Contact Tracing for MercyOne Colleagues

Updated August 28, 2020

Process for Response to Suspect Ministry- Associated SARS-CoV-2 Exposures among Health Care Personnel (HCP) and Patients

During the initial wave of cases during the pandemic many ministries detected widespread transmission of SARS-CoV-2 among the populations they served and there was less need to conduct formal contact tracing within health ministries as most inpatients were either PUIs or those with confirmed COVID-19. Currently, the epidemiology has shifted and there is variation in incidence of COVID-19 across the U.S. Therefore, CDC is recommending exposure management process be in place. Refer to the following, existing resources for exposure management and safety tips for people with COVID-19 who are stable enough to recover at home.

- 10 Ways to Manage COVID-19 Symptoms at Home

If technology to help support screening of people as they enter ministry facilities is available, consider capturing details of those entering should there be subsequent inadvertent, unprotected exposure to someone with COVID-19 in the ministry. This technology can be used for contact tracing of those with exposure if needed, e.g., identification of new health care associated SARS-CoV-2.

Key Elements of Exposure Management:

- In most cases, state or local public health departments are responsible for contact tracing. MercyOne should initiate contact tracing in the event of a lab-confirmed case where there is a question of possible exposure of a colleague or a patient in a MercyOne facility. Examples of this include:
  o Public Health notifies MercyOne of a positive colleague with no known exposure outside of work
  o Several colleagues on the same unit all test positive
  o Colleagues performing high risk procedure (i.e. AGP) on a positive COVID-19 positive later in the hospital stay
  o Multiple colleague on a COVID-free unit tests positive

- Notify and collaborate with local public health about suspected or confirmed cases of SARS-CoV-2 infection that involves possible clusters of infection within the ministry.
  o Under this collaboration, the IP also is likely to receive notice from public health regarding their case investigation if this finds the newly identified person with infection is a colleague at the health ministry of the IP. For these instances, the IP will work with public health, EHS and the colleague to address work restrictions, testing, etc., on a case by case basis.

- Use contact tracing as indicated to identify and notify those with possible exposure.
  o Contact tracing should be carried out in a way that protects the confidentiality of affected individuals and is consistent with applicable laws and regulations.
  o HCP and patients who were exposed by a MercyOne colleague or clinician, within a MercyOne Health facility, AND are currently admitted to the facility or were transferred to another health care facility should be prioritized for notification. These groups, if infected, have the potential to
expose a large number of individuals at higher risk for severe disease, or in the situation of admitted patients, are at high risk for severe illness themselves.

- Include the following in MercyOne policies or plans:
  - Define and establish a process for who is responsible, e.g., infection preventionists or colleague safety, for identifying contacts of a newly identified case of SARS-CoV-2 among personnel and others with possible unprotected exposure and notifying those with potential exposure.
  - Define how notifications occur
  - Identify actions and follow-up recommendations for those who were exposed

Roles and Responsibilities of IP and EHS

- The infection preventionist (IP):
  - Conducts surveillance for HAIs and reports diseases and conditions to local public health.
  - Identifies risk of communicable diseases to the patient and HCP, including possible clusters or outbreaks of infection.
  - Coordinates implementation of pre-exposure and post-exposure management and evaluates the effectiveness of interventions.

- Employee / Occupational Health personnel:
  - Communication and collaboration with HCP and others in the ministry:
    - Report interventions needed to appropriate supervisors and unit/service line leaders and/or individuals.
    - Provide assistance with MercyOne Employee Incident Reporting (THEIR) process in coordination with the ministry Gatekeeper (person responsible for processing work-related incidents that have been reported through the THEIR application).
  - Management of potentially infectious exposures and illnesses that may require testing and/or treatment:
    - Communicate any work restrictions to appropriate individuals and ministry leaders, such as supervisors, HR, etc., while maintaining the HCP right to privacy.
    - Assist with determining nature of exposure.
    - Evaluation, treatment and counseling for exposed or ill HCP.
    - Recommendations on monitoring and reporting symptoms of infection.
  - Management of healthcare personnel health records

Components of Case Investigation and Contact Tracing;

- Case investigation: IP should interview newly identified case of SARS-CoV-2 (case investigation) to identify everyone with whom the new case of infection has had close contact during the time when they may have been infectious. See also case investigation workflow from APIC Text Online (Figure 1) and CDC case investigation and contact tracing workflows (Figures 2,3). Steps used by IP and EHS team will differ from those in the CDC workflows which reflect process used by public health professionals in communities, however, the elements are similar.
  - To determine whether an exposure was prolonged or brief- gather details about exposure incident and compared to level and extent of the PPE from the System PPE Guidebook. If PPE appropriate to the circumstances based on the Guidebook was used by the colleague with possible exposure the management may be able to be closed out.
o Exposure definition for close contacts:
  ▪ **Prolonged:**
    ▪ Anyone who was within 6 feet of an infected person for > 15 minutes starting from 48 hours before the person began feeling sick until the time this person was isolated or identified with infection…AND;
    ▪ Colleague or other contact was not protected, e.g., colleague in break room for prolonged time and neither the infected nor exposed colleague were wearing a mask and/or eye protection. The details around the exposure to a fellow colleague, a PUI or confirmed case of COVID-19 or other person.
  ▪ **Brief:**
    ▪ Anyone within 6 feet of an infected person for at least 15 minutes without wearing a mask applicable PPE, e.g., a mask or other face covering. The details around the exposure should be evaluated for each instance as it could be exposure to a fellow colleague, a PUI or confirmed case of COVID-19 or other person. Note: According to CDC, walking past a person with infection briefly in a corridor is not likely to result in exposure.

  ▪ **Investigation and classification of exposure of patients to HCP with SARS-CoV-2:**
    ▪ During case investigation interview, ask colleague with newly identified infection if there were any patients for whom they recall not wearing appropriate PPE during direct care of any patients (e.g., did not wear mask) during the 48 hours prior to onset or date of specimen that was positive.
      o For those identified, the IP will notify the patient's attending physician or advanced practice professional of the possible exposure incident.
      ▪ If appropriate PPE was consistently worn, exposure of the patient is unlikely.

  • **Incubation period for SARS-CoV-2:** 2-14 days;
    ▪ Median time of 4-5 days from exposure to symptoms onset. One study reported that 97.5 percent of persons with COVID-19 who develop symptoms will do so within 11.5 days of SARS-CoV-2 infection.

  • **Notification:** EHS, supervisor of colleague and leader to whom IPC reports
  • **Actions:** If colleagues meet either the CDC or OSHA definition of close contact and exposure is categorized from low to high:
    ▪ Have exposed colleague complete a THEIR report and notify their supervisor. Tools exist on the COVID-19 site to assist with this process.

  • **Contact tracing:** Involves notifying exposed individuals (contacts) of their potential exposure to someone with SARS-CoV-2 as rapidly and sensitively as possible, not revealing the infected person's identity.
    • Notify contacts of their potential exposure and enter details into a line listing (resource contact tracing template tool is available on COVID-19 web site).
    • Refer HCP contacts for testing – if symptomatic,
      ▪ Test HCP contacts with signs or symptoms consistent with COVID-19 with a molecular or antigen testing method; high priority.
      ▪ **Work restrictions required until meeting return to work criteria – see below.**
    ▪ Testing asymptomatic HCP with known or suspected exposure to SARS-CoV-2; optional if IP and EHS agree and recommend.
- No need for work restrictions for possible occupational exposure. However, exposed HCP need to be aware of symptoms of possible COVID-19 and adhere to screening prior to each work shift and adhere to use of PPE, e.g., mask for source control at all times when working except during eating or drinking.
- If testing is recommended use incubation period to determine optimal timing of specimen collection, e.g., 5-7 days after last exposure to person with infection.

  - Monitoring contacts for signs and symptoms of COVID-19 and notify EHS and their supervisor if these develop during the incubation period following exposure, i.e., 2-14 days.

**Additional Definition – Criteria:**
For definitions of and investigations of possible work-related exposures, please refer to THEIR Gatekeeping and OSHA Recordability FAQs.

**Cluster/Outbreak Criteria from CDC**

- Two or more\(^a\) laboratory-confirmed\(^b\) COVID-19 cases among workers at a facility with onset within a 14-day period\(^c\), who are epidemiologically linked\(^d\), do not share a household, and are not a close contact of each other outside of the workplace.

**Footnotes:**

  a) Health departments may consider a higher threshold of defining an outbreak if there is a high case rate in the community (community transmission)

  b) Detection of SARS-CoV-2 RNA or antigen in a clinical specimen using molecular amplification test.

  c) For onset, use a symptom onset date whenever available. If symptom onset date is unknown or if a case is asymptomatic, use specimen collection date for the first specimen that tested positive. The 14-day period refers the 14 days before the date of the first symptom onset or first positive test sample.

  d) Health departments should verify to the best extent possible that cases were present in the same setting during the same period (e.g., same shift/department, same physical work area); that the timing fits with likely timing of exposure; and that there is no other more likely source of exposure for identified cases (e.g., household or close contact to a confirmed case outside of workplace setting).
Figure 1. Case investigation Decision Flow

- Index Case – verify the diagnosis
- Is the patient contagious?
  - Yes: Was barrier technique absent, or was there a breach in technique?
    - Yes: Identify exposed individuals
    - No: No action
  - No: No action
- Is individual susceptible?
  - Yes: Does the disease have potential for further spread?
    - Yes: Implement intervention measures
    - No: Monitor employee for clinical symptoms
  - No: Monitor employee for clinical symptoms, follow policy for work restriction
**Figure 2**

**CASE INVESTIGATION WORKFLOW (COVID-19)**

1. **Positive test result or COVID-19 case report**
   - Case reported to health department
   - Start self-isolation

2. **Case entered into data system**

3. **Case triaged for assignment**

   - Patient continues self-isolation
   - Patient interviewed
   - Patient identifies contacts (contact tracing)
   - Refer patient for support services
   - Confirm patient knows test results
   - Refer patient to medical provider if severe symptoms

4. **Follow up with patient daily**
   - Refer patient to medical provider if symptoms worsen

5. **Patient discontinues self-isolation**
References:


