Case, Contact and Outbreak Management Policy

Victorian COVID-19 Public Health Unit Network

OFFICIAL

Document Type	Policy
Version/Date	10.0

VICTORIA State Government | Department of Health

CONTENTS

INTRODUCTION

Purpose

The Case, Contact, and Outbreak Management Policy (the policy) describes the State's approach to COVID-19 case, contact, exposure site and outbreak management to ensure Victorian guidance aligns with national policy and is consistent across the decentralised response to COVID-19 in Victoria.

The policy will be updated to reflect changes in national guidance and local strategy.

This document should be read in conjunction with the Communicable Disease Network of Australia Coronavirus Disease 2019 (COVID-19) National Guidelines for Public Health Units and locally developed protocols and standard operating procedures.

Governance

The Department of Health (the department) through the Targeted Outbreak Management (TOM) team of the Public Health Division is responsible for the provision of overall guidance on case, contact and outbreak management and for coordinating the response across the Local Public Health Units (LPHUs). The current operating model has nine LPHUs; three in metropolitan Melbourne and six in regional Victoria.

The policy is approved by the Deputy Chief Health Officer, COVID-19 Branch, Public Health Division.

1. CASE MANAGEMENT

Objectives of case management

Contact with confirmed and probable cases should occur as soon as possible after notification to facilitate safe isolation and ensure all urgent medical, support and welfare needs are met.

Definition

A **confirmed case** of COVID-19 requires laboratory definitive evidence:
Laboratory definitive evidence:

Detection of SARS-CoV-2 by nucleic acid amplification testing (NAAT);

OR

Isolation of SARS-CoV-2 in cell culture, with confirmation using a NAAT;

OR

SARS-CoV-2 IgG seroconversion or a four-fold or greater increase in SARS-CoV-2 antibodies of any immunoglobulin subclass including 'total' assays in acute and convalescent sera, in the absence of vaccination.

AND

Has NOT been determined to be an historic case, nor false positive NAAT result, nor recently recovered confirmed case whose period of isolation ended within the past 4 weeks, see below.

A **probable case** of COVID-19 requires laboratory suggestive evidence:

Laboratory suggestive evidence:

Detection of SARS-CoV-2 by rapid antigen (RA) test.

AND

Has NOT been determined to be an historic case, nor recently recovered confirmed case whose period of isolation ended within the past 4 weeks, see below.

Note: Use of the terminology 'confirmed case' in this document and the definition of 'diagnosed persons' as described in the Quarantine Isolation and Testing Orders (QIT) Orders is intended to, and should be interpreted to have, the same meaning.

Infectious period

A standardised operational definition of infectious period is applied to support public health activities including contact identification and management.

An individual's infectious period, however, can vary based on host or clinical factors and the variant of concern. Individuals with severe disease, or who are significantly immunocompromised may have prolonged infectious periods – see the Coronavirus (COVID-19) – CDNA National Guidelines for Public Health Units <https://www.health.gov.au/resources/publications/coronavirus-covid-19-cdna-national-guidelines-for-public-health-units>

For operational purposes, a person diagnosed with COVID-19 is considered to be infectious from 48 hours prior to symptom onset (or 48 hours prior to date of positive specimen if asymptomatic) until release from isolation, or until such other time as specified by an officer or nominated representative of the Department; see Release from isolation.

For the purposes above, a positive specimen may refer to either a NAAT or RA test.

Key activities

Notification

Laboratories are required to notify the department of all confirmed cases of COVID-19 as soon as practicable, and within 24 hours, under the *Public Health and Wellbeing Act 2008*.

Probable cases of COVID-19 are required to notify the department as soon as practicable upon returning a positive RA test result.

Contact with case

All confirmed and probable cases are contacted by the department by text message on notification.

Completion of a case interview may be considered in exceptional circumstances.

