

Stand By You



**A CamBright Research program
to help you meet the workforce demands of contact tracing due
to COVID-19**

Many County and State health agencies across the nation are at risk of being overwhelmed by the volume of persons they will need to contact in connection with possible exposure to COVID-19. Is this you? Please take a minute now to see how **Stand By You** will help you control the spread of infection.

Stand By You Core Activity

CamBright Research offers a program to supplement public health agency workforce when they need help with the tracing work overflow. Agencies transfer contact information for Index cases and/or contacts to the CamBright locating/contacting team when their agency capacity is overloaded. We work like your own staff to locate and contact, and provide back detailed records of all contacting effort.

Stand By You Benefits

Support how and when you need it – Stand By You bills on an “as used” basis. The agency only incurs costs when names are transferred and work performed. Our staff will be directed to do as little or as much of your contacting protocol as you need. Staff will be trained in your protocol.

Exceptionally qualified contacting staff – CamBright staff have 5-25 years’ experience locating and contacting diverse populations across the nation for public health research. They hold certificates from the **Global Health Network** training in Informed Consent contacting plus over 100 hours training in project specific contacting protocols for health and medical research. Multi-lingual staff are available.

Staff are on board and ready get on the phones – In March 2020 all staff underwent criminal background checks and DMV checks, I-9 verification, and W-2 submissions. CamBright is responsible for all employment agreements, wages, and withholdings.

Onboarding your agency is simple and quick – CamBright management staff will establish your account, identify services sought, and set up programs to train staff in your protocol. Our IT staff will work with you to establish how we will receive contact information from you, how we will collect and record information, and how we will return that information to you.

We would like to perform contact tracing for you and advance your efforts to curb the tide of COVID-19. Please contact Victoria Albright at 919-599-9771 or valbright@CamBright.com to learn more. Additional detail is attached on our services and experience.

More Details About the Stand By You Program

Setup

Here are the steps to setting up your **Stand By You** program.

- To set up the **Stand By You** program for your agency, you will work with CamBright Principal and Survey Research Specialist, Victoria Albright, to identify the kind of support you are looking for.
- We will follow the attached protocol document that lists all activities and staffing requirements related to contact tracing for COVID-19 infection. Together we will identify the types of activities and staffing your agency needs and the kind of support you want CamBright to provide.
- Based on those choices, CamBright will work with you to develop a training program for the CamBright staff specific to your requirements and ways of doing things.
- Our IT staff will work with you to establish how we will receive contact information from you, how we will collect and record information, and how we will return that information to you. CamBright will prepare and conduct a training program with our staff that is specific to your requirements and way of doing things.
- We will prepare our staff to do things the way you would if you could.

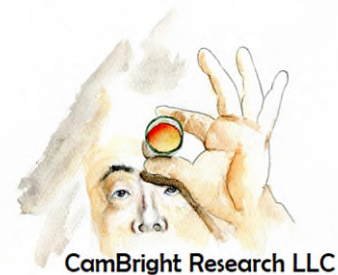
Services

Your Stand By You program can include as much support as you need.

- Your **Stand By You** program can be limited to locating Index cases and contact, and returning that information to your agency for follow-up. We can go further and notify people of exposure. We can provide your message to people, e.g., advice and instructions. We can provide follow-up activities as well, e.g., mail out thermometers. We can plan callbacks to monitor and follow-up with people. Our activities will be customized to your needs.
- On the technical front, all CamBright tracers are equipped with secured laptops, telephones, and internet service. CamBright can use our internal case management system (CMS) or arrange for our staff to access your CMS. CamBright IT staff will work with you to address technical and privacy issues related to accessing your confidential contact information, securing those data on our systems, and reporting back to you on our findings.
- In all scenarios, CamBright Research is responsible for all hiring and employment related arrangements. Invoicing is based on hours expended.

Attachments:

CamBright Contact Tracing Services Summary
Contact Tracing Protocol



CamBright Qualifications for Contract Tracings

The need for contract tracers has sprung up as mobility restrictions have reduced the number of people an infected person may come in contact with. It is worthwhile now to contact everyone the infected person came in contact with and encourage them to self-quarantine. This is how the spread of infection is stopped. It worked with Ebola and SARS. It will work for COVID-19.

