Operator: This is a recording of the Dawn Glossa conference with The Joint Commission on October 30, 2014 at 11:00 a.m., Central Time. Ladies and gentlemen, thank you for your patience in holding. We now have your presenters in conference. Please be aware that each of your lines is in a listen-only mode. At the conclusions of today’s presentation, we will open the floor for your questions. At that time, instructions will be given as to the procedure to follow if you would like to ask a question. It is now my pleasure to introduce today’s first presenter, Ms. Dawn Glossa.

Dawn Glossa: Welcome everyone. We’re pleased to have you on the call today, on our webinar on Ebola Preparedness: Identify, Isolate, Inform. I am Dawn Glossa, Director of Communications and Corporate Marketing at The Joint Commission. Hospitals nationwide are preparing for what to do if they find themselves face-to-face with a potential Ebola patient. In response to the recent cases, the Centers for Disease Control and Prevention last week updated recommended protocols for infection control in hospitals and emergency departments. In addition, hospitals across the country have ramped up training for employees. Today’s webinar is a collaborative effort hosted by The Joint Commission and the CDC. The objective of this webinar is to provide information on recommended hospital protocols and containing the spread of infectious diseases. A Q&A session will commence at the conclusion of formal remarks. And now I am very pleased to introduce our first speaker, Dr. Ana McKee, Chief Medical Officer and Senior Vice President at The Joint Commission.

Ana McKee, M.D.: Good afternoon. The Joint Commission has a tradition of partnering with the CDC, and this webinar is an example of that long-standing partnership. We have all been watching the unfolding of the Ebola Virus Disease (EVD) with heightened concerns. We are pleased to cohost this webinar and hope that the information will be highly beneficial. The safety
of patients and health care workers is a core value of The Joint Commission’s mission. To that effect, there are standards specifically designed to protect patients and health care workers. The specific standards exist in the following chapters of the hospital manual: Leadership, Environment of Care, Emergency Management, Human Resources, Infection Control, Nursing, and National Patient Safety Goals. For easy access, we have posted the specific and relative standards on our website for your review. It is important for organizations not to lose sight of these basic requirements because of the infection-related concerns and threats of not just Ebola Virus Disease but influenza, enterovirus and other infections. We have instructed our surveyors to focus on these relevant standards during surveys. Unfortunately, by the end of this year as we complete surveys in a third of the 4,000 hospitals that we accredit, we will have observed more than 1,600 opportunities where staff failed to wash their hands or observed breaches in high-level disinfection and sterilization. These numbers represent only a fraction of the opportunities for improvement that exist in organizations today. I also want to emphasize that our Emergency Management standards are critically important to your emergency preparedness strategy. We have heard from organizations who have successfully cared for patients with Ebola Virus Disease, the importance of simulation training and practice. The Joint Commission standards on emergency management are the framework organizations need to have in place in order to adequately prepare. This is an extraordinary opportunity for organizations to make significant improvements in these processes. It is time for all of us to eliminate variation in practice and strive towards consistency and high reliability.

Dawn Glossa: Thank you, Dr. McKee. And now I’d like to introduce our speakers from the CDC. Miss Abigail Tumpey, MPH, Associate Director of Communications Sciences, Division of Healthcare Quality Promotion; Dr. Sridhar Basavaraju, Medical Officer, Division of Healthcare Quality Promotion, National Centers for Emerging and Zoonotic Infectious Diseases; Dr. Clifford McDonald, Senior Advisory for Science and Integrity, Division of Healthcare Quality Promotion; Dr. Joseph Perz, Quality Standards Safety Team Leader, Division of Healthcare Quality
Abigail Tumpey: Thank you so much, and thank you to The Joint Commission for your leadership in putting on this webinar. As Dr. McKee said, CDC has been approaching this as working to improve overall infection control across health care facilities that could impact, not only Ebola, but also other events like flu, health care safety infections, drug resistant infections, etc. We’ve been really talking about the Five Pillars of Safety that all health care facilities should keep in mind.

