



Health and
Wellness

Prince Edward Island Guidelines for the Management and Control of COVID-19

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Department of Health and Wellness
Chief Public Health Office

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Case Definition

Confirmed case

A person with confirmation of infection with SARS-CoV-2 documented by:

The detection of at least 1 specific gene target by a validated laboratory-based nucleic acid amplification test (NAAT) assay (e.g. real-time PCR or nucleic acid sequencing) performed at a community, hospital, or reference laboratory (the National Microbiology Laboratory or a provincial public health laboratory)

or

The detection of at least 1 specific gene target by a validated point-of-care (POC) NAAT that has been deemed acceptable to provide a final result (i.e. does not require confirmatory testing)

or

Seroconversion or diagnostic rise (at least 4-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

Probable case – lab

A person who:

1. Has symptoms compatible with COVID-19

and

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

and

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

or

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

OR

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

OR

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

Probable case – epi-linked

A person who:

1. Has symptoms compatible with COVID-19

and

Had a high-risk exposure with a confirmed COVID-19 case (i.e. close contact) from their household

and

Is unable to be tested (i.e., unable to drive/be driven, age, mobility, unwell)

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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, as listed on a registered death certificate.

Resolved case

A case is considered resolved when:

1. Fever has resolved without the use of fever reducing medication, and other symptoms have improved

and

If the case is not immunocompromised and does not have severe illness, at least 10 days have passed since symptom onset or, if asymptomatic, the episode date

or

If the case is immunocompromised or has severe illness (e.g. admitted to hospital due to COVID-19), a minimum of 20 days have passed since symptom onset

Notes:

A Medical Officer of Health or relevant public health authority (which may include other infection prevention and control experts) may use their discretion when determining if a COVID-19 case requires continued public health management, and their judgement will supersede the above-mentioned criteria.

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

If symptom onset date is unavailable or the case is asymptomatic, the earliest of the following dates (i.e. the episode date) could be used as proxy for classification: laboratory specimen collection date, laboratory testing date or reported date. If a case is lost to follow-up or information required for classification is unavailable, the case can be classified as resolved a minimum of 20 days after the initial report.

Reinfection case

Laboratory-based reinfection

A [confirmed case](#) that was previously classified as [resolved](#), that has a subsequent infection of SARS-CoV-2 where there is laboratory evidence supporting two different infections.

Laboratory evidence includes:

- Genome sequencing¹ or variant of concern (VOC) screening PCR testing indicates two distinct SARS-CoV-2 infections
- **or**
- One of the infections was confirmed to be a variant of interest ([VOI](#))/[VOC](#) or mutations associated with VOI/VOC based on genome sequencing¹ or VOC screening PCR testing
- **and**
- The other infection occurred when the VOI/VOC was not circulating in Canada

Note: A viral lineage is a group of viruses defined by a founding variant and its descendants

Time-based reinfection

A [confirmed case](#) that was previously classified as [resolved](#)* that has a subsequent confirmed infection of SARS-CoV-2 at least 90 days after the previous infection using episode date**

and

Does not meet the laboratory-based reinfection case definition

Notes:

*Public health or clinical judgement should be used to rule out situations where a possible reinfection has been attributed to prolonged viral shedding (i.e., consider if prolonged viral shedding is more likely than reinfection).

** If case is symptomatic, then episode date uses symptom onset date and if symptom onset date is unavailable or the case is asymptomatic, then the earliest of the following dates could be used as proxy for classification: laboratory specimen collection date, laboratory testing date or reported date.

The judgement of a Medical Officer of Health or relevant public health authority may be used to identify reinfection cases based on new exposures or symptoms if the above criteria are not met.

Reporting Requirements

Health Practitioners

Health practitioners, shall, in accordance with the [Notifiable Diseases and Conditions and Communicable Diseases Regulations](#), as part of the Prince Edward Island (PEI) [Public Health Act](#) report all confirmed and probable cases by phone and mail, fax or electronic transfer, as soon as suspected to the Chief Public Health Officer (CPHO) (or

¹ Genome sequencing indicates two distinct SARS-CoV-2 infections as:

- They belong to different genetic lineages **or**
- They belong to the same lineage but contain sufficient single nucleotide variants to support two different infections

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designate) as per the [PEI Reporting Notifiable Diseases, Conditions, and Events Regulations](#).

