Local Public Health Frequently Asked Questions about Case Investigation and Contact Tracing Guidelines

Context:

Due to a surge in case numbers and to address urgent LHD needs to support COVID-19 vaccination, Dr. Zack Moore, State Epidemiologist, communicated in a NC DHHS Memo new case investigation and contact tracing prioritization guidelines in January 2021. This FAQ is provided to address LHD questions and to clarify the intent of the guidance.

GENERAL QUESTIONS

• What is the purpose of the NC DHHS memo and why was it communicated at this time?
  The purpose of the memo was to issue new recommendations for case investigation and contact tracing activities. Given that LHD staff that have been actively involved in case investigation and contact tracing may be needed for vaccine activities, and that case numbers may continue to rise, focusing on only the highest priority groups supports shifting staff to vaccination.

• Can I reassign CCTC staff currently performing case investigation and contact tracing to vaccine distribution activities?
  While CCTC staff cannot be used for clinical/medical activities in your vaccine distribution clinic at this time, they may be assigned to answer phones, direct individuals to vaccine stations, schedule appointments, scan or enter forms into CVMS and support vaccine clinic logistics. Please submit all requests to transfer CCTC staff from CI/CT to vaccine efforts through the ServiceNow portal. Requests for clinical/medical staff can be placed via WebEOC working through your Emergency Preparedness Coordinator and local Emergency Management.

• Can I continue to request new surge staff from CCTC to perform case investigation and contact tracing?
  Because case investigation has been prioritized to only categories 1 and 2 in the NC DHHS Case Investigation Prioritization guidance, and because vaccination is currently highest priority, no further case investigation or contact tracing staff are being approved at this time. Contact tracing staff can continue to be transferred to case investigation positions. If you have a specific case investigator request that you would like to elevate for consideration, please email richard.rosselli@dhhs.nc.gov. CCNC staff can be requested for vaccine duties through the CCNC ServiceNow portal.

• Does this email communication allow us to curtail case investigation for individuals not in priority categories?
  Yes, during this time of high caseload, case investigation is no longer recommended for any priority groups outside of priority group 1 and 2.

• We are looking at only doing case investigation on those in congregate care living, clusters/outbreaks and K-12. Is it ok to try and weed those out and not contact the other folks?
  Yes, only individuals that are known to be in high priority groups (priority 1 & 2) are recommended for case investigation during this time of high caseload. These priority groups are
listed in the [NC DHHS Case Investigation Prioritization](#) guidance. All cases with a valid mobile number and/or email are receiving an initial digital notification attempt which provides a link to information on how to safely isolate and guidance on notifying contacts.

- **If a person falls outside the priority categories and doesn’t require investigation, will we need to enter them into NC COVID?**
  Yes, all cases need to be entered into NC COVID to ensure accurate numbers are available for statewide case surveillance and the state dashboard. However, the interview field can be marked “not interviewed.” Information on how to manage and close out uninvestigated cases is available in the ‘[Reporting COVID-19 Cases with no Follow-up to the State](#)’ slide set.

- **Which groups are currently being prioritized?**
  Groups currently recommended for case investigation include clusters/outbreaks; cases known to be living in a congregate or healthcare setting or known to be working or potentially exposed in a high-density setting. Congregate or health care settings (priority 1) include correctional facilities, homeless shelters, migrant farm worker housing, skilled nursing, mental health and long-term care facilities, and university dormitories. Additional high-density settings (priority 2) include educational institutions/schools, critical infrastructure work settings (e.g., food processing plants, manufacturing plants, transportation, food service to critical workers, childcare), and community settings with large numbers of people (e.g., mass gatherings, religious events).

  Note that while cases that are clusters/outbreaks and living or working in a congregate setting or health care setting are prioritized regardless of the testing date, other cases that fall in priority 2 are only prioritized if the testing date is within 4 days or the report to public health.

- **What does this mean in the prioritization document: “last in, first out?”**
  Since the greatest opportunity to prevent transmission is among those who have most recently tested positive, the “last in, first out” method attempts to contact the most recently reported case patients first and improves the effectiveness of case investigation. In practice, the case investigator should review all cases in priority 1 and 2 groups and contact the newest cases first.

- **Can we stop calling employers right now to determine close contacts at work?**
  While the determination of whether to investigate and identify close contacts of cases in most occupational settings is a local decision, this latest guidance recommends that most case investigation and contact tracing activities be scaled down to allow staff to pivot to COVID vaccine related activities. Case investigation, including identification and digital notification of contacts, should continue for persons in priority 1 & 2. Employers of particular relevance to these priority groups include healthcare organizations (e.g., hospitals, skilled nursing homes), congregate settings (e.g., correctional facility, homeless shelters), educational institutions/schools, and critical infrastructure work settings such as food processing and manufacturing plants. For a complete list of high priority workplace settings, see the [NC DHHS Case Investigation Prioritization](#) guidance.
- Is it okay for the LHDs to focus mainly on events reported to them by LTCFs and other congregate settings and not address individual events that only come in as electronic lab reports?
  Yes, the approach to prioritize clusters/outbreaks and events in congregate settings is consistent with this guidance. Individual events not known to be listed in the groups in Priority 1 and 2 can be reported to the state.

- Can we conduct brief case interviews with non-priority groups for cluster identification or should we restrict case investigation to only people KNOWN to be in priority groups 1 or 2?
  Restricting calls to only people known to be in priority groups 1 or 2 is recommended. However, if sufficient staff are available for vaccine work, LHDs may choose to attempt to reach case patients by telephone for a brief interview to determine whether they are in a high priority group.

- If we have the capacity to continue case investigation and contact tracing, are we required to implement this new guidance?
  The Governor has asked that all available resources be prioritized to vaccine delivery; this new guidance is designed to support moving staff resources to vaccine delivery. National guidance on contact tracing suggests, as current numbers place us in the “mitigation” phase vs. “containment phase,” that efforts be shifted from contact tracing to promotion of other interventions.
  Establishing collaborations to have contact tracing performed by staff of other organizations is a way to expand contact tracing capacity while prioritizing vaccine delivery by LHD staff and can support continued case investigation to identify people in priority groups 1 and 2, and contact tracing as needed.

- What automated digital notifications options for cases and contacts are available to LHDs in CCTO?
  Beginning on December 24, case notification has been set as a default within CCTO. All case records with a valid phone number or email receive notification. Since inception, roughly 80% of cases have had the required information to receive an attempted initial digital notification within 24 hours of case report to public health. This Job Aid provides information about the digital case notification process.
  Currently, the use of automated notification of contacts is at the discretion of the LHD, however, digital notification decreases time to notification. Digital notification does not preclude telephone call outreach, and text and emails can be a very useful addition to phone contact. This Job Aid provides information on how to activate digital notification for your contacts. We are expecting automated notification for all contacts entered in NC COVID to become active on January 27.

- Who at DHHS can help us implement this new prioritization guidance?
  TATP nurses and CCTC staff including regional supervisors are available to assist you with implementation planning and use of digital notification.