



RON CHAPMAN, MD, MPH
Director & State Health Officer

State of California—Health and Human Services Agency
California Department of Public Health



EDMUND G. BROWN JR.
Governor

October 29, 2014

TO: California Local Health Officers
California Health Executives

FROM: Dr. Ron Chapman
Director & State Health Officer,
California Department of Public Health

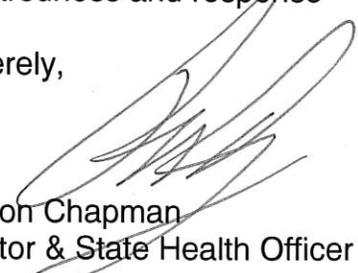
RE: Guidance for the Evaluation and Management of Contacts to Ebola Virus
Disease – Monitoring of Travelers

Thank you for your ongoing efforts to monitor and manage travelers from Ebola-affected countries that arrive in your jurisdictions. On October 27, 2014, the Centers for Diseases Control and Prevention (CDC) released *Guidance for Monitoring and Movement of Persons with Potential Ebola Virus Exposure*, found at <http://www.cdc.gov/vhf/ebola/exposure/monitoring-and-movement-of-persons-with-exposure.html>.

The California Department of Public Health (CDPH) concurs with CDC recommendations for monitoring travelers from Ebola-affected countries and is providing the attached additional recommendations on how to carry out quarantine of these individuals following their return. Combined, the CDC and CDPH recommendations are consistent with the Order of Quarantine I issued today. In addition, CDPH is providing a travel history data collection instrument to assist you in gathering standardized information from returning travelers.

If you have any questions about the CDC or CDPH guidance documents, please contact me. Again, thank you for your continued good work and efforts in Ebola preparedness and response

Sincerely,



Dr. Ron Chapman
Director & State Health Officer



RON CHAPMAN, MD, MPH
Director & State Health Officer

State of California—Health and Human Services Agency
California Department of Public Health



EDMUND G. BROWN JR.
Governor

Guidance for the Evaluation and Management of Contacts to Ebola Virus Disease

Part 1: Guidance for the Evaluation and Management of Travelers Returning from Countries with an Ebola Virus Disease Outbreak

October 28, 2014

The California Department of Public Health (CDPH) endorses the U.S. Centers for Disease Control and Prevention (CDC) Guidance for Monitoring and Movement of Persons with Potential Ebola Virus Exposure, released 10/27/2014 (<http://www.cdc.gov/vhf/ebola/exposure/monitoring-and-movement-of-persons-with-exposure.html>). This document is intended to provide supporting operational guidance to California local health departments.

Mode of Transmission

Ebola virus disease (Ebola) is spread through direct contact (through broken skin or mucous membranes in, for example, the eyes, nose, or mouth) with the following:

- Blood or body fluids (including but not limited to urine, saliva, sweat, feces, vomit, breast milk, and semen) of a person who is sick with Ebola; and/or
- Objects (like needles and syringes) that have been contaminated with the virus.

For a more detailed review of human to human transmission of Ebola virus, please see this CDC document:

<http://www.cdc.gov/vhf/ebola/transmission/human-transmission.html>

Incubation Period

From 2 - 21 days (average 8-10 days)

Infectious Period

Persons with Ebola are considered infectious from the day of onset of symptoms until clinically convalescent and no longer viremic based on a negative Ebola virus PCR blood test. Ebola virus has been detected in human semen for up to 3 months.

Returning Traveler definitions

A Returning Traveler is defined as:

- Any person who was present in the last 21 days in a country with an active Ebola outbreak.



Guidance for the Evaluation and Management of Contacts to Ebola Virus Disease

Part 1: Guidance for the Evaluation and Management of Travelers Returning from Countries with an Ebola Virus Disease Outbreak

Traveler Screening

Travelers are screened at ports-of-entry by federal Customs and Border Protection (CBP) and CDC's Division of Global Migration and Quarantine (DGMQ) for travel to a country or region with an active Ebola outbreak. CBP conducts a secondary screening of all returning travelers for fever with a no-touch thermometer. Travelers are queried on recent history of signs and symptoms of Ebola and possible risk exposures. Travelers are either released after secondary screening with a CARE kit (including digital thermometer and fever and symptom log) or referred to CDC for tertiary screening with medical staff.

CDPH receives daily line lists from DGMQ with contact information for all travelers who were screened and whose final destination is California. CDPH disseminates this information the same day to local health departments with jurisdiction over the traveler's final destination.