CamBright Research has available:

- 16 Contact Tracers all with wi-fi and top-flight cellular phones and the ability to bring in more
- Experienced management staff to serve as Case Investigator, Resource Coordinator, and Data Team leader (each with 20+ years' experience in survey research in the public health sector)
- Experience using locating services (e.g., BeenVerified, Seek.Verify, FaceBook).
- All arrangements necessary to hire and pay the tracers including W-2s and I-9
- Ability to recruit additional staff as needed
- Highly secured laptops (e.g., BitLocker protected) with internet connections

CamBright Research Tracers have the following credentials and experience:

- CamBright Tracers have 5-25 years' experience contacting subjects for public health research.
- Our Tracers are accustomed and skilled in providing instruction and guidance to subjects.
- All Tracers hold ***Informed Consent Training Certificates*** from the Global Health Network plus training in IRB-approved protocols for privacy, confidentiality, and data security.
- All Tracers have successfully completed ***Global Pharmacovigilance Safety Information Training***.
- CamBright Tracers all have
 - passed criminal background and DMV checks in the past month,
 - I-9's verified in past month, and
 - have employment agreements in place.
- Tracers routinely work nights and weekends.
- Bi-lingual (English/Spanish) are on staff; speakers of other languages are can be recruited.
- All Tracers are experience in use of electronic case management systems.
- Tracers are accustomed to managing their activities and workloads while at the same time providing detailed reporting on their activities and outcomes of each phone contact.
- Tracers are located across the nation and work from home offices.
- Tracers are available for on-the-ground tracking.

- We are available immediately.
- We provide all you need.
- We are exceptionally well-trained.
- We have a proven success record.

Most tracing operations expect contacts to have cell phones and unlimited service. In fact, some of the most vulnerable populations don't have a phone or pay by the minute for their service. CamBright has the capability to provide contacts with personal devices to communicate with us and use while we monitor them. We are also able to add minutes to contact's cell phone contracts so they can spend time on the phone with us at no cost to them.

We would like to perform contact tracing for you and advance your efforts to curb the tide of COVID-19. To learn more, call Victoria Albright, 919-599-9771, Principal and Senior Survey Specialist.

TABLE OF CONTENTS

| | |
|------------------------------------|----------------|
| 1. Contact Tracing Protocol | page 1 |
| 2. Public Health Workforce | page 8 |
| 3. Social Supports | page 10 |

Contact Tracing Protocol

Overarching issues for jurisdictions to address (Not in priority order)

- 1 Decide if legal vs voluntary**
 - a. Isolation for index cases – status known to be positive
 - b. Quarantine for close contacts – exposed, status unknown
- 2 Establish priority threshold for in-person outreach**
 - a. Case non-response – known positive
 - b. Contact in high-risk congregate setting
 - c. Close contact non-response
- 3 Define close contact**
 - a. Household member
 - b. Intimate contact
 - c. High risk / congregate setting
 - d. Contact <6 ft for >30m (or >10m?)
- 4 Determine how to manage presumptive cases (non lab-confirmed)**
 - a. Symptomatic, presumed positive
 - b. Home testing
 - c. Other missing test info
- 5 Define social supports package and eligibility**
 - a. Hoteling
 - b. Essentials
 - c. Incentives
 - d. Staffing
- 6 Arrange clinical linkage for contacts**
 - a. Telemedicine support for symptoms
 - b. Testing if symptomatic

TABLE 1. PROTOCOL FOR CONTACT TRACING / COVID-19 INFECTION

| Step | | Description | Data Elements | Traditional Process | Critical Operational Issues |
|------|------------------------------------|--|--|--|---|
| 1 | Index case identification | DOH receives case report of a confirmed or presumptive case [e.g. NYC today new onset fever or cough or anosmia – presumptive] | Demographics (name, age/DOB, gender), exposure category contact info (all phones, emails, social media, street address), translation needed? | Confirmed lab test reported to DOH, including method of testing and test result, including cycle threshold if PCR And/or Case notification by provider | Report of case <ul style="list-style-type: none"> • Source? – lab (less info) vs provider (more info, higher proportion w poc increase) • How report received at DOH? Electronic reporting? Manual? • Is case info entered into database? • How to identify case if home testing becomes available? How to prioritize non lab-confirmed cases? <ul style="list-style-type: none"> • Home testing cases • Presumptive cases (symptomatic, no test) |
| 2 | Index case notification | Initial notification of a confirmed or presumptive case [e.g. NYC today new onset fever or cough or anosmia – presumptive] | | Cascade: <ul style="list-style-type: none"> • Phone • Email • Mail a letter • In-person outreach | Need to establish contact with case: <ul style="list-style-type: none"> • Often insufficient locator info with lab reporting. • Phone number reliability estimated around 75% • In-person outreach if no locator info or unreachable? Communicate in patient's language? |
| 2A | Communicate with index case | Verify identity of case. If case is deceased, seek out surrogate and use them for contact tracing. Engage and build trust. Explain availability of social supports and clinical linkage. | Updated contact medium and preferences | Phone call | Translation or other language services available to communicate with patient? App as primary contact when human back-up unavailable? App as initial screen with in-person outreach to review and verify information? Note: Simpler during physical distancing since fewer contacts. Much more complicated physical distancing is relaxed. |