The first is that facility leadership has a responsibility to provide resources and support for the implementation of infection prevention precautions. This means that management should maintain a culture of worker safety in which appropriate personal protective equipment (PPE) is available and properly maintained, and workers have been provided with appropriate training. There should also be a designated on-site “Ebola Manager.” This person should be responsible for oversight of implementing precautions for health care personnel and patient safety throughout the health care facility. We want to make sure there’s also clear standardized procedures where facilities choose one of two options that Dr. Cliff McDonald is going to talk through with regard to personal protective equipment, and have a backup plan in case supplies are not available. We also want to make sure that health care personnel are trained and that facilities need to make sure that all health care personnel practice, practice, practice. Once they choose a protocol for personal protective equipment and infection control, that those are followed and practiced rigorously. We need to make sure there’s oversight of these practices. We’re going to talk in a little bit more detail about the concept of having a buddy system and having an individual who is a trained observer who can assist in this.

Next slide. The enhanced personal protective guidance that we put out last week reflects lessons learned from recent experiences of caring for patients with Ebola in U.S. health care facilities.
We’ve been stressing the importance of four things: training, practice, calmness and observation. We want to make sure that there’s no ambiguities for health care workers caring for patients with Ebola.

Next slide. We also want to remind people that personal protective equipment is only one aspect of infection control. It’s important to focus on other areas that can help prevent the spread of Ebola within health care facilities. For example, prompt screening and triage of patients, having a designated site manager to ensure proper implementation of precautions, limiting personnel in isolation rooms, and effective environmental cleaning.

With the next slide, I’m going to hand it over to my colleague, Sridhar, who is going to talk in more detail about screening and isolation in emergency departments.

**Dr. Sridhar Basavaraju:** We developed an algorithm that is for emergency department providers dealing with patients with possible Ebola Virus Disease. First was to identify potential cases. The next was to isolate them appropriately, and third was to inform the relative parties. We’ll just flip through the algorithm quickly.

The first step would be to identify an appropriate exposure history in all patients who present to the emergency department almost immediately or immediately upon arrival to the emergency department. These would be questions that are directed at whether the patient has lived in or traveled to a country that has widespread Ebola transmission, or whether they’ve been identified as a contact of an individual with confirmed Ebola Virus Disease within the last 21 days. If the answer to that is ‘no,’ then the recommendation is that the usual triage and assessment continue. If the patient answers ‘yes’ to any of these questions, more targeted questions regarding signs and symptoms of Ebola Virus Disease are to be elicited. These include fever and other compatible symptoms such as headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain or hemorrhage. If the answer to these are ‘no,’ then the usual triage and assessment can be
continued. Another recommendation is that the local relevant health department be notified so that the patient could be appropriately monitored for fever and other symptoms for 21 days after the last exposure. If the patient answers ‘yes’ to any of the questions that are concerning for Ebola, then the patient should be isolated immediately. This would include a private room or separate enclosed area that has a private bathroom or covered bedside commode. Then, from there on, only essential personnel with designated roles should be involved in the evaluation and care of the patient, in order to minimize risk to the health care workers. The use of PPE should be determined based on the patient’s clinical status. If the patient, for example, is exhibiting bleeding, vomiting, diarrhea, or if they have a clinical condition that will warrant invasive or aerosol-generating procedures – these include intubation, suctioning or active resuscitation – then the PPE that’s designated for the care of hospitalized patients should be used. If the patient does not have bleeding, vomiting, diarrhea or is not predicted to undergo an invasive or aerosol-generating procedure, then health care workers, at a minimum, should wear a face shield, surgical face mask, an impermeable gown, and two pairs of gloves.

Also, if the patient earlier in the algorithm has signs or symptoms that are concerning for Ebola, then the hospital infection control program should be immediately notified and the local health department should also be immediately notified. Once the appropriate PPE has been donned by the health care worker, then the further evaluation and treatment could be continued, including the history and physical exam, any routine intervention such as placing peripheral IV or phlebotomy, and the patient should be evaluated with dedicated equipment.

