducted will identify the contact’s exposure risk level and to
determine the required level and parameters of self-isolation (quarantine), and public health
actions for the 14-day monitoring period.

**Immunization status**

Individuals who, at the time of the exposure to a case, have received a full series of
immunization, and more than 2 weeks have elapsed since the last dose in the series, are not
required to self-isolate (quarantine) or be tested if:

- they are asymptomatic, and
- do not have a medical condition (e.g. immunocompromised) that would impact vaccine
effectiveness.

Follow acute care and long term care guidelines for management of residents in these facilities.
For other high risk congregate settings such as Corrections or shelters, testing with release from
quarantine with a negative test may be employed for fully vaccinated residents. Workers in
health care and congregate settings should also consult with occupational health or their
workplace manager for further guidance.

Individuals are considered fully vaccinated:

- 2 weeks after their second dose in a 2-dose series, such as the Pfizer, Moderna, or
  Astra Zeneca vaccines, or
- 2 weeks after a single-dose vaccine, such as Johnson & Johnson’s Janssen vaccine

Individuals who have been fully immunized outside Canada with COVID-19 vaccines that are
not approved in Canada, but are on the WHO Emergency Use Listing
([https://www.who.int/teams/regulation-prequalification/eul/covid-19](https://www.who.int/teams/regulation-prequalification/eul/covid-19)) are also considered fully
immunized.

These individuals should self-monitor for symptoms of COVID-19 for 14 days following an
exposure. If symptoms develop, they should isolate and be tested.

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The risk of asymptomatic transmission after immunization remains uncertain. However, immunization has been shown to prevent symptomatic COVID-19, and symptomatic and pre-symptomatic transmission is thought to have a greater role in transmission than purely asymptomatic transmission.

This guidance on immunization status of contacts is consistent with guidance from the CDC\textsuperscript{13} and will be updated as new evidence becomes available, or if a COVID-19 variant with impacts on vaccine effectiveness becomes established in Manitoba.

However, at this time all vaccinated individuals should continue to follow all other current provincial and federal public health orders and key public health fundamentals, including:

- Use of PPE as per sector specific guidance, including infection prevention and control protocols in health care settings.
- Adoption of non-pharmaceutical interventions (i.e. physical distancing, hand hygiene, staying home when sick, and wearing masks where distancing is not possible).

**Contact management**

Public Health should attempt to identify, notify, and direct all contacts to self-isolate (quarantine) as soon as possible, ideally within 24 hours of notification of a confirmed or probable case. A provincial target has been established to notify 80% of contacts within one day of case notification.

A contact who develops symptoms compatible with COVID-19 within the monitoring period should be managed as a suspect case.

- If laboratory testing is conducted and the test results are negative for the virus that causes COVID-19, the individual is no longer a managed as a case, but should continue to self-isolate (quarantine) until 10 days from last exposure since they are still a contact of a case, followed by 4 days of self-monitoring for symptoms. The contact may be considered for re-testing if they have worsening /progression of symptoms.

- If laboratory testing is not conducted, the contact, who is now being managed as a suspect or probable case, after completing at least 10 days of home isolation may need to resume self-isolation (quarantine) until 10 days from last exposure since they are still a contact of a case and not a lab confirmed case themselves.

Laboratory testing is recommended for close contacts 7 days after the last exposure to the case. This testing is not required if there is a logistical reason for which testing would be a challenge (e.g. asymptomatic newborn infant whose mother is a confirmed case and for whom collection sites may be unable to swab due to the size of the child and familiarity with swabbing a newborn). If negative, they should continue to self-isolate (quarantine) until 10 days, followed by 4 days of self-monitoring for symptoms, from last exposure. Additional laboratory testing should be advised if the contact subsequently develops symptoms. If positive, the contact should be managed as a

\textsuperscript{13} https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html

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laboratory confirmed case. If the contact is asymptomatic and identified more than 7 days after the last exposure to the case, they should be tested as soon as possible.

The first testing of asymptomatic contacts in the self-isolation (quarantine) period is optional to allow earlier identification of asymptomatic cases, and initiation of contact tracing and isolation if positive. This has the potential to reduce further exposures in the household and overall isolation/self-isolation (quarantine) periods for the household. This optional testing will not be recommended routinely during times when COVID-19 activity is high in the community and testing capacity is limited. In situations where the first test is important to determine potential exposures, such as in congregate or crowded settings, it may still be recommended by public health as part of outbreak management, even during times where testing capacity is limited.

- If tested at day 5 or earlier, repeat testing is recommended at day 7. Contacts should be notified of the need for 2 tests.
- If tested at day 7 or later, repeat testing is not required.

Testing at day 7 is important to identify asymptomatic cases who develop infection later in the self-isolation (quarantine) period (i.e. longer incubation periods). This avoids asymptomatic cases being removed from isolation when they may be still infectious.

**If the case isolates in the home:**

- **If the case is unable to isolate from household contacts:** All household close contacts, unless otherwise exempt, must also self-isolate (quarantine) for the same period (minimum 10 days) as the positive case, and must self-isolate (quarantine) for a further 10 days to ensure the virus was not transmitted in the final days of the case’s isolation. This should be followed by 4 days of self-monitoring for symptoms. If subsequent cases are identified in the household, this may result in a longer self-isolation (quarantine) period for household close contacts. Testing is recommended at day 7 after the last exposure to the case, but not required to remove from self-isolation (quarantine). Encourage the use of AIA and separate isolation spaces for younger contacts who are not eligible for immunization to avoid prolonged disruptions to in-class learning.

- **If the case is able to isolate from household contacts** (e.g. separate living space and washroom and no shared space or close contact with other household members): All household close contacts, unless otherwise exempt, must self-isolate (quarantine) for 10 days following the last exposure to the case. This should be followed by 4 days of self-monitoring for symptoms. Testing is strongly recommended at day 7, but not required to remove from self-isolation (quarantine).

**If the case does not isolate in the home:**

- All close contacts, unless otherwise exempt, must self-isolate (quarantine) for 10 days from the last exposure to the case. This should be followed by 4 days of self-monitoring for symptoms. Testing is recommended at day 7 after the last exposure to the case, but not required to remove from self-isolation (quarantine).

**Household members of contacts**

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Household members of close contacts who are asymptomatic do not need to self-isolate (quarantine) if the close contact remains asymptomatic.

If the close contact becomes symptomatic, all household members, unless otherwise exempt, should self-isolate (quarantine) until the symptomatic individual’s test result is available.

If a close contact has symptoms compatible with COVID-19 and is not tested, they will be considered a probable case, and household members will be considered close contacts and must self-isolate (quarantine), unless exempt.

Household members of symptomatic individuals (based on screening tool symptom assessment and not identified as a close contact) do not need to self-isolate (quarantine) while awaiting the symptomatic individuals’ test result.

It is recommended that household members who do not need to self-isolate (quarantine) should wear a mask and physically distance where possible when outside the household in these circumstances, and avoid leaving the home for non-essential reasons. This messaging is recommended to alert the household members that they are at increased risk of exposure based on sharing a household with a close contact and/or symptomatic individual and reinforce adherence to strict public health prevention measures.

The following exemptions are in place for household members:

- Exemption from self-isolation (quarantine) if the household member is asymptomatic AND:
  - is fully immunized (i.e. it has been at least two weeks since their last dose of the vaccine series) at the time of the exposure, and
  - do not have a medical condition (e.g. immunocompromised) that would impact vaccine effectiveness, OR
- recently infected (i.e. within the previous 6 months).
- Exemptions are also allowed for household members (who are not fully immunized or recently infected) who are essential workers required to wear PPE at work if:
  - everyone in the household is asymptomatic, including the close contact, AND
    - they self-isolate (quarantine) when not at work, AND
    - the close contact can self-isolate (quarantine) from the essential worker in the household.
    - Note that this exemption DOES NOT APPLY to essential workers if they have been identified as a close contact themselves.

All individuals exempt from self-isolation (quarantine) requirements, should continue to self-monitor for symptoms, and isolate immediately if any develop and go for testing.

Active monitoring should occur 2-3 times for all close contacts (on notification, during period of self-isolation (quarantine), and to remove from self-isolation (quarantine)), including recommendations for testing at day 7 if they remain asymptomatic and if symptoms develop. Active monitoring should provide recommendations for testing, and to assist with self-isolation (quarantine) issues. Priority should be given to the final call to remove cases from self-isolation.
(quarantine) if capacity does not allow multiple calls during the quarantine period. Contacts should be advised to call Health Links Info Santé or go to a test site if they develop symptoms, or if they have additional questions.

**Management of close contacts for providers of services for people experiencing homelessness and/or living in crowded congregate settings**

Individuals experiencing homelessness and/or living in crowded congregate settings may have increased risks associated with COVID-19 due to a number of factors, including:

- Increased exposures due to crowded settings,
- Difficulties maintaining physical distancing,
- Limited or irregular access to hand hygiene supplies and/or masks,
- Higher rates of underlying chronic health conditions compared to the general population, and
- Inadequate facilities in which to adequately self-isolate (quarantine)

Providers of services for people experiencing homelessness and/or living in crowded congregate settings should follow overall guidance for case and contact management of COVID-19. However, it is more difficult to extrapolate the definition of household members as it relates to contact management in these settings.

In general, household members of close contacts are also advised to self-isolate (quarantine), due to the risk of ongoing exposure with the self-isolating (quarantining) close contact, as well as exposure to the contact before their COVID-19 status is known (based on test results). In congregate settings, the close contact should be self-isolating (quarantining) away from other individuals using the shelter/congregate setting, which addresses the risk of ongoing exposure. To address the risk of exposure prior to the initiation of self-isolation (quarantine), testing of the close contact(s) at the time of contact notification, including use of rapid testing platforms where available, should be strongly encouraged and facilitated in shelter/congregate living settings. If negative at the time of notification, the risk of transmission to contacts of the close contact prior to the initiation of the self-isolation (quarantine) period is low.

For shelters for people experiencing homelessness, if the close contact is not tested, individuals who are in close relationship with the close contact (e.g. partners, those regularly sharing sleeping arrangements within 2M, or someone they spend most of the day with) should be advised where possible to also self-isolate (quarantine) until test results are known, or the self-isolation (quarantine) period has ended and the contact remains asymptomatic.

In congregate settings with shared common washrooms and kitchens, with cleaning protocols in place, individuals who are not otherwise identified as close contacts themselves, would not generally be advised to self-isolate (quarantine), unless there is evidence of further transmission in the facility. In dormitory settings where a bathroom is assigned to a small number of individuals who would be responsible for cleaning procedures (e.g. shared between 2-3 people), or in
crowded living settings with a shared washroom, these individuals should be considered as a household unit, and instructed to also self-isolate (quarantine) until the close contact tests negative, or finishes their self-isolation (quarantine) period and remains asymptomatic.

Given the risks and challenges associated with self-isolating (quarantining) Alternative Isolation Accommodations (AIA) are strongly recommended for close contacts experiencing homelessness and/or living in crowded congregate settings to minimize the potential for further transmission. Individuals who are identified as “household members” may also require AIA if they cannot self-isolate (quarantine) in their current living space. The use of AIA should also be encouraged in situations where younger individuals, who are ineligible for immunization, live in the household to minimize disruptions to their in-class learning.

Public health should work with clients to address any barriers to testing, including access (e.g. mobile testing), and type of test/swab required. Public health can use discretion in type of test if required.

**Categories of Contacts**
Depending on exposure risk level, there are two main categories of contacts (high, and low). Table 1 Categories of contacts by exposure risk level describes the risk level, provides isolation
and contact management advice as well as associated public health actions\textsuperscript{14}.

\textbf{See} additional resources which include:

- The Temperature Self-Monitoring form
  \url{https://manitoba.ca/asset_library/en/coronavirus/temperature.pdf}

- The Novel Coronavirus Screening Tool for Public Health and Health Links

\begin{table}[h]
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\hline
\textbf{Risk Level} & \textbf{Description of Risk Level} & \textbf{Isolation Level/ Contact actions} & \textbf{Public health authority (PHA) actions} \\
\hline
High & \textbf{1) Close contact(s) of a case:}  \\
& - provided direct care for the case (including health care workers, family members or other caregivers), or who had other similar close physical contact (e.g. intimate partner) \textbf{without consistent and appropriate use of recommended personal protective equipment}, OR  \\
& - who lived with or otherwise had \textbf{close prolonged contact} (within 2 metres) with a case up to 48 hours prior to symptom onset or while the case was symptomatic and not  \\
& & - Self-isolate (quarantine)\textsuperscript{18}, unless exempt, at home for 10 days from last unprotected exposure, followed by 4 days of self-monitoring for symptoms.  \\
& & - Note: Exemptions are in place for asymptomatic close contacts who have been fully immunized at the time of the exposure, and have no medical condition that could compromise vaccine effectiveness, OR have been previously infected with COVID-19 in the previous 6 months, are exempt from self-isolation (quarantine). They should self-monitor for symptoms for 14 days from their last exposure, immediately isolate if any develop and get tested.  \\
& & - Active monitoring of contacts for symptoms. Refer to the Temperature Self-Monitoring Form for specific guidelines.  \\
\hline
\end{tabular}
\caption{Categories of contacts by exposure risk level}
\end{table}


\textsuperscript{15} Adapted from Public Health Ontario. Public health management of cases and contacts of novel coronavirus (COVID-19) in Ontario February 12, 2020 (version 4.0).

\textsuperscript{16} 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. Prolonged exposure is defined as lasting for more than 10 minutes. There is insufficient evidence available to define risk in terms of the length of exposure time required for transmission. For public health contact identification and management purposes only, a period of more than 10 cumulative minutes over 24 hours has been selected to distinguish between brief and prolonged exposure. This parameter should not replace the conclusions derived from an individual risk assessment that addresses a variety of factors (i.e. infectiousness of the case at time of exposure, likely route of transmission, risk factors, etc.) that will more precisely inform risk.

\textsuperscript{18} In general, self-isolation means that a contact stays in their home and does not go out, and avoids being within the same room with others within the home setting. If this cannot be avoided, a distance of at least 2 metres should be maintained from others.

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The high and low risk exposure categories in Table 1 offer a simple guide for assessing a contact’s risk of exposure to COVID-19 during contact tracing. In reality, there is a spectrum of risk, where adherence to public health risk mitigation measures helps to decrease the chance of infection. Individual-level risk mitigation measures for consideration in the risk assessment include a contact’s adherence to personal preventive practices (e.g., mask wearing, type of mask, hand washing, physical distancing, etc.), and avoiding settings or activities where they may be exposed. These settings may include closed spaces, crowded places, and those where close interactions (e.g., social gatherings, workplaces, etc.) occur. Setting-specific considerations include those places where a contact was potentially exposed, including whether the exposure was indoors (higher risk) or outdoors (lower risk), ventilation quality, the size and number of people in the setting, and risk mitigation measures in place in the setting (e.g., requirements for wearing masks, type of mask, physical distancing, cleaning high-touch surfaces, etc.). Although outdoor settings are not generally considered high risk, the potential for transmission still exists under certain circumstances, such as close conversations or rigorous exercise when participants are in close proximity and are not wearing masks; therefore, consider these risks when classifying contacts based on risk.

17 The high and low risk exposure categories in Table 1 offer a simple guide for assessing a contact’s risk of exposure to COVID-19 during contact tracing. In reality, there is a spectrum of risk, where adherence to public health risk mitigation measures helps to decrease the chance of infection. Individual-level risk mitigation measures for consideration in the risk assessment include a contact’s adherence to personal preventive practices (e.g., mask wearing, type of mask, hand washing, physical distancing, etc.), and avoiding settings or activities where they may be exposed. These settings may include closed spaces, crowded places, and those where close interactions (e.g., close-range conversations) occur; as well as settings where these factors overlap and/or involve activities such as singing, shouting, or heavy breathing. Setting-specific considerations include those places where a contact was potentially exposed, including whether the exposure was indoors (higher risk) or outdoors (lower risk), ventilation quality, the size and number of people in the setting, and risk mitigation measures in place in the setting (e.g., requirements for wearing masks, type of mask, physical distancing, cleaning high-touch surfaces, etc.). Although outdoor settings are not generally considered high risk, the potential for transmission still exists under certain circumstances, such as close conversations or rigorous exercise when participants are in close proximity and are not wearing masks; therefore, consider these risks when classifying contacts based on risk.
| Low Risk Exposure | appropriate individual-level and setting-specific risk mitigation measures. | • Avoid close contact with those who are at risk for developing more severe disease or outcomes from COVID-19.  
• Contacts who are at risk for developing more severe disease or outcomes should not provide care for the case and should stay elsewhere if feasible. |  |
|---|---|---|---|
| | • HCW who provided direct care for the case, or a laboratory worker handling COVID-19 specimens, **with consistent and appropriate use of personal protective equipment and infection prevention and control practices** OR  
• Anyone who has shared an indoor space (e.g., same room) with a case, including closed spaces, crowded places, or settings where close interactions occur (e.g., social gatherings, workplaces, etc.), with adherence to appropriate individual-level and setting-specific risk mitigation measures.  
• Anyone who has had a close-range conversation with a case or has been in settings where a case engaged in singing, shouting, or heavy breathing (e.g., exercise), with adherence to appropriate individual-level and setting-specific risk mitigation measures. | **Self-monitor** for symptoms for 14 days following their last contact.  
Follow actions recommended for the entire population.  

a. Self-isolation (quarantine) is not required.  
b. Isolate as quickly as possible should symptoms develop, and contact Health Links or public health for further direction, which will include:  
• where to go for care,  
• appropriate mode of transportation to use, and  
• IPC precautions to be followed.  
If it is an emergency and the case is unable to contact public health or Health Links in advance, instruct the case to call 911 and report travel/contact history.  
c. Avoid close contact with individuals at higher risk for severe illness | • No active monitoring |
| Minimal/No risk | 1) **Only transient interactions** (e.g., walking by the case or being briefly in the same room) or unknown but possible transient interaction | • Follow actions recommended for the entire population  
• No monitoring required | • Provide community level information  
• Provide individual advice, if required |
Variants of Concern

COVID-19 variants of concern, such as those first identified in the UK, South Africa and Brazil, continue to spread globally. The first variant of concern, originally found in the United Kingdom, was detected in Canada in December 2020. Since then cases of COVID-19 due to variants of concern have been identified in a number of Canadian provinces.

Knowledge and understanding of these variants is rapidly evolving. Additional measures for case and contact management are recommended in Appendix I.

Alternative contact management strategies

To complement or accommodate limited local resources, alternative approaches to traditional contact tracing may be considered, particularly when experiencing a local surge in cases. These may include the following:

- Using well-trained non-public health staff and volunteers for certain contact tracing activities;
- Repurposing existing resources, such as call-centres or hotlines;
- Reducing the intensity of follow-up of contacts based on risk assessment, for example, automated calls or text messages to low-risk contacts, or follow-up text messages instead of daily calls; and
- Leveraging available technology, such as contact tracing software, as well as web-based and mobile phone applications (e.g., COVID Alert).

During local peaks in COVID-19 cases and declared outbreaks, prioritizing contact tracing activities may be considered for specific settings where transmission may have occurred (e.g., schools, events, workplaces, remote communities, etc.), and/or specified contacts (e.g., those who are vulnerable, work in high-risk settings, provide care to someone who is vulnerable, etc.).

Alternative approaches may also be considered where cases, employers, or event coordinators notify contacts (i.e., simple referral); or notify contacts and provide additional information related to infection prevention and control, quarantine (self-isolation), and symptom monitoring (i.e., enhanced referral).