| Step | | Description | Data Elements | Traditional Process | Critical Operational Issues |
|-----------|------------------|---|--|---------------------|---|
| 2B | Supports | <ul style="list-style-type: none"> Send digital thermometer Review, identify, and connect for social supports, wraparound services – handoff to Care Coordinator Offer linkage to clinical services, esp if no primary care provider available – provide website/ telephone info | | | <p>Range and type of wraparound services to be offered (e.g., food, laundry, pharmacy svcs) – include childcare, mental health svcs (incl sud support), support for caregivers (eg, disability svcs)</p> <p>Voluntary offer of non-hospital isolation (hotel, dormitory) with services provided (e.g., food, laundry) if unable to isolate at home safely (e.g., elderly housemate), homeless, or if preferred.</p> <p>Clinical linkage to telemed safety net if no primary care provider</p> <p>Income support for people out of work?</p> |
| 2C | Interview | Identify potential infectious period before isolation (48 hours before symptom onset for symptomatic patient) | <p>Epi investigation (definitions for exposure settings, interactions)</p> <p>Nice to have: Lab cycle threshold (CT) value (lower CT correlates w > viral load)</p> | | How to establish earliest plausible infectious period for asymptomatic cases reported? |

| | Step | Description | Data Elements | Traditional Process | Critical Operational Issues |
|----|---|--|---|---------------------|--|
| 2D | <p>Elicit and obtain locating information about contacts</p> | <p>Contacts from 48h prior to symptom onset thru beginning of isolation period or thru 7 days after symptom onset and 72h after fever resolved:</p> <ol style="list-style-type: none"> 1. Household members 2. Intimate partners 3. Individual providing care in a household 4. Individual who has had close contact (< 6 feet) for a prolonged period (>30 minutes as an initial threshold) | <p>For each contact, name and nickname, email, all phones, social media handles, address, risk type</p> | | <p>All contacts to be notified anonymously – i.e., the identity of the index patient will not be revealed, and will not be confirmed if asked.</p> <p>App opportunity for pt to select contacts from phone to download to contact list, improve accuracy of data.</p> <p>Some jurisdictions ask cases to notify contacts directly.</p> <ul style="list-style-type: none"> • Ask index case to notify household contacts directly? • Ask index case to notify all known contacts directly? <p>Does HIPAA apply to contact notification/ monitoring? Ie, this is public health work, exempt?</p> <p>Close contact length of time for exposure? (10m v 30m)</p> |
| 2E | <p>Advice and instructions</p> | <ul style="list-style-type: none"> • Isolate • Monitor symptoms – contact caregiver if short of breath • Duration of isolation/ criteria for lifting • Inform might be back in touch in case need more information about either locating contacts or epi investigation | | | <p>How is case monitoring different from contact monitoring? E.g., closer medical monitoring, reports of contacts that have happened since isolation began</p> <p>Voluntary vs mandatory isolation? Monitor compliance?</p> <p>Need to address question of duration of quarantine for contacts who are household members of case.</p> |