**Abigail Tumpey:** Next slide. Emergency department guides were posted on October 27, and we are working to ensure that every health care provider, regardless of setting, gets this information. With that, I want to turn it over to Dr. McDonald who is going to talk in more detail about the personal protective equipment guidance that was released last week. Next slide.
**Dr. Cliff McDonald:** Thank you, Abbigail. As you heard already, there are two options described in this. We tried to limit the number of different PPE combinations to really two major ensembles. Both of these involve the use of a respirator N95 or powered air purified respirator or PAPR. This marked a change in our thinking. We don’t believe that EVD is airborne, but we do know that, here in the U.S., when we have a hospitalized patient (which is what these guidelines are about), that these patients can be very ill to the point that aerosol-generating procedures may be done. To streamline and standardize the type of PPEs that are being warranted, we made this decision to go this route with either of these forms of protection.

The other major thing you find in this guidance is this idea of no exposed skin. This translates into covering the feet by wearing standardized footwear or boot covers, a disposable hood and then, of course, a gown or a coverall. All of this must be fluid impermeable to limit exposure to liquids. Many of these patients can have profuse diarrhea and vomiting. Double gloves are part of this, which is not something we normally do. Sometimes in surgery people are asked to wear double gloves to prevent needle sticks or to reduce the risk of those. This is about the safe removal of these gloves or all the PPEs. The double gloves function in an important way there. I’ll come back to that. There’s even mentioned in this guidance the wearing of standardized clothing underneath this PPE, although we’re not quite as emphatic about that, scrubs should probably be worn and also a shower should be made available to the health care worker at the end of their shift. An apron is used if they’re really in the wet phase or the fluid phase of the disease where there is a lot of exposure.

Next slide. Probably more important though, and you’ve heard this already, more important than any particular piece of PPE, or glove, gown or whatever, is how it’s used, and the training behind that, and the supervision. You already heard about the importance of a site manager. The other thing, though, is this trained observer who is watching the doffing or removal process. We think self-contamination is very important. Certainly that’s long been a concern in Africa, and I think for various reasons it could be a concern here. The standardization about the actual way you remove
this. The donning process is also outlined, but it’s not quite so important. As long as you get it all on and have it on correctly is the key there. There is an order to it, though, to be systematic, and that should be followed, but especially in the doffing, the removal, it has to be rigidly adhered to. People need to be trained. We need to highly train these individuals before they go into these settings. Integrated hand hygiene all along the way – that’s part of, for the first time really that I’m aware of, we actually recommend the use of alcohol-based hand rub on gloves. We never wanted to consider that because we know the temptation then is to wear the same pair of gloves into another room, when the whole idea of glove use in other settings is to prevent patient-to-patient transmission. This is glove use to prevent disease transmission to the health care provider and so, in addition to the double gloves, after each piece of PPE has been removed, you are reducing the bio-burden on the gloved hand usually through using alcohol-based hand rub. That’s also true for other parts of PPE that become heavily soiled. Decontaminating those also, the idea is getting the bio-burden down on this, reducing the bio-burden I should say, on the piece of the PPE before you remove them. And it’s also important in the room to be constantly cleaning. I’ll come back to that. There’s other resources out there – the list is here to help with understanding how to safely don and doff this.

Next slide. As to other considerations, we are still in the process, well you’ve already heard about the emergency room guidance where there is a slightly different level of protection, but that reflects the fact that patients are in a different point in their disease. And yet, if they are at the same point of the disease at the fluid stage, then the guidance is all the same, actually. There are other important aspects that are reflected in this guidance, including where you do this donning and doffing; the idea of a hot, warm and cold zone approach; and redesigning patient care areas to make that safer. There are other concerns we know, and that includes the use of PAPRs. PAPRs offer a lot of advantages. Commander Delaney can say more about this. Face protection is paramount here, though. They do provide comfort to the provider and a full field of vision and allow the patient to see the face of the provider, all these things. There are different types of PAPRs and it’s reflected in this guidance. There’s a type with a blower in the helmet which offers
several advantages. Then there’s others that have a blower on the belt. Those, the latter type, which are more common, do pose somewhat of a challenge for disinfection. We can certainly say more about that in the Q&A. With that, I think I’ll turn it over to Dr. Joe Perz, to talk some more about the training because it’s so critical in all of this. For the health care provider level, the facility level, and the regional level.

