

Interim Guidance Public Health  
Measures

*Managing Novel Coronavirus (COVID-19)  
Cases and Contacts in Community*

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## Summary of Changes

### January 19, 2021

- Updates to Public Health Case and Contact Management -
  - impacts of vaccination status
  - risk assessment
  - alternative contact management strategies
  - backwards contact tracing
- Updates to Process for Notification and Posting of Affected Flights with COVID-19 Cases
- Notification Process for Individuals Demonstrating Intent to Travel while in Isolation
- Minor update to surveillance definitions
- Revised Appendix C – Process for investigating COVID-19 cases in school/ child care setting
- Addition of Appendix H – Supports for Community Members

### December 8, 2020

- Guidance for discontinuation of isolation in community for cases discharged from hospital
- Minor updates to Laboratory Testing – Specimen types
- Updates to Public Health Management of Cases - Individuals who were previously a case
- Updates to Public Health Management of Contacts - Laboratory testing of asymptomatic newborns
- Addition to Appendix F – Abbott Panbio™ COVID-19 Antigen Rapid Testing

### November 24, 2020

- Minor updates on Reporting Cases and Contacts – Guidance on notifying other jurisdictions of a case’s exposures (either acquisition or transmission events)

### November 21, 2020

- Guidance on public health management of a contact who was previously a case
- Update on testing strategies for PCH outbreaks
- Minor updates on Appendix C – School process, including updates to letters on active monitoring and contact notification.
- Addition of Appendix D – Role of the Chief Occupational Medical Officer
- Addition of Appendix E – Updates to notification process for Department of Families
- Addition of Appendix F – Guidance on use of rapid detection tests

### November 4, 2020

- Changes to asymptomatic period of time required (now 24 hours) before discontinuing isolation for health care workers

## 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<sup>1</sup>. 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%).<sup>2</sup>

Current case numbers can be found on the Johns Hopkins coronavirus website ([www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6](http://www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6))

## 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

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

<sup>2</sup> Hui, D. S., Azhar, E., Madania, T. A. et al 2020. Continuing COVID-19 epidemic threat of novel coronavirus to global health – the latest 2019 novel coronavirus outbreak in Wuhan, China. *International Journal of Infectious Diseases*, 91; 264-266 ([https://www.ijidonline.com/article/S1201-9712\(20\)30011-4/fulltext](https://www.ijidonline.com/article/S1201-9712(20)30011-4/fulltext)).

control triage. For current screening and testing advice, please refer to [https://manitoba.ca/asset\\_library/en/coronavirus/screening\\_tool.pdf](https://manitoba.ca/asset_library/en/coronavirus/screening_tool.pdf)

### **Suspect case –**

A person with symptoms that include two or more of:

- Fever (signs of fever)
- Cough (new or exacerbated chronic)
- Sore throat
- Runny nose
- Headache, **AND**

Meets the exposure criteria **OR**

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

- has a fever (> 38°C), **AND/OR**
- has new onset of (or exacerbation of chronic) cough or difficulty breathing, **AND**
- meets exposure criteria, **AND**
- for whom laboratory diagnosis of COVID-19 is:
  - inconclusive (inconclusive is defined as a positive test on a single real-time PCR target or a positive test with an assay that has limited performance data available),
    - NAATs must be validated for detection of the virus that causes COVID-19.
    - 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 (LOC) 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 with initial indeterminate result.
  - Any case classified as probable based on an epidemiological link, which subsequently tests negative/not detected for the SARS-CoV-2 virus should no longer be classified as a case. Exceptions may be made for negatives on a compromised sample or if NAAT testing is delayed (e.g. >10-14 days following symptom onset), whereby such persons remain as probable cases.

### **OR**

- A (un-tested) person with:

- Fever (over 38 degrees Celsius), **AND/OR**
- Cough (new or exacerbated chronic); **AND**
- Close contact<sup>3</sup> with a confirmed case of COVID-19, **OR**
- Lived in or worked in a closed facility known to be experiencing an outbreak of COVID-19 (e.g., long-term care facility, correctional facility)

**Confirmed case** – A person with

- laboratory confirmation of infection with the virus that causes COVID-19 performed at a community, hospital or reference laboratory (NML or a provincial public health laboratory) running a validated assay, or performed in a community facility with approved point of care testing (e.g. GeneXpert). This consists of detection of at least one specific gene target by a NAAT assay (e.g. real-time PCR or nucleic acid sequencing).

*Note:*

- *nucleic acid amplification tests must be validated for detection of the virus that causes COVID-19. Positive laboratory tests during early stages of testing (e.g. first 10 positive tests) at a non-reference laboratory require additional testing at a reference laboratory for confirmation.*
- *laboratory tests are evolving for this emerging pathogen, and laboratory testing recommendations will change accordingly as new assays are developed and validated.*

**Exposure Criteria:**

In the 14 days before onset of illness, a person who:

- Traveled to an affected area (including inside Canada). OR
- Participated in a mass gathering identified as a source of exposure (e.g., conference) OR
- Close contact with a person with acute respiratory illness who has been to an affected area within 14 days prior to their illness onset OR
- Laboratory exposure to biological material (e.g. primary clinical specimens, virus culture isolates) known to contain COVID-19.

Factors that raise the index of suspicion should also be considered. Other exposure scenarios not specifically mentioned here may arise and may be considered (e.g. history of being a patient in the same ward or facility during a nosocomial outbreak of COVID-19).