Returning Traveler Investigation Steps

1. Interview the Returning Traveler with the CDPH Ebola Virus Disease Travel History Form to assess whether the returning traveler definition has been met and assess if exposure may have occurred. If there is indication that an exposure may have occurred, assign a risk category based on CDC guidance (<http://www.cdc.gov/vhf/ebola/exposure/monitoring-and-movement-of-persons-with-exposure.html>)
2. If the traveler is at "high risk" or "some risk" of Ebola, issue a health officer order for quarantine that outlines specific isolation requirements based on an individual risk assessment.
3. Implement other public health action, including a system for daily monitoring, based on level of risk.
4. Report interview results and follow-up plan in CalREDIE under the condition "Returning Traveler". If a traveler is determined to be in the "high risk" or "some risk" category, please alert CDPH staff at 510-427-3769.
5. Instruct the traveler to contact the local health department and remain isolated at home if any of the following develop:
 - a. Single oral temperature of $\geq 100.4^{\circ}$, or,
 - b. Other symptoms suggestive of Ebola such as severe headache, muscle pain, weakness, diarrhea, vomiting, abdominal pain, unexplained hemorrhage, or,



Guidance for the Evaluation and Management of Contacts to Ebola Virus Disease

Part 1: Guidance for the Evaluation and Management of Travelers Returning from Countries with an Ebola Virus Disease Outbreak

- c. Persistently elevated oral temperature between 99.6° F and 100.3° F across at least 8 hours.

(Note: fever reducers such as acetaminophen or ibuprofen may impact temperature)

6. Call CDPH (During business hours call the Ebola clinical consult line: 510 427-3769; after hours call the DCDC Duty Officer) to report a symptomatic traveler immediately. Depending on initial symptoms and risk level, a decision on movement to a healthcare facility and testing will be made in consultation with CDPH and CDC. If symptoms resolve a decision to resume twice daily monitoring may be recommended.
7. Update traveler temperature and symptom data daily in CalREDIE.

Returning Traveler Interviews

CDPH recommends that traveler interviews and daily symptom checks occurs via telephone, Skype, FaceTime, or other real time electronic means to minimize any potential exposure to local public health investigators. If a local public health department prefers to make home visits, it is recommended that staff call ahead to ensure that the contact is not symptomatic; additional training and access to PPE might be recommended.



I. Interview Information

Interviewer: _____ Date of interview: MM / DD / YYYY
Interviewer Name (Last, First): _____
State/Local Health Department: _____
Business Address: _____
City: _____ State: _____ Zip: _____ County: _____
Phone number: _____ Email address: _____

II. Traveler Information

Traveler:
Last Name: _____ First Name: _____
Current Street Address: _____ Apt. # _____
City: _____ County: _____ State: _____ Zip: _____
Phone number: _____ Email address: _____
Alternate phone number/email: _____
Time at current residence: _____
Is this the permanent residence: Yes No If No, Please provide permanent address:
Street Address: _____ Apt. # _____
City: _____ County: _____ State: _____ Zip: _____
Country: _____
Who is providing information for this contact?
 Contact (Self)
 Other, specify person (Last, First): _____
Relationship to contact: _____
Reason contact unable to provide information: Contact is a minor Other _____
Contact primary language: _____ Was this form administered via a translator? Yes No



III. Traveler Demographics

Date of birth: MM / DD / YYYY Age:

Sex: Male Female If female, pregnant? Yes No

What is your occupation? _____

What is your occupation setting? _____

Place of work and address:

Do you currently reside in a congregate setting? _____

IV. Symptoms

Do you currently have any of the following symptoms (note date of onset):

- No symptoms
- Fever _____ °F
- Chills
- Weakness
- Fatigue
- Headache
- Muscle Aches
- Abdominal Pain
- Diarrhea _____ times/day
- Vomiting
- Unexplained hemorrhage
- Other _____





V. Exposure History

Which countries outside the United States have you visited in the last 21 days?

Questions specific to travel in Ebola-affected countries (i.e. Guinea, Liberia, Sierra Leone):

What was the purpose of your travel to the region? _____

What activities did you undertake in the region? _____

If travel was for Ebola-response related activities, what was your role? _____

Which agency or group did you work with in country? _____

Which areas of the affected countries did you visit (e.g. county, district, region names)?

What type of setting did you reside in when in the region (e.g. hotel, relative's home, work lodging)?

- 1) **Were you near anyone in the last 21 days while abroad who was sick with signs of fever, vomiting, diarrhea, OR unexplained bleeding?** Yes No
- 2) **Were you in a medical facility, clinic, treatment unit, clinical laboratory, or Ebola diagnostic laboratory in the past 21 days while abroad, in any capacity (e.g. seeking care, providing care, accompanying a patient)?** Yes No
- 3) **Did you attend a funeral while abroad in the last 21 days and touch the deceased person or clean or bathe the body?** Yes No

***** If the respondent answers **YES** to any of question 1, 2, or 3, please administer the appropriate CONTACT INVESTIGATION FORM to further assess exposures and risk.*****

If the respondent answers NO to questions 1, 2, and 3, the interviewer can use discretion in administering CONTACT INVESTIGATION FORM.

