

FAQ (Updated 10.20.14 @ 13:15 hours)

From CDC Website:

Are there any cases of people contracting Ebola in the U.S.?

CDC confirmed on September 30, 2014, the [first travel-associated case of Ebola to be diagnosed in the United States](#). The person traveled from West Africa to Dallas, Texas, and later sought medical care at Texas Health Presbyterian Hospital of Dallas after developing symptoms consistent with Ebola. The medical facility has isolated the patient. Based on the person's travel history and symptoms, CDC recommended testing for Ebola.

CDC recognizes that even a single case of Ebola diagnosed in the United States raises concerns. Knowing the possibility exists, medical and public health professionals across the country have been preparing to respond. CDC and public health officials in Texas are taking precautions to identify people who have had close personal contact with the ill person and health care professionals have been reminded to use meticulous infection control at all times.

Is there a danger of Ebola spreading in the U.S.?

Ebola is not spread through casual contact; therefore, the risk of an outbreak in the U.S. is very low. We know how to stop Ebola's further spread: thorough case finding, isolation of ill people, contacting people exposed to the ill person, and further isolation of contacts if they develop symptoms. The U.S. public health and medical systems have had prior experience with sporadic cases of diseases such as Ebola. In the past decade, the United States had 5 imported cases of Viral Hemorrhagic Fever (VHF) diseases similar to Ebola (1 Marburg, 4 Lassa). None resulted in any transmission in the United States.

Are people who were on the plane with this patient at risk?

A person must have symptoms to spread Ebola to others. The ill person did not exhibit symptoms of Ebola during the flights from West Africa and CDC does not recommend that people on the same commercial airline flights undergo monitoring. The person reported developing symptoms five days after the return flight. CDC and public health officials in Texas are taking precautions to identify people who have had close personal contact with the ill person and health care professionals have been reminded to use meticulous infection control at all times.

ATC System:

What are we doing locally to identify possible Ebola cases?

The probability of contacting an Ebola patient in our community remains extremely low. However several processes have or soon will be in place to increase our surveillance. These processes are designed to be overlapping or redundant to minimize the risk of a symptomatic Ebola patient being missed.

- Federal government has begun screening travelers at the 5 airports that receive the majority of patients arriving in the US from W. Africa;
- 911-call takers will screen patients with fever and flu like symptoms for travel history and alert responding providers;
- First responders and transport providers have been given an Ebola screening checklist as a quick reminder of what to ask, what PPE to wear and what to do if a suspected case is identified;
- Hospitals have begun screening all patients who present with fever and flu like symptoms for travel history.

We are entering flu season and the symptoms are very similar. How do we know who is at risk for Ebola?

With the coming flu season system providers are far more likely to encounter a patient with seasonal flu. The symptoms of influenza are very similar to those of Ebola. Ebola is only transmitted when a patient is symptomatic and through close contact with blood or body fluids. The only uncontained disease is currently in the West African countries of Sierra Leone, Guinea, and Liberia. If patients have not travelled to these area in the last 21 days, or been in contact with a symptomatic Ebola patient they are not at risk for Ebola.

What is the appropriate PPE for managing a patient with Ebola?

Fortunately the PPE for Ebola is similar to that recommended for patients with influenza. Like influenza providers should place a surgical mask on the patient after they have donned gloves, gown, glasses or goggles and surgical mask. Invasive procedures such as IVs or IOs and aerosolizing procedures such as suctioning, nebulized medications and intubation should be kept to a minimum whenever possible. If aerosolizing procedures must be performed providers should utilize their fit tested N-95 masks and apply a surgical mask or oxygen mask to the patient as soon as possible. Special attention should be paid to proper donning and doffing procedures to avoid secondary contamination and exposure.

If Ebola is not an airborne disease, why do we have the patient wear a surgical mask?

Ebola is a blood borne pathogen transmitted through contact with infected materials. Like other infectious diseases part of limiting provider exposure is limiting the amount of infectious material in the environment. Patients should be wrapped in liquid impervious material (cot cover is recommended) and placed in a surgical mask. Since saliva can be an infectious bodily fluid, the application of a surgical mask reduces the introduction of potentially infectious material into the immediate area around the patient (3 foot treatment zone).

What should we do with contaminated waste?

Medical waste from patient care activities should be red bagged and transported with the patient. Any soiled or contaminated patient clothing can also be red bagged and transported with the patient. Whenever possible providers not attending to the patient during transport should doff their PPE and red bag it for transport with the patient.

What should we do with the residence or the location where a suspected Ebola patient was treated?

It will take some time to evaluate the patient and test for Ebola. If a patient is encountered outdoors any blood or body fluids can be washed away or sprayed with a 10% bleach solution. If the patient is in a residence heavily soiled cloth clothing or sheets can be placed in red bags and transported with the patient. The residence should be secured to avoid inadvertent entry into the residence and the health department notified. The health department will follow up on patient testing and direct the need for additional decontamination. There is NO expectation that the site be decontaminated by public safety personnel.

What if I take care of an Ebola patient am I exposed or a risk to my family?