## Laboratory Testing

- 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.

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<sup>3</sup> A close contact is defined as a person who provided care for the patient, including healthcare workers, family members or other caregivers, or who had other similar close physical contact or who lived with or otherwise had close prolonged contact with a probable or confirmed case while the case was ill. Prolonged exposure is defined as lasting for more than 15 minutes

- Rapid testing for COVID-19 with point-of-care test kits has the potential to increase testing capacity; however, current data suggests that these methods are less sensitive than the current RT-PCR assays. Refer to APPENDIX F: Interim Guidance on the Use of Rapid Detection Tests for further guidance on the use of point of care tests.
- 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.
- Serological testing to investigate immune response to COVID-19 infection is not yet available for clinical use in Manitoba. Serological assays have been developed to detect the host antibody response to COVID-19. At this time, serological assays can only determine past exposure to COVID-19. Given the variable test performance and the uncertainty of true disease prevalence, caution needs to be taken when interpreting results from serological assays. There is no current role for serologic tests in case and contact management.
- 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 [protocol on microbiological investigation of emerging respiratory pathogens, including severe acute respiratory infections](#).<sup>4,5</sup>

## Contact Definitions

***Period of communicability***<sup>6</sup> - 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.

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<sup>4</sup> Respiratory Virus Infections Working Group. Canadian Public Health Laboratory Network Best Practices for COVID-19. Can Commun Dis Rep 2020; 46(5):113–20. [Accessed June 1, 2020] <https://www.canada.ca/en/public-health/services/reports-publications/canada-communicable-disease-report-ccdr/monthly-issue/2020-46/issue-5-may-7-2020/covid-19-health-professional-cphln.html>

<sup>5</sup> Respiratory Virus Infections Working Group. The Canadian Public Health Laboratory Network protocol for microbiological investigations of emerging respiratory pathogens, including severe acute respiratory infections. Can Commun Dis Rep 2020; 46(6):205–9. [Accessed June 4, 2020] <https://doi.org/10.14745/ccdr.v46i06a09>

<sup>6</sup> 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.

**Discontinuing home isolation:** An individual who has been placed on home isolation can stop home isolation 10<sup>7</sup> 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. 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.** Decisions on discontinuing isolation should be made in conjunction with the case's health care providers, 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>

- For cases that are discharged from hospital, who did not require ICU admission for COVID-19 management 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>

**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

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<sup>7</sup> 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.

- 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 15 minutes, cumulative.*

## 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).

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:
  - Household social and economic circumstances such as insecurity, violence or abuse;
  - 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);
  - 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.
  - 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;

- 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<sup>8</sup>. **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 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)<sup>9</sup> for 14 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.

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<sup>8</sup> WHO. Home care for patients with suspected novel coronavirus (nCoV) infection presenting with mild symptoms and management of contacts. [Online] 4 February 2020. [Accessed on 7 February 2020] [https://www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-\(ncov\)-infection-presenting-with-mild-symptoms-and-management-of-contacts](https://www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-(ncov)-infection-presenting-with-mild-symptoms-and-management-of-contacts)

<sup>9</sup> 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.

**Alternative Isolation Accommodations** 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. Further information is available at <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**.

- 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 is recommended to occur three times during the isolation period. Follow-up monitoring 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. Priority should be given to the final call to remove cases from isolation if capacity does not allow multiple calls during the isolation period. 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 using the following criteria:

- For symptomatic cases:
  - at least 10 days have passed since onset of first symptom,
  - the case did not require hospitalization,
  - the case is afebrile and has improved clinically,
  - absence of cough is not required for those known to have chronic cough or for those who are experiencing reactive airways post infection,
  - loss of taste or smell can persist after the period of communicability so on their own are not reasons for continuing isolation.
- For asymptomatic cases:
  - at least 10 days have passed since the specimen collection date of the confirmatory laboratory sample.
- In general, repeat laboratory testing (i.e., a negative test result) as the basis for discontinuing home isolation is not recommended.
- 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 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 additional 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.

- 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.
- 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.

## 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> For aerosol-generating medical procedures<sup>10</sup> (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>
- Medical equipment should be cleaned, disinfected or sterilized in accordance with routine practices.

### ***Caregivers and others sharing the living environment***

- If direct contact care must be provided, the case should wear a surgical/procedure mask and follow respiratory etiquette.

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<sup>10</sup> 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>

- 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.
- 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.
  - <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/clinical-management-covid-19.html>
- HCWs providing care for a case should follow relevant guidance developed for infection prevention and control including Routine Practices and Additional Precautions<sup>11,12</sup>, and COVID-19-specific infection prevention and control (IPC) guidance<sup>13</sup>. 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:

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<sup>11</sup> Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings [Online] September 2017 [Accessed on 30 March 2020] <https://www.canada.ca/en/public-health/services/publications/diseases-conditions/routine-practices-precautions-healthcare-associated-infections.html>

<sup>12</sup> <https://sharedhealthmb.ca/covid19/providers/>

<sup>13</sup> PHAC. Infection prevention and control for novel coronavirus (2019-nCoV): Interim guidance for acute healthcare settings. [Online] February 24, 2020. [Accessed April 5, 2020] <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/interim-guidance-acute-healthcare-settings.html>

**Part A: Prior testing**

- 1) The deceased did not have a NP swab positive for COVID-19 prior to death  
OR
- 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. Based on our understanding of other human coronaviruses, individuals appear to be susceptible to reinfection around 3 months after initial infection. However, reinfection with SARS-CoV-2 has been reported less than two months after the initial infection. 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 considered carefully.

### **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 three 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 three 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 three 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 three 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 three 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 three 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 three months or more since they were determined to be a confirmed or probable case, they should self-isolate (quarantine) for 14 days from their last exposure. Should they develop symptoms of COVID-19, the individual must isolate and should go for testing.

## 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 is not possible
- 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.

All recommendations for contacts of COVID-19 cases apply regardless of vaccination status or vaccine rollout progress. This content will be updated as needed based on new evidence regarding vaccine effectiveness and coverage.

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 managed as a case, but should continue to self-isolate (quarantine) until 14 days from last exposure since they are still a contact of a case. 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 14 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 contacts who remain asymptomatic 5 to 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 14 days from last exposure. Additional laboratory testing should be advised if the contact subsequently develops symptoms. If positive, the contact should be managed as a 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.

Active monitoring for close contacts is recommended to occur a minimum of three times during the self-isolation (quarantine) period. Active monitoring should occur on notification (around day 4-5), at the end of self-isolation (day 14), and once around day 10 to monitor for development of symptoms, 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.

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<sup>14</sup>.

See additional resources which include:

- The Temperature Self-Monitoring form  
[https://manitoba.ca/asset\\_library/en/coronavirus/temperature.pdf](https://manitoba.ca/asset_library/en/coronavirus/temperature.pdf)
- The Novel Coronavirus Screening Tool for Public Health and Health Links  
[https://manitoba.ca/asset\\_library/en/coronavirus/screening\\_tool.pdf](https://manitoba.ca/asset_library/en/coronavirus/screening_tool.pdf)

<b>Table 1. Categories of contacts by exposure risk level</b>			
<b>Risk Level</b>	<b>Description of Risk Level <sup>15</sup></b>	<b>Isolation Level/ Contact actions</b>	<b>Public health authority (PHA) actions</b>
<b>High</b>	<p><b>1) Close contact(s) of a case:</b></p> <ul style="list-style-type: none"> <li>• <u>provided direct care</u> for the case (including health care workers, family members or other caregivers), or who had other similar close physical contact (e.g. intimate partner) <b>without consistent and appropriate use of recommended personal protective equipment, OR</b></li> <li>• who <u>lived with or otherwise had close prolonged</u><sup>16</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Self-isolate (quarantine)<sup>18</sup> at home for 14 days from last unprotected exposure</li> <li>• Follow good respiratory etiquette and hand hygiene practices.</li> <li>• Self-monitor for the appearance of symptoms consistent with COVID-19.</li> <li>• 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; if</li> </ul>	<ul style="list-style-type: none"> <li>• Active monitoring of contacts for symptoms. Refer to the Temperature Self-Monitoring Form for specific guidelines.</li> </ul>

<sup>14</sup> Adapted from Public Health Ontario. At-a-Glance Risk Levels and Precautions for COVID-19. February 2020.

<sup>15</sup> 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).

<sup>16</sup> 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 15 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 15 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.

<sup>18</sup> 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.

	<p><u>contact</u> (within 2 metres) with a case up to 48 hours prior to symptom onset or while the case was symptomatic and not isolating, <b>OR</b></p> <ul style="list-style-type: none"> <li>• had direct contact with infectious body fluids of a case (e.g., was coughed or sneezed on) without the appropriate use of recommended personal protective equipment,</li> <li>• Anyone who has shared an indoor space (e.g., same room) with a case for a prolonged period of time including closed spaces, crowded places, or settings where close interactions may occur (e.g., social gatherings, workplaces, etc.), without adhering to appropriate individual-level and setting-specific risk mitigation measures.<sup>17</sup></li> </ul> <p>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), without adhering to appropriate individual-level</p>	<p>these medications must be taken, advise public health.</p> <ul style="list-style-type: none"> <li>• Follow measures outlined in COVID-19 self-isolation factsheet.</li> <li>• Isolate within the home setting as quickly as possible should symptoms develop, and contact Health Links or public health for further direction, which will include: <ul style="list-style-type: none"> <li>○ where to go for care,</li> <li>○ appropriate mode of transportation to use, and</li> <li>○ IPC precautions to be followed. Instruct to wear a surgical/procedure mask if attending a health care facility. 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.</li> </ul> </li> <li>• Avoid close contact with those who are at risk for developing more severe disease or outcomes from COVID-19.</li> <li>• 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.</li> </ul>	
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<sup>17</sup> 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.

	and setting-specific risk mitigation measures. <sup>17</sup>		
<b>Low Risk Exposure</b>	<ul style="list-style-type: none"> <li>• HCW who provided direct care for the case, or a laboratory worker handling COVID-19 specimens, <b>with consistent and appropriate use of personal protective equipment and infection prevention and control practices OR</b></li> <li>• 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.<sup>17</sup></li> <li>• 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.<sup>17</sup></li> </ul>	<p><b>Self-monitor</b> for symptoms for 14 days following their last contact.</p> <p>Follow actions recommended for the entire population.</p> <ol style="list-style-type: none"> <li>a. Self-isolation (quarantine) is not required.</li> <li>b. Isolate as quickly as possible should symptoms develop, and contact Health Links or public health for further direction, which will include: <ul style="list-style-type: none"> <li>• where to go for care,</li> <li>• appropriate mode of transportation to use, and</li> <li>• 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.</li> </ul> </li> <li>c. Avoid close contact with individuals at higher risk for severe illness</li> </ol>	<ul style="list-style-type: none"> <li>• No active monitoring</li> </ul>
<b>Minimal/No risk</b>	<ol style="list-style-type: none"> <li>1) <u>Only transient interactions</u> (e.g., walking by the case or being briefly in the same room) or unknown but possible transient interaction due to the occurrence of local community transmission</li> </ol>	<ul style="list-style-type: none"> <li>• Follow actions recommended for the entire population</li> <li>• No monitoring required</li> </ul>	<ul style="list-style-type: none"> <li>• Provide community level information</li> <li>• Provide individual advice, if required</li> </ul>

### ***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. In addition, domestic travellers from outside Manitoba may also be recommended to self-isolate (quarantine) for 14 days if arriving from a destination that is not excluded by current Public Health Orders. Travellers should:

- Follow good respiratory etiquette and hand hygiene practices.
- Wear a non-medical mask or face covering while travelling to the place of 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:
  - 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 Order, asymptomatic 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](#).

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
- 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.

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>.

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.

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 10 days from the appearance of symptoms (as per the [Mandatory Isolation Order](#)). 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.

Manitoba has a monitoring program in place along with other provinces and territories to identify new COVID-19 variants in Canada. All international travellers should be tested for COVID-19 immediately upon arrival in Manitoba, regardless of if they are displaying symptoms, and whether they are visiting Manitoba or are returning from out of the country. 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 country and share the location of travel. They should also be tested again after seven days if their previous test was negative, even if still asymptomatic. International travellers need to observe the full 14-day self-isolation (quarantine) period regardless of symptoms and test results. The recommendation for testing on day 0 and 7 after arrival includes those who are exempt from the self-isolation (quarantine) order, but these individuals do not need to self-isolate (quarantine), even while waiting for test results, assuming they remain asymptomatic and their test result is negative. 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.

### ***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](mailto: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.aspc@canada.ca](mailto:phac.cns-snc.aspc@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 14 days after the last exposure.

- 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 14 day 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 14 days 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 14 days after the last exposure.

**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 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 or been exposed to a case, they should continue to self-isolate (quarantine) for the remainder of the 14-day period.

### ***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, the Public Health Agency of Canada's Interjurisdictional Notices team can assist in obtaining a flight manifest; however, it should be noted that flight manifests are not kept indefinitely and do not contain contact information on all travellers. Public health may be required to provide a letter citing their authorities under the Public Health Act in order to obtain the manifest. 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
- 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.

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.iijn-nij.aspc@canada.ca](mailto:phac.iijn-nij.aspc@canada.ca)); this information is posted on PHAC's central website.

### **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 PHIMS** for transmission events that require public posting through routine surveillance processes (flag will be the instructions for public posting), and monitor email notices.
2. **Email draft notice to region (CD coordinator) for confirmation.**
3. **Coordinate** with MHSAL Public Health and 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.  
[https://www.gov.mb.ca/health/publichealth/cdc/protocol/mhsu\\_0013.pdf](https://www.gov.mb.ca/health/publichealth/cdc/protocol/mhsu_0013.pdf)
- 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.
- If during the course of the investigation it is determined that there was either acquisition or transmission in another jurisdiction (e.g. other health region, province, or territory) this should be noted under the Exposures section of MHSU-6683 COVID-19 Case Investigation Form and 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.

### **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.

### **Surveillance Definitions:**

**Recovered:** A case is recovered 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.
- 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 proxys for classification: laboratory specimen collection date, laboratory testing date or reported date. If case is lost to follow up or is missing required information for classifying as resolved, the case can be classified as resolved at least 20 days after the initial report.

#### **Fatal:**

##### **Death due to 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). There should be no period of complete recovery\* from COVID-19 between illness and death.

##### **Death not due to COVID-19:**

A death in an active COVID-19 case with an alternative cause of death that cannot be related to COVID disease (e.g., trauma).

\*note “recovery” in this context means no residual effects or complications from COVID-19, and does not refer to the status of “recovered”, which refers to clients who are off isolation precautions and are no longer considered infectious.

#### **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.

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.

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.<sup>19</sup>

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<sup>19</sup> WHO. Global surveillance for COVID-19 caused by human infection with COVID-19 virus Interim guidance. [Online] 20 March 2020. Accessed on April 7, 2020. [https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-\(2019-ncov\)](https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-(2019-ncov))

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.<sup>20</sup>

### **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.

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<sup>20</sup> 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

With no targeted therapies or vaccine currently available, 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;
- 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 or 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.

For high risk settings, a single case of COVID-19 in a resident, staff, or volunteer is considered an outbreak. High risk settings include: personal care homes, health-care facilities, correctional centres and shelters. The case must have worked or resided at the facility during the period of communicability.

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>.

## 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. As a result, one case in a PCH facility warrants immediate outbreak procedures to be in place.

- 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.
  - Mass sampling of all residents and staff is not routinely recommended, and has the potential to overwhelm testing capacity. 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 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.

## 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).
- 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.
- 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 and Manitoba Families have a directory as well as a Smart sheet for after-hours contacts 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 verify potential exposures/ close contacts in the classroom/cohort during case's period of communicability. 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.
- 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 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 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.
  - If the situation is evolving and the extent of contact is thought to be broad, regional public health may also recommend that the facility be closed for 24 hours to allow for a more detailed investigation of the situation. Further communication can then be

- provided the next day based on the results of the investigation. Communication to the school body can be done by school officials based on public health guidance. It is anticipated that this will not be required in most situations, but may assist with more complex investigations involving multiple cases or multiple cohorts.
- 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 to ensure they receive active monitoring from the call center and have an opportunity to ask general questions.
- 7) 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.
  - 8) 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 data collection and reporting for cases in schools.
  - 9) If public health identifies an outbreak in a school or child care facility, notify Communication Services Manitoba and the Department of Education or Families, for a public posting on the Pandemic Response System. For definition of an outbreak, refer to Appendix B.
    - 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.
  - 10) PHIMS documentation should include the school/ child care facility as a transmission exposure, 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).
  - 11) 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:

- 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.

## 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)

- 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](mailto: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; and unknown acquisition; 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:

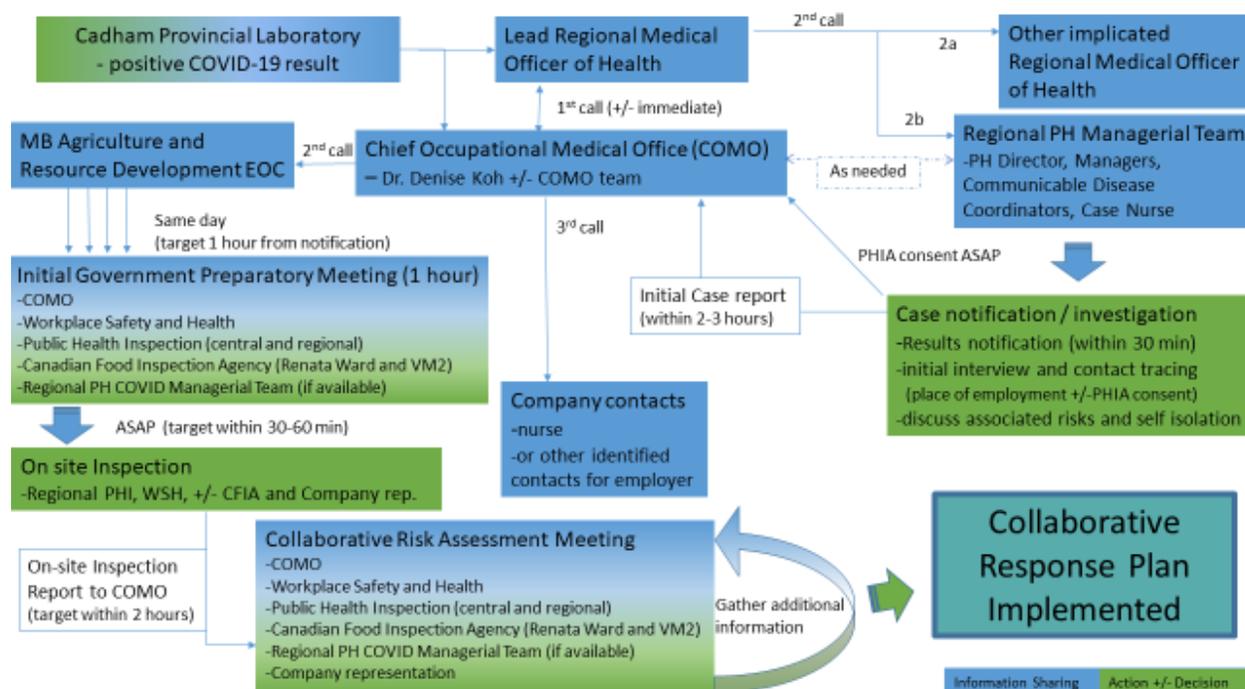
- Case identifiers (e.g. limited to DOB; work cohort; gender etc.)
- Consents to share information
- Last day worked
- Shift hours worked

- 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

## 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 15 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.

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 14 days 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) 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](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,

## 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: Interim Guidance on the Use of Rapid Detection Tests

### Abbott ID NOW™ Testing

Abbott ID NOW™ COVID-19 assay has been approved by Health Canada under emergency authorization use as a diagnostic test for the rapid detection of SARS-CoV-2

Based on the limited data and the concerns regarding its reduced sensitivity, the following guidelines are to be followed when considering who to test with the Abbott ID NOW™ COVID-19 assay.

- Can only be used for **symptomatic** people early in the course of illness (within 7 days of symptom onset).
- Recommended for use in a high prevalence setting to optimize the test's sensitivity.
- To support urgent decision-making in high-risk settings, and in remote and isolated areas where turn around time for tests is longer with transportation delays. In addition, it may be useful for decision making in high consequence settings such as shelters.

At this time, given the limited data on the performance characteristics of the Abbott ID NOW™ COVID-19 assay, all individuals who are offered this test should have **two swabs** collected. A mid-nasal turbinate swab for the Abbott ID NOW™ COVID-19 assay and a nasopharyngeal swab either for the GeneXpert or to be sent to the public health laboratory or its designate for nucleic acid amplification test (NAAT). **Regardless of the results from the Abbott ID NOW™ COVID-19 assay, send both swabs to the public health laboratory (i.e. this includes the used swab).**

#### Positive Results:

A positive result from the Abbott ID NOW™ COVID-19 assay can be treated as a positive and should be reported to the Public Health Surveillance Unit as lab probable.

