STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ROBERT GORDON
DIRECTOR

MEMORANDUM

Date: Jul 28, 2020

To: Health Officers, Local Public Health Department Medical Directors

From: Joneigh S. Khaldun, MD, MPH, FACEP
Chief Medical Executive and Chief Deputy for Health
Michigan Department of Health and Human Services (MDHHS)

Thank you for your continued hard work the last several months. We know this remains a challenging time, and we are thankful to have you as our partners in the fight against COVID-19.

Since the MDHHS memo regarding case investigation and contact tracing expectations on May 29, 2020, we have seen significant improvement in our statewide performance metrics. Previously, MDSS data showed that we were attempting 45-50% of case investigations statewide within one day and reaching about 35% of residents within that first day. Now, with improved training and variables in the case report form, MDSS data shows that jurisdictions in the state are attempting 70-75% of investigations in one day and successfully reaching 50-55% of all cases within that same time period. Thank you for making this a priority. As you know, ensuring effective case investigation and contact tracing are among our most important public health tools to prevent the spread of COVID-19.

The Department continues to closely monitor these investigation and tracing targets and will do so throughout the duration of the response. This monitoring helps ensure each jurisdiction has the resources it needs to successfully contain COVID-19 and allows MDHSS make decisions regarding surge capacity. While we are proud of our recent improvements, we are not yet achieving or documenting the achievement of these benchmarks statewide. In response to our ongoing data reviews and conversations with Local Health Departments, this memo seeks to reiterate MDHHS expectations for LHDs and reminds that there are resources from the Department to help achieve these outcomes.

MDHHS Case Investigation and Contact Tracing Guidance

Expectations to Reiterate:

- Case investigation and contact tracing targets were outlined in the Department's memo to LHDs on May 29, 2020 and are included with this memo as Attachment 1. Reference and training materials are available on the MDHHS "Communicable Disease Information & Resources" webpage.

- The targets mentioned above are based on calendar days. It is expected that LHDs will attempt to reach cases and contacts within 24 hours of referral, including on weekends.

- All close contacts of an index case must be entered into the contact information section of the MDSS case report form.
- MDHHS may reach out to LHDs to conduct technical assistance meetings to clarify data or data trends and discuss opportunities for assistance.

New Guidance:

- LHDs should have established cross-jurisdictional referral processes to ensure that cases and contacts residing in other LHD jurisdictions are referred to the correct jurisdiction to receive the appropriate case investigation and monitoring. To assist with these referrals, MDHHS has posted a table of each LHD and the technical solution they use for contact monitoring (Traceforce, OMS, or a local solution) on the MDHHS "Communicable Disease Information & Resources" webpage.
- MDHHS has developed a set of recommendations for contact monitoring best practices, including the engagement of external partners, like businesses and universities. The guidance document is included with this memo as Attachment 2. This document will be updated as new best practices emerge, and MDHHS welcomes your questions and feedback on this guidance.

Resources and Support from MDHHS:

If you need any resources or support from MDHHS, please contact Joe Coyle (CoyleJ@michigan.gov) or Katie Macomber (MacomberK@michigan.gov) for assistance. Assistance may include surge capacity for contact tracing or case investigations, onboarding to MDHHS's contact tracing platform, Traceforce, or training. Many of these resources are located on the MDHHS "Communicable Disease Information & Resources" webpage as well.

As always, we deeply appreciate your partnership in achieving these goals. Thank you for all you do to protect the health and safety of Michigan residents.

***

For the latest information on Michigan's response to COVID-19, please visit www.michigan.gov/coronavirus. You may also email our Community Health Emergency Coordination Center at: checcdeptcoor@michigan.gov

Attachment 1: MDHHS Case Investigation and Contact Monitoring Targets for LHDs

Case Investigation Targets

1.) Within one calendar day of referral to MDSS, 90% of cases will have an interview attempted;

2.) Within one calendar day of referral to MDSS, 75% of cases will have an interview completed;

3.) At least one contact elicited, per case, for at least 50% of cases, within one calendar day of case referral to MDSS. For cases where there is no legitimate close contact, MDHHS will use the selection of a "yes" response to the prompt "Subject has no close contacts", within one calendar day of case referral to MDSS as a proxy measure; and,

4.) Race AND ethnicity will be documented on at least 75% of cases within seven (7) calendar days of referral to MDSS

Close Contact Monitoring Targets

1.) Within one calendar day of contact information elicitation in MDSS, initial close contact monitoring outreach will be attempted on at least 90% of close contacts of COVID-19 cases; and,

2.) Within one calendar day of contact information elicitation in MDSS, initial close contact monitoring outreach will be successfully initiated on at least 75% of close contacts of COVID-19 cases.

