

Management of Persons Potentially Exposed to Ebola Virus and Suspected EVD Cases

The Guinean Ministry of Health, the Ministry of Health and Sanitation of Sierra Leone, and the Ministry of Health and Social Welfare of Liberia are working with national and international partners to investigate and respond to the outbreak. The CDC is assisting with active screening and education efforts on the ground in the affected countries to prevent sick travelers from getting on planes. In addition, airports in the affected countries are screening all outbound passengers for Ebola symptoms, including fever, and passengers are required to respond to a health care questionnaire.

In October, 2014 the CDC and U.S. Customs and Border Protection implemented entry screening of passengers arriving from the Ebola-affected countries of Guinea, Liberia, and Sierra Leone at five U.S. airports – New York’s JFK International Airport, Washington-Dulles, Newark, Chicago-O’Hare, and Atlanta. Together, more than 94 percent of all travelers to the Ebola-affected countries had been arriving through these five airports; on 21 October 2014, the U.S. Department of Homeland Security announced that all travelers from these three countries in West Africa would arrive in the U.S. at one of the five designated airports. The screening consists of observing entering travelers for general overt signs of illness, asking a series of health and exposure questions, providing information about Ebola virus disease and self-monitoring for symptoms, and temperature measurement by trained medical staff.

Nonetheless, there is the potential for additional persons to have been exposed to Ebola virus in the affected countries to arrive in the United States, including Kansas.

The Kansas Department of Health and Environment’s Bureau of Epidemiology and Public Health Informatics (KDHE-BEPHI) has developed a Disease Investigation Guideline for viral hemorrhagic fever (www.kdheks.gov/epi/Investigation_Guidelines/VHF_Disease_Investigation_Guideline.pdf), which has been updated. This Ebola Virus Preparedness and Response Plan is not intended to replace the KDHE Disease Investigation Guideline, but rather provides specific information relevant to the current epidemic in West Africa.

Risk Assessment

As noted above, the CDC and Customs and Border Protection (CBP) are conducting entry screening of travelers who have traveled from or through Guinea or Sierra Leone. The CDC will distribute contact information for screened passengers to the state health department based on the passenger’s designation.

Effective 17 June 2015, CDC discontinued routine notification to state health departments of persons arriving in the U.S. from Liberia (as long as persons had no travel to Guinea or Sierra Leone in the previous 21 days) unless that the state specifically requested to receive such notifications. Kansas requested to continue receiving notifications for these travelers and has relayed this information to the appropriate local health department.

Effective 21 September 2015, following a CDC determination that the risk of Ebola importation into the United States by travelers from Liberia is low and that Liberia has implemented effective control measures, CDC has announced several changes regarding travelers from Liberia:

- Travelers from Liberia will no longer be funneled through the five selected U.S. airports.
- CDC will no longer send Epi-X notices to state, local, and territorial health departments regarding travelers from Liberia.
- In accordance with other changes implemented in June 2015, travelers from Liberia will no longer undergo active monitoring, maintain daily contact with state health departments, or do “self-observation” for 21 days after departure from Liberia to check for symptoms consistent with Ebola.

For persons arriving in Kansas with known travel to or residence in one of the currently affected countries (Guinea or Sierra Leone) within the previous 21 days, KDHE or the local health department will conduct a risk assessment (Appendix 1). This risk assessment is based on exposure guidelines recommended by the CDC. The health care facility and public health actions to be taken are based on three defined levels of exposure risk and whether or not persons are experiencing any potential signs or symptoms of EVD. There are special considerations for health care and laboratory workers.

The risk assessment will focus on contact with persons known or suspected to have EVD, including visiting or working in health care facilities, household contact with or providing in-home care to persons with potential EVD, or other activities that could pose a risk of transmission.

As in most previous outbreaks, those at highest risk of EVD are health care workers and family and other close contacts of patients with EVD. The risk assessment includes details for health care workers regarding contact with patients known or suspected to have EVD and infection prevention practices, including use of personal protective equipment and potential breaches in infection prevention practices.

Persons undergoing a risk assessment will be classified into one of four exposure categories: 1) high risk; 2) some risk of exposure; 3) low (but not zero) risk; and 4) no identifiable risk. Health care facility / provider and public health actions to be taken will be based on the exposure category, clinical criteria, and other factors. Details regarding exposure category definitions and actions to be taken are provided in Appendix 2.

Monitoring and Restricted Movement

For persons with potential exposure to EVD, monitoring for EVD symptoms with daily follow-up and reporting to the local health department or KDHE may be indicated. Restricted movement may also be indicated for some individuals. Persons undergoing public health monitoring shall be given information about EVD and an instruction sheet for self-monitoring (Appendix 3).

Active monitoring will entail self-monitoring for fever and other potential symptoms of Ebola virus infection twice per day until 21 days since last potential exposure, with the requirement of

daily public health follow-up via telephone or other means of regular communication. For direct active monitoring, a public health worker from the local health department or KDHE will directly observe the individual at least once daily to review symptoms and monitor temperature measurement. It is recommended that an initial visit by a public health worker be conducted in person early in the direct active monitoring process to help build rapport. This initial visit should be preceded by a telephone call to ensure the individual is well and is not experiencing any symptoms of EVD. Subsequent visits throughout the 21-day period may be conducted via videoconference at the discretion of the local health department or KDHE. The information from the monitoring process shall be recorded on a log sheet (Appendix 3). The public health monitoring process will help to ensure compliance with self-monitoring, assess and identify symptoms early, reduce risks of transmission if the individual develops EVD, and to address any potential concerns.

Asymptomatic persons classified as having either a high-risk exposure or at some risk of exposure within the preceding 21 days will undergo direct active monitoring. Persons with no symptoms in the low (but not zero) risk and no identifiable risk categories will undergo active monitoring. However, in-person, direct active monitoring may be indicated in some circumstances for these individuals as determined by the local health officer or KDHE.

Although the potential risk of exposure to Ebola virus for public health workers conducting in-person, direct active monitoring would be low, public health workers should minimize any potential exposure by maintaining a distance of at least three feet from the person under monitoring and avoiding any direct, hands-on patient care.

Most persons in the high risk exposure and some risk of exposure categories will be subjected to restricted movement and will be requested to remain at their residence or other living location as determined by KDHE or the local health officer for a period of 21 days following their last potential exposure; any movement outside the residence or other living location must be approved in advance by KDHE or the local health officer on a case-by-case basis. During this 21-day period of restricted movement, there shall be no visitors to the residence or living location except those approved by KDHE or the local health officer in advance.

Local health departments and other agencies should develop local plans to ensure basic needs of those persons whose movement is restricted are met. Such needs likely include food and other household necessities, etc.

Failure to comply with the provisions of active monitoring or restricted movement may result in the issuance of more restrictive quarantine orders pursuant to K.S.A. 65-119, K.S.A. 65-128 and K.A.R. 28-1-5.

Most persons in the low (but not zero) risk category shall also be subjected to active monitoring, but the only restrictions regarding travel will be the requirement to notify the local health officer or KDHE before any overnight travel outside the state of Kansas. This requirement is in place to ensure appropriate notification to other states and coordination of the active monitoring process. U.S.-based health care workers caring for Ebola patients while wearing appropriate personal protective equipment (as indicated in Appendix 4) and travelers on an aircraft with, and sitting

within three feet of, a person with Ebola virus disease will be subjected to direct active monitoring.

Any person undergoing either active monitoring or self-monitoring who develops a fever ($\geq 38.0^{\circ}\text{C}$ / 100.4°F **OR** subjective history of fever) *or other symptoms of EVD* shall immediately contact their local health department or the **KDHE Epidemiology Hotline at 877-427-7317**. If such persons contact a health care provider or local health department worker first, then the health care provider or local health department worker shall have the responsibility for contacting KDHE. A KDHE Epidemiologist is on call 24 hours per day. The on-call Epidemiologist shall assess self-reported symptoms to determine appropriate public health actions.

Special Considerations for Health Care Workers and Other Potential Occupational Exposure to Ebola Virus

United States-based health care workers, broadly defined as any person working in a health care setting (including laboratory workers and emergency responders), and other workers who are potentially exposed to Ebola virus while caring for a patient with EVD or during environmental cleanup activities will be subject to the same requirements for active monitoring and restricted movement as any other person, with the following exceptions.

Workers who utilize appropriate personal protective equipment (PPE) as detailed in Appendix 4 will be exempt from the 21-day restricted movement period that begins after their last contact with the patient or potentially infectious materials. These workers will be subjected to direct active monitoring and the requirement to notify the local health officer or KDHE before any overnight travel outside the state of Kansas for 21 days after last potential exposure. However, if the employee reports or is observed by a PPE trained observer to have experienced a needle stick or breach in PPE protocol, the full 21-day restricted movement period will apply.

Health care workers potentially exposed to Ebola virus who do not utilize the appropriate level of PPE during patient care will be subjected to direct active monitoring and restricted movement, depending on a risk assessment until 21 days after the last known potential exposure. The risk assessment will include consideration of whether or not the patient was exhibiting vomiting, diarrhea, or obvious bleeding which would increase the risk of transmission of Ebola virus.