

Notification Timeline:**From Lab to Public Health:** Within 1 business day**Practitioner/Institution to Public Health¹:****Deceased:** Within 24 hours via [Notification Form](#).**From Public Health to Ministry of Health²:****Individual case reporting of deaths:** Within 1-2 business days**Outbreaks:** Initial report within 24 hours.

Updates as necessary.

Final report within 30 days of completing the investigation.

Public Health Follow-up Timeline:**Non-novel:** No follow-up required**Public Health Purposes for Notification of COVID-19**

- To ensure timely analysis of mortality caused by COVID-19;
- To take timely and evidence informed actions on outbreaks in high-risk settings; and
- To inform the public and medical community about COVID-19.

Table 1. Surveillance Case Definitions^{3,4} (Public Health Agency of Canada, updated December 17, 2021)

Confirmed Case	<p>A person with confirmation of infection with SARS-CoV-2 documented by:</p> <ul style="list-style-type: none"> • The detection of at least one specific gene target by a validated laboratory-based nucleic acid amplification test (NAAT) assay (e.g. real-time PCR or nucleic acid sequencing) performed at a community, hospital, or reference laboratory (the National Microbiology Laboratory or a provincial public health laboratory) <p>OR</p>
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¹ Local public health is encouraged to collaborate with their partners in ERs, long-term care facilities and hospitals to ensure all roles and responsibilities are well understood and agreed upon, specifically the timely reporting to public health of outbreaks and deaths associated with COVID-19.

² Notification via Panorama

³ Surveillance case definitions ensure uniform reporting to allow comparability of surveillance data. The definition is not intended to be used for clinical or laboratory diagnosis or management of cases.

⁴ Reinfection monitoring is based on the **Lab-based reinfection case definition**:

A previously confirmed case that has a subsequent infection of SARS-CoV-2 where there is laboratory evidence supporting two different infections, namely genome sequencing or variant of concern (VOC) screening PCR testing indicates two distinct SARS-CoV-2 infections. Genome sequencing indicating two distinct SARS-CoV-2 infections (they belong to different lineages OR to the same lineage but contain sufficient single nucleotide variants to support two different infections). NOTE – a viral lineage is a group of viruses defined by a founding variant and its descendants.

Or **Time-based reinfection case definition**:

A confirmed case that was previously classified as resolved that has a subsequent confirmed infection of SARS-CoV-2 at least 90 days after the previous infection using episode date AND does not meet the laboratory-based reinfection case definition.

	<ul style="list-style-type: none"> The detection of at least one specific gene target by a validated point-of-care (POC) NAAT^a that has been deemed acceptable to provide a final result (i.e. does not require confirmatory testing) <p>OR</p> <ul style="list-style-type: none"> Seroconversion or diagnostic rise (at least four-fold or greater from baseline) in viral specific antibody titre in serum or plasma using a validated laboratory-based serological assay for SARS-CoV-2
Probable⁵	<p>A person who:</p> <p>I. Has symptoms compatible with COVID-19</p> <p>AND</p> <ul style="list-style-type: none"> Had a high-risk exposure with a confirmed COVID-19 case (i.e. close contact) OR was exposed to a known cluster or outbreak of COVID-19 <p>AND</p> <ul style="list-style-type: none"> Has not had a laboratory-based NAAT assay for SARS-CoV-2 completed or the result is inconclusive^b <p>OR</p> <ul style="list-style-type: none"> Had SARS-CoV-2 antibodies detected in a single serum, plasma, or whole blood sample using a validated laboratory-based serological assay for SARS-CoV-2 collected within four weeks of symptom onset <p>II. Had a POC antigen test for SARS-CoV-2 completed and the result is positive (Refer to Table 2.)</p>
Deceased	<ul style="list-style-type: none"> A probable⁵ or confirmed COVID-19 case whose death resulted from a clinically compatible illness, unless there is a clear alternative cause of death identified (e.g., trauma, poisoning, drug overdose). A Medical Officer of Health, relevant public health authority, or coroner may use their discretion when determining if a death was due to COVID-19, and their judgement will supersede the above-mentioned criteria. A death can be attributed to COVID-19 when COVID-19 is the cause of death or is a contributing factor.
Outbreak	Two or more individuals with confirmed or probable COVID-19 for whom the MHO has determined that transmission likely occurred ⁶ within the high risk setting ⁷ .
<p>^a The only POC test in Saskatchewan deemed acceptable to provide final results is the Abbott ID NOW.</p> <p>^b Inconclusive is defined as an indeterminate test on a single or multiple NAAT target(s) without sequencing confirmation or a positive test with an assay that has limited performance data availability</p>	

⁵ The probable case definition should only be used for declaring outbreaks in high-risk settings. For quality assurance purposes, the rapid antigen test should be administered with oversight of a staff member or a health care provider.

⁶ Reasonable evidence that transmission likely occurred within a common non-household setting include:

- Close contact is confirmed with COVID-19 from 2 to 14 days following exposure;
- Individual with exposure to a setting where confirmed case was present and onset of symptoms consistent with incubation period of COVID-19;
- The individual has been located within a closed setting (e.g. admitted to hospital, residing at a work camp, correctional facility) for ≥ 7 days before symptom onset or date of specimen collection if asymptomatic;
- No obvious source of exposure other than at the setting.

⁷ High risk settings includes but are not limited to hospitals, long-term care and integrated facilities, personal care homes, correctional facilities, homeless shelters, group homes.

Source: Public Health Agency of Canada. (June 6, 2023). National case definition: Coronavirus Disease (COVID-19). Retrieved from: <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/national-case-definition.html>

Epidemiology and Occurrence

Understanding of COVID-19 infection patterns continues to evolve and we will likely continue to experience regular surges with some seasonal activity. Severe illness is more likely to occur in persons who are unimmunized or partially immunized and who are older, immunosuppressed or have co-morbidities. Vulnerable populations within Canada are at increased risk of acquiring SARS-CoV-2, may not access the healthcare system in traditional ways and appear to be at risk of more severe COVID-19. Reporting of comprehensive COVID-19 data in relation to race and ethnicity is currently limited in Saskatchewan and Canada.

Variants of Concern (VOC)

SARS-CoV-2 VOCs have been reported globally since December 2020⁸. The dominant variant will continue to shift. The National Microbiology Laboratory (NML) and Public Health Agency of Canada (PHAC) continue to monitor for variants with evidence of vaccine escape or increased severity.

Refer to [Saskatchewan.ca/coronavirus](https://saskatchewan.ca/coronavirus), [Public Health Agency of Canada \(PHAC\)](https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/national-case-definition.html) and [World Health Organization \(WHO\)](https://www.who.int/en/activities/tracking-SARS-CoV-2-variants/) for information.

Additional Background Information

Causative Agent

- COVID-19, caused by SARS-CoV-2, is the most recent of seven known strains of Coronavirus. Of the six others, four cause only minor respiratory symptoms similar to those of a cold, and two (severe acute respiratory syndrome [SARS-CoV-1] and Middle East respiratory syndrome [MERS-CoV]), have been associated with more serious and life-threatening diseases.
- Viruses such as SARS-CoV-2 naturally mutate over time. The majority of mutations do not change the characteristics of the virus.
- Some mutations, or combination of mutations, can impact disease characteristics in a meaningful way (e.g. increased transmissibility, increased severity of disease, or decreased effectiveness of therapeutics and vaccines), leading to designation as a VOC. Over time a VOC may become the dominant strain.

⁸ <https://www.who.int/en/activities/tracking-SARS-CoV-2-variants/>

Symptoms (Government of Canada⁹, 2022, July 18)

Symptoms can vary from person to person and by age group and can depend on the variant (e.g. approximately 30% of cases with Omicron were asymptomatic⁸).