Confirmed and probable cases must take all reasonable steps to notify:

- all close contacts, including household members with whom they reside and other individuals that meet the definition of a close contact (see below for definition);
- their workplace(s) or education facility if they attended during their infectious period; and
- all social contacts they have been in contact with during their infectious period.

Confirmed and probable cases, through the notification SMS, are directed to online resources outlining their isolation requirements and obligations to notify contacts: see Contact Management.

Clinical Management

The clinical management of an eligible confirmed or probable case is the responsibility of the COVID-19 Positive Pathways program or equivalent clinical program.

There are a range of oral medications provisionally approved by the Therapeutic Goods Administration and available in Victoria through the Pharmaceutical Benefits Scheme (PBS) and National Medical Stockpile (NMS). These medications are for the treatment of patients in the early phase of infection with COVID-19 who are at risk of progression to severe disease.

Advice for healthcare workers on medications for patients with COVID-19 is available at - Medications for patients with COVID-19 <https://www.health.vic.gov.au/covid-19/vaccines-and-medications-in-patients-with-covid-19#consumer-medicine-information>

Welfare support

Provision of welfare support to confirmed and probable cases and their households is the responsibility of the Department of Family, Fairness and Housing (DFFH) and partner organisations including local government. Supports include but are not limited to; financial assistance, emergency accommodation, food, and other supplies.

Release from isolation

Cases (confirmed and probable) must isolate for at least five days after their first positive specimen collection date (RA test, NAAT), and up to seven days, depending on the existence of symptoms. Day 0 is considered the specimen collection date (RA test, NAAT).

Cases who are asymptomatic on the commencement of the fifth day, or at any point thereafter, can automatically leave isolation. For the purposes of this policy, the following acute COVID-19 symptoms apply:

- fever;
- chills or sweats;
- cough;
- sore throat;
- shortness of breath;
- runny nose;
- or loss of or change in sense of smell or taste.

For example: a person who undertook a COVID-19 NAAT or RA test on Monday, and received a positive test result from that test, can end their self-isolation period from 12:01 am on the Saturday if they do not have symptoms.

All cases (confirmed and probable) are automatically released at the commencement of the seventh day from their first positive specimen collection date (RA test, NAAT), without consideration of their clinical history or assessment of symptoms.

Following release from isolation

Cases may be infectious after release from isolation, in particular, if they have ongoing acute COVID-19 symptoms, were severely unwell, or are severely immunocompromised.

Cases are strongly recommended to:

- stay at home until their acute COVID-19 symptoms have resolved and should seek advice from their medical practitioner if required.
- wear a face make indoors away from home and outdoors where you cannot physically distance until the tenth day.
- consider taking a RA test prior to attending a workplace, sensitive settings or visiting people at higher risk of severe illness until the tenth day. If you are positive, stay home.

Cases (confirmed and probable) are provided with clearance requirements upon initial notification and contact from the department.

Additional requirements for sensitive or high-risk settings

Cases who are released from isolation prior to completing seven days of isolation (i.e. they are released on the fifth or sixth day) must not until the seventh day:

- work at a hospital, residential aged care facility, disability care facility or in-home care premises.
- visit a hospital, residential aged care facility or disability care facility, unless:

- In relation to a care facility, the person is permitted to do so under the Pandemic (Public Safety) Order; or
- In relation to a hospital, the person is permitted to do so by an officer of a hospital with the position of Executive Director of Nursing and Midwifery or equivalent.

It is strongly recommended that sensitive settings including hospitals, residential care and disability care facilities continue to manage cases in their facility, regardless of symptoms, under appropriate precautions until the commencement of the seventh day.

At their discretion, hospitals, aged care and other residential care facilities, health care settings and other businesses can continue to manage cases who have ongoing symptoms or may be infectious beyond the five to seven days of isolation under appropriate precautions.

