What are the key points to understand when defining processes that support preparedness for high-consequence infectious diseases or special pathogens?

Any examples are for illustrative purposes only.

Is there a definition or list of those diseases that fall under high-consequence infectious diseases or special pathogens?
The R3 report Introduction to Standard IC.07.01.01 states: "While there is not a standardized definition for high-consequence infectious diseases (HCIDs) or special pathogens, expert consensus defines these as novel or reemerging infectious agents that are easily transmitted from person-to-person, have

limited or no medical countermeasures (such as an effective vaccine or prophylaxis), have a high mortality, require prompt identification and implementation of infection control activities (for example, isolation, special personal protective equipment), and require rapid notification to public health authorities and special action. Examples of high-consequence infectious diseases or special pathogens include MERS, novel influenzas, and Ebola or other viral hemorrhagic fever diseases. This list may change, however, to reflect current regional or global outbreaks or to include future emerging agents."

The definitive list is not provided because the identity of the pathogen may not always be known or certain. The intent is routine screening using a syndromic-based approach (fever, rash, respiratory symptoms), and travel history to determine if the symptomatic patient traveled to an area with an active outbreak. Organizations should also examine information or definitions provided by local and state law and regulation.

What is meant by "points of entry"?

Points of entry are typically understood as the first point of contact, but the organization can operationalize the appropriate location or what constitutes the first point of contact (for example, front desk, triage area at the emergency room, electronic check-in prior to the appointment, etc.) Note that points of entry may include the emergency department, urgent care, and ambulatory clinics.

What are the expectations regarding the "identify" screening protocols at the points of entry?

The requirement for "Identify" protocols builds on the CDC Core Practice "Minimizing Potential Exposures" that includes the development and implementation of "systems for early detection and management (e.g., use of appropriate infection control measures, including isolation precautions, PPE) of potentially infectious persons at initial points of patient encounter in outpatient settings (e.g., triage areas, emergency departments, outpatient clinics, physician offices) and at the time of admission to hospitals and long-term care facilities (LTCF)."

The expectation is that screening is implemented at the point of entry for fever, respiratory symptoms, rash, and travel history. However, the Joint Commission is not prescriptive on the implementation details, leaving it to organizations to develop the screening protocols that best fit their care environments and resources. For example, hospitals and critical access hospitals may consider the following:

- Active and/or passive screening processes, such as staff at the point of entry asking specific questions, posting visual alerts at the entrances of clinics on signs and symptoms that patients/visitors should report to staff when they first register for care, etc.

- The organization can determine the threshold at which screening will escalate from passive (e.g., signs at the entrance) to active (e.g., direct questioning).

- The organization can define the threshold at which travel screening will be initiated, such as after ascertaining that persons entering the facility present with fever, fever & rash, fever & respiratory symptoms.

Ambulatory/behavioral health clinics that are affiliated with acute hospitals and critical access hospitals (and accredited under the HAP/CAH accreditation manual) may choose to use modified protocols based on the setting, volume or population served, such as pre-screening symptomatic individuals before ambulatory visits and making a referral to the appropriate acute care setting.

The organization may revise or adjust screening protocols based on: The absence/or presence of known transmission locally, regionally, nationally or internationally; in the setting of suspected or identified special pathogen locally, regionally, nationally or internationally; the guidance of public health authorities.

What are the expectations regarding competencies?
Hospitals have the flexibility to define the competencies required by the organization, in accordance with HR.01.06 01 EP 1. This includes competencies associated with the practical applications

of the Identify-Isolate-Inform protocols. In general, competencies must be based on observable and measurable methods, such as use of a written test or a demonstration of accurate completion of procedure or process. The organization decides what type of education and training must have a competency associated with it.

Is there an expectation to address each special pathogen separately?

There is no expectation to address each special pathogen separately since the identity of the pathogen may not always be known or certain. Hospitals should focus on screening using a syndromic-based approach (fever, rash, respiratory symptoms) and travel history to determine if the symptomatic patient traveled to an area with an identified active outbreak or known organism of concern.

Does IC.07.01.01 apply to psychiatric hospitals?

IC.07.01.01 applies to acute hospitals. The requirements under IC.07.01.01 are not applicable to psychiatric, surgical specialty, long term care acute hospitals or swing beds.

Additional Resources

Infectious disease outbreaks reported on by CDC
CDC Health Department Directories

Last updated on June 14, 2024 with update notes of: Reflects new or updated requirements

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