

Ebola Preparedness and Response
Moderator: Ingrid Caples
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12:00 pm CT

Coordinator: Welcome and thank you for standing by.

At this time all participants are in a listen-only mode until the question-and-answer session of today's conference. At that time, you may press Star 1 on your touchtone phone to ask a question.

I'd also like to inform all parties that today's conference is being recorded. If you have any objections, you may disconnect at this time.

I would now like to turn the call over to Ms. Melissa Harvey. Thank you, ma'am. You may begin.

Melissa Harvey: Thank you so much. And good afternoon and thanks for joining us for this national call with our Healthcare Coalition Leaders on Ebola preparedness and response.

The purpose of the call today is to really discuss how the Healthcare Coalition can be involved in the planning and response for their communities because as you know, our Healthcare Coalitions are the cornerstone of our entire national healthcare system preparedness.

So today, we're going to have introductory remarks and kind of a description of our strategy for Ebola screening facilities and treatment facilities from Dr. Lurie, the Assistant Secretary for Preparedness and Response.

We're also - we also have speakers from the Centers for Disease Control and Prevention. So we'll talk about these rapid Ebola Preparedness Teams, and I'm sure many of you have heard about especially if you joined us for the past two days for the call with the states and as well as the call with the hospitals yesterday.

We are well aware that there is a quite a bit of concern about personal protective equipment, and we have speakers from ASPR Critical Infrastructure Protection Division as well as from CDC's Strategic National Stockpile to speak a little bit about that.

And also concerns about inner-facility transport, and we have Gregg Margolis from ASPR who will discuss those issues as well.

So I think we have quite a packed agenda, and I will at this point turn it over to Dr. Lurie. And we're grateful for her to be able to be on this call right now.

Dr. Nicole Lurie Great. Well, hi everybody and thank you very much for joining the call. It's good to be with all of you.

And moreover, thank you to all of you for the work that you are already doing to prepare, and I think in some cases, to respond to Ebola in the US. And for those of you who were in that latter category, I think you have a lot to teach the rest of us.

The purpose of this call is really to talk further about the role of healthcare coalitions in planning for and response to Ebola virus disease in your communities.

I think all of you, or most of you probably know, that we believe that all hospitals need to be prepared to identify and to isolate a person with suspected Ebola until you can get help or able to transfer a patient who is ill to another facility.

And even within that category, I think we also all know that not all hospitals have an equal risk of ever encountering a patient with suspected Ebola disease. So some of you are in areas of the country where there are more likely to be returning travelers or there are the ASPR populations and others of you are not, and so you'll be at different risks on this.

It's also the case that people within your facilities have different likelihood of ever encountering a suspected Ebola patient if they would at all. So it's not the case, as you'll hear later from others, that everybody needs to be dressed to be in Tyvek suits and peppers all the time.

But on top of that strategy for being sure that every sort of frontline facility and provider is prepared to recognize and isolate a case, you know, we've also been moving forward with a strategy to develop treatment beds around the country for potential cases of Ebola.

We have started, as I think you know, by building on the capacity of the Biocontainment Units of (Emery) Nebraska and NIH. And then moving to facilities in the airport screening hub; New York, Chicago, Newark, Atlanta and Dulles near Washington D.C. And you know, now have I think done a

nice job identifying and having hospitals really ready to take Ebola patients in those.

We are moving now to the next tier which are hospitals that are in geographical locations where either lots of returning travelers come or they are West African Diaspora populations. And there's a lot of overlap not surprisingly between those two.

As we have been building out this strategy, one of the things that have been really clear, at least to us, is that we think that healthcare coalitions play a really central role in the strategy in the their communities, again in particular, in communities where you are near the airports or where you have Diaspora communities.

And I think I would put those activities in a variety of categories that I think are really familiar to you.

First is knowing who is in your coalition and being sure that those who are frontline providers in your coalition get themselves prepared and trained.

Secondly, I think being involved in taking a leadership role and exercising and training for the facilities in your coalition is an important role for you.

The third is to take a note or look at your structures especially for situational awareness, and ensure that there is appropriate information sharing across facilities in your coalition and with the health department.

And especially to be sure, quite honestly, that all your hospitals and ambulatory care facilities, especially those frontline emergency departments,

actually know how to contact your health department because I think that that's a really critical piece of this, as well as know how to contact you.

For those of you who are in communities where hospitals are going to treat patients have been identified, CDC has been sending out rapid emergency preparedness teams to evaluate, using a checklist, the readiness of those hospitals. I would imagine that you would all want to be involved with the facility readiness and some of those assessments.

And then finally around the issue of PPE and other equipment, I think you play a particularly important role.

