COVID-19 Contact Tracing Strategy Adaptations
Approved November 16, 2020

Overall Context

During an epidemic, contact tracing can be useful as a mitigation strategy to reduce the overall burden of disease. When disease incidence is too high, however, it exceeds public health system capacity and must be adapted to prioritize efforts.

This document describes adaptation strategies implemented by consensus agreement between the Commissioner for Public Health and the 61 local Public Health Directors within the Commonwealth of Kentucky.

In the interest of clarity, this strategic medication applies only to SARS-CoV-2 (aka COVID-19) emergency response efforts, not to any other communicable disease response efforts. Additionally, when disease burden decreases sufficiently, these adaptations may be relaxed if public health capacity is sufficient.

Guiding Principles

This strategic prioritization seeks to: 1) maximize efficacy of disease mitigation efforts, 2) optimize efficiency of case investigation and tracing efforts, and 3) maintain public health workforce wellness to sustain its essential COVID-19 emergency response efforts.

Local Determination with Statewide Consistency

LHDs exercise their public health authority in the best interests of their communities with reference to statewide guidance and in consultation with KDPH to promote an efficient, standardized, sustainable system supporting all Kentuckians.

COVID-19 Case Identification and Isolation

Rapidly identifying and isolating new COVID-19 cases remains a high-yield public health intervention to mitigate unrestrained spread of disease. LHDs should prioritize this activity. All new COVID-19 cases should be provided written and/or verbal education related to exposure criteria and they should be asked to notify all family, friends, coworkers, and any others who may meet exposure criteria to self-quarantine for 14 days.

If citizens refuse to voluntarily cooperate with isolation guidance, at the determination of the LHD based on an individualized risk assessment, court-ordered isolation may be considered.

Additionally, because policymakers and citizens rely upon accurate information to make informed decisions, rapid and accurate entry of minimum-necessary data into NEDSS/CTT to track new cases consistently across local and state governments should also be prioritized.

COVID-19 Quarantine

In the context of widespread COVID-19 transmission, all citizens should assume they are at heightened risk of exposure every time they interact with other persons within transmission range of the disease.

Enforcing quarantine for exposed persons in these circumstances is impractical and low-yield due to poor compliance and inability to enforce quarantine on such a large scale. As such, LHDs should provide quarantine guidance to close contacts and urge voluntary compliance. Additionally, these persons should be reminded of the elevated importance of maintaining social distancing, universal mask use, hand hygiene, and immediate self-isolation if symptoms develop.

Except in situations of uniquely elevated public health risk, court-ordered quarantine for possible COVID-19 exposure is not recommended.

In general, LHDs will not provide individual release from quarantine documentation. Instead, LHDs should provide standardized documentation to schools, employers, and other entities to educate and guide them in the safe return of persons to these environments.

COVID-19 Contact Tracing

Widespread disease and public non-compliance with contact tracing both make traditional contact tracing impractical and low-yield. In this situation, LHDs should focus on new cases as noted above and enlist the participation of new cases to advise their own potential exposures of their possible exposure and need to quarantine. Contract tracing is still desirable to the extent possible, but when the public health system is overwhelmed due to widespread disease, greater reliance on cases notifying their own contacts and use of assistive technology (e.g., texts, emails, etc.) should extensively utilized.

Surveillance of Cases and Contacts

Calling close-contacts via telephone outreach for surveillance on a regular basis is not practical in the midst of a large surge of COVID-19 cases. New cases should be provided educational material to share with their close contacts. For close contacts identified by public health professionals, this same educational material should be provided to the close contacts whenever possible.

If automated patient self-reporting (e.g. online, mobile, and/or text, etc.) is possible for contacts to provide daily updates, these methods should be used as alternatives to telephone surveillance.

Prioritization for COVID-19 Case Investigation, Isolation, Contact Tracing, and Follow-Up

<u>High Priority</u>

- Healthcare workers and first responders
- Vulnerable populations/Congregate settings (disproportionately impacted minority populations, hospitalized patients, senior living facilities, prisons, shelters, etc.)

LHDs should follow currently defined case investigation and contact tracing procedures for these populations. Ongoing surveillance is not required, but efforts to contact new cases and provide education, isolation, and quarantine guidance should be a priority.

At the end of the isolation period, if possible, LHD staff should attempt to contact the case to discuss their symptoms and determine if release is appropriate.

In educational institutions, due to the large number of potential contacts, a form letter can be sent to school health personnel to be distributed to those determined to be contacts of cases. This letter will explain the 14-day quarantine process and provide the number for the LHD if the family desires additional information.

<u>All others</u>

In all other situations, when case volume exceeds staff capacity, a modified case investigation will be conducted, and pre-printed guidance will be issued to the person under investigation (PUI). Further, the PUI will be provided with instructions to give to their contacts. Contacts will not be gathered by the LHD.

Delayed Cases

Beginning initial case investigation beyond a reasonable number of days substantially reduces the efficacy of the investigation and tracing. Accordingly, if an investigation has not started seven (7) or more days after a positive test, LHDs should adopt a streamlined approach for these cases:

1) gather the minimum necessary information to meet CDC and DPH reporting requirements;
2) provide the index patient standardized information to share with contacts; and
3) close the file without further action.