

Executive Summary

HIGH CONSEQUENCE INFECTIOUS DISEASE (HCID) TOOLBOX FOR FRONTLINE HEALTH CARE FACILITIES

We live in a world where people travel the globe and pathogens evolve. These forces make health care facilities throughout the state vulnerable to risks posed by High Consequence Infectious Diseases (HCID), such as Ebola Virus Disease (EVD), Middle East Respiratory Syndrome (MERS), and others that are easily transmissible, highly fatal, and not preventable through routine vaccines. Delayed detection and isolation of HClDs may result in spread to others in health care facilities and the community.

In response to the 2014-2015 outbreak of EVD in West Africa and its accompanying risk of imported cases, the U.S. developed a tiered approach to health care preparedness, consisting of frontline, assessment, and treatment facilities. Frontline facilities included all locations that provide emergency care, including hospital-based emergency departments, critical access hospitals, and urgent care clinics. These facilities were responsible for quickly identifying and isolating patients who may have EVD before safe transfer to an assessment or treatment facility could be arranged. Even after the EVD outbreak passed, this tiered approach remains vital for ongoing HCID preparedness.

However, preparing for HClDs can be daunting for frontline facilities. On one hand, HClDs are rare and could be seen as competing with other pressing infection control priorities. On the other hand, HClDs may present with signs and symptoms that are indistinguishable from common infectious diseases making rapid identification challenging. Therefore, this Toolbox aims to blend HCID preparedness efforts into routine trainings and infection control practices that help reduce the spread of infections ranging from EVD and smallpox to common infections like measles and seasonal influenza. Although frontline facilities are defined as emergency or urgent care settings, persons with HClDs may also present to primary care clinics. Thus, we encourage ambulatory care clinics to utilize the Toolbox as well.

The core of the Toolbox is a new screening algorithm that can be integrated into routine clinical workflows. This algorithm is combined with simple planning, training, and exercise tools that facilities can use and modify to ensure preparedness components are in place and regulatory requirements are met. In addition, an HCID Readiness Binder has been created which contains point of care tools to help aid responses to any suspect HCID situation. This Toolbox will be continually updated in response to user needs. The recommendations in this Toolbox are meant to create a standard for Minnesota frontline facilities and are not regulatory.

CDC has outlined two levels of PPE requirements for Ebola. The first is for a person who is clinically stable with no bleeding, vomiting, or diarrhea and the second is for a person who is clinically unstable or has bleeding, vomiting, or diarrhea. We adapted this two-level concept so it can be easily applied to other HClDs as well. We are categorizing isolation needed for other HCID into Level 1 and Level 2 Full Barrier Isolation. We suggest that hospitals designate at least three experts to call upon in the event of an HCID presentation and that hospitals be prepared to manage a patient in HCID Level 1 Full Barrier Isolation for at least 24 hours.

The Minnesota Department of Health (MDH), the Minnesota Chapter of the Association for Infection Control and Epidemiology (APIC MN), and the Healthcare Coalitions of Minnesota worked collaboratively to develop this Toolbox.