Routine care of an Ebola patient when wearing appropriate PPE does not constitute an exposure unless there is failure or violation of the PPE. If you care for a patient with fever and flu like symptoms AND travel to Ebola endemic countries within the last 21 days you should notify your organization's infection control officer. The infection control officers will assess your level of contact and instruct you on what to do. For more information on what constitutes and exposure visit the CDC website. You are NOT a risk to your family or close contacts. Individuals are only contagious when they are having symptoms.

Two of the countries in West Africa are no longer on the endemic countries list; why is that?

Senegal and Nigeria have been removed from the CDC's list of Ebola countries because they no longer have ANY active cases of Ebola. The Ebola patients in these countries were identified and all their contacts tracked much like we do here in the United States. In these countries all the Ebola infected patients have recovered or died and all their contacts are now beyond the 21-day incubation period of the virus. This means there are no longer any active infections in these countries and travel there is no longer a risk factor. The other countries that remain on the list lack the modern health facilities and the surveillance and tracking tools available to countries like the United States. This makes the virus harder to contain and contributes to the spread and duration of the epidemic.

How did the healthcare provider from Dallas become infected?

The transmission to the healthcare worker in Dallas is currently being reviewed by the CDC. We have limited information at this time. The CDC currently recommends the use of droplet and contact precautions as appropriate PPE. It is important to remember that PPE, like any other tool, must be used properly to be effective. Providers must pay careful attention to the proper donning and doffing of PPE. It is recommended that doffing be completed using a buddy system to help assure slow and purposeful removal. If you would like to review the donning and doffing procedure there is a video on the Ebola resource page. Please keep in mind there are many correct ways to don and doff PPE and several videos showing different methods. This video is just one of those methods. It is important to pick one method, review it carefully and follow the process consistently each time PPE is used.

Where can I find more information related to Ebola and our system?

<http://www.atcomd.org/index.php/ebola-updates>

<http://www.cdc.gov/vhf/ebola/>

I'm seeing different temperatures for Ebola, which should I consider?

The CDC is continually evaluating their requirements based on their most current findings. Fever is technically defined as 100.4° F and will better capture potential patients. It is our desire to err on the conservative side as well and go with the 100.4° F temperature. We realize that may cause some over-triage.

As a first responder and EMS provider what are my exposure risks when providing care for potential patients.

The CDC has defined, in their case definition what defines a potential Ebola patient and further outlines exposure risks. Below are those definitions, categorized from High to Low Risk.

A high risk exposure includes any of the following:

Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids of EVD patient

- Direct skin contact with, or exposure to blood or body fluids of, an EVD patient without appropriate personal protective equipment (PPE)
- Processing blood or body fluids of a confirmed EVD patient without appropriate PPE or standard biosafety precautions
- Direct contact with a dead body without appropriate PPE in a country where an EVD outbreak is occurring*

Low¹ risk exposures

A low risk exposure includes any of the following

- Household contact with an EVD patient

- Other close contact with EVD patients in health care facilities or community settings. Close contact is defined as
 - being within approximately 3 feet (1 meter) of an EVD patient or within the patient's room or care area for a prolonged period of time (e.g., health care personnel, household members) while not wearing recommended personal protective equipment (i.e., standard, droplet, and contact precautions; see [Infection Prevention and Control Recommendations](#))
 - having direct brief contact (e.g., shaking hands) with an EVD patient while not wearing recommended personal protective equipment.
 - Brief interactions, such as walking by a person or moving through a hospital, do not constitute close contact

No known exposure

Having been in a country in which an EVD outbreak occurred within the past 21 days and having had no high or low risk exposures

¹For purposes of monitoring and movement restrictions of persons with Ebola virus exposure, low risk is interpreted as some risk. See www.cdc.gov/vhf/ebola/hcp/monitoring-and-movement-of-persons-with-exposure.html

Can I get Ebola from Mosquitos?

No. The only vectors in the United States for Ebola are human-to-human transmission of blood or body fluids.

10/20/2014 – 13:15 hrs

I have heard that there are statements out that Ebola can be transmitted via airborne particles.

Response to statements falsely attributed to CIDRAP regarding Ebola transmission.

On Sep 17, CIDRAP News, a service of the University of Minnesota's Center for Infectious Disease Research and Policy (CIDRAP), published a guest commentary by Lisa M Brosseau, ScD, and Rachael Jones, PhD, titled "**Health workers need optimal respiratory protection for Ebola.**" Dr. Brosseau is a Professor and Dr. Jones an Assistant Professor in the School of Public Health, Division of Environmental and Occupational Health Sciences, at the University of Illinois at Chicago.

The commentary addresses potential modes of transmission for Ebola in healthcare settings and discusses the implications for optimal respiratory protection for healthcare workers. CIDRAP concludes that the commentary is based on sound science and believes it is an important consideration in the safety of healthcare workers who provide care to Ebola patients.

- CIDRAP has not made claims that "Ebola is Airbone" or that "Ebola [is] Transmittable by Air."
- The guest commentary cited by *Breitbart* and *The Inquisitr News* was authored by two leading researchers with the University of Illinois at Chicago (not the University of Minnesota as wrongly reported).
- The Twitter account @UnivMinnNews, which tweeted the article published by *The Inquisitr News*, is not managed or authorized by the University of Minnesota.

Transmission of Ebola must be considered in both the context of healthcare settings and within the general community. This commentary in question specifically addressed transmission risk within a healthcare setting and does not address community transmission.