Laboratories

The Provincial Laboratory shall, in accordance with the PEI [Public Health Act](#), report all positive laboratory results by phone and mail, fax or electronic transfer, as soon as the result is known, to the CPHO (or designate), as per the [PEI Reporting Notifiable Diseases, Conditions, and Events Regulations](#).

Etiology

Coronaviruses are a large family of viruses that are common in many different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people such as with Middle East Respiratory Syndrome (MERS), Severe Acute Respiratory Syndrome (SARS), and now with COVID-19.

Cases of COVID-19 were initially linked to exposure to live animals at a seafood market in Wuhan City but the substantial increase in cases thereafter is due to human-to-human transmission of the virus.

Clinical Presentation

COVID-19 includes clinical features that present in varying type, frequency, severity and within different age groups. Symptoms that are absent at the onset of illness may develop over time with disease progression. To date, there is no comprehensive list of symptoms that has been validated to have high specificity or sensitivity for COVID-19. It is possible, that as new variants emerge there may be changes in the patterns of symptoms that individuals display. Clinical diagnosis should therefore always be confirmed through SARS-CoV-2 laboratory testing. Patients should always be encouraged to seek medical consultation if experiencing new or worsening symptoms not related to any other known causes or conditions. Symptoms of COVID-19 may include:

- New or worsening cough
- Shortness of breath or difficulty breathing
- Fever
- Chills
- Sore throat
- Runny nose, nasal congestion
- Headache
- Myalgia, joint pain, body aches
- Fatigue
- Acute loss of smell and/or taste
- Gastrointestinal symptoms (nausea, vomiting, diarrhea) – *typically along with other symptoms and more frequent in children*
- Skin manifestations (a rash on skin, or discolouration of fingers or toes)

Cough, fever and shortness of breath are the three most common features amongst hospitalized adult patients, while cough, fever and myalgia were the most common symptoms amongst non-hospitalized individuals.

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Clinicians should be aware of signs and symptoms that warrant more urgent or emergency medical attention. Patients with mild disease should be informed to seek medical attention should they experience any of the following:

- Trouble breathing or severe shortness of breath
- Persistent pressure or pain in the chest
- New confusion or altered level of consciousness
- Inability to wake or stay awake
- Pale, gray, or blue-colored skin, lips, or nail beds

Fever

The frequency of fever varies amongst studies but remains one of the primary symptoms of COVID-19. A patient may not present with a fever but may progress to one after a few days of experiencing other symptoms. Older adults and those with underlying comorbidities may experience fever and respiratory symptoms later during the course of illness, when compared to younger persons or those without comorbidities. In some cases, COVID-19 may occur without fever.

Cough and shortness of breath

Other more prevalent symptoms that have been reported include cough and shortness of breath. Cough is one of the most prevalent symptoms along with fever. Both dry (58%) and productive (25%) coughs have been described in the literature. Shortness of breath was more frequently reported in hospitalized patients and associated with more severe disease.

Other symptoms

Many other symptoms have been associated with COVID-19. Of particular note, fatigue, myalgia, and loss of taste and/or smell are experienced in about 1/3 of all cases. Some uncommon symptoms found in COVID-19 but reported during acute illness include congestion or runny nose, skin rashes and eye issues (including conjunctivitis, eye pain and light sensitivity). These other symptoms do not typically occur on their own and are found in conjunction with the more prevalent symptoms. Some of the more uncommon symptoms may also become more prevalent as new variants emerge. Two rare but important syndromes associated with SARS-CoV-2 have been described in the literature and are called Multisystem Inflammatory Syndrome – Children (MIS-C) and Multisystem Inflammatory Syndrome – Adults (MIS-A). These are described below.

Multisystem Inflammatory Syndrome – Children (MIS-C)

In early 2020, this syndrome in children was newly recognized as related to SARS-CoV-2 infection and characterized by hyper-inflammation and multi-organ involvement and presenting with clinical features similar to Kawasaki disease and toxic shock syndrome.