| Step | | Description | Data Elements | Traditional Process | Critical Operational Issues |
|-----------|--|--|--|---|--|
| 3 | High risk/ congregate setting investigation | If contacts include exposure via congregate setting, hand off case to higher level investigation | Index case contact info, high-risk/ congregate exposure setting info (location, date/time, known contact info). | | How to hand off from app to traditional DOH investigators? How much information, when to advise case? Media or other public notifications about exposure? (eg, on the 4 train bw 11-1130am Th). Consider only if index confirmed to have transmitted to others? How to handle interjurisdictional communication and handoffs? |
| 4 | Notify contacts | <ul style="list-style-type: none"> Notification of exposure | | <ol style="list-style-type: none"> 1. Send SMS/ Email/ Phone/ Letter to notify 2. Received 3. Acknowledgement and response | Speed is essential for this step. App can facilitate. How to handle interjurisdictional communication and handoffs? |
| 4A | Interview | <p>Notification of exposure</p> <p>Engage and build trust</p> <p>Assessment of symptoms</p> | <p>Update contact medium and preferences</p> <p>Symptoms?</p> | <p>Email</p> <p>OR</p> <p>Phone call</p> <p>Return to index case if hard to reach or missing info.</p> | <p>App as primary w human back-up?</p> <p>In-person outreach if unreachable?</p> <p>In-person outreach if no locating info?</p> <p>Structure for reaching household contacts, i.e., one point of contact per household vs every household member as separate contact (because HIPAA)</p> |

| Step | | Description | Data Elements | Traditional Process | Critical Operational Issues |
|------|------------------------------------|--|--|---------------------------|---|
| 4B | Supports | <ul style="list-style-type: none"> Send thermometer Wraparound services Linkage to clinical services | | | <p>Range and type of wraparound services to be offered (e.g., food, laundry, pharmacy svcs)</p> <p>Relocation for quarantine in exceptional cases? What is threshold for offer, i.e., different from index case or same?</p> <p>Clinical linkage to telemed safety net if no primary care provider. Connect to testing via providers.</p> <p>Income support for people out of work?</p> |
| 4C | Advice and instructions | <ul style="list-style-type: none"> Quarantine 14d from date of last potential exposure Monitor symptoms Call if fever, cough, shortness of breath | | | <p>Voluntary vs mandatory quarantine?</p> <p>Maybe more efficient to motivate compliance with apps</p> <p>App can give health advice and answer questions, e.g., educ video, chatbot.</p> |
| 5 | Monitor contacts | Daily report on symptoms (for 14d after last date of contact during infectious interval) | <ol style="list-style-type: none"> Sent Received Acknowledged | Phone call | <p>App only? Digital upload of temperature?</p> <p>Whether and how to monitor compliance with quarantine.</p> |
| 5A | Follow up: non-response | Outreach to patient | | Email OR Phone call | In-person outreach? How intensive? (e.g., same day home visit if no response by 3pm) |
| 5B | Follow up: reported illness | If patient reports illness, linkage to clinical services | | | <p>Do symptomatic contacts need testing, or just assume positive? – will depend on context.</p> <p>If testing symptomatic contacts, how? E.g., home test kit</p> |

| Step | | Description | Data Elements | Traditional Process | Critical Operational Issues |
|------|---------------------------------|--|---------------|--|--|
| 5C | Follow up: reported test | <p>If patient reports testing, follow up to confirm results submitted to DOH/provider?</p> <p>If positive, contact becomes case, return to step 1.</p> | | | <p>Testing questions -</p> <ul style="list-style-type: none"> Any role for testing in asymptomatic contacts? – if resources allow, should be done and evaluated for yield. Perhaps closest contacts, or contacts of pt who has been known to transmit. How does contact report test results if self-administered? Do the results need to be confirmed? |
| 6 | Close out contact case | <p>After 14d without symptoms, notify of release from monitoring and instructions, provide general health education</p> | | <p>Email</p> <p>OR</p> <p>Phone call</p> | <p>Offer warmline for post-monitoring issues? eg, new case among contact case close contacts</p> |

DRAFT

Public health workforce

The essential work of contact tracing (CT) involves four tasks: successful contact and notification of exposure; assessment of symptoms and clinical linkage, if needed; education and instructions for quarantine, and arrangements for social supports, if needed; continued monitoring and close-out. Individuals with customer service skills and experience could fulfill this role with training in basic public health educator skills, including health information confidentiality.

The challenge is to implement this workforce at scale in a jurisdiction. The anticipated number of contacts is potentially massive, given the considerable number of new index cases identified each day and the highly infectious nature of the virus. Many jurisdictions abandoned contact tracing early on in the outbreak, overwhelmed by the sheer volume of contacts to be traced, reliant on traditional time-consuming methods and a limited workforce.