Negative NAAT result following a positive RAT

If a probable case has undertaken a NAAT within 48 hours of their RA test result and returned a negative result, they may be released from isolation. See current testing advice <https://www.coronavirus.vic.gov.au/get-a-covid-19-test> for the limited circumstances when a false positive RA test may be suspected, and a confirmatory NAAT may be considered after receiving a positive RA test.

Expert review panel

An Expert Review Panel (the panel) may be convened at the request of a public health unit to adjudicate on the diagnosis of COVID-19 for specific cases, including identifying false positive diagnoses. Evidence to be considered includes clinical presentation, epidemiological information, and laboratory test results. The panel determines whether the initial diagnosis is consistent with the laboratory, clinical and epidemiological findings, and may also advise on the likely timing of infection.

Lost to follow up

Reasonable attempts to contact a case, via SMS or phone call for cases with a landline only, must be exhausted before classifying a confirmed case as 'lost to follow up'. Contact attempts may include data linkage. Victoria Police referrals may be considered in exceptional circumstances.

Death notifications

For surveillance purposes, a COVID-19 death is defined as a death in a confirmed COVID-19 case, unless there is a clear alternative cause of death that is unrelated to COVID-19 (e.g. trauma). For a death to be classified as a COVID-19 death there should be no period of complete recovery from COVID-19 between the COVID illness and death of the person. Where a Coroner's report is available, these findings are to be reflected as the definitive determination.

Reinfection and re-exposure period for recovered cases

Reinfection is defined as a subsequent confirmed SARS-CoV-2 infection in a person with a past known history of confirmed COVID-19, that is determined to be a separate episode to the first based on epidemiological and/or laboratory findings. SARS-CoV-2 RNA or antigen detection must be greater than 4 weeks after the date of release from isolation to be considered reinfection.

If a recently recovered case of COVID-19 is identified as a close contact of a confirmed or probable case, they do not need to quarantine nor undertake surveillance testing again if:

- the re-exposure was less than 4 weeks since the recovered case's release from isolation date.

Within this 4 week period, recovered cases:

- can continue to attend high-risk settings.
- do not need to be furloughed from work if re-exposed.
- do not need to participate in surveillance testing as part of their employment or education if re-exposed.

If a recovered case develops new symptoms during the 4-week period they should remain at home until symptoms resolve. Those at higher risk of severe disease should seek advice from their primary care provider and undertake testing for COVID-19, and consider testing for other respiratory viruses including influenza, to ensure they are able to access treatment, if eligible. Factors and conditions which increase the risk of severe disease include, older age, primary or acquired immunodeficiencies, undertaking immune suppressive therapies, or having a significant medical illness.

2. CONTACT MANAGEMENT

Objectives of contact management

The purpose of contact management is to identify and notify individuals who have been exposed to a confirmed case of COVID-19 to prevent ongoing transmission.

Contact definitions

Close contact

A **close contact** is defined as an individual who is not a recent confirmed case or recent probable case and:

- has had a total of four or more hours of contact (cumulative) in an indoor space with a confirmed case or a probable case in a residential setting** during their infectious period, OR
- is an individual who has been determined to be a close contact of a diagnosed person by an officer or nominated representative of the department, including in the event of an outbreak, and has been given notice of this.

Note: * A **recent confirmed case or recent probable case** means a person:

1. who is currently within their infectious period and has begun, but not yet completed a period of self-isolation; OR
2. whose infectious period ended within the previous 4 weeks.

A **residential setting is a building or a part of a building where individuals:

1. spend the night for sleeping; including a house, apartment, or other private dwelling, AND
2. share facilities for acts of daily living which have the potential to create exposure between residents.

A residential setting includes:

a. Aged care facilities
b. Military residential settings
c. Boarding schools
d. Boarding houses
e. Homeless shelters

Social contact

A **social contact** is defined as an individual who is not a close contact or a recent confirmed case*, and has had:

- at least 15 minutes face to face contact, OR
- greater than 2 hours within an indoor space with a confirmed case or probable case of COVID-19 during their infectious period.