MIS-C signs and symptoms include:

- Kawasaki disease-like features: conjunctivitis, red eyes; red or swollen hands and feet; rash; red cracked lips, and swollen glands. In some children, coronary artery enlargement and/or aneurysms have been described. Some children presenting with Kawasaki disease-like syndrome have been noted to have a broader age range and presentation with more gastrointestinal (abdominal pain or diarrhea) and neurologic (headaches or meningitis) manifestations

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- Gastrointestinal symptoms such as abdominal pain, diarrhea, nausea/vomiting (patients have presented with colitis, hepatitis, and questionable appendicitis)
- Toxic shock syndrome-like features with hemodynamic instability and poor heart function. Cytokine storm/macrophage activation or hyper-inflammatory features
- Thrombosis or acute kidney injury
- Shortness of breath

Common laboratory findings in case reports have included:

- An abnormal level of inflammatory markers in the blood, including elevated ESR/CRP and ferritin, LDH
- Lymphopenia, thrombocytopenia, neutrophilia
- Elevated B-type natriuretic peptide (BNP) or NT-proBNP (pro-BNP), hyponatremia, elevated D-dimers

In children presenting with a persistent fever (≥ 3 days) who are moderately to severely ill with clinical signs of organ dysfunction (e.g. gastrointestinal, respiratory, cardiac, skin, or neurologic), the diagnosis of MIS-C should be considered.

Multisystem Inflammatory Syndrome – Adults (MIS-A)

Since June 2020, several case reports and series have been published reporting a similar multisystem inflammatory syndrome in adults (MIS-A) that was previously identified in children. Three studies identified 27 patients who had cardiovascular, gastrointestinal, dermatologic, and neurologic symptoms without severe respiratory illness and who also have positive test results for SARS-CoV-2 by PCR or antibody assays indicating recent infection. Clinicians should consider MIS-A in adults with similar signs and symptoms as seen with MIS-C. It is important to note that 30% of adults and 45% of children with MIS-C/A reported a negative PCR and a positive SARS-CoV-2 antibody test results, suggesting MIS-A and MIS-C might represent a post-infectious process. If suspicious of MIS-C/A and a patient has a negative PCR test, consider both antibody and viral testing to assist with diagnosis.

Symptoms in children

A systematic review of the signs and symptoms of laboratory-confirmed COVID-19 disease in children and youth under 19 years of age found cases of asymptomatic positive laboratory tests ranged from 15% to 42%. Fever and cough were the most common symptoms; with the proportions with fever ranging from 46% to 64% and for cough from 32% to 56%. All other signs and symptoms were present at less than 10% to 20%. Vomiting, diarrhea and abdominal ranged from 7% to 18%.

One should also consider when assessing children, that the signs and symptoms of COVID-19 are similar to those of other infections and non-infectious processes, including influenza, other viral upper respiratory infections, streptococcal pharyngitis, asthma and allergies. The lack of specificity of signs or symptoms and the significant proportion of asymptomatic infections make symptom-based screening for identification of SARS-CoV-2 in children difficult.

Symptoms in older adults

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Symptoms amongst older adults may be atypical or subtle. Confusion, delirium, and/or loss of movement, mobility and speech may occur in older people. Fever, cough and shortness of breath may be absent or less common.

Symptoms in older adults that differ from typical symptoms include:

- fever and other symptoms may take longer to manifest
- delirium, confusion, falls, functional decline
- decrease in blood pressure
- hypoxia without respiratory symptoms

Asymptomatic, pre-symptomatic and pauci-symptomatic infection

A person who is **asymptomatic** is someone with a positive SARS-CoV-2 test who never develops any symptoms, whereas a person who is **pre-symptomatic** is someone who is infected with SARS-CoV-2 and may have detectable virus, but is not yet showing symptoms (these individuals develop symptoms later on in the course of infection). Individuals who are **pauci-symptomatic** will have a positive SARS-CoV-2 test in the presence of very limited symptomatology. A systematic review and meta-analysis looking at prevalence of SARS-CoV-2 in persons who are asymptomatic from 28 studies, found that 25% of COVID-19 cases were asymptomatic (95%CI: 16–38). Asymptomatic, pre-symptomatic and pauci-symptomatic SARS-CoV-2 infection and how much each of these contributes to transmission is still unknown. The proportion of asymptomatic cases may differ for different variants of SARS-CoV-2.

Diagnosis

Diagnosis is made by isolation of the virus in a mid-turbinate swab, nasopharyngeal swab, throat and nose swab, or mouth gargle by PCR at the provincial lab with a confirmatory result. Abbott ID Now point of care (POC NAAT) testing may also be completed and considered as a positive result.

Epidemiology

Reservoir

Early on, many of the patients in the outbreak of respiratory illness caused by COVID-19 in Wuhan, China had some link to a large seafood and live animal market, suggesting animal-to-person spread. Later, a growing number of patients reportedly did not have exposure to animal markets, indicating person-to-person spread.