The proposed approach relies on the rapid and efficient recruitment, training, and deployment of a contact tracing workforce to meet the needs of a jurisdiction for containing and suppressing local transmission. This approach can be further augmented with the use of digital applications to facilitate components of the contact tracing work, including contact elicitation, contact notification, and contact monitoring. It is possible, however, to begin with the implementation of a large-scale jurisdiction-level workforce, operating under the management of the local health department.

1 Hiring models

CT workers may be recruited from the community in the jurisdiction, from among the many unemployed workers in the current landscape. The need for rapidity and scale may be best accomplished by contracting with a third party, under the oversight of the local health department. Hiring models might include:

- a. Call center company
- b. Telehealth company
- c. Local health department

2 Training models

- a. Standardized vs jurisdiction-designed and mounted
- b. Online module-based

3 Workforce projections

- a. # CT workers per team
- b. # contacts per case
- c. # cases per team / # contacts per team
- d. # cases at time (t) per jurisdiction population
 - i. # CT teams (# CT team supervisors)

4. Public health workforce tasks and roles

| Task | Role (descriptive title) | Task expectations |
|--|--|--|
| Locating information for case | Locator | Low skill, time intensive |
| Making connection with case | Locator (Case investigator if connection is field-based?) | Low skill, potentially time intensive |
| Interviewing case, advising and eliciting contacts | Case investigator | Moderate skill, time intensive |
| Arranging social supports for case | Care Coordinator | High skill, time intensive |
| Monitoring case | Case manager | Low skill, brief |
| Locating information for contact | Locator (Contact investigator if connection is field-based?) | Low skill, time intensive |
| Making connection with contact | Locator | Low skill, potentially time intensive |
| Interviewing and advising contact | Contact tracer | Moderate skill, potentially time intensive |
| Arranging social supports for case | Care Coordinator | High skill, time intensive |
| Monitoring contact | Contact manager | Low skill, brief |
| Closing out contact | Contact manager | Low skill, brief |

Social supports

Jurisdictions should consider contracting with a local care coordination provider to facilitate social supports for contacts entering quarantine and, where necessary, for cases in isolation. Funding must cover staffing and resource needs, where these cannot be delivered directly by the jurisdiction.

1 Basic resources

For many contacts, a brief intervention may be sufficient, including basic resources and warmline support for follow-up. The basic resources for all contacts entering 14d quarantine must include:

- Daily check-in phone calls
- Instructions of how to keep space clean for those sharing space
- Hotline for counseling, information, social services, and medical support
- Masks
- Thermometers
- Health education materials
- Hand sanitizer & alcohol-based cleanser

2 Eligibility for social supports

Jurisdictions will need to determine eligibility criteria for the provision of social supports. Considerations may include: income level, housing status, occupational status.

3 Social supports are wraparound services, and include:

a. Care package

To control COVID-19 infection and prevent transmission, it is important that contacts maintain the requisite quarantine period. To accomplish this, individuals may require basic social supports for daily living. The care package offered to all contacts entering 14d quarantine should include:

- Food, laundry, pharmacy services
- Garbage removal

b. Hoteling services

Hoteling services for the 14d quarantine period may be necessary for individuals who live with vulnerable individuals, are precariously housed, unsheltered, or homeless, or who otherwise cannot remain in their current residence.

c. Financial support

Jurisdictions should also consider arrangements for providing financial support for individuals to recover lost income during the quarantine period. These could include:

- Stipend from government to those without sick leave or who need to take care of child or elderly dependents
- Work with employers to provide support, with possible tax credits

d. Incentives

Jurisdictions may consider incorporating incentives into the care package to reinforce quarantine, such as:

- Passwords for on-demand movies, e-books, learning channels
- Access to high-speed internet and laptop
- Encouraging note from the mayor

Clinical linkage

The quarantine and monitoring of contacts relies on self-reported information provided by the contact. Contacts will receive basic resources to support symptom monitoring, such as a digital thermometer, but may require symptom management advice and clinical consult services during the 14d quarantine period. Contacts may have telephonic or video access to their regular primary care provider for addressing this need.

1 Telemedicine safety net

For contacts who do not have access to a regular primary care provider, jurisdictions should arrange a telemedicine safety net pool of providers for on-call clinical consult with contacts in quarantine. Given current advice for testing first directs symptomatic individuals to seek clinical advice from their provider, the availability of this service will be indispensable to ensuring contacts in quarantine can be rapidly connected to testing and care.