Note: in workplaces such as health services, primary care, community care and emergency services, if either the staff/visitor/client case or the people who interacted with a case were correctly wearing a P2/N95 mask for the duration of contact, and there are no concerns of PPE breach, they are generally considered neither social nor close contacts.

Key activities

Quarantine

Close contacts

- Close contacts are required to;
    - If continuing to reside with a case, undertake five rapid antigen tests within seven days of notification, spaced at least 24 hours apart, should they return a positive result, then they are designated a Probable Case
    - If not continuing to reside with a case, undertake five rapid antigen tests within seven days following contact (as defined in the close contact definition above) , spaced at least 24 hours apart, should they return a positive result, then they are designated a Probable Case
    - Wear a face covering when attending any indoor space outside their home (unless an exception applies under the Pandemic Orders – e.g. for those aged younger than 8 years);
    - Not visit hospitals and care facilities unless;
        - In relation to a care facility, the person is permitted to do so under the Pandemic (Public Safety) Order; or
        - In relation to a hospital, the person is permitted to do so by an officer of a hospital with the position of Executive Director of Nursing and Midwifery or equivalent
    - Notify their employer and/or educational facility that they attend during the seven-day period and that the above conditions apply.
- Close contacts who do not comply with testing and other requirements must quarantine for a period of 7 days and follow testing requirements.

Social contacts

- There are no quarantine requirements for social contacts.

Testing

Testing requirements and recommendations for close contacts and social contacts are specified in the Testing Requirements Policy.

3. EXPOSURE SITE MANAGEMENT

Objectives of exposure site management

Exposure site management aims to identify individuals who may have been exposed to a case and aims to ensure there is no ongoing environmental risk at the site.

Key activities

Workplaces

Workplaces includes any setting where Occupational Health and Safety laws apply.

Confirmed and probable cases are required to notify their workplace if they are diagnosed with COVID-19 and attended an indoor space at the work premises during their infectious period.

If the case has attended their workplace during their infectious period, the facility must take reasonable steps to:

- to notify workers who attended the work premises during the relevant infectious period
- advise workers to monitor for symptoms and undertake testing if symptoms develop

Workplaces are required to notify the department in the event of an outbreak as defined below.

Evidence of cleaning certificates and approval to reopen after cleaning has been completed is not required but may be considered in some circumstances. Support and guidance may be provided on request.

Education facilities

Education facilities are defined as premises at which a childcare or early childhood service is provided, premises at which an outside school hours care service is provided, a school and school boarding premises.

Confirmed and probable cases are required to notify their education facility if they are diagnosed with COVID-19 and attended and indoor space at the facility during their infectious period.

If the case has attended the education facility during their infectious period, the facility must take reasonable steps to:

- notify the parents, guardians and carers of the persons enrolled at the education facility during the relevant infectious period of the potential exposure.
- advise staff, students and visitors to monitor for symptoms and undertake testing if symptoms develop
- collect, record, and store a list of all confirmed and probable cases, date of notification, and date(s) of attendance during their infectious period.

Notes

Other settings: routine exposure site management is not required but may be considered in exceptional circumstances. Support and guidance may be provided on request by the Department or LPHU.

4. OUTBREAK MANAGEMENT

Objectives of outbreak management

Outbreak management aims to control ongoing transmission through active case finding, contact identification, environmental assessment, and consequence management.

Definition

An outbreak in a **high-risk residential care setting*** is defined as:

- two or more residents who have been diagnosed with COVID-19 within a 72-hour period.

In **all other settings** (excluding households and high-risk residential care settings as above), an outbreak is defined as five or more persons who are:

- diagnosed with COVID-19 within a 7-day period; AND
- epidemiologically linked

Note: * A **high-risk residential care setting** means:

- Residential aged care facilities (RACF)
- Locations where Supported Independent Living (SIL) is provided
- Specialist Disability Accommodation (SDA) facilities
- Forensic residential disability settings
- Short Term Accommodation and Assistance (STAA) or respite facilities
- Supported residential services (SRS)

Notification and response

Settings are required to notify the department if the relevant outbreak definition is met.