We are hearing from a lot of hospitals around the country that they're having a lot of difficulty getting PPE. We are also hearing a lot of anxiety from hospitals about potentially sharing PPE, that they might have excess of with other hospitals or facilities in their communities.

So I think that you all can play a critically important role in figuring out what PPE exists in your community, sort of doing an inventory, making a plan with all the facilities to allocate that appropriately so that if any one facility ends up with a suspected case of Ebola, that we are sure that we can get them additional PPE quite quickly.

And potentially through all other kind of sharing agreements you have, whether it's (EMAC) or whether it's just agreements within your coalition, see if you can do some stuff to rationalize this.

PPE is expensive, it is much more efficient if it is purchased at the end of the day at a coalition level or a community or state level than it is by every hospital in the country.

I know that the CDC guidance provides a lot of options for what you might do with PPE. It may be that your coalitions want to standardize across the facilities, what it is they choose to stockpile, just as an example, so that it will facilitate sharing down the road.

I think there are a lot of other roles that you can play as well, but I really wanted to highlight the major ones.

I think as you know, the President has sent a request for emergency supplement funding up to the Hill, and that includes some funding for treatment facilities as well as funding for PPE purchases. And it's really very much our intent to provide support for regional purchases and coalition level purchases of PPE if that funding is awarded and approved by Congress.

So you'll hear more about PPE and other issues later on the call. But I just wanted to give you a sense from the ASPR perspective of what it is that we think are the opportunities, and quite honestly the expectations for you. I think this is an opportunity to really practice what you do in your coalition and to really strengthen areas where you might still have some gaps.

So with that, I'll turn it back over to Melissa.

Melissa Harvey: Great. Thank you so much, Dr. Lurie, for that fantastic introduction.

And before we turn it over to the additional speakers, I do want to highlight that we want to save a lot of time to have some discussion, to hear from you about what your coalitions are doing so that we can share some of those best practices that are really working well for you with other coalitions.

But also hear about some of the concerns you're having, and kind of this ongoing dialogue we've been having with you over the past few months about models of your coalitions and structures of your collations, and what is working well with the structures that you have specifically for this response.

So with that, I will now turn it over to (Joe Purse) from the Centers for Disease Control and Prevention who can tell us a little bit about these Rapid Ebola Preparedness Teams and what facilities can expect from them and from visits to their jurisdiction.

(Joe Purse): Thanks Melissa. Yes, this is (Joe Purse) from the CDC. I've been helping manage our Rapid Ebola Preparedness Team activities.

We've been working with hospitals that have identified by state or local health authorities as facilities that might be well-suited to handle Ebola care as part of their state or local concepts of operations or State Ebola Plan.

And so we've been active at this point in approximately ten jurisdictions. We had an initial focus to support the enhanced entry screening that was occurring at New York at JFK, Washington D.C. at Dulles, New Jersey, Newark Airport; Illinois at Chicago O'Hare, and then of course right here in Atlanta supporting Hartsville Jackson.

And so these teams have been made up of eight or ten individuals, a number of federal staff including typically three or four CDC and (Niache) staff. But also I'm joined in many cases by staff from ASPR, and in some cases by staff from the Veterans Administration.

There's also an emphasis on having some local partnering and local expertise. So besides being joined by state/local health officials, we've also been joined

by experts in infectious control hospital epidemiology infectious diseases; groups like APIC, SHEA and IDSA.

And so these tend to be one day visits that involve a review of the plans, but also a walk through so that we can help with an initial assessment of the facility's readiness to safely treat a patient.

And again the objective here, these facilities are selected because they've identified as having a potential role in providing, what I might call, an in-state or local/regional option to manage Ebola through the entire course of care, not just for the initial phase.

The teams offer technical assistance and guidance including pointing the way to training resources and technical support. It's not a certification process, but in general it's been seen as a helpful component of establishing readiness at the state and regional level.

The current focus is on supporting regions and/or areas that have higher volumes of return travelers in terms of, you know, what is the ultimate destination for people who are currently returning from Sierra Leone, Guinea, Liberia. So there's - as I say, we've been active in about ten states. Those ten states represent probably two-thirds of the return traveler volume.

Obviously there's a good deal more work to do, but you know, we're happy to discuss how we might continue to support this.

Melissa Harvey: Thanks so much, (Joe); that was great.

If we can now turn it over to (Steve Curran) and Lisa Dillard who can talk about PPE planning and guidance.

(Steve Curran): Thanks Melissa, I appreciate that. And I will give a brief overview of what the PPE situation looks like nationally and then go into a little bit of the challenges we've been hearing from healthcare facilities in obtaining PPE, and the approach that we're taking to be helpful as far as we can with that given the current shortages.

Just as a background, we are working very closely as HHS operating a staff division as well as other federal agency partners. We have regular calls to make sure that we're all on the same page in terms of what the national supply situation looks like with PPE.