Attachment 2: MDHHS Recommendations for COVID-19 Close Contact Monitoring Best Practices and Engagement of External Partners for Case Investigation and Contact Tracing Support, for Local Health Departments (LHDs)

Section 1 – Purpose:

This Guidance is to serve as MDHHS best practice recommendations on conducting contact monitoring for close contacts of confirmed and probable COVID-19 cases. This guidance should not be considered exclusively, but in combination with other available literature resources. Such resources include:

- MDHHS. Michigan State and Local Public Health COVID-19 Standard Operating Procedures. Interim Guidance 06/18/2020: https://www.michigan.gov/documents/mdhhs/nCoV_SOP_TEAM_680994_7.pdf; and,
- Centers for Disease Control and Prevention (CDC). Contact Tracing for COVID-19. June 17, 2020 Update: https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/contact-tracing.html
- MDHHS COVID Case Investigation Targets: https://www.michigan.gov/documents/mdhhs/COVID_Case_Investigation_Target_Webinarv2_696740_7.pdf
- Dr. Joneigh Khaldun. Case Investigation and Contact Tracing Targets – Memo. May 29, 2020: https://www.michigan.gov/documents/mdhhs/Case_Investigation_and_Contact_Tracing_Targets_Memo_696741_7.pdf

Section 2 – Contact Monitoring, General Practice Recommendations:

1.) Local Health Departments (LHDs) should initiate close contact monitoring as soon as possible, following identification of a confirmed or probable index case, for all close contacts of that index case.

   a. MDHHS will be monitoring key contact monitoring performance indicators. The measures of these indicators include:
      - Case Investigation Target #3: "Contacts elicited on 50% of cases within 1 day of referral to the MDSS (or no contacts or refused to provide contacts);"
      - Contact Tracing Target #1: "Within one calendar day of contact information elicitation in MDSS, initial close contact monitoring outreach will be attempted on at least 90% of close contacts of COVID-19 cases;" and,
      - Contact Tracing Target #2: "Within one calendar day of contact information elicitation in MDSS, initial close contact monitoring outreach will be successfully initiated on at least 75% of close contacts of COVID-19 cases."

   b. All close contacts to an index case should be documented in the Contact Information section of the MDSS COVID-19 case report form. Exceptions to this may include:
      - Contacts already known to be COVID-19 cases
      - Contacts of Cluster Investigation in healthcare facilities

   c. At a minimum, the following information should be documented on each contact:

- ➢First Name
- ➢Last Name
- ➢Working Phone Number
- ➢County of Residence

2.) Initial contact outreach should include at a minimum:
   - ➢Contacts can be referred to additional information for testing, quarantine, and supportive services at www.michigan.gov/containcovid

   a. Identification of whether the contact is experiencing or has recently experienced one or more known COVID-19-associated symptoms;
   b. Notification that the LHD will continue to reach out to contact during contact monitoring period (for up to fourteen days);
   c. Information on how and where the contact can obtain COVID-19 testing as well as when contacts should seek COVID-19 testing;
   d. Information on safe quarantine practice during the monitoring period;
   e. Referral to local testing site/center in the event that the contact develops symptoms consistent with COVID-19;
   f. Referrals for supportive services and resources to ensure that the contact is able to successfully quarantine during the monitoring period; and,
   g. Contact information of LHD personnel who can be contacted for any follow-up questions/information needed.