**Dr. Joe Perz:** Next slide please. As Cliff was saying, we have a lot of activity focusing on health care worker training. Equally important is facility level preparedness, which also includes training. I would be happy to talk more about that during the question and answer period. Just to highlight some of what we’ve been doing, we’ve been helping to conduct and participate in numerous webinars and partner calls on a daily basis. We have reached many thousands of health care workers with these activities, including one that’s worth highlighting – a live event in New York City that reached over 5,000 participants in person and nearly 20,000 more via webstream. There is a second event that’s planned for November 7 in Los Angeles. This is also complemented by specific training materials, for example, videos that would address different aspects of PPE use. We actually have a series that’s been developed with partners that will be released this week. We are working hard to develop plain language messaging and materials from the CDC guidance that’s tailored to the particular settings and roles that health care workers may find themselves in. As I said, a lot of active partnering with professional organizations and benefiting from public and private partnerships. I would say that today’s event is a great example of that. We’re very appreciative that The Joint Commission is giving us this forum to help reach you. I think I’ll pause there. Again, we want to make sure there’s plenty of time for Q&A.

**Abbigail Tumpey:** This is Abbigail. I think we’ll turn it over to Lisa from The Joint Commission to finish.

**Dawn Glossa:** Thank you, Abbigail. I would now like to introduce Miss Lisa Waldowski, Infection Control Specialist from The Joint Commission. Lisa has been with The Joint Commission since
Lisa Waldowski: Thank you, Dawn. In preparing your health care organization for a suspected or confirmed Ebola Virus Disease patient, I would like to highlight current Joint Commission accreditation standards that support your preparedness and response efforts.

First slide please? I will begin with the Emergency Management chapter, as it is specific to the emergency operations plan document and subsequent standards that I will discuss with you that can assist in defining your organization’s response to the Ebola Virus Disease. Organizations can identify potential threats or adverse events such as Ebola Virus Disease by assessing Ebola impact to the care, treatment and services provided to patients through a “hazards vulnerability analysis.” Part of the planning activities should involve early identification and prompt notification by having phone numbers to your external community resources such as the Department of Health and other partners that may need to be notified once identification is recognized within your organization. There are also four phases in emergency preparedness, and that may vary across organizations with their mitigation or decreasing risk, preparedness before the emerging event, and response and recovery efforts during and after the emergency.

Next slide, please. Having an emergency operations plan within that document, you will have the following items: Communication as it pertains to your internal communication among staff and key stakeholders, and external communication and specifying when the notification that the response to Ebola has been initiated within your organization. Resources and assets I will address on a subsequent slide. Safety and security, how you will manage hazardous materials and waste for example. Staff roles and responsibilities.
Next slide please. Two standards that are pertinent within the Emergency Management chapter is looking at preparing for and managing resources and assets. These would be specific to what has already been mentioned to include personal protective equipment, which will be more intensive and utilized more comprehensively than ever before. You’re also looking at what your assets pertaining to dedicated equipment and supplies, as noted with the increased use of alcohol-based hand sanitizer. You may want to look at the volume that you’ll be going through within your organization.

How you’re going to manage staff during this emergency. Description of specific staff functions. You’re talking about a core team, those identified within your organization, the support needs of those staff, the response roles and who they will report to, what the chain of command would look like – should all be worked out in advance.

Next slide. After conducting an emergency response exercise, by putting the action items into play to identify your gaps or opportunities for improvement, and then evaluate the entire Emergency Operations Plan to move forward with making modifications or interim measures, as needed.

Next slide. Within the Infection Prevention and Control chapter, you will notice a wealth of information that will help support your efforts. One is identification of your risk, where your portal of entries are within your organization. We heavily stressed already the emergency room department. Looking at your population served and your geographical location, your community, will help identify your risk areas. Having an Infection Prevention and Control (IC) Plan which includes incorporation of evidence-based guidelines, and the lack thereof, reaching out in utilization of expert consensus. The information that I am presenting here within Infection Prevention and Control also includes laboratory resources. This includes the same standards within what context I’m talking about Ebola today, if the lab services are within that hospital setting. When we look at response to an influx of potentially infectious patients, we’re talking
about identifying resources in advance so they can provide information within the organization internally specific to Ebola, and have current clinical and epidemiologic information from its resources, so specific to today’s CDC resources that we’ve been discussing prior to my talking. Whenever risks significantly occur, this continues to evolve and we continue to provide updated information. Identifying risks at this point should be a continual process, not a one-time stop here.