We are in regular contact with manufacturers and distributors. We are doing that as a group effort so that we're trying to make sure that we all have the same information from all those partners.

And generally what we're hearing is I'm sure what you are experiencing yourselves which is that for many of the higher protection level products, and that would include things like coveralls, that would include things like peppers and hoods and other accessories, that there are backorders for most of those products. Those are in the range of perhaps eight to ten weeks for a lot of products, even more for some, perhaps a little less for others. But we do expect that most facilities that are ordering will experience some level of backorder with those products, so we are taking a multi-pronged approach to address this.

The first is asking facilities to - that are ordering - to look at what their needs are. You know, in fact, (Delauria) was saying earlier that every hospital needs the PP to treat a patient or do some need the PP to screen a patient? And then, how many days of PP do you need?

There's an assessment that needs to happen in terms of how much is needed. And then a collaborative approach with the coalition partners to see what other resources are available. We know there are products out there; it's not enough to give everyone the maximum amount that we might want for preparedness.

But there's probably doubt there; we think sharing can help with that. When it doesn't work - when there's not enough at a coalition level, we ask facilities to work with their state health departments to see what state resources may be available. And if all of that, there is still a shortfall, that's when a state can approach the federal government and see if there's things that we can do to assist.

When we look at those requests, we'll work very closely with the S&S program at CDC and we will do an assessment, one, of what is the need that's being expressed. Then, look at that need against what other needs are out there and what'll - we'll play to that equation - is what type of facility is this?

Is this one of the facilities that has an Ebola patient? Is this a facility that is involved in the airport screening - a treatment process? If so, those will be ones that we'll be able to respond to. There'll be other considerations, of course, they'll have to make to see that we're not just using all resources and just scattering them far and wide.

We're actually targeting the assistance that we're able to provide. So in one scenario, we can often go to the manufacturers and distributors if there's some issues to troubleshoot. And we have specific requirement that's been communicated up to the state, we can often help troubleshoot that and see if there's alternative distributors that you can go to to get the product, if the

manufacturer can work with their supply to the priority facilities though that really, we think, may have a patient or be getting a patient can have those supplies.

And that's one way we'll do at the first line just to make sure that we can just troubleshoot any issues in the normal supply chain so we don't have to go to other processes. And the second part will be consideration of federal assets. And that's the part where I think I'd like to turn it over to the S&S and, Lisa, if you'd like to give more explanation on that.

Anita Patel: This is actually Anita Patel for the S&S explanation part. So to complement some of these efforts, one of the other things we've done on the federal side is increase the quantity of PPE in the strategic national stockpile. And our goal is to be able to assist the hospital-based clinical teams in caring for Ebola patients in the event that the supplies are not immediately available at (unintelligible) locations.

We want to make sure that we have the supplies on-hand and be able to provide additional products if needed, if the patient is presented. The purposes for the products that are in the S&S are based on the current CDC PPE guidance for caring for Ebola patients. And the S&S adds that the quantities that we'd be shipping out in these PPE kits would be enough to be able to support the care of a patient for the first four to five days.

So it's really enough supplies to be provided to a facility to be a (unintelligible) before we can assist in getting additional supplies from the commercial supply chain. One of the things we do want to make folks aware of is that we're working closely with manufacturers to avoid disruption to the commercial supply chain and to make sure that they're - the purchases made for S&S are not interfering with the already-stressed supply chain situations.

No products are being held by manufacturers or distributors specifically federal orders, for S&S orders. And our orders are not being prioritized ahead of those already being placed by hospitals. I'm also going to turn it over to Lisa Dillard to talk about some of the work that we're doing alongside (Jill) and the rep team.

Lisa Dillard: So, to bring this coordination effort full-circle for the government, we are supporting the rep team visits directly at the hospital level and working with them to try to get an accurate picture of what the current inventory status is within those hospitals. We do that in close coordination with our state public health officials because we realize in some areas, they may also have caches that can support once they have gone through the hospital coordination process, meaning, your coalitions and other avenues.

So it's very important that public health and the health care system do this collaboratively. So one of the things that our group is doing is getting that accurate picture of the inventory status within those hospitals. And from the feedback I've been receiving thus far, a lot of you are doing a great job in managing that ordering effort for them.

We're looking forward to specific information not only about the line items, but also the types of manufacturers and distributors so we can help provide that information back through the federal system and, hopefully, get the product where you need it when you need it. So we just appreciate your help if we are coming to your area for the rep assessment and collecting that granular information at each hospital to help inform these processes.

Melissa Harvey: Thank you so much. And finally, we've heard a lot of concerns about EMS and inter-facility transfers. So I'd like to ask Gregg Margolis to make a few

comments about that before we turn it over to discussion from everybody on the call.