Backward contact tracing

In addition to traditional (forward) contact tracing, ‘backward’ contact tracing may be considered, which focuses on trying to determine where and when the case likely acquired their infection. Backward contact tracing is routinely done as part of case or outbreak investigations for communicable diseases of public health significance, when public health collects information on a case’s potential acquisition history. In this guidance, backward contact tracing is proposed as
less intensive activity, and therefore potentially less resource intensive, compared to outbreak investigation.

While COVID-19 has been observed to spread steadily in the community, with one case infecting one or two other cases on average, clusters have been identified where some individuals disproportionately infect a larger number of secondary cases. This is a statistical concept called over-dispersion, where there is high individual-level variation in the distribution of the number of secondary transmissions. Clusters associated with these cases have been referred to as super-spreading events (SSEs).

In these circumstances, ‘backward’ contact tracing may help to:
  1. Find additional cases by focusing on the setting where a case’s exposure likely took place; and
  2. Interrupt additional chains of transmission by then employing traditional (forward) contact tracing for the newly identified cases.

If the source case is identified through backward contact tracing, traditional (forward) contact tracing should be employed as detailed above, and contacts managed based on their risk of exposure as described in Table 1. As in the case of forward contact tracing, testing requirements and public health interventions may need to be scaled based on local epidemiology.

Backward contact tracing is considered to be most useful when localized outbreaks may be occurring in areas experiencing relatively low levels of transmission. It is considerably more challenging when there is widespread community transmission, due to the volume of cases and uncertainty created by having multiple potential sources of transmission for any given case. Backward contact tracing may also be less useful during periods of restrictive public health measures, due to fewer events or localized settings where outbreaks or SSEs might occur. Employing backward contact tracing approaches may have significant resource implications, depending on the specific contact tracing strategies used, approaches to testing, and local epidemiology.

There is currently limited evidence regarding the effectiveness of backward tracing in relation to COVID-19, so it is not possible to be more definitive about when it would be most useful. A limited number of countries have utilized this strategy, and beneficial impact was correlated with low incidence and limited community transmission.

**Persons possibly exposed through travel**

As of March 25, 2020, all travellers incoming to Canada are subject to mandatory quarantine (self-isolation) enforceable through an emergency order under the Quarantine Act: Minimizing the Risk of Exposure to COVID-19 in Canada - Order (Mandatory Isolation). Therefore, all incoming travellers without symptoms are required to quarantine (self-isolate) at home (or another
designated location) where they will have no contact with vulnerable people for 14 days following their arrival to Canada. Travellers should:

- Follow good respiratory etiquette and hand hygiene practices.
- Wear a non-medical mask or face covering while travelling to the place of self-isolation (quarantine),
- Self-monitor for the appearance of symptoms consistent with COVID-19.
- Take and record temperature daily and avoid the use of fever reducing medications (e.g., acetaminophen, ibuprofen) as much as possible. These medications could mask an early symptom of COVID-19.
- Isolate within the quarantine setting as quickly as possible should symptoms develop, and follow directions provided by public health, which will include:
  - Go for COVID-19 testing
  - where to go for care (if required),
  - appropriate mode of transportation to use, and
  - IPC precautions to be followed.
  - Arrange to have someone pick up essentials like groceries or medication, or order deliveries,
  - Not have visitors,
  - Stay in a private place (i.e., yard or balcony) for fresh air,
  - Keep a distance of at least 2 metres from others

According to the Federal Order, asymptomatic international travellers who develop symptoms or test positive for COVID-19 while in the 14 day quarantine period must extend quarantine to 14 days following the date of the positive test result or appearance of symptoms.

Effective January 6, 2021, all air passengers five years of age or older, including Canadians, will be required to show a negative COVID-19 test result taken within 72 hours prior to boarding their scheduled departure to Canada, unless they are travelling from a destination temporarily exempted from this measure. Federal orders have also been updated to include test requirements on arrival and toward the end of the quarantine period.

Exemptions from the mandatory quarantine due to travel outside of Canada have been made for certain individuals who provide essential services as long as they are asymptomatic. Included are individuals who cross the border regularly to ensure the continued flow of goods and essential services, or those who provide other essential services to Canadians (e.g., health care workers, truck drivers, airplane crews).

These individuals should:
  - follow good respiratory etiquette and hand hygiene practices
  - practice physical distancing from others, and avoid settings where physical distancing is not possible
  - self-monitor for symptoms of COVID-19, and
  - isolate within the home-setting should symptoms develop and go for COVID-19 testing

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- take appropriate precautions to protect close contacts who are at highest risk of serious complications from COVID-19 (i.e., people older than 60 years and those living with chronic conditions), including the requirement to self-isolate for 14-days prior to visiting persons in an acute care or long-term care facility.

Any traveller who develops symptoms compatible with COVID-19 within the 14-day mandatory self-isolation (quarantine) period should be considered and managed as a suspect case.

- If laboratory testing is conducted and the results are negative for COVID-19, the individual is no longer considered a suspect case but must continue their mandatory self-isolation (quarantine) for the remainder of the 14-day monitoring period as per the emergency order, and 24 hours after symptoms have resolved. The traveller may be considered for re-testing if they have worsening/progression of symptoms.
- If laboratory testing is not conducted, the symptomatic traveller should extend their isolation 14 days from the appearance of symptoms (as per the Mandatory Isolation Order). On day 14, if they still have a fever or have not clinically improved, their eligibility to discontinue home isolation should be assessed by the local public health.
- If the symptomatic traveller requires transfer to acute care or further medical assessment, they should call ahead to the receiving facility to ensure the appropriate IPC measures are in place.

**Domestic travel**

In addition, domestic travellers from outside Manitoba are also required to self-isolate (quarantine) for 14 days. Testing is recommended on arrival in Manitoba (optional), and at 10 days after arrival in Manitoba. The test on arrival in Manitoba may not be recommended during times where COVID-19 activity is high in the community and testing capacity is limited. International travellers should follow federal guidance for COVID-19 testing and quarantine requirements. Exemptions from self-isolation (quarantine) for travel outside Manitoba and guidelines to follow have also been established and can be found in the current Public Health Orders [https://www.gov.mb.ca/covid19/soe.html](https://www.gov.mb.ca/covid19/soe.html).

Manitoba has a monitoring program in place along with other provinces and territories to identify new COVID-19 variants in Canada. All travellers, unless exempt from self-isolation (quarantine), should be tested for COVID-19 immediately upon arrival in Manitoba, regardless of if they are displaying symptoms, except during times when test capacity is limited. They should make an appointment with a provincial testing site or visit a drive-thru test site, and indicate at the time of testing that they have been out of the province and share the location of travel. They should also be tested again after ten days if their previous test was negative, even if still asymptomatic. Travellers need to observe the full 14-day self-isolation (quarantine) period regardless of symptoms and test results. Individuals (e.g. temporary foreign workers) for whom there is a pre-existing process for testing post-arrival in Manitoba do not need to alter their testing schedule. Re-testing is advised if an asymptomatic individual develops symptoms at any point, unless the individual had already tested positive. Individuals who test positive for COVID-19 and
have had close contact to an international traveller should identify this contact to public health during the public health investigation and follow-up.

Any domestic traveller who develops symptoms compatible with COVID-19 within the 14-day mandatory self-isolation (quarantine) period should be considered and managed as a suspect case.

- If laboratory testing is conducted and the results are negative for COVID-19, the individual is no longer considered a suspect case but must continue their mandatory self-isolation (quarantine) for the remainder of the 14-day monitoring period as per the emergency order, and 24 hours after symptoms have resolved. The traveller may be considered for re-testing if they have worsening /progression of symptoms.
- If laboratory testing is not conducted, the symptomatic traveller should extend their isolation 10 days from the appearance of symptoms. On day 10, if they still have a fever or have not clinically improved, their eligibility to discontinue home isolation should be assessed by the local public health.
- If the symptomatic traveller requires transfer to acute care or further medical assessment, they should call ahead to the receiving facility to ensure the appropriate IPC measures are in place.

Health Care Workers (HCW): In general, HCW’s should self-isolate (quarantine) and not work in health care settings for 14 days after travel to locations that require self-isolation (quarantine) in Public Health orders after return to Manitoba.

- Exceptions should be provided for HCW’s who reside in another country/province and travel regularly into Manitoba for essential work (including remote fly-in communities).
- If staff are deemed to be essential for service (essential is defined by the number of staff required to perform the service), management/human resources should consult with occupational health to perform a risk assessment, taking into account the type of work, exposure to high risk clients, and the travel exposure to determine if an exemption can be made.
- If deemed essential, HCWs must self-monitor for symptoms, including monitoring their temperature twice a day, and wear continuous PPE for the duration of their shift and self-monitoring period. The HCW must immediately remove themselves from work if any symptoms develop, isolate and notify Occupational Health. When not at work, and if asymptomatic, they should self-isolate (quarantine) at home for the full 14 day period.

**Individuals Who Demonstrate an Intent to Travel Internationally while in Isolation**

Travelers who demonstrate an intent to travel internationally while in isolation can be identified to the Public Health Agency of Canada (PHAC)’s Compliance and Enforcement group through their isolation inbox (phac.isolation-isolement.aspc@canada.ca).

For the process to add someone to a public health travel restriction (PHTR) which can be an addition to the “do not board” list or a Canadian Border Services Agency “lookout”, Public Health
can email the PHAC’s Central Notification System at phac.cns-snc.aspca@canada.ca with their case for consideration. To be added to the ‘Do not board’ list, three requirements must be met:
1) Infectiousness
2) Non-compliance
3) Intention to travel internationally

Health Care Workers

Further information on health care workers and return to work is available at https://sharedhealthmb.ca/files/covid-19-hcw-and-fr-testing-algorithm.pdf

Self-isolation (quarantine): Health care workers (HCW’s) who are potentially exposed (as per above contact and travel guidance) should self-isolate (quarantine) for 10 days if a close contact to a case (followed by 4 days of self-monitoring for symptoms), and 14 days if due possible exposure from travel.

- If the HCW develops symptoms, they should be referred for testing. If positive, follow guidance for HCW’s who are cases. If negative, they need to continue self-isolating (quarantine) until their initial self-isolation (quarantine) period is completed, and 24 hours after symptoms are resolved.
  - If a false negative result is suspected due to compatible clinical symptoms and clear history of exposure, Occupational Health may advise isolation for 10 days after symptom onset and 24 hours after symptoms are resolved, if this exceeds the initial self-isolation (quarantine) period.
- If staff are asymptomatic and deemed to be essential for service (essential is defined by the number of staff required to perform the service), and have not been specifically identified as a close contact but are potentially exposed, the HCW could continue to work if continuous PPE is utilized, with twice daily screening for symptoms while at work. When not at work, they should self-isolate (quarantine) for 10 days if a close contact to a case or 14 days if due to possible exposure from travel.

HCW’s with No Exposure History: Health care workers who have no exposure history and develop symptoms, should be referred for testing. If positive, follow guidance for HCW’s who are cases. If negative, they could return to work 24 hours after symptoms are resolved in consultation with Occupational Health regarding return to work. If there are exceptional circumstances where a false negative result is suspected, occupational health may advise isolation for 10 days after symptom onset and 24 hours after symptoms are resolved. If the HCW is not tested, they should not return to work until 10 days after symptom onset and 24 hours after symptoms are resolved.

Management of Individuals with Respiratory Symptoms in the Community without Exposures (not Self-Monitoring or Self-Isolating)

All individuals who have symptoms, should isolate at home for 10 days after symptom onset, and until symptoms are resolved for 24 hours. Isolation is recommended to lower the chance of

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spreading the illness to other people. Testing of all symptomatic individuals is recommended. If testing exceeds laboratory capacity, priority populations for testing will be established. If the COVID-19 test results are negative, individuals should stay home until symptoms have resolved for 24 hours. If they have travelled, they should continue to self-isolate (quarantine) for the remainder of the 14-day period. If they have been exposed to a case, they should continue to self-isolate (quarantine) for the remainder of the 10-day period followed by 4 days of self-monitoring for symptoms.

Contact tracing for airplane passengers

Decisions related to contact tracing individual air travellers/crew who may have been exposed to a confirmed case of COVID-19 on a flight should be made based on a risk assessment conducted by the public health authority to which the case is notified, considering the:

- the type and severity of symptoms during the flight.
- current messaging to all international travellers - specifically that they must enter into a legally mandatory 14 day quarantine (self-isolation) period starting the day they enter Canada
- timing of notification and likelihood of getting sufficient passenger contact information (i.e., within 14 days of flight),
- incremental benefit of individual communication to those seated within 2 metres of the case versus public communication of the flight number (with or without identification of the section of the plane where the case was seated).

Should public health determine that contact tracing individual air travellers is warranted, Medical Officers of Health (MOH) can request flight manifests and passenger name records directly from airlines in order to facilitate contact tracing of individual international, domestic and inter-provincial air travellers/flight crew who may have been exposed to a confirmed case of COVID-19 on a flight. The Public Health Agency of Canada’s Inter-jurisdictional Notices team can also assist in obtaining a flight manifest if required. It should be noted that flight manifests are not kept indefinitely and do not contain contact information on all travellers. Airline contact information and template letters to request flight manifests are stored on the MOH password protected website. If contact tracing is not feasible, a public advisory to notify the public of the potential exposure may be considered.

Contact tracing efforts should focus on those seated within a 2 metre radius of the case, as this is the accepted exposure risk area for droplet transmission.

Contact tracing efforts oriented towards individual air travellers/ crew should, at a minimum, focus on:

- passengers seated within two metres of the index case AND

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19 For flights which did not terminate in Canada but for which a Canadian jurisdiction is aware that a case of COVID-19 travelled, the specifics of the flight (airline, flight number, origin and destination cities, and seat number of the case) should be conveyed to PHAC via the Health Portfolio Operations Centre. PHAC will transmit this information to the appropriate countries via the International Health Regulations National Focal Point.
• 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.

Public health may wish to request the aircraft seat map from airlines to best target the contact tracing efforts. If the seat map isn’t available, public health may wish to trace economy class passengers seated in the 5 seats surrounding the case in all directions, up to and including 3 rows in front and 3 rows behind the case. In business class, due to seat spacing this may only involve tracing passengers in the 2 surrounding rows due to the space between seats. Public health may also wish to confirm that the case sat in the assigned seat for the duration of the flight, and ask about the case’s movements during the flight.

Public health could consider expanding the scope of their contact tracing for individual travelers if the case had severe symptoms, such as persistent coughing and sneezing, or had diarrhea or vomiting during the flight. Alternatively, public health could consider publicly communicating the flight number and possibly the section of the plane where the case was seated, as long as it does not reveal the identity of the case. The process to request airline flight manifests is posted on the MOH password protected website, including airline contact information and template letter.

In the event that a crew member is a confirmed case and was symptomatic during the flight, passengers seated in the area served by that crew members, as well as the other crew members, should be included in any individually-oriented contact tracing efforts.

**Process for Notification and Posting of Affected Flights with COVID-19 Cases**

Regional Health Authority / Regional CD Coordinator:

1. **Consider period of communicability**: Flights are considered affected if the case flew during the period of communicability, which includes 48 hours prior to symptom onset. For asymptomatic cases, consider up to two days prior to date of specimen collection.

2. **Document flight details in PHIMS**: Create a transmission event for each flight and include the following details:
   - Airline(s)
   - Flight number(s)
   - Departing city/airport
   - Destination city/airport
   - Flight date(s)
   - Seat number(s)

3. **Email Communications Services Manitoba** so that they can issue a public notification. Communication Services Manitoba will post relevant information online. The public notification will contain information on the airline(s), flight number(s), departing city / airport, destination city / airport, flight date(s), and impacted rows. Please also cc’ the Epidemiology and Surveillance Unit (MHSAL) and PHAC (phac.jn-nij.aspc@canada.ca); this information is posted on PHAC’s central website.
Note: Charter flights may not require public posting if all contacts on the flight are known to Manitoba. Ensure the airline is aware for follow-up of staff. If public notification is required, the above steps should be followed.

**Process for Notification and Posting of Public Exposures**

**Regional Health Authority:**
1. The determination on whether notification of a public exposure is required is made by the Region (CD Coordinator in consultation with the MOH). Consider the following:
   - Ensure the exposure is within the period of communicability
   - Assess the potential for close prolonged contact with unknown or unidentified contacts.
     - Transient interactions while shopping would not generally warrant a public notification unless close prolonged contact was identified.
     - Prolonged periods of time in one public location would increase risk (e.g. employee)
     - Multiple cases present in the location would increase risk (e.g. family cluster)
   - Consider use of PPE or non-medical masks and whether appropriately used. This would not be the primary consideration due to inability to confirm proper use, but may influence the decision if exposure is considered lower risk.
   - If subsequent cases are identified from the same exposure location, consider updating the notification.
2. Determine whether notification of the Chief Occupational Medical Officer is required. (e.g. workplace action is required, or is a sensitive occupation (e.g. temporary foreign worker, meat processing plant). Most public exposures from investigations identified on the weekend can wait until the next business day for notification, unless identified as high risk and/or requiring more immediate public notification. All public notifications should occur as soon as possible once details confirmed on regular business days.
3. **Document public exposures in PHIMS and indicate that information is for public posting:** Create a transmission event for each public exposure (in addition to all other exposures) that includes details on location, date, and time of exposure. Clearly indicate within the transmission event “exposure location name” that the exposure is: “FOR PUBLIC POSTING”. This determination is made by the Region (CD Coordinator in consultation with the MOH).
4. Email Epidemiology and Surveillance and Communications to notify of a public exposure that requires posting.

**Epidemiology and Surveillance Unit, MHSAL:**
1. ** Routinely monitor** email notices.
2. Contact regional MOH or CD coordinator for further review and to confirm coordination of communications.
3. Region to coordinate with Communications to notify and request posting public exposure to provincial website and inclusion in the daily bulletin: 
https://manitoba.ca/covid19/updates/flights.html#event.

**Reporting Cases and Contacts**

**Surveillance objectives:**

- To rapidly identify laboratory-confirmed cases, in order to isolate and treat them, and prevent transmission to their contacts.
- To identify contacts in order to ensure appropriate public health interventions are put into place, such as symptom monitoring.
- To describe the epidemiology of COVID-19 infection in Manitoba, in order to characterize cases, identify risk factors for transmission, and guide public health action.

**Cases:**

- The Clinical Notification of Reportable Diseases and Conditions Form only needs to be completed and sent to MHSAL in the event of the death of a probable or lab-confirmed case of COVID-19. 
- All investigations of COVID-19 cases should be entered into PHIMS in real time utilizing the MHSU-6683 COVID-19 Case Investigation Form to guide data entry. Organizations who do not have access to the PHIMS investigation module should complete and submit the MHSU-6683 COVID-19 Case Investigation Form within 2 working days post confirmation of diagnosis.

**Contacts:**

- All known close contacts to probable and confirmed cases should be identified and documented within 24 hours, and must be reported to the MHSU with 48 hours of a confirmed case. The method of symptom surveillance should be identified – self-isolation (quarantine), symptom monitoring (active, passive), education only.
- All travellers or contacts from identified high risk exposures (e.g. outbreak settings, cruise ships, repatriated individuals) that are recommended to self-isolate (quarantine) at home should also be reported within 48 hours of identification. Returning travellers from these areas will be identified and contact details forwarded for public health follow-up and education on self-isolation.
- Contacts can be entered in PHIMS directly, or reported using the Case report form. When referred through the Manitoba Health Surveillance Unit (MHSU), the MHSU will enter contact investigations in PHIMS when processed for regional referral, and close the investigation when the contact form is received and entered.
Organizations can document ongoing symptom monitoring in either PHIMS, or their regional system. If a contact becomes symptomatic, the contact should be reported as a new case following case definitions.