Next slide. Implementation of the Infection Control Plan. Not only do you have to identify risks and implement goals within the construction of your IC Plan, you need to actually put it to work. We’re looking at the implementation of standard precautions, transmission based precautions as already has been stated; we’re looking at standard contact and droplet transmission-based precautions for Ebola. Also within this standard, we’re talking about decreasing the risk of storage and disposing of infectious waste. Investigation of outbreaks. The Infection Prevention and Control program should have written documentation once an Ebola patient has been identified, how they will track that patient, and how they will monitor them. The internal and external communications is supported within this standard. You’re keeping key stakeholders within your organization and externally aware of the status and reporting as appropriate to your local state department of health. Also within this standard is, when the occasion arises, that you’re either transferring a patient out of your organization to a recipient organization or vice versa, when you’re receiving a patient with Ebola, that the notification and communication of the hand-off of this information needs to take place. The standard pertaining to reducing the risk of transmission of infection with medical equipment devices and supplies is pertinent to looking at your cleaning, disinfection, high-level disinfection and sterilization, as appropriate, and the utilization of hospital-approved, EPA-registered products, and following to the line manufacturer’s instructions for use of the products you have.

Next slide. We’re still within the Infection Prevention and Control chapter standard related to prevention of transmission of infectious disease among patients, licensed independent practitioners and staff. This means working with your employee health and/or occupational health
department when, and if, an exposure occurs as to appropriate identification, follow-up and resources provided to that staff member to handle that situation as soon as it arises. Again, the communication and process that is involved so staff are clearly aware of the process. Then evaluation of the Infection Control Program as specified, with some of the elements I’ve identified and brought to your attention to include an ongoing risk assessment as Ebola continues to be an issue within the United States.

Next slide. Within our Environment of Care chapter, we’re looking at management risks similar to what was identified in the Infection Prevention and Control chapter pertaining to hazardous materials and waste. This, however, goes further to explain what procedures need to be in place that include the use of personal protective equipment when involved with touching, removing, storing, and handling of hazardous waste and materials. Establishing and maintaining a safe functional environment. This pertains to what was spelled out as to the numerous elements involved with wearing PPE and covering your entire skin. We’re talking about being in a room that can get quite warm for a staff member over a period of time. Look at the environment as it pertains to temperature, humidity and ventilation. Granted, we’re not talking about ventilation for airborne isolation at this point in time, but there is a ventilation requirement in an isolation room for negative pressure – if warranted or need be. But this is not the case, at this point in time, that we’re discussing Ebola and an airborne isolation event.

Next slide. Human Resources, as it pertains to orientation of staff and ongoing education and training based on the needs of the patient population. This includes how to report anticipated events, such as a breach in PPE when putting it on and removal of it, in particular, if an exposure occurs, and staff competency in performing their responsibilities. When I say staff, I’m looking at multi-disciplines. We’re looking at nurses, physicians, laboratory personnel that are going into the room, environmental services that is cleaning that room so often. Those are just to name a few and include my counterparts, infectious disease preventionists, which may also be part of that process. Specific competencies and procedures to donning and doffing and placing and removing
of personal protective equipment, what isolation procedures actually mean. The early
identification, and not to forget, safe injection practices given the potential for route of
transmission with a needle stick.

Next slide. Leadership. The overall safety and quality of care falls within this chapter. Under
Leadership we’re complying with law and regulation. We’re looking at the policies and procedures
you’ve put in place that support your Ebola response that guide and support the patient care
treatment and services.

Next slide. Nursing. We have a Nursing chapter. We’re looking for nurses to be specifically
looking at their care, treatment and services, and their staff plans. If you have a core team of
nurses that are going to be providing care to Ebola patients, how your operations are going to be
conducted. You want that spelled out in clear communication lines that everything is standardized
and compliant with your procedures and policies within that department.

Last but not least, next slide, is hand hygiene. Our National Patient Safety Goal. We’re looking at
compliance, your goals, your overall hand hygiene program given the amount of hand hygiene
that is involved in coupling your response to decrease an infectious agent such as Ebola Virus
Disease and your risk of transmission to yourself, other health care members and patients. Thank
you.