#### Negative Results:

**A negative result should only be treated as a presumptive negative.** A negative result should not be used as the sole basis for patient management decision, and should not alter any clinical pathways or patient disposition recommendations (e.g. isolation) that would have been recommended if this rapid test was not available.

If test result is **negative**:

- Advise the individual the following:
  - They have tested negative, but this is a **presumptive** result. This means that the result needs to be checked with another test. They must continue to isolate at home until the second test result is available.

- Send both swabs to the public health laboratory and include documentation of the result from the ID NOW™ COVID-19 Assay.

**Do not use the Abbott ID NOW™ COVID-19 assay for asymptomatic testing except under the consultation of public health medical microbiology.** There are ongoing considerations by public health regarding expanding the criteria of use for the Abbott ID NOW™ COVID-19 assay. As such, this guidance may change in the future to reflect this.

### **Abbott Panbio™ COVID-19 Antigen Rapid Testing**

Abbott Panbio™ COVID-19 antigen rapid test has been approved by Health Canada under emergency authorization use as a diagnostic test for the rapid detection of SARS-CoV-2.

Based on limited data, antigen tests appear to have lower sensitivity compared to molecular-based tests. The relative ease of performing this test allows it to be used outside of a laboratory setting, but the test must still be performed by a trained medical professional. Given its reduced sensitivity, the following guidelines are to be followed when considering whom to test with the Abbott Panbio™ COVID-19 antigen rapid test.

- **Symptomatic** people early in the course of illness (testing sensitivity most optimal in the first 5 to 7 days of symptom).
- Recommended for use in a high prevalence setting to optimize the test's sensitivity.
- To support urgent decision-making in high-risk settings, and in remote and isolated areas where turn around time for tests is longer with transportation delays and if other, more sensitive, molecular-based tests are not available.
- In addition, it may be useful for decision-making in high consequence settings such as shelters.
- Can be used for repeated testing as surveillance in high-risk settings where early detection is important to minimize the chance of spread in a vulnerable population (e.g. long term care facility) or in a setting where SARS-CoV-2 may more readily spread (e.g. corrections facility). Individuals who qualify for surveillance testing by rapid antigen test are asymptomatic and do not have known COVID-19 exposure (symptomatic persons and/or those with known COVID-19 exposures should be isolating/quarantining and should seek conventional testing if required). Repeated testing theoretically helps mitigate the lower sensitivity.

**Except in the setting of repeated testing for surveillance, the Abbott Panbio™ COVID-19 antigen rapid test should only be used for symptomatic individuals.** There are ongoing considerations by public health regarding expanding the criteria of use for the Abbott Panbio™ COVID-19 antigen rapid test. As such, this guidance may change in the future to reflect this.

### **Panbio™ COVID-19 Antigen Rapid Test on Symptomatic Individuals:**

At this time, given the limited data on the performance characteristics of the Abbott Panbio™ COVID-19 antigen rapid tests, all symptomatic individuals who are offered this test should have

**two swabs** collected. A nasopharyngeal swab for the Abbott Panbio™ COVID-19 antigen rapid test and a nasopharyngeal swab for conventional nucleic acid amplification testing (NAAT). **Regardless of the results from the Abbott Panbio™ COVID-19 antigen rapid test, send both swabs to the public health laboratory (i.e. this includes the used swab) and include documentation of the Panbio™ COVID-19 antigen rapid test result.**

- **Positive results:**
  - Treat the result as positive and report to Public Health Surveillance Unit as lab probable.
  - Confirmatory testing to be done by public health laboratory or its designate, or if a GeneXpert is available and the individual meets criteria for testing by GeneXpert, this can be done instead.
- **Negative results:**
  - **Treat the result as presumptive negative.** A negative result should not be used as the sole basis for patient management decision, and should not alter any clinical pathways or patient disposition recommendations (e.g. isolation) that would have been recommended if this rapid test was not available.
  - **The individual must continue to isolate at home until the second test result is available.**
  - Confirmatory testing to be done by public health laboratory or its designate using conventional NAAT testing, which includes GeneXpert if available and if the individual meets criteria for testing by GeneXpert.

#### **Panbio™ COVID-19 Antigen Rapid Test for Surveillance:**

If the test is being performed on an individual for surveillance (i.e. they are asymptomatic and do not have known exposure to COVID-19) the following should occur:

- **Positive results:**
  - Treat the result as positive and report to Public Health Surveillance Unit as lab probable.
  - A repeat nasopharyngeal swab in viral transport media should be collected for confirmatory testing. Send both swabs (i.e. includes the used swab) to the public health laboratory and include documentation of the Panbio™ test result.
  - Confirmatory testing to be done by public health laboratory or its designate.
- **Negative results:**
  - **Treat the result as presumptive negative.** Reporting the individual's result into the health systems is not required, although sites will be asked to report daily volumes of tests performed.

As this test was done for surveillance, no confirmatory testing will be done. The individual can continue with their daily activities. They should continue to follow public health guidance regarding screening prior to leaving the house for work/school/other reasons, staying home when sick and going for COVID-19 testing, maintaining physical distancing, frequent hand hygiene, covering coughs, and wearing a mask when physical distancing is not possible or as required by public health orders.