- In PHIMS, organizations will close the contact investigation after amending the disposition to “Contact turned to case” (refer to COVID QRC 7.19l) and create a case investigation with classification “Case-Probable” (refer to QRC 7.4c)

Inter-jurisdictional Notifications:

- If during the course of the investigation it is determined that there was either acquisition or transmission in another jurisdiction (e.g. exposure in a workplace, public location, or school in another health region, province, territory, or other country) this should be noted in PHIMS or under the Exposures section of MHSU-6683 COVID-19 Case Investigation Form. If outside of Manitoba, the Surveillance Unit should be notified to refer this information to the appropriate jurisdiction. The Surveillance Unit must also provide exposure location and other pertinent details, such as dates that the individual was at the location, as part of the referred information. If the exposure occurred in another jurisdiction within Manitoba, the primary investigator must notify the region where the exposure occurred. In general, the region where the exposure occurred is responsible for follow-up related to the exposure (e.g. in the workplace or school).
- If the MHSU receives a positive lab for a client who has tested within Manitoba, but has a current address out of province, the investigation will be forwarded to the jurisdiction where the client resides, but will also be assigned to a Manitoba responsible organization as a secondary investigator based on the test location. Regions, when identified as secondary ROs, would contact the client and assume responsibility for managing the case or contact while they remain in Manitoba. If the client is no longer in Manitoba, any relevant exposures in Manitoba should be elicited from the client if possible and managed as appropriate. When the Manitoba investigation is complete, the investigation disposition should be set to “Pending - Referral Out of Region”, which will flag the MHSU to close the investigation and redirect to the province where the client resides. **If the disposition is not changed by the Region, the case will not be redirected to the province.** The case will NOT be counted in MB as the address is out of province, but the bidirectional process will ensure there is awareness of any exposures or follow-up required in Manitoba.

Surveillance Definitions:

**Recovered/Resolved:** A case is recovered or resolved when:
- Isolation has been discontinued **OR**
- Precautions have been discontinued (for hospitalized and facility-based cases)
  - Lost to follow up: for surveillance purposes, cases that are lost to follow-up will be considered recovered once the time period for isolation has elapsed.
  - A COVID-19 case which is classified as resolved may still have ongoing clinical indications and symptoms, but should no longer require isolation measures or public health follow up.

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• If symptom onset date is unavailable or the case is asymptomatic, the earliest of the following dates defined as the episode date could be used as proxy for classification: laboratory specimen collection date, laboratory testing date or reported date.

• If the case is lost to follow up or is missing required information for classifying as resolved, the case can be classified as resolved if a minimum of 20 days have passed since the symptom onset or initial report.

A COVID-19 case which is classified as resolved may still have ongoing clinical indications and symptoms, but should no longer require isolation measures or public health follow up.

The recovered/resolved case definition was developed for surveillance purposes and is not related to clinical management of cases. It is based on existing evidence to determine when a case of COVID-19 is no longer infectious or capable of transmitting the SARS-CoV-2 virus. Some cases may remain infectious beyond the time period specified, and the judgement of a Medical Officer of Health or relevant public health authority supersedes the specified criteria.

**Deceased case of COVID-19:**
A death resulting from a clinically compatible illness, in a probable or confirmed COVID-19 case, unless there is a clear alternative cause of death that cannot be related to COVID disease (e.g. trauma, poisoning, drug overdose).

A Medical Officer of Health, relevant public health authority, or coroner may use their discretion when determining if a death was due to COVID-19, and their judgement will supersede the above-mentioned criteria.

A death due to COVID-19 may be attributed when COVID-19 is the cause of death or is a contributing factor.

**Active:**
A case is active when:
• Case is currently in isolation OR
• Case is currently under precautions (for hospitalized and facility-based cases)

**PHIMS Reporting:**
Cases are considered “active” unless there is a recorded Status Assessment of “Recovered” or a Fatal outcome within the client’s investigation. A date must be recorded for all statuses.
APPENDIX A: Instructions for Isolating a case in the home or co-living setting

Isolating in the home setting

Stay at home

The case (confirmed, probable, or suspect) should isolate themselves in the home setting for a minimum of 10 days from the onset of symptoms. The criteria for discontinuing home isolation includes: at least 10 days have passed since onset of first symptom or laboratory confirmation of an asymptomatic case, the case did not require hospitalization, the case is afebrile and has improved clinically.

Staying at home means:

- Not going out unless directed to do so (i.e. to seek medical care)
- Not going to school, work, or other public areas
- Not using public transportation (e.g. buses, subways, taxis)

Personal protective measures for infection prevention and control

The case should follow good respiratory etiquette and hand hygiene practices.

Respiratory etiquette

Respiratory etiquette describes a combination of measures intended to minimize the dispersion of respiratory droplets when coughing, sneezing and talking.

- Cover coughs and sneezes with a medical/procedure mask, or if not available, a non-medical mask or facial covering, (e.g., homemade cloth mask, dust mask, bandana) or tissue. Dispose of tissues in a lined waste container and perform hand hygiene immediately after a cough or sneeze
  OR
- Cough/sneeze into the band of your arm, not your hand

Hand hygiene

Hand hygiene refers to hand washing or using an alcohol-based hand sanitizer and actions taken to maintain healthy hands and fingernails. It should be performed frequently with soap and water for at least 15-20 seconds:

- Before and after preparing food;
- Before and after eating;
- After using the toilet;
- Before and after using a medical/procedure mask
- After disposing of waste or handling contaminated laundry;
- Whenever hands look dirty.

Handwashing with plain soap and water is the preferred method of hand hygiene, since the mechanical action is effective at removing visible soil and microbes.

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If soap and water are not available, hands can be cleaned with an alcohol-based hand sanitizer (ABHS) that contains at least 60% alcohol, ensuring that all surfaces of the hands are covered (e.g. front and back of hands as well as between fingers) and rub them together until they feel dry.

When drying hands, disposable paper towels are preferred, but a dedicated reusable towel may be used and replaced when it becomes wet.

**Monitor your symptoms.**

The case should monitor their symptoms and immediately report worsening of symptoms to Health Links or public health for further assessment. If it is determined that transfer to an acute care facility is required, instructions will be provided regarding transportation (e.g. by ambulance or private vehicle). If calling an ambulance, the dispatcher should be notified that the case may have COVID-19. If the person is transferred by private vehicle, the receiving facility should be notified to ensure that appropriate infection prevention and control measures are in place. During travel, the ill person should wear a medical/procedure mask, or if not available, a non-medical mask or facial covering, (e.g., homemade cloth mask, dust mask, bandana), if tolerable or cover their nose and mouth with a tissue. Those transporting the ill person should use appropriate personal protective equipment when within 2 metres of the ill person (details below).

**Limit contact with other people.**

The case should avoid being in close proximity (within 2 metres) of other people, including household members and visitors who do not have an essential need to be in the home, with the exception of individuals providing care or delivering supplies or food.

When interactions within 2 metres are unavoidable, these should be as brief as possible, and the case should wear a medical mask, or if not available, a non-medical mask or facial covering, (e.g., homemade cloth mask, dust mask, bandana). If possible, the ill person or caregiver should arrange to have supplies dropped off at their front door to minimize direct contact. If the case must leave the home setting, a mask should be worn.

**Masks**

Medical masks (surgical or procedure masks) provide a physical barrier that helps prevent the transmission of the virus from an ill person to a well person by blocking large particle respiratory droplets propelled by coughing, sneezing and talking. However, using a mask alone is not enough to stop transmission and must be combined with other prevention measures including physical distancing, respiratory etiquette and hand hygiene.

The following steps will help to ensure masks are used effectively:

- Medical masks are recommended for cases of COVID-19 and for any household member providing direct care to a case; the coloured side of the mask should be worn facing out.
• N95 respirators must be reserved for health care workers and should not be used for by a case or household caregivers.
• If medical masks are not available for home use, non-medical masks or facial coverings, (e.g. homemade cloth masks, dust mask, bandanas) worn by the ill person, if tolerable, to cover their mouth and nose may prevent respiratory droplets from contaminating others or landing on surfaces. These non-medical masks may also be worn by any household member providing care to a case. Children under 2 years of age should not wear a mask. Children ages 2 years and above should wear a child-sized medical mask or if not available, a non-medical mask or cloth face covering adapted to their size where feasible.
• Before putting on a mask, wash hands with soap and water or ABHS.
• Cover mouth and nose with mask and make sure there are no gaps between your face and the mask, press the mask tight to your face using your fingers to secure along the perimeter of the mask, pressing firmly over the bridge of your nose. After putting on a new mask, wash hands again with soap and water or ABHS.
• Avoid touching the mask while using it; if you do, clean your hands with soap and water or alcohol-based hand sanitizer.
• Replace the mask with a new one as soon as it is damp or dirty with secretions. Do not re-use single-use masks.
• Non-medical masks should be carefully removed and replaced when soiled or damp and laundered in hot water and then dried thoroughly.
• To remove the mask, remove both straps from behind the ears or untie from behind head. Do not touch the front of mask, and ensure that the front of the mask does not touch your skin or any surfaces before you discard it in a waste container or place it in a hamper for laundering. Wash hands with soap and water or ABHS.

Limit contact with animals

There have not been any reports of pets transmitting the SARS-CoV-2 virus to humans. However, there have been several reports of infected humans spreading the virus to their pet dog or cat. It is still not clear how often this happens and under what circumstances. From the limited information available, it appears that some animals can get sick, therefore, it is recommended that the case also refrain with contact with pets and, if possible, have another member of the household look after them. If this is not possible, practice good hand hygiene before and after touching animals, and their food/supplies, as well as good respiratory etiquette. Restrict the pet's contact with other people and animals outside the household while the case is in isolation.

Avoid Sharing Personal Household Items

The case should not share personal items with others, such as toothbrushes, towels, washcloths, bed linen, cigarettes, unwashed eating utensils, drinks, phones, computers, or other electronic devices.

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In the event that the case must prepare food for others (e.g. single parent with young children), the case should perform hand hygiene before and after, adhere to respiratory etiquette, including wearing a mask, during meal preparation. **Clean all high-touch surfaces**

Disinfectants can kill the virus making it no longer possible to infect people. High-touch areas such as toilets, bedside tables and door handles should be cleaned daily using approved hard-surface disinfectants that have a Drug Identification Number (DIN). A DIN is an 8-digit number given by Health Canada that confirms the disinfectant product is approved and safe for use in Canada.

- While most disinfectants will work against coronavirus, Health Canada has created a list of hard-surface disinfectants that are supported by evidence demonstrating that they are likely to be effective and may be used against SARS-CoV2.
- Always read and follow the directions on the label to ensure safe and effective use, including information about how long the surface should be visibly wet to be disinfected.
- You can also find more information on all other approved disinfectants and other drug products on Health Canada’s searchable Drug Product Database.

When approved hard surface disinfectants are not available, for household disinfection, a diluted bleach solution can be prepared in accordance with the instructions on the label, or in a ratio of 5 millilitres (mL) of bleach per 250 mL of water OR 20 mL of bleach per litre of water. This ratio is based on bleach containing 5 % sodium hypochlorite, to give a 0.1 % sodium hypochlorite solution. Follow instructions for proper handling of household (chlorine) bleach. Be sure to prepare the solution fresh, when you are intending to use it, and only dilute bleach in water (and not with additional chemicals). Check the labelled intended use- some bleaches, such as those designed for whitening laundry, may not be suitable for disinfection. Ensure the product is not past its expiration date. Disinfectants, household cleaners, and bleach are meant to be used to clean surfaces. Never use these products on the skin or internally (e.g. by swallowing or injecting these products) as this could cause serious harm.

Find more information on Health Canada's website about using household chemicals safely and protect yourself and your family from poisonings when using disinfectants, household cleaning products and bleaches.

If they can withstand the use of liquids for disinfection, high-touch electronics such as phones, computers and other devices may be disinfected with 70% alcohol (e.g. alcohol prep wipes) following recommended manufacture contact time.20

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Disposable gloves should be used when cleaning or handling surfaces, clothing, or linen soiled with body fluids. Dormitories and co-living settings where ill persons are convalescing should be cleaned and disinfected daily.

Toys and other objects children may have contact with that may have been contaminated by a case should be cleaned and disinfected daily.

All used disposable contaminated items should be placed in a lined container before disposing of them with other household waste.

**Self-care while convalescing**

**Treatment**

At this time, there is no specific pharmaceutical treatment for COVID-19. The case should rest, eat nutritious food, stay hydrated with fluids like water, and manage their symptoms. Over the counter medication can be used to reduce fever and aches. If using vitamins or alternative medicines, the case should check with their healthcare provider whether they should continue use while awaiting test results.

**Monitor temperature regularly.**

The case should monitor their temperature daily, or more frequently if they have a fever (e.g., sweating, chills), or if their symptoms are changing. Temperatures should be recorded and reported to public health as per its instructions. If the case is taking acetaminophen (e.g. Tylenol) or ibuprofen (e.g. Advil), the temperature should be recorded at least 4 hours after the last dose of these fever-reducing medicines.\(^\text{21}\)

**Maintain a suitable environment for recovery.**

The environment should be well ventilated and free of tobacco or other smoke. Ventilation can be improved by opening windows and doors to the outside, as weather permits.

**Stay connected.**

Staying at home and not being able to do normal everyday activities outside of the home can be socially isolating. Public health can encourage people who are isolating themselves at home to connect with family and friends by phone or computer.

\(^{21}\) The peak effect of temperature reduction was found to be 2.5-3.0 hours after ingestion for both acetaminophen and ibuprofen treatments in a systematic review of antipyretic effect of ibuprofen and acetaminophen in children. Wahba H. The antipyretic effect of ibuprofen and acetaminophen in children. Pharmacotherapy: The Journal of Human Pharmacology and Drug Therapy. 2004 Feb; 24 (2):280-4.
Precautions for household members (e.g. caregivers, roommates) to reduce risk of transmission to others in the home

For caregivers of a case, it is important to take appropriate steps to protect yourself and others in the home environment from contracting COVID-19.

- **Perform Regular hand hygiene.** The ill person and the household members should perform hand hygiene regularly.
- **Practice good respiratory etiquette** followed by hand hygiene.
- **Limit the number of caregivers.** Ideally, the ill person should be able to care for themselves. Caregiving within 2 meters of the ill person should be limited to one person. Household members with risk factors for severe disease or outcomes (i.e., older adults, chronic medical conditions, immunocompromised, or obesity (BMI of 40 or higher)) should not provide care for the case and should stay elsewhere if feasible.
- **Prevent exposure to contaminated items and surfaces.** Do not use personal items that belong to the case such as toothbrushes, towels, washcloths, bed linen, cigarettes, unwashed eating utensils, drinks, phones, computers, or other electronic devices. The lid of the toilet should be down before flushing to prevent contamination of the environment.
- **Frequent cleaning and disinfecting.** High-touch areas such as toilets, bedside tables and door handles should be cleaned daily using approved hard-surface disinfectants that have a Drug Identification Number (DIN). A DIN is an 8-digit number given by Health Canada that confirms the disinfectant product is approved and safe for use in Canada. When approved hard surface disinfectants are not available, for household disinfection, a diluted bleach solution can be prepared in accordance with the instructions on the label, or in a ratio of 5 millilitres (mL) of bleach per 250 mL of water OR 20 mL of bleach per litre of water. This ratio is based on bleach containing 5 % sodium hypochlorite, to give a 0.1 % sodium hypochlorite solution.
- **Disposing of waste.** All used disposable contaminated items should be placed in a lined container before disposing of them with other household waste.
- **Use precautions when doing laundry.** Contaminated laundry should be placed into a laundry bag or basket with a plastic liner and should not be shaken. Gloves and a surgical/procedure mask should be worn when in direct contact with contaminated laundry. Clothing, linens and non-medical masks belonging to the ill person can be washed together with other laundry, using regular laundry soap and hot water (60-90°C). Laundry should be thoroughly dried. Hand hygiene should be performed after handling contaminated laundry and after removing gloves. If the laundry container comes in contact with contaminated laundry, it can be disinfected using approved hard-surface disinfectants that have a Drug Identification Number (DIN). A DIN is an 8-digit number given by Health Canada that confirms the disinfectant product is approved and safe for use in Canada. When approved hard surface disinfectants are not available, for household disinfection, a diluted bleach solution can be prepared in accordance with the instructions on the label, or in a ratio of 5 millilitres (mL) of bleach per 250 mL of water OR 20 mL of bleach per litre of water. This ratio is based on bleach containing 5 % sodium hypochlorite, to give a 0.1 % sodium hypochlorite solution.
• Use of personal protective equipment. If household members have direct contact with the case, they should wear a medical/procedure mask or if not available, a non-medical mask or facial covering, (e.g., homemade cloth mask, dust mask, bandana) and eye protection when within two meters and should perform hand hygiene after contact. Caregivers should wear disposable gloves when in direct contact with the ill person, or when in direct contact with the ill person’s environment as well as soiled materials and surfaces. Hand hygiene should be performed before putting gloves on and after removing them.

• Use of personal protective equipment. Household members, who have direct contact with the case, should wear a medical mask, or if not available, a non-medical mask or cloth face covering (i.e., constructed to completely cover the nose and mouth without gaping, and secured to the head by ties or ear loops) and eye protection when within two metres and should perform hand hygiene after contact. Caregivers should wear disposable gloves, if available, when in direct contact with the ill person, or when in direct contact with the ill person’s environment as well as soiled materials and surfaces. Hand hygiene should be performed before putting gloves on and after removing them.

Eye Protection

Eye protection is recommended to protect the mucous membranes of the eyes during case care or activities likely to generate splashes or sprays of body fluids including respiratory secretions.

• Eye protection should be worn over prescription eye glasses. Prescription eye glasses alone are not adequate protection against respiratory droplets.
• Protective eye wear should be put on after putting on a mask.
• After applying eye protection, gloves should be donned (see above).
• To remove eye protection, first remove gloves and perform hand hygiene. Then remove the eye protection by handling the arms of goggles or sides or back of face shield. The front of the goggles or face shield is considered contaminated.
• Discard the eye protection into a plastic lined waste container. If the eye protection is not intended for single use, clean it with soap and water and then disinfect it with approved hard-surface disinfectants that have a Drug Identification Number (DIN). A DIN is an 8-digit number given by Health Canada that confirms the disinfectant product is approved and safe for use in Canada. When approved hard surface disinfectants are not available, for household disinfection, a diluted bleach solution can be prepared in accordance with the instructions on the label, or in a ratio of 5 millilitres (mL) of bleach per 250 mL of water OR 20 mL of bleach per litre of water. This ratio is based on bleach containing 5 % sodium hypochlorite, to give a 0.1 % sodium hypochlorite solution, a store bought disinfectant, or if not available, a diluted bleach solution of one part bleach to 9 parts water, being mindful not to contaminate the environment with the eye protection.
• Perform hand hygiene.

Gloves
Disposable single use gloves, if available, should be worn when in direct contact with the ill person, cleaning contaminated surfaces, and handling items soiled with body fluids, including dishes, cutlery, clothing, laundry, and waste for disposal. Gloves are not a substitute for hand hygiene; caregivers must perform hand hygiene before and after putting on and taking off gloves.

- Gloves should be removed, hand hygiene performed, and new gloves applied when they become soiled during care.
- To remove gloves safely, with one of your gloved hands pull off your glove for the opposite hand from the fingertips, as you are pulling, form your glove into a ball within the palm of your gloved hand. To remove your other glove, slide your ungloved hand in under the glove at the wrist and gently roll inside out, and away from your body. Avoid touching the outside of the gloves with your bare hands.
- Gloves must be changed and hand hygiene performed when they are torn.
- Discard the gloves in a plastic-lined waste container.
- Perform hand hygiene.
- Double-gloving is not necessary.