Dawn Glossa: Thank you, Lisa. We would now like to take questions. I also wanted to mention
to everyone on the call that these slides will be available later for you and we will send those out.
Due to the large number of participants on today’s call, we will ask that you limit yourself to one
question.

Operator: Our first question comes from Cindy Jenkins with Decatur Memorial Hospital.
Cindy Jenkins: Yes. CDC stated last week I believe that they were going to come out with some guidelines for drilling for Ebola. We have not seen those yet. I was just wondering if those were going to be forthcoming soon.

Abbigail Tumpey: Yes. This is Abbigail Tumpey of the CDC. We’re actually having discussions with The Joint Commission and others about resources that we can create on how to drill for a patient with Ebola.

Joe Perz: This is Joe Perz. I would add that we have seen some good sample materials coming from partners. One that comes to mind is the Tennessee Department of Health. Their website has a whole page devoted to exercise functions and drills that might be worth reviewing.

Operator: Our next question comes from Wendy Miley with Havasu Regional Medical Center.

Wanda Miley: Hi, I was just curious to find out if there was a more specific doffing process for if we’re truly using a PAPR, because lifting N95 – it’s one of the last items that’s removed for protecting your mucosa. What about when we’re doing a PAPR?

Dawn Glossa: Lisa Delaney, do you want to answer that one?

Lisa Delaney: Sure. The PPE donning and doffing guidance that we released last week contains supplements for both doffing the N95 filtering face piece respirator, as well as the two different PAPR options that Cliff mentioned. With the PAPR, there are two options. The more common PAPR is the one that contains the blower unit that is worn on a belt, a configuration around the waist. Then there’s really only one other option. One company manufacturers this other PAPR that has the integrated blower filter unit actually in the hood or the helmet of the PAPR. It does simplify the doffing procedures because you can take it off when you remove the hood. In our current guidance, we do have the PAPR hood being removed in the unit prior to removing the
coverall and the gown. We are revisiting that as to whether that’s going to remain the guidance. But, you know, it does cause some concerns about how you doff the PAPR when you have the other options. They’re both really good PAPRs.

Dawn Glossa: Next question.

Operator: The next question comes from Amy Colson with Select Specialty Hospital.

Amy Colson: Yes. I apologize if I overlooked it, but are the slides from this presentation going to be made available, especially the section on the Emergency Management? It could be very helpful as we go through and review our process and make certain that we’re addressing all the elements that need addressing for Ebola.

Dawn Glossa: I’ll answer the question about the slides. They will be available. We’re also going to send them out along with the replay of this webinar to everyone who registered. That’s going to be in the next few days.

Operator: Our next question comes from Terri Argumosa with The Joint Commission.

Terri Argumosa: Hi. I’d like to know, have they looked at education specifically for housekeeping or laundering services when they have to do those things for patients that actually had Ebola?

Abbigail Tumpey: This is Abbigail Tumpey from CDC. Right now we have some guidance documents on our website. But we are working to create easy-to-use pieces of information. For example, we’re trying to add videos and audio podcasts with each guidance document so people don’t have to read the entire guidance document, they can get it in a bite-sized chunk. We’re also working with partners on disseminating information through a variety of networks to make sure that all health care providers who potentially could come in contact with a patient with Ebola has
the necessary information to do their jobs appropriately and protect themselves in that process. There’s some resources right now available on CDC.gov/ebola (http://www.cdc.gov/vhf/ebola/). If you look under the health care worker spot. Additional materials are also going to be forthcoming.

Joe Perz: Let me add just one thing. We’re instructing people to discard the sheets from the confirmed Ebola patients and not to launder them at this time. We know that the waste stream is swollen by that, and then there’s the waste considerations. Right now, we’d rather have that than the laundry going to another site in the hospital; that is our standing guidance right now. That came out before this recent CDC guidance and probably all the more reason to do that.

Dawn Glossa: Next question.

Operator: Our next question comes from Amber Fisk of the Children’s Hospital of Omaha.

Amber Fisk: Our question is, is there a certain standard that covers our staff safety in the case of a code or a need to go into a room fast?

Dawn Glossa: Lisa from Joint Commission, can you answer that question?

Ana McKee: This is Dr. McKee. I believe that the question is not so much of a standard, because there are no standards around resuscitation or codes. I thought maybe the person was referring to guidelines regarding the management of a code. Is that correct?