Transmission

The understanding of COVID-19 transmission has evolved since the beginning of the pandemic and has informed the public health measures (PHM) used in Canada. Infected individuals generate respiratory droplets and aerosols, which can be transmitted to others. Activities that are more likely to generate respiratory droplets and aerosols include: heavy breathing (e.g., during exercise), talking, singing, shouting, coughing, and sneezing. The droplets vary in size from large droplets that may fall to the ground relatively quickly near the person who is infected, to small droplets called aerosols which may remain suspended in the air and travel on ambient air currents. The risk of transmission via respiratory aerosols is greater in poorly ventilated indoor environments where there is a high density of people and extended duration of contact.

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The relative infectiousness of droplets of different sizes, and the amount of virus in respiratory droplets needed to cause infection (i.e., infectious dose), is not clear.

Infectious droplets or aerosols may come into direct contact with the mucous membranes of another person's nose, mouth, or eyes, or they may be inhaled into the nose, mouth, and airways, with smaller aerosols penetrating deeper into the lungs. The virus may also spread when a person touches another person (e.g., a handshake) or an object (referred to as fomites) that has the virus on it, and then touches their mouth, nose, or eyes with unwashed hands.

Other factors that may affect the transmission of COVID-19 are age, infectiousness, presence of symptoms, illness severity, and characteristics of the virus itself (e.g., VOC), as well as adherence to personal preventive practices, such as physical distancing, proper use of well-constructed and well-fitting masks, hand hygiene, and respiratory etiquette. There is no evidence to date to suggest differences in mode of transmission of circulating VOC.

Environmental factors, settings, and specific activities can contribute to the risk of viral transmission, including enclosed spaces, especially those with poor ventilation, crowded settings, congregate living settings and close interactions. Settings where these factors overlap or involve activities such as singing, shouting or heavy breathing (e.g., aerobic exercise) are considered higher risk. Examples of these settings include family gatherings and other social gatherings, religious services, funerals, and choir practices, as well as in occupational settings including health care facilities and meat/seafood processing plants. The duration of exposure in such settings is also likely to increase the risk of transmission. It is exceedingly important that PHM be applied in a “layered” manner in these settings to reduce the risk of transmission

Incubation Period

The incubation period for COVID-19 has been estimated to range from 2 to 14 days, with a median of 5-6 days from exposure to symptom onset. Of all individuals who develop symptoms, 97.5% of the symptoms occur within 11.5 days of exposure and 75% will develop symptoms between 6.7 and 8.5 days. The Omicron variant of concern, which is currently the dominant strain in PEI, has a shorter median incubation period of 3 days (range 0-8 days).

Period of Communicability

The time period in which an individual with COVID-19 can transmit the virus is said to be from 48 hours prior to the onset of symptoms to 10 days after symptom onset for immunocompetent people. The levels of viral RNA from nasopharyngeal, saliva/sputum samples, upper respiratory specimens, and stool samples appear to be highest soon after symptom onset. Transmissibility declines rapidly 2-3 days after symptom onset and is estimated to be less than 3% after seven days from symptom onset. Asymptomatic cases are estimated to be 25% less infectious than symptomatic cases.

Live viral shedding may occur for longer in those with illness of greater severity (e.g., admitted to hospital directly due to COVID-19) and those who are severely immunocompromised², and the period of communicability may extend to 20 days after onset of symptoms in these groups.

² Immunocompromised include cancer chemotherapy, untreated HIV infection with CD4 T lymphocyte count <200, combined primary immunodeficiency disorder, taking prednisone >20 mg/day (or equivalent) for more than 14 days and taking other immune suppressive medications.

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Note that SARS-CoV-2 RNA may be detectable in the upper or lower respiratory tract for weeks after illness onset. However, detection of viral RNA does not necessarily mean that the patient can transmit the virus.

A systematic review and meta-analysis found that SARS-CoV-2 cases with serial upper respiratory tract samples showed peak viral loads within the first week of symptom onset. The highest viral loads were reported soon after or at the time of symptom onset or at day 3–5 of illness, followed by a consistent decline.

Disease severity and risk factors for severe disease

There is a spectrum of COVID-19 disease severity, ranging from asymptomatic to mild, to moderate, severe and critical disease. Severe disease more often occurs in those with increasing age and those with underlying medical conditions, with the risk increasing with the number of underlying conditions.

High risk for mortality was associated with increasing number of comorbid conditions. A comprehensive CDC scientific evidence review process and a Canadian rapid review have recently been published to update the list of underlying medical conditions associated with more severe COVID-19 disease. The conditions identified in these reviews are listed in Table 2 below:

Table 2: Underlying medical conditions associated with more severe COVID-19 disease

Asthma (moderate to severe) Cancer Chronic kidney and end-stage disease Chronic lung diseases Cystic fibrosis Dementia or other neurological conditions Diabetes (type 1 or type 2) Down syndrome Epilepsy Heart conditions <ul style="list-style-type: none">• such as heart failure, coronary artery disease, cardiomyopathies or hypertension	HIV infection Immunocompromised state Interstitial lung disease Liver disease Motor neuron diseases Overweight and obesity* Pregnancy Pulmonary hypertension Sickle cell disease or thalassemia Smoking, current or former Solid organ or blood stem cell transplant Stroke or cerebrovascular disease Substance use disorders
*Overweight = body mass index (BMI) > 25 kg/m² but < 30 kg/m², obesity (BMI ≥30 kg/m² but < 40 kg/m²), or severe obesity (BMI of ≥40 kg/m²)	

Patients with certain medical and/or social vulnerabilities, including people experiencing intellectual and developmental disabilities, persons who use substances regularly, people experience cognitive disabilities, mental health conditions or experiencing homelessness or are unhoused, may make it more difficult for the patient to recognize, clearly communicate, or act on symptom progression. These patients need closer attention and monitoring.

Variants of concern (VOC)

Genetic variations of viruses, such as the one that causes COVID-19, are common and expected. SARS-CoV-2, the virus that causes COVID-19, will naturally develop mutations, which are changes to the genetic material in the virus over time.

Monitoring for genetic changes in the virus allows us to better understand the potential impact of the mutation. VOCs detected in Canada to date include; Alpha (B.1.1.7), Beta (B.1.351), Gamma (P.1), Delta (B.1.617.2) and Omicron (B.1.1.529; including BA.1, BA.2, BA.3, BA.4, BA.5 and descendent lineages).

Clinical Reinfection

Reinfections have been confirmed to occur in several individuals through the detection of two different viral genomes associated with what appear to be separate episodes of infection. While these are rare, clinical reinfection of COVID-19 should be considered in a patient with a previously confirmed COVID-19 infection (as determined by a positive SARS-CoV-2 molecular test), who is experiencing a recurrence of COVID-19 symptoms and has a subsequent positive SARS-CoV-2 PCR test. This reinfection should include a sufficient time period between the first infection and the second (using clinical judgement and epidemiological investigation). As new variants are introduced, reinfection may become more common. Fully vaccinated people who are admitted to hospital with COVID-19 should have genetic sequencing performed.

As variants of concern (VOC) emerge in Canada it will be important to continue to assess patients with symptoms of COVID-19, particularly as breakthrough cases may occur amongst the vaccinated and those previously infected.

Occurrence

General

Novel coronavirus (COVID-19) was first detected in Wuhan City, China in December 2019. As of March 22, 2022, over 470 million cases have been detected across the world with over 6.1 million deaths (global case fatality rate: 1.3%). Up to date global case and death numbers can be found here: <https://covid19.who.int/>

Canada

There have been 3,897,879 cases and 41,363 deaths (case fatality rate 1.1%) as of June 17th, 2022. Updated numbers of COVID-19 in Canada are available on the [Public Health Agency of Canada](#) website.

Prince Edward Island

As of June 14, 2022, there are 39,377 cases of COVID-19 reported in PEI and 44 deaths due to the virus.

Control

Management of a Case

A case diagnosed in the Community:

- Lab or testing clinic (for Abbott ID Now test results) notification is made to the CPHO by phone, fax or electronic transfer.

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- Patient will receive instruction upon testing (Lab or testing clinic (for Abbott ID Now test results) about how to access test results through on-line portal, phone, or email.
- Follow-up calls are completed by Public Health Nursing (PHN) or Statistics Canada to positive cases in the community. The ultimate goal is to connect with all positive cases but focused attention to higher risk groups (i.e. younger children, individuals over 50 years of age, etc.) may occur.
- When necessary, additional follow-up calls to monitor health status of the infected person may occur when concerns about health status, risk factors.
- Isolation can be discontinued for a case, 7days³ after symptoms onset or date of positive test, as long as the infected person has improvement of symptoms and is fever free for 24 hours and is not taking any immunosuppressive therapies.
- Isolation can be discontinued for a case, who is immunocompromised⁴ (not requiring hospitalization), 10 days after symptom onset or date of positive test, as long as the infected person feels well.
- Isolation can be discontinued for a case, who is immunocompromised and experiencing severe disease requiring hospitalization, 14 days⁵ after symptoms onset or date of positive test.
- If the infected person is a health care worker, they may return to work after their isolation is complete.

Management of Contacts

Most close contacts may be notified by the individual who tested positive directly. There may be situations where a facility or organization assists in the notification of close contacts when necessary. Individuals should assess their personal risk for immune compromise, and other factors that would make them more likely to contract COVID-19.

A close contact is defined as someone who had close contact with a positive case of COVID-19 during the infectious period (48 hours before symptoms started or before testing positive if no symptoms to 10 days after the onset of symptoms). Close contact is described below:

- Had face to face interaction indoors or outdoors for at least 15 minutes, including 15 minutes in total over a 24-hour period, or
- Was within 2 meters (6 feet) indoors for at least 15 minutes, including 15 minutes in total over a 24-hour period, or
- Was hugging, kissing, coughing, sneezing near, or those who provided care for the case, including healthcare workers, family members or other caregivers, or who had other similar close physical contact without consistent and appropriate use of personal protective equipment, OR

³ Viable virus has not been obtained from a recovered case infected with COVID after 10 days post symptom onset or positive test result. 14 days of isolation for contacts is still required since the incubation of the virus can be up to 14 days.

⁴ Immunocompromised include cancer chemotherapy, untreated HIV infection with CD4 T lymphocyte count <200, combined primary immunodeficiency disorder, taking prednisone >20 mg/day (or equivalent) for more than 14 days and taking other immune suppressive medications.

⁵ Hospitalized patients isolate for 10 days (or at discretion of hospital IPAC) after the date of specimen collection or symptom onset(whichever is earlier/applicable).

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- those who lived with or otherwise had close prolonged⁶ contact (within 2 metres) with a probable or confirmed case while the case was ill or within 48 hours of symptom onset, OR
- those who have had direct contact with infectious body fluids of a probable or confirmed case (e.g., was coughed or sneezed on) while not wearing recommended personal protective equipment.
- Other exposure scenarios not specifically mentioned here may arise and may be considered at the discretion of the CPHO.

Close Contacts

- Are not required to self-isolate but should monitor for symptoms closely and follow enhanced measures:
 - Monitor for symptoms closely and if symptoms develop, isolate immediately and get tested
 - Complete testing on day 4 after exposure if you live, work, or access services in a vulnerable setting*
 - Wear a properly fitted, three-layer mask or medical mask outside the home (and as much as possible during physical/recreational activities).
 - Work from home as much as possible.
 - When at work, practice physical distancing including while eating or drinking.
 - Do not visit high-risk settings or individuals* until after 10 days (settings such as long-term care, community care and other congregate living facilities, childcare facilities, and individuals who may be at risk for severe COVID-19 outcomes). This 10 day restriction does NOT apply to:
 - staff who have completed the 4 day isolation and testing and wear well-fitting masks and following appropriate COVID-19 protocols, and
 - children attending childcare facilities.

Individuals who are identified as close contacts who previously tested positive for COVID-19 or were considered to be positive for COVID-19 based on exposure history and symptoms in the last 90 days AND do not have symptoms are not required to isolate but should monitor for symptoms. If symptoms develop, those individuals should stay home until symptoms have resolved. Testing is not recommended for 90 days

Outbreak management

Outbreaks may occur in a variety of settings in the community, such as long-term care facilities, hospitals and other high-risk settings. These settings have specific guidelines that address outbreak management. Other exposure scenarios not specifically mentioned in the close contact definition may arise and may be considered at the discretion of the CPHO.

⁶ There is insufficient evidence available to define risk in terms of the length of exposure time required for transmission. For public health contact identification and management purposes only, a period of 15 cumulative minutes over 24 hours has been selected to distinguish between brief and prolonged exposure. This parameter should not replace the conclusions derived from an individual risk assessment, conducted by the public health authority that addresses a variety of factors (i.e. infectiousness of the case at time of exposure, exposure is to a VOC, likely route of transmission, risk factors, etc.) that will more precisely inform risk.