Reusable utility gloves may be used; however, they must be cleaned with soap and water and decontaminated after each use with approved hard-surface disinfectants that have a Drug Identification Number (DIN). A DIN is an 8-digit number given by Health Canada that confirms the disinfectant product is approved and safe for use in Canada. When approved hard surface disinfectants are not available, for household disinfection, a diluted bleach solution can be prepared in accordance with the instructions on the label, or in a ratio of 5 millilitres (mL) of bleach per 250 mL of water OR 20 mL of bleach per litre of water. This ratio is based on bleach containing 5 % sodium hypochlorite, to give a 0.1 % sodium hypochlorite solution.
Supplies for the home when isolating

- Medical mask, or if not available, a non-medical mask or facial covering, (e.g., homemade cloth mask, dust mask, bandana) for case and others in the home
- Disposable Gloves
- Eye protection
- Thermometer
- Fever-reducing medications
- Running water
- Hand soap
- Alcohol based hand sanitizer (ABHS) containing at least 60% alcohol.
- Tissues
- Waste container with plastic liner
- Regular household cleaning products
- Approved hard-surface disinfectants that have a Drug Identification Number (DIN). or if an approved hard surface disinfectant is not available, bleach containing 5% sodium hypochlorite, and a separate container for dilution.
- Alcohol (70%) prep wipes or cleaners suitable for cleaning high-touch electronics (e.g., phones)
- Regular laundry soap
- Dish soap
- Disposable paper towels

Core personal public health practices

Until broad community immunization rates have reached the necessary targets for herd immunity, core personal public health practices are recommended for the entire population for the duration of the pandemic to help to reduce the spread of COVID-19 in Canada. These practices include:

- Staying informed, being prepared and following public health advice;
- Getting vaccinated
- Practicing good hygiene (i.e., frequent hand hygiene, avoid touching face, respiratory etiquette, disinfect frequently touched surfaces);
- Maintaining a physical distance of at least 2 metres from others as much as possible when outside of the home (i.e. from non-household members);
- If symptomatic/feeling ill, staying at home and away from others – not going to school/work and following jurisdictional/local public health advice;
- If at higher risk of severe disease or outcomes, staying at home as much as possible;
- Wearing a medical mask if experiencing symptoms and in close contact with others in the home setting or if going out to access medical care; if a medical mask is not available, a non-medical mask (NMM) or cloth face covering should be worn;
- Wearing NMM or cloth face covering for periods of time when it is not possible to consistently maintain a two-metre physical distance from others, particularly in crowded public settings
- Reducing personal non-essential travel.
APPENDIX B: Definitions and Management of COVID-19 Outbreaks and Clusters

A COVID-19 cluster is defined as two or more confirmed cases clustered in time and geographic location, without an epidemiological link (e.g., common exposure or transmission event), or until an epidemiological link is established. Aggregated in time means that the cases’ symptom onset or if asymptomatic, the date that the diagnostic laboratory sample was collected, occurred within 14 to 28 days (i.e., one to two incubation periods). The identification of a cluster considers the setting/location type and level of community transmission, and is at the discretion of the investigating health authority. Identification of a cluster may trigger an investigation to determine if an outbreak should be declared.

An epidemiological link is 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.

Reasonable evidence of transmission at a setting could include:

- Close and prolonged contact with a known case who was communicable at the setting,
- Exposure to a setting where known cases were present within a reasonable time period, given the incubation period of COVID-19,
- The person has been located within a closed setting (e.g., admitted to hospital, or residing at a work camp, correctional facility, or rural/remote community) for ≥7 days before symptom onset or collection of a diagnostic laboratory sample,
- No obvious source of exposure other than at the setting, or
- Other exposure scenarios, at the discretion of the investigating health authority.

A COVID-19 Outbreak is defined as two or more confirmed cases of COVID-19 epidemiologically linked to a specific setting and/or location. This definition also excludes cases that are geographically clustered (e.g., in a region, city, or town) but not epidemiologically linked, and cases attributed to community transmission. Declaration of an outbreak is at the discretion of public health and/or Infection Prevention and Control (IP&C) in the health authority where the setting or location is located.

In a highly vulnerable setting, a single laboratory-confirmed case of COVID-19 in a staff member, volunteer, or resident may define an outbreak at the discretion of the Medical Officer of Health after consultation with IP & C and the Office of the Chief Provincial Public Health Officer.

Upon declaration of an outbreak, regional Public Health is responsible to communicate the existence of a COVID-19 outbreak to Epidemiology and Surveillance, and MHSAL Communications, who will ensure the outbreak is communicated in the media bulletin and listed in the Manitoba Pandemic Response System [https://manitoba.ca/covid19/restartmb/prs/index.html#provinciallevel].

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Outbreak Management in Personal Care Homes:

LTCH residents are vulnerable to infection with COVID-19 due to behavioral factors, shared spaces, and transit between other healthcare facilities. Older adults and those with pre-existing medical conditions are also at risk for more severe disease and have higher mortality when infected with COVID-19.

Outbreak management strategies are listed in COVID-19 Infection Prevention and Control Guidance for Personal Care Homes https://sharedhealthmb.ca/files/covid-19-ipc-guidance-for-pch.pdf. Strategies include (see document for complete list):

- Immediate isolation of residents with signs or symptoms or potential exposures.
- Determination of applying outbreak precautions to the affected unit or entire PCH based on knowledge of the PCH and staffing, and in accordance with provincial public health guidance and directives.
- Increased frequency of cleaning and disinfecting with a focus on high-touch surfaces.
- Further restriction of movement of residents within the PCH, with discontinuation of all non-essential activities, including communal activities.
- New resident admissions are generally not recommended in the context of an outbreak of COVID-19.
- Increased frequency of active screening for COVID-19 symptoms in residents.
- Reviewing and reinforcing visitor restrictions.
- Consultation with their regional IPC staff regarding resident and staff cohorting.

- Testing strategies:
  - PCHs must test all individuals who have symptoms compatible with COVID-19.
  - To identify additional cases of COVID-19, testing of asymptomatic residents who are in potential contact with the case, or who may have contact with the same staff is recommended. This will be dependant on the layout and processes within the facility.
  - To identify additional cases of COVID-19 in staff, testing of asymptomatic staff who may have been in potential contact with the resident or staff cases is recommended. This will also be dependant on the layout and processes within the facility.
  - A systematic concentric circle approach to testing is recommended, sampling from highest transmission risk to lowest transmission risk, with expanding circles as required.
  - In PCHs where asymptomatic surveillance staff testing is occurring with point of care testing methods, this should continue during an outbreak for staff who are asymptomatic and not identified by public health as a contact.

Other Vulnerable Settings:
Other high risk settings based on increased transmission risk or populations at risk of severe outcomes, include health-care facilities, correctional centres and shelters. These facilities may implement similar measures, based on the situation and setting.

Processes are in place to monitor certain industries and worker groups, including food processing, temporary foreign workers associated with agriculture, food processing industry programs, and truckers/transport workers. Notification of the Chief Occupational Medical Officer and Workplace Safety and Health is required for all cases in these industries.

For school and child care settings, see appendix C.

**Workplace Clusters and Outbreaks:**

The guidance below was developed in response to the increasing proportion of more transmissible Variants of Concern (VOC), and the increasing number of outbreaks linked to workplaces, particularly those settings where close contact between workers in facilities facilitates spread.

More aggressive case and contact management is required to limit transmission within and outside of the workplace, and is strongly recommended in workplace clusters where there is reason to suspect acquisition/transmission in the workplace, AND/OR no obvious source of infection identified outside the workplace.

More aggressive measures for management of outbreaks/ clusters in workplaces include:

- Using a lower time threshold for considering significant exposure (e.g., including any prolonged contact more than a transient exposure). If there is uncertainty on the time or nature of exposure, consider a close contact.
- If there is reasonable acquisition within the workplace despite the use of PPE, PPE use would no longer be a reason to rule out an individual as a close contact if they otherwise meet the time and physical distance thresholds to be considered a close contact. (see COVID-19 exposure assessment tool)
- Where physical distancing cannot be easily assessed (e.g. mobile during shift– not limited to work station), consider cohort of workers as close contacts.
- Larger workplaces may have more complex workplace interactions, and require further assessment. Workplace Safety and Health and the Chief Occupational Medical Officer should be involved in management of clusters and outbreaks as indicated in Workplace Cluster Guidance.
- All close contacts identified, unless otherwise exempt, are required to self-isolate (quarantine). Additional requirements for close contacts and their household members would follow regular public health management of cases & contacts.
- More aggressive case and contact management may result in some businesses closing temporarily due to staffing shortages. Exemptions for contacts identified may be made for workplaces essential to the wellbeing of the community, and/ or providing critical care services. These workplaces should work with public health and Workplace Safety and...
Health to adopt additional protective measures, and use limited staffing where possible. Examples of essential workplaces include:
- Fire halls, EMS stations, police stations
- Courthouses
- Health care facilities
- Health and social services
- Shelters
- Distribution hubs of necessary goods such as food and medicines
- Critical infrastructure (e.g., water & waste, hydro, gas, food processing (animal welfare), etc.)

- Consider use of point of care testing for early identification of cases in the workforce for individuals who are not identified as close contacts and continue to work. Targeted vaccination strategies should also be considered where possible if vaccine uptake is low and there are barriers for the population to access vaccine sites.

- Workplaces can be required in the Public Health Orders to report clusters of cases to Public Health. When clusters are reported, public health should communicate with the reporting workplace, verify case information reported, and review mitigation strategies with the workplace. A number of workplace resources have been created by the Chief Occupational Medical Officer to assist with this.

- Regional MOHs should consider issuing health protection orders to close workplaces in situations where required if there is evidence of workplace transmission and more aggressive case and contact measures are not sufficient to control the outbreak. It is anticipated that this would not be required in most situations if aggressive case and contact measures are utilized to isolate contacts. If a health protection order under the Public Health Act is required, consultation with civil legal services and the office of the CPPHO is required, in addition to working with Workplace Safety and Health and the Chief Occupational Medical Officer.
APPENDIX C: Process for investigating COVID-19 cases in school/child care settings

1) Upon receipt of a positive lab report for a school/child care aged child or staff working in a school/child care facility, a Public Health Nurse (PHN) interviews the parent and child or staff and confirms their attendance at a school/childcare facility during their period of communicability (including 48 hours prior to symptom onset or 48 hours prior to specimen collection date if asymptomatic).

2) If the school/child care facility is NOT identified as a potential exposure, regions should still provide notification to the school, in case schools have initiated pre-emptive actions in anticipation of a public health investigation. For schools, the Education e-form should be completed for notification, and can be found in the Quick Reference Notification Guide. Regions may also considering providing a courtesy call to notify the school.

3) If a school/child care facility is identified as a potential exposure, Regional Public Health (PH) notifies the Principal of the affected school, or director/provider of the child care facility that a confirmed COVID-19 case has been identified in a student/child/staff member from their school/child care facility and that the investigation is ongoing. Manitoba Education has a Smart sheet for after-hours contacts. Manitoba Families has a directory that is posted on the MOH password protected website.

4) Regional PH interviews Principal and/or relevant staff (i.e. teacher, early childhood educator, child care assistant or other child care staff) to determine existing preventive measures in place within the school/classroom, all cohorts/classes exposed by the case, and verify potential exposures/close contacts in the classroom/cohort during case’s period of communicability who were not wearing masks. In the controlled school setting, the use of non-medical and medical face masks are considered adequate protection for the setting, and individuals will not be identified as close contacts if wearing a mask consistently. Note that the region may not identify the case to school or child care authorities if notification to the school or child care by the case has not occurred, or consent has not been obtained. However, verification of school/child care processes and settings for the class/cohort with school/child care authorities is still required, and disclosure may be necessary as part of this process.

Note:
- If only a single case is reported in the school, or if there is more than one case but they have most likely acquired the infection outside the school, the students (excluding the case[s] and confirmed close contacts) can continue to attend school with preventive measures in place, as long as they self-monitor for symptoms and isolate and get tested if symptoms occur. Regional PH may review the existing preventative measures and recommend any changes as necessary.
- A 10 day period of self-isolation (quarantine) with remote learning may be required if ongoing in-class or in-school transmission is suspected (e.g. meets definition of an outbreak). In grades 7 – 12 the recommendation for self-isolation (quarantine) for contacts in classrooms would only be for those students who are not fully immunized or recently infected (i.e. within the previous six months), unless there is a widespread outbreak. For grades K-6, it is encouraged to keep the cohort size as small as feasible.
to avoid large group disruptions to in-person learning. As well, for grades K-6, the recommendation for self-isolation (quarantine) for contacts in classrooms would only be for those students who were not recently infected (i.e. within the previous six months), unless there is a widespread outbreak. Self-isolation (quarantine) can also be applied at the cohort level instead of the class if supported based on exposure risk.

5) School officials may have initiated preliminary information gathering and identification of potential close contacts according to their toolkit (https://www.edu.gov.mb.ca/k12/covid/toolkit/index.html) if an individual (student/staff) has already informed the school of their positive COVID-19 test result prior to regional PH reaching out to the school. School officials may have already advised close contacts to self-isolate (quarantine) until they hear from public health, and may have sent out preliminary letters to the school community. Information gathered by school officials for the potential close contacts identified can be collected by the public health nurse when they connect with the school Principal, and reviewed to ensure the assessment is complete.

6) Regional public health assesses whether the most likely acquisition for the case was at school (see definitions), and whether other cases have been reported in the school/cohort.

7) Regional public health recommends actions for the facility -
   - If the full investigation is not complete by the end of the work day, priority is for case isolation and identification and isolation of close contacts. School officials can be directed to send out a preliminary email letter to those identified as close contacts, informing them that a confirmation letter will be sent out once the investigation is complete. For a child care facility, the public health nurse may notify individuals identified to be close contacts.
   - Anyone who is identified as a close contact to the case(s) will be contacted directly by public health or by a letter notifying that they are a close contact of a case, ideally the same day as the case notification. Preliminary letters may have already been sent out by the school to potential close contacts if the school initiated preliminary information gathering as outlined in the toolkit. All contacts must be entered in PHIMS and sent for contact notification to ensure they have an opportunity to ask general questions and have a complete contact investigation, including assessment of exemptions.

8) After confirmation/completion of investigation by public health, the school will send out the appropriate confirmation letters to identified recipients, as well as the school community. For child care facilities, public health can modify the letter templates in the schools toolkit and send to the facility for distribution.

9) For schools, the public health nurse will submit an e-form (found in the Quick Reference Notification Guide) to Education at the end of the investigation, to aid with data collection and reporting for cases in schools.

10) If public health identifies an outbreak in a school or child care facility, notify Communication Services Manitoba and the Department of Education (casesinschools@gov.mb.ca) or Families (FAMtaskforce@gov.mb.ca), for a public posting on the Pandemic Response System. Note that the Principal or director of the child care center should be notified of the outbreak status prior to the public posting. For definition of an outbreak, see below definitions at the end of this appendix.
• Note: For schools or child care centres on private land, including First Nations communities, there will not be a public posting on the Department of Education website/Education Dashboard.

11) PHIMS documentation should include the school/child care facility as a transmission exposure if applicable, and consider whether it was also a possible acquisition exposure. Ensure the correct name of the school, address, and setting type is completed. Details on the class setting (e.g. physical distancing, cohort, masks, etc.) can be recorded in the risk factor for sensitive environment/occupation (additional details).

12) Data reporting and surveillance on the number of cases in schools will be provided by Manitoba Epidemiology and Surveillance on a regular (twice weekly) basis for evaluation by regional public health, and can inform further action as needed.

For exposures on school transportation, the bus cohort and any close contacts should be identified and notified directly or by a close contact notification letter sent by the school, under the guidance of public health.

If assigned seating and limited movement on the bus was in place, identification of close contacts can follow a similar approach as contact tracing for air transportation, and will also consider the use of face masks (non-medical and medical) as appropriate PPE for:

- passengers seated within a two meter radius of the index case AND
- persons who had close contact with the index case, e.g. travel companions or persons providing care.

Note: In most standard school buses, this includes two rows in front, and two rows behind the case.

Assessment of Multiple Cases In a School

The below definitions should be used to guide public health recommendations for moving classes/cohorts/schools to remote learning. Cohorts that meet the definition of a K-12 school outbreak should be moved to self-isolation (quarantine)/remote learning for a period of 10 days. In general, this period of self-isolation (quarantine) will not be extended unless there is evidence of extensive transmission within the cohort. Entire schools will only be moved to remote learning when there are already multiple cohorts on self-isolation (quarantine) and there is evidence of transmission throughout the facility.

For schools that meet the cluster definition, close ongoing monitoring, review of existing preventative measures in the school and investigation is recommended to look for further cases in the school. Remote learning will not be recommended, but ongoing communication between public health and the school is required to monitor the situation and look for evidence of further transmission (e.g. absenteeism, symptomatic individuals). Schools should also ensure preventive measures are in place, avoid higher risk activities, and ensure ventilation systems are functioning well.
Declaring School Outbreaks Over

- Outbreaks that have been declared at the class, cohort, or school level can be declared over once the period of remote learning has ended and students are back in school. Public health will continue to monitor for a total of two incubation periods. Schools should continue to focus on preventive measures and avoid higher risk activities such as group activities and assemblies during this monitoring period.

Definitions:

K-12 school-associated COVID-19 case:
A lab confirmed or probable case of COVID-19 in a staff/student/volunteer affiliated with a K-12 school in Manitoba, who was present in the school during:

- the 14 days prior to symptom onset or, if asymptomatic, 14 days prior to their positive specimen collection date, or
- within 10 days after illness onset or, if asymptomatic, the specimen collection date of a positive test result.

The case record must identify the affiliated school for it to be included in the data. Cases among school-aged children with no school identified are not included in the data. A school case does not mean there was acquisition or transmission at the school.

K-12 school transmission/acquisition
A subset of school-associated cases where the place of exposure is determined to likely to be the school setting or a school-sanctioned extracurricular activity. The most likely source of acquisition is determined by examining whether the case was exposed by documentation of:

- contact with a known case outside the school setting
- travel
- a confirmed outbreak outside the school setting

If none of these exposures are present and the case was school-associated, transmission within the school should be assessed as possible.

K-12 school-associated cluster description (adapted from CDC):
Multiple cases comprising at least three (3) cases of student, teachers, or staff within a school that:

- meet the criteria for a school-associated COVID-19 case;
- have a symptom onset or, if asymptomatic, specimen collection date of a positive test result within 14 days of each other;
- meet the definition of K-12 school transmission/acquisition; AND
- have NO epidemiologic link to each other or a known case in the school setting or a school-sanctioned extracurricular activity.

K-12 school-associated outbreak description [adapted from CDC]
Multiple cases comprising at least three (3) cases of students, teachers, or staff, within a specified cohort that:

- meet the criteria for a probable or confirmed school-associated COVID-19 case;
• have a symptom onset or, if asymptomatic, specimen collection date of a positive test result within 14 days of each other;
• meet the definition of K-12 school transmission/acquisition; AND
• epidemiologically linked to a known case in the school setting or a school-sanctioned extracurricular activity.
COVID-19 Assessment Tool for Exposures in School and Child Care Settings

- This tool is meant to be used by public health practitioners as part of case and contact management for school and child care settings. This is a guidance document and may not apply to all situations. A thorough risk assessment by public health should still be completed including assessment for breaches in masks and other PPE and the presence of other preventative measures.

- The following scenarios refer to situations where the Exposed individual and the Case were < 2 metres apart and for > 10 minutes (cumulative in a 24 hour period) together, or when using a lower threshold for determining close contact.