3.) Contacts should be monitored for fourteen (14) days for signs or symptoms of COVID-19 following the last known day of exposure to the index case.
   a. In the event that the last known date of exposure to the index case unknown, LHDs should monitor the close contact for fourteen days from the index case's referral date to MDSS.
      - ➢Some contacts may need more than 14 days of monitoring if the contact is not able to safely quarantine from the index case

4.) Attempts to monitor contacts should be made daily, by any method of outreach (e.g., phone, text, email, etc.).
   a. It is recommended that LHDs use a multi-modal approach, as feasible, to increase the likelihood of contact engagement. The contact's preferred method of outreach should be used during the duration of the contact monitoring period to increase the likelihood of contact responsiveness.
   b. In the event that LHDs cannot make daily outreach attempts, LHDs should:
      - ➢Minimally, initiate outreach as soon as possible, from the point of contact elicitation;
      - ➢Minimally, conduct outreach to the contact on the last day of the contact monitoring period to ensure that the contact has not experienced any COVID-19-associated symptoms during the course of the monitoring period; and,
      - ➢Conduct ongoing outreach at a reasonably feasible frequency during the ongoing monitoring period (e.g., every other day or every three days), if daily monitoring is not possible.

5.) While daily monitoring of all close contacts is recommended, LHDs may choose to prioritize targeted risk groups to sustain contact monitoring capacity.
    a. When prioritizing targeted risk groups for contact monitoring, MDHHS recommends that LHDs follow the CDC prioritization guidance (see: "Box 4. Close Contact Evaluation and Monitoring Hierarchy," https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/contact-tracing.html)
    b. This hierarchy prioritizes those who may be at greater risk of contributing to disease transmission and/or at greater risk of severe complications of disease.
    c. Such targeted prioritization should *only* be leveraged by LHDs as a last resort.
        - It is strongly recommended that LHDs contact MDHHS to identify whether centralized contact monitoring capacity could be leveraged *prior* to initiating a strategy targeting only specific risk groups based on potential for disease spread and/or complications.

6.) Other considerations:
    a. LHDs should offer contact monitoring mechanisms that minimize the burden on staff while not compromising the effectiveness of outreach (automated text/e-mail monitoring);
    b. If at all possible, LHDs should consider multiple outreach attempts (even within the same day) to a newly elicited contact;
    c. LHDs should have mechanism in place for cross-jurisdictional referral of contacts or contact their MDHHS Regional Epidemiologist if the process is unclear;
        - Contacts identified as living in another jurisdiction should be referred to that county within 1 calendar day of identifying that the contact resides in another jurisdiction.
    d. LHDs must document in the weekly LHD SITREP which contact monitoring system they are using (TraceForce, OMS, or a homegrown system);
    e. If a homegrown system is being used for all or part of an LHD's contact tracing efforts, specific self-reported data must be included in the weekly LHD SITREP responses to MDHHS. The self-reported data is called out in the SITREP for those jurisdictions not using TraceForce or OMS; and
    f. It is expected that contact monitoring is conducted on weekends and holidays.

Section 3 – Working with employers:

- Please note that this section broadly covers case investigation and contact tracing, not just the contact monitoring component of contact tracing.

1.) MDHHS understands that many LHDs have been contacted by employers who wish to assume all or primary responsibility for contact tracing on their premises. These requests have come from academic institutions, large employers, and other community leaders.

2.) While employers and other leaders play an important role in the contact tracing process, it is the position of MDHHS that contact tracing efforts (including both case investigation and ongoing contact monitoring) should not be delegated by an LHD to non-Public Health entities as individuals live and move through communities in ways that aren't limited to the employer's environment.

3.) While LHDs may enter into an agreement, contract, or arrangement to assist the LHD in carrying out its duties and functions (MCL 333.2435), the LHD remains responsible for ensuring adequate public health practice in the conduct of all case investigation and contact training activities in response to COVID-19.