Gregg Margolis: Thank you, Melissa. So I'd just like to overview a little bit about some of the things that we're doing to provide support in regards to inter-facility transfer. Clearly, as we transition to a regionalized approach in which only some facilities will be providing definitive care for Ebola patients, but obviously receiving patients from screening facilities, one of the logical questions, of course, is how would we get the patient from a screening facility to a treatment facility?

And we recognize that this is a potentially complicated inter-facility transfer that goes beyond the resources of some inter-facility transfer organizations. So, clearly, there are certain hospitals, locations, coalitions and medical transportation companies that are able to accomplish this transfer safely. And in the event that the local resources are able to draw on those resources, they certainly can and should do so.

But I'll also point out that last week, we published in FedBizOpps a request for information about the possibility of entering into a national contract that would provide inter-facility transfer services for facilities or locations that are not able to do this sort of transfer within their own capabilities. So, like I said, this is an effort to support local inter-facility resources, not supplant them.

And if there are local resources, you certainly should use them. But we are exploring a single contract mechanism that would enable this to be accomplished for any facility or region that was unable to secure such transport resources on their own.

Melissa Harvey: Thank you very much, Gregg. And at this time, if I can ask the Operator to open the lines up for questions to - for questions as well as discussion about what you've had your coalition do that has been helping you and you've found to be successful for both the preparedness and response efforts.

And also, if you have any concerns about how to use your coalitions especially during an infectious disease event like Ebola.

Coordinator: Thank you. And at this time, if anyone would like to ask a question or make a comment or have a discussion today, please press Star 1 on your phone. Unmute your phone and record your name clearly when prompted. Again, for any questions, comments, or - discussions, please press Star 1.

It'll take a moment or so for the questions to come through. One moment - we have our first question from Linda Murray. Go ahead, your line is open.

Linda Murray: Yes, this is Linda Murray from Cabell Huntington Hospital in West Virginia. Our issue is our coalition that we're working with does not have any PPE to share with us either. We only - we're not - we don't even really have a full complete set. We're lacking in some hoods that we need for our Versaflo PAPRs and we can't get a hold of those.

And at this point, we have no one that can supply those. We've asked our state for assistance and been told they can't supply us any. So I'm wondering what would be our next move.

We are a pretty large hospital in this area. And what we're having to use is definitely makeshift; it's not recommended at all. We don't have the recommended PPE right now.

Melissa Harvey: Thank you so much. And just to clarify, that's PPE at the coalition level, correct. And do you have awareness of what PPE you have at those facilities or what PPE is on-hand at the facilities in your coalitions?

Linda Murray: Yes, I do. But unfortunately, they do not use the Versaflow PAPRs. And they do not have access to get the hoods either.

Melissa Harvey: Is (Steve Curran) available?

(Steve Curran): Yes, this - I can take a crack at this. And also, just - I'll also check with my - the CDC colleagues on the phone. The question of getting - of having difficulty obtaining PPEs is, of course, one that we're hearing from a number of facilities nationwide and understand that with your particular coalition, there may be challenges getting within the coalition as well.

So I - when we hear those requests and if they come to us, you know, through the state level, we'll take on a case-by-case basis to assess what level of support we can provide and try to help that way. One thing I can say - and this, I know is not the perfect answer or the perfect solution - that there are, you know, some alternative products that can be used, especially substitutes for the ones that are in short supply.

You know, in fact, the PAPRs are in very short supply and the - especially, you know, PAPRs as well as the hood - that's one of the problems. The accessories that go with the PAPRs are - have that same situation as the PAPRs. And so, we hear a lot of folks having issues finding the hoods.

So, yes, we look to - or recommend looking at the other forms of protection that are in the guidance, you know, including the (unintelligible) 95 respirator,

the gown - the other things that can be substituted. But I'll also, you know, check in with CDC if they have other suggestions on that.

Linda Murray: (Unintelligible) we need suggestions for a hood because we have nothing that will come down to the shoulders - not for the N95 or for the PAPR use. Then - so you're saying that you can get some suggestions.

Anita Patel: So this is Anita Patel from CDC's Chief National Staff. So I think - a couple things just to build on what (Steve) said - I think it's important for folks to note that there's two areas in the PPE guidance where the guidance stratifies the types of products that you can use. And we have gowns or coveralls. And the other stratification is N95 respirators versus PAPRs.

So we are seeing definite supply situation issues for some of those products and not necessarily for all of them. It's important to have that understanding that although your facility may want PAPRs from a preparedness standpoint, until those PAPRs that you've ordered have arrived, you may want to consider looking at what your protocols for support for N95 product use.

So it's just another thing to keep in mind as we're going through this. The other thing is if you have a patient that does present within your facility and you find yourself in a situation where additional products are needed, that would - I - that would obviously be a good time to be able to coordinate with your state to see if you do need some additional federal support.

Melissa Harvey: Great. Thank you so much. Can we go to the next question?

Coordinator: Our next question is from (Tim Stevens). Go ahead, your line is open.

(Tim Stevens): Thank you; good afternoon. I wonder, Gregg, can you put a time frame around when the National Ambulance contract might be available?

Gregg Margolis: Hi. Yes, we - the sources sought document is open until the end of today. And we will then be looking at the information that we received from that to look at drafting contract language and evaluating whether such a program is really feasible and that is desired by the community.

Melissa Harvey: Excellent. And then we'll move on to the next question or comment.

Coordinator: Our next question or comment is from (Catherine Richards). Go ahead; your line is open.

(Catherine Richards): Hi, good morning from Argon. This is more of a comment. And we had a person under monitoring transition to a person under investigation who was transferred from one county of her residence to another where she received treatment in a hospital. So we had a response organization set up in the county of her residence.

So you can imagine, that might get complicated, but we really benefitted a great deal from having a regional public information office or group in place as well as a tri-county health office or group. And we had high collaboration with state public health and we had just pretty magically done some collaborative pre-planning just two weeks before that person transitioned to being under investigation.

So, really emphasizing the pre-planning benefits and the collaborative planning benefits across jurisdictions and agencies. Thank you.

Melissa Harvey: Thank you so much. That is a great example of what it is we are trying to achieve especially with all of the coalition members working together when either there is a PUI or a confirmed case, and obviously that has to start well before either of those two things happen, so thank you. And moving on to the next comment or question.

Coordinator: Our next question or comment is from Linda Scott. Go ahead your line is open.

Linda Scott: Yeah hi, this question is for Greg on the proposed ambulance support contract. Will that be - I know you are looking at the information, but are you intending that to be the identification within specific states or are you looking similar to the ambulance contract where you may mobilize EMS agencies from other states to respond when needed?

Gregg Margolis: The source's (sought) document is gathering information about again the feasibility but I think the hope was that there might be one or a consortium of companies that would be able to provide appropriately trained and appropriately equipped inter-facility transport for units to EVD screening facilities anywhere in the country within a couple of hours' notice, so we are hoping that there is going to be a national ambulance provider or a consortium of national ambulance providers that might be able to engage in such a contract.

Linda Scott: Okay and then I would just put the plug in for making sure we communicate with the states for which those folks are mobilized so it doesn't interrupt what we are building for our own inter-facility transfers with our organizations.

Gregg Margolis: Absolutely.

Linda Scott: Thank you.

Melissa Harvey: Thank you so much, Linda. I know you've let us know some of the activities that are going on within the Michigan coalitions and I wonder if you wouldn't mind sharing some of those with the other listeners' on the call.

Linda Scott: Sure thank you. I would be happy to. You know in Michigan, we have eight regional health care coalitions that have been established since 2002 so we are very fortunate that we have a pretty solid infrastructure that we often use for day to day support of our health organizations and we count very heavily on those health care coalitions at times like this where we are really working hard to establish preparedness and response for the potential Ebola patient.

Each of our health care coalitions have a medial coordination center which is functions like a MAC and (NIMS) and those organizations in each of our coalitions have been very integral to both information sharing between information that comes out from the state to our health care organizations and their health care coalition members as well as providing really important situation awareness for us.

Our state health coordination center is operational now for four weeks, so we count on our health care coalitions to be that conduit of information gathering from our health care organizations to the state health coordination center and that is a very important role. We fielded surveys to look at the status of readiness in each of our hospitals. When we have hospitals that haven't had the opportunity to complete that survey, our health care coalitions will do follow up with them so that we do in fact get 100% data collection.

We also have established caches of equipment, supplies, including PPE in each of our health care coalitions and although some of that - the quantity of

those have decreased - would decrease funding over time, we still have transparency and knowledge of the PPE that is available within our health care coalitions and we will use that response framework so that any hospital that has a diagnosed patient who starts to get low on their PPE will of course first look within themselves, their systems, look to any corporate partners that they have. Then they would communicate with the health care coalition.

At that health care coalition level, they would see what resources they can identify which could be their regional cache but it could also be communicating with other health care organizations that are within that coalition because they have knowledge of what caches are at the hospitals as well or in their regional cache. So we count on that coalition to be that first step in mitigating any gaps that are available and then providing that information to us at the state level so that we can begin to ready and start doing our planning to see what we have at the state level or our knowledge which is available at other health care coalitions.