The outbreak definitions do not preclude a setting from contacting the department for pre-emptive advice or support.

Settings are encouraged to notify the department of vulnerabilities associated with multiple confirmed cases, such as when service deliverability is impacted, impending critical failures, or vulnerability of confirmed cases or exposed persons – including vaccination rates and barriers to care (including COVID-19 treatment).

Outbreak notifications should trigger the provision of guidance and advice with active outbreak management only occurring in certain circumstances.

Outbreak management activities

Where an outbreak team from the department or an LPHU provides direct public health input, key activities to be performed in conjunction with the outbreak facility may include:

- Establishment of an Outbreak Management Team

- Agree outbreak and contact definitions
- Develop a testing strategy
- Lead an environmental investigation
- Establish an Incident Management Team if required
- Outbreak reporting

Outbreak Management Team

An Outbreak Management Team (OMT) is a multi-agency public health-focused group that is led by either an LPHU or by a SPOR team with accountability derived from the Chief Health Officer. Its primary goal is to ensure public health control measures are implemented to contain or reduce the spread of COVID-19. Other specialist stakeholder agencies may be invited to attend based on the outbreak setting (e.g. Department of Justice and Community Safety, Department of Jobs, Precincts and Regions, Department of Education Training, Department of Family, Fairness and Housing).

Incident Management Team

An Incident Management Team (IMT) is responsible for managing the wider impacts of the outbreak; this includes establishment of testing centres, provision of food and accommodation support to cases or contacts, liaising with community organisations and local government to ensure robust communications and partnerships, and emergency management logistics and reporting.

5. DOCUMENT REVISION HISTORY

Version	Date	Key changes from prior version
V.1.0	16 October 2021	N/A
V.1.1	31 October 2021	Inclusion: Reduced quarantine period for vaccinated non-household primary close contacts. Revision: Exposure Site Risk Assessment Tool. Removal: Deputy Chief Health Officer notification for confirmed cases classified 'Lost to Follow Up'.
V.2.0	20 November 2021	Inclusion: Re-exposure period for recovered cases, infectious period definition Revision: Contact definitions, outbreak definitions, isolation period for confirmed cases, quarantine period for contacts Removal: References to Tier 1 exposure sites
V.2.1	30 November 2021	Inclusion: Case and contact definition notes to align with the Pandemic (Quarantine, Isolation and Testing) Orders Inclusion: Management of contacts for aircraft passengers and crew Removal: Border permits for interstate travellers
V.2.2	22 December 2021	Revision: Contact definitions, outbreak definitions, quarantine, and testing requirements for contacts, updated Re-exposure period for recovered cases, addition of reinfection
V.3.0	30 December 2021	Revision: Requirement for confirmed cases to notify all contacts. Changes to isolation, quarantine, and testing settings. Inclusion: Presumptive case definition
V.4.0	7 January 2022	Revision: Phase 2 settings – "presumptive case" replaced with "probable case", requirement for probable cases to notify all contacts and Department of Health.
V.5.0	6 February 2022	Revision: changes to outbreak definitions, revision of reinfection and re-exposure period.
V.6.0	18 March 2022	Revision: changes to confirmed case definition, reinfection and re-exposure period.
V.7.0	22 April 2022	Revision: changes to quarantine and testing requirements for close contacts, outbreak definition, reinfection and re-exposure period.
V.8.0	24 June 2022	Revision: amendment to definition of close contact, surveillance testing requirements and obligations on educational facilities
V.9.0	12 July 2022	Revision: reinfection and re exposure period
V.10.0	8 September 2022	Revision: changes to isolation period and recommendations for sensitive settings, change to outbreak definition in aged and disability residential care settings