NWT Office of the Chief Public Health Officer

Coronavirus Disease (COVID-19)

Interim Public Health Disease Management for the Northwest Territories

August 16, 2021

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Version Date	Summary of Updates
September 16, 2020	Version 1
October 14, 2020	Version 2 - Formatting changes
October 22, 2020	Version 3 - Guidance on Management of Side Effects after Routine Immunization
October 29, 2020	Version 4 - Updates on symptom inclusion for testing - Any symptoms as indicated in symptoms of COVID-19 require testing
November 27, 2020	Version 5 **Definitions** - Added Considerations for Home Isolation Requirements **Updates on COVID-19 Reporting Requirements** - Report form COVID-19 AND OTHER RESPIRATORY ILLNESS REPORT FORM (TESTING) – Part A (NEW) updated **Updates on Transmission** - Airborne (or "Aerosol") transmission can occur in specific settings outside of medical facilities, particularly in indoor, crowded and inadequately ventilated spaces, where infected person(s) spend long periods of time with others, such as restaurants, choir practices, fitness classes, nightclubs, offices and/or places of worship. More studies are underway to better understand the conditions in which aerosol transmission is occurring outside of medical facilities. **Management of Suspect Cases** - Changes to discontinuation of isolation - Requirements for repeat negative testing on symptom resolution to determine management of discontinuation of entire household if all household members are isolating in the home (see section for further guidance) **Updates on Isolation Day Counting Guidance - added Section Isolation-Counting**

	Days Guidance – Public Health Measures - Guidance to appropriate counting of isolation period **NWT School Screening Criteria** - Links to school screening criteria for healthcare providers **Updates on notification of exposure via COVID19 apps - Table 5a: Contact Exposure Assessment to Identify and Management for Contacts** - Public Health and HCPs should manage individuals notified of exposure via COVID-19 Federal Exposure Notification App as a contact of COVID-19. - Advised to isolate 14 days from receipt of exposure notification unless, individual has been notified of exposure through traditional contact notification process **Updates to Appendix B - Isolation Requirements for Individuals and their Household Members with COVID-19 Symptoms or Exposures** - Changes to guidance related to Public Health Advisory on travellers and household self isolating **Management of Confirmed and Probable Cases** - Additional guidance and considerations on isolation in the household **Guidance on isolation for Healthcare Workers or essential service workers who are confirmed or probable cases for COVID-19** - Healthcare providers who are confirmed or probable COVID-19 cases should NOT go back to work in a health care setting for 14 days from the onset of symptoms, or until symptoms resolve, whichever is longer.
19 April 2021	**Case Definitions and Other Reference Definitions For NWT's Covid-19 Response** • Updated case definitions in accordance to PHAC National Surveillance Definitions • Deceased Case- NEW • Resolved Case - NEW • Clusters - UPDATED • Point of Care Tests - NEW • Severe COVID-19 – NEW • Critical COVID-19 – NEW • Contact of Case - UPDATED ○ Exposure duration 10 minutes

Contact Identification

- 10 minutes of exposure, cumulative total of 10 mins for all contacts
    - Updated: Contact of a Case, Management of Contacts and Contact Tracing, Table 5a: Contact Exposure Assessment to Identify and Manage Contacts

Point of Care Tests (NEW)

- Statement on use of point of care tests and recommended use by OCPHO

Causative Agent (NEW)

Information added on variants of concern and indentfiication

NWT's COVID-19 PUblic Health Orders (Updates)

April 21, 2021- Public Health Order Self-Isolation Reduction for Travellers

- HCP's conducting Day 8 testing for fully vaccinated travellers seeking exemption of isolation for the remainder of the 14 day isolation period, are responsible for the validation of vaccination status prior to the collection of a specimen for COVID19 testing. See Table 5b for vaccination confirmation status

Guidance on Repeat RT-PCR Testing for Previously Positive COVID-19 (NEW)

- Information added on recommendations for repeat testing and public health management of previously positive
- Table on recommended testing based on symptoms and exposure risk if testing is required within 90 days from previously positive

Management of a Hospitalized Case (UDPATED)

- Depending on if the individual is severe COVID19 or critical COVID19 and admitted to intensive care unit severity of the hospitalized cases should be on appropriate precautions for a minimum of 14 days for severe cases and 20 days for critical cases from onset of symptoms, and should follow HSSA's IPAC policy for discontinuing precautions.

Management of Immunocompromised Case (UPDATES)

- Medical Conditions that can mak you more likely to get severely ill from COVID-19 (see section for list of medical conditions)

Table 4: Discontinuation of Isolation of a Case (UPDATES)

- Guidance added on discontinuation of isolation requiring 24 hours of afebrile before discontinuation
- Isolation of critical cases 20 days
- Isolation of all hospitalized cases 14 days

	• Healthcare providers, individuals working in congreget settings, and high risk for transmission who are confirmed or probable COVID-19 cases should complete 14 days from the onset of symptoms, or until symptoms resolve, whichever is longer. **Guidance on Determining Exposure when using Masks (NEW)** • Review of PPE used by healthcare providers and deeming exposed - New **Management of Individuals Immunized Against COVID-19 with Exposure to COVID19 (NEW)** • NEW public health management of individuals immunized against COVID19 **COVID19 Immunization Types (NEW)** • Identification of fully vaccinated/Partially Vaccinated Status based on vaccine type **Management of Aysmptomatic positive COVID19** • Instruct the case to monitor for symptoms in Table 1: Common Symptoms for COVID-19 and Testing and if symptoms develop during the isolation period, the case must remain in isolation for 10 days after onset of symptoms, and be managemed as a mild/moderate, or severe case based on symptom severity= **Updates to Appendix B - Isolation Requirements for Individuals and their Household Members with COVID-19 Symptoms or Exposures** • Update on management of fully vaccinated travellers and household members based on vaccination status
15 August 2021	**COVID19 Immunization Types (UPDATES)** • Identification of fully vaccinated/Partially Vaccinated Status based on vaccine type- new guidance **Key Investigation and Management of Suspect Cases** Updates on management of suspect cases based on vaccination status **Contact Risk Assessment Based on Exposure** **Management of Individuals Immunized Against COVID-19 with Exposure to COVID19 (NEW)- Table 5b: Recommended Testing and Public Health Management of Contacts Based on Vaccination Status Table 5b** **Management of Household members of contacts (UPDATES)**

	Key Management of Contacts (UPDATES) Isolation period for all contacts changed to 10 days **NWT's COVID-19 PUblic Health Orders (Updates)** New orders outlining travellers not required to isolate if fully vaccinated and requirements of unvaccinated and partially vaccinated travellers **See Appendix B for updates**

This document was adapted from Alberta Health's *Public health disease management guidelines: coronavirus-COVID-19 January 2021* with their permission. The Office of the Chief Public Health Officer (OCPHO) will update this document as new information emerges.

1. CASE DEFINITIONS AND OTHER REFERENCE DEFINITIONS FOR NWT'S COVID-19 RESPONSE

Confirmed Case

A confirmed case is a person with laboratory confirmation of infection with severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) from an appropriate clinical specimen [nasopharyngeal (NP) swab, throat swab, NP aspirate, endotracheal tube (ETT) suction/sputum, or bronchoalveolar lavage/bronchial wash (BAL/BW)]. Laboratory confirmation requires:

- Detection of at least one specific gene target by a validated nucleic acid amplification tests (NAAT) assay at the National Microbiology Lab (NML), provincial public health laboratory, or community hospital

OR

- A validated point-of-care (POC) nucleic acid amplification test (NAAT) that has been deemed acceptable to provide a final result (i.e. does not require confirmatory testing)*

OR

- Demonstrated 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.*

*See Public Health Agency of Canada (PHAC) Laboratory Comments for further details on testing. Please see Alberta Precision Laboratories bulletin on serologic testing.

Probable Case

A person who:

1. Has symptoms compatible with COVID-19

AND

- Had a high-risk exposure with a confirmed COVID-19 case (i.e. contact) **OR** was exposed to a known cluster or outbreak of COVID-19

AND

- Has not had a laboratory-based NAAT assay for SARS-CoV-2 completed or the result is inconclusive

OR

- Had SARS-CoV-2 antibodies detected in a single serum, plasma, or whole blood sample using a validated laboratory-based serological assay for SARS-CoV-2 collected within 4 weeks of symptom onset

OR

2. Had a POC NAAT **OR** POC antigen test for SARS-CoV-2 completed and the result is preliminary (presumptive) positive.In NWT at present all results on POC tests are reported as presumptive positive until confirmed on validated PCR.

OR

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

Suspect Case

A suspect case is a person with clinical illness **AND in the last 14 days:**

- Returned to Canada/Northwest Territories (NWT) from outside the country;

OR

- Returned to the NWT from within Canada (excluding areas within NWT's bubble);

OR

- Travelled to an affected area (i.e. community spread within the NWT);

OR

- Is a contact to a probable case;

OR

- Interacted in a COVID-19 cluster or outbreak without being identified exposed (i.e. is not a probable case)

OR

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

Deceased Case

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

Resolved Case

Resolved COVID-19 means a person is no longercapable of transmitting the SARS-CoV-2 virus. Resolved does not necessarily imply complete clinical resolution of symptoms from COVID-19. Some individuals may remain infectious beyond the time period specified below (e.g. severe immune suppression), and the judgement of a Medical Officer of Health or relevant public health authority supersedes the specified criteria. OCPHO does not recommend routinely using laboratory testing to classify cases as resolved.

In most instances an individual's confirmed COVID-19 infection resolves if: :

- If the individual is not immunocompromised and does not have severe illness, and at least 10 days have passed since symptom onset or, if asymptomatic, since the date of diagnosis
  OR
- If the individual has severe illness, a minimum of 14 days have passed since symptom onset
- If the individual is immunocompromised or has critical illness a minimum of 20 days have passed since symptom onset

AND

- the individual is afebrile for a minimum of 24 hours without the use of fever reducing medication

AND

- Clinical resolution of symptoms. Symptoms such as cough, fatigue, loss of sense of taste or smell, however, may persist and do not necessarily infer infectiousness.

Office of the CPHO must be consulted on the discontinuation of self-isolation criteria for ALL cases of COVID19 in the community.The assessment by CPHO will supersede the above mentioned criteria.
Discontinuation of COVID-19 precautions in hospitals requires consultation with regional health authorities' infection prevention and control.

Refer to Table 4: Discontinuation of Isolation of a Case for further information on discontinuation of isolation for recovered cases. Please see section "Communicable Period" for further review.

Contact of a case

A contact is a person exposed to a probable or confirmed case during their communicable period, who:

- Provided direct care for the case or had other similar close physical contact without the recommended personal protective equipment (PPE);
- Had direct physical contact with the case or their body fluids;
- Lived with, shared a closed space (e.g. room or vehicle), or interacted within two metres without the recommended PPE with a case for a cumulative total of 10 minutes or more;
- An individual who is notified by the national COVID-19 exposure notification app that they were exposed.

See Table 5 Contact Risk Assessment for examples and clarification.

Reinfection

- For clinical practice: reinfection may be defined as clinical recurrence of symptoms compatible with COVID-19, accompanied by positive PCR test, more than 90 days after the onset of the primary infection, supported by close-contact exposure or outbreak settings, and no evidence of another cause of infection.

Outbreak

- A **closed facility outbreak** is defined as one confirmed or probable case of COVID-19 where infection is acquired within the facility;
  - For Long Term Care facilities (LTCFs), an outbreak is one confirmed or probable case of COVID-19 regardless of where infection was acquired .
- A **community outbreak** or community transmission is one or more cases of COVID-19 in a community or region with no exposure or chains of transmission clearly identified or postulated;
  - OCPHO will declare early stages of community transmission if we identify a low incidence of locally acquired, widely dispersed cases not linked to specific clusters or identified chains of transmission.

Clusters

Cases that are linked by time, geographic location and common exposures.

Multi-System Inflammatory Syndrome in Children (MIS-C)

WHO Preliminary Case Definition: Children and adolescents 0–19 years of age with fever ≥ 3 days

AND two of the following:

- Rash or bilateral non-purulent conjunctivitis or muco-cutaneous inflammation signs (oral, hands or feet);
- Hypotension or shock;

- Features of myocardial dysfunction, or pericarditis, or valvulitis, or coronary abnormalities (ECHO findings or elevated Troponin/NT-proBNP);
- Evidence of coagulopathy (abnormal PT, PTT, elevated d-Dimers);
- Acute gastrointestinal problems (diarrhea, vomiting or abdominal pain);

AND

- Elevated markers of inflammation such as ESR, C-reactive protein or procalcitonin

AND

- No other obvious microbial cause of inflammation, including bacterial sepsis, staphylococcal or streptococcal shock syndromes

WITH OR WITHOUT*

- Evidence of COVID-19 (RT-PCR, antigen test or serology positive);

OR

- COVID-19 exposure (see Exposure Criteria).

*The Public Health Agency of Canada requests notification of MIS-C even in the absence of evidence of COVID-19 or exposure.

Critical COVID-19

- Meets criteria for acute respiratory distress syndrome, sepsis, septic shock, or other conditions that would normally require the provision of life sustaining therapies such as mechanical ventilation, or vasopressor therapy.

Severe COVID-19

- Oxygen saturation less than 90% on room air; OR
- Respiratory rate greater than 30 breaths per minute in adults and children greater than 5 years old; ≥ 60 breaths per minute in children less than 2 months old; ≥ 50 in children 2- 11 months old; and greater than 40 in children 1-5 years: OR
- Signs of severe respiratory distress (accessory muscle use, inability to complete full sentences, or other signs of respiratory distress in children).

Non-severe COVID-19

- Is the absence of any criteria for severe or critical COVID-19.

Exposure Criteria

Exposure criteria assist in risk assessments for diagnosing COVID-19 and guide further public health management. In the 14 days before onset of illness, OCPHO considers a person as definitely, or potentially, exposed if they:

- are a contact to a confirmed, or probable case, or suspect case of COVID-19;
  OR
- Returned to Canada/Northwest Territories (NWT) from outside the country;
  OR
- Returned to the NWT from within Canada (excluding areas within NWT's bubble);
  OR
- Travelled to an affected area (i.e. community spread within the NWT);
  OR
- Prolonged interaction (e.g. household or work environments) with traveller (s) from an affected area (ie. Household/Work)
  OR
- Interacted in a COVID-19 cluster or outbreak;
  OR
- Had laboratory exposure to biological material (e.g., primary clinical specimens, virus culture isolates) known to contain COVID-19.

Validated Positive Test

As of April 21, 2021 sites providing validated positive nucleic acid amplification test (NAAT)-based assay, such as:

- RT-PCR results Alberta Precision Laboratories (APL-ProvLab AB)
- DynaLIFE Medical Labs in Alberta
- National Microbiology Laboratory (NML)
- Stanton Territorial Hospital
- Inuvik Regional Hospital

Point of Care Tests

Rapid test device that is simple to use, provides results within a short time, and can be used in multiple healthcare settings.

Closed facility

A closed facility is a hospital or long-term care facility (LTCF), correctional institution, or closed work site (e.g. oil and gas or mining camp).

- Closed facilities increase risk of transmission of COVID-19 as it is difficult to maintain recommended public health measures (i.e. physical distancing).

Presumptive Positive

A presumptive positive result is a result from a test run on an unvalidated or POC test platform. A presumptive positive requires confirmatory testing on a validated instrument.

2. TESTING AND DIAGNOSIS

Real time PCR (RT-PCR) testing of respiratory samples for SARS-CoV-2 is presently the clinical "gold standard" for the diagnosis of COVID-19 infection. NWT's Chief Public Health Officer (CPHO) recommends testing those with COVID-19 symptoms. OCPHO will make specific testing recommendations with different testing modalities as new information emerges.

Follow Health and Social Services Authority (HSSA) directives regarding testing for COVID-19, and follow Alberta Public Health Laboratories (formally ProvLab) for procedures regarding testing, specimen collection and handling.

- Acceptable specimen types for COVID-19 testing include NP swab, throat swab, NP aspirate, endotracheal tube (ETT) suction/sputum, or bronchoalveolar lavage/bronchial wash (BAL/BW).
- **NP and throat swabs are recommended** over nasal swabs for COVID-19 testing.
- Collecting a respiratory sample into Universal Transport Media (UTM) allows detection of further respiratory pathogens including RSV and influenza.
- Other infections (pertussis, tuberculosis) require specific considerations of sample or media type.
- CPHO recommends testing for COVID-19 and respiratory pathogen panel (RPP), including at least influenza A, influenza B, and RSV, in the following situations:
  - the person is or will be hospitalized
  - the person lives, works, trains, volunteers in, or visited a closed facility and has COVID-19 symptoms or influenza like illness (ILI)
  - CPHO will provide separate guidance regarding influenza or RSV surveillance
- For patients with a lower respiratory tract infection and who are intubated, healthcare providers (HCPs) should submit a sample from ETT suction or BAL/BW for COVID-19 RT-PCR.
- CPHO or delegate, or HSSA may recommend asymptomatic testing for specific populations as the pandemic evolves.
- Clients may refuse testing however they must follow appropriate isolation guidance.
- CPHO recommends that if an individual is symptomatic for COVID-19, or tested as asymptomatic contact and HCPs use a point of care test they obtain parallel sample for validated PCR. If high

suspicion of COVID19 based on symptoms follow public health management for cases while awaiting PCR.

- For more information about diagnostic tests and education on collection method, refer to Alberta Precision labs (formally ProvLab) and NTHSSA for laboratory guidance:
  - Alberta Precision Labs Testing Directory
  - Laboratory Bulletins
  - NTHSSA Lab Memos
  - NTHSSA: How to link POCT COVID-19 results through EMR manual entry

3. REPORTING

As set out in the *NWT Public Health Act, Reportable Disease Control Regulations (Section 4) and Disease Surveillance Regulations (Sections 6-10 and Schedule 3)* healthcare professionals (HCPs) and laboratories must report a diagnosis or formed opinion of a reportable disease to the CPHO or designate **within the timeframe identified in the regulations**.

Health Care Professionals

Report the following **immediately** by telephone to the OCPHO's reporting line (867) 920-8646:

- Confirmed or Probable Cases;
- Suspect Cases if:
  - They are hospitalized
  - They who have lived, worked, trained, volunteered or visited a closed facility
- All outbreaks or suspect outbreaks;
- Contacts of confirmed or probable cases; and
- Multi-system Inflammatory Syndrome in children (MIS-C) .

Reporting Forms

HCPs must submit COVID-19 report forms to OCPHO in a timely manner, i.e. within 24 hours, or as specified on the form. HCPs must fax the forms to the Medical Confidential fax line (876-873-0442), or send them electronically via secure file transfer (SFT).

1. COVID-19 AND OTHER RESPIRATORY ILLNESS REPORT FORM (TESTING) – Part A for **all** COVID-19 tests
2. For a confirmed or probable case:
   - COVID-19 Report Form for Confirmed Case-Part B
   - COVID-19 Exposure Investigation Form to identify settings of exposures
   - Contact Line List submitted upon initiating, updating, or completing a contact investigation

- The COVID-19 Case Status Report Form-Part C to report any significant changes in clinical status, and at least once weekly where the status is unchanged, until the case recovers and is no longer infectious.

3. For a suspected case of Multisystem inflammatory syndrome (MIS-C), HCPs must submit World Health Organization (WHO) Report Form

Laboratories

Report all positive results **immediately** by telephone to the Reporting Line of the OCPHO (867) 920-8646 and submit the **laboratory report** to the Medical Confidential fax line (867) 873-0442 **within 24 hours.**

4. OVERVIEW

Causative Agent

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

- Four types are responsible for generally mild illness- 229E, OC43, NL63 and HKU;
- Two types that can cause severe illness: Middle East respiratory syndrome coronavirus (MERS-CoV) and severe acute respiratory syndrome coronavirus (SARS-CoV); and
- SARS-CoV-2 is a coronavirus first identified in December 2019 that is responsible for COVID-19 illness.

Variants of Concern (VOC)

- Genetic variations of viruses, such as the one that causes COVID-19, are common, natural and expected. Genetic variants of SARS-CoV-2 have developed.
- WHO provides definitions of Variants of Interest (VOI) and VOCs. A VOI is a genetic variantwhich causes community transmission or is identified in multiple countries.A VOC is a VOI which impacts:
    - Epidemiology (e.g transmissibility, or affecting a different population)
    - Disease severity
    - Tests used to detect the virus
    - Vaccines
    - Treatments
- The Public Health Agency of Canada and WHO currently identifies three variants of concern:
    - B.1.1.7 (Alpha)
    - B.1.351 (Beta)
    - P.1 (Gamma)
    - B.1.617.2 (Delta)

- There is consensus that these VOCs are more infectious, each infection will produce more cases than the original SARS-CoV-2 virus if all other factors remain equal.
- There is emerging evidence that VOCs produce more severe disease resulting in increased hospitalizations and intensive care admissions.
- The variants don't currently affect diagnosis through authorized laboratory tests.
- There is scientific uncertainty as to whether variants can cause reinfection or escape immunity provided by vaccines.

Clinical Presentation

- Several studies document SARS-CoV-2 infection in patients who never develop symptoms (asymptomatic) and in patients not yet symptomatic (pre-symptomatic).
- In those with symptoms, they range from mild to severe, see Table 1: Common Symptoms and Testing Recommendations.
- Bilateral pneumonia on imaging should raise concern for COVID-19.
- In children, reported signs and symptoms are similar to those in adults, though they may be less severe or absent. Infants may present with reducing oral intake.
- Coughing, fatigue, and altered sense of taste and smell may persist and this does not necessarily mean the individual is infectious.
- Older adults may present with mild symptoms that are disproportionate to the severity of their illness or symptoms that are atypical for COVID-19.
- See Table 1 for symptoms and testing guidance. Health care providerswho suspect COVID-19 should test as appropriate.