Some of the more common symptoms include:

- Sore throat
- Rhinorrhea
- New or worsening cough
- Shortness of breath or difficulty breathing
- Fever – extremely variable
- Chills
- Fatigue and myalgia
- New loss of smell and/or taste
- Gastrointestinal symptoms (nausea, vomiting, diarrhea)

Symptoms among older adults (65 years of age and older) and those with underlying medical conditions may be atypical or subtle. Atypical symptoms that may present in older adults include delayed onset, delirium, confusion, falls, functional decline, decrease in blood pressure or hypoxia without respiratory symptoms.

Risk Factors for Fatal Outcomes

Risk factors associated with individual susceptibility to severe presentations include:

- Not being up-to-date with immunizations;
- Increasing age;
- Various co-morbidities have been reported among severe cases with varying frequencies. The top four include¹⁰:
 - Cardiac disease including hypertension;
 - Diabetes mellitus;
 - Lung disease (does not include asthma)
 - Obesity (BMI ≥ 30 kg/m²)
- Pregnant women also are reported to experience severe COVID.
- Other chronic or underlying medical conditions may also be associated with severe COVID (PHAC, June 2022) (e.g. cancer, immunosuppression).

⁹ <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/symptoms.html#s>

¹⁰ <https://nccid.ca/2019-novel-coronavirus-outbreak/#:~:text=The%20most%20common%20comorbidities%20found%20in%20people%20with%20COVID%2D19%20are%20shown%20in%20Table%202%3A>

Post-COVID conditions

<https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html>

People can experience a wide range of new, returning, or ongoing health problems more than four weeks after first being infected with the virus that causes COVID-19:

- **Multisystem inflammatory syndrome – Children (MIS-C)** is a condition characterized by hyper-inflammation and multi-organ involvement. Refer to <https://www.cdc.gov/mis/mis-c.html> for more details.
- **Multisystem Inflammatory Syndrome – Adults (MIS-A)**, similar in presentation as among children.
- **Post COVID-19 condition (Long COVID)** is when symptoms of COVID-19 persist for more than 12 weeks after the infection. Symptoms can be quite different from those during the initial infection and can vary in severity. They can disappear and reappear and may be exacerbated by physical or mental over-exertion (Government of Canada, 2023). <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/post-covid-19-condition.html>

Reservoir/Source

The report from the WHO-China Joint Mission on COVID (WHO, 2020) indicates COVID-19 is a zoonotic virus. Phylogenetic analyses suggest bats are the reservoir but the intermediate host(s) has not yet been identified.

Incubation Period

The incubation period for SARS-CoV-2 may differ depending on the VOC. Pre-Omicron, the incubation period ranged from 1-14 days with a median of 5-6 days. 97.5% of people developed symptoms within 11.5 days of exposure. (Public Health Agency of Canada, pre-publication Jun 6, 2022). Studies have shown the mean incubation period of Omicron was shorter (BA.1 was 2.5-4.6 days and BA.2 was 4.4 to 4.6 days).

Period of Communicability

Pre-Omicron, evidence generally indicated a person may be infectious for up to three days before showing symptoms (pre-symptomatic) with viral RNA levels appearing to be highest just before or after (2-3 days) symptom onset. Evidence for the Omicron variant suggests that infectious viral shedding may occur for three to six days after onset of symptoms. Those with severe illness or those who are immunocompromised are considered communicable for longer.

Mode of Transmission

SARS-CoV-2, the virus that causes COVID-19, spreads from an infected person to others through respiratory **droplets** ranging in size from large (that fall to the ground near the infected person within seconds or minutes) to smaller (sometimes called **aerosols**, which will remain suspended

in the air for a period of time). These infectious droplets or aerosols are created when an infected person breathes, talks coughs, sneezes, sings or shouts.

- These droplets or aerosols may come into direct contact with the mucous membranes of another person's nose, mouth or eyes, or they may be inhaled into their nose, mouth, airways and lungs.
- Poor ventilation may be a contributing factor. In closed environments, viral particles can accumulate in the air increasing the risk for transmission.
- Aerosol-generating medical procedures¹¹ pose higher levels of risk and require additional precautions.
- The virus may also spread via fomites, which is when a person touches another person (i.e., a handshake) or a surface or an object that has the virus on it, and then touches their mouth, nose or eyes with unwashed hands.
- There is limited epidemiological evidence to support SARS-CoV-2 transmission via fomites, compared to transmission via droplets ([National Collaborating Center of Environmental Health, 2021](#)).
- Zoonotic transmission associated with the COVID-19 has occurred, however, there is currently no evidence to suggest that animals, including companion animals or pets, play a role in the spread of COVID-19.

Lab Reports and Interpretation

Important considerations in interpreting test results include the type of test (i.e. NAAT vs. antigen), the sensitivity and specificity of the test, and the timing of the test relative to the clinical presentation.

Molecular Tests (i.e. nucleic acid amplification tests [NAAT], including reverse transcriptase polymerase chain reaction [RT-PCR]) are conducted using both laboratory-developed and commercial platforms on nasopharyngeal swabs, oral/throat swabs, and lower respiratory specimens (including bronchoalveolar lavage, bronchial wash, endotracheal tube suction, and sputum). In-lab NAAT tests are considered the gold standard for diagnosis, however, the overall clinical picture must be considered. Patient setting and clinical considerations will determine the most appropriate specimen type for this test.

¹¹ High-risk Aerosol-Generating Medical Procedure (AGMPs) needing negative pressure room placement: Intubation, BIPAP, CPAP, bronchoscopy, CPR with bag valve and mask.

Lower risk AGMPs, negative pressure room if available, otherwise private room with hard walls and door closed: Optiflow (for infectious patients only), nebulized therapy, open airway suctioning, sputum induction. NOTE: Nasopharyngeal swab is not considered an (AGMP).

Antigen Tests include self-administered rapid tests or Point of Care tests, may support timely access to testing, and may be most suitable for screening (e.g. high-risk congregate settings where testing can be repeated on the same individuals over time. Interpretation requires information about the timing of the collection in comparison to symptom onset.

Whole Genome Sequencing (WGS) is a genetic fingerprint to identify and monitor genetic mutations and variations, which will continue to grow and evolve. WGS is used to identify VOCs. PHAC's priority groups for WGS include hospitalized/severe cases under 50 years of age, travel-associated and reinfections.

Serologic tests detect antibodies that are produced in response to infection or vaccination; they do not detect the virus.

Table 2. Interpretation of Test Results (RRPL, 2023)

Type of Test	Test Result	Interpretation as per Case Definition	Comments
NAAT ¹	Positive	Confirmed	SARS-CoV-2 virus detected
	Negative	Not a Case	No SARS-CoV-2 virus detected
	Indeterminate	Probable	Virus may have been detected near the limit of detection of the test. Recommend recollection of new sample for repeat testing.
	Invalid	Does not meet case definition	Specimen failed Quality Control or exhibited non-specific amplification. Recommend recollection of new sample for repeat testing.
Antigen ²	Positive	Probable	If confirmation is needed, send specimen for NAAT
	Negative	Suspect or Not a Case, depending on test indication	No SARS-CoV-2 virus detected. Repeat testing may be indicated depending on indication for test
	Invalid	Does not meet case definition	Specimen failed Quality Control. Recommend recollection of new sample for repeat testing

¹ NAAT tests include all assays performed in SHA Laboratories as well as point of care Abbott ID NOW testing

²Antigen tests include those administered by HCWs and self-tests

Treatment/Supportive Therapy

Treatment for clinical management is at the discretion of the primary care provider. As of January 2022, Paxlovid has been approved for use by Health Canada.

Public Health Investigation

General information about self-management of cases and contacts is included under [Prevention Measures](#) for reference.

I. Case

NOTE – Investigation and reporting is required of all **deceased cases**.

History

A. Deceased - Refer to [Attachment – Notification of COVID-19 Death](#)

- Communication with the primary care provider may be required to determine the association of their COVID infection with their fatal outcome and underlying risk factors that may have predisposed the individual to the fatal outcome.
- Notify RRPL by email to RRPL.TypingandSurveillance@saskhealthauthority.ca to ensure WGS is performed for lineage determination.

II. Pandemic Measures

Local or provincial measures may be ordered for the purposes of preventing, reducing and controlling the transmission of SARS-CoV-2 – refer to *Disease Control Regulations* (Section 25.2).

General Prevention Measures

Prevention

- General guidance on personal preventive practices and community based measures can be found in the PHAC document [Summary of evidence supporting COVID-19 public health measures](#).

Surveillance

- Refer to the [Community Respiratory Illness Surveillance Program \(CRISP\) Section 2-220](#)

Immunization

- COVID-19 vaccines have been shown to be very effective at preventing severe disease, including hospitalization and death due to COVID-19 (Government of Canada, March 2023). Information can be found in the Saskatchewan COVID-19 Immunization Manual, <https://www.ehealthsask.ca/services/Manuals/Pages/COVID-19.aspx>.

Definitions:

- Primary vaccine series – receiving two doses of a two dose COVID-19 vaccine series (Pfizer, Moderna, Astra Zeneca) OR one dose of a single-dose COVID-19 immunization series (Janssen or Johnson and Johnson) administered in accordance with the approved minimum interval.

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- **Booster dose** – an additional dose of vaccine that helps maintain and lengthen the protection against severe outcomes of COVID-19 as immunity decreases over time. It is given after completion of a primary series (Immunize BC, Feb 2022). Additional booster doses may be available to high-risk individuals.
 - Vaccine performance against emerging SARS-CoV-2 variants is an important consideration when evaluating the need for prevention measures in vaccinated people and requires continued monitoring. When evaluating risk, considering regional and local circulation of SARS-CoV-2 variants is also relevant (U.S. Centers for Disease Control and Prevention, 2021)

Education

- Core public health measures are the foundation of public health practice to control respiratory viruses including COVID-19. These include staying home when ill, practicing good hand hygiene and respiratory etiquette and should be everyday practices. These measures should be reinforced routinely.
- Additional measures are related to physical distancing, wearing masks, avoiding non-essential travel. Individuals may choose to implement these measures based on their individual risk assessment.
- Inquiries from the public who self-report positive results can be advised as follows:

Self-Management Approaches

Case Exclusion and Isolation

- All cases should [self-isolate](#) in a suitable environment for at least 5 days and take additional precautions to reduce exposures for an additional 5 days (to day 10). In the case of individuals who are immunocompromised, the additional precautions should extend to day 20.
 - Avoid exposing individuals who have risk factors that put them at greater risk of complications (e.g. underlying chronic or immunocompromising conditions, or the elderly) and follow recommended personal preventive practices, wear a well-constructed and well-fitting non-medical mask when in shared spaces within the home and stay at least two meters apart.
 - Limit contact with pets and other animals and at a minimum practice good hand hygiene before and after touching animals, and their food/supplies, as well as good respiratory etiquette.
 - Individuals who are providing care of cases should take personal precautions in providing care including masking, distancing when possible and practice frequent hand hygiene.

Infection Prevention and Control Measures in a Home Environment

- Individuals should strive to reduce exposures with a case in their home by:
 - avoiding shared air spaces;
 - eliminating direct contact with the case or with their infectious fluids;
 - eliminating close range conversations with the case;

- eliminating use of shared items; and
- wearing masks when outside of room.

Contacts/Contact management

Exposed individuals should self-monitor for 10 days and if eligible for early treatment, should seek medical attention if they develop signs of illness.

Environment

- Proper ventilation of indoor settings is key in limiting transmission of COVID-19. Ventilation, airflow, air filtration and access to fresh air are important in reducing COVID-19 transmission in indoor spaces.
- Routine cleaning and disinfection of common high touch surfaces may help to reduce the presence of SARS-CoV-2 on environmental surfaces and the possibility of transmission.
- Routine [Cleaning and disinfecting](#), particularly of frequently touched surfaces, can kill viruses. Using water and regular household cleaning products or a diluted bleach solution (0.5% sodium hypochlorite) is sufficient.

Setting-Specific Control Measures¹²

Core public health measures should be reinforced routinely. These include staying home when ill, practicing good hand hygiene and respiratory etiquette and promoting adequate ventilation. Wearing a well-constructed and well-fitting non-medical mask is an added measure that individuals may choose to use or may be requested to be used by administration of various settings.

- **Home and co-living setting:** Clean frequently touched areas such as toilets, bedside tables, light switches and door handles on a regular basis. Use the same solution or an alcohol prep wipe to clean frequently touched electronics such as phones, computers and other devices.
- **Workplaces and other similar community settings:** Maintain cleaning and disinfecting policies.
- **Health Care settings:** Follow routine environmental cleaning procedures. For Long Term Care Facilities (LTC) - refer to [Response Guidance for Long Term Care Facilities](#).
- **Child care centres:** Maintain cleaning and disinfecting policies and refer to the [Saskatchewan Ministry of Health Infection Control Manual for Child Care Facilities](#).
- **Schools:** Maintain cleaning and disinfecting policies and refer to [Attachment – Approaches in Schools and Daycares](#) and [Reducing COVID-19 risk in community settings: A tool for operators](#)

¹² <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/guidance-documents/summary-evidence-supporting-covid-19-public-health-measures.html>

Revisions

Date	Change
June 23, 2023	<ul style="list-style-type: none"> - Updated Notification timelines Lab to public health to 1 business day. - Incorporated the updated PHAC Reinfection definition and moved it into a footnote where it is less prominent. - Removed outbreak section and added outbreak definition to surveillance definitions section. - Simplified all sections and updated incubation period based on Omicron studies - Combined “Interpretation of Lab Results” Tables 3A and 3B into one table. - Moved case and contact management details to General Prevention Measures section and reframed to self-management. - Archived and removed all Novel VOC details. - Created NEW Attachment – Notification of COVID-19 Deaths
May 25, 2023	<ul style="list-style-type: none"> - Removed requirement for Public Health to follow up on severe cases - Rearranged notification timelines to align with likelihood of frequency and adjusted notification from public health to Ministry of Health to 1-2 business days for deceased cases - Updated the Public Health Purpose for Notification to align with the removal of severe case investigations. - Updated footnote related to Novel VOC - Added statement to Footnote C of case definition table regarding viral lineage. - Removed severe case definition. - Minor update to language in incubation period - Rearranged case investigations: <ul style="list-style-type: none"> A. Deceased B. Novel VOC
December 5, 2022	<ul style="list-style-type: none"> - Updated Surveillance section to remove outdated details and replaced with link to Section 2-220 Community Respiratory Illness Surveillance Program (CRISP) - Revised language in Table 3A, Invalid test result is interpreted as does not meet case definition.
August 31, 2022	<ul style="list-style-type: none"> - Updated Public Health Purpose for Notification to focus on signals of changing in epidemiology; - Updated Epidemiology and Occurrence and VOC; - Removed dated references and language within causative agent; - Updated signs and symptoms to include more generalized language; - Added other Risk Factors associated with severity; - Added statement from World Health Organization regarding post-COVID

	<p>condition;</p> <ul style="list-style-type: none"> - Contact Definition – removed reference to fully vaccinated; - Setting-Specific Control Measures – added general statement regarding core and additional individual and community-based public health measures; - Revised Attachment – Approaches in Schools and Daycares; - Updated the objective of outbreak measures to shift focus to reduce severe outcomes rather than identify all cases and contacts; - Provided specificity that outbreak definition relates to high-risk settings; - Removed full immunized, partially immunized and unimmunized definitions related to immunization under Prevention; - Added bullets related to core and additional measures under Education; - Added new heading of Environmental Controls; - Updated References
<p>March 25, 2022</p>	<ul style="list-style-type: none"> - Added footnote for Immediate Notification of Novel VOC for better clarity; - Updated Risk factors for severe presentations by adding “does not include asthma” by the RF of lung disease; - Updated the priority groups identified for WGS when lab capacity is limited; - Provided better clarity of the focus of severe, deceases and Novel VOC investigations under Public Health Investigations - Included reference to new data collection worksheets - Novel VOC and Severe or Deceased that are under development and being finalized; - Added a table to cross-reference the criteria of severity with Panorama documentation of s/s to support severity indicator in Panorama; - Updated exclusion to provide clarity of minimum of 5 days isolation with continued measures for the entire period of communicability; - Removed reference to ASIS and Voluntary self-isolation site; - Removed reference to document “recovered” in Panorama in Table 4; - Updated Testing timelines for close contacts. - Outbreaks – defined high-risk settings that was previously included and removed in error; included considerations for declaring an outbreak over.
<p>February 4, 2022</p>	<p>Editorial updates (reference, etc) Updates to:</p> <ul style="list-style-type: none"> - Timeline for Notification and Reporting with focus on investigation and notification of severe cases, Novel VOCs and deaths. - Public Health Purpose for Notification - Probable case definition to include POC Antigen test in accordance with PHAC case definition; incorporated PHAC Reinfection definition. - Definition of severe. - Epidemiology and Occurrence – VOC - Risk Factors associated with Severe Presentations (additions included);

	<ul style="list-style-type: none"> - Post COVID Conditions - Incubation Period; Period of communicability - Lab Reports and Interpretation – removed reference to suspect, updated Antigen test <p>Significant changes to Public Health Management of Cases and Contact with a focus on severe cases, deceased cases and cases with a Novel VOC. Rearranged details related to health care workers and settings to Setting Specific Measures.</p> <p>Removed Suspect outbreak definition and outbreak definitions for non-household settings; updated confirmed outbreak definition. Removed details of vaccine effectiveness as the evidence is rapidly evolving.</p>
<p>December 30, 2021</p>	<p>Updated Epidemiology and Occurrence section (Variants of Concern) to include details of Omicron Variant</p> <p>Updates based on decreased isolation for cases who are fully vaccinated:</p> <ul style="list-style-type: none"> • Period of Communicability based on vaccination status • Cases Management – assessment include vaccination status • Table 4 - Criteria for discontinuing isolation – incorporated immunization status and if five or 10 days isolation accordingly <p>Updated Prevention Measures - Immunization to include information on Omicron vaccine effectiveness and details of the Saskatchewan COVID-19 vaccine booster program</p>
<p>December 8, 2021</p>	<ul style="list-style-type: none"> • Updated Lab Report and Interpretation section to include information on Omicron and introduction of a new SNP screen as an early indicator of this variant.
<p>November 25, 2021</p>	<ul style="list-style-type: none"> • Updated attachment – Approaches in Schools and Daycares 2021-22 School Year • Added references/links to the Attachment - approaches in Schools and Daycares where appropriate within the chapter itself • Operational immunity section – heading changed to Post-Infection Immunity and added statements regarding: <ul style="list-style-type: none"> ○ antigen test results are not anticipated to remain positive for extended periods of time following infection. ○ Post-infection immunity is not equivalent to immunity provided through immunization. Post-infection immunity does not replace a proof of vaccination where those policies are in place • II. Contacts/contact management <ul style="list-style-type: none"> ○ Included new section "Special considerations for children ineligible for

	<p>vaccination"</p> <ul style="list-style-type: none"> • IV. Setting-Specific control measures <ul style="list-style-type: none"> ○ Updated link to PHAC school guidance document "Planning for the 2021-2022 school year in the context of COVID-19 vaccination" • V. Outbreak measures <ul style="list-style-type: none"> ○ Updated outbreak criteria to include: An outbreak will be declared when three or more individuals are confirmed to be positive with COVID-19 in a classroom or cohort (e.g. sports team, bus route, club or other group) within 14 days and attended school while infectious • Attachment – Active Daily Monitoring Form for Contacts of a Case of COVID-19 removed as form no longer utilized
<p>October 1, 2021</p>	<ul style="list-style-type: none"> • Following template letters updated to reflect change to <i>Public Health Order Mandatory Isolation and Face Covering</i>, that unvaccinated pupils that are identified as a close contact of a household case will not be exempted from the requirement to isolate for 14 days. <ul style="list-style-type: none"> ○ Letter Template COVID-19 Notification to School Administrator ○ Letter Template Parents/Guardians ALERT in class ○ Letter Template COVID-19 Notification to Daycare Administrator ○ Letter Template Parents/Guardians ALERT of case in daycare
<p>September 23, 2021</p>	<ul style="list-style-type: none"> • Included new attachments (daycare template letters) <ul style="list-style-type: none"> ○ Letter Template COVID-19 Notification to Daycare Administrator ○ Letter Template Parents/Guardians ALERT in Daycare ○ Letter Template General Parents/Guardians Alert of Case in Daycare ○ Letter Template for COVID-19 Daycare Outbreak • Updated attachment – Approaches in Schools and Daycares 2021-22 School Year
<p>September 17, 2021</p>	<ul style="list-style-type: none"> • Updated attachment – Approaches in Schools and Daycares 2021-22 School Year • Removed COVID-19 Fact Sheet as this SHA document will be maintained by SHA and the link to this fact sheet has been added to the appropriate template letter • School template letters updated <ul style="list-style-type: none"> ○ COVID-19 Notification to School Administrator - Replaces the previous Notification to School Principal; references to "school principal" have been amended to the more broader term of "school administrator", recognizing that some areas are providing notification to an administrator at the school division; amendments to align with current Public Health Order; removed CC to CDC and OCMHO mailbox.

	<ul style="list-style-type: none"> ○ Parent alert – classroom - Added line to capture the date of last exposure "We have determined that the case was in attendance while communicable on <EXPOSURE DATES>"; amendments to align with current Public Health Order ○ Parent alert – school - Added line to capture the date of last exposure "We have determined that the case was in attendance while communicable on <EXPOSURE DATES>"; updated title of COVID fact sheet What you Need to Know About COVID-19 and included link to this SHA document ○ Outbreak declared - Added statement "When an outbreak has been declared, it is assumed that there is an ongoing risk of exposure within the school and a classroom notification may not be sent with each additional case in the school during the outbreak".
September 13, 2021	<ul style="list-style-type: none"> ● Included new Attachment – Approaches in Schools and Daycares 2021-2022 School Year
September 2, 2021	<ul style="list-style-type: none"> ● Alternative Contact Management Strategies section expanded to support direct identification and notification of close contacts by the case (pg 16) ● Contact assessment of immunization history now includes statement regarding the approved minimal interval i.e. individuals that received two doses without adhering to the approved minimum interval would be considered partially immunized. ● Testing recommendation for asymptomatic close contacts amended to advise testing after exposure, rather than "immediately and at day 10" ● Testing recommendation for fully vaccinated HCW amended to test after exposure, rather than "immediately and at day 10"? ● Table 6 removed statement "conduct a risk assessment for non-close contacts if feasible" ● Suspect outbreak definition updated to remove schools and high risk workplaces from list of high-risk settings
August 3, 2021	<ul style="list-style-type: none"> ● Notification timeline from Public Health to Ministry of Health has been updated to within 24 hours (page 1). ● Table 3B clarity added to Positive results to make clearer distinction made between Abbot ID Now and other POCTs with addition of "(Other POCTs)" to second row (page 12). ● Contact management <ul style="list-style-type: none"> ○ Exclusion and self-isolation (page 23). Language amended that close contacts that have been advised to self-isolate should do so for 14 days from their last exposure.

	<ul style="list-style-type: none"> ○ Testing (page 24). Clarity added for asymptomatic contacts. <ul style="list-style-type: none"> ▪ Testing of asymptomatic non-close contacts is not routinely required. ▪ Fully immunized individuals are not considered close contacts and should not routinely be tested if they are exposed. <ul style="list-style-type: none"> – The exception is asymptomatic fully immunized HCW who should still be tested following exposure and at day 10 after exposure; antigen testing is acceptable. ● Surveillance (page 31) <ul style="list-style-type: none"> ○ Statement added: Surveillance of COVID-like illness (CLI) from Emergency departments (EDs) - Upward trends in the number of visitors to EDs with CLI can be indicator of increased COVID activity in the community, particularly among those without a personal health care provider or those without access to their personal health provider. ● Template letters for case, close contacts, potential exposure to a group have been updated (attachments) <ul style="list-style-type: none"> ○ Per legal advice, language that has been amended is that the individual “should” rather than “must” take all precautions as advised by Public Health and all reasonable measures to reduce significantly the risk of infecting others. ○ Further detail has been added in regards to fully vaccinated visitors in the case and close contact letters
<p>July 12, 2021</p>	<ul style="list-style-type: none"> ● Public Health Purposes for Notification of COVID-19 revised ● Case definitions: <ul style="list-style-type: none"> ○ Suspect case definition removed ○ Probable case definition revised and positive antigen test removed to align with other jurisdictions and to adapt to antigen tests being deregulated in Saskatchewan. ● Symptoms updated and information on post COVID conditions added. ● Case management: <ul style="list-style-type: none"> ○ Active Daily monitoring no longer recommended ○ Amended monitoring, education, exclusion and isolation sections ○ Added details in monitoring, education and case preventive measures ● Contact management: <ul style="list-style-type: none"> ○ Contact definitions updated as PHAC definitions updated to include immunization information ○ Active daily monitoring no longer recommended ○ Amended assessment, monitoring, education, exclusion and isolation sections ○ Testing recommendations amended. Testing of non-close contacts no

	<p>longer required unless symptomatic.</p> <ul style="list-style-type: none"> ○ Amended Table 6 Public Health Management of Contacts based on Risk ● New section IV. High Risk Setting-Specific Control Measures created to replace information in previous pandemic measures section ● Outbreak definitions updated ● New attachments: <ul style="list-style-type: none"> ○ Template letter to COVID-19 case ○ Template letter to COVID-19 close contact ○ Template letter to Group exposed to a COVID-19 case
<p>June 15, 2021</p>	<ul style="list-style-type: none"> ● Updates to Lab Reports and Interpretation section (pages 8-12) <ul style="list-style-type: none"> ○ Molecular testing section amended to remove RRPL and RUH as only labs performing molecular testing ○ Added BD veritor antigen test to Table 3B ○ Included details of the new SNP assay used to identify the B.1.617 variant <ul style="list-style-type: none"> ▪ Whole genome sequencing (WGS) section amended to include updated SNP information and L452R mutation ▪ Table 3C updated with L452 mutation added ● Information on vaccine effectiveness added to immunization section (page 20-21) ● Updates to Contacts/Contact management section (pages 23-28) <ul style="list-style-type: none"> ○ Incorporated definitions and impacts of immunization with amendments to assessment, isolation and testing sections ○ Table 6 amended to added clarity of contact management based on unimmunized/partially immunized and fully immunized/symptomatic or /asymptomatic including assessment, isolation and testing ● Re-opening roadmap steps added (page 35) ● New attachment added for modified self isolation
<p>April 30, 2021</p>	<ul style="list-style-type: none"> ● Updated information on screening for VOC in Saskatchewan, recognizing current SNP assay in Saskatchewan detects the N501Y and E484K mutations (page 9). Table 3C updated. ● Provided better clarity into the Attachment - Exposure Risk Matrix reasons why PPE is only considered in work related exposures.
<p>April 16, 2021</p>	<ul style="list-style-type: none"> ● Inserted reference to the Voluntary Self Isolation Support Program (VSISP) (page 17) ● Amended link to SK Immunization Manual (page 20) ● Inserted additional info to Assessment section for HCWs (page 22) ● Clarification that all cases in SK are to be considered as VOC (page 23) and amended box on page 24 to reflect same

	<ul style="list-style-type: none"> • Additions to special considerations for HCW (page 26) • Revisions to workplace settings section (page 30)
April 6, 2021	<ul style="list-style-type: none"> • Removed Attachment - Risk Classification for HCWs with Potential Workplace Exposures to COVID-19 Cases in Healthcare Settings as this document updated and only applicable to Saskatchewan Health Authority (SHA) health care workers. SHA will house and maintain this document. <ul style="list-style-type: none"> ○ Removed links to Attachment in footnote 11 (pg. 21) and assessment section (pg. 22) and added links to PHAC guidance documents and SHA HCW risk classification.
March 30, 2021	<ul style="list-style-type: none"> • Updated information on whole genome sequencing and screening for VOC in Saskatchewan (pg. 10) • Updated Table 3C Table of SNP and WGS Result Possibilities and Comments (pg. 12) to provide further clarify on SNP per RRPL update March 29, 2021. Specifically, amended SNP (N501Y) report result of “N501Y: Potential Variant of Concern Identified” to “VOC, undetermined lineage” and included statement that positive results are considered final. • Amended section on exclusion and isolation of the case (pg. 16) to note increased transmissibility of the VOC and need for an appropriate mitigation plan. Added link to isolation considerations for household member of a VOC case. • Added link to the SIM in immunization section for further information (pg. 20) • Updated isolation/exclusion section of the contact and included isolation considerations for household members of a VOC positive case (pg. 23)
March 12, 2021	<ul style="list-style-type: none"> • Added additional information on variants of concern into additional background information – causative agent (page 4) • Added additional information on WGS and SNP (page 10) • Added new Table 3C - Table of SNP and WGS Result Possibilities and Comments (pg. 12) • Added details to Public Health Investigation – case regarding assessing for contacts and when backward tracing should be considered (pg. 15) • Included clarification under exclusion and isolation of the case that exposures in households cannot be eliminated but measures can reduce the extent of ongoing exposures (pg. 16) • Included clarification under exclusion and isolation of the contact that all household members of a case are considered close contacts due to the risk of exposure before diagnosis or symptom onset and the inability to eliminate

	<p>ongoing exposures in household settings (pg. 23)</p> <ul style="list-style-type: none"> • Added new testing recommendations for contacts (pg. 23 and Table 6): <ul style="list-style-type: none"> ○ Test all asymptomatic close contacts as soon as possible following exposure and at day 10 after exposure ○ Immediately test all non-close contacts; repeat testing if symptoms develop
February 11, 2021	<ul style="list-style-type: none"> • Updated the Case Definitions based on PHAC updated definitions. Added definition of Deceased. • Updated the symptoms information. • Added contextual information about impact of COVID in children from CPS (Treatment pg. 11) Included reference to Assisted Self-Isolation Sites (pg. 13) • Added reference to persistent symptoms • Updated incubation period reference • Updated period of communicability with new reference; provided explicit clarity on contact tracing periods for symptomatic and asymptomatic cases • Updated Mode of transmission with more scientific details. • Included reference to the COVID Alert App • Updated Risk Factors to include settings that are considered higher risk • Incorporated information on variants of concern and the surveillance plan within WGS. • Updated Table 3B to reflect confirmed classification via Abbott ID now test. • Reformatted history under Public Health Investigation pg. 17) • Added details to symptom monitoring (pg. 18) • Added referral to primary care provider • Added reference to ASIS and SIS • Refine purpose of contact managements (pg. 23) • Added information on alternative strategies for contact management • Updated Contact Definitions (Table 5) to align with updated PHAC guidance. • Included link to Exposure Risk Matrix as a new attachment • Provided reference to testing timeframe for symptomatic and asymptomatic contacts (pg. 27 and Table 6) • Updated Table 6 to align with PHAC contact management guideline • Added details for outbreak management including reporting suspect outbreaks and when suspect outbreaks are deemed not to be outbreaks. • Added details of outbreaks in school settings including the communication protocol • Added section on outbreaks in workplace settings (pg. 36)

	<ul style="list-style-type: none"> • Added Link to immunization information (pg. 39) • Updated references • Included criteria for when a suspect outbreak investigation can be considered closed (Table 7)
January 7, 2021	<ul style="list-style-type: none"> • Removed reference to the initial notification via e-mail template by 10am. • Updated Lab Reports and Interpretation section to include reference to point of care testing and antigen testing and interpretation of those test results. • Updated number of tables and figures and associated references throughout the chapter. • Updated the Criteria for Discontinuing case Isolation to include details of mild to moderate infection, severe immune compromised and severe illness and associated notes. • Included reference to acknowledge immunization for COVID-19 has begun in Saskatchewan and does not impact contact investigations at this time.
December 16, 2020	<ul style="list-style-type: none"> • Updated the Criteria for Discontinuing Case Isolation to 10 days from 14 days.
September 10, 2020	<ul style="list-style-type: none"> • Added new outbreak definitions Table 5 • Included reference to School Exposure Risk Matrix in Contact investigation • Included new attachments - template letters for cases/outbreaks in schools and School Exposure Risk Matrix
June 22, 2020	<ul style="list-style-type: none"> • Changed reference from multisystem inflammatory syndrome in children to Pediatric inflammatory multisystem syndrome (PIMS) (pg. 5) • Updated Daily Active Monitoring Attachment to align with symptoms update and included Attachments for Contact tracing (initial assessment and Contact tracing DCW) that align with the Go.data contact tracing application.
June 9, 2020	<ul style="list-style-type: none"> • Added loss of taste or smell to list of symptoms (pg. 4) • Added Multi-system inflammatory syndrome in children under signs and symptoms (pg. 4-5) • Introduced serologic testing to the Lab Reports and Interpretation (pg. 7) • Added graphic that displays timing of laboratory findings following exposure to COVID-19 (pg. 8) • Added section entitled Operational Immunity to provide context around the decision for managing re-exposure of recovered cases in the 3 months following recovery (pg. 8) • Added detail about investigating cases for acquisition attributed to a workplace exposure under History (pg. 10) and the requirement as per the Disease Control Regulations to report these instances to the Ministry of Labor under Referrals (pg. 11)

	<ul style="list-style-type: none"> Added reference to reporting obligations under the International Health Regulations (pg. Provided explicit detail of contact tracing period for asymptomatic contacts with no known exposure (i.e. 2 days before specimen collection date) (pg. 11) Added clarity to the meaning of diagnosis date in the Criteria for Discontinuing Isolation for asymptomatic cases by adding specimen collection date (pg. 12) Added bullet under Assessment of Contact Investigation about COVID-19 cases that have recovered <u>in the past 3 months</u> do not require public health follow-up if named as a contact (pg. 15). Updated Flight Protocol to include details to send to PHAC for international cases or contacts. Updated Contact tracing algorithm to include response to test results.
May 14, 2020	<ul style="list-style-type: none"> Updated timeline for reporting into Panorama to 11 a.m. (pg. 1) Added atypical signs and symptoms that may present in children, older adults and persons with developmental disabilities (pg. 4) Added details to incubation period based on unpublished PHAC data (pg. 5). Added details about source investigation when no known source can be found under section I. “Case Investigation – History” (pg. 8). Updated the Incubation and communicability graphic with additional details (Figure 1) Updated to align with PHAC guidance re: active daily monitoring of cases (pg. 9) Added a bullet regarding Education for cases about self-isolating in the home and in co-living settings as well as environmental cleaning in the home (pg. 9). Added reference to Health Care Worker Risk Assessment in Table 3). New addition “Attachment – Health Care Worker Risk Assessment.” Added a section specific to Health Care Workers (pg. 15) Added Outbreak Definitions (Table 5)
April 17, 2020	<ul style="list-style-type: none"> Added a visual to represent incubation and communicability (pg. 8) Added information about limiting contact with pets (pg. 11) Corrected reference from Table 4 to Table 3 in Assess for Contacts. Updated Close Contact definition in Table 3 to include “up to 48 hours prior to symptom onset”
April 15, 2020	<ul style="list-style-type: none"> Added reference to Canadian Clinical Management guidelines. Updated period of communicability to address asymptomatic and pre-symptomatic transmission. Included further details related to self-isolation. Included importance of recognizing and mitigating outbreaks in Long Term

	<p>Care facilities and added reference to the LTC Guidelines.</p> <ul style="list-style-type: none"> • Added definition of prolonged in contact definition. • Clarified self-isolation for non-close contacts following a negative test result • Incorporated contact tracing timelines for asymptomatic cases that have been lab confirmed. • Included Assessment under contact management to assess for level of risk. • Included a link to the Public Health Order that identifies exemptions for mandatory self-isolation following return to Canada.
April 3, 2020	<ul style="list-style-type: none"> • Case Definition - removed person under investigation, added suspect, updated probable to include epi-linked, changed lab criteria for confirmed case. • Updated transmission details based on updated scientific knowledge. • Removed reference to person under investigation throughout. • Updated contact-tracing period to up to 48 hours before symptom onset. • Updated definition of mass gathering to include public and private events of large and small sizes. • Updated the IPAC lifting criteria for hospitalized and residents in Long-term care.
March 21, 2020	<ul style="list-style-type: none"> • Updated process for notification to Ministry of Health. • Added RRPL to confirmed case definition as their testing now meets criteria. • Updated period of communicability based on mild symptoms and isolation requirements. • Added lab report interpretation in accordance with case classifications. • Updated exclusion based on Sask decision for 14 days post-onset of symptoms for mild cases. • Updated close contact by removing flight crew and lab exposures. • Updated public health measures. • Removed requirement for daily public health follow-up of contacts on self-isolation and self-monitoring.
March 2020	<ul style="list-style-type: none"> • NEW

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Please see the following page for the COVID19 Fatal Outcomes Notification Form.

Please complete all fields

A) PERSON REPORTING – HEALTH CARE PROVIDER INFORMATION

Attending Physician or Nurse: Phone number: Hospital Name and Unit (if applicable): Location:	FOR PUBLIC HEALTH OFFICE USE ONLY: Service Area: Date Received: Panorama Client ID: Panorama Investigation ID: Panorama QA complete: <input type="checkbox"/> Yes <input type="checkbox"/> No
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B) CLIENT INFORMATION (please complete or affix patient label in the table below)

Last Name:	First Name: and Middle Name:	Alternate Name (Goes by):
DOB: YYYY / MM / DD Age: _____	Health Card Province: _____ Health Card Number (PHN): _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Next of Kin: _____ Relationship: _____ Contact phone: _____	Address Type: <input type="checkbox"/> No fixed <input type="checkbox"/> Postal Address <input type="checkbox"/> Primary Home <input type="checkbox"/> Temporary <input type="checkbox"/> Legal Land Description Mailing (Postal address): Street Address or FN Community (Primary Home):	

C) LABORATORY DETAILS

LAB TEST INFORMATION: Test type: <input type="checkbox"/> PCR Date specimen collected: YYYY / MM / DD <input type="checkbox"/> Antigen Date specimen collected: YYYY / MM / DD
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D) RISK FACTORS (check all that apply)

Chronic Medical Condition - Cardiac Disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked <input type="checkbox"/> Unknown	Chronic Medical Condition – Morbid Obesity <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked <input type="checkbox"/> Unknown
Chronic Medical Condition - Diabetes Mellitus <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked <input type="checkbox"/> Unknown	Chronic Medical Condition - Other (Add'l Info) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked <input type="checkbox"/> Unknown
Chronic Medical Condition - Hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked <input type="checkbox"/> Unknown	Immunocompromised - Related to disease or treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked <input type="checkbox"/> Unknown
Chronic Medical Condition - Lung Disease (does not include asthma) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked <input type="checkbox"/> Unknown	Pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked <input type="checkbox"/> Unknown
Special Population – Long Term Care Facility Resident Include the name of the facility <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked <input type="checkbox"/> Unknown	
Special Population – Personal Care Home Resident Include the name of the facility <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked <input type="checkbox"/> Unknown	

E) OUTCOMES

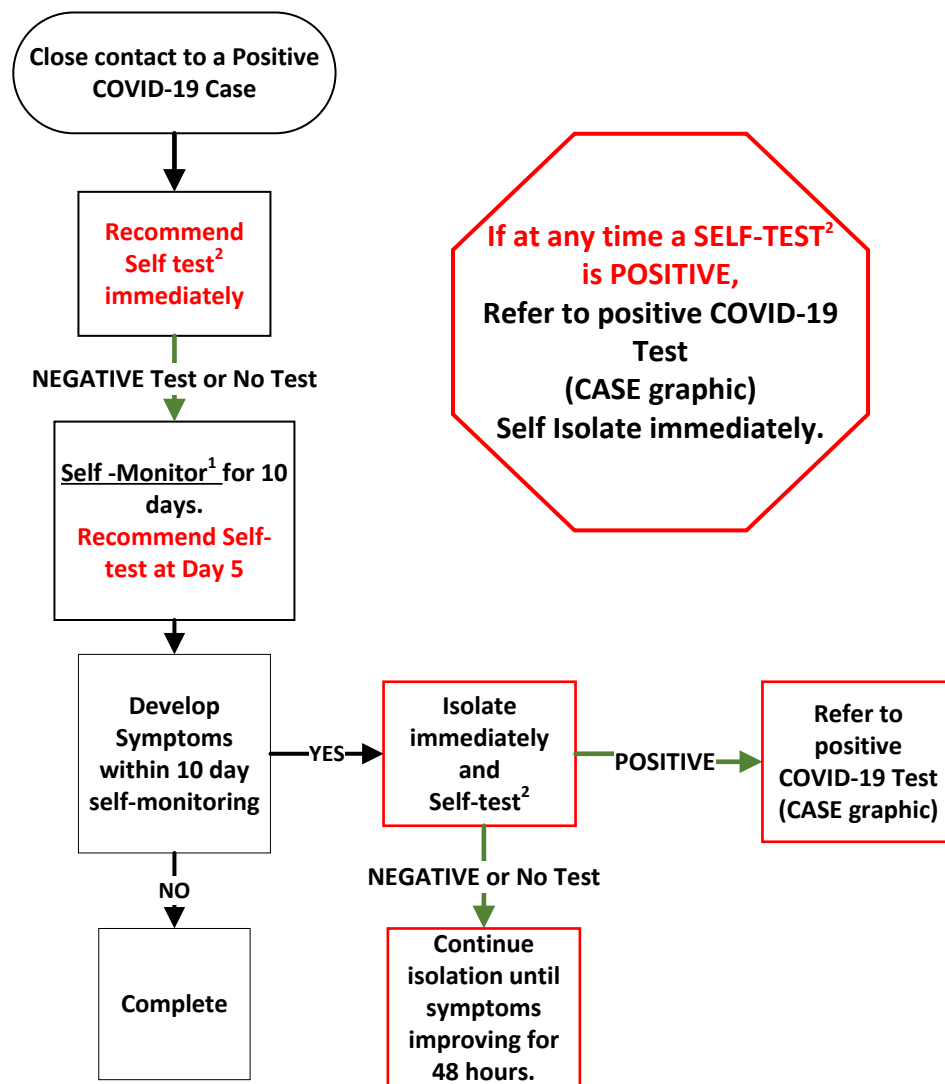
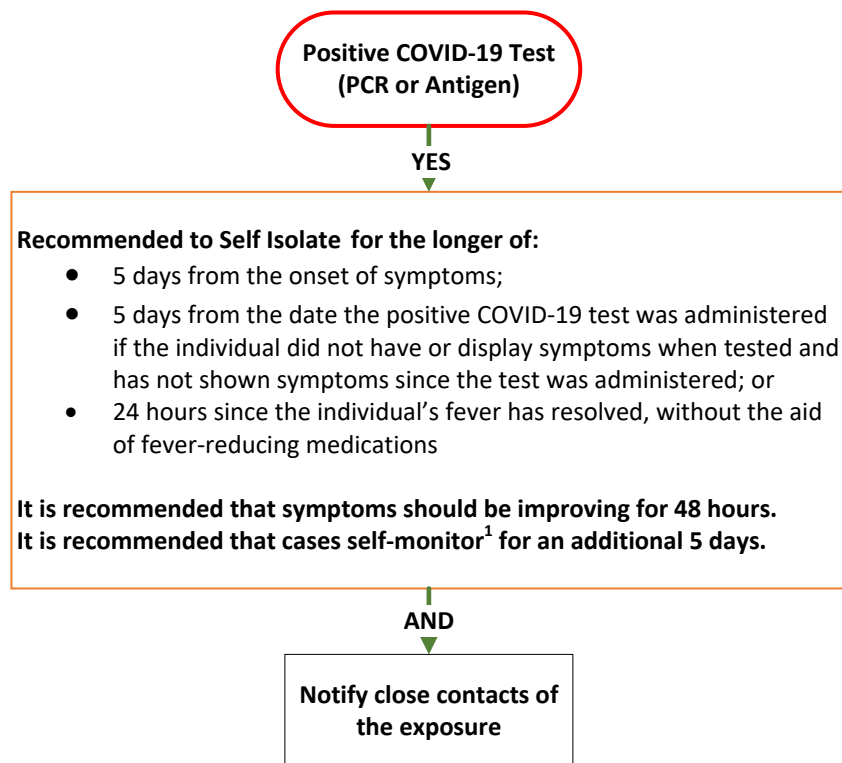
Fatal - Date of Death YYYY / MM / DD How was COVID-19 Related to Cause of Death:	<input type="checkbox"/> Underlying cause of death <input type="checkbox"/> Contributed to but was not underlying cause of death <input type="checkbox"/> Unrelated to cause of death
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Report completed by:	Date report completed: YYYY / MM / DD
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Please save a copy for your file and fax to the local public health office.

Cases

Close Contacts



¹Self-monitor- in addition to symptom monitoring, includes self-modified behaviors to reduce risk of transmission for the entire risk period (10 days) even though isolation is shortened . This includes isolating immediately if symptoms are present or develop; continuously masking when outside of their household, and avoiding high risk individuals and high risk settings.

²Self-test— all close contacts should self-test immediately and after day 5 and again if symptoms develop.