So our health care coalitions serve a very important role and again information sharing and situational awareness and they are working very hard with all of our hospitals. We have had over 200 exercises that have been completed in the hospitals in Michigan and we get that information through our health care coalitions and the training that is going on with our pre-hospital providers, our EMS partners, we count on our health care coalitions to help facilitate that as well. So they really are an important liaison if you will and conduit between our organizations and the state.

Melissa Harvey: Thank you so much for that Linda and again as others of you are joining on the call, we would be happy to hear some information such as that that you are doing with your states or with your coalitions as well, so we really appreciate you sharing that with everybody on the call.

And operator I think we will take the next question or comment now.

Coordinator: Our next is from (Thorn Coleman). Go ahead, your line is open.

(Thorn Coleman): Hi, this is Sacramento, California. One way that I have found to satisfy some of our PPE needs at least here at the health department and I am going to share this with our coalition members as well is to look outside of standard hospital suppliers and I am going to paint auto parts and they have all of the same material. Maybe more expensive, but for a small scale, say at a clinic, was looking just to staff - get a few staff trained or a health department to get them trained or equipped in PPE. It is a quick measure to get the right materials and I can get - and we can get our staff ready to go long before the major suppliers are going to - you know they are not going to have materials until December or January and that is too long to wait to get our staff trained up. So we are able to do that just with local purchases from those other industries.

Melissa Harvey: Thank you so much and that is a great suggestion and we have been hearing that from many others as well that you know for things like (unintelligible), many health care entities and hospitals have not typically been huge buyers of those types of products, but there certainly are other industries within your communities that are and looking outside of health care might be a part of the solution to the PPE shortages that we are seeing. So thank you for sharing that.

Do (unintelligible) or the colleagues at SMS have anything to add to that?

Melissa Harvey: No, I think it is wonderful looking outside of the health care industry for these products. It is a wonderful idea.

Melissa Harvey: Great and thank you again. And we will turn it over to the next question or comment.

Coordinator: Our next question or comment is from (Margie Moore). Go ahead your line is open.

(Margie Moore): Yes, (Margie Moore) from South Carolina. It would be great if school districts are considered more in Ebola training or planning or any mock drills. At this point in time, many school nurses do not have recent experience donning and offing PPE. And I know there are videos out there, they talked about a video yesterday, but the ideal is hands on. We are finding it very difficult to get that training. I was told yesterday that there may be an opportunity for a mobile simulating truck, van of sorts, and I did send an email to South Carolina Ebola, but that is a particular concern to school nurses.

Melissa Harvey: Thank you for that comment. I don't know if our CDC colleagues in the Medical Care Task Force have anything to add or respond to with that. I mean certainly from the health care coalition perspective here at HPP we agree that the broader the coalitions are the better and tapping into resources like school nurses is a great idea. But as far as their role in a potential Ebola response in the community, I don't know if Dr. (Kerr) or anybody else from the Medical Care Taskforce have anything else to add.

Dr. (Joe Kerr): Yeah thanks (unintelligible) this is (Joe Kerr). I guess I would you know try to reassure the person asking the question as the likelihood of encountering a patient is very low. Nonetheless, it is good to be thinking ahead and think about you know everybody's potential role here as a part of the system. So you know one of the things that we ask of outpatient providers and I think the school nurses would sort of qualify under that category is to be ready to identify a person who has you know bonafide exposure history. In other

words, somebody who has traveled within the last 21 days to one of the three affected African countries. And it is possible that a student would qualify in that group.

The next part then is you know if this child you know has that kind of identified exposure and again it is mainly going to be travel history at the present time. Then if they have symptoms including fever or you know other symptoms that are consistent with Ebola to isolate that patient and inform public health. So you know if a child like that presented, presumably they would be very early in the course of illness and also keep in mind that active monitoring of return travelers, which instituted approximately 10 or 12 days ago.

So we will soon be at the point where everybody who is in their incubation period who has returned on a flight from one of the three countries in question will already be receiving guidance and counseling in terms of self-monitoring. So I think that the odds of you know a patient taking by surprise in the school setting or really outpatient setting will become quite low.

Melissa Harvey: Thank you. Excellent. That was a great point to make. Thank you Dr. (Kerr). And moving on to the next question.

Coordinator: Our next question or comment is from (Dan Manly). Go ahead. Your line is open.

(Dan Manly): Good afternoon, my name is (Dan Manly). I am with Kansas City, Missouri. I was calling about the repurposing of personal protective garments. Is there going to be any statement or position to allow that from a regulatory perspective when we are evaluating the level of protection.

Melissa Harvey: Thanks and I will ask our SMS colleagues to respond to that question.

Melissa Harvey: Just to clarify, you are looking at reusing products that are on the PPE list.