Table 1: Common Symptoms and Testing Recommendations

Symptoms	OCPHO Indications for Testing
Fever ≥ 38°c* Cough (new cough or worsening chronic cough) Dyspnea (new or worsening shortness of breath/difficulty breathing) Congestion or Rhinorrhea (runny nose) Sore throat Fatigue (tiredness) Malaise (generally feeling unwell) Myalgia (muscles aches) Chills Headache Diarrhea Nausea or Vomiting Abdominal pain Anosmia/Dysgeusia (loss of sense of smell/taste) Anorexia (loss of appetite) Skin changes and rashes * Children may experience poor appetite, and infants less than one year may experience poor feeding	Client is experiencing any of these symptoms not definitively attributable to another cause
Delirium Loss of orientation to surroundings Sleepiness Increase in falls Onset of incontinence Increased agitation or sluggishness Sleep disturbances Dizziness Chest pain Hemoptysis Abdominal pain General change in behaviour or level of consciousness	***Older adults are experiencing*** atypical symptoms of COVID-19 not definitively attributable to another cause
	OR any other concerns for COVID-19 (for example if a clinician is concerned that a single symptom represents COVID-19, i.e. anosmia/dysgeusia)

**Young children, older adults, immunocompromised, or those taking medication such as corticosteroids, Nonsteroidal anti-inflammatory (NSAIDs), acetaminophen may not develop an elevated body temperature during infection.*

Complications

Some individuals with COVID-19 infection progress to severe illness including severe pneumonia, acute respiratory distress syndrome (ARDS), septic shock, multi-organ failure, thrombosis, or death. HCPs should be aware of the potential for some patients to rapidly deteriorate, and this often occurs approximately one week after illness onset.

The following vulnerable populations are at risk of more severe outcomes:

- Increasing age - the risk of dying (case-fatality rate) from COVID-19 increases dramatically with age greater than 20, and essentially tripling for each successive ten year age group until the age of 80.
- People with pre-existing medical conditions (such as obesity, chronic obstructive pulmonary disease, diabetes, heart disease, and smoking history). Those living with suppressed immune systems may be more vulnerable to complications of the disease.

There is concern that COVID-19 may induce chronic disease. Published case series indicate that those who recover from COVID-19 often report worsening quality of life, fatigue, dyspnea, joint pain, and chest pain. The prevalence and duration of symptoms persistenting after infection remain uncertain.

Children infected with SARS-CoV-2 typically have mild symptoms or none at all. Multi-system Inflammatory Syndrome in children (MIS-C) is a reportable, acute inflammatory illness reported in a small proportion of children with COVID-19 infection.

- Clinicians should maintain a high index of suspicion of MIS-C
- Clinical presentations include:
  - Persistent fever and features suggestive of Kawasaki disease (complete or incomplete),
  - Toxic shock-like syndrome,
  - Euvolemic shock states,
  - Severe gastrointestinal illness
  - Severe myocardial dysfunction and multiple organ failure have also been reported

See Canadian Paediatric Society position statement on MIS-C and Alberta Health Services Public Health Management Guidelines for MIS-C for more information.

Transmission

- SARS-CoV-2 is primarily transmitted person to person via respiratory droplet (i.e. coughing, sneezing, or talking) or direct contact (e.g. hugging or kissing).
- SARS-CoV-2 may be transmitted from indirect contact via contaminated objects or surfaces (fomites) and then touching one's own mouth, nose, or eyes. Transmission risk from surfaces, however, is low and is not the main route of transmission of COVID-19.
- The virus can survive on some surfaces for days but is easily inactivated by disinfectants.

- A US CDC scientific brief published on April 5, 2021 estimates that the risk of a person acquiring COVID-19 from an infected surface is low—each contact with an infected surface has a 1 in 10,000 risk of causing an infection.
- Virus is excreted in the stool and even urine in some patients. As of April 2021, there is scientific uncertainty about fecal-oral transmission of SARS-CoV-2.
- The role of bloodborne transmission remains uncertain.
- A systematic review published in January 2021 concludes that vertical transmission of SARS-CoV-2 is possible and likely occurs in a small proportion (approximately 3 percent) of mothers with COVID-19 who developed infection in the third trimester.
- Although there is detection of viral RNA in breast milk samples, there is no evidence of transmission during breast feeding. See Table 3: Determining isolation site and guidance to reduce transmission in households for suspect, confirmed, and probable cases and their contacts for guidance on breastfeeding if mother has COVID-19.
- Current evidence suggests humans infected with COVID-19 can infect other mammals. There is uncertainty about transmission from mammals to humans, but the best estimate is that the risk of transmission from pets to humans is very low.
- Airborne transmission can occur during aerosol-generating medical procedures (AGMPs), e.g. cardio-pulmonary resuscitation, sputum induction, nebulized treatments, intubation, dental procedures, etc.
- Airborne (or “Aerosol”) transmission can occur in specific settings outside of medical facilities, particularly in indoor, crowded and inadequately ventilated spaces, where infected person(s) spend long periods of time with others, such as restaurants, choir practices, fitness classes, nightclubs, offices and/or places of worship. More studies are underway to better understand the conditions in which aerosol transmission is occurring outside of medical facilities.
- The World Health Organization (WHO) and scientific community continue to investigate whether airborne transmission occurs outside of AGMPs.

Communicable Period

There is evidence of transmission occurring up to 48 – 72 hours before symptom onset or from individuals who are asymptomatic.

For mild cases that do not require hospitalization, evidence from observational and laboratory studies suggest they are no longer communicable 10 days after the onset of illness, as long as they have improved clinically. Severe and critical cases are communicable for longer periods. Experience from other respiratory viral infections suggests that immunocompromised individuals with COVID-19 may be infectious for longer periods.

There is no current evidence suggesting that VOCs cause infection beyond the communicable period of wild-type SARS-CoV-2.

The communicable period (Figure 1) of the confirmed or probable case is:

- **Symptomatic**: Two days before until a minimum of 10 days after symptom onset in a confirmed or probable case in those with mild illness. Severe cases are likely communicable for 14 days after symptom onset, and critical cases for 20 days after symptom onset.
- **Asymptomatic**: Two days before until a minimum of 10 days after the date the lab sample was collected from a confirmed case
    - The communicable period may be longer in those with progressive or severe illness
    - NAAT positivity from respiratory samples or cough may persist for prolonged periods after an infection and does not necessarily infer communicability

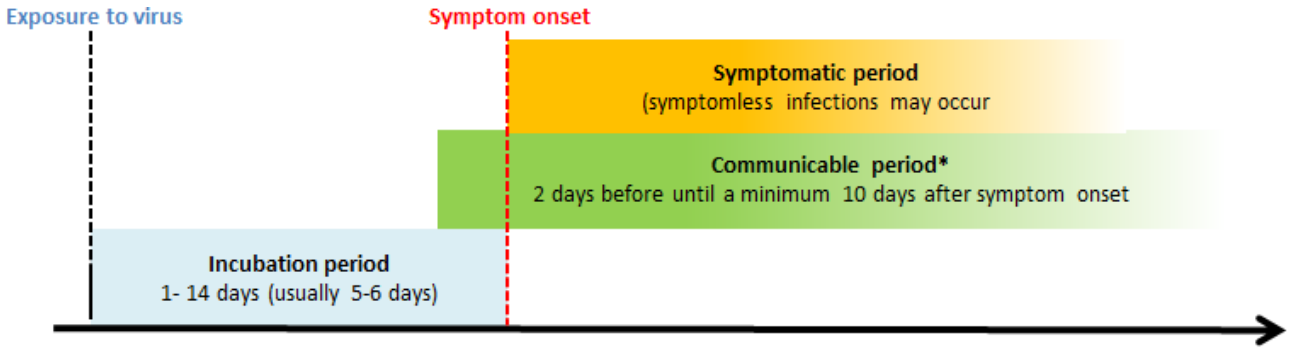
Risk of transmission is likely greatest during the early symptomatic period, since viral shedding is greatest at that time.

Please see Table 4 for decisions on discontinuing isolation of a case.

Incubation Period

Incubation period is the time period between exposure and onset of symptoms or illness and ranges from 0 - 14 days for COVID-19 (Figure 1). Best estimates from early in the pandemic are that the median incubation period is 5 - 6 days and that about 95% of those with COVID-19 become sick between 2 and 11 days after exposure.

Figure 1: Incubation and Communicable Periods of COVID-19



Communicable period for asymptomatic case: 2 days before until a minimum of 10 days after date the lab sample was collected from the confirmed case. Review symptoms that persist for ≥ 24 hours in the 7 days before testing. If symptoms are present, use symptom onset date to determine communicable period.

5. PUBLIC HEALTH MEASURES

Public Health Advice and Advisories

In an effort to help prevent or reduce the spread of COVID-19 in the NWT, OCPHO advises that the NWT population:

- Stay home when sick;
- Keep your social circle small and spaces large;
- Avoid non-essential travel outside of NWT;
- When outside or with others not from your home; practice physical distancing from others;
- Avoid crowded places;
- Wear non-medical masks in public places;
- Use healthy respiratory practices and perform frequent hand hygiene;
- If a returning traveler lives in a residence without a self-contained unit, everyone in the household must self-isolate for the same duration as the returning traveler; and
- As per the NWT Public Health Order - *Travel Restrictions and Self-Isolation Protocol*, if there is an essential service worker in the home, the worker must contact ProtectNWT and complete a Permission to Work application.

For a complete listing of CPHO public health advisories see: https://www.hss.gov.nt.ca/en/advisories

NWT Student and Teacher Screening Criteria

The health and wellbeing of children depends on attending school. The CPHO and Education Culture and Employment developed guidance to balance risks of introducing COVID-19 into schools while maintaining attendance. HCP's can access school screening criteria for all teachers and students that attend schooling in the NWT at https://www.gov.nt.ca/covid-19/en/student-daily-symptom-screening-tool

NWT's COVID-19 Public Health Orders

The CPHO instituted NWT COVID-19 public health orders which restrict travel into the NWT, provide guidance to the mineral and petroleum industry, and restrict gathering sizes.

- See Table 6b for vaccination confirmation status

Management of Cases and Contacts and Outbreaks

The CPHO or delegate will provide direction to HCPs on the case and contact investigation, and will make recommendations for testing, monitoring of cases and contacts, and outbreak management.

Guidance documents, including an algorithm for managing exposures, cases, and contacts, are on the Department of Health & Social Services Health Professionals website

Clinical Guidance

- For patient-specific clinical management follow HSSA clinical practice guidelines, directives, protocols and procedures
- The Public Health Agency of Canada, Association of Medical Microbiology, and Canadian Critical Care Society provide guidance for the clinical management of patients with COVID-19

Isolation Counting Guidance

- When determining the duration of isolation for individuals HCPs and public health officials should use complete 24 hour periods. For example, a contact whose last exposure was February 2nd at 09:00 and must isolate for 14 days, day 0 would be February 2nd and isolate ends at February 16th at 09:00.

Guidance on Repeat RT-PCR Testing for Previously Positive COVID-19

- Although an individual develops immunity after a COVID-19, the duration of immunity is uncertain. Individuals who have been infected with SARS-CoV-2 should be counseled about the possibility of reinfection and the importance of continued adherence to public health (e.g. physical distancing and masking) and infection prevention and control measures (e.g. use of recommended personal protective equipment by healthcare workers).
- PCR positivity may persist or fluctuate for weeks or in some cases months, and positive results are known to persist for even 3 months. At present, in the absence of known re-infections from VOCs, a positive PCR test done within 3 months of previous COVID-19 infection likely represents persistent PCR positivity and not re-infection.
- See Table 2: Re-Testing and Management of Resolved Cases for further information

Indications to Re-test Cases within 90 days

- Re-testing for COVID-19 within 90 days from a previous positive test can be considered if a HCP has concerns about re-infection. Situations which warrant consideration of re-testing include:
    - new symptoms of COVID-19 in a recovered case, especially if there are exposure criteria;
    - severe COVID-19-like illness or hospitalized; and
    - Symptoms or exposures in immunocompromised person.
- Asymptomatic testing within 90 days of a COVID positive test is generally not indicated.
- For individuals previously positive within the last 90 days for COVID-19 who are undergoing screening (e.g. admission to hospital, repatriated individuals, employer screening requirements), HCPs conducting testing should consider factors such as time from last test, symptoms, reexposure risk, return from higher incidence area, outbreaks, and characteristics of setting when deciding to test those without symptoms. Repeat positive tests in asymptomatic individuals who previously tested positive should be interpreted consultation with CPHO or delegate.
- Additional guidance related to reinfection and retesting can be found at: **PHAC- Guidance for repeated PCR testing in individuals previously positive for COVID-19**

Table 2: Re-Testing and Management of Resolved Cases

Timing of Test from Previous Positive Result	New onset of COVID-19 Symptoms*	Exposure Assessment	Testing Recommendation	Management and Recommendations
Less than 90 days	Asymptomatic	No identified exposure	No testing generally recommended, but HCPs should consider context	If tested for COVID-19 within 90 days & result positive: ▪ Review COVID19 exposures in preceeding 14 days ▪ review symptoms within the past 14 days ▪ *Consult CPHO if positive for public health management*
Less than 90 days	Asymptomatic	Exposure Identified ie. Outbreak setting, contact of a case	Testing recommended	▪ If positive manage as reinfection ▪ Conduct Case and Contact Investigation ▪ Refer to section **Management of Confirmed and Probable Cases** ▪ *Consult CPHO if positive for additional public health management*
Less than 90 days	Symptomatic	Does not impact decision to test	Recommend re-testing	▪ Depending on symptoms & setting, consider testing for other pathogens ▪ Confirm no identified COVID19 exposures in preceeding 14 days ▪ Further management is based on lab results and assessment. ▪ *Consult CPHO if positive for additional public health management*
More than 90 days	Asymptomatic/ Symptomatic	Does not impact decision to test	Testing indications are unchanged	▪ If positive manage as reinfection ▪ Conduct Case and Contact Investigation ▪ Refer to section **Management of Confirmed and Probable Cases**

This is 90 days from test date which yielded the initial positive result

Key Investigation and Management of Suspect Cases

- Utilize Contact Tracing Line List when determining details of exposure with each case and contact
- Clarify exposure criteria in the last 14 days;
- Identify symptoms – mild or severe, time of onset;
- Assess for other respiratory illnesses (e.g. pertussis, TB, influenza);
- Initiate infection prevention and control (IPAC) practices as appropriate for signs and symptoms;
- Test for COVID-19 as appropriate;
- Determine disposition of client, (i.e. hospital or community):
    - HCPs should determine place of isolation as outlined in Table 3: Determining Isolation Site and Guidance to Reduce Transmission in Households for Suspect, Confirmed and Probable Cases and thier contacts;
    - HCPs should follow organizational/HSSAs' directives, protocols and procedures; and
    - HCPs should make every effort to support the client remaining in the community unless medically necessary.
- Advise suspect cases regardless of vaccination status to isolation, isolate until they meet discontinuation criteria based on vaccination status as a suspect case. Advise the client that they may end self-isolation after:

Fully Vaccinated Suspect Case

- Negative PCR test at symptom onset; AND
- Afebrile; AND
- Clinical Resolution of symptoms- *Absence of cough not required for symptom improvement in those with chronic cough or reactive airway*
    - *Household members of suspect cases must follow the same isolation guidance as the suspect case and additional guidance specified* (see Appendix B).

Partially Vaccinated Suspect Case

- Negative PCR Test at symptom onset; AND
- Negative Test at symptom resolution;
- Afebrile; AND
- Clinical Resolution of symptoms- *Absence of cough not required for symptom improvement in those with chronic cough or reactive airway*
    - *Household members of suspect cases must follow the same isolation guidance as the suspect case*

Unvaccinated Suspect Case

- Negative PCR Test at symptom onset; AND
- Isolate a minimum of 10 days; AND
- Day 10 Negative Test; AND
- Afebrile; AND
- Clinical Resolution of symptoms- *Absence of cough not required for symptom improvement in those with chronic cough or reactive airway*
    - *Household members of suspect cases must follow the same isolation guidance as the suspect case and additional guidance specified* (see Appendix B).

- If there is high concern that a suspect case has COVID-19 and the laboratory result will not be received within 48 hours, or the suspect case works within a closed facility, then, HCPs should review with the CPHO or delegate to consider initiating a case and contact investigation.
- **For additional guidance on vaccinated households and management of households with suspect cases see Appendix B: Isolation Requirements for Individuals and their Household Members with COVID-19 Symptoms or Exposures**

Key Investigation of Confirmed and Probable Cases

- Collect appropriate clinical specimens, confirm diagnosis, and apply case definition; and
- Notify the case immediately and begin the case and contact investigation upon determining that a person is a confirmed or probable case. HCPs and the public health team must ensure:
  - **Prompt isolation of cases is essential to protect the public**
- Determine the communicable period:
  - Obtain history of illness including date of symptom onset, type of symptoms and date COVID-19 swab was collected/
  - If case was asymptomatic at the time the swab was collected, in addition to the usual information collected for reporting forms, clarify whether the case had any symptoms of COVID-19 for at least 24 hours in the 7 days prior to specimen collection to determine communicable period.
  - Refer to Communicable Period section.
- Initiate a COVID-19 Exposure Investigation Form. In the 14 days prior to onset of illness or positive test, determine if the case:
  - Is a contact of a confirmed, probable, or suspect case;
  - Has a travel history, specifying dates of travel, mode of transportation, itinerary, including if they:
    - Returned to Canada from outside the country
    - Returned to the NWT from within Canada
    - Travelled to an affected area (i.e. community spread within the NWT)
  - Meets any other exposure criteria including:
    - Participated in a mass gathering or cluster outbreak identified as a source of exposure (i.e. a conference, restaurant, etc.);
    - Lived, worked, trained, volunteered or visited in a closed facility experiencing a COVID-19 outbreak;
    - Had laboratory exposure to biological material (e.g., primary clinical specimens, virus culture isolates) known to contain COVID-19;
    - Had direct contact with animals (e.g., visited a live animal market or other animal contact while travelling outside of Canada).
- Assess if other members in the household have symptoms of COVID-19.
- Determine the case's occupation and if they are a healthcare worker, work with vulnerable people, or work in a closed facility.

Management of Confirmed and Probable Cases

- **The CPHO requires isolation of all those with confirmed and probable COVID-19 despite vaccination status.**
- HCPs should follow organizational/HSSA directives, protocols, and procedures to determine whether the individual can be managed at home, by reviewing severity of illness including comorbidities, and need for oxygenation.
    - See Table 3: Determining Isolation Site and Guidance to Reduce Transmission in Households for Suspect, Confirmed and Probable Cases and their Contacts and follow organizational/HSSA directives, protocols and guidelines to determine site of isolation.
- Provide the case with information about disease transmission and measures to minimize transmission, including practicing proper hand hygiene and respiratory practices, physical distancing and use of medical/non-medical masks (NMM) as per organizational/HSSAs directives, protocols and procedures.
- Follow these links for information on isolation and caring for people with COVID-19 in the home:
    - Appendix B: Isolation Requirements for Individuals and their Household Members with COVID-19 Symptoms or Exposures
    - Mandatory Self-Isolation Information Sheet (NWT Public Health Orders)
    - Mandatory Isolation Information Sheet (NWT *Public Health Act*)
    - Mandatory Quarantine / Isolation (*Federal Quarantine Act*)
    - Self-monitoring Information Sheet
    - Care in the home for people with COVID-19 (long version), (short version)
    - Enhanced Cleaning Guidelines
    - Any other relevant information found in prevention and education sections
- **A negative COVID-19 test is NOT required for ending self-isolation of asymptomatic or mild cases**. NAAT positivity from respiratory samples can be prolonged.
- The isolation period may be longer than 10 days depending on the severity of the disease, the client's location and if they are immune compromised.
- Instruct the asymptomatic case to monitor for symptoms in Table 1: Common Symptoms and Testing Recommendations and if symptoms develop during the isolation period following asymptomatic test, the case must remain in isolation for 10 days after onset of symptoms, or until symptoms have improved and afebrile for 24 hours, without the use of fever-reducing medications, whichever is longer.
- Clinical management of all cases as per HSSA's directives policies and procedures. Complete Case Report Form (Case Status Update) - Part C on any updates to status to OCPHO.
- **Healthcare providers, individuals working in congregate settings, and high risk for transmission who are confirmed or probable COVID-19 cases should complete 14 days of isolation from the onset of symptoms, or until symptoms resolve, whichever is longer.**

Management of a Hospitalized Case

- Isolation precautions apply for all hospitalized cases whether they are symptomatic or not
  - Consult with facility or Territorial IPAC as appropriate, and follow organizational/HSSAs directives, protocols and procedures for IPAC recommendations. Management includes:
    - › Contact and droplet precautions
    - › Airborne precautions for AGPs
- Provide the case with information about disease transmission and measures to minimize transmission, including practicing proper hand hygiene and respiratory practices, physical distancing and use of medical/non-medical masks (NMM) as per organizational/HSSAs directives, protocols and procedures.
- Depending on case severity if severe COVID19 or critical COVID19 and admitted to intensive care unit the hospitalized cases should be on appropriate precautions for a minimum of 14 days for severe cases and 20 days for critical cases from onset of symptoms, and should follow HSSA's IPAC policy for discontinuing precautions.
- HCPs should consult with CPHO or delegate prior to discharge from hospital or any facility.
- Hospitalized cases that are discharged to their own home before hospital isolation is complete, should remain on isolation for 14 days from onset of symptoms or until symptoms have resolved, whichever is longer, after arrival at home or to an isolation facility.
  - Hospitalized cases being discharged or transferred to LTCF/continuing care/group homes/shelters etc. should not be transferred until their isolation period is complete.
  - If delay of discharge is not an option and the case must be discharged to another closed facility then they should remain on isolation, upon arrival to the facility, for **14 days** from onset of symptoms or until symptoms have resolved, whichever is longer.
  - The isolation period for hospitalized cases may be longer than 14 days depending on the severity of illness and discharge destination. Consult with CPHO or delegate.

Management of a Case in the Home or Alternate Care Site/Isolation Centre

Follow guidance in these documents while caring for and monitoring cases who are isolating at home or in an alternate site:

- Isolation (*Public Health Act*)
- Care in the home for people with COVID-19 (long version), (short version)

- Symptomatic confirmed or probable cases of COVID-19 are required to isolate in their home, alternate care site, isolation centre, or licenced supportive living/LTCFs for 10 days from onset of symptoms or until the symptoms have resolved (absence of cough not required for those with chronic cough or reactive airway), whichever is longer.
  - CPHO or delegate may extend isolation based on severity of illness.
- Cases and household members should not (if possible) isolate in the same household as household transmission can occur.

- If the case requires medical attention:
    - Cases should wear a surgical, medical grade (ASTM Level 1 or greater) mask in any health facility, or for any medical service including transport.
- HCPs should call ahead and advise receiving facility of symptoms and diagnosis of COVID-19 if they are arranging transfer.
- If transfer via ambulance or med response is required, notify 9-1-1/med-response that the client has COVID-19 so staff can use appropriate precautions.
- Determine frequency of active daily monitoring as per HSSA directives, guidelines or protocols – the CPHO strongly recommends persons at high risk for severe complications of COVID-19 receive active daily monitoring.
- Provide the case with information about disease transmission and measures to minimize transmission, including practicing proper hand hygiene and respiratory practices, physical distancing and use of non-medical masks.
- Due to theoretical risk of transmission to and from household pets, inform the case that they should avoid interactions with household pets, if possible. (e.g. have another member of the household look after them.) If this is not possible, cases should:
    - Use healthy respiratory practices and perform hand hygiene before and after touching animals, or their food/supplies; and
    - Restrict the pet's contact with other people and animals outside the household while the case is in isolation.
- Due to theoretical risk of fecal-oral transmission, reinforce importance of:
    - hand hygiene;
    - Safe food handling practices; and
    - Refraining from preparing foods for others in the household until isolation is lifted (as possible).

Management of Immunocompromised Case

- Those who are immunocompromised should isolate for a minimum **20 days** from onset of symptoms. HCPs should consult CPHO to review community isolation requirements, and territorial IPAC hospitalized immunocompromised cases.

Table 3: Determining isolation site and guidance to reduce transmission in households for suspect, confirmed, and probable cases and their contacts (as applicable)

The HCP should consider the following factors to determine if a suspect, confirmed or probable case or contact (as applicable) should isolate at home or an alternate site:

• **Ability to self- manage:**
  ▪ The case should be able to monitor their own symptoms and be able to report if their condition is worsening.
  ▪ They should be able to maintain healthy respiratory practices, physical distancing within the home, and perform hand hygiene.
• **Distance from medical care in remote settings:** Follow HSSAs' directives, protocols and procedures for determining whether a case can isolate in their home community or should move to a regional hub (Inuvik, Fort Smith, Hay River, Yellowknife)
• **Clinical condition:** Does the case require hospitalization now or are they at risk for hospitalization due to underlying factors that increase the risk for severe disease or complications of COVID-19
• **Access to care:** Some cases 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 for the case, should have access to recommended PPE, should be healthy, and have no underlying medical conditions that increase their risk for severe disease
  ▪ HSSAs should provide PPE to prevent transmission in households, as required
  ▪ When awake, the case should wear a medical mask if available (preferred), or a well-constructed and well-fitting non-medical mask, when they are sharing a closed space (for example, in the same room) with other household members.
• **Suitable home environment:** Ideally the case should stay in a room of their own, with access to a private bathroom, and separate bedroom, or alternative location
  ▪ Determine if an overcrowded household may limit the case's ability to isolate within the home
  ▪ If a separate bathroom is not available, the bathroom should be frequently cleaned and disinfected
  ▪ If a separate room is not feasible, ensure that shared spaces are well ventilated (e.g. windows open, as climate permits) and there is sufficient room for other members of the home to maintain a 2 metre distance from the case
  ▪ Hanging a sheet from the ceiling, or creating a barrier, to separate the ill person from others may be protective
Note: If household members cannot safely isolate from the case within the home, they must self-isolate for an additional 14 days from date of last exposure to the case during their communicable period.
• **Access to supplies and necessities:** The case should have access to food, running water, drinking water, and supplies (see Supplies for the home when isolating) for the duration of isolation. Supplies might include:
  ▪ Medical mask or if not available a non-medical mask or facial covering
  ▪ Disposable gloves

  - Eye protection
  - Thermometer
  - Fever-reducing medications
  - Hand soap
  - Alcohol based hand sanitizer containing at least 60% alcohol
  - Tissues
  - Waste container with plastic liner
  - Regular household cleaning products/approved hard-surface disinfectants that are approved by Health Canada and have a Drug Identification Number (DIN) or bleach containing solution
  - Cleaners suitable for cleaning high-touch electronics (70% alcohol)
  - Regular laundry soap
  - Dish soap
  - Disposable paper towels
- **Risk to others in the home:** Household members with conditions that put them at higher risk of complications of COVID-19 (e.g. underlying chronic or immunocompromising conditions, or the elderly) should not provide care for the case and alternative living arrangements may be necessary.
- This could include temporarily relocating these individuals or the case outside of the home to a location determined by HSSAs directives, procedures or protocols.
- If the case is a breastfeeding mother, HCPs should consider the benefits of breastfeeding. There is no demonstrated transmission of COVID-19 through breastmilk. HCPs should recommend continuation of breastfeeding with the following precautions:
  - Have the mother wear a medical mask, or if not available a close fitting facial covering while breastfeeding
  - Cover the baby with a blanket or towel while breastfeeding
  - Assist the mother to adhere to healthy respiratory practices and perform hand hygiene before and after contact with the baby
- **Cohorting:** 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, efforts should be made to cohort cases together (e.g. 2 cases in the same household, dormitory or shelter could share the same room).
- **Unsafe home environment:** If client expresses fear of repercussions of self-isolating at home consider relocating the case outside of the home to a location determined by organizations/HSSAs directives, procedures or protocols.
- **Psycho-social considerations for people on isolation:**
  - Encourage individuals, families and communities to create a supportive environment for people who are isolating to minimize stress and hardship such as financial, social and psychological impact

Discontinuation of Isolation for the Case

HCPs must consult the CPHO or delegate prior to discontinuation of isolation of ALL COVID-19 cases.

For anyone diagnosed with asymptomatic testing, clarify if they had any symptoms (see Table 1) for at least 24 hours in the 7 days before laboratory specimen collection. If so, utilize discontinuation criteria for "mild to moderate cases with symptoms" and consult with OCPHO to confirm isolation period.

Table 4: Discontinuation of Isolation of a Case*

Asymptomatic Cases	Mild to Moderate Cases with symptoms	Severe Cases
• Discontinue isolation 10 days from the date of sample collection if remains asymptomatic throughout course of illness • If symptoms develop after asymptomatic test follow guidance for Mild to Moderate/Severe cases • Consult with OCPHO to prior to discontinuation of isolation • **Healthcare providers, individuals working in congregate settings, and areas for high risk of transmission should isolate for 14 days from the onset of symptoms, or until symptoms resolve, whichever is longer** Complete COVID-19 Case Status Report Form-Part C weekly and if there is any change in condition.	• Minimum of 10 days from onset of symptoms or until symptoms have resolved, AND afebrile for 24 hours, whichever is longer • Symptoms such as cough, fatigue, loss of sense of taste or smell may persist beyond 10 days and does not necessarily infer infectiousness. • **Healthcare providers, individuals working in congregate settings, and areas for high risk of transmission should isolate for 14 days from the onset of symptoms, or until symptoms resolve, whichever is longer** • Consult with OCPHO to prior to discontinuation of isolation Complete COVID-19 Case Status Report Form-Part C weekly and if there is any change in condition.	In addition to the criteria for discontinuing isolation for mild cases, severe of hospitalized cases: • Requires additional isolation up to 20 days depending on their condition, symptoms, or if they are immune compromised • Consult facility or territorial IPAC for discontinuation of COVID-19 precautions **AND** • Consult with CPHO or delegate before discharge from hospital Complete COVID-19 Case Status Report Form-Part C weekly and if there is any change in condition.

*For HCPs with COVID-19 infection, the employer may have additional requirements prior to the employee returning to work

Management of Contacts and Contact Tracing

Public Health Units and Health Centres should initiate contact investigation upon identification of a **confirmed or probable case**.

Key Activities in a Contact Investigation

- Initial interview with the case to identify exposures/contacts
- A contact of a case is a person exposed to a probable or confirmed case during their communicable period, who:
    - Provided direct care for the case or had other similar close physical contact without the recommended personal protective equipment (PPE) *See Section on Recommended PPE use for healthcare professionals based on case status.
    - Had direct physical contact with case or their body fluids
    - Lived with, shared a closed space (e.g. room or vehicle) or otherwise had close prolonged contact for a total of 10 minutes or more and within two metres without the recommended PPE (this includes cumulative amount of time equivalent to 10 minutes)
- HCPs can use Table 5: Contact Exposure Assessment and Management to assist with categorizing exposed individuals exposed as contacts or not.
- HCPs must initiate contact tracing immediately, or next day as appropriate, and submit COVID-19 Report Form (For Confirmed Cases) - Part B and the Exposure Investigation form to the CPHO or delegate within 24 hours.
- HCP's should utilize COVID-19 contact line list as a guidance document when interviewing contacts
- Identify and list possible transmission settings and document this information on the Exposure Investigation Form and COVID-19 contact line list. Important settings include:
    - Visits to health care facilities (hospital, health centre, primary care, dental care etc.) or other closed facilities
    - Schools
    - Work sites
    - Friends and family gatherings
    - Religious/cultural gatherings
    - Sports events as a participant or spectator
    - Restaurants and bars
    - Conveyances (airplanes, taxis, ride shares, buses, trains)
    - Stores including grocery or department stores
    - Community gatherings
    - Other mass gatherings

- Other settings of concern to HCP
- Document all identified exposures and contacts on the Contact Line List Spreadsheet
  - HCP must use Medical Confidential fax/SFT to send the contact line list with as much initial information as possible to OCPHO within 24 hours; and
  - Send Medical Confidential fax/SFT updates daily or as required or requested by OCPHO.
- Confirm if any of the contacts have co-morbidities that would put them at higher risk for complications of COVID-19.
- Determine vaccination status of contacts
- Provide contacts educational resources.
- Inquire if case has federal COVID-19 Exposure Notificaiton App. If case would like to enter a one-time key, contact the Reporting Line for the Office of the Chief Public Health Officer at (867) 920-8646 to receive the one-time key to provide to the case for entering into the app.

Guidance on Determining Exposure when using Masks

- Medical masks and non-medical masks/face coverings are "source control" which, when used as recommended, reduce the exit of respiratory droplets from the person wearing them. Wearing only a medical mask/non-medical mask/face covering is **not** sufficient PPE to protect a person with an exposure that would deem them a contact (see definition of "contact" and Table 5 and 5b).
  - Based on incomplete effectiveness of source control, use of medical or non-medical masks by the person with COVID-19 infection does not sufficiently eliminate exposures. Contact investigations should proceed as if the case was not using source control, with the following exception:
    - Continuous masking, consisting of medical grade mask and face-shields for HCP and medical or non-medical mask for patient, along with other routine precautions such as proper hand hygiene, offers **sufficient** protection for HCPs who provide care for patients with pre-symptomatic/asymptomatic COVID-19 infection
  - HCPs working with symptomatic patients with COVID-19 require droplet and contact precautions, and airborne precautions if performing AGMPs. Continuous masking, as described above, is not sufficient protection.

