Checklist for Control of Pertussis for Local Health Departments

This optional checklist may be used to organize pertussis follow-up. For more detailed information, refer to the pertussis chapter. The starting point for follow-up is usually a **lab-confirmed** case of pertussis in a patient with cough. Control recommendations are not usually made for suspected cases (other than to isolate the suspected case while being treated and consider treating household).

- □ Is there a positive lab result for *B. pertussis*? (Positive culture, PCR, or serology (note: serology result is only valid if performed at the MA SPHL or CDC).
- □ **Call the provider first and then the family (once they have been notified by the provider) if necessary, to determine:**
  - □ Demographics (race, Hispanic status, gender, school/occupation), Symptom History (particularly around cough symptoms), and Vaccine History.

    If **serology positive** at MA SPHL, patient must have two weeks of cough to be a confirmed case. If patient not tested at MA SPHL, was <11 years of age, or had received Tdap within 3 years of the serologic test: revoke event. It is not possible to interpret the results and therefore no public health control measures can be initiated.
  - □ Find out when the case began coughing. **Cough onset**: _____
  - □ Based on the cough onset, determine the **infectious period**: one week before cough onset, and three weeks after (or until the case completed five days of appropriate antibiotic therapy, whichever comes first).

    Infectious from _____ to _____
- □ **Isolate the case if the case is still infectious.**
- □ **Identify exposed close contacts, and dates of exposure(s).** This includes household contacts and other close contacts, including healthcare workers who may have examined case without using a mask.
  - □ **Symptomatic** close contacts should be referred for evaluation, testing and treatment, and excluded as per confirmed cases of pertussis. Providers should consider treating high risk (of severe disease, like infants) symptomatic contacts within 42 days of contact's cough onset.
  - □ Asymptomatic close contacts should be referred for prophylaxis if <21 days since exposure to the infectious case. If >21 days, no further action necessary. If asymptomatic there is usually no recommendation for exclusion. However, per 105 CMR 300.000, "in certain situations deemed to be high-risk, the public health authority may require exclusion of asymptomatic contacts not receiving antibiotic prophylaxis and/or other contacts."
  - □ Focus on those at high risk: All exposed close contacts who are infants <6 months, pregnant, or immunocompromised should be referred for evaluation, testing and treatment. They are at increased risk of complications from pertussis.
  - □ Focus on transmission risk to vulnerable patients: All close contacts likely to expose infants <6 months, pregnant women, and immunocompromised, should be given special attention, to avoid transmission to vulnerable groups. Examples: HCWs, daycare staff.
- □ Ensure that case and contacts are up-to-date with pertussis-containing vaccine (DTaP and Tdap).
- □ Complete the necessary variables and steps in MAVEN including complete vaccination history.
- □ Link cases to an outbreak event after creating one in MAVEN if necessary.
- □ Conduct surveillance (monitor for any new cough illnesses) for two incubation periods (42 days).

Manage pertussis in daycare, schools, healthcare and other institutions:

- □ Notify and educate staff, students, and/or patients, by phone call and/or letter. Sample letters are available by calling 617-983-6800.

  Ensure all exposed healthcare and other personnel serving high-risk patients receive antibiotic prophylaxis. In ongoing outbreaks, active surveillance of asymptomatic health care personnel for 21 days by Occupational Health may be an alternative to repeated rounds of antibiotics.

Checklist for Control of Pertussis for Local Health Departments

Identification of Close Contacts

Identification of close contacts is not an exact science. Do your best to identify those who were in very close contact with the case while the case was infectious, where contact with respiratory aerosols is likely. Start with those in close proximity to the case. **Prioritize those at high risk of medical complications, and those at high risk of transmitting pertussis to medically vulnerable populations.**

Household contacts	Almost always considered close contacts. Includes persons who occupy a particular housing unit as their usual residence, or who live there at the time of disease in the case, and other close contacts, including caregivers who come to the house regularly, friends/relatives who visit often, overnight guests, and intimate contacts of the case.
Face-to-face contact	Have had close face-to-face contact (within three feet), regardless of duration, with a case while the case is infectious. It includes sharing the same confined space in close proximity to an infected person for ≥1 hour, e.g., ≥1 hour in a small car. This does not usually include casual contact, like sharing the same classroom, waiting room, office space, or other casual types of interactions, except in some rare circumstances**.** Note: Some sports (e.g., hockey, lacrosse) can involve a lot of face-to-face contact.
Direct contact	Have had direct contact with respiratory, oral, or nasal secretions from an infectious case. Examples include an explosive cough or sneeze in the face; sharing food/eating utensils during a meal; kissing; sharing lip gloss, lipstick, cigarettes, or similar items; or performing medical/dental examination or procedure (e.g., suction, intubation, exam of mouth/throat, or bronchoscopy) without appropriate PPE.

Identification of "High-Risk" Close Contacts – High Priority for Follow-Up

High risk of serious complications from pertussis and adverse outcomes.	• Infants <1 year of age (particularly those <6 months of age*); • Immunocompromised individuals; • Individuals with chronic lung disease (including asthma and cystic fibrosis); • Individuals with neuromuscular disorders that prevent or reduce the ability to clear secretions; or • Unimmunized or under-immunized children. *For infants <1 year, particularly those <6 months, consider treatment within 42 days of onset of cough onset, and prophylaxis within 42 days of exposure (in consultation with MDPH).

Identification of "Transmission-Risk" Close Contacts – High Priority for Follow-Up

Transmission-risk contacts: may transmit pertussis to those at high risk for severe disease and adverse outcomes.	• Household members and other close contacts in a household setting where there is a high-risk individual. • Pregnant women in their 3rd trimester (due to concern about transmission to their newborn). • Those attending or working in childcare settings (i.e., same room), if there are infants or a pregnant woman who is in her 3rd trimester or other high-risk individuals in the setting. • Healthcare workers providing direct patient care, particularly to those listed as high-risk (e.g., NICU, obstetrics, labor and delivery, or bone marrow transplant unit).

See the full pertussis chapter at https://www.mass.gov/handbook/guide-to-surveillance-reporting-and-control

For questions, please contact the **MDPH Division of Epidemiology at 617-983-6800**.