- These are not for situations where an aerosol-generating medical procedure (AGMP) is being performed unless otherwise stated.

- Individuals with unprotected contact (i.e. no gown and/ or gloves) with a significant amount of a case’s vomit and/ or diarrhea should self-monitor for 14 days from last exposure.
If an outbreak has been declared, public health officials may consider all exposed individuals who have been < 2 metres apart and for > 10 minutes as close contacts (regardless of non-medical mask or PPE use by the case or the exposed individuals) and be required to self-isolate (quarantine), unless otherwise exempt, for 10 days from the last exposure followed by 4 days of self-monitoring for symptoms.

Exposure Scenario | Case Mask Use | Recommendation
--- | --- | ---
**Medical Mask and Eye Protection** | Wore Mask (Medical or Non-Medical) OR NO Mask | No contact tracing required

Note: Eye protection, as described in the Interim Guidance Public Health Measures document, should be worn over prescription eye glasses. Prescription eye glasses alone are not adequate protection against respiratory droplets.

**Medical Mask and NO Eye Protection¹ OR Non-Medical Mask +/- Eye Protection¹** | Wore Mask (Medical or Non-Medical) | **Not considered a close contact**

If exposed asymptomatic
1. Self-monitor for symptoms for 14 days from last exposure
2. No restrictions/continue daily activities while continuing to follow public health recommendations

If exposed develops symptom
1. Isolate and go through COVID-19 Screening Tool to determine testing recommendations

**NO Mask (Medical or Non-Medical)¹** | Wore a Medical Mask | Exposed is considered a close contact and must self-isolate (quarantine).

However, if a low-risk exposure, public health may recommend that the exposed individual can continue to attend school / child care while self-monitoring for symptoms for 14 days from last exposure if they are asymptomatic and:
1. Able and willing to wear PPE / non-medical mask, OR
2. If exempt from wearing a mask, is seated > 2M from others

**Medical Mask and NO Eye Protection** | Wore NO Mask | Exposed is considered a close contact

If exposed asymptomatic
1. Self-isolate (quarantine), unless otherwise exempt (i.e. fully vaccinated or recent COVID-19 infection within 6 months), for 10 days from last exposure, followed by 4 days of self-monitoring for symptoms

If exposed develops symptom
1. Isolate and go through COVID-19 Screening Tool to determine testing recommendations. If test negative, still need to complete self-isolation (quarantine) for 10 days and until symptoms have resolved for 24 hours.

---

¹If an outbreak has been declared, public health officials may consider all exposed individuals who have been < 2 metres apart and for > 10 minutes as close contacts (regardless of non-medical mask or PPE use by the case or the exposed individuals) and be required to self-isolate (quarantine), unless otherwise exempt, for 10 days from the last exposure followed by 4 days of self-monitoring for symptoms.
APPENDIX D-1: Role of the Chief Occupational Medical Officer (COMO)

Responding to potential or confirmed workplace outbreaks during COVID-19 is complex due to the many types of workplaces and the social and economic implications of an outbreak.

The Workplace Safety and Health Act defines the role and powers of the COMO in ensuring workplaces are safe and healthy for workers in all provincial workplaces. The current role undertaken by the COMO under COVID-19 necessitates referencing and balancing of both PH and WSH mandates.

*Generally speaking,* in relation to non-health care workplaces, the COMO:

- leads on risk assessment of workplaces, determination of potential workplace transmission, and coordinates/ ensures needed workplace inspections, actions and controls are in place.
  - Note: The COMO’s priority work under COVID-19 particularly targets high risk workplaces/ workers such as food processing; complex worker groups (e.g. work camps, Temporary Foreign Workers, truckers), and less public-facing workplaces (where Workplace Safety and Health inspections may play a role).
- chairs high-risk workplace case management meetings and aids in coordination and problem solving in relation to a wide range of concerns when workplace acquisition/transmission is suspected, or when workplace transmission has significant socioeconomic implications for Manitoba or Canada.
- provides consultation in relation to case or cluster management as required/requested by PHUs, or - as appropriate – if requested by partners and colleagues within government or industry
- may be consulted in relation to non-public facing workplaces where Occupational Safety and Health is federally regulated

Note: Health Care Workplaces including Long Term Care

- Health Care Workplace typically fall under Occupational and Environmental Safety and Health (OESH). However, COMO should be advised of multiple cases within any LTC facility and will in turn engage Workplace Safety and Health Branch as appropriate. Manitoba’s WSH Branch has requested MHSAL advise them of clusters given that their occupational hygienists attend to these sites, as do PHIs. WSH may subsequently be able to help identify issues or undertake focused inspections as required.

**Food Processing (FP) Sector**

*Suspect, probable and confirmed cases with workplace acquisition or transmission*

**Introduction:**

- Since the beginning of the pandemic, industry has been seeking input from Health on preparedness, prevention and response.
One agricultural sector of particular concern and under multiple high-level scrutiny is Food Processing (FP), given the worker health and safety, animal welfare, and socioeconomic consequences of COVID outbreaks and/or facility closures.

A Workplace COVID-19 unit (WCU) currently led by a medical officer of health (MOH) in the joint role of Chief Occupational Medical Officer (COMO) and PH MOH, responds to COVID-related workplace prevention, preparedness and response issues and guidance requirements.

Roles and key actions related to FP case investigation and management, inclusive of the COMO and PH roles, are outlined below in this guidance.

This guidance reflects a FP Collaborative Response Model developed with key governmental and nongovernmental partners; it includes lessons learned from the multiple cases at Maple Leaf Foods in Brandon MB and those in other FP facilities to date. (Refer below to Manitoba’s Collaborative Response Model – Food Processing Sector diagram). This collaborative and standardized approach has helped ensure role clarity, created efficiencies, all with the goal of improved outcomes in management of cases.

Notification of potential FP case

- Case definition: The Canadian Food Inspection Agency (CFIA*) defines a positive case within the Canadian Food Sector as: one positive case in a food-processing employee or exposure to a case within a food processing plant. *Note that exposure does not equal a case but may warrant a risk assessment through the usual collaborative processes outlined here. Furthermore, an additional confirmatory laboratory test may be required depending upon the lab at which the testing occurred.

- To facilitate a timely response to a potential FP workplace transmission, special investigation (SI) codes have been set up by the COMO with Cadham Provincial Lab in partnership with Agriculture and Resource Development (ARD). SI codes are on lab requisitions provided to FP facilities for use by their employees.

- The lab results associated with SI codes are automatically sent to the COMO. This allows the links between facilities and lab results to be rapidly determined and acted upon. It also allows workers to be grouped together (or linked); the SI code permits workers’ tests to be retroactively added to a facility’s list of test results if needed.

- Per established process with CPL, the tests can be given priority for shortened turnaround time; CPL immediately notifies COMO of positive lab results via email and the PH Workplace COVID-19 Unit (WCU) receives them via fax at 300 Carlton.

- The quick turn-around time for testing high risk workers is in place to facilitate:
  - rapid risk assessment of the workplace and institution of control measures to mitigate the risk of any potential transmission
  - engagement of regional Public Health Units (PHUs) to undertake/prioritize the PH investigation (if it has not already begun)
  - immediate triggering of any required inspections by MB Workplace Safety and Health, Health Protection Unit, ARD and/or CFIA* to quickly identify and address any potential gaps in COVID-19 workplace controls
  - determining whether CFIA or ARD inspectors need to be pulled from the plant (effectively shutting down production/operations)

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There are however times when, for various reasons, a person is not identified as a Food Processing worker at the point of testing. Consequently, in some instances, regional PHU may be the first to identify a positive case with potential workplace acquisition/ transmission because of their regional investigation.

In the case of any confirmed FP case, the regional Public Health Unit (through a regional Medical Officer of Health (MOH) or some other established regional staff person) will immediately notify the COMO/WCU (Denise.Koh2@gov.mb.ca). This includes after hours/weekends.

- This prompt action will permit PH/COMO to prepare for the concerns and questions that may quickly arise from the Facility, ARD, CFIA and others (including media/public, unions, and other stakeholders). Another designated person may take on the coordination role as required, most typically an MOH.
- Similarly, any on-call MOH who is made aware of a potential workplace case will notify the COMO immediately.

In some instances, due to risk level or other factors, or by arrangement with the COMO, FP facilities may provide lists of tested employees to the WCU where they are tracked. Consequently, facility workers that were tested without the SI code on their lab requisitions can be retroactively linked to the facility and the situation better assessed and monitored.

**FP investigation and risk assessment**

The regional PHU will conduct/prioritize a regional investigation and contact tracing in relation to the identified case to aid in prompt assessment of the risk of workplace acquisition or transmission.

In the event of cases that reside in a different regional health authority than the location of the facility, both regional PHUs will work with the COMO to coordinate a timely response and gather appropriate information (from the workplace, cases, and partners such as HPU, CFIA, WSH, ARD). Whenever possible, PHUs should attend the collaborative meetings per the Response Model, and particularly those crucial in assessing the likelihood of workplace transmission.

If an individual regional health authority or other partner in the collaborative risk assessment is unable to undertake the outlined activities in this guidance, they should advise the COMO immediately so as not to delay the necessary investigative and response activities at the workplace, and the necessary cross-departmental and jurisdictional coordination.

The COMO and CPPHO are to be advised as soon as possible when a regional MOH determines that any of the following action(s) are required in relation to a food processing facility:

- immediate shut down of a facility (or a production line/area within a facility)
- declaration of a FP workplace outbreak
- reporting on a workplace cluster/outbreak to the media
- mass testing of employees in a workplace
Where possible and practicable, COMO is to be notified in advance of the regional PHU shutting a facility/line down so the collaborative process can be immediately triggered to manage the risk as well as the broader implications of a workplace shut down. This will include advising CFIA should there be implications for exports from Canada to another country.

Note: Some facilities are under federal jurisdiction exclusively (in which case provincial COMO does not have workplace safety and health jurisdiction); however, upon advising the COMO she/he will work with ARD and other partners to determine the jurisdictional status and which agency needs to engage with the workplace regarding workplace COVID risk assessment, inspection and controls.

From the first notification of a positive case, the following is likely to occur within 24 – 48 hours (Refer to Collaborative Response Model).

- On initial contact with case, PHU should undertake to:
  - Notify case that COMO will be notified
  - Notify case that COMO /PH is to communicate with employer (using non-identifying data). Data will be shared with employer and government regulatory bodies related to any potential exposure in the workplace or to coworkers (such as location in plant/department and dates in plant).
  - Determine whether case consents to identifying data being shared with the employer. The case simply advising they will call the employer with their diagnosis is not sufficient consent by itself.
    - If the case refuses, PHU will collect non-identifying information that can help the workplace protect other workers (such as area case worked in; last day worked etc.)
    - In some instances the COMO may be notified first of the case and will seek required consent.
  - Regional PHU will share initial investigation findings including identifying data of case and workplace contacts with the COMO in preparation for multi stakeholder meetings and initial risk assessment.
  - Should the PHU require/request COMO to call the cases, workplace contacts, or workplaces, they must provide the contact information to the COMO.

- **Collaborative meetings** (refer to response model below)
  - *If the situation warrants*, a small Initial Governmental Preparatory Meeting may be immediately held by COMO, PHU and government partners without the presence of the facility in order to clarify any concerns or needed steps. ARD sets up these and other collaborative meetings, often functioning as a liaison between partners and COMO/PH. Meetings are chaired by the COMO.
  - Depending upon the situation, at the request of the COMO, or when the facility or CFIA is made aware of a potential case (usually within 24-48 hours) ARD will also arrange a Collaborative Risk Assessment Meeting with PHU/regional MOHs, WSH, ARD, CFIA (in federally-regulated facilities), HPU, and the facility. If a facility has a confirmed occupational health care provider(s), they may also attend.
The purpose of the Risk Assessment meeting is information sharing and collaborative risk assessment, and to identify/prioritize actions over the next 24-48 hours.

- PHU staff should contribute regional risk assessment information at this and any other related FP meetings that occur.
- HPU, WSH, ARD, and CFIA (as applicable) will attend and update on their prior engagement and assessment of the facility in relation to COVID-19 preparedness and controls (e.g. dates, types and outcomes of prior workplace inspections, and any identified gaps). New inspections may be arranged to support the facility response and mitigation.
- COMO and PHU will continue to ensure PHIA protections and consent considerations/protocols underpin all information sharing among the stakeholders at all meetings.
- Minimum information related to cases will be given to allow for identification and communication purposes (e.g. initials, year of birth, department) for planning of investigation and control measures in the workplace.
- The facility can be anticipated to undertake their own internal investigation insofar as they acquire information from the case(s). In some instances, they may provide very detailed information to assist in the risk assessment.
- The FP meetings provide opportunity to collaborate and clarify details in relation to cases, the nature of potential workplace risks, and actions to mitigate any risks through a range of agreed upon strategies.
- Risk assessment is done to try to determine whether evidence of workplace transmission exists. Effort is made to categorize acquisition into the following: contact with a known case outside of workplace; contact with a known case inside workplace; travel-related; attendance at mass gathering or group events without consistent mask/PPE use; link to known outbreak; unknown acquisition; and pending.
- COMO (or designate from PH) will chair each of the FP facility meetings, identify key action items, confirm risk assessment perspectives, confirm inspection activities and timeframes (i.e. inspections to be undertaken by PHU and/or CFIA and/or WSH as required) and consensus on initial category of acquisition.
- The collaborative meetings also include discussion on potential communications requirements (staff communications; external communications) and media issues, cross-jurisdictional issues, and emerging issues and concerns.
- Depending upon the number of cases, FP facility meetings may occur daily or as deemed necessary by the COMO and other stakeholders.

For reference:
1) Case(s) information and other topics discussed at the FP Collaborative Risk Assessment Meeting may include but are not limited to the following:

- Case identifiers (e.g. limited to DOB; work cohort; gender etc.)
- Consents to share information
- Last day worked
- Shift hours worked

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- Symptom onset if applicable
- Date tested
- Location and set up of work area within facility
- Common areas in use by case (lunch room; break areas, bathrooms etc.)
- Onsite health screening results for case
- Potential sources of infection/acquisition
- Carpooling activities
- Social interactions/ group activities within and outside of work

Other topics:
- PPE and other general workplace controls
- Community misconceptions and rumors
- Communication strategy – internal with employees and external /media communications

2) Manitoba’s Collaborative Response Model
Food Processing Sector - COVID-19 management

Note:
* ARD works closely with PH and WSH and supports the collaboration between Health, industry and CFIA. They lead on assessing the implications of COVID-19 related interruptions to key aspects of agricultural operations/food processors and the implications to animal health/welfare and the economy.
* CFIA provides the inspection services that are required in order to maintain the ability to market products from Canadian food processing facilities

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APPENDIX D-2: Sample Letter ‘Confirmed Case of COVID-19 in a Workplace/ Business’

Workplaces/ Businesses may, or may not receive a letter from public health officials. Issuance of this letter is at the discretion of regional public health officials depending on the results of their investigation and the case-specific circumstances/ scenarios. It is intended to provide additional information for workplaces/ businesses identified through the course of the public health investigation. Regional public health may adapt this letter as required.

Confirmed Case of COVID-19 in a Workplace/ Business

<<DATE>>

Dear <<insert business name/owner/operator>>

Please be advised that there has been a confirmed case of COVID-19 in your workplace.

The individual was potentially infectious between the below dates:

___/___/___ to ___/___/___

□ The individual was not in your workplace during the period of infectivity

□ The individual was in your workplace during the period of infectivity. No close contacts were identified. No further action is required from your workplace.

□ The individual was in your workplace during the period of infectivity. Close contacts have been identified and notified by public health officials. No further action is required from your workplace.

□ The individual was in your workplace during the period of infectivity. Public health officials will be contacting you for further discussion of recommendations for your workplace.

Be assured that public health investigations to identify individuals who may have been exposed begin within 24-48 hours of a confirmed laboratory test. Any employee identified as a close contact is contacted directly by public health officials and provided instructions for self-isolation (quarantine). Close contacts are defined as anyone within two metres/ six feet of the case for 10 minutes or more during the period of communicability.

Public health officials will contact you should they require any additional information to assess the risk to employees or the public or, if any other measures need to be taken by the workplace to reduce the risk of transmission.

If a risk to the general public is identified, the public will be notified via the daily media bulletin and the information will be posted online at: https://www.gov.mb.ca/covid19/updates/flights.html. You will be notified if this is required.

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If the public health investigation determines that there was no risk of exposure in the workplace, Public health officials will not contact you.

Cases and contacts do not require a negative test result to return to work. Provided cases no longer have a fever and their condition has improved, they can stop isolation as early as 10 days from the start of their symptoms. Contacts will be advised that they can stop self-isolating 10 days, followed by 4 days of self-monitoring for symptoms, after their last known contact with a confirmed case, provided they have not developed any symptoms of COVID-19 during the 14-day self-isolation (quarantine)/self-monitoring period. Public health officials will be in contact with cases and contacts, and will provide direction to them on when it is safe to stop isolating and return to work.

Continue to advise employees to complete the daily symptom and exposure screening questions (https://www.gov.mb.ca/asset_library/en/coronavirus/covid19_screening_checklist.pdf) before coming to work, and advise them that if they develop symptoms, even if they are mild, they are to immediately isolate themselves from others, and call Health Links – Info Santé for information on testing, assessment and duration of isolation.

Please note: Under privacy legislation, your workplace is not permitted to release the name or any identifying information about the confirmed case of COVID-19 to any member of the workplace, community or media.

More information for workplaces is available at https://www.safemanitoba.com/COVID-19, including draft template letters to notify employees in your workplace, should that be desired.

For more information, please visit; https://manitoba.ca/covid19/updates/resources.html.

Sincerely,
APPENDIX D-3: Sample Workplace Exclusion Letter

<<DATE>>

Attn: 

Re: 

Please be advised that the above-named individual is excluded from attending work / school due to the investigation of a communicable medical condition.

You will be notified when he / she / they will be allowed to return.

Please contact ________________, Public Health Nurse @ ________________ if you have any questions.

Sincerely, 

or 

<<DATE>>

Attn: 

Re: 

Please be advised that the above-named individual has been cleared to return to work / school as of this date: ________________

Sincerely, 

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APPENDIX E: Other Notification Processes

Post-Secondary Educational Institutions:

- Cases who attended a post-secondary educational institution while in the period of communicability should have an assessment of the risk of transmission in the institution.
- The post-secondary educational institution should be notified. Contact information is located on the MOH password protected site.
- Public health will identify all close contacts. The institution may be able to assist with identification of close contacts in classes.
- If a risk of transmission is present and all the close contacts cannot be identified, a larger announcement may be required. The school letters can be adapted for this purpose. The institution will be responsible for delivery of the message to impacted staff and students.
- If an outbreak or ongoing risk of transmission is present, the notification should be posted on the Pandemic Response System, along with a change in alert level if applicable.

Department of Families:

- The Department of Families funds agencies that provide residential or group care to adults with intellectual disabilities and for children in care. Cases who work in Child and Family Services or Adult Disability (also referred to as Community Living disAbility Services or CLDS) group or residential care homes while in the period of communicability should have an assessment of the risk of transmission within these facilities.
- Many of these staff work in more than one home.
- The Department of Families should be notified so that the department can work with agencies to support Public Health with contact tracing.
- The department also funds child care facilities. Many child care centres are co-located in schools.
- Email contacts for the Department of Families are listed on the MOH resources password-protected website. Notification should occur by email for cases related to:
  - CLDS residential/group care homes,
  - CFS residential/group care homes
  - Child care facilities
- Public health will identify all close contacts and provide advice on isolation. The department and agencies may assist with identification of close contacts within the facilities. The department can also provide a coordination function with the agencies.
APPENDIX F: Direct COVID-19 Tests in Manitoba – A User’s Guide to Characteristics and Interpretation

- The following table is to help healthcare providers and public health practitioners interpret results from the various tests that are available and that have been validated through the Manitoba Health system. This does not include interpretation for tests completed outside of the Manitoba Health system or tests that have not been validated through the Manitoba Health system. This document will be updated as information becomes available.

