Section 5: **Contact Management**

Policy number: **5.1**

Subject: **Contact Investigation for Respiratory TB Cases**

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1. POLICY

1.1 Timely contact tracing is an essential component of tuberculosis (TB) prevention and control programs. All respiratory sputum smear negative or sputum smear positive TB cases require contact management.

1.1.1 Contact tracing must be completed for all cases of respiratory TB with the objective of identifying and treating any secondary cases

1.1.2 Contact tracing aims to identify any contacts with latent TB infection (LTBI) in order to offer preventive treatment.

1.1.3 Source-case investigation is required for children under 5 years old with a diagnosis of active TB disease.

1.1.4 Prioritization of contact follow-up is determined by the infectiousness of the source case, extent of exposure and immunologic vulnerability of those exposed.

1.1.5 Interviews with the infectious case should include questions about locations, activities and time spent with each contact. Specific names of contacts must be provided, however the case must be assured that their confidentiality will be maintained.

1.1.6 Contacts are grouped in relation to their vulnerability and sequenced into high, medium and low priority contacts.

1.1.6.1 In smear positive/cavitary/laryngeal TB, the initial contact follow up includes both high and medium priority contacts.

1.1.6.2 In smear-negative, non-cavitary pulmonary TB, the contact follow up will start with high priority contacts.

1.1.6.3 In both these situations, the contact investigation will be expanded if the initial follow-up indicates that transmission has occurred.

1.1.7 The CHN will develop a contact list and complete the contact investigation for each case of pulmonary TB or TB of the larynx in the community in consultation with the Communicable Disease (CD) nurse and the local public health unit (PHU).

2. PROCEDURE

2.1 A collaborative approach among all players (community, FNIHB, and local public health unit) is critical for successful completion of contact tracing.

2.2 The CHN will begin contact investigation as soon as the diagnosis of active TB or suspected active TB is made.

2.3 In collaboration with the CD nurse, and in discussions with the local PHU, the CHN will make a plan for contact tracing and establish limits for the investigation. The CHN will:

2.3.1 Make a list of all appropriate contacts based on information given by the index case, visit the index case's home and if necessary place of work, school, and other institutions to assess risk of TB transmission in those environments and obtain relevant contact information while ensuring the confidentiality of the index case.

2.3.2 Consult with the respective local PHU, and/or attending physician to establish how infectious the case is in order to establish priorities for contact tracing. Classify contacts as high priority, medium priority or low priority according to risk of exposure (CTBS 7th ed., Chapter 12 page 293). High priority: household contacts PLUS close non-household contacts who are immunologically vulnerable, such as children under 5 years. Medium priority: close non-household contacts with daily or almost daily exposure, including those at school and work. Low priority: Casual contacts with lower amounts of exposure. A list of high priority contacts will be compiled within 48 hours of a source case being identified.

2.2.3 The contact list is to be reported to the CD nurse.

2.4 Assess the risk of progression in contacts from latent tuberculosis infection (LTBI) to active TB disease to establish appropriate management of LTBI. Refer to Policy 3.2: Management of Positive TST Results.

2.5 Inform contacts about the exposure and arrange for contacts to have appropriate assessment.

2.6 High priority contacts, children <5 years, and persons with medical conditions associated with an elevated risk of progression from LTBI to active disease, should be identified within 48 hours of notification of the index case and should be assessed to rule out active TB by symptom inquiry, followed by appropriate diagnostic tests if necessary.

2.7 High priority contacts should have an initial TST and symptom assessment, followed by a repeat TST 8 weeks post exposure (CTBS, chapter 12, page 294). Medium priority contacts with no previous TST, undocumented TST, or previous negative TST, require a TST and symptom assessment at least 8 weeks after the end of exposure.

2.8 Contacts with a history of a previous positive TST should not have a repeat TST but do require assessment to rule out active TB or the need for treatment of LTBI.

2.9 Evaluate the results of the contact tracing to determine the risk of transmission. The contact investigation must begin promptly with high priority contacts and is expanded to medium priority if transmission of TB is demonstrated. Transmission is considered to have occurred if a secondary case is identified, or if there is documented conversion.

2.10 Prior to expanding to medium priority, the CHN will contact the CD nurse for consultation. Expansion of the list must be approved by the CD nurse and/or the Regional Medical Officer (FNIHB-OR) in consultation from the local PHU.

2.11 Ensure all documentation is completed and shared with the CD nurse, including the **Contact Report Form** (Refer to Appendix E).

2.12 In order to ensure clear messaging in the community, the CHN will work with the CD nurse to develop a communication plan.

3. REFERENCES

3.1 Ontario Ministry of Health and Long Term Care. (2008). Tuberculosis Prevention and Control Policy. Retrieved from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/tuberculosis_prevention_control.pdf

3.2 PHAC. (2014). Canadian Tuberculosis Standards, 7th Edition, chapter 12. Retrieved from: http://strauss.ca/OEMAC/wp-content/uploads/2013/11/Canadian_TB_Standards_7th-edition_English.pdf