Joe Perz: I’m sorry? Maybe you want to clarify?

Amber Fisk: Do you have a policy or a regulatory guidance on keeping employees safe prior to responding to a situation?
Joe Perz: Okay. Thank you for that question. We don’t have specific guidance about policies for code status for patients. That has been discussed certainly in different venues. You can find online discussions about that. Certainly in the general care of patients, discussing with patients their preferences for resuscitation is always important. I think there are Joint Commission standards about that. In this situation, we do know that they can get quite ill and those discussions can be very important as the patient’s condition and the course of their disease dictates. But, also I think what’s being alluded to is that aerosol-generating procedures are more likely to happen during such a resuscitation and codes. That would of course mean that you are in the hospital setting, even if you’re in the emergency room. You’re using the full hospital PPE with the respirator. There is always, whether it’s an Ebola patient, or any patient, there is that need to consider both the patient’s needs but also the safety of the health care providers. That’s not unique to Ebola. Maybe it becomes more acute. That tension is always there and that is something that we always have to be mindful of. Our recommendation is to use the full PPE we’re talking about and still do everything that you can do for the patient. That’s the reality.

Dawn Glossa: Next question.

 Operator: Our next question comes from Jena Dadanado with Spring Harbor Hospital.

Jena Dadanado: Yes. My question is about recommendations for ambulatory settings in the event that after screening a patient who is positive for travel or for exposure and symptoms?

Joe Perz: There is actually specific guidance forthcoming. The essential messages here are that, typically, patients are not presenting with an Ebola risk history, specifically travel, and systems compatible with Ebola to the outpatient setting. Be aware that CDC and other partners in local and state public health have instituted active monitoring of return travelers. A person who has symptoms would be advised to seek care in all likelihood in an emergency department setting. Nonetheless, if an ambulatory setting or an outpatient office encountered a patient who had the
travel history and symptoms compatible to Ebola, the advice is similar to what you've been seeing in terms of isolating the patient, contacting the health department.

**Jena Dadanado:** And for PPE?

**Male Voice:** There is advice there related to PPE as well. Obviously we wouldn't expect every doctor's office to have things like a PAPR and a Tyvek suit. It's actually very hard to imagine where a patient would be in the phase of Ebola disease where that would even be necessary. I would be thinking about more conservative PPE requirements that involve what we might be talking about in the emergency department.

**Joe Perz:** Sure. Let me just add one thing, Jena. I think that as we think about it, you've emphasized already – and you can't even discuss this in abstraction from the monitoring and movement guidance that has just come up – that basically there's about 2,100 to 3,000 or so persons, right now, who have traveled from West Africa in the United States in the 21-day window. I mean this is a finite number that we can actually determine. And we know, day-by-day, actually how many this number is, and it's in that range because it's about 100 to 150 arrivals per day. More and more the health departments, the public health infrastructure is going to know where these people are. They come into five airports predominantly, and then they go out to other places and that will be tracked more and more with active monitoring. Hopefully, the intention is that there would be some contact made from the health department to each of these individuals. They will be more and more informed so that the idea of them coming unannounced into your office setting is something that, while we have to always have in the back of our minds, it's something we need to be prepared for; not something that we should be thinking about as the way we want to manage this. And it's not going to be. It's going to be predominantly managed through people calling the health department because they know they've been informed, or the health department calling them and say, oh you say that you had a fever today. This is what you do.
**Male Voice:** And it’s not to go to the doc-in-the-box down the street; it’s to go to the designated facility where the emergency room is ready and waiting for you.

**Ana McKee:** So regardless of this monitoring and movement being put into place, we still are working on some outpatient guidance and that will be forthcoming, and we’ll make sure that our colleagues at Joint Commission have that so they can share it with the folks on the phone as well.

**Joe Perz:** Let me just say though, the emphasis will not be on the CDC, the emphasis will be on the emergency department and there are recommendations there. That’s not the idea to manage these people in the office setting. It will be really to keep them there and give them training at another site.

**Operator:** Our next question comes from Janine Kingston with SummitRidge Hospital.

**Janine Kingston:** Yes. Our concern here is how would we set up a barrier for the donning and doffing of PPE, in the event that a patient walks into the facility and we triage them at the front desk, but we don’t have a room that contains an anteroom?