Students have experienced multiple, prolonged periods without in-person learning during the COVID-19 pandemic, and there is evidence demonstrating related harms (Public Health Ontario, Aug 2022). Given the importance of in-person schooling for the learning and overall well-being of children, it is important to balance the harms of losing in-person learning with reducing transmission in kids especially now that broad societal measures to prevent health system collapse are no longer required. Efforts to reduce transmission utilizes multiple layers of prevention in schools, which may include a stronger recommendation for masking especially when community transmission higher, to mitigate the harms of disruption to in-person learning is advisable.

We are in a better state; we know more about COVID-19 and given the reduction in severe infection across communities, availability of vaccinations that prevent severe infections broadly across the population, and a lower risk of severe disease overall in children our recommendations this year encourage a less stringent approach to school-based COVID-19 mitigation. The aim is to optimize in-person classroom time and participation in extracurricular activities, and minimize attendance disruptions.

Expectations

- As more people are vaccinated and there are more recoveries from infection, a level of population immunity is developing and the level of immunity in the population will play a crucial role in disease control.
- Current evidence indicates that eradication of SARS-CoV-2 does not appear feasible (Public Health Ontario, Feb 2022).
- Population immunity should be considered as something that is “continuous” and dynamic (i.e. level of immunity in the population is proportional to decreases in incidence of infection and may vary across regions or sub-populations) and we can anticipate peaks of infection due to seasonality, new variants and/or the unclear effects of waning of immunity and long-term durability of protection with resulting disease not necessarily being mild.
- Communities throughout the country including Saskatchewan continue to experience cycles of high COVID-19 transmission as new variants are associated with a higher risk of infection or reinfection in both vaccinated and unvaccinated individuals.
- We could anticipate a winter season with higher case incidence.
- Public health guidance may vary from community to community, with some health departments enacting targeted recommendations to protect high-risk individuals and others choosing to retain broader mitigation strategies.

Our strategies will focus on the following recommendations:

- **Stay home when ill** – School administrators should ensure that staff, other adults entering the school, parents, caregivers, and students are aware that they should not come to school if they are sick and unable to participate fully in routine activities. School administrators can support this practice by communicating the importance of everyone doing a health check (BCCDC, 2022).

- **Hand Hygiene and Respiratory Etiquette** – these are standard individual healthy practices that can help reduce illness and disease spread.
- **Environmental Cleaning** – Cleaning and disinfection of the physical environment is important. It reduces the numbers of microorganisms that may potentially be transmitted to other individuals.
- **Ventilation** – We have learned the value of improving ventilation to reduce the transmission risk for COVID-19 and other respiratory illness during the fall and winter. We encourage to continue making wise investments in ventilatory improvements and, when possible, flexing to outdoor or less-crowded indoor locations during periods of high seasonal transmission, so long as such practices do not impose major challenges to normal program operations and safety.
- **Symptom Monitoring** – Isolation of contacts (also referred to a quarantine) is no longer required by public health for close contacts of COVID, however it is good health practice to pay attention to early signs of illness and to take steps to reduce the risk of spreading to others including self-testing, masking and self-isolation when ill. This is particularly important for Individuals who are aware of an exposure to COVID – these individuals should isolate if they develop symptoms.
- **Self-Testing** – At home tests are expected to be available for the foreseeable future. Individuals experiencing mild cold-like symptoms including cough, sore throat, sneezing without fever, it is recommended that you stay home, use rapid antigen testing and self-isolate.
 - Anyone who tests positive for COVID-19 should self-isolate immediately at home or in another suitable environment, regardless of their vaccination status.
 - It is recommended that individual self-isolate for five days from the date of test or 24 hours after any fever has resolved without the aid of fever-reducing medications and all other symptoms are improving for at least 48 hours, whichever is later.
 - Individuals with a negative test should follow the general self-isolation guidelines (as outlined below).
- **Self-Isolation** – The strongest mitigation practice for reducing school outbreaks of any seasonal respiratory illness remains the expectation that students who are ill (particularly those with cough, muscle aches and fever) stay home to recuperate. Individuals should remain home until fever-free for at least 24 hours, and until symptoms are improving. Individuals with a positive test should follow the guidelines outlined under testing above.
- **Masking** – Schools no longer need to enact masking requirements within school settings. However, we should continue to communicate to families any updates/recommendations for masking when indoors during periods of high community transmission. Such communications can inform the voluntary decisions of students and staff of whether to mask during these periods. Schools must be supportive of individual students and staff who choose to continue to mask.
- **Vaccination** – Students and staff should complete at least the primary series of COVID-19 vaccinations given the strong protection they provide against severe infections. Akin to seasonal influenza vaccination, which we perform each year to prevent reinfection, we would encourage schools and early childhood programs to inform staff and student families of recommendations for COVID-19 booster vaccinations when appropriate.

- **Outbreaks** – To avoid lengthy periods of learning loss and school closure, schools might adopt practical strategies, in consultation with local public health, when confronted by large outbreaks.
 - **Communication** - Schools should first and foremost communicate to families when a large outbreak occurs. These communications can inform voluntary decisions among staff and students of whether to mask when a large outbreak occurs within the school.
 - **Masking** - During an outbreak within a classroom or school, school leadership might ask affected classrooms (or if large enough, the school) to do a “mask sprint” for a week to limit the extent of the outbreak (Children’s Hospital of Philadelphia, Aug 2022).
 - **Testing** - If testing is available, they might offer voluntary outbreak testing to quickly identify individuals who are positive and must isolate at home.

The Public Health Agency of Canada, [Reducing COVID-19 risk in community settings: A tool for operators](https://health.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/guidance-documents/reducing-covid-19-risk-community-settings-tool-operators)¹ may help administrators to identify different strategies that may help to lower the risk of COVID-19 spread in their specific setting.

¹ <https://health.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/guidance-documents/reducing-covid-19-risk-community-settings-tool-operators.html>

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Revisions

August 31, 2022	<ul style="list-style-type: none"> Updated the document to align with the general approaches for COVID-19 that focuses on a self-management approach. Added references and 2022-23 resources.
January 7, 2022	<ul style="list-style-type: none"> Case isolation period updated to 5 days for fully vaccinated individuals Contact isolation period updated to 10 days for all individuals Amendments to reflect change in process that positive COVID-19 test results for school-based students or daycare attendees, from either rapid antigen or PCR tests, are to be reported to the local school office or daycare by parents or guardians. The school or daycare will then send a notification to parents/guardians of the class and/or bus cohort that may be considered close contacts.
November 29, 2021	<ul style="list-style-type: none"> Removed reference to enhanced precautions applying to the whole school in the outbreak table and replaced it with a footnote that clarifies that enhanced precautions are based on the local context and the scope of the outbreak; measures may be applicable to a class, a cohort (as defined in outbreak criteria), a grade or the whole school/facility Removed details of self-isolation exemption as Public Health Order updated October 1, 2021 to specify that unvaccinated pupils that are identified as a close contact of a household case will not be exempted from the requirement to isolate for 14 days. Inserted references to the current Public Health Order posted at Saskatchewan.ca to seek most up to date details on current exemptions for self-isolation Updated outbreak criteria to include: <ul style="list-style-type: none"> ➤ An outbreak will be declared when three or more individuals are confirmed to be positive with COVID-19 in a classroom or cohort within 14 days and attended school while infectious ➤ Examples provided for cohort (sports team, bus route, club or other group)
September 23, 2021	<ul style="list-style-type: none"> Added definition of daycare and removed reference from preschool in the table as these exposures are not recognized in the Public Health Order.
September 17, 2021	<ul style="list-style-type: none"> Amendments to align with current Public Health Order.
September 13, 2021	<ul style="list-style-type: none"> Attachment posted.