Assessment of PPE Use for HCPs

A surgical/procedure mask, eye protection and good hand hygiene is considered sufficient PPE for HCP's working with asymptomatic patients including the 48 hours prior positive test.

  - **If a HCP** becomes symptomatic, all contacts (patients and coworkers) in the 48 hours prior to symptom onset will NOT be considered close contacts if the HCP wore a surgical/procedure mask (continuous masking), eye protection and practiced routine, frequent hand hygiene.
  - **If a patient** becomes symptomatic, all contacts (HCPs, staff and other patients) in the 48 hours prior to symptom onset, would NOT be considered close contacts if they were wearing a surgical/procedure mask and practiced good hand hygiene.
- If the time of symptom onset for the patient cannot be reliably ascertained (e.g., patient with cognitive impairment), CPHO or designate should be consulted regarding period of communicability and its relationship to appropriate PPE use.
- A surgical/procedure mask and good hand hygiene is NOT considered sufficient or appropriate PPE for HCP caring for symptomatic patients or if identified as a close contact of a symptomatic co-worker.
- Sufficient or appropriate PPE (full contact and droplet precautions) for HCPs caring for symptomatic patients or confirmed/probable cases of COVID-19 includes:
  - Medical masks (or N95 respirators when AGMP is performed);
  - Eye protection (e.g., goggles, visor, or face shield – eyeglasses are NOT considered eye protection);
  - Gloves and gown; and
  - For more information refer to Health Authorities IPAC -Personal Protective Equipment procedures and NTHSSA guidance on approved PPE

Table 5a: Contact Risk Assessment Based on Exposure

Exposure Setting	Risk Level	Types of Exposure that Defines a Contact
Household • Household members providing ongoing, close prolonged hands on care with a case who cannot take care of themselves – infant, young child, disabled or bedridden cases **Other** • Congregate Living environment (Shelters, dormitories, group homes) • Child/daycare settings • Schools • Community/Workplaces	**HIGH** A risk assessment of all contacts should be completed in every case investigation to determine the degree of close contact and the setting in which the contact occurred. Certain scenarios may warrant a fully immunized contact to isolate vs self monitor if the risk is deemed high in a particular setting.	**Examples include:** • Provided direct care for the case or was exposed to bodily fluids without the use of recommended PPE; • Lived/stayed with , or shared a close space with case for ≥ 15min without recommended PPE; • Has had cumulative exposure of ≥ 15min in a congregate living or closed worksite setting without the use of recommended PPE; • Was identified as a contact to a critical variant of concern • Was notified by another jurisdiction or national COVID-19 exposure app
Conveyance • e.g. Aircraft, passenger vans, buses, other vehicles**)** **Short Indoor Public Exposures** **Outdoor Public Exposures**	**LOW** Assess if any risk mitigation measures in place (ie. masking, distancing, hand hygiene practices)	• Passengers or crew seated within 2 metres of the case (i.e including those in the same row and two rows in all directions), depending on the type of aircraft/conveyance and seating) • Store interactions, gym, resturants • Farmers markets, outdoor interactions with friends, concerts, events

Notification via electronic COVID-19 Exposure App	**LOW**	• Notification through COVID19 application will not identify the characteristics and duration of exposure and will only provide a date of exposure to the individual • Consider exposed and treat as contact of COVID19

Table 5b: Recommended Testing and Public Health Management of Contacts Based on Vaccination Status

Immunization Status of contact at time of exposure	Symptoms	COVID19 Testing Recommendations	Contact Management
FULLY VACCINATED - 14 days after receiving the second dose of a two-dose vaccine series	NO	Initial test(on notification of exposure): **NEGATIVE**	• NO Isolation required • Symptom monitor for 10 days from last exposure to case
	YES	If no test done	• **Isolate** • Manage as probable case
		• Initial test **NEGATIVE** • Test again in 48hrs after initial test • Exit test prior to D/C isolation	• **Isolate** • Limit contact with others in home while symptomatic
		POSITIVE	**Manage as a confirmed case of COVID-19**
PARTIAL VACCINATION OR UNVACCINATED - More than 14 days after receiving one dose in a two-dose vaccine series - No vaccine	NO	• Initial test: **NEGATIVE** • Test again in 48hrs after initial test • Exit test prior to D/C isolation	• **Isolate** if meets criteria of a contact • Complete 10 days of isolation from last date of exposure • Symptom monitor
		If tested on or AFTER day 8 (as initial test) & result is **NEGATIVE**	• Complete 10 days of isolation from last date of exposure – no further testing required • Symptom monitor
		POSITIVE	• **ISOLATE** • **Manage as a confirmed case of COVID-19**
	YES	If no test done	**ISOLATE** Manage as probable case

		• Initial test: **NEGATIVE** • Test again in 48hrs after initial test • Exit test prior to D/C isolation	**ISOLATE** • Complete 10 days of isolation • symptom resolution required before isolation discontinuation • Entire household must isolate until results of initial test and 48 hour tests of the contact come back **NEGATIVE**

		If tested on or after day 8 (as initial test) & result is **NEGATIVE**	• Complete 10 days of isolation from last date of exposure – no further testing required
			  • symptom resolution required before isolation discontinuation
			  • Additional testing if symptoms persist beyond 48 hours
			• Entire household must isolate until results of initial test and 48 hour tests of the contact come back **NEGATIVE**

		If tested any time and result is **POSITIVE**	**Manage as a confirmed case of COVID-19**

NOTE: CPHO will assess and provide guidance for contacts in complex exposure settings e.g. gatherings, health facilities, or workplace outbreaks.

Key Management of Contacts

- HCPs, should make every effort to identify, notify and complete an exposure assessment on all contacts within 24 hours.
- Prioritize notification of contacts who live in remote locations, and those who have known conditions that increase risk for severe disease.

- All contacts, whether symptomatic or not, must isolate for 10 days from last day of exposure to case during their communicable period
- HCP should determine the feasibility of the contact to safely isolate at home versus an alternate site based on the nature of the exposure, risk of the contact developing COVID-19, and implication to the household if they become sick.
    - If the contact cannot safely isolate away from household then all members of household must isolate together.
    - HCP should follow any organizational/HSSA directives, protocols, and procedures to guide decisions, for example for contacts living in cabin communities.
    - See Table 3: Determining isolation site and guidance to reduce transmission in households for suspect, confirmed, and probable cases and their contacts (as applicable).
- Determine frequency of active daily monitoring as per organizational/HSSA directives, guidelines or protocols. CPHO strongly recommends active daily monitoring of all contacts.
- Symptomatic contacts should be tested for COVID-19:
    - HCPs should determine if they meet case definition for **probable case** of COVID-19**, and if so, follow guidance for probable case which includes initiating an exposure assessment and contact investigation**.
    - Contacts who develop symptoms should be advised to isolate away from the rest of their household if possible.
    - If the contact requires health services, they should call their local HCP, public health unit or community health centre for mild symptoms or 9-1-1 if they have difficulty breathing or severe symptoms.
        - Contacts should wear a facial covering, preferably a medical grade mask (ASTM level 1 or higher) if required to travel for medical attention.
        - Contacts or HCP should call ahead and advise transferring or receiving facility of symptoms and presumed diagnosis of COVID-19.
        - If transfer via ambulance or med response is required, HCPs must notify 9-1-1/med-response that the client has probable COVID-19 so staff can use appropriate droplet and contact precautions.
- Fully vaccinated contacts that reside in the home and provide prolonged, close contact with the case of COVID19 that will be required to isolate due to the persistent exposure to the case. An example situation may include a mother caring for a child, or caregiver for elderly. Consult CPHO or delegate on further guidance.
- Isolation will be based on contacts vaccination status and exposure risk level- See table 5a & 5b
- If the contact's COVID-19 test is in negative, they must continue to isolate for 10 days from last exposure during case's communicable period and follow outlined public health management based on vaccination status.

- Individuals identified as potentially exposed but who are not contacts **should follow routine public health and workplace advice** including:
    - Self-monitoring for symptoms;
    - Self-isolating and contacting public health /health centre for testing if they develop symptoms; and
    - Usual workplace risk management including screening questionnaires and IPAC recommendations.

Discontinuation of Isolation for Contacts

- Isolation of contacts will be based on vaccination status and last exposure to the case during their communicable period – See table 5a & 5b for guidance on isolation criteria based on exposure risk and vaccination status.
- For household contacts with ongoing exposure, such as those who must stay in the home (e.g. caregiver or parent) and are unable maintain 2 metres distance from the case (e.g. do not have their own space, sleeping arrangements, bathroom) the last date of exposure is the last day of the case's communicable period*. Consult CPHO or delegate for further guidance.
- If a contact develops COVID-19 symptoms during their isolation period, follow guidance outlined in Table 5:
- Isolate a minimum of 10 days since symptom onset or 14 days from their last exposure to the case during their communicable period, whichever is longer.*

For example, if a child has mild COVID-19 and the parent is the contact and caregiver, the child isolates during their communicable period (10 days) and parent isolates with the child **plus 14 days after the child's isolation ends. The parent isolates for 24 days in this situation. If the parent develops COVID-19 symptoms on day 24 , they should be tested. If they test positive and have mild illness, they must isolate for a minimum of 10 further day.*

Additional Contact Tracing Measures

Health care professionals should consult CPHO or delegate for direction on the management of contacts or non-contacts throughout the case and contact investigation. Situations that may require additional follow-up include:

- School, LTCF or remote or closed worksite outbreaks;
- COVID-19 exposures in densely populated public settings;
- COVID-19 infections involving sporting events or teams, or family/group/community gatherings;
- COVID-19 infections at work sites, apartment buildings, shelters, or other communal living; and arrangements
- COVID-19 infections on conveyances such as airplanes, taxis, ride shares, or buses.

Public health interventions to communicate potential exposures in the above situations may include:

- Public health notices or advisories;
- Individual letters of notification; and
- Group notification or mail outs.

Management of Household Members of Contacts

A contact to COVID-19 has a variable risk of developing COVID-19. Household contacts, for example, have a high risk of developing COVID. Current publications estimate the secondary attack rate for household members is about 15% or higher. Variants of concern have an increased rate of transmissibility. With asymptomatic transmission possible, contacts may become cases and transmit to household members without knowing. Household members of a contact who cannot isolate within the home away from the contact, risk transmission to the public. This risk is low, but not negligible. The risk multiplies with increased numbers of household members.

- Isolation in the home means staying in a separate locations in the home so that household members do not meet criteria of a contact (see Table 5b and definition of contact), and practising hand hygiene, healthy respiratory practices, and enhanced environmental cleaning.
- HCPs should ask households with a contact to COVID-19 to attempt to isolate away from the contact if possible. Adopting measures as soon as possible will reduce risk of household transmission should a contact become a case. See Appendix B.
- Provide educational resources (See Education and Resources sections)
- See Appendix B for management of household members of contacts of a case
- Additional considerations for households of contacts:
    - If any household member becomes symptomatic, they should self-isolate and contact an HCP for assessment. HCPs should consider testing all household members for COVID-19 in this situation.
    - Household members of a contact of a case who is isolating in the home are NOT required to isolate if the contact **is fully vaccinated** unless the contact is symptomatic. If symptomatic contact in the home, household must isolate until public health assessment on immunization status is conducted.
    - The symptomatic contact should isolate separately in the home and follow guidance on "isolating safely in the home", HCP's should review household situation to support safe isolation.
    - Household members of a contact who is partially vaccinated or unvaccinated, and symptomatic are required to isolate and follow the same guidance as the contact until public health can assess vaccination status of household members.
    - OCPHO recommends that if any household member is an essential service worker, review vaccination status of household member and contact and inform employer. The decision to return to work should be based on risk assessment. If return to work is necessary, worker should follow exposure control plan.

COVID-19 Vaccines

Current vaccines have been approved by Health Canada for administration in Canada. The NWT'allocated vaccines areModerna and Pfizer, both which received approval by Health Canada for administration in December2020.

Table 6a: COVID-19 Vaccine Types

Product Brand Name	Pfizer-BioNTech COVID-19 Vaccine	Moderna COVID-19 Vaccine	Janssen COVID-19 Vaccine	AstraZeneca COVID-19 Vaccine
Type of vaccine	mRNA	mRNA	Non-replicating viral vector	Non-replicating viral vector
Authorized ages for use	12 years of age and older	18 years of age and older	18 years of age and older	18 years of age and older
Dose	0.3 mL (30 mcg of mRNA)	0.5 mL (100 mcg of mRNA)	0.5 mL(5×10^{10} viral particles)	0.5 mL (5×10^{10} viral particles)
Schedule	2 Doses, 3 weeks apart	2 Doses, 4 weeks apart	1 dose	2 Doses, 4 to 12 weeks apart
Route of administration	IM	IM	IM	IM

The Moderna and Pfizer vaccines are both mRNA vaccines. BothModerna and Pfizer COVID-19 vaccines require two doses into the muscle, with at least 3 – 16 weeks between the first and second dose. For additional guidance related to the Moderna and Pfizer vaccine administration follow NTHSSA's policies and procedures.

Table 6b: Vaccination Status Based on COVID-19 Vaccine Type and Doses

Situation	Vaccination Status*
All vaccines must be given within the recommended time frame as per NACI	
2 doses of viral vector or mRNA vaccine	Fully Vaccinated
2 doses of viral vector or mRNA vaccine; 2nd dose given prior to minimal spacing recommended by NACI	Partially Vaccinated
One dose of Pfizer-BioNTech COVID-19 vaccine followed by one dose of Moderna COVID-19 vaccine (or vice versa)	Fully Vaccinated
One dose of COVISHIELD vaccine followed by one dose of AstraZeneca COVID-19 vaccine (or vice versa)	Fully Vaccinated
One dose of AstraZeneca COVID-19 vaccine or COVISHIELD vaccine (viral vector vaccines) followed by one dose of a mRNA vaccine (or vice Versa)	Fully Vaccinated

** NWT adopts international definitions (ie. US CDC) that a person is "fully vaccinated" at ≥2 weeks after they have received the second dose in a 2-dose series (Pfizer-BioNTech,Moderna or AstraZeneca) in accordance to vaccination interval outlined by NACI.*

Interchangeability of Covid-19 Vaccines

All currently authorized COVID-19 vaccines in Canada use the spike protein of the SARS-CoV-2 virus as the antigen. Combining different COVID-19 vaccines that induce an immune response against the SARS-CoV-2 spike protein will lead to a robust immune response.

NACI recommends that, if readily available, the same mRNA COVID-19 vaccine product should be offered for the subsequent dose in a vaccine series started with an mRNA COVID-19 vaccine. However, when the same mRNA COVID-19 vaccine product is not readily available, or is unknown, another mRNA COVID-19 vaccine product recommended for use in that age group can be considered interchangeable and should be offered to complete the vaccine series. The previous dose should be counted, and the series need not be restarted.

NACI recommends that while either an AstraZeneca/COVISHIELD COVID-19 vaccine or an mRNA COVID-19 vaccine product may be offered for the subsequent dose in a vaccine series started with an AstraZeneca/COVISHIELD COVID-19 vaccine, an mRNA COVID-19 product is preferred as a subsequent dose, due to emerging evidence, including the possibility of better immune response, and the safety of heterologous schedules. Regardless of which product is offered, a complete two-dose series is important for protection; the previous dose should be counted, and the series need not be restarted. Individuals who receive two doses of the AstraZeneca/COVISHIELD vaccine are considered protected and do not require further vaccination.

The recommendation to offer mRNA as the second dose is based on expert opinion and on the following elements:

- The risk of VITT after the first and second doses of the AstraZeneca/COVISHIELD vaccine
- The possibility of increased short-term reactogenicity with a mixed schedule
- Emerging data on immunogenicity of a mixed schedule of the AstraZeneca followed by the Pfizer-BioNTech vaccine

Guidance On Management of Side Effects after Routine Immunizations (e.g. influenza or COVID-19)

- Following the administration of a vaccine, an immunized person should be counseled about the risk of short-term self-limited side effects, including local reactions and systemic reactions.
- Some side effects following immunization such as fever, headache, muscle/joint ache, are similar to symptoms for COVID-19. Ifa vaccine recipient develops these symptoms after vaccination in the expected timeframe for that vaccine (for most vaccines: within 24 hours; for MMR, Varicella and MMRV, usually within five to 12 days), they should stay home and away from others.
- If the symptoms resolve within two days (48 hours), they can resume normal activities, unless they have been instructed to quarantine or isolate for other reasons.
- If the symptoms do not resolve within two days (48 hours) of symptom onset, they should continue to stay home and arrange for testing and assessment by a healthcare provider.
- HCPs should be vigilant for other causes of symptoms following immunizations with COVID-19, especially if symptoms persist for beyond 24 hours.
- All vaccine recipients who develop symptoms compatible with COVID-19 should be tested for SARS-CoV-2 to document breakthrough illness, particularly in the context of the emergence of VOC. Genetic sequencing should be strongly considered for those with SARS-CoV-2 infection after vaccination with either one or two doses of a COVID-19 vaccine.

Other Public Health Prevention Measures

In addition to public health advisories, orders, GNWT communications regarding COVID-19 prevention and guidance in this document, OCPHO believes the following measures and considerations remain important.

Immunizations

- Health centres, public health teams, and HCPs should prioritize routine immunizations for those in the NWT and identify priority populations who especially benefit from seasonal influenza vaccine and pneumococcal vaccines as indicated.

Screening Measures for high risk environments

- Organizations/HSSAs/HCPs must implement active and passive screening measures for those who live, work, train, volunteer or visit in all closed facilities. Active screening means asking individuals questions regarding travel and other COVID exposures, symptoms of COVID-19, and whether they must be isolating. Passive screening means posting signage eliciting the same information.

Workplace Health and Safety

- NWT's *Safety Act* and *Occupational Health and Safety Regulations* are key measures to protect workers in NWT. Employers must have an exposure control plan to outline how employers, supervisors, and employees will eliminate or control the risk of COVID-19 exposure at work. Workers' Safety and Compensation Commission (WSCC) collaborates closely with employers to create safe working environments. Health centres, public health teams, HCPs, GNWT departments, and HSSAs should follow WSCC guidance, and advocate for safe workplaces for their clients.

Social Determinants of Health and Unintended Consequences of Public Health Actions to Prevent COVID-19

The social determinants of health (SDOH) are the conditions in which we live, learn and grow and include income and socioeconomic status (SES), employment and working conditions, education, housing conditions, and health services. Early analysis demonstrates that the SDOH modify the impact the of COVID-19 infection, with worse outcomes in lower SES groups. SDOH also modify the effectiveness of public health actions meant to protect populations.

COVID-19 and the widespread societal and public health actions, while intended to reduce the impact of COVID-19, have complex social, legal/ethical, economic, environmental, and political implications. Unintended consequences of COVID-19 are any adverse impacts on health or wellbeing. Potential unintended consequences include:

- Increases in substance use and harms from substance use;
- Increases in interpersonal violence or family violence;
- Increases in child maltreatment;
- Worsening mental health outcomes including anxiety and depression, especially in elderly;
- Increases in shelter use;
- Reduction in workable hours or employment resulting in income inequities and increased poverty;
- Reduced food security (e.g. through reduced access to food programs in schools or through non-government organizations); and
- Disruption in essential supply chains leading to increase costs and expenses.

Addressing the SDOH will improve NWT's COVID-19 outcomes, and improve the effectiveness and safety of public health measures. Addressing the SDOH requires a societal, pan-government approach, and long-term horizon. Specific COVID-19 objectives include:

- Protecting under housed individuals;
- Addressing smoking rates;
- Maintaining school and day care services while addressing COVID-19 risks;
- Preventing problematic substance use;
- Maintaining food security;
- Addressing systemic racism and impacts of colonial policies and intergenerational trauma;
- Maintaining job security and safe working condition; and
- Addressing overcrowding living conditions.

Efforts to protect high risk individuals

During times of community transmission or when exposures are occurring in the community, those at higher risk of exposure should avoid close contact with individuals at higher risk of severe illness, as possible. For example, health care workers who are assessing people with COVID-19, even though they are not deemed a contact, should avoid close contact with the elderly outside of work.

6. EDUCATION and RESOURCES

For more information about COVID-19:

- **Government of the NWT Public**: GNWT/COVID-19
  - Public Resources: https://www.gov.nt.ca/covid-19/en/resources
  - Public Health Orders: https://www.gov.nt.ca/covid-19/en/public-health-orders
  - Care in the home for people with COVID-19: https://www.gov.nt.ca/covid-19/en/services/health-and-well-being/care-home-people-covid-19-advice-caregivers
  - Emerging Wisely: https://www.gov.nt.ca/covid-19/en/services/public-health-orders/emerging-wisely
- **Government of the NWT Healthcare Professional**: GNWT HCP/COVID-19
  - Emergency Response Documents
  - Reporting Documents
  - Department Resources (Public Health Management of Case & Contacts, Outbreak management documents)
- **Northwest Territories Health & Social Services Authority Resources**: NTHSSA/COVID-19
- **Call the 8-1-1 Information Line or email** covid-19@gov.nt.ca if you:
  - Need assistance to navigate the HSS website for COVID-19 related information.
  - Have questions related to COVID-19 as it relates to the NWT.
  - Need to advise callers about next steps based on the completion of the NWT COVID-19 Self-Assessment Tool.
  - Need access to HSS Navigator (support to isolation centres and HCP).
  - Contact ProtectNWT (also by protectnwt@gov.nt.ca) to:
    - Assist with all travel related inquiries into the NWT including self-isolation plans.
    - Request for entry exceptions
    - Report a complaint
  - To coordinate with Municipal and Community Affairs to:
    - Arrange isolation accommodations.
    - Facilitate access to services within communities.
    - Assist with “at home on the land” initiative

- **The Government of Canada**: Canada/COVID-19
  - *Health Canada Quarantine Act* and Information: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/latest-travel-health-advice.html#f
- **Centers for Disease Control and Prevention** (CDC): CDC/COVID-19
- **World Health Organization** (WHO): WHO/COVID-19

7. EPIDEMIOLOGY

For current epidemiology of COVID-19 in the Northwest Territories (NWT) see: COVID-19 Dashboard

8. REFERENCES

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Appendix A: Isolation Orders

1. *Federal Quarantine Act:* https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/latest-travel-health-advice.html#f
   - **Mandatory Isolation**: means that as a person enters Canada, if they have symptoms of COVID-19, they:
     - **Must go directly to their place of isolation;**
     - **Must not take public transportation; and**
     - **Should contact a health care provider.**

Because NWT does not receive international travelers directly through commercial flights, mandatory isolation under the federal Quarantine Act will typically occur in other centres.

- **Mandatory Quarantine** means that as you enter Canada, if you don't have COVID-19 symptoms, you must:
  - Provide contact information;
  - Monitor yourself for symptoms;
  - Ensure you have a suitable place of quarantine that has necessitates for living;
  - Go directly to your place of quarantine;
  - Wear a mask or face covering while in transit;
  - Practise physical distancing;
  - Use private transportation in transit if possible;
  - Not leave your place of quarantine unless it is to seek medical assistance;
  - Not have any guests even if you are outside; and
  - Only use private outdoor spaces or shared spaces in your place of quarantine provided you avoid contact with others who didn't travel with you, disinfect spaces after use, and wear a non-medical mask or face covering if you can't maintain 2 m of distance.

Note: Guidance changes frequently for these orders so please visit the links for the most up to date requirements.

2. *Isolation* (NWT Public Health Act Reportable Disease Control Regulations):

   Isolation: Under NWT's Reportable Disease Control Regulations, the CPHO may direct a person who is, or probably is infected with, or who has or may have been exposed to a reportable disease, to isolate himself or herself in an isolation facility or conduct himself or herself in a manner that will not expose another person to infection.

Under the *NWT Public Health Act*, the following people must isolate at home or alternate isolation centre:

- Confirmed, probable, or suspect cases of COVID
- Those who are close contacts of someone who has been diagnosed with COVID-19,

- Household members of contacts of COVID-19 who cannot isolate at home" from the exposed individual (e.g. parent of a child exposed at school)

3. Public Health Order amended July 16, 2020 - COVID-19 Travel Restrictions and Self-Isolation Protocol
    - Self-isolation: a person who has arrived into the NWT from another province or territory in Canada shall self-isolate for 14 days immediately following entry into the NWT in one of Yellowknife, Inuvik, Hay River, or Fort Smith.
    - Public Health Advisory: is a notice issued by the Chief Public Health Officer advising residents to take cautionary measures to protect their health

4. Public Health Advisory, verbal Public Health Order "Updates to Self-Isolation Protocols Effective Immediately" November 18, 2020:
    - If a returning traveler lives a residence without a self-contained unit, everyone in the household must self-isolate for the same duration as the returning traveler.
    - If there is an essential service worker in the home, the worker must contact ProtectNWT and complete a Permission to Work application.

5. Public Health Order dated April 21, 2021 – Self-Isolation for Fully Vaccinated Persons
6. Public Health Order dated April 21, 2021 - Remote Tourism
7. Public Health Order dated June 9, 2021- Relaxing Outside Restrictions
8. Public Health Order dated June 21, 2021- Removal and Reduction in Self-Isolation Periods Depending on Vaccination Status
9. Public Health Order dated June 28, 2021– Removal of Self-Isolation for Fully Vaccinated Persons
10. Public Health Order dated June 29, 2021 –Amendments Mineral Petroleum and Recourses Order
11. Public Health Order dated June 29, 2021 – Gatherings Order- Relaxing Restrictions

Appendix B: Isolation Requirements for Individuals and their Household Members with COVID-19 Symptoms or Exposures

COVID-19 status of client		Type of Isolation Required	Isolation Requirements for Client (Please refer to management sections of chapter for comprehensive advice)
☐	Case of COVID-19	Isolation (*NWT Public Health Act*)	• Monitor for symptoms and report if they develop or worsen • Isolate at home, isolate at hospital, or isolate at alternate site depending on condition and circumstance • At home, case should isolate in separate location from household members during their communicable period, as feasible and acceptable • *Vaccination status of cases does not change the public health management or isolation requirements*
☐	Household member of case of COVID-19	Isolation (*NWT Public Health Act*) if they are contacts	• Monitor for symptoms and report if develop or worsen • Household members of case must continue to isolate for 10 days from their last exposure to the cases' communicable period • Should isolate in separate location in home, or at alternate site, during case's communicable period as feasible and acceptable • *Vaccination status and on going exposure to COVID19 case considered and household contact will be required to isolate*
☐	FULLY VACCINATED Contact of case of COVID-19	Isolation (*NWT Public Health Act*)	• Not required to isolate, unless contact is symptomatic • Symptom monitor for 10 days from last exposure to case • Complete initial test (at 48 hours from last exposure to case)Follow routine public health prevention measures • *Not required to isolate* • Monitor for symptoms and report if develop or worsen • *Test and isolate if symptoms develop*
☐	PARTIALLY VACCINATED/UNVACCINATED Contact of a case of COVID19	Isolation (*NWT Public Health Act*)	• Must Isolate 10 days from last exposure to case • Testing required throughout isolation period, initial test, 48 hours from initial test and on exit of isolation • Should isolate in separate location in home, or at alternate site, during case's communicable period as feasible and acceptable for 14 days from last exposure to the case. • Recommend mask wearing in the home and practicing distancing • Active daily monitoring for symptoms
☐	Household members of FULLY VACCINATED contact of case	Not required to isolate (*NWT Public Health Act*) **IF** unable to safely isolate at home for contact's incubation period, OCPHO will perform risk assessment to determine if longer isolation required for household members of contacts	• Monitor for symptoms, even beyond duration of isolation of contact, and isolate and notify HCP if symptoms develop • Household members NOT required to isolate • If symptoms develop in contact should isolate in separate location in home, or at alternate site, during contacts incubation period as feasible and acceptable. • Must isolate if contact develops symptoms • Follow routine public health prevention measures • Household members that are essential service workers must self isolate and inform employer. Decision to return to work based on risk assessment. If return to work is necessary, worker should follow exposure control plan.

**Please follow all advice provided by a Public Health Official or Health Care Professional. This guidance is generalized and situations may require further risk assessment considerations. August 16, 2021*

☐	Household members of PARTIALLY VACCINATED/UNVACCINATED contact of a case	Isolation based on household members vaccination status (*NWT Public Health Act*) **IF** unable to safely isolate at home for contact's incubation period, OCPHO will perform risk assessment to determine if longer isolation required for household members of contacts	• Fully vaccinated household members should monitor for symptoms, even beyond duration of isolation of contact, and isolate and notify HCP if symptoms develop • Should separate location in home, or at alternate site, during contacts incubation period as feasible and acceptable. • Follow routine public health prevention measures • **If unable to safely isolate in separate residence or suite from the contact, unvaccinated household members must follow the same isolation recommendations as the contact during the contact's incubation period** • **Household members of contacts can end isolation at the same time of the contact if the contact tests negative on day 10 and household member does not develop symptoms** • If symptoms develop in contact should isolate in separate location in home, or at alternate site, during contacts incubation period as feasible and acceptable. • Must isolate if contact develops symptoms • Follow routine public health prevention measures Household members that are essential service workers must self isolate and inform employer. Decision to return to work based on risk assessment. If return to work is necessary, worker should follow exposure control plan.
☐	Suspect case (exposure and Symptoms):	Isolation/Self-Isolation *(NWT Public Health Act* and *Public Health Order and Public Health Advisory "Update to Self-Isolation Protocol" April 21, 2021) depending on circumstances*	• Isolate at home, isolate at hospital, or isolate at alternate site depending on condition and circumstance • Determine exposure type ie. travel, outbreak, or exposure to biological material Determine vaccination status of suspect case • Based on vaccination status follow discontinuation guidelines for suspect case in COVID19 chapter • **At any point if the traveller develops symptoms during isolation and is fully vaccinated must treat as Suspect Case and follow guidance on same**
☐	Fully Vaccinated Traveller , Symptomatic within 14 days of return	Isolation/Self-Isolation *(NWT Public Health Act* and *1)depending on circumstances*	• Isolate at home, isolate at hospital, or isolate at alternate site depending on condition and circumstance • Test at symptom onset • Must have symptom improvement, afebrile with negative, validated COVID-19 tests before isolation discontinuation*absence of cough not required for symptom improvement in those with chronic cough or reactive airway* • • **Household members must isolate if symptomatic traveller in the home** • **If symptoms persist greater than 48 hours repeat PCR test** •
☐	UNVACCINATED/PARTIALLY VACCINATED Traveller , Symptomatic	Isolation/Self-Isolation *(NWT Public Health Act* and *Public Health Order and Public Health Advisory "Update to Self-Isolation Protocol" April 21, 2021)depending on circumstances*	• Isolate at home, isolate at hospital, or isolate at alternate site depending on condition and circumstance • Duration of isolation 10 days from symptom onset • Must have symptom improvement, afebrile with two negative, validated COVID-19 tests. i.e. a negative test at first assessment, and repeat negative test at symptom resolution • **Household members must isolate if symptomatic traveller in the home until further public health advice is provided**
☐	All Household members of suspect case (exposure and symptoms)	Isolation (*NWT Public Health Act and and Public Health Advisory "Update to Self-Isolation Protocol" April 21, 2021*) **IF traveller is isolating in the same residence**	• Monitor for symptoms, even beyond duration of isolation of suspect case,isolation of household members will be based on the vaccination status of each household member • Assess household vaccination status • Household members that are essential service workers must self isolate and inform employer. Decision to return to work based on risk assessment. If return to work is necessary, worker should follow exposure control plan • Individuals who begin isolating with a traveller who is unvaccinated will be required to isolate from the date of shared accomodations beginning. Follow the same guidance as the least vaccinated person in the household and the symptomatic individual

**Please follow all advice provided by a Public Health Official or Health Care Professional. This guidance is generalized and situations may require further risk assessment considerations. August 16, 2021*

		must all self isolate for duration of isolation guidance	
☐	Symptomatic individual no exposure	Self -Isolation (*NWT Public Health Act* - someone suspected to have COVID-19)	• Monitor for symptoms and report if symptoms worsen • Stay home from work or school until direction from the health care provider has been received • Follow routine public health prevention measures • Self isolate from household members until results received and symptom improvement, as feasible and acceptable. End self isolation as per guidance OCPHO algorithm https://www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/covid-19-exposure-algorithm.pdf –maintain • *Vaccination status does not change the public health management or isolation requirements*
☐	Household member of symptomatic individual who had no exposure	No isolation requirement Unless symptomatic individual is unable to self-isolate safely and requiring care	• Monitor for symptoms, even beyond duration of symptomatic person, and notify HCP if symptoms develop • Follow regular public health prevention measures • **Should attempt to isolate safely in the home from symptomatic individual if feasible and acceptable *** • **If household member fully vaccinated, they do not need to self isolate. If symptomatic individual becomes a confirmed case, household member than treated as contact**

Updated: August 16, 2021