VI. Traveler Follow-up

Do you have a thermometer devoted for only your personal use? Yes No

If yes, what type? Oral Axillary Ear Non-touch, ear Non-touch, forehead Rectal
If no, please provide the traveler with a thermometer and instructions on its use.

Do you have travel planned outside of the county in the next three weeks? Yes No

If yes, where? _____

Do you have any medical or dental appointments or procedures scheduled in the next three weeks?



If yes, what is the appointment or procedure for? _____
 Health care facility name and address: _____

 Health care provider name and phone number: _____

SECTION III: SUMMARY

- POTENTIAL EXPOSURES BESIDES TRAVEL
- DID NOT TRAVEL TO AN AFFECTED COUNTRY OR REGION
- TRAVELED TO AN AFFECTED COUNTRY OR REGION

DATE OF LAST DAY IN AFFECTED COUNTRY OR REGION _____

FOLLOW-UP ACTIONS

- Risk category and exposure history assessed through interview with Contact Investigation Form with ID# _____
- No follow-up is needed (ONLY for those who did not travel to an affected country or region)
- 21-day fever and symptom monitoring
 Last date of monitoring required: _____
 Monitoring to be conducted: In-person By phone By email Other, specify: _____
- Who at the local health department will be responsible for follow-up?
 Name: _____ Phone Number: _____ Email: _____
- Will a translator be required? Yes No
- Is the traveler comfortable with using the thermometer? Yes No
- Is the traveler considered a flight risk or unlikely to follow public health recommendations? Yes No
- If yes, please provide detail _____

NOTES:



| VII. Contact Symptom Follow-Up Diary | | | | |
|---|---|---|---|---|
| 1 day after last exposure MM / DD / YYYY | 2 days after last exposure MM / DD / YYYY | 3 days after last exposure MM / DD / YYYY | 4 days after last exposure MM / DD / YYYY | 5 days after last exposure MM / DD / YYYY |
| <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____°F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____times/day <input type="checkbox"/> Vomiting <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact | <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____°F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____times/day <input type="checkbox"/> Vomiting <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact | <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____°F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____times/day <input type="checkbox"/> Vomiting <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact | <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____°F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____times/day <input type="checkbox"/> Vomiting <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact | <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____°F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____times/day <input type="checkbox"/> Vomiting <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact |
| 6 days after last exposure MM / DD / YYYY | 7 days after last exposure MM / DD / YYYY | 8 days after last exposure MM / DD / YYYY | 9 days after last exposure MM / DD / YYYY | 10 days after last exposure MM / DD / YYYY |
| <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____°F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____times/day <input type="checkbox"/> Vomiting | <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____°F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____times/day <input type="checkbox"/> Vomiting | <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____°F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____times/day <input type="checkbox"/> Vomiting | <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____°F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____times/day <input type="checkbox"/> Vomiting | <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____°F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____times/day <input type="checkbox"/> Vomiting |



Ebola Virus Disease Travel History | ID _____

| | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact | <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact | <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact | <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact | <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact |
| 11 days after last exposure | 12 days after last exposure | 13 days after last exposure | 14 days after last exposure | 15 days after last exposure |
| MM / DD / YYYY |
| <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____°F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____times/day <input type="checkbox"/> Vomiting <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact | <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____°F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____times/day <input type="checkbox"/> Vomiting <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact | <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____°F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____times/day <input type="checkbox"/> Vomiting <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact | <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____°F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____times/day <input type="checkbox"/> Vomiting <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact | <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____°F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____times/day <input type="checkbox"/> Vomiting <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact |



| 16 days after last exposure MM / DD / YYYY | 17 days after last exposure MM / DD / YYYY | 18 days after last exposure MM / DD / YYYY | 19 days after last exposure MM / DD / YYYY | 20 days after last exposure MM / DD / YYYY |
|---|---|---|---|---|
| <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____ °F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____ times/day <input type="checkbox"/> Vomiting <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact | <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____ °F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____ times/day <input type="checkbox"/> Vomiting <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact | <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____ °F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____ times/day <input type="checkbox"/> Vomiting <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact | <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____ °F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____ times/day <input type="checkbox"/> Vomiting <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact | <input type="checkbox"/> No symptoms <input type="checkbox"/> Fever _____ °F <input type="checkbox"/> Chills <input type="checkbox"/> Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea _____ times/day <input type="checkbox"/> Vomiting <input type="checkbox"/> Unexplained hemorrhage <input type="checkbox"/> Other _____ <input type="checkbox"/> Unable to contact |



21 days after last exposure

MM / DD / YYYY

- No symptoms
- Fever _____ °F
- Chills
- Weakness
- Headache
- Muscle Aches
- Abdominal Pain
- Diarrhea ____ times/day
- Vomiting
- Unexplained hemorrhage
- Other _____
- Unable to contact

NOTES: