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To: Local and Tribal Health Departments

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Crisis Standards of Practice for COVID-19 Contact Tracing and Symptom Monitoring

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Summary

Systematic testing, contact tracing, and supported isolation and quarantine remain the cornerstone of an effective public health response to the COVID-19 epidemic. However, the ongoing high level of disease activity across Wisconsin is resulting in numbers of cases and exposed contacts that at times exceed the capacity of the public health workforce in many jurisdictions. With the current level of staffing and financial resources, state, local, and tribal health departments may not be able to feasibly achieve goals that have been set for completing disease investigations and contact tracing interviews at all times.

In this setting, there is both a need to scale-up and support state, local and tribal health department staffing, as well as to adopt modified standards of practice that result in the highest achievable level of disease containment given the resources currently available.

A working group comprised of leaders from local and tribal health departments have collaboratively identified a number of activities related to disease investigation, contact notification, and symptom monitoring, which may be modified or suspended during periods of increased disease activity, in order to meet the current demands in a sustainable way. This memo outlines considerations for appropriate modification of contact tracing practices that allow the most effective use of available resources during workforce shortages or surge situations.

Background

Current standards of practice for contact tracing and symptom monitoring in Wisconsin are based on the goals of reaching 100% of confirmed and probable COVID-19 cases for disease investigation interview, provision of isolation guidance and eliciting a comprehensive list of individuals in close contact with the case during their infectious period. In turn, under ideal circumstances, all identified contacts are notified, asked to actively monitor symptoms and to remain in quarantine for 14 days following their last exposure to a COVID-19 case.

Accomplishing all of these tasks is highly resource intensive for health departments. Full interviews for cases can take an hour or longer to complete, and interviews for contacts may take 15 minutes or longer.

The success of contact tracing efforts is threatened by a number of factors. In the months after the statewide stay-at-home order was lifted, and as restrictions on social gatherings have been relaxed in most Wisconsin communities, the number of close contacts identified per infected case has grown substantially larger and transmission events and settings have become more complex, both of which add to the workload of contact tracers. A significant proportion of individuals cannot be reached by phone, and some clients once reached express unwillingness to provide the names of contacts when interviewed. Ideally, contact tracers are expected to make multiple attempts to contact a person within 24 hours of the report of a positive test result to facilitate rapid isolation and contact elicitation. Low levels of public cooperation exacerbate challenges.

Recognizing the need to significantly increase contact tracing capacity, the Department of Health Services (DHS) provided Local and Tribal Health Departments (LTHDs) with $49.9 million from the Federal Coronavirus Aid, Relief, and Economic Security (CARES) Act in May 2020 intended to fund 1,394 FTEs to conduct disease and contact investigations and daily monitoring for those in isolation and quarantine. DHS also hired over 200 contact tracers to provide surge and supplemental support to LTHDs. Multiple factors, including the temporary nature of CARES Act funding and local hiring policies, have limited the full utilization of these funds. Despite these hurdles, LTHDs have added 894 FTEs to their contact tracing ranks, and both DHS and LTHDs continue to recruit staff to enhance the existing workforce who are meeting this Herculean challenge. Refining the approach to contact tracing, as outlined in this memo, bolsters the ability to meet critical contact tracing needs while continuing to boost staffing capacity to reach the highest proportion of infected and exposed individuals who are at risk of furthering disease transmission.

Recommendations

In the face of surging disease or limited staffing, local and tribal health departments are encouraged to adopt flexible strategies to meet the goals of contact tracing and monitoring as best they can. Best practices in addressing disease surges and critical staffing shortages should be explored, implemented and evaluated using the best judgment of local health officers and their teams, informed by their experience and familiarity with their local communities. Lessons learned through these efforts should be shared and communicated among state and local health departments as a means to strengthen our collective response.

A description of potential modifications to current contact tracing practices is presented in Box 1. These modifications are intended to be implemented after all other resources, including accessing available state contact tracing resources have been exhausted. This list is not intended to be comprehensive, and each option can be considered by health departments on its own merits.