(Dan Manly): There was actually - the previous caller from Sacramento had talked about using some garments that were manufactured for other industries that may have similar characteristics to the PPE that we would be using. However, because it is manufactured for that purpose, my question is from a regulatory perspective, is that - is there going to be some type of statement or waiver that would allow the use of that garment or something that would say that that would meet that criteria.

Melissa Harvey: So a lot of the products that are on the CDC PPE list aren't necessarily approved by any regulatory body. There are some that have FDA clearances and (NAIS) approvals but the products that were referenced, I believe that they do still meet the same types of standards. So if we are looking at some of the standards that govern and describe these products, ASTM is one of them for example or (AME) standards, if these products in these other industries meets those standards, they would still be appropriate for hospital use.

(Dan Manly): Thank you.

Melissa Harvey: And just to add to that, one of the things that the CDC is looking at doing is getting some more detail about the products listed in the PPE guidance and what standards - which standards would be associated with each of those line items to help (unintelligible) products actually appropriate.

(Dan Manly): Thank you.

Melissa Harvey: Great, thanks for that, and the next question please.

Coordinator: The next question or comment is from (Fred Peterson). Go ahead. Your line is open.

(Fred Peterson): Good afternoon from Pittsburgh. My questions and comments are about training. I think the second level anxiety here at least after not having the program (unintelligible) for PPE is the issue of training people. And while there are a couple of pretty good videos widely available now, I am hearing from a lot of hospitals that they are not sure what the training should consist of. And so, my first request I guess would be that you consider developing some sort of a standard national curriculum for that. Pull together people who are (NAIS) and (OSSA) and (APIC) and CDC and all of the folks that you have at your disposal and develop some sort of a guideline if not a standard curriculum fairly quickly that could be widely distributed.

One of my concerns quite frankly is we are beginning to see opportunistic consultants come into the field offering all kinds of training, and we have no idea as to the adequacy of that training or whether or not it's standardized. That's in the hospital environment.

In parallel fashion in the pre-hospital environment, to have some sort of a curriculum like that so that we could have, I don't know what to call them, infectious disease transport response teams, and not burden a single ambulance service with this responsibility but perhaps being able to create from among ten regional ambulances, 20 people who are ready to do this kind of thing that could be pulled together at a fairly short notice and not put all the burden on one particular provider. Thank you.

Melissa Harvey: Thanks so much for that. So just to clarify the first part of your question, which is about the standard curriculum, are you looking for a standardized

way of donning and adopting the PPE or a curriculum in terms of how many times an individual needs to demonstrate competency before they can be, you know, deemed able to don and adopt properly? The reason I ask is I know that we've been talking a lot about the videos and I would see maybe if our CDC colleagues want to talk a little more about where they can find those videos, because I believe that was at least standardizing a way of putting on and putting off PPE was the aim of those videos.

(Fred Peterson): And I think it'd be a little bit of both, you know. It's the didactic portion about dealing with an Ebola or a highly infectious patient, if you broaden it out, and then secondly, the psychomotor part of donning and adopting.

Melissa Harvey: Okay. Thank you. Dr. (Purse), you want to respond in any way?

Dr. (Purse): Sure, Melissa, I guess, you know, first of all just to acknowledge that those are very good suggestions and I think that is very much the direction that we're going. You know, an important part of the preparedness here in terms of PPE is understanding, you know, what level to use in what situation and, again, to more clearly define roles and expectations. And so we are moving in that direction in terms of some of the training materials.

(Fred Peterson): Thank you very much.

Melissa Harvey: And, I don't know, Gregg Margolis, did you have any comments about the pre-hospital issues identified by (Fred Peterson)?

Gregg Margolis: Yes, (Fred Peterson), that was a great comment and I do agree that, you know, like the notion that not every hospital might be doing a long-term or definitive management of Ebola patients, it may very well be that not every EMS agency would be expected to do the inter-facility transfer of Ebola patients.

Again, a good analogy is that just like every hospital needs to be a screening facility, every 911 EMS agency certainly needs to know how to respond and identify and appropriately protect and take care of an Ebola patient who might enter the 911 system. But we also recognize that the inter-facility transfer of these patients might be a level of complexity that is beyond many inter-facility transfer organizations.

So your notion of identifying a small number of regional resources that might be able to do this is a good one, and it is in fact sort of the foundation of the idea that we might be able to identify a national provider that could offer these services if it were not available locally. But as is the case with everything else, the closer to the action that these situations can be solved the better, and if there are regional resources to do the inter-facility transfer safely, then you should absolutely develop them and use them if that's available.

Melissa Harvey: Great. Thank you so much. And I think we have time for a few more questions and comments if we can turn it back over to the operator.

Coordinator: Yes, our next question or comment is from (Robert Neal). Go ahead, your line is open.