- Considerations for tests completed by a non-licenced private laboratory and/or settings outside of the Manitoba Health system and/or tests that have not been validated through the Manitoba Health system (i.e. tests not listed in the table below):
  - Positive results – should be classified as Lab Probable and confirmatory testing by RT-PCR through the Manitoba Health system is recommended. The individual should go for re-testing as soon as possible.
    - If the confirmatory RT-PCR is positive, regional public health can change the classification to Lab Confirmed.
    - If the confirmatory RT-PCR is negative, this would most likely be considered NOT a case, but regional public health should complete a risk assessment to make this determination between Lab Probable and Not a Case. This risk assessment should include timing between the initial and confirmatory test, type of exposure, symptoms, and the impact to the setting (e.g. communal living, work camp).
  - Negative results – confirmation is not required, but considerations for:
    - If tested when symptomatic, consider retesting if symptoms worsen/is significantly ill.
    - If tested when asymptomatic, retesting is warranted if symptoms develop.
<table>
<thead>
<tr>
<th>Assay name</th>
<th>Method</th>
<th>Intended Use</th>
<th>Targets</th>
<th>Specimen type</th>
<th>Sens. relative to GS/Ref</th>
<th>Spec.</th>
<th>Comments/Considerations for Interpretation of Results</th>
<th>Case Classification (Positive Result)</th>
<th>Action if Negative Result</th>
</tr>
</thead>
</table>
| Lab Developed Test (LDT) – based on CDC +/or WHO | RT-PCR       | Lab          | E gene  | Nasopharyngeal (NP) | reference              | >99%  | Gold standard (GS): considered ~95% sens, 99% spec, subject to collection, transport, etc. Requires batching.  
NP swab is the preferred specimen.  
False negatives (FN) are more likely if NP swab done when asymptomatic or in first 24 hours of symptoms.  
Can continue to detect low levels of virus for weeks after infection | Lab Confirmed for both symptomatic and asymptomatic. If previously a case, needs review to determine if this positive is due to persistent virus shedding or is indicative of new infection (i.e. re-infection) | No confirmation required, but considerations for:  
• If tested when symptomatic, consider retesting if symptoms worsen/is significantly ill.  
• If tested when asymptomatic, retesting is warranted if symptoms develop. |
<p>| GeneXpert – COVID                  | RT-PCR       | Lab POCT     | E, N2   | NP            | reference              | 99%   | Comparable to GS: positives and negatives both reliable. Run one at a time or four at a time. Supply issues for kits. | Lab Confirmed – same considerations as GS | Same considerations as GS |
| GeneXpert – FluVID                 | RT-PCR       | Lab POCT     | E, N2   | NP            | TBD                     | TBD   | TBD. In addition to COVID-19, kit also tests for influenza A and B and RSV. Competition with other viruses may cause FN with COVID-19 at limit of detection (LOD). | Lab Confirmed – same considerations as GS | Same considerations as GS |
| Roche COBAS - COVID                | RT-PCR       | Lab          | E, ORF1A| NP            | reference              | &gt;99%  | Comparable to GS: positives and negatives both reliable. Requires batching. | Lab Confirmed – same considerations as GS | Same considerations as GS |
| Hologic TMA                        | TMA NAAT1    | Lab          | ORF1ab (2 targets) | NP            | &gt;99%                    | Comparable to GS: positives and negatives both reliable. Does not provide a Ct value. | Lab Confirmed – same considerations as GS | Same considerations as GS |
| Abbott ID NOW™ COVID-19 Assay      | Isothermal NAAT2 | Lab POCT     | RdRp gene | Nasal1         | &gt;97% in first 5-7 days of symptoms | ~99% | Less sensitive than GS: most reliable if symptomatic and collected in the first 7 days of symptoms, but negative tests should be confirmed. | Lab Confirmed – if tested in Shared Health lab. | If tested when symptomatic, result should be confirmed by RT-PCR. Ideally, the |</p>
<table>
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<tr>
<th>Hyris bCUBE bKIT Virus Finder COVID-19</th>
<th>RT-PCR</th>
<th>Lab POCT</th>
<th>N gene (2 targets)</th>
<th>NP</th>
</tr>
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<td></td>
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<td>TBD, preliminary validation data seems to suggest it is similar to the Abbott ID NOW.</td>
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</table>

50-67% overall

Specificity is described as ~99.4%, which means that ~1 in 150 specimens could be false positive.

Per manufacturer, can also use NP or throat swab, but kit only comes with nasal swab.

**Lab Probable** – if tested in any other setting. Needs confirmation by RT-PCR regardless if symptomatic or asymptomatic testing. If confirmatory RT-PCR is positive → change classification to Lab Confirmed. If confirmatory RT-PCR is negative → change classification to NOT a case.

**Lab Confirmed** – same considerations as GS

**Lab Probable** – confirmatory sample should be taken within 24 hours of the first sample.

If tested when asymptomatic, retesting is warranted if symptoms develop.

If tested when symptomatic and:
(1) Test positivity < 15%
No confirmation required, but consider retesting if symptoms worsen/is significantly ill.
(2) Test positivity ≥ 15%
Needs confirmation by another RT-PCR method. Ideally, the confirmatory sample should be taken within 24 hours of the first sample.

If tested when asymptomatic, retesting is warranted if symptoms develop.
<table>
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<tr>
<th>Abbott Panbio COVID-19 Ag Rapid Test</th>
<th>Antigen (Lateral flow assay)</th>
<th>POCT</th>
<th>Nucleocapsid (N) protein</th>
<th>NP Nasal</th>
<th>67% overall in local studies</th>
<th>TBD, less sensitive than GS</th>
<th>Positives need to be confirmed if symptomatic and collected in the first 7 days of symptoms positives are likely reliable</th>
<th>Lab Probable</th>
<th>Needs confirmation by RT-PCR regardless if symptomatic or asymptomatic testing. If confirmatory RT-PCR is positive → change classification to Lab Confirmed. If confirmatory RT-PCR is negative → change classification to NOT a case.</th>
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</thead>
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<tr>
<td>BD Veritor System for Rapid Detection of SARS-CoV-2</td>
<td>Antigen (Chromatographic assay)</td>
<td>POCT</td>
<td>Nucleocapsid (N) protein</td>
<td>Nasal</td>
<td>67% overall in local studies</td>
<td>Similar to Abbott Panbio COVID-19 Ag Rapid Test</td>
<td>Lab Probable</td>
<td>Needs confirmation by RT-PCR regardless if symptomatic or asymptomatic testing. If confirmatory RT-PCR is positive → change classification to Lab Confirmed. If confirmatory RT-PCR is negative → change classification to NOT a case.</td>
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<td>If tested when asymptomatic, retesting is warranted if symptoms develop.</td>
<td></td>
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</tr>
</tbody>
</table>

2021-10-22
1TMA = transcription-mediated amplification; NAAT = nucleic acid amplification test
2NAAT = nucleic acid amplification test
3There have been infrequent situations where the Abbott ID NOW™ COVID-19 Assay has provided a positive test, but the confirmatory RT-PCR is negative. As long as the RT-PCR was completed from a sample taken on the same day as the Abbott ID NOW™ COVID-19 Assay, this is most likely a false positive and should be classified as NOT a case. However, retesting may be indicated based on risk assessment including exposure, symptoms, and the impact to the setting (e.g. communal living, work camp).

Definitions:
Gold Standard (GS) in diagnostics refers to the benchmark test by which the performance of all other tests are measured against. It is not necessarily a perfect test, but is the best one available that has standards with known results.
Reference (Ref) refers to the diagnostic test, in the absence of a gold standard, that has standards with known results that is likely very close to the gold standard and by which other diagnostic tests can be measured against.
Sensitivity (Sens) refers to how accurate the test is in identifying disease in individuals who actually have the disease or the proportion of individuals with disease who have a positive test.
Specificity (Spec) refers to how accurate the test is in identifying individuals who actually do not have the disease or the proportion of individuals without disease who have a negative test.
APPENDIX G: COVID Alert App Quick Reference for One Time Key Providers

1. A positive COVID case report is received by the health care provider and client contacted.

2. Ask client if they have downloaded the COVID Alert App.
   If no, offer them some information about the benefit and how to download the free app from the App Store or Google Play Store (remind the client that an IPhone 6, IS0 13.5 or Android 10 is required or app will not download)

   If yes:
   • Ask if Bluetooth was on all the time on the case’s phone in the past 14 days?
   • Would they like to receive a COVID Alert unique one-time key to enter the app to notify users of the app who have been within 2 metres of their phone for more than 15 minutes in the past 14 days? Remind the client that no personal information about the client or their phone will be received by those exposed.
   • If yes, proceed with retrieving a one-time key following the below steps, and document the intervention in PHIMS.

Steps to Retrieve a One-Time Key:

A. Navigate to the login URL below and enter your email and password. A secondary identification password will be sent to you cell phone that you also need to enter. Note: if your account information changes, such as name, cell phone number etc., please contact your manager to send the request to the Digital Health service desk. https://covid-alert-portal.alpha.canada.ca/en/login/?next=/en/start/

B. Follow the instructions on the page to generate a one-time key. Ensure the client is ready to enter the key in the app or record it somewhere. Remember this key expires in
Generate a one-time key

Check that the patient:

1. Has tested positive for COVID-19.
2. Has installed the COVID Alert app on their phone.
3. Is ready to enter the key in the app or record it somewhere safe.
4. Understands the key expires in 24 hours. If the key expires before the patient enters it, they will not be able to get a new key.

Help us keep accurate stats. Only generate keys for real patients and only one key per patient.

Generate key
C. Follow the instructions to **give client their key:**

**Give patient this key**

4 7 7  K F Y  Q Q Z R

Read key phonetically and ask patient to read it back to you:

Four. Seven. Seven.
K as in Kangaroo. F as in Family. Y as in Yoga.
Q as in Question. Q as in Question. Z as in Zebra. R as in Radio.

Key expires on **September 30 at 10:13 am** local time.
No new keys after expiry.

**Instructions for patient**

1. Tap “Enter your one-time key”.

   **Diagnosed with COVID-19?**
   You need a one-time key to let people know they’ve been exposed.

   ![Enter your one-time key button](image)

2. Tap “Next” on “Let people know they may have been exposed”.

   **Let people know they may have been exposed**
   Step 1. Enter the one-time key you got when you were diagnosed.
   Step 2. Agree that COVID Alert can let people know they were exposed.
   Step 3. Allow your phone to share your random codes.
   Nobody will get any information about you or the time you were near them.

   ![Next button](image)
3. Enter your one-time key and tap “Submit”.

**Enter your one-time key**

Enter the key you got when you were diagnosed.

Submit

4. If you want to notify people, you need to give COVID Alert permission to upload random codes. Tap “Agree” on “Now you can upload codes”.

**Now you can upload your codes**

Your phone will ask your permission to upload your random codes or “random IDs” from the past 14 days.

Nobody will get any information about you or the time you were near them.

You can help slow the spread of COVID-19 if you agree.

Agree

5. Tap “Share” on “Share your random codes from this device with COVID Alert?”.

**Share Your Device’s Random IDs with “COVID Alert”?!**

Sharing your IDs from today and the past 16 days helps the app determine who should be notified that they may have been exposed to COVID-19.

Don’t Share  Share

6. COVID Alert will ask permission to upload random codes daily for the next 13 days.
D. **Inform the client** that they will be asked permission daily by their phone app to continue to share. They should continue to share the code until public health advises that they can discontinue their isolation. Once they are off isolation, they should not share the codes for the remaining days.

**Quick Guide to the COVID Alert Portal:**

**COVID Alert Portal**

**Quick guide to the portal**

**Part of the COVID Alert system**


COVID Alert does not replace manual contact tracing by local health authorities. It is just one part of the public health effort to limit the spread of COVID-19.

**One-time keys turn on exposure notifications**

You’ll give one-time keys to patients with COVID-19 who want to notify people they’ve been near. **Only give one key per patient.**

Before giving a key, check the patient has the COVID Alert app on their phone.

**How the portal displays a one-time key**

```
A H J 2 3 2  Z W F A
---
Read key phonetically and ask patient to read it back to you:
A as in Animal. H as in Hospital. J as in January.
Two. Three. Two.
Z as in Zebra. W as in Wi-Fi. F as in Family. A as in Animal.
---
The key expires in 24 hours.
No new keys after expiry.
```

The portal also links to detailed instructions. You can use these instructions to help patients enter the key in the app.

**Only authorized healthcare workers generate and give one-time keys**

By entering the key, the patient confirms they have COVID-19. Then the app guides the patient through the steps to notify people of possible exposure.

Notifications do not give information about the patient or time of exposure.
Only generate keys for real patients

By comparing 3 stats, we learn how much the app slows the spread of COVID-19. We need the number of:

- People with COVID-19.
- One-time keys generated for patients.
- Patients who enter keys in the app.

To keep stats accurate, only generate a key when you intend to give it to a patient. This condition is part of our terms of use.

Create an account to generate keys

You’ll get an email if you’re invited to create a portal account. Check your spam folder for the email.

Both administrators and healthcare workers can generate one-time keys.

Administrators can also:

- Invite healthcare workers to create portal accounts.
- Delete portal accounts.

Keep a mobile phone with you

The portal texts a security code to your mobile phone:

- When you create your account.
- Anytime you log in.

Check your browser is compatible

The portal works on any mobile or desktop device using a browser with automatic updates, including Chrome, Edge, Firefox, Opera and Safari. It’s also supported on Internet Explorer 11.

If the portal is down

Follow local procedures for patients who need keys

Public health authorities must determine what to do for:

- Situations when an individual healthcare worker cannot use their portal account.
- System-wide portal outages.

Contact us for tech support

To ask questions or give feedback about the portal, contact the Canadian Digital Service.

A training video is posted at the following link https://home.sharedhealthmb.ca/digital-health/covid-tracing-app/
APPENDIX H: Supports for Community Members

Resource lists are challenging as the availability of supports are continually changing. This quick reference guide was first compiled in late October 2020, and updated in April 2021, by the WRHA to support Public Health team members navigate community members access to resources during the pandemic. It was created specifically for team members contacting COVID-19 positive clients and their contacts. It includes many resources already listed on government websites, including Government of Manitoba sites (e.g., https://www.gov.mb.ca/covid19/protection/index.html).

It is not possible to have a fully comprehensive resource list. Other local resources and supports may be available in communities that are not included here.

<table>
<thead>
<tr>
<th>Resource</th>
<th>Details</th>
<th>Contact information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Resources</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manitoba 211</td>
<td>211 Manitoba is a searchable online database of government, health, and social services that are available across the province.</td>
<td>Visit: <a href="https://mb.211.ca/">https://mb.211.ca/</a> Call: 211</td>
</tr>
<tr>
<td>Help Next Door MB</td>
<td>Service connects volunteers with individual needs. Must have internet access and email address to sign up and create an account.</td>
<td>Visit: <a href="https://helpnextdoormb.ca/">https://helpnextdoormb.ca/</a></td>
</tr>
<tr>
<td><strong>Food Delivery Options</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Winnipeg Harvest</td>
<td>Harvest will arrange one time delivery of emergency food hamper that is estimated to last 10-14 days.</td>
<td>PHN to FAX 204.775.4180 ATTENTION DEB SWEREDA ONLY with the following information:</td>
</tr>
<tr>
<td></td>
<td>*PHN please email Deb at <a href="mailto:dswereda@harvestmanitoba.ca">dswereda@harvestmanitoba.ca</a> and <a href="mailto:appointments@harvestmanitoba.ca">appointments@harvestmanitoba.ca</a> to let her know you are sending over a fax with client information.</td>
<td>Client name Address with postal code Phone number 6 digit health card number Family composition (how many kids and ages) Any additional comments (apartment, house, drop off)</td>
</tr>
<tr>
<td>For seniors 55+: 311 Food Security Line</td>
<td>Resources available through Age &amp; Opportunity Support Services for Seniors.</td>
<td>Client calls 311 and indicate need help with food delivery. They will then be connected with the services provided through A&amp;O.</td>
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</tr>
<tr>
<td><strong>Meal Delivery for isolating cases and contacts in single resident occupancy (SRO) hotels/rooming houses.</strong>&lt;br&gt;Aims to support those who have few amenities to prepare foods. Government of Manitoba in partnership with Made with Love and Sscope will provide daily meals:&lt;br&gt;- One fully cooked fresh meal that includes instructions on how to reheat multiple ways (and can be eaten cold).&lt;br&gt;- Prepared food items for breakfast and lunch.</td>
<td>Meal packages will be delivered once a day during isolation period by Sscope.</td>
<td>PHN to email Sscope at <a href="mailto:covid.wpgdeliveries@gmail.com">covid.wpgdeliveries@gmail.com</a> with the following:&lt;br&gt;- Indicate new client for meal delivery (DO NOT provide name)&lt;br&gt;- Address/name of hotel&lt;br&gt;- Your phone number for a Sscope rep to call back and obtain additional identifying information.&lt;br&gt;<em>Please do not ask clients to initiate this service.</em></td>
</tr>
</tbody>
</table>

**Access to income and benefits**

| Community Financial Helpline | This service answers questions from community members living on low incomes about:<br>- Tax filing<br>- Obtaining identification<br>- Income supports (such as CERB, EI, OAS, CPP, and CPP-D)<br>- Benefits and credits such as the Canada Child Benefit, and debt | Client calls or texts 431-813-4357 (431-813-HELP) or toll free 1-855-955-4234 (1-855-955-4CFH) |
| Government of Canada – Service Canada | The Government of Canada has made temporary changes to the Employment Insurance (EI) program and new benefits are available:  
• Canada Recovery Benefit  
• Canada Recovery Sickness Benefit  
• Canada Recovery Caregiving Benefit | For a complete list of programs, services and resources available through the Government of Canada visit: Canada.ca/coronavirus  
Clients can also answer questions directly here to determine eligibility visit: https://covidbenefits.alpha.canada.ca/en/start |
| Community Financial Helpline | This service answers questions from community members living on low incomes about:  
• Tax filing  
• Obtaining identification  
• Income supports (such as CERB, EIA, EI, OAS, CPP, and CPP-D)  
• Benefits and credits such as the Canada Child Benefit, and debt management and credit counselling. | Client calls or texts 431-813-4357 (431-813-HELP) or toll free 1-855-955-4234 (1-855-955-4CFH) |
| Government of Canada – Service Canada | The Government of Canada has made temporary changes to the Employment Insurance (EI) program and new benefits are available:  
• Canada Recovery Benefit  
• Canada Recovery Sickness Benefit  
• Canada Recovery Caregiving Benefit | For a complete list of programs, services and resources available through the Government of Canada visit: Canada.ca/coronavirus  
Clients can also answer questions directly here to determine eligibility visit: https://covidbenefits.alpha.canada.ca/en/start |
| Government of Canada - Employment Insurance (EI) | If you are eligible for EI benefits, you will receive a minimum taxable benefit at a rate of $500 per week, or $300 per week for extended parental benefits. | Client visits: Canada.ca/coronavirus  
Only if no internet, clients calls 1-800-206-7218 |
<p>| Canada Recovery Benefit (CRB) | The CRB provides $500 per week for up to 26 weeks for workers who have stopped working or had their income reduced by at least 50% due to | Client Visits: Canada.ca/coronavirus |</p>
<table>
<thead>
<tr>
<th><strong>Canada Recovery Sickness Benefit (CRSB)</strong></th>
<th>COVID-19, and who are not eligible for Employment Insurance (EI).</th>
<th>Only if no internet, Clients call 1-833-966-2099</th>
</tr>
</thead>
<tbody>
<tr>
<td>The CRSB provides $500 per week for up to a maximum of two weeks, for workers who:</td>
<td></td>
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<tr>
<td>• Are unable to work for at least 50% of the week because they contracted COVID-19</td>
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<tr>
<td>• Are self-isolated for reasons related to COVID-19 have underlying conditions, are undergoing treatments or have contracted other sicknesses that, in the opinion of a medical practitioner, nurse practitioner, person in authority, government or public health authority, would make them more susceptible to COVID-19.</td>
<td></td>
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</tr>
<tr>
<td><strong>Canada Recovery Caregiving Benefit (CRCB)</strong></td>
<td>The CRCB provides $500 per week for up to 26 weeks per household for workers:</td>
<td>Client visits: Canada.ca/coronavirus</td>
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<tr>
<td>• unable to work for at least 50% of the week because they must care for a child under the age of 12 or family member because schools, daycares or care facilities are closed due to COVID-19 because the child or family member is sick and/or required to quarantine or is at high risk of serious health implications because of COVID-19.</td>
<td></td>
<td>Only if no internet, Clients call 1-833-966-2099</td>
</tr>
</tbody>
</table>

**Mental Health Supports**

<table>
<thead>
<tr>
<th><strong>Government of Manitoba – Care for Your Mental Health</strong></th>
<th>A summary of Manitoba resources is available online.</th>
<th>Clients visit: <a href="http://www.manitoba.ca/cov/id19/bewell/index.html">http://www.manitoba.ca/cov/id19/bewell/index.html</a></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AbilitiCBT</strong></td>
<td>Digital therapy program available to all Manitobans experiencing low to mild symptoms of anxiety due to the pandemic.</td>
<td>Clients visit:</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Contact Information</td>
</tr>
<tr>
<td>---------------------------------------------</td>
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<td>----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mental Health Virtual Therapy - Two-</td>
<td>Starting October 13, every Manitoba resident age 16 or older have access to up to two free counselling sessions with a trained professional at Morneau Shepell. Sessions are offered in multiple languages until December 31.</td>
<td><a href="https://manitoba.abiliticbt.com/">https://manitoba.abiliticbt.com/</a></td>
</tr>
<tr>
<td>session virtual counselling</td>
<td>Clients call toll free 1-844-218-2955 and the virtual counselling sessions can be by video or telephone, as preferred.</td>
<td>----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Anxiety Disorders Association of Manitoba</td>
<td>ADAM’S online, six-week Anxiety and Worry Support Program (AWSP) is designed to help people find effective ways to address anxiety and worry related to COVID-19, as well as health and social anxiety.</td>
<td>Clients email <a href="mailto:adam@adam.mb.ca">adam@adam.mb.ca</a> or phone 204-925-0600 for more information.</td>
</tr>
<tr>
<td>(ADAM)</td>
<td>This program is available across Manitoba. Participants meet weekly with a trained peer support worker — in a small online group or individually over the phone or on Zoom — as they work through each module.</td>
<td>----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Klinic Crisis Line</td>
<td>Klinic offers a variety of crisis phone lines and online support services, providing free and confidential counselling. For more information: <a href="http://klinic.mb.ca/crisis-support/">http://klinic.mb.ca/crisis-support/</a></td>
<td>To access Klinic’s crisis line clients call: 204-786-8686 or 1-888-322-3019 TTY 204-784-4097 Clients call 1-855-242-3310</td>
</tr>
<tr>
<td>First Nations and Inuit Hope for Wellness</td>
<td>Counselling available in English and French - upon request, in Cree, Ojibway, and Inuktitut.</td>
<td>----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Help Line</td>
<td></td>
<td>----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Kids Help Phone</td>
<td>This national phone line available to Manitoba Youth (generally 16 years and younger)</td>
<td>1-800-668-6868</td>
</tr>
<tr>
<td>Inspire Community Outreach</td>
<td>Inspire provides COVID-19 supports and information for families members and caregivers of those living with mental health issues and neurological/cognitive differences.</td>
<td>Clients visit: <a href="https://inspirecommunityoutreach.ca/covid-19/">https://inspirecommunityoutreach.ca/covid-19/</a></td>
</tr>
<tr>
<td><strong>Manitoba Suicide Prevention &amp; Support Line</strong></td>
<td><strong>Klinic offers this 24/7 confidential telephone support service for people at risk of suicide, concerned family / friends, those who have lost a loved one to suicide, and service providers / helpers</strong></td>
<td><strong>Clients call 1-877-435-7170 (1-877-HELP170)</strong></td>
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</tr>
<tr>
<td><strong>Sara Riel’s Seneca Warm Line</strong></td>
<td><strong>This is a telephone support service between the hours of 7:00 pm and 11:00pm. Dedicated Peer Support Workers are available to talk, provide support and/or suggest possible resources to persons calling during these times. Calls are limited to 15 minutes to ensure assistance to as many callers as possible.</strong></td>
<td><strong>Clients call 204-942-9276</strong></td>
</tr>
</tbody>
</table>
APPENDIX I: Recommendations for COVID-19 Variants of Concern

Background:
- Variants of concern (VOCs) are those with a mutation in the SARS-CoV-2 genome where there is convincing evidence that it will have an impact on public health and the health care system, including impacts on transmission, virulence, and vaccine efficacy.
- The emergence of new variants better adapted to human-to-human transmission is expected.
- More transmissible strains are more difficult to control, and may require stronger or additional public health measures.
- Lower prevalence of COVID-19 will delay emergence of new variants, and allow a large number of Manitobans to be vaccinated if/when they do.
- Current VOC’s include:
  - **B.1.1.7**: First identified in the United Kingdom (UK)
  - **B.1.351**: First identified in South Africa
  - **P.1**: First identified in Brazil
  - **B.1.617 lineage**: First identified in India. This includes B.1.617.1, B.1.617.2, and B.1.617.3 sublineages
- Information is rapidly evolving on their impacts, with emerging evidence on increased risk of death from B.1.1.7, and increased risk of vaccine escape and reinfection with the E484 mutation found in B.1.351, P.1, and some of the B.1.617 sublineages.
- Early anecdotal evidence from Ontario suggests a shorter incubation period.
- **A SARS-CoV-2 variant is a variant of interest (VOI) if it:**
  - has a genome with mutations associated with changes in epidemiology, antigenicity, or virulence, or changes that potentially have a negative impact on available diagnostics, vaccines, therapeutics, or public health measures; **and**
  - is known to cause community transmission/multiple COVID-19 cases/clusters in Canada or has been detected in multiple countries; **or** is otherwise assessed to be a VOI by WHO; **or**
  - is otherwise assessed to be a VOI by the Canadian SARS-CoV-2 Variant Surveillance Group (CSVSG).
- **A SARS-CoV-2 variant is a VOC if, through a comparative assessment, it has been demonstrated to be associated with one or more of the following:**
  - increased transmissibility or detrimental change in COVID-19 epidemiology;
  - increased virulence or change in clinical disease presentation;
  - decreased effectiveness of available diagnostics, vaccines, therapeutics, or public health measures; **or**

---

This Appendix details updated case and contact management guidance for all cases of COVID-19 in relation to the control of VOC’s, as well as additional guidance for VOC screen positive cases.

**Laboratory Measures:**

SARS-CoV-2 Variants of Concern (VOC) screening has been implemented in Manitoba. The PCR screening test assesses whether key mutations from the VOC’s are present. Screening for the variant first identified in the UK began the week of February 1, with screening for the variants first identified in Brazil and South Africa following. The PCR screen was developed to detect these specific mutations, but does not assess for mutations in other sites, and may also detect mutations in the same region of the genome in circulating strains. Screening results were initially considered preliminary and sent to the National Microbiology Lab (NML) for confirmatory sequencing. With increased prevalence of VOC’s and validation of results, routine sequencing of all screen positives is being discontinued. Targeted sequencing will continue.

Cadham Provincial Laboratory (CPL) is screening all positives, or representatives of all positives (for example, in a household or community cluster). Screening results from CPL are anticipated to be available within 1-2 days of a confirmed positive result or when received for processing from another lab.

In addition, COVID-19 samples have been and continue to be submitted for genome sequencing per the Canadian COVID-19 Genomics Network’s framework for ongoing surveillance of circulating strains in Canada. Examples of priority samples to be sent for sequencing include:

- International travellers
- Contacts of international travellers
- Suspected reinfection
- Severe acute COVID-19 in individuals <50 years old without significant comorbidities
- Vaccinated individuals with subsequent lab confirmed COVID-19
- Known or suspected super-spreading events
- Geographic sampling in sub-regions with pronounced increase in case notification rate
- Outbreaks or clusters

Requests for sequencing in the above priority groups can be made through MOH’s and regional epidemiologists, who will forward the request to Cadham Provincial Laboratory. Requests should be made for lab confirmed COVID-19 cases only. Note that sequencing by NML, when requested, may take up to two weeks.

As of late April 2021, B.1.1.7 (Alpha) has become the predominant strain of COVID-19 in the province. However, since late August 2021, B.1.617.2 (Delta) has become the predominant strain.
in the province. Only a selection of the cases screening positive for B.1.1.7 or B.1.617.2 will continue to be sequenced. All samples that screen positive for non-B.1.1.7 / B.1.617.2 will be sequenced. As well, to maintain a high degree of vigilance, positive samples from all travelers and transport workers, as well as most health care worker and educators will be sequenced regardless of their screen result.

Effective June 1, 2021, all cases will no longer be informed if they have a positive screen or sequencing indicating a VOC or VOI, as VOC’s are the most predominant strains and do not have any clinical implications for individual management. The additional notification step and investigation checks will no longer occur in most regions. Regions where the proportion of VOC’s remain low may continue to do this notification for VOC’s as appropriate for management (e.g. new introduction into a small community). Reporting of VOC’s will be limited to population-based reports, and will not be included in school-based reports where individual cases could be identified. Regions should continue to review the VOC line list and ongoing surveillance data and reports to monitor for any cluster or outbreak related to known or emerging VOCs.

**Updated Contact Management for All COVID-19 Cases:**
Enhanced identification of contacts is now recommended for all cases, including non-VOC strains.

- Use a **lower threshold for identifying close contacts** requiring self-isolation (quarantine).
  - Consider all household members close contacts, unless otherwise exempt (based on immunization status or previous infection), or exceptional circumstances exist that eliminate contact within the period of communicability. Transmission risk among household members is higher than other categories of close contacts, and infectivity is high early in the incubation period when isolation precautions may not be implemented.
  - Use a lower time threshold for considering significant exposure, and consider time periods over 10 minutes as a significant exposure. If there is uncertainty on the time of exposure, consider a close contact. The PPE exposure tool should be used for evaluating exposures during the assessment.
  - Continue to consider anyone with potential direct contact with infectious body fluids or providing care for a case a close contact. This includes being coughed or sneezed on; physical contact such as hugging, kissing, or handshaking; shared items such as drinks, eating utensils, or cigarettes/vapes; or close face to face interaction without a mask.

- **Immunization status:**
  - Individuals who, at the time of the exposure to a case, have received a full series of immunization, and more than 2 weeks have elapsed since the last dose in the series, are not required to self-isolate (quarantine) or be tested, if:
    - they are asymptomatic, and
    - do not have a medical condition (e.g. immunocompromised) that would impact vaccine effectiveness.
• These fully immunized individuals should self-monitor for symptoms of COVID-19 for 14 days following an exposure. If symptoms develop, they should isolate and be tested.
  o Follow acute care and long term care guidelines for management of residents in these facilities. For other high risk congregate settings such as Corrections or shelters, testing with release from quarantine with a negative test may be employed for fully vaccinated residents. Workers in health care and congregate settings should also consult with occupational health or their workplace manager for further guidance.
  o The risk of asymptomatic transmission after immunization remains uncertain. Immunization has been shown to prevent symptomatic COVID-19, and symptomatic and pre-symptomatic transmission is thought to have a greater role in transmission than purely asymptomatic transmission.
  o This guidance is consistent with guidance from the CDC and will be updated when new evidence becomes available, or if a COVID-19 variant with impacts on vaccine effectiveness becomes established in Manitoba.

• Reinfections: If the individual is asymptomatic and it was less than six months since they were determined to be a confirmed or probable case, they also do not need to self-isolate (quarantine), but should self-monitor for symptoms for 14 days following exposure. Should they develop symptoms of COVID-19, the individual must isolate and should go for COVID-19 testing.

• Recommend testing all asymptomatic contacts at 7 days. Testing is also recommended for anyone with symptoms as per existing guidelines.
  o Earlier testing (at time of notification) may be recommended in certain higher risk settings for transmission (e.g. crowded housing, shelters, or other congregate living) to allow earlier identification of asymptomatic cases, and earlier initiation of contact tracing and isolation if positive. This has the potential to reduce further exposures in the household and overall isolation/self-isolation periods for the household.
    o If tested at day 5 or earlier, repeat testing is recommended at day 7. Contacts should be notified of the recommendation for 2 tests.
    o Testing at day 7 is important to identify asymptomatic cases who develop infection later in the self-isolation period (i.e. longer incubation periods). This avoids asymptomatic cases being removed from isolation when they may be still infectious.

Contact management:

• If the case isolates in the home:
  ▪ If the case is unable to isolate from household close contacts: All household close contacts, who are not otherwise exempt, must also self-isolate (quarantine) for the same duration as the case (minimum 10 days), and must self-isolate (quarantine) for

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23 https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html

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a further 10 days to ensure the virus was not transmitted in the final days of the case’s isolation (minimum 20 days). Testing is recommended at 7 days after the last exposure to the case. The close contact must be asymptomatic, but is not required to be tested to remove from self-isolation (quarantine) (i.e. at day 20). If subsequent cases are identified in the household, this may result in a longer self-isolation (quarantine) period than 20 days for household close contacts. Encourage the use of AIA and separate isolation spaces for younger contacts who are not eligible for immunization to avoid prolonged disruptions to in-class learning.

- **If the case is able to isolate from household close contacts** (e.g. separate living space and washroom and no shared spaces including the kitchen (regardless of cleaning/disinfection practices) or close contact with other household members*): All household close contacts, unless otherwise exempt, must self-isolate (quarantine) for 10 days following the last exposure to the case. Testing is strongly recommended at day 7, but not required to remove from self-isolation (quarantine).

  If subsequent cases are identified in the household, this may result in a longer quarantine period for household close contacts.

  *Note that the risk of household transmission remains while the case is isolating in the household, and can occur during contact for food delivery, cleaning dishes, laundry etc. The household should be instructed to avoid contact with the case when delivering/picking up items and ensure mask use, appropriate disinfection, and hand hygiene is followed.

- **If the case does not isolate in the home:**
  - **If the case does not isolate in the home:** All close contacts, unless otherwise exempt, must self-isolate (quarantine) for 10 days from the last exposure to the case. Testing is strongly recommended at day 7. The close contact must be asymptomatic, but is not required to be tested to remove from self-isolation (quarantine) at day 10.
  
  - Public health should work with clients to address any barriers to testing, including access (e.g. mobile testing), and type of test/swab required. Public health can use discretion in type of test if required.
  
  - Low risk contacts identified by name, including close contacts who are exempted from quarantine due to immunization or recent COVID-19 infection, or close contacts with significant exposure but who wore PPE in settings outside health care, can be entered in PHIMS. This will assist with identifying potential acquisition sources if the low risk contact subsequently becomes a case. Do not create an isolation intervention. An intervention of “symptom monitoring” can be added. When notified, disposition should be set to “follow-up complete” with note indicating advice to self-monitor.

**Household members:**

- All household members of close contacts who are asymptomatic do not need to self-isolate (quarantine) if the close contact remains asymptomatic. Given, their increased risk of exposure, it is recommended that household members wear a mask and physically distance where possible when outside the household, and avoid leaving home for non-essential reasons until the close contact completes their self-isolation (quarantine).
- Household members of symptomatic individuals (based on screening tool assessments and not identified as a close contact) do not need to self-isolate (quarantine) while waiting for the symptomatic individual’s test results. Given, their increased risk of exposure, it is recommended that household members wear a mask and physically distance where possible when outside the household, and avoid leaving home for non-essential reasons.
  - If the close contact is not tested, and has symptoms compatible with COVID-19, they will be considered a probable case, and household members will be considered close contacts and must self-isolate (quarantine), unless otherwise exempt.
  - Public health is not expected to collect individual level information on the household members of the close contact, and they should not be entered into PHIMS as close contacts.
  - Exemptions from self-isolation (quarantine) are allowed if the household member is asymptomatic and:
    - Fully immunized (i.e. it has been at least two weeks since their last dose), OR
    - Recently infected (i.e. previous COVID-19 infection in the last 6 months).
  - Exemptions are also allowed for household members (who are not fully immunized or recently infected) who are essential workers required to wear PPE at work if:
    - everyone in the household is asymptomatic, including the close contact, AND
    - they self-isolate (quarantine) when not at work, AND
    - the close contact can self-isolate (quarantine) from the essential worker in the household.
  - All individuals exempt from self-isolation (quarantine) requirements, should continue to self-monitor for symptoms for 14 days following exposure, and isolate immediately if any develop and go for testing.

- **Reinfections and those fully immunized**: Follow guidelines in this document for management of exposures in individuals who have been previously infected with COVID-19, or are fully immunized. If quarantine and testing is not required as per guidelines, the contact should be notified that they have been exposed to a case of COVID-19. They should self-monitor for symptoms for 14 days from the last exposure, and be advised to use all precautions to avoid further exposure to the case during the isolation period if in the household. They should be advised to notify public health/Health Links Info Santé if they do develop symptoms.
- **Active monitoring should occur 2 – 3 times** for all cases and close contacts with SMS used where possible to supplement calls. Close contacts are strongly recommended for close contact testing at day 7 if they remain asymptomatic.
- **Use a lower threshold for escalation if a case or close contact does not respond to active monitoring calls within 24 hours.** Follow guidelines for enforcement for follow-up to ensure adherence to isolation/self-isolation (quarantine).

**Cases on public transportation:**
• Public health may request flight manifests for VOC and non-VOC cases on a case by case basis, but is not done routinely. Public notification should occur for all flights with COVID-19 cases during their period of communicability.
• All close contacts identified should be advised to quarantine and be tested according to above recommendations.
• Lower thresholds for public notification of exposures for all cases on other conveyances such as buses, taxis, etc. should be considered if close contacts cannot be identified.
• Since VOC’s are now the predominant strains, the public notice does not need to indicate that a VOC was identified.

Documentation
• VOC screen positives will be documented in the epi marker “Further Differentiation” in PHIMS, and will display in the disease event table under Epi Markers. Epi Markers are also displayed on the investigation search report.
• When genome sequencing is completed, the epi marker “WGS Pattern” will be used to record the VOC or VOI type, and will similarly display in the disease event table.
**Summary Table of Guidelines for Case and Contact Management**

<table>
<thead>
<tr>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority is identification of contacts in high risk settings for transmission or severe disease (e.g. household, schools/daycares, workplaces, health and community care facilities, congregate settings, current cluster/outbreak settings.)</td>
</tr>
<tr>
<td>Cases must isolate for a minimum of 10 days – follow guidelines for removal of isolation precautions.</td>
</tr>
<tr>
<td>If source unknown in an outbreak, or in a high risk congregate setting (e.g. shelters, long term care facilities, corrections), consider implementing backward contact tracing where feasible to identify potential source, followed by forward contact tracing to identify additional contacts. Recommend testing of other individuals exposed to same source, or suspected source if not yet tested.</td>
</tr>
<tr>
<td>Public notification will be focused on outbreaks. Notification of exposures from individual cases in public settings will not occur routinely, but may occur at the discretion of public health for high risk exposures only.</td>
</tr>
<tr>
<td>Public facilities and public-facing businesses are not required to maintain lists of clients for contact tracing.</td>
</tr>
<tr>
<td>Active monitoring should occur 2-3 times during the isolation period (on notification, during period of isolation (may be missed in short quarantine periods), and to remove from isolation), with SMS used where possible to supplement calls.</td>
</tr>
</tbody>
</table>

**Schools/Child Care**

The following recommendations should be reviewed together with Appendix C.