Vaccination

Vaccination is one of the most effective ways to protect our families, communities and ourselves against COVID-19. Evidence indicates that the vaccines used in Canada are very effective at preventing severe illness, hospitalization and death from COVID-19.

COVID-19 vaccines approved for use in Canada are free of charge. They are available to everyone eligible to get the vaccine 5 years of age and older. COVID-19 vaccines approved for use in Canada include:

- mRNA COVID-19 vaccines:
 - Pfizer-BioNTech Comirnaty® for those 5 years of age and older
 - Moderna Spikevax® for those 6 years of age and older
- viral vector COVID-19 vaccines:
 - AstraZeneca Vaxzevria® for those 18 years of age and older
 - Janssen (Johnson & Johnson) for those 18 years of age and older
- protein subunit COVID-19 vaccines:
 - Novavax Nuvaxovid® for those 18 years of age and older
- plant-based COVID-19 vaccines:
 - Medicago Covifenz® for those 18 to 64 years of age

The primary series of mRNA vaccines (Pfizer-BioNTech Comirnaty® or Moderna Spikevax®), plus a booster dose, offers better protection against Omicron infection and severe disease than the primary series alone. Among people who are vaccinated, studies show that:

- their level of protection against infection from the primary series decreases over time and is low against Omicron, but can be improved with a booster dose
- the primary series appears to maintain good protection against severe disease (such as hospitalization) caused by Omicron
- protection against severe disease is higher after a booster dose

Vaccination is very important, even if you've been previously infected with COVID-19. While infection alone provides some protection, vaccination after infection helps improve the immune response and may provide better and longer-lasting protection.

More information on COVID-19 vaccines authorized for use in Canada can be found at: <https://www.canada.ca/en/public-health/services/diseases/coronavirus-disease-covid-19/vaccines.html>

For information on Prince Edward Island COVID-19 vaccine clinics visit: <https://www.princeedwardisland.ca/en/information/health-and-wellness/getting-the-covid-19-vaccine>

Treatment

Several different types of treatments for COVID-19 have been developed and are being evaluated in Canada and around the world. Examples include drugs that reduce or stop the virus from multiplying in human cells and drugs that treat the symptoms of COVID-19. Health Canada only authorizes treatments, including those for COVID-19, following a thorough scientific review of the safety, efficacy and quality data. A treatment must show evidence that it works well, is of high quality and is safe. The available data must demonstrate that the treatment's benefits outweigh its risks.

COVID-19

Health Canada has authorized the following COVID-19 treatments. These treatments are available for provinces and territories to use in their health care systems. Each province and territory are determining the appropriate administration of these drugs based on their needs.

- [Remdesivir \(Veklury\)](#)
- [Bamlanivimab](#)
- [Casirivimab and imdevimab](#)
- [Sotrovimab](#)
- [Nirmatrelvir and ritonavir \(Paxlovid™\)](#)

The antiviral drug Paxlovid™ (nirmatrelvir and ritonavir) is authorized to treat symptomatic adults with mild to moderate COVID-19 who are at high risk of serious illness, including hospitalization or death. This is the first authorized COVID-19 treatment that can be taken orally at home.

A central referral process has been established in PEI to ensure that the patients at highest risk of progressing to hospitalization due to COVID-19 are prioritized for treatment. Eligibility criteria for Paxlovid™ is as follows:

- COVID-19 positive (confirmed by PCR or NAAT)
AND
- Presenting with symptoms of COVID-19 that started within the last 5 days AND at least one of the criteria below:
 - Age 18 years and older with underlying medical conditions that lead to high risk of severe outcomes including hospitalizations or death* regardless of COVID-19 vaccine status
OR
 - Age 50 years and older (regardless of vaccine status)

* <https://www.princeedwardisland.ca/en/information/underlying-medical-conditions>

More information on medications authorized in Canada to treat COVID-19 can be found here: <https://www.canada.ca/en/health-canada/services/drugs-health-products/covid19-industry/drugs-vaccines-treatments.html>

Self-Isolating

Up to date information on self-isolation can be found at:

<https://www.princeedwardisland.ca/en/information/health-and-wellness/covid-19-self-isolation>

Testing

There are three types of testing available on PEI, point of care (POC) testing, lab-based PCR testing and rapid antigen test kits.

Rapid antigen testing requires a confirmation with either POC or PCR.