4.) As such, MDHHS recommends the following:

   a. The responsibility for all case investigation and contact monitoring activities should be fully retained by the LHD.

   b. To the extent that employers have a role in the case investigation and contact monitoring processes, LHDs should recommend the following to employers:

      i. Monitor the health and wellbeing of staff – daily temperature checks, symptom monitoring, etc.

      ii. Provide for access to protective equipment and supplies (e.g., masks or other personal protective equipment [PPE]), as needed.

      iii. Enforce the use of protective measures amongst all personnel, including visitors and other non-employee roles, while on employer's premises.

      iv. Contact and engage the local health department any time when there is a known or suspect case of COVID-19.

      v. Keep completely and timley records of who works where, where and when they move through the employer's facilities, and with whom cases may have come in contact during the course of any given day.

      vi. Assist the LHD in risk assessments. This may include providing a list of potentially exposed persons to local public health (name, phone number, county of residence, date of last potential exposure), along with other information as requested by the LHD.

      vii. Assist employees in complying with public health recommendations as it relates to testing, isolation, quarantine, and stay home/return to work rules.

      viii. Facilitate clear communication with employees and liaise with employees on behalf of Public Health.

      ix. Routinely meet with LHD during an identified exposure event to discuss challenges and barriers to testing, tracing, and isolation

5.) To the extent that LHDs choose to engage the support of external partners (i.e., non-Public Health entities) for support of case investigations and contact monitoring, LHDs should ensure the following:

   a. That these arrangements are contractually arranged under a formal agreement such that the external partner is acting on behalf of the LHD pursuant to MCL 333.2435. The LHD remains responsible for ensuring adequate public health practice in the conduct of all case investigation and contact training activities in response to COVID-19.

   b. At a minimum, these contractual arrangements should clearly specify the COVID-19 case investigation and/or close contact monitoring activities in which the external partner will participate, the extent of and limits of their role and responsibilities, the protocols by which the external partner will conduct such activities, and the oversight that the LHD will maintain in support of these efforts. LHDs should ensure that:

      i. Access to the data for which the LHD is otherwise responsible is retained and not limited by the external partner;

ii. Access to the external partner is limited to the specific data need to perform the function and the risk of over-sharing is mitigated – i.e., ensuring that the engaged external entity (whether a university or employer) doesn't inadvertently get access to data beyond the scope of the population(s) or geographic area that they are covering (e.g., security and privacy protection measures needed before granting access to MDSS, OMS, or contact tracing applications, etc.);
iii. Delegated entities are held to the same standard as LHDs with respect to case investigation and contact tracing targets;
iv. MDHHS has visibility of all case investigation and contact tracing efforts conducted by the LHD and/or the LHDs designated entity;
v. The LHD manages access to data systems, either MDHHS-hosted or internal and adds/removes users appropriately and in a timely manner;
vi. The formal agreement must allow for a mechanism where cases and/or contacts can directly reach the LHD, bypassing the external partner in question; and
vii. That the formal agreement accounts for, and provides remedy for, situations where cases and/or contacts identify or raise additional needs, questions, or concerns that are outside the scope of the formal agreement;

c. Notify MDHHS and provide a copy of the agreement, in the event that they engage external partners for case investigation and/or contact tracing support.
d. That the engagement of these external partners is in an effort to support the LHD – i.e., the engagement of such partners results in the partner becoming an extension of the LHD for the specified activities. The LHD does not delegate case investigation or contact monitoring, or permit the external partner to conduct such activities, without adequate controls and oversight from the LHD.
e. That the LHD carefully considers and addresses the types of mechanisms available to the LHD to ensure oversight of its public health responsibilities and the degree to which the LHD has the capacity to enact and ensure that these mechanisms are being successfully employed;
f. The extent to which transparency into the external entity's environment has been optimized and how the risk of perverse incentives has been mitigated – i.e., does an employer have reason to limit view into actual disease incidence in their facilities and/or minimize contact elicitation;
g. That there is documentation of how the engagement of external entities in support of any public health response activity accounts for and effectively refers out-of-jurisdiction contacts on a timely basis to the correct jurisdictional authority (employees, faculty, or students who may not live on campus or within the LHD's jurisdiction).
h. That there is documentation of how the LHD will be actively notified of adverse tracing events for resolution, as needed (refusals, unable to locate, etc.)

Section 4 – Conclusion:

MDHHS is sharing these recommendations in an effort to promote clarity and consistency in COVID-19 response across a statewide public health system. MDHHS welcomes the opportunity for additional discussion with LHD partners about these recommended best practices for COVID-19 close contact monitoring. MDHHS will continue to amend and share updated best practices, as new information becomes available.