## 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, iOS 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/>

Government of Canada / Gouvernement du Canada

COVID Alert Portal

Log in

Email address

Password

Log in

[Forgot your password?](#)

Only an authorized healthcare worker can use a portal account and give a COVID Alert key.

Thanks for your essential work

COVID Alert

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- 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 24 hours and cannot be re-issued

The screenshot shows the 'COVID Alert Portal' interface. At the top left is the Government of Canada logo. To its right are the links 'Your account', 'Log out', and 'Français'. Below the logo is the title 'COVID Alert Portal'. A navigation bar contains 'Start', 'Manage team', and 'Contact us'. The main heading is 'Generate a one-time key'. Below this, it says 'Check that the patient:' followed by a numbered list of four instructions. A yellow callout box contains a note about generating keys for real patients. At the bottom is a 'Generate key' button.

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[Your account](#) [Log out](#) [Français](#)

**COVID Alert Portal**

[Start](#) [Manage team](#) [Contact us](#)

## 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**:
[Your account](#) [Log out](#) [Français](#)

## COVID Alert Portal

[Start](#) [Manage team](#) [Contact us](#)

### 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

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

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 14 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.

New patient

- 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:



Government  
of Canada

Gouvernement  
du Canada

[Your account](#)

[Log out](#)

[Français](#)

### COVID Alert Portal

[Start](#) [Manage team](#) [Contact us](#)

## Quick guide to the portal

### Part of the COVID Alert system

The COVID Alert Portal is part of the system behind Canada's free exposure notification app, [COVID Alert](#).

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

**EXAMPLE ONLY.**

**NOT A VALID**

**ONE-TIME KEY.**

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](#).

[Contact us](#) [Quick guide](#) [Privacy](#) [Terms of use](#)

Canada 

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 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.

Resource	Details	Contact information
<b><u>General Resources</u></b>		
Manitoba 211	211 Manitoba is a searchable online database of government, health, and social services that are available across the province.	Visit: <a href="https://mb.211.ca/">https://mb.211.ca/</a> Call: 211
Help Next Door MB	Service connects volunteers with individual needs. Must have internet access and email address to sign up and create an account.	Visit: <a href="https://helpnextdoormb.ca/">https://helpnextdoormb.ca/</a>
<b><u>Food Delivery Options</u></b>		
For clients with financial means, it may be useful to know which grocery stores deliver in your community area.		
<b>Winnipeg Harvest</b> Only under these circumstances are Harvest to be contacted: <ul style="list-style-type: none"> <li>Client is isolating because they are COVID-19 positive, a close contact, or waiting for test results.</li> <li>Client has no neighbours, friends or relatives who can pick up and drop off groceries or hamper</li> </ul>	Harvest will arrange one time delivery of emergency food hamper that is estimated to last 10-14 days.  *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.	PHN to FAX <b>204.775.4180</b> ATTENTION DEB SWEREDA ONLY with the following information: Client name Address with postal code Phone number <b>6 digit health card number</b> Family composition (how many kids and ages) Any additional comments (apartment, house, drop off point, etc.)  <b>*Please do not ask client to initiate this service.</b>

<b>For seniors 55+:</b> 311 Food Security Line	Resources available through Age & Opportunity Support Services for Seniors.	Client calls 311 and indicate need help with food delivery. They will then be connected with the services provided through A&O.
<b>Meal Delivery for isolating cases and contacts in single resident occupancy (SRO) hotels or rooming houses.</b> 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 meal provision: <ul style="list-style-type: none"> <li>• One fully cooked fresh meal that includes instructions on how to reheat multiple ways (and can be eaten cold).</li> <li>• Prepared food items for breakfast and lunch.</li> </ul>	Meal packages will be delivered once a day during isolation period by Sscope.	PHN to email Tiana <a href="mailto:tianna.sscope@gmail.com">tianna.sscope@gmail.com</a> with the following: Indicate new client for meal delivery (DO NOT provide name) Address/name of hotel <b>Your phone number</b> for Tiana to call back and obtain additional identifying information. <b>*Please do not ask clients to initiate this service.</b>
<b><u>Access to income and benefits</u></b>		
Community Financial Helpline	This service answers questions from community members living on low incomes about: <ul style="list-style-type: none"> <li>• Tax filing</li> <li>• Obtaining identification</li> <li>• Income supports (such as CERB, EIA, EI, OAS, CPP, and CPP-D)</li> </ul>	Client calls or texts 431-813-4357 (431-813-HELP) or toll free 1-855-955-4234 (1-855-955-4CFH)

	<ul style="list-style-type: none"> <li>Benefits and credits such as the Canada Child Benefit, and debt management and credit counselling.</li> </ul>	
Government of Canada – Service Canada	<p>The Government of Canada has made temporary changes to the <a href="#">Employment Insurance</a> (EI) program and new benefits are available:</p> <ul style="list-style-type: none"> <li><a href="#">Canada Recovery Benefit</a></li> <li><a href="#">Canada Recovery Sickness Benefit</a></li> <li><a href="#">Canada Recovery Caregiving Benefit</a></li> </ul>	<p>For a complete list of programs, services and resources available through the Government of Canada visit:  <a href="https://www.canada.ca/coronavirus">Canada.ca/coronavirus</a>  Clients can also answer questions directly here to determine eligibility visit:  <a href="https://covid-benefits.alpha.canada.ca/en/start">https://covid-benefits.alpha.canada.ca/en/start</a></p>
Government of Canada - Employment Insurance (EI)	<p>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.</p>	<p>Client visits:  <a href="https://www.canada.ca/coronavirus">Canada.ca/coronavirus</a>  Only if no internet, clients call 1-800-206-7218</p>
Canada Recovery Benefit (CRB)	<p>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 COVID-19, and who are not eligible for Employment Insurance (EI).</p>	<p>Client visits:  <a href="https://www.canada.ca/coronavirus">Canada.ca/coronavirus</a>  Only if no internet, Clients call 1-833-966-2099</p>
Canada Recovery Sickness Benefit (CRSB)	<p>The CRSB provides \$500 per week for up to a maximum of two weeks, for workers who:</p> <ul style="list-style-type: none"> <li>Are unable to work for at least 50% of the week because they contracted COVID-19</li> <li>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.</li> </ul>	<p>Client visits:  <a href="https://www.canada.ca/coronavirus">Canada.ca/coronavirus</a>  Only if no internet, Clients call 1-833-966-2099</p>
Canada Recovery Caregiving Benefit (CRCB)	<p>The CRCB provides \$500 per week for up to 26 weeks per household for workers:</p>	<p>Client visits:  <a href="https://www.canada.ca/coronavirus">Canada.ca/coronavirus</a>  Only if no internet, Clients call: 1-833-966-2099</p>

	<ul style="list-style-type: none"> <li>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, day-cares or care facilities are closed due to COVID-19</li> <li>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.</li> </ul>	
<b>Mental Health Supports</b>		
Government of Manitoba – Care for Your Mental Health	A summary of Manitoba resources is available online.	Clients visit: <a href="http://www.manitoba.ca/covid19/bewell/index.html">http://www.manitoba.ca/covid19/bewell/index.html</a>
AbilitiCBT	Digital therapy program available to all Manitobans experiencing low to mild symptoms of anxiety due to the pandemic.	Clients visit: <a href="https://manitoba.abiliticbt.com/">https://manitoba.abiliticbt.com/</a>
Mental Health Virtual Therapy - Two-session virtual counselling	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.	Clients call toll free 1-844-218-2955 and the virtual counselling sessions can be by video or telephone, as preferred.
Anxiety Disorders Association of Manitoba (ADAM)	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. 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.	Clients email <a href="mailto:adam@adam.mb.ca">adam@adam.mb.ca</a> or phone 204-925-0600 for more information.
Klinik Crisis Line	Klinik offers a variety of crisis phone lines and online support services, providing free and confidential counselling. For more information: <a href="http://klinik.mb.ca/crisis-support/">http://klinik.mb.ca/crisis-support/</a>	To access Klinik's crisis line clients call: 204-786-8686 or 1-888-322-3019 TTY 204-784-4097
Manitoba Suicide Prevention & Support Line	Klinik offers this 24/7 confidential telephone support service for people at risk of suicide, concerned family / friends, those who have	Clients call 1-877-435-7170 (1-877-HELP170)

	lost a loved one to suicide, and service providers / helpers	
Sara Riel's Seneca Warm Line	This is a telephone support service between the hours of 7:00 pm and 11:00 pm. 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 ensure assistance to as many callers as possible.	Clients call 204-942-9276
First Nations and Inuit Hope for Wellness Help Line	Counselling available in English and French - upon request, in Cree, Ojibway, and Inuktitut.	Clients call 1-855-242-3310
Kids Help Phone	This national phone line available to Manitoba Youth (generally 16 years and younger)	1-800-668-6868
Inspire Community Outreach	Inspire provides COVID-19 supports and information for families members and caregivers of those living with mental health issues and neurological/cognitive differences.	Clients visit: <a href="https://inspirecommunityoutreach.ca/covid-19/">https://inspirecommunityoutreach.ca/covid-19/</a>
Canadian Mental Health Association (CMHA)	This is a resource list page with resources/supports for clients. The Service Navigation Hub supports Manitobans find the best type of care or service to match their needs: <a href="https://mbwpg.cmha.ca/programs-services/snh/">https://mbwpg.cmha.ca/programs-services/snh/</a>	Visit: <a href="https://cmha.ca/news/covid-19-and-mental-health">https://cmha.ca/news/covid-19-and-mental-health</a> Call a navigation specialist at 204-775-6442
<b>Domestic Violence Supports</b>		
MB Government - Family Violence Prevention Program & Domestic Violence Support Service	Family Violence Prevention Program: <a href="https://www.manitoba.ca/familyviolence">https://www.manitoba.ca/familyviolence</a> Domestic Violence Support Services: <a href="https://www.gov.mb.ca/justice/crown/victims/dvss.html">https://www.gov.mb.ca/justice/crown/victims/dvss.html</a> Map of community organizations that support individuals affected by domestic violence: <a href="https://www.gov.mb.ca/justice/crown/victims/pubs/resource_map.pdf">https://www.gov.mb.ca/justice/crown/victims/pubs/resource_map.pdf</a>	Clients can call toll free Province-Wide Domestic Abuse Crisis Line (24 hours) 1-877-977-0007 Or text 204-792-5302 or 204-805-6682