COVID-19 Healthcare Provider Q&A for Return to School - September 17, 2020

Questions:

High-risk exposures

1. If everyone is wearing a mask, what constitutes a high-risk exposure?
2. Is there a clear guideline for defining high-risk exposure that we can share? Further, does primary care need to contact Public Health for all these suspected high-risk patients?
3. If school/student based contact tracing indicates presence of high-risk exposure leading to public health direction to isolate, when should those cases be tested? 5-7 days after exposure or sooner?
4. If infectious while at school, does this apply to all circumstances as exposure? If everyone in the cohort is masked, would everyone still need to self-isolate, or would self-monitor be allowed?
5. What are the factors considered and who makes this judgement about a high-risk exposure?

Symptoms and self-isolating

6. What is the process for dealing with a symptomatic child and their household members?
7. If someone receives a negative COVID-19 test result, are they required to self-isolate for 14 days before returning to school?
8. For exposed asymptomatic children and symptomatic children who test negative, how long should they stay home? Document says 14 days of high-risk exposure, 24 hours after symptoms end if no known high-risk exposure. Is this adequate process?
9. Who communicates to parents/students on the need to mandatory isolate?
10. If a health care worker's child is required to isolate, what is the impact on the health care worker?
11. Are there any circumstances where a student has respiratory symptoms and won't be sent home from school (e.g. seasonal allergies)? Who makes such decisions, or will any respiratory symptom require a COVID-19 test? Will kids with ongoing symptoms, despite a negative test, need to stay home indefinitely if they are due to another cause like asthma or allergies?
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35. Can you clarify the “no alternative diagnosis” with no test suggested and going back in 24hrs? Would that be someone who is completely asymptomatic with no known exposure?
36. What exactly is the role of the school nurse? Seems they could be better utilized if they could work with local primary care to address specific local needs in the schools and to provide support to all parties.
37. Will school stakeholders - students/principals/teachers - be provided with information about the assessment centre - locations/hours?
38. Does the clinician seeing symptomatic patients have any obligation to report cases they see or suspect of COVID, or is the positive testing the only reason and happens automatically?
39. How do we clinically make the differentiation between a possible false negative/true negative in symptomatic patients? Having clear alternate diagnosis?
40. Should we be more aggressive in using Tamiflu when Influenza is suspected and known to be in the community?
41. How can primary care providers, who may be willing to see symptomatic patients, get support with testing supplies, IPAC and PPE?
42. Under what circumstances should a school call their local PH unit? Is it only for positive confirmed COVID cases or for all students that are sent home when ill?
43. Any guidance on how we manage the many teachers and adult workers who either have mild chronic illnesses or have family members who have chronic disease or who simply have significant anxiety and are requesting notes to exempt them from work?

Busing Considerations

44. How will busing affect cohorting? Given these buses will likely be transporting multiple/different cohorts and a mix of elementary and high school.
45. What are the considerations of busing?
46. What accountabilities are in place regarding school transportation? Will Public Health oversee the accountability or does this fall to the Board?

High-risk exposures

1. **If everyone is wearing a mask, what constitutes a high-risk exposure?**
    - A close contact is defined as a person who had a high-risk exposure with someone who has COVID-19 during their period of communicability.
    - In a school setting, if there is a confirmed case in the student or staff and the case attended school during their period of communicability, then the entire class/cohort will be considered as having high-risk close contact. Some exceptions may apply.
    - Evidence on the effectiveness of masks in non-clinical settings is still emerging. Additionally, non-medical masks are unregulated and not considered PPE.
    - Current evidence indicates that wearing a non-medical mask is likely helpful for keeping the wearer’s respiratory droplets inside the mask, but will not protect the wearer from respiratory droplets from other people. Non-medical masks do not filter these droplets, so wearing a non-medical mask will not affect exposure status.
    - Teachers and other school staff are required to wear medical masks and a face shield. During our risk assessment, if it is determined that these were used consistently and appropriately, then it is possible that individuals may not be considered to have a high risk exposure.

- High-risk exposures are determined using the following parameters from the case and contact management guidance document:
  - Household members when the case was not self-isolating;
  - Had close (less than 2 meters), prolonged (generally more than 15 minutes), unprotected contact;
  - Had direct contact with infectious body fluids of the case (e.g. coughed on or sneezed on).