Box 2 describes a suggested prioritization scheme for contact tracing efforts to notify and monitor contacts of cases when having to perform the work within constrained resources.

Box 1. Accepted Modifications to Contact Tracing During Disease Surges or Staffing Shortages

Use shortened versions of interview forms for case and contact investigations.

- Utilize DHS' modified versions of interview guides, which can be completed in about 20 minutes for cases, and 10 minutes for contacts.

Make fewer attempts to contact individuals who test positive before classifying them as unreachable.

- Consider reducing the number of attempts to reach each client, using a combination of phone calls and text messages.
- Consider forgoing contact investigations if 14 days or more have elapsed since a person was identified to have exposure to a person with COVID-19.

Support people who test positive for the disease in notifying their own close contacts to disseminate education and instructions about testing and quarantine.

- If case patients demonstrate interest and capability, health departments may agree to transfer responsibility to communicate key messages to their household contacts.

Rely on electronic symptom monitoring as the default method for monitoring individuals under quarantine.

- Promote use of the WEDSS self-monitoring tool as the primary strategy.
- Reserve monitoring phone calls for individuals with special needs or those who "opt-in" for more intensive monitoring.
- Reduce frequency of phone contacts, such as at Day 7 and Day 14 of the quarantine period.
- Allow individuals to opt-out of active monitoring by health departments.
- In crisis situations, suspend monitoring for selected contacts, in favor of providing instructions to call if symptomatic.

Suspend certain data collection and data entry requirements.

- Enter household contacts into WEDSS, but only create a Contact Investigation if the household contact requires a separate notification phone call.
- Do not scan all PUI and Patient Information Forms received via fax. File hard copies in case they need to be referenced.
- Do not routinely send negative result letters unless the patient was tested through the health department.

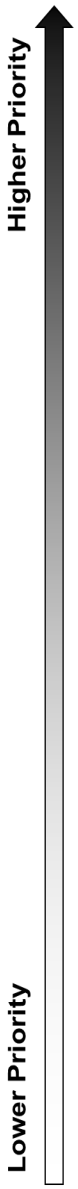
Suspend notification of contacts in low priority categories, as necessary to maintain timeliness of response to confirmed cases and high priority contacts.

- See Box 2.

Defer responsibility of contact tracing activities to other qualified organizations.

- Collaborate with universities, school systems, and large employers to facilitate, develop, and implement contact tracing plans.
- Send a single letter to organizers of events or gatherings, rather than to individuals known to attend events where they were exposed.

Box 2. Prioritization Scheme for Notification of Contacts



Household Contacts
Identify household contacts, obtain demographic information, and create Contact Investigations in WEDSS. Positive cases may agree to notify household contacts if requested and approved by local and tribal health department (LTHD) staff.

High-intensity Contacts Outside of the Household
(e.g., boyfriend, girlfriend, best friends; this does not include school exposures)
Identify contacts, obtain demographic information, and create CIs in WEDSS. Positive case may choose to notify high-intensity contacts in place of LTHD calls with notification.

Other High-risk Contacts
LTHD should determine which other high-risk contacts need to be notified and monitored.

Workplace Contacts
LTHD should work with workplace management to identify workplace contacts. LTHD will determine if contacts should be notified by letter or via individual notifications depending on circumstances.

Activities such as Schools, Youth Activities, and Team Sports
LTHD should coordinate with coach, school, league director, etc. to notify contacts of exposure with a letter and information on self-monitoring form.

Large Gatherings and Events
(e.g., family reunions, graduation parties, festivals)
LTHD should send a letter to the event coordinator (when information is available) and ask them to share with attendees. If LTHD has no contact information for event coordinator, they may consider other options for notifying the public as necessary.

Places
(e.g., restaurants, taverns, grocery stores, etc.)
If there is an individual that can be identified as someone that had significant exposure, LTHD may choose to notify or send information to another jurisdiction as appropriate. If no close contact has been identified, do not send information to another jurisdiction.