**Abbigail Tumpey:** This is Abigail Tumpey. We actually have been working with health care facilities to help them better figure out how to take existing rooms in their existing infrastructure, so they can ensure that their health care workers are safe. I think we’re looking at some of the plans that have been put into place in other health care facilities so that we can share them more broadly when folks are thinking through how to do this effectively. Joe or Chris, do you want to add anything to that?

**Joe Perz:** Yeah, there’s a little bit in the PPE guidance about using plastic sheeting and other things to construct such barriers. Anterooms are designed well for a doffing area. You don
somewhere else and then go into it and then doff on the way out. If you don’t have that, there are other options such as using a room next door, using one room on one side and another room on the other side, or building something into the hallway. But that has other considerations, like fire codes. You really have to stop traffic in that hallway, if that’s the case. It depends upon the layout of the system. There’s principles in there. I can’t give you exact specifications, of course. I think that we’re looking at that further, is the idea of some facilities actually building something new in terms of giving them guidance on what they’re going to build.

Operator: The next question comes from Erin Redding from Wayne Memorial Hospital.

Jeff Bonya: Hey, this is actually Jeff Bonya. We have two quick questions. One is specifically related to the PAPR and I’m looking for guidance regarding decontamination of the PAPR unit itself, as far as what’s required for external cleaning, and cleaning the internal structure. What needs to be done and cleaned, or is cleaning the external housing sufficient? The other question is related to the shower after you have doffed your PPE. The way we’re set up, we have two options for showers. One is our decontamination room, and one is a staff shower which is further away. If we have the ability to walk through the departments after we have doffed our PPE to take a shower, would that be considered safe, and where would be the best place to shower post-doffing?

Dawn Glossa: Lisa, can you answer?

Lisa Delaney: Sure, I can answer the PAPR question. We currently do not have PAPR decontamination guidance. We recommended that you work with the manufacturer and follow their decontamination protocols. There are many different configurations of PAPRs, so it would be difficult for us to provide that detailed information. I can say that certain PAPRs and certain manufacturers are designing PAPRs with the type of use in mind that will require decontamination. They have some models that are designed to be amenable to decontamination,
and more easily deconned. I know certain manufacturers have issued very detailed guidance on decontamination. We encourage you to work with manufacturers and look at their decontamination protocols.

**Joe Perz:** Regarding the showers, it is mentioned in the PPE guidance about the preference of having showers nearby. I don't think that's stated very strongly in there. We realize the showers can be controversial, frankly, there were some voices as we were developing this guidance that pushed up against that. What are we really doing with a shower? But it is a final step of additional safety that's there. At that point, though, they're completely doffed of any of the PPE that was in the room, including footwear, so they are safe to walk anywhere. It’s more for personal safety that they’re taking the shower. I think the wording of the guidance was more along the guidelines of making it convenient, but not that these health care workers pose a risk.

**Operator:** Our next question comes from Julianne McCray with the Avita Health System.

**Julianne McCray:** Hi. Our question is in the emergency department setting, what is the best standard of practice to protect the greeter and the registrar?

**Joe Perz:** Yeah, I think just a safe distance, as is normally done anyway.

**Julianne McCray:** I think that what we were looking at was approximately 3 feet.

**Joe Perz:** I think the main point here is that there's no direct patient contact, that they're initiating the screening process promptly in terms of bringing in the appropriate staff and moving out.

**Abbigail Tumpey:** Great. Dr. McKee I think we’re at our time. Can I kick it back to you for final comments?
Ana McKee: Thank you. It has been a very rich discussion and we appreciate the fact that we have been able to spend this time and share the information. Thank you to everyone who took the time to participate in today’s webinar, and thanks to all of you who listened in. We hope it was of value.

Dawn Glossa: A link to today’s webinar, along with the slide presentations will be posted on The Joint Commission website within the next week, if not sooner. You can find it on The Joint Commission Ebola Preparedness Resources area of our website. You can get to there from our home page. We also want to let you know that we will be sending the recorded version and the PowerPoint slides out to everyone who signed up for this webinar. Again, we want to thank you, and enjoy your day.

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