Case Investigation and Contact Tracing Update
November 16, 2020

Timely investigation of COVID-positive cases and identification of close contacts is critical to prevent further disease transmission. All new COVID-positive cases will be transferred from CDRSS into CommCare (Login: https://www.commcarehq.org/accounts/login/, helpdesk: oit-esd@tech.nj.gov) and should be interviewed accordingly. Local health departments (LHDs) should enter all investigation information into CommCare including outbreak information (E# case linkage), which now ports over to CDRSS.

To minimize further transmission, COVID-19 cases should be interviewed within 24-hours and LHDs should identify and communicate with close contacts within 24 hours of case creation/contact identification. The level of disease transmission in each jurisdiction and the availability of local resources may determine if public health efforts should focus on identifying areas of potential exposure, all close contacts, or high-concern contacts (e.g., healthcare, long-term care, other congregate settings with vulnerable populations). Active cases should always take priority for investigation.

Sufficient local capacity to investigate cases and contacts within 24 hours

When the case and contact workload is manageable, all cases should be investigated within 24 hours of case creation, isolation recommendations should be provided, and all close contacts should be solicited. All close contacts should be reached within 24 hours and provided with information on self-isolation and/or quarantine, testing, and be actively monitored to ensure compliance with recommendations and to quickly identify additional cases should symptoms develop. In addition, high-concern exposure sites (e.g., long-term care facilities, schools, large gatherings) should be contacted and provided with prevention recommendations.

Insufficient local capacity to investigate cases and contacts within 24 hours

If the LINCS agency reaches >= 20% of cases with no outreach attempted, LHDs in that county should expand the number of staff working on COVID-19 case investigations. Strategies may include reassigning additional local/county resources, bringing on Medical Reserve Corps (MRC) volunteers, cross-training all staff on both case investigation and contact tracing, utilizing PCG staff for case investigation (if not already doing so), and/or requesting additional investigation/tracer resources from NJDOH. If there are still insufficient resources to handle the burden of COVID-19 reports, LHDs may prioritize investigations as follows:

> **Case Investigation**: Investigating cases in a timely manner is the highest priority and is vital to informing containment/mitigation strategies. If all cases cannot be investigated in a timely manner, resources should be targeted towards investigating persons who are more likely to have many contacts or who may expose persons at greater risk for severe disease. When reviewing cases in CommCare, or when receiving reports by telephone, the highest priority for investigation include[1]:
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> - Cases created in CommCare ≤7 days (followed by those created ≤14 days)
> - Persons ≤ 18 and ≥ 65 years old
> - Hospitalized patients

[1] Some high-priority categories will not be known from reviewing reports in CommCare. Information can be supplemented via reporting relationships with community partners.

- Persons potentially associated with a cluster or outbreak or who may have exposed large numbers of people
- Healthcare or other critical infrastructure workers
- Persons known to live, attend, visit, or work in congregate settings including:
    - Healthcare facilities
    - Homeless shelters
    - Correctional facilities
    - K-12 schools or childcare centers
    - Colleges / universities
- Racial and ethnic minority groups

Contact Tracing: When local resources are inadequate, instead of soliciting information on all close contacts, ask specifically about CDC Priority 1 and 2 contacts (Box 4). Create records only for Priority 1 and 2 contacts in CommCare (unless Priority 1 or 2, do not create household contacts in CommCare).

Box 4. Close Contact Evaluation and Monitoring Hierarchy

EVALUATE/MONITOR CLOSE CONTACTS WHO ARE:

PRIORITY 1

- Hospitalized patients
- Healthcare personnel (HCP)
- First responders (e.g., EMS, law enforcement, firefighters)
- Individuals living, working or visiting acute care, skilled nursing, mental health, and long-term care facilities
- Individuals living, working or visiting community congregate settings (e.g., correctional facilities, homeless shelters, educational institutions, mass gatherings, and workplaces including production plants)
- Member of a large household living in close quarters
- Individuals who live in households with a higher risk individual or who provide care in a household with a higher risk individual (Note: Household members who likely had extensive contact with a patient with COVID-19 should constitute the highest risk close contacts.)

PRIORITY 2

- Critical infrastructure workers*
- Individuals 65 years of age and older
- Individuals at higher risk for severe disease
- Pregnant people

PRIORITY 3

- Individuals **with** symptoms who do not meet any of the above categories

PRIORITY 4

- Individuals **without** symptoms who do not meet any of the above categories

Consider moving to Priority 1 any critical infrastructure worker who works closely with other critical infrastructure workers and/or is in close contact with large numbers of people (e.g., transportation, food service).

Close contacts should be provided with public health recommendations:

1. Quarantine for 14 days;
2. If symptomatic, consult a healthcare provider and seek testing right away; (if negative, continue 14-day quarantine)
3. If asymptomatic, seek testing 5-7 days after last exposure (if negative, continue 14-day quarantine);
4. If symptoms develop during quarantine, consult a healthcare provider, seek testing, and notify the LHD.

LHDs should prioritize high-concern contact settings for prompt follow-up to ascertain if there are additional cases and to provide public health recommendations and reporting procedures should additional cases be detected. High-concern settings include:

- Healthcare settings (e.g., acute care, post-acute care, long-term care, residential mental health, outpatient healthcare);
- First responders (e.g., EMS, law enforcement, firefighters) and other critical infrastructure worksites (e.g., food production, government services);
- Community congregate settings (e.g., correctional facilities, homeless shelters, group homes, educational institutions, mass gatherings); and
- Persons at higher risk of severe illness (e.g., persons ≥65 years, those with underlying medical conditions, or those who are pregnant).

Additional contact tracing strategies that can be used to conserve public health resources include:

- Relying on others to provide public health recommendations to close contacts. This strategy may be considered in the following situations:
    - Household members. Provide recommendations to the case-patient as part of case investigation and ask them to share with household.
    - Ask case-patient to notify their close contacts and other close contacts they know personally and to provide public health recommendations.
- Suspending active contact monitoring during the 14-day monitoring period unless there is an automated monitoring process.

NOTE: When staff resources are sufficient to handle the volume of COVID-19 reports and your LINCS Agency is reaching more than 80% of cases for outreach, the LHDs within that county should pivot back to investigating all cases and identifying and creating records for all close contacts.