(Robert Neal): I just wanted to comment on actually the last question or comment relative to the availability of a standardized donning and adopting process. And I felt like the follow up touched on it just a bit, but CDC, working with John Hopkins, (APIC) and others, have published I believe it was on the 29th of October step-by-step guidelines with videos for each step in the process. So I believe that that is available and has been for at least since the 29th. And really I guess my follow up to that would be to see how we are going to approach this

and if we are truly adopting this as a standardized approach for donning and adopting.

(Joe Kurt): This is (Joe Kurt), I'll jump in. And, yes, thanks for highlighting that that is already available in the format. And, you know, the whole movement here has been to standardize to reduce risk in terms of self contamination, so again, these are very good points and I hope that coalitions can take advantage of the resources that are available and that are becoming available.

(Robert Neal): Thank you.

Melissa Harvey: Okay. Next question, please.

Coordinator: Our next question or comment is from (Robert Feldman). Go ahead, your line is open.

(Robert Feldman): Hello from Chicago. I just wanted to make a couple of comments. One about the personal protective equipment. We found in our training that using the tie-back coveralls because they open on the front, it is difficult to get those off if the front is soiled without contaminating yourself. Also the PAPRs for a lot of them, they're built mounted, it's difficult to get them off while maintaining respiratory protection.

So I would just say that although the PAPRs are being asked for by some of the nursing unions and there's a lot of interest in those in the tie-back jump suits that really you should try it out before you commit to a big expense on that, because we have found that it's a little challenging to get those off.

The other comment I wanted to make was that now that the election's over it would be nice for the federal government, I don't know if it would be CDC, to

put out some more guidance to the states about the provider quarantine. We found certainly in our facility that the worry about being quarantined for three weeks possibly in our state is causing a lot of anxiety among staff, and having a clear message for that would certainly help us with our staff willingness to be able to respond and if necessary provide mutual aid to other facilities.
Thank you.

Melissa Harvey: Great. Thank you very much. Are they any - do any of the speakers want to comment on anything?

Man: No, just that those were very good points. Thank you.

Melissa Harvey: Exactly. Thank you. Okay, and then moving on to the next one.

Coordinator: Our next question or comment is from (William Fails). Go ahead, your line is open.

(William Fails): Yes, good afternoon from Michigan's Fifth District Medical Response Coalition. I have a - just a quick comment and a question as it relates to the EMS and inter-facility transport aspects. We have in our region been able to put together kind of a model protocol for our nine counties and it's been disseminated. Part of that protocol calls for a single agency that's been willing to stand up and be the primary transport unit, particularly if we have an anticipated transport. Currently we don't - we're not aware of any patients under observation in our region.

If we have a patient or person come in under observation, then that agency would work with our local EMS provider to make kind of just-in-time training and equipment for a unit to be able to be more readily available. So that seems like a - we think a reasonable strategy so we don't have every EMS agency

dedicating resources to be prepared for something that they will not likely have to do.

My question goes back to the PPE standards. Throughout Michigan and our region we've procured over the years PAPRs primarily for chemical decontamination that use the butyl rubber hood. The current CDC guidance calls for use of a disposable hood, and that seems to be one of our big weaknesses in terms of PPE, getting access to those disposal hoods that could be used in conjunction with that PAPR. The question is, has anyone looked at the possibility of being able to do kind of a standard decontamination with bleach or virucidal agent for the butyl rubber hood so that we could be able to use that and incorporate that into our PPE ensemble? Thank you.

Woman: Sure. CDC, I don't know if you have any comments either from the Medical Care Taskforce or from FMS on that.

Melissa Harvey: We can take that in the suggestion box in my office and see if there's been additional work done on that.

Gregg Margolis: And this is Gregg Margolis. Again, I appreciate the comment about EMS and for anybody that may not be aware I'd just also point you to the interim guidance for emergency medical services and 911 PSAPs that exist currently on the CDC Ebola Web site. That document is also currently under review and we hope to have some updated information soon, but I hope everybody is familiar with that resource.

Melissa Harvey: Great. It looks like we have time for just one more question so we'll take the final question right now.

Coordinator: We're actually showing no additional questions at this time.

Melissa Harvey: That's perfect timing then. We'll I'd like to thank everybody for joining the call. I think there were certainly some productive discussions. And I'd especially like to thank our speakers for lending some of their time to provide the most current information that we have. As always, you can contact HPP at hpp@hhs.gov if you have follow up questions, and we would love to hear from you.

So thank you all very much, and you can continue to expect communication from us as this continues to evolve over the next days, weeks and months. Thank you again for all of your efforts to better prepare and to respond to Ebola and all different types of hazards within our community and making our healthcare system more resilient every day. Thanks again, and have a great weekend. Take care. Bye.

Coordinator: Thank you. That does conclude today's conference. Thank you for participating. You may disconnect at this time.

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