2. **Is there a clear guideline for defining high-risk exposure that we can share? Further, does primary care need to contact Public Health for all these suspected high-risk patients?**
   - Excerpted from the Management of Cases and Contacts in Ontario provincial guidance:

Community/ Workplaces	• Had direct contact with infectious body fluids of the case (e.g., coughed on or sneezed on) • Had close (<2m) prolonged[2] unprotected contact	High risk exposure – self-isolate
	• Had prolonged unprotected contact but only while the case was consistently physically distancing (e.g., attendees at a gathering, co-workers in a common work area). • Only transient interactions (e.g., walking by the case or being briefly in the same room)	Low risk exposure – self-monitor

[2]As part of the individual risk assessment, consider the duration and nature of the contact's exposure (e.g., a longer exposure time/cumulative time of exposures likely increases the risk, an outdoor only exposure likely decreases the risk, whereas exposure in a small, closed, or poorly ventilated space may increase the risk), the case's symptoms (coughing or severe illness likely increases exposure risk) and whether personal protective equipment (e.g., procedure/surgical mask) was used. To aid contact follow-up prioritization, prolonged exposure duration may be defined as lasting more than **15 minutes**; **however**, data are insufficient to precisely define the duration of time that constitutes a prolonged exposure, and exposures of <15 minutes may still be considered high risk exposures depending on the context of the contact/exposure.

   - Any patient with COVID-19 symptoms with a suspected high-risk exposure meets the probable case definition. If they **decline testing**, they should be reported to public health.
   - Public health routinely follows close contacts of confirmed cases so we would be primarily unaware of high risk exposures from returning travellers.

3. **If school/student based contact tracing indicates presence of high-risk exposure leading to public health direction to isolate, when should those cases be tested? 5-7 days after exposure or sooner?**
   - It is recommended that individuals get tested as soon as COVID-19 symptoms develop. If no symptoms develop, testing should occur approximately 7 days after exposure to a confirmed case.

4. **If infectious while at school, does this apply to all circumstances as exposure? If everyone in the cohort is masked, would everyone still need to self-isolate, or would self-monitor be allowed?**
   - When a positive case occurs at a school, the local public health unit will be responsible for conducting the investigation and assessment to understand: 1) whether an unprotected exposure occurred; and 2) what degree of exposure occurred. Schools are being asked to collect data on cohorts, student attendance, etc. to better assist with conducting these investigations appropriately and accurately. This information is necessary to then make recommendations on self-isolation and/or self-monitoring.
   - If close contacts (which will include the cohort and the teacher) at the school have been identified, they will be appropriately directed for testing and self-isolation.
   - Even though non-medical masks are known to help prevent the spread of respiratory droplets from infected individuals, non-medical masks are not considered PPE and will not be considered as protection from a close contact with a case.

5. **What are the factors considered and who makes this judgement about a high-risk exposure?**
   - Public health units follow up all cases, and from their histories, identify all high risk contacts (i.e., exposures).

- High-risk contacts may be defined as individuals who have been within 2 meters of a case for at least 15 minutes or who have been in contact with bodily fluids (such as with coughing and sneezing), without appropriate PPE. Local public health will consider these factors and the context of the situation to make the determination of a high-risk contact, however, such instances identified by primary care practitioners should be reported to the health unit in which the individual resides.
- With cases who have been in the school setting during their period of communicability, local public health will work with the school principal to identify the affected cohorts (classes, buses) and determine risk of exposure.
- Primary care practitioners may become aware of probable cases whose exposure is from travel outside of Canada (as local public health is not routinely notified of all travelers returning to Canada). Primary care practitioners who become aware of such situations should inform the health unit in which the patient resides, in keeping with the Health Protection and Promotion Act.

Symptoms and self-isolating

6. What is the process for dealing with a symptomatic child and their household members?

- The symptomatic child must be medically assessed (and tested) for COVID-19 and remain in self-isolation until COVID-19 is ruled out.
- Based on the relatively lower case counts (compared to earlier in the pandemic) and the lower test positivity rate (percentage of Halton Residents testing positive) at this time, Halton Region Public Health has decided to align our practice with the provincial direction. This means asymptomatic close contacts of a symptomatic individual will not need to self-isolate until test results are received. Siblings will not have to be sent home or miss school while the symptomatic person is awaiting test results.
- If testing is not done for the symptomatic child and COVID-19 cannot be ruled out by a physician, then the child must self-isolate at home for 14 days from the onset of symptoms. At the end of the 14 days, if the child has been symptom free a minimum of 24 hours, they may resume activities outside their place of isolation (such as school or work).
- Close contacts of a confirmed case and international travellers will have to self-isolate for 14 days even if they test negative during their isolation period.

7. If someone receives a negative COVID-19 test result, are they required to self-isolate for 14 days before returning to school?

- For individuals who had a COVID-19 test and test results are negative, the individual may resume activities outside their place of isolation (such as school or work), provided they have been symptom-free for 24 hours. However, if they were identified as a close contact of a confirmed case or they have recently travelled outside of Canada, they must complete the 14-day self-isolation period regardless of a negative test result.

8. For exposed asymptomatic children and symptomatic children who test negative, how long should they stay home? Document says 14 days of high-risk exposure, 24 hours after symptoms end if no known high-risk exposure. Is this adequate process?

- Ill students and teachers who have had a high risk contact with a case must isolate for 14 days (and 72 hours following being afebrile and symptoms improving), even if they have a negative test.
- Ill students and teachers who have not had a high-risk contact, have not returned from travel out of Canada within the preceding 14 days and who have a negative test can return to school 24 hours following the resolution of their symptoms.
    - Note: Mild symptoms known to persist in young children (e.g., runny nose) may be ongoing at time of return to school if other symptoms have been resolved and there is a negative test.
- Ill individuals may be allowed to return to school without a COVID-19 test by their primary care practitioners if an alternative diagnosis is provided. Such a decision would be made based on the ongoing and past medical history of the patient, and would probably be best informed with a negative test for COVID-19 on the first instance of the condition in question.

9. Who communicates to parents/students on the need to mandatory isolate?

- Public Health has been playing this role for all cases and contacts since March and will continue to do so.
- When a confirmed case has been identified at a school, Public Health will work with the school principal to identify close contacts.
- Both the school and Public Health will communicate with close contacts.

10. If a health care worker's child is required to isolate, what is the impact on the health care worker?

This will depend on why the child is isolating.

If the child is a confirmed case:

- All household members will have to isolate for 14 days.
- If the household contact is a HCW and is asymptomatic, they can practice work-self-isolation during the period of self-isolation. This means they can provide patient care wearing full PPE but must practice self-isolation outside of the workplace (e.g. not going grocery shopping or doing other activities outside of the home).

If the child is symptomatic and awaiting test results:

- The child must self-isolate, seek testing and remain in self-isolation until they receive a negative test result and are symptom free for 24 hours.
- Household members do not have to isolate but must ensure appropriate adult supervision for the child during self-isolation.

If child is symptomatic and testing is not done:

- If testing is not done and a physician does not rule out COVID-19, the child must self-isolate for 14 days from the onset of symptoms.
- Household members do not have to isolate but must ensure appropriate adult supervision for the child during self-isolation.

If child is asymptomatic but identified as a close contact of a confirmed case:

- Household members do not have to isolate but must ensure appropriate adult supervision for the child during self-isolation.

11. Are there any circumstances where a student has respiratory symptoms and won't be sent home from school (e.g. seasonal allergies)? Who makes such decisions, or will any respiratory symptom require a COVID-19 test? Will kids with ongoing symptoms, despite a negative test, need to stay home indefinitely if they are due to another cause like asthma or allergies?

- Such circumstances will be challenging and efforts will be needed to allow children with ongoing symptoms from chronic conditions to avoid unnecessary school absences. Primary care practitioners are best positioned to assess and to identify such situations, including the need for COVID-19 testing. Children with new symptoms not related to allergies or another pre-existing condition should be assessed by a health care provider.

12. If a student gets sick at school and is sent home, should any siblings get sent home as well?

- The symptomatic child must be medically assessed (and tested) for COVID-19 and remain in self-isolation until COVID-19 is ruled out. Any household members of the ill individual are to self-monitor for 14 days (i.e. no longer required to self-isolate) as long as they are asymptomatic.

13. Does the self-isolation recommendation for parents also apply to front-line /medical workers? Or can they return to work if asymptomatic and use full PPE while in a clinical scenario?

- If you are a healthcare provider, you should check with your occupational health department prior to returning to work.
- The following table may direct some of the decision making

Scenario	**PH Recommendation**
HCW's child is an asymptomatic close contact	Inquire if the child is able to effectively isolate in the home. If the child cannot isolate in the home from the HCW parent, consider allowing work self-isolation until the child's isolation period is complete.

HCW's child is symptomatic, **no known** exposures and COVID-19 test is pending	consider allowing work self-isolation until the child's test result returns
HCW's child is symptomatic, **known** exposures and COVID-19 test is pending	Child likely meets the probable case definition. Exclude HCW while child's test is pending and test the HCW.
HCW's child is a positive case	Test and exclude HCW for 14 days after last exposure to the positive case (timing will vary depending on if the child can self-isolate from the parent). If considering work self-isolation where clinical care would be severely compromised without additional staffing, test staff immediately and then may consult with public health as needed
HCW is positive	Follow provincial guidance on work self-isolation

Testing

14. What is the planned approach to testing of the school population?

- The ministries of Health and Education have taken into account the potential increase in medical assessments and testing as a result of school reopening. Local Public Health Units have been preparing internally to ensure capacity to support contact tracing upon school reopening and have also been working closely with local hospitals and Ontario Health to address issues regarding the availability of testing and turnaround time and to develop solutions that are sustainable.
- Students and staff members with symptoms of COVID-19 are encouraged to get assessed and tested at an Assessment Centre. Individuals can also contact their healthcare provider for medical assessment as some primary care physicians are providing testing in their clinics.

15. Can you explain why there is hesitation for testing school-aged children?

- The Ministry of Education requires all staff and students, with the support of parents, to self-screen every day before attending school. If a student or staff member is experiencing any one symptom of COVID-19 (for example, runny nose or sore throat), they must stay home from school and should seek medical assessment.
- Sometimes the medical assessment may help determine an alternate diagnosis for the symptoms, such as seasonal allergies, strep throat, influenza etc. However, the only way to be sure that a symptom is not related to COVID-19 is to conduct testing. Hence we are requesting all primary care physicians to have a low threshold for recommending testing.
- We have seen some resistance among the parent population to subject children to testing. If the medical assessment recommends COVID-19 testing and it is not done, the child must self-isolate for 14 days. However, if COVID-19 testing is completed and the results are negative, the child and household members can end their self-isolation after symptoms resolve for 24 hours.

16. Will information be sent to all parents stating that all children should get tested with upper respiratory infection symptoms?

- Public health supports the provincial school guidance in that staff with symptoms and parents/guardians of children with symptoms should use the provincial self-assessment tool and follow instructions (including to seek testing when recommended).
- The province has adapted their self-assessment tool to be more specific to the school setting (available here), and it includes more details/nuances regarding how to appropriately distinguish some upper respiratory symptoms that are typical for a child versus those that would warrant a strong recommendation to seek testing.
- Local public health units have sent parent letters via school boards advising parents to symptom screen and/or use the self-assessment tool and get tested accordingly.

17. Who will ensure that the test results are negative prior to the child returning to school?

- A written or verbal attestation from parents that a child was seen by a physician and cleared to return to school should suffice. Proof of negative test results are not required. However, school polices may vary on return to school requirements.

18. Clearing to return to school post positive test is stated to be either public health or primary care – creates a degree of confusion. Is there a preference?

- The local public health unit follows all cases (and their high-risk contacts) in order to determine when they can be released from isolation. All positive tests are reported to local public health for follow up. Public health will determine when cases can return to school.
- Students (with support from their parents / guardians) and teachers with symptoms are to self-identify through daily screening, exclude themselves from attending school, self-isolate and seek medical assessment. In most instances testing should be sought.
- Individuals may seek consultation from their health care provider (HCP), as usual, if they believe symptoms are due to an alternative diagnosis. COVID-19 symptoms may be mild and do overlap with other viral illnesses, making a clinical diagnosis to rule out COVID-19 very difficult. Erring on the side of testing is highly encouraged to ensure accurate diagnosis, public health surveillance and early outbreak prevention and control. If the HCP is confident of an alternative diagnosis and provides it to the individual, they can return to school when symptoms are resolved for at least 24 hours.
- If the individual chooses not to be tested for COVID-19 and there is not a known and firm alternative diagnosis, then the individual must self-isolate for 14 days from symptom onset, and be symptom-free for 24 hours prior to returning to school.

19. For a student who <u>tests negative</u>, but <u>continues to have symptoms</u>, do they need repeat testing for COVID-19? If so, is it after 3 days, 5 days and 10 days?

- Ill students and teachers who have had a high-risk contact with a case must isolate for 14 days, even if they have a negative test.
- Ill students and teachers who have not had a high-risk contact, have not returned from travel outside of Canada within the preceding 14 days and who have a negative test, can return to school 24 hours following the resolution of their symptoms.
    - Note: Mild symptoms known to persist in young children (e.g., runny nose) may be ongoing at time of return to school if other symptoms have been resolved and there is a negative test.
- Ill students and teachers from either of the above groups with a negative test whose symptoms persist or worsen should be tested again. If this is not tolerated by students, particularly younger children, then a throat swab may be an option if repeat swabbing is necessary. There are no specific time intervals regarding when such testing should take place. However, in particular, if they have had a high-risk exposure, then testing again towards the end of their incubation period (e.g. day 10-14) would be warranted.

20. With some evidence showing that testing is less accurate in children, how much should we depend on it?

- We are not aware of evidence that testing is inherently less accurate in children, however nasopharyngeal (NP) swabs can be more difficult to obtain in children. The sensitivity of COVID-19 NP testing has been estimated to be 70% to 90% for detecting SAR-CoV-2 on initial testing, with a specificity of over 99%. A throat or nasal swab (which is better tolerated) can be used as a substitute if necessary, however it is less sensitive, and thus more likely to provide false negative findings. Therefore, negative findings from throat or nasal swab results need to be interpreted with caution, and decisions regarding health protection made accordingly.

21. Does a positive Influenza test help confirm a case is not COVID? Is there merit in doing this testing when influenza is more prevalent in the community?

- Ill individuals may be allowed to return to school without a COVID-19 test by their primary care practitioner if an alternative diagnosis is provided. Such a decision would be made based on the ongoing and past medical history of the patient, and would probably be best informed with a negative test for COVID-19 on the first instance of the condition in question.
- An alternative diagnosis can be influenza, and a positive test for influenza would be very helpful in achieving this. During the influenza season it may be helpful to test for both COVID-19 and influenza via NP swab. Public Health Ontario is currently determining their approach to testing NP swabs potentially for multiple respiratory viruses. In rare instances, simultaneous co-infections can occur and dual testing may be helpful to rule out this possibility.

However, during the pandemic, **if only one test is available for testing for ambulatory patients, COVID-19 would be of greater importance to be done.**

22. **How do COVID test results get to schools and Public Health in a timely and automatic way from the ER, symptomatic clinics or primary care who are doing the tests? Is there any consideration for how to simplify and ease this burden of reporting?**
    - All positive test results for COVID (and other Diseases of Public Health Significance) are reported to the health unit in which the patient resides by the laboratory, as required by the Health Protection and Promotion Act. Health Units are required to contact cases within 24 hours of having received these results. In our experience laboratory testing is usually reported to local public health within two days of the testing being initiated.
    - When speaking with your patient who has a positive test, if you become aware that Public Health has not contacted them as yet, then please report this to Public Health,
    - In Halton, primary care providers can report all suspected/confirmed cases of Diseases of Public Health Significance to Public Health immediately by calling 311, 905-825-6000 or toll-free at 1-866-442-5866.

Notes

23. **Will school boards require notes from physicians to confirm that symptoms are not related to COVID-19?**
    - Public Health's recommendation to school boards has been that medical notes and reports of negative test results should not be a requirement. A written or verbal attestation from parents that a child was seen by a physician and cleared to return to school should suffice.
    - However, some schools may still require a medical note when a symptomatic child is **not** tested for COVID-19.

24. **How can primary care manage the probable demand for "mask exception letters" that is already referenced in communication from schools/school boards to parents?**
    - The provincial guide to reopening schools outlines that reasonable exceptions to the requirement to wear masks are expected to be put in place by schools and school boards. Further, that staff or students with sensory or breathing difficulties may be exempted by the school principal, guided by school board policies.
    - Many local public health units are suggesting to school boards that no 'proof of exemption' (e.g., letter or note from a primary care practitioner) be required, and that examples of mask use exemptions be included in the school board reopening plans.
    - School boards may review mask use exemption requests on a case by case basis and public health can continue to support school boards in messaging and communications on this matter.
    - If primary care practitioners are receiving requests for mask exemption letters/notes, they may first suggest to patients to check whether proof of exemption is in fact required by their school board, or whether a parent and/or student attestation to requiring a mask exemption is sufficient.
    - If a school requires a medical note for mask exemption, then please do so based on your medical assessment and knowledge of patient medical history.

25. **Is PH reinforcing the message that notes are NOT required from MDs to return to school post-testing?**
    - Through communications with schools and school boards, many public health units, including Halton Region Public Health, continue to support and reinforce the protocols outlined in the provincial school guidance, including that medical notes or proof of negative tests should not be required for staff or students to return to school.
    - However, schools may require a medical note for a symptomatic person who is not tested for COVID-19.

26. **What is in the purview of the Ministry versus Board in terms of decision-making authority?**
    - The ministries of Education and Health provide direction and set minimum requirements. Local Boards of Education must align with that direction and meet the minimum requirements. Local Boards may decide, based on their local assessment, to exceed the Ministry requirements.
    - For example, the Ministry of Education requires students in Grade 4 – 12 to wear a non-medical or cloth mask while indoors on school property. They encourage (but do not require) students in Kindergarten to Grade 3 to wear masks in indoor spaces.
    - HDSB requires students in grades 1-12 to wear a non-medical or cloth mask indoors in school. Kindergarten students will be encouraged, but not required to wear masks indoors. Reasonable exceptions will apply. HCDSB requires all students (K-12) to wear a non-medical mask/face covering while indoor at school. Reasonable exceptions will apply.

Outbreaks

27. How do you define "widespread transmission"?

- In terms of school outbreaks, we define widespread transmission when it is difficult to connect cases epidemiologically. For example, if there were several class outbreaks or several cases that could not be connected through households, class cohorts, transportation, or external activities.

28. What is the cut-off for an infection rate that would close schools/communities?

- If there is a positive COVID-19 case in a school, public health would conduct a risk assessment and detailed contact tracing. As each situation is unique, public health will work closely with the schools to identify close contacts, and will advise close contacts and other individuals from the same cohort on exclusion and isolation requirements. Confidentiality of the confirmed case will be maintained to the greatest extent possible.
- The decision to close a classroom or school depends the findings of the risk assessment. We look at the likelihood that the confirmed case got the infection at the school and their presence/activities at the school during the time when they may have been able to transmit the disease to others. We will work with schools to provide appropriate communication to everyone involved.
- Closing schools and communities is a big decision and will involve multiple factors. Infection rate (i.e. local epidemiology) will be one such factor that will be considered.

29. Please clarify exactly what constitutes an outbreak where the whole school needs to be dismissed for a 14-day period.

- Public health units are responsible for investigating cases and their contacts, and declaring and responding to school outbreaks of COVID-19.
- Outbreaks in schools are defined as two or more lab-confirmed COVID-19 cases in students and/or staff (or other visitors) in a school with an epidemiological link, within a 14-day period, where at least one case could have reasonably acquired their infection* in the school (including transportation and before/after school care).
  *Examples of reasonably having acquired infection in school include:
  - No obvious source of infection outside of the school setting; or
  - Known exposure in the school setting
- The actions required in response to an outbreak will be directed by the local public health unit, and will be in keeping with their findings regarding the extent and locations of cases. Contacts within the affected cohorts (groupings of students associated with the cases, such as classes and school buses) will be identified for isolation and testing.

  Whole school dismissal will be considered if:
  There is evidence of potential widespread transmission within the school. Examples may include:
  - A number of cases in students, staff or essential visitors with no known source of acquisition outside of the school and no obvious epidemiologic links within the school. Dismissal would allow for break in contact and testing for students, staff, and essential visitors as part of case finding; or
  - Many cohorts have been dismissed based on management of cases and secondary cases (as outlined in rows 1, 2, 3).
  - Outbreaks will be declared over by the local public health unit, and will require at least 14 days to have passed with no evidence of ongoing transmission that could reasonably be related to exposures in the school, and no further ill individuals associated with the initial exposed cohorts with tests pending.

  Testing when the school is dismissed:
  - If a school is dismissed due to widespread transmission, consideration can be given to recommending all school attendees be tested, as part of case finding, particularly if epidemiological links between cases cannot be established and there is evidence of transmission beyond contacts in a case's cohort(s).
  - Given the large volume of testing this includes, coordination with Ontario Health Region will be needed to plan broader testing and ensure timely access and accessibility of testing options.

  Re-opening the school:
  - The outbreak does not necessarily need to be over to re-open the school. Cohorts without evidence of transmission can be gradually brought back to school as additional information and test results become available. Consideration should be given to implementing additional preventive measures and active surveillance as part of re-opening.

30. **Should we anticipate using a mobile team to come to a site (group of teachers/students) where a large outbreak has occurred?**
    - The Central Region of Ontario Health has responsibility to provide mobile assessment centres when and where needed for large scale testing (e.g., during a school outbreak).

Miscellaneous

31. **How does primary care and acute care get timely access to Public Health?**
    - At Halton Region Public Health, health care providers can call Halton Region at 311 for any COVID-19 related questions or email doctors@halton.ca. The Information for Physicians webpage at halton.ca/physicians is updated frequently with COVID-19 information.

32. **What does hand washing education look like for schools/teachers/children? How is handwashing being incorporated into the school day?**
    - The provincial school guidance outlines hand hygiene to be one of the most important protective strategies. It outlines that schools should be prepared to train students and staff on appropriate hand hygiene, including the use of alcohol-based hand rub, and to reinforce its use. The guidance further suggests that regularly scheduled hand hygiene breaks can be considered by school boards. Proper hand hygiene before and after lunch/nutrition breaks and before/after physical education and/or equipment use are also discussed.
    - The provincial school guidance also directs schools to adapt their school environments, both physically and operationally, to support multiple protection strategies/prevention measures, such as signs, to reinforce hand hygiene and the availability of hand sanitizer at school entrances/exits and in classrooms.
    - In working with school boards and reviewing the school reopening plans, local public health reinforces the importance of hand hygiene where appropriate – such as ensuring staggered breaks are provided to students for washroom use and hand washing (and for before/after eating), and availability of sanitizer throughout the schools.

33. **Are children less efficient spreaders - what age do they become as efficient as adults?**
    From the WHO Q & A on Schools and COVID-19:
    - The role of children in transmission is not well understood. To date, few outbreaks involving children or schools have been reported. However, the small number of outbreaks reported among teaching or associated staff also suggests that spread of COVID-19 within educational settings may be limited.
    - As children generally have milder illness and fewer symptoms, cases may sometimes go unnoticed. Importantly, early data from studies suggest that infection rates among teenagers may be higher than in younger children. Some modelling studies suggest that school re-opening might have a small effect on wider transmission in the community, but this is not well understood.
    - Further studies are underway on the role of children in transmission in and outside of educational settings. WHO is collaborating with scientists around the world to develop protocols that countries can use to study COVID transmission in educational institutions, which will soon be available at this link.

34. **Do teachers need gown and gloves which are recommended in HC settings for anyone suspected of COVID-19?**
    - School staff are supplied with full PPE for droplet/contact precautions when caring for a symptomatic child, including gown, gloves, eye protection and medical mask.

35. **Can you clarify the "no alternative diagnosis" with no test suggested and going back in 24hrs? Would that be someone who is completely asymptomatic with no known exposure?**
    - PCPs should err on the side of caution and recommend testing whenever someone is experience COVID-19 like symptoms;
    - PCPs should monitor the current epidemiology in the region that they practice in to help assess the risk of COVID-19 for any of their patients arriving with COVID-19 symptoms. You can find Halton epidemiology data at halton.ca/covid19.
    - The provincial guidance recommends medical assessment for children with COVID-19 symptoms to allow for PCPs to use their clinical judgement for their patients – for example, if a child is sent home due to ear pain and fever, and the child is diagnosed with an ear infection (and there are no other reasons to suspect COVID-19, such as known sick contacts, travel, large social circles, recent large gatherings, etc.), then the child should be able to return to school once improved for over 24 hours.

36. **What exactly is the role of the school nurse?**

- The province has outlined priorities for the role of the school-focused nurses, which include:
  - Providing support to school boards and schools in the development and implementation of COVID-19 health and safety plans.
  - Providing sector-specific support for: IPAC, surveillance/screening/testing, outbreak management, and case and contact management.
  - Supporting communication and engagement with parents and local communities, in addition to the broader health care sector.
- Public health is currently actively recruiting for school health nurses and further determining their specific roles and functions within the context of the priorities noted by the province.

37. Will school stakeholders - students/principals/teachers - be provided with information about the assessment centre - locations/hours?

- Halton Public Health regularly promotes the local assessment centre information online at halton.ca/covid19, as well as communicating it directly to the school board.

38. Does the clinician seeing symptomatic patients have any obligation to report cases they see or <u>suspect of COVID</u>, or is the positive testing the only reason and happens automatically?

- Under the Health Protection and Promotion Act, physicians are obliged to report suspected cases of diseases of public health significance, including COVID-19. If you truly suspect that your patient has COVID-19 (i.e. meets the definition of a probable case which is someone with symptoms and had recent contact with a confirmed case or someone with symptoms and has recently traveled) then do report to Public Health. Just having symptoms does not make it a suspect case. We are being cautious and testing everyone with symptoms because we are still in a pandemic.
- Please note: Public Health receives all positive reports directly from the laboratory. If when speaking with your patient you are made aware that Public Health has not contacted your patient about the positive result, please report it to us immediately.

39. How do we clinically make the differentiation between a possible false negative/true negative in symptomatic patients? Having clear alternate diagnosis?

- The danger of a false negative test is the potential to release infectious cases from isolation, potentially resulting in avoidable transmission. False negative tests can occur while a patient is incubating. Given this, testing for high risk contacts who are asymptomatic is recommended to take place immediately if they have had ongoing exposure to a case or wait until 7 days from last exposure.
- The sensitivity of COVID-19 NP testing has been estimated to be 70% to 90% for detecting SAR-CoV-2 on initial testing, with a specificity of over 99%.
- A pharyngeal/throat swab (which is better tolerated) can be used as a substitute for children if necessary, however it is less sensitive, and thus more likely to provide false negative findings. Therefore, negative findings from throat swabs results need to be interpreted with caution, and decisions regarding health protection made accordingly.
- It is important to recognize the potential for false negative tests, and thus to follow the precautionary practices inherent to provincial COVID-19 guidelines. In keeping with this, all probable cases (those with symptoms and either contact with a confirmed case or a history of travel out of the Canada within the last 14 days) as well as all positive cases need to be reported to the health unit in which the patient resides. Similarly, all ill students and teachers who have had a high risk contact with a case must isolate for 14 days even if they have a negative test.

40. Should we be more aggressive in using Tamiflu when Influenza is suspected and known to be in the community?

- The potential use of Tamiflu during influenza season in individuals without laboratory confirmed influenza does not change the approach required for the management of possible cases of COVID-19. A change in the approach to managing suspected influenza cases regarding possible treatment with Tamiflu is not recommended at this time. All probable cases of COVID-19 (those with symptoms and either contact with a case or a history of travel out of the country within the last 14 days) as well as all positive cases need to be reported to the health unit in which the patient resides. Similarly, all ill students and teachers who have had a high risk contact with a case must isolate for 14 days (and 72 hours following being afebrile and symptoms improving), even if they have a negative test.
- It is worth noting that influenza rates may be reduced with the public health control measures (distancing, hand sanitation, face coverings, self-monitoring and self-isolation with symptoms) for COVID (as they were in Ontario in March, and through the winter in the southern hemisphere). We will be working hard in conjunction with primary care, pharmacies and other health care partners to provide influenza vaccination to the community.

41. **How can primary care providers, who may be willing to see symptomatic patients, get support with testing supplies, IPAC and PPE?**

- Ontario Health is currently offering a transitional supply of PPE to primary care offices from the provincial stockpile. These PPE supplies can be accessed by placing an order online by completing the Critical Personal Protective Equipment (PPE): Intake Form. The PPE supplies will then be couriered to the primary care provider's office or a local depot location will be provided for pick up.

42. **Under what circumstances should a school call their local PH unit? Is it only for positive confirmed COVID cases or for all students that are sent home when ill?**

- Schools and school boards can call their local public health unit whenever they feel we can be of assistance. School Health has been a very long standing priority and area of program delivery for public health.
- Where there is sufficient concern that an individual may have COVID-19 (e.g. school is informed by a parent/guardian that a student has been diagnosed with COVID-19, or informed by a staff that they have been diagnosed with COVID-19), or there are concerns about multiple ill individuals in a cohort, the school should report this to their Local Health Unit immediately. Note: Health units also receive lab reports directly on all positive COVID-19 cases.
- Under the Health Protection and Promotion Act, schools are to report cases of communicable disease to their local public health unit. The Ministry of Education is providing schools with a reporting tool to facilitate such reporting of both individual probable and confirmed cases and an aggregate numbers of absences daily.

    - In general, schools should not report all instances of ill individuals in the school setting to the PHU as these are frequent occurrences and typically students have non-specific symptoms, however, as required by Section 28 of the *Health Protection and Promotion Act*, school principals are required to report to the medical officer of health if they are of the opinion that a pupil has or may have a communicable disease.
    - Principal should connect with the PHU if they have concerns about student(s) related absences or attendance concerns within their school community.
    - The local PHU may be consulted if there are questions about the management of individuals with symptoms, environmental cleaning, and other measures, as necessary

43. **Any guidance on how we manage the many teachers and adult workers who either have mild chronic illnesses or have family members who have chronic disease or who simply have significant anxiety and are requesting notes to exempt them from work?**

- Similarly to the medical management of students, the management of chronic conditions in school staff can be challenging at this time. Primary care practitioners are best positioned to assess and to manage such circumstances, including the need for COVID-19 testing.
- Working in a school environment during the COVID-19 pandemic will be stressful for teachers and other workers, adapting to the new demands and requirements, and managing their own infection prevention and control practices. Some will have underlying medical conditions that would put them at higher risk of complications from a COVID-19 infection. Such individuals may require counselling and support as they determine what is best for their own health and wellbeing.

Busing Considerations

44. **How will busing affect cohorting? Given these buses will likely be transporting multiple/different cohorts and a mix of elementary and high school.**

- Buses will essentially constitute another cohort for the students traveling to school in this way, with masking requirements, assigned seating, and record keeping. This is yet another risk exposure that needs to be managed as part of the return-to-school process.
- The contacts of students who are diagnosed as cases will include those with whom they bus. Thus there will be the potential for students to be placed under isolation by their local public health unit as part of the response to cases in schools.

45. **What are the considerations of busing?**

- Halton Region Public Health has created guidelines for student group transportation.
- Busing can be a challenge, as it is a small space. Additional challenges may be seen when children from multiple schools use the same bus at the same time. This could lead to one exposure resulting in cases in multiple schools.
- Based on Federal and Provincial guidelines, we recommend the following:

- Students with COVID-19 symptoms should not attend school, child care or any other program and should not use student transportation services.
- Students use an alcohol-based hand rub (60-90% alcohol) upon entry to the vehicle.
- Drivers clean and disinfect commonly touched surfaces (e.g. door handles, handrails, seats, windows, seat belts, steering wheel, mirror) at least twice a day and when visibly soiled.
- Students handle their own personal bags and belongings during pick-up and drop-off.
- Students maintain as much distance between students as feasible with the help of visual cues such as floor decals, coloured tape, or signage.
- Students are assigned spaced seating and a record is kept of the seating plan to assist with contact tracing. Students who live in the same household or are in the same classroom cohort should be seated together, where possible.
- Consider boarding and exiting strategies such as filling seats back-to-front for boarding and front-to-back for exiting.
- Where possible, leave the seat directly behind the driver empty.
- Where possible, open windows to increase ventilation.

46. What accountabilities are in place regarding school transportation? Will Public Health oversee the accountability or does this fall to the Board?

- School boards are accountable to adhere to the transportation protocols outlined in the provincial school guidance. Measures discussed in the transportation section of the guidance relate to mask use, distancing, cohorting and assigned seating, and documentation/record keeping.
- Through supporting school boards in their reopening plans, local public health will review aspects related to school bus transportation within the context of the provincial guidance. For example, public health continues to emphasize the importance of record keeping/documentation by schools, including as it relates to transportation use, in case required for case and contact tracing.