For more testing information visit: <https://www.princeedwardisland.ca/en/information/health-and-wellness/covid-19-testing-in-pe>

Patients Admitted to Acute Care

Health PEI Acute Care COVID guidance can be found on the Spectrum app.

Residents Admitted to Long Term Care (LTC) or Community Care Facility (CCF)

Refer to [Prince Edward Island Guidelines for the Management and Control of COVID-19 in Long-Term Care Facilities](#) for specific information.

Infection Prevention and Control in the Community

At this time the following Public Health Measures are recommended:

- Wash your hands frequently with soap and water or use alcohol-based hand rub. Use soap and water when hands are visibly soiled.
- Cough and sneeze into your elbow or a tissue. If using a tissue, immediately place it in a waste disposal and wash your hands.
- If possible, stay home when ill with acute respiratory symptoms; if this is not possible, limit close contact with others.
- Limit touching your eyes, nose, and mouth.
- Use of masks by members of the general public when in public places
- Physical distancing (2 metres/6 feet) is recommended in public spaces
- Everyone eligible should get vaccinated with a complete series (and booster dose if applicable) of Health Canada-approved COVID-19 vaccines.

National COVID-19 and Infection Prevention and Control Guidelines

[Infection Prevention and Control for Novel Coronavirus \(COVID-19\): Interim Guidance for Acute Healthcare Settings](#)

[Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings](#)

[Interim guidance: Public health management of cases and contacts associated with novel coronavirus disease 2019 \(COVID-19\)](#)

[Planning for the 2021-2022 School Year in the context of COVID-19 vaccination](#)

[Reducing COVID-19 risk in community settings](#)

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<https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/guidance-documents/signs-symptoms-severity.html>
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- 4. Prince Edward Island Legislative Council Office.** Prince Edward Island Public Health Act. [Online] May 13, 2021.
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- 5. PEI Department of Health and Wellness.** It's the Law: Reporting Notifiable Diseases, Conditions, and Events. [Online] PEI Department of Health and Wellness.
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Appendix A: At a Glance: Case and Close Contact Management

Scenario	Isolation Requirement	Further Testing	Notification of Result	Public Health Unit Follow-Up Responsibilities
POSITIVE CASE	7 days	Further testing not recommended for 90 days	Results available On-line Portal; email; phone line	Followed as a case by PHN or Statistics Canada
POSITIVE CASE (Immunocompromised not requiring hospitalization)	10 days	Further testing not recommended for 90 days	Results available On-line Portal; email; phone line	Followed as a case by PHN or Statistics Canada
POSITIVE CASE (Immunocompromised and severe illness requiring hospitalization)	14 days (or at discretion of hospital Infection Prevention & Control) after the date of specimen collection or symptom onset (whichever is earlier/applicable)	Further testing not recommended for 90 days	Results available On-line Portal; email; phone line	Followed as a case by PHN or Statistics Canada
CONTACT	No isolation required <i>*Enhanced Monitoring</i>	Test at Day 4 if lives, works, or accesses service in vulnerable setting	Results available On-line Portal; email; phone line	To be notified of close contact by positive case. <i>In some situations, notification may be done by facility or organization (e.g. school, sport)</i>

**Enhanced Monitoring includes:*

- Wearing a properly fitted, three-layer cloth mask or medical mask outside your home (and as much as possible during physical/recreational activities)
- Work from home as much as possible.
- When at work, practice physical distancing including while eating or drinking.
- Be tested on day 4 at a testing clinic if you live, work, or access service in a vulnerable setting.
- Monitor closely for symptoms, if symptoms develop isolate immediately and be tested at a testing clinic.

Vulnerable settings/roles include:

- Health Care Workers
- First Responders
- Members of First Nations communities
- Staff and residents of shelters and transition houses; homeless population
- Long-term care, community care residents
- Corrections staff and inmates
- Mental Health & Addictions inpatients
- Essential workers approved for Test to Stay

COVID-19

Appendix B: Symptom Diary for Self- Isolation

Name:								
MRN:								
Start Date of Isolation:								
Day	Symptoms							
	Symptoms	Temperature C°/F°	Sore Throat	Cough	Runny Nose	Shortness of Breath	Other Symptoms	Have you had contact with anyone outside of isolation?
0	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No		
1	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No		
2	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No		
3	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No		
4	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No		
5	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No		
6	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No		
7	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No		
8	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No		
9	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No		
10	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No		
11	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No		
12	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No		
13	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No		
14	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No		
...								