# EBOLA CONTACT TRACING

## N.C. Contact Tracing Procedures

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### OVERVIEW

Ebola contact tracing is the systematic identification and monitoring of all persons who might have been exposed to a person diagnosed with or under investigation for Ebola. Because these persons are at risk of developing disease, contacts are monitored by public health officials for 21 days (the maximum incubation period) from the last date they had exposure to a person under investigation (PUI) or a confirmed case (both PUI and confirmed cases will be referred to as cases in this document).

The goals of contact tracing are to:

1. Identify all potential contacts rapidly,
2. Ensure rapid and appropriate medical evaluation and care if the contact becomes symptomatic, and
3. Ensure immediate and appropriate isolation precautions are implemented if the contact becomes symptomatic.

Aggressive contact tracing effectively interrupts the chain of disease transmission and is the single most important public health intervention to prevent or stop an outbreak of Ebola.

### INITIATING CONTACT TRACING

Contact tracing begins during the investigation of a known or suspected Ebola case. Contact tracing should be initiated for all PUI, as well as all confirmed Ebola cases (both alive and dead). If an appropriately-timed laboratory test rules out Ebola in a PUI, contact tracing can be discontinued.

### IDENTIFYING POTENTIAL CONTACTS

To begin identifying contacts, the case or other informant with knowledge of his/her activities should be interviewed using Form E: *N.C. Case Investigation Form*. Contacts are identified by questioning the case or any other people who may know details about the case during the course of his/her illness, including family members, friends and community members. Key pieces of information collected will include:

1. All places the case visited since the onset of illness,
2. All individuals who had direct, physical contact with the case (dead or alive) since the onset of illness,
3. All individuals who resided in the same household as the case since the onset of illness,
4. All individuals who may have shared a food dish, drinking cup, utensils, linens, or clothing with the case since the onset of illness,
5. All individuals who visited or cared for the case at home or at a healthcare facility since the onset of illness,
6. All individuals who attended the funeral of the case, if the case has died,
7. All individuals who participated in washing or preparing the body for burial, if the case has died,
8. All individuals who cleaned up body fluids of a case since the onset of illness, and
9. The morgue where the body was placed and morgue workers who had contact with the body.

As community contacts are identified during the course of the interview with the case or other informant, they should be added to the *List of Community Contacts since Date of Symptom Onset* (included in Form E: *N.C. Case Investigation Form*). This list includes basic information about the contact, such as demographics, relationship to the case and contact information. Additional contacts identified may be listed on the supplemental lists of community contacts if necessary (document E2).

In situations where potential healthcare worker exposures have occurred, the local health department will need to work closely with occupational health, infection control and/or hospital epidemiology to identify potential contacts. Healthcare or other occupational contacts identified should be added to the *List of Occupational Contacts since Date of Symptom Onset* (included in Form E: *N.C. Case Investigation Form*). Additional contacts identified may be listed on the supplemental lists of occupational contacts if necessary (document E3).

Once identified as a potential contact, Document F: *N.C. Contact Tracing Checklist* should be started to ensure all necessary steps are taken and necessary documentation is provided.

The identification of contacts will occur during several interviews over time; thus, the list of contacts for a case will be routinely updated. As each contact is identified, the most recent date that the individual had contact with the case is also determined. This date will be used to determine the time period of follow-up.

## INTERVIEWING POTENTIAL CONTACTS

All potential contacts identified by the case or other informant will be interviewed in-person by a public health official or designee (such as in the case of a healthcare exposures). The purpose of this interview is to determine the nature of their exposure, assign a risk level and determine appropriate public health action. Form C: *N.C. Contact Investigation Questionnaire* should be used to guide and record information collected during the interview. Once complete, each potential contact should have an exposure risk classification assigned.

Important information for the initial in-person visit is described below:

1. Before the visit, call ahead to verify that the person is asymptomatic.
2. When on-site and prior to entering the premises, again ask and observe for any signs and symptoms of Ebola. Do not enter the premises if the person appears or reports being unwell.

***Adhere to the following guidelines until a risk classification of low or no is established:***

3. When in the presence of the potential contact, maintain a distance of three feet and defer any direct contact, such as handshakes.
4. While in the premises, remain standing, avoid leaning on walls or furniture, and to keep yourself between the potential contact and the door.
5. If at any point during the visit, the person appears ill or affirms that they have symptoms consistent with Ebola, ask the person to go to a room, close the door, and await further instruction. Exit the residence, taking care to let yourself out only after putting on the gloves in your pocket.
6. Also exit if you see any blood or bodily fluid contamination of surfaces, again asking the potential contact to isolate him/herself in a room and to await further instruction.

## MONITORING CONTACTS WITH POSSIBLE EXPOSURE

Persons classified as having no identifiable risk are not considered contacts and do not need to be monitored. Persons with any high risk, some risk or low (but not zero) risk are considered contacts and will need to be monitored if within 21 days of their last exposure.

Document D1: *N.C. Instructions for the Local Health Department* provides guidance for local health department staff for the 21-day period of monitoring and movement restrictions for persons who have had known or possible exposure to Ebola. It is important to be familiar with the content of this document prior to the in-person visit with the potential contacts, as monitoring may be initiated during this visit.

## HEALTHCARE WORKER EXPOSURES

In the event healthcare workers are potentially exposed, the local health department will need to work closely with occupational health, infection control and/or hospital epidemiology to identify potential contacts, complete the risk assessment interview and monitor exposed personnel.

In some circumstances, the local health department may choose to delegate these responsibilities to the healthcare facility. However, because it is the legal responsibility of the health department to ensure appropriate public health measures are being implemented, the health department should establish and maintain close communication with the facility. At a minimum, the local health department will need to have a listing of all persons identified as healthcare contacts and will need to maintain close communications with the facility to receive daily updates on each person under monitoring.