Masks required for all students K-12, except where exempt. Masks can be removed when outdoors.

If a mask (non-medical or medical) is worn by all in class/cohort, there will be no routine self-isolation (quarantine) of classroom contacts. Enhanced preventative classroom/school measures (e.g. ensure attention to consistent mask use (masks mandatory to continue to attend for 14 days – if exempt from using a mask, ensure 2 M physical distancing from other students is in place), physical distancing as much as possible, avoid higher risk group activities, optimize ventilation) is recommended for 14 days after identification of a case. Close contacts who have not worn masks will be identified by the school or case.

If 1 or 2 unlinked cases in the class/cohort, notify the school, school to send notification letter, and recommend attention to preventative measures to reduce transmission within the classroom (as listed above). Monitor for further cases. Public health will identify close contacts from the case investigation, which may or may not include students. If other sources of acquisition are more likely and good prevention measures in the school are in place, students (excluding the case[s] and confirmed close contacts) may continue to attend with enhanced preventative measures in place.
If ≥ 3 cases in a classroom/cohort within 14 days, public health assessment of transmission risk is required to determine most likely source of acquisition. If the most likely acquisition is not in-school, continue above measures. If an outbreak is suspected (see outbreak definitions), follow guidance below.

For grades K-6:
- If in-school transmission suspected, a 10 day period of self-isolation (quarantine) and remote learning for the class/cohort will be required if ongoing in-class transmission is suspected. Exception in place for self-isolation (quarantine) and remote learning for students with recent infection (i.e. within the previous 6 months).

For grades 7-12:
- A 10 day period of self-isolation (quarantine) and remote learning for all students not fully immunized or recently infected (i.e. within the previous 6 months) in the exposed class(es) will be recommended if ongoing in-class transmission is suspected.

If further cases are identified, public health will determine the most likely source of acquisition for the new cases, reassess the overall situation and recommend further actions. In the event of an outbreak that includes fully immunized or recently infected (i.e. within the previous 6 months) close contacts, public health may also require fully immunized or recently infected close contacts to self-isolate (quarantine).

Self-isolation (quarantine) with remote learning for a classroom/cohort will occur for 10 days and will not be routinely extended, unless there are exceptional circumstances with high transmission rates. Students and staff should follow close contact guidance for self-isolation (quarantine) and testing. Anyone in the school who is symptomatic should isolate and get tested.

Classes and cohorts will be managed individually and remote learning not applied at the school level, unless there is evidence of a widespread outbreak in the school. If exposures are isolated to a class within a cohort, self-isolation (quarantine) with remote learning should be applied at the class level and not extended to the full cohort, unless indicated based on exposures.

Mass closures of schools are not anticipated in 2021-22, and will be targeted to respond to local situations, primarily at the classroom/cohort level. Periods of remote learning may also be required by the school as a result of staff shortages during periods of high respiratory disease activity.

**Symptomatic people, regardless of immunization status (as per screening tool)**
If sick, isolate and get tested as per current guidelines. If not tested stay home for 10 days and until symptoms have resolved for 24 hours.
Contacts

**Self-isolation (quarantine)** – recommended for all high risk contacts, unless exempt, for 10 days. Continue to self-monitor for symptoms for an additional 4 days.

**Close Contacts** include:

- Anyone within 2M/6ft for 10 minutes cumulative without use of appropriate personal protective equipment (PPE). In schools / child care settings, both non-medical and medical masks are considered appropriate PPE. In all other settings, non-medical masks are not considered appropriate PPE. If uncertain on time, consider a close contact.

- All household members of a case are considered close contacts, unless otherwise exempt, regardless of measures used by the case to isolate within the home, unless in a separate and independent suite.

- Anyone with potential direct contact with infectious body fluids (without the appropriate use of recommended PPE), or providing care for a case without PPE.

Focus on identifying contacts in higher risk settings (risk based on severe outcomes or risk of ongoing transmission) – i.e. household, schools/daycares (following school contact management), workplaces, health and community care facilities, congregate settings, current cluster/outbreak settings.

For other settings, identify contacts with interactions within 2 M/6 ft for ≥ 10 min without appropriate PPE.

Unidentified contacts in public settings will not be notified unless there is an active outbreak occurring (e.g. restaurants, movie theatres, etc.). Transmission settings with significant prolonged exposures without appropriate PPE, or higher risk of transmission (e.g. gyms, singing, large events) should be documented in PHIMS to monitor for outbreak activity, even if contacts cannot be identified. Factors to consider in transmission risk include:

- Use of PPE
- Duration of the exposure (e.g., a longer exposure time likely increases the risk)
- The case’s symptom severity (coughing or severe illness likely increases transmission risk)
- Exposures in high-risk settings, e.g. daycares and health care, or where there is interaction with those at the extremes of age, who are immune compromised, or at risk of severe outcomes.

All eligible unimmunized contacts should receive an active offer to be immunized. Regional public health should develop a strategy on how to offer vaccine to all eligible contacts. Vaccine should be administered when the self-isolation (quarantine) period is over to minimize risk of exposure to immunizer.
Lab Testing

Asymptomatic close contacts should be tested at 7 days after the last exposure to the case.

Testing is also recommended for anyone with symptoms. If a close contact has symptoms compatible with COVID-19 and is not tested, they will be considered a probable case.

- In PHIMS, organizations will close the contact investigation after amending the disposition to “Contact turned to case” (refer to COVID QRC 7.19I) and create a case investigation with classification “Case-Probable” (refer to QRC 7.4c)

Testing may be recommended on notification for certain high risk settings such as congregate shelters to facilitate case identification and contact management.

Self-Isolation (Quarantine)

Self-isolation (quarantine) is recommended for all high risk contacts, unless exempt, for 10 days following the last exposure to the case. Followed by an additional 4 days of self-monitoring for symptoms.

If case isolates in the home:

- If the case is unable to isolate from household contacts: All household close contacts, who are not otherwise exempt from self-isolation (quarantine), must also self-isolate (quarantine) for the same period (minimum 10 days) as the positive case, and must self-isolate (quarantine) for a further 10 days to ensure the virus was not transmitted in the final days of the case’s isolation. If subsequent cases are identified in the household, this may result in a longer self-isolation (quarantine) period for household close contacts. Encourage the use of AIA and separate isolation spaces for younger contacts who are not eligible for immunization to avoid prolonged disruptions to in-class learning.

- If the case is able to isolate from household contacts (e.g. separate living space and washroom and no shared space or close contact with other household members): All household close contacts must self-isolate (quarantine) for 10 days following the last exposure to the case. Testing is strongly recommended at day 7, but not required to remove from self-isolation (quarantine).

If case does not isolate in the home: All close contacts must self-isolate (quarantine) for 10 days from the last exposure to the case.

Active monitoring should occur 2-3 times for all close contacts (on notification, during period of self-isolation (quarantine), and to remove from self-isolation (quarantine)), including recommendations for testing at day 7 if they remain asymptomatic and if symptoms develop.
Household members of a Close Contact

Household members of close contacts who are asymptomatic do not need to self-isolate (quarantine) if the close contact remains asymptomatic. It is recommended that household members wear a mask and physically distance where possible when outside the household in these circumstances, and avoid leaving the home for non-essential reasons.

This messaging is recommended to alert the household members that they are at increased risk of exposure based on sharing a household with a self-isolating (quarantining) individual and reinforce adherence to strict public health prevention measures.

If the close contact becomes symptomatic, all household members who are not otherwise exempt from self-isolation (quarantine), should self-isolate (quarantine) until the symptomatic individual’s test result is available.
If a close contact has symptoms compatible with COVID-19 and is **not tested**, they will be considered a probable case, and household members will be considered close contacts and must self-isolate (quarantine) unless exempt.

Household members of symptomatic individuals (based on screening tool symptom assessment and **not** identified as a close contact) do not need to self-isolate (quarantine) while awaiting the symptomatic individuals’ test result. It is recommended that household members wear a mask and physically distance where possible when outside the household in these circumstances, and avoid leaving the home for non-essential reasons.

This messaging is recommended to alert the household members that they are at increased risk of exposure based on sharing a household with a symptomatic individual and reinforce adherence to strict public health prevention measures.

Recommendations for household members may change if COVID-19 activity increases either regionally or provincially.

**Exemptions From Self-Isolation (Quarantine)**

Exemptions for household members from self-isolation (quarantine) are allowed if the household member is asymptomatic and:

- fully immunized (i.e. it has been at least two weeks since their last dose of the vaccine series) at the time of the exposure, **AND**
  - do not have a medical condition (e.g. immunocompromised) that would impact vaccine effectiveness, **OR**
- recently infected (i.e. within the previous 6 months)

All household members exempt from self-isolation (quarantine), should self-monitor for symptoms for 14 days, isolate immediately if any develop, and go for testing. If they remain asymptomatic, it is recommended that they wear a mask in indoor public settings for 14 days to avoid potential exposures to others.
APPENDIX J: Flight Manifest Request Process

Key terms:

**Flight Manifest (FM)** – a list of all passengers who travelled on a flight and the seat that the passenger was assigned.

**Passenger Name Record (PNR)** – a document that provides information provided by the traveller when booking the travel, such as email address, phone number and sometimes, home address. If the travel is booked by a travel agent, the travel agent’s information is provided. The PNR can be used in conjunction with the manifest to identify and locate travellers.

In Manitoba, Medical Officers of Health (MOH) can request flight manifests and passenger name records directly from airlines in order to facilitate contact tracing of individual international, domestic and inter-provincial air travellers/flight crew who may have been exposed to a confirmed case of COVID-19 on a flight\(^\text{24}\). Manitoba Health CDC MOH’s can assist with the request as required.

The decision to access the flight manifest is based on a risk assessment conducted by the Medical Officer of Health.

**Note:** The Public Health MOHs should copy the Public Health Agency of Canada’s Interjurisdictional Notices team at phac.ijn-nij.aspc@canada.ca, and Manitoba Epidemiology and Surveillance at epiCOVID@gov.mb.ca in their request to the airlines.

The following process is intended to guide Manitoba Public Health and Medical Officers of Health as designated requestors, in accessing the Airline flight manifest and Passenger Name Records to assist in the contact tracing process.

Please keep in mind:

1. Some airlines, particularly those that are headquartered outside of Canada, do not have a counter at certain airports, and/or do not operate 24/7.
2. Airlines rarely provide flight manifest for flights that have landed outside of Canada. Should this manifest be necessary for contact tracing and follow-up: it should be facilitated by the Public Health Agency of Canada’s Interjurisdictional Notices team at phac.ijn-nij.aspc@canada.ca. The province or territory (P/T) where the flight either landed (or originated) should be the requestor. If Manitoba is not the requestor but we have knowledge that Manitoba will be implicated, Manitoba should communicate with the requesting P/T to ensure information needs are met.

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\(^{24}\) For flights which did not terminate in Canada but for which a Canadian jurisdiction is aware that a case of COVID-19 travelled, the specifics of the flight (airline, flight number, origin and destination cities, and seat number of the case) should be conveyed to PHAC via the Health Portfolio Operations Centre. PHAC will transmit this information to the appropriate countries via the International Health Regulations National Focal Point.
The flow chart below outlines the steps to access the flight manifest from Airlines for Public Health purposes.

Designated Public Health requestor/Medical Officer of Health identifies the need for Airline Flight Manifest (AFM) and/or Passenger Name Record (PNR) and initiates a request for AFM/PNR.

Designated Public Health requestor/Medical Officer of Health completes the AFM request letter template

E-mail the completed AFM letter to the Airline designated representative (see Airline contact information list). **Subject line:** COVID-19 Flight Manifest request. **Copy** MHSC Epi& surveillance at epiCOVID@gov.mb.ca and the Public Health Agency of Canada’s Inter-jurisdictional Notices team at phac.ijn-nij.aspc@canada.ca on request to airlines.

Airline receives request form and emails the corresponding airline flight manifest(s)/personal name record/airplane cabin layout, and copy of the letter request form to the requestor, with copy to Epidemiology and Surveillance Unit at epiCOVID@gov.mb.ca

**Note:** For government email, options for file transfer in requests for Manifests include, otherwise the file may be blocked by the firewall:
- Excel or other files without encryption
- PDF files with encryption if encryption is required per policy of airlines (regional recipients may not have same limitations and may be able to receive other file types)

Region receives the AFM/PNR.
NOTES:

- Public health will generally request flight manifests only for those flights that originate or arrive in Manitoba, as there is limited ability to confirm client information or contact information for flights outside of Manitoba.

- For exposures on flights that do not originate or arrive in Manitoba, regions should send details of the case and flight information, including seat details, to Epi and Surveillance. Epi and Surveillance will notify the jurisdiction where the flight originated/arrived, and that jurisdiction will determine if further follow-up will occur. Manitoba may or may not be asked to facilitate the request for the flight manifests of out of province flights.

- Epi and Surveillance would also communicate bilaterally with other P/Ts when residents of other P/Ts are identified as contacts of the case on the flight manifest requested by Manitoba.

- For international flights, or clients who are contacts and known to be non-residents of Canada, Epi and Surveillance provides, via the Public Health Agency of Canada’s Inter-jurisdictional Notices team at phac.ijn-nij.aspca@canada.ca, the flight information or information available on any travellers non-resident in Canada who were seated in the zone of concern (2 metre radius) so that PHAC can make the appropriate international notifications. This information should be shared to ensure confidentiality (e.g., password protected file).

- Re: Crew members - regional public health communicates with the crew members to advise them of the exposure on the flight, providing information about risk and public health measures indicated.

- If the crew members reside outside of Manitoba jurisdiction, PHN advises the crew members that the relevant authorities in their home province will be advised of the exposure and the crew members’ contact details will be shared with their home province’s PH authority for follow up.

- If relevant, regional public health forwards to Epi and Surveillance to share the contact details of the crew with the P/T in which the crew resides, for their follow-up. Individuals identified on the flight manifest for follow-up should be entered in PHIMS as known contacts (or unknown contacts if unable to identify) to the case, with the disposition reflecting whether the contact was notified.

2021-10-22
APPENDIX K: Enforcement of COVID-19 PH Orders; Regional PHN and PHI roles

Enforcement approaches disproportionately impact BIPOC (black, indigenous and people of colour) populations and those who face homelessness or mental health issues. In addition, data from the WRHA continues to show that individuals in the lowest income quintiles continue to experience a more significant COVID-19 burden. Consequently, this process considers these disproportionate impacts and ethical questions and is therefore not focused on clients experiencing barriers to isolating/ self-isolating (quarantining). Rather, the focus is on those intentionally not cooperating with the requirements of the Order. This process systematically elevates uncooperative cases fully capable of meeting requirements and posing substantial risk to a compliance strategy.

Regional PHN role

Cases/ contacts referred to provincial call center for regular monitoring and f/u

- **Successful** - no further action
- **Unsuccessful** - Unable to connect with case/contact refer back to region for f/u. Call centre will try two times before referring back to the regions

Unsuccessful calls to cases/ contacts referred back to regions for f/u. Regional staff attempt connect with cases/ contacts

- **Successful** - no further action
- **Unsuccessful** - assign PHN for f/u

Regional PHN attempts first via call, and if unsuccessful via text, email, social media, etc. Last resort is a door stop (home visit)

- **Successful** - Regional PHN able to connect and case/contact is cooperative. No further action
- **Unsuccessful** - Unable to contact, or case/contact unwilling to work with PH. Review case with CD Coordinator and regional MOH, looking at risk factors, time remaining in isolation/self-isolation period. Consider escalating to PHIs.
Additional considerations –

- Differentiate between **hard to reach** clients from those who are **unwilling to work** with PH. Only those unwilling to work with PH should be considered for escalation using an enforcement approach (Note: PHIs expected to still consider education before issuance of ticket).
  - Often inability to reach cases/contacts relates to equity issues (i.e. not having access to a phone).
  - Cases/contacts who are initially unwilling to work with PHN, often come around by the second call and cooperate. PHN often try various approaches to reach the unwilling case/contact. PHN will work with cases/clients to identify and address barriers that may make self-isolation/isolation difficult (i.e. food security, housing, etc.).
  - Where cases are unwilling to isolate, door stop visits by PHNs are not an encouraged intervention. PHI involvement considered here once all efforts of engagement have failed.
- Caller ID display recently changed to state ‘Manitoba Health/Public Health’ should improve ability to reach cases/contacts.
- When reviewing cases regionally are there general criteria whereby referral to PHIs would not be considered (i.e. minimal time remaining in isolation/self-isolation period, preliminary risk assessment)?
- Call centers have a standardized process to refer cases back to regional PH for follow-up. Consideration to refer cases back more quickly to ensure response before conclusion of isolation/self-isolation periods.
**PHI role**

**Cases referred from regional PH:**

1. PHIs receive referral from regional MOH/CD Coordinator regarding case/contact not following self-isolation/isolation requirement and unwilling to work with PH.
2. Regional PH provides PHIs with pertinent information (i.e., name, home address, work address, isolation/self-isolation date range).
3. PHIs connect with case/contact. Confirm they understand need to isolate/self-isolate; confirm if barriers exist; inquire if they have left home since direction provided; provide education (including fines); advise future visits are possible; allow for questions.
4. PHIs provide summary of discussions to regional MOH and manager flagging any barriers and cooperation level. Determine if further follow up, warning or ticket is required.

**Note:** If proceeding to ticket, letter of confirmation of self-isolation requirement from the MOH is required and to be included in court brief.
Cases received from the public by the Health Protection Unit (HPU):

HPU receives complaint from the public of a case/contact not isolating/self-isolating

Regional managers provide case/contact information to regional MOH for review and decision for PHI investigation.

PHIs collect information and review with regional manager and regional MOH. If decision to proceed with enforcement, witness statement from complainant required.

Note: If proceeding to ticket, letter of confirmation of self-isolation requirement from the MOH is required and to be included in court brief.
Process for Isolation checks on Cases and Contacts where VCC has been unsuccessful in reaching via phone or text.

VCC unable to reach case/contact

Update intervention follow-up disposition to display in Axway report – unsuccessful – follow up required
*Cases/contacts who have missed calls for 2+ days may be the priority for follow-up

HPU downloads data daily, assigns lists to PHIs to visit homes with addresses

Unsuccessful PHI leaves letter

Successful PHI speaks to cases/contacts – Change in symptoms, may require medical assistance. Call ambulance if in distress or advise to call health care provider or Health Links-Info Sante for assistance in accessing care.

Successful PHI speaks to cases/contacts – client understands the need to answer calls. No change in symptoms.

Unsuccessful unable to reach contact. HPU to enter intervention follow-up in PHIMS.

Make 2nd attempt for cases
Unsuccessful unable to reach case –
• If other people in household, no further follow-up required.
• If unknown if living alone, contact PHN/CD coordinator to check for additional information in PHIMS or eChart (e.g. if hospitalized) or confirm if lives alone.
• If lives alone, PHI to escalate for wellness check (e.g. community police)
• HPU to enter intervention follow-up in PHIMS