

Ambulatory Health Providers Transcript

**Moderator: Ingrid Caples
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1:30 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.

And I would now like to turn the call over to Lieutenant Commander Collins. Thank you Ma'am, you may begin.

Lieutenant Commander Collins: Thank you very much. Thank you everyone for joining the Ambulatory Providers' Call.

I'm Lieutenant Commander Collins providing staff support to the acting ASH, the Assistant Secretary for Health here at HHS, Dr. Karen DeSalvo. Ma'am, the call is all yours.

Karen DeSalvo: Thank you Lieutenant Commander.

Good afternoon everybody, this is Karen DeSalvo and I just wanted to thank you all for taking time out of your busy schedules to give us a chance to brief you on angels for guidelines and have opportunity to hear some feedback and thoughts from you all on the ground about them and anything else that might be top of your mind.

I'm just going to make a few general comments about where the Administration is and has been with respect to Ebola Virus Disease, and then turn the agenda over to some of my colleagues from the CDC, and we have some others on the call from ASPR who will be able to answer questions should they be available.

Before I forget, I did want to just acknowledge Dr. Srinivasan from the CDC who is going to be walking everybody through the ambulatory care evaluation and patients' guidelines, and our colleague (Dr. Paulus) who helped to craft those as well.

And we have joining us also Dr. Gregg Margolis from ASPR, the Assistant Secretary for Planning & Response. He's the Director of the Division of Health and Policy.

So let me just back up and make a few general comments about where the Administration is with Ebola.

I think you all know that this has been a top priority for the President and the Administration from both a public health and a national security standpoint, and we have been working to take a whole government approach to responding from here and abroad.

We had recently in September the first reported confirmed case of Ebola Virus Disease diagnosed in the United States from a patient who had traveled from Liberia to Dallas Texas, and he died in early October. Two of the nurses who provided care for him later tested positive for Ebola and have now been declared Ebola-free as have dozens of community contacts and his family members who provided care for him in his apartment, and others in healthcare field who had provided care for him while he was in the hospital.

And currently, we have a case in New York City that you likely are all familiar with Dr. Spencer. He may be soon discharged; doing well as someone who had been overseas serving in West Africa and contracted Ebola Virus Disease.

These are all examples of the Public Health and Healthcare System working and working well in most cases to screen and treat Ebola, and the Public Health System working to identify and undertake contact tracing from monitoring and remit oversight for their various communities across the country.

This is all built into a larger framework that I want to make sure is in all of your awareness, that some of the steps that we've been taking. So first of all, I just want to make sure you are all aware that we have been working to funnel all travelers from impacted countries in West Africa, Ebola impacted countries, through five airports in the US.

These travelers go through JFK or (unintelligible), Dulles, Atlanta or Chicago O'Hare. And so the screening that happens there - and there is also an alert of the manifest of those travelers to the local health departments, generally the state health department, to then undertake an additional assessment when the person comes to the end of their itinerary and are in the home community. And those

public health officials undertake the risk assessment and then follow individuals generally for 21 days.

There have been six states for when 70% of incoming travelers arrive, those states being New York, Pennsylvania, Maryland, Virginia, New Jersey and Georgia, who we've been intensively focused on supporting those states to see that they're prepared and ready for the monitoring and movement guidelines and implementation for particularly active monitoring and direct-monitoring where appropriate. That we've been rolling out with other states additional support to see if they are ready and able to handle travelers and others as well.

The guidelines that I believe you're all aware of were put out by CDC at the end of October, and really essentially set out to stratify people into four categories ranging from high-risk, some, low or no risk. And in many cases, because people have been in Ebola-impacted countries and/or providing care to people in ETU, treatment units in Ebola-impacted countries, on return home, they're generally in some low, some or high-risk category.

And the guidelines set a floor and the health departments in your states and localities are working from that to build their expected monitoring and movement guidelines that give them some sense of whether they're going to direct monitoring in person once or more times a day and what their expectations are if there's individuals for return to work or clinical duty use of public conveyance for travel.

So this work to support the healthcare system and public health in the US and abroad also includes work that we've been doing in the US to see that hospitals are appropriately prepared, not only in training and support should they need to undertake treatment, but also the right supplies and equipment.

And just a point to this group, a lot of this work, as you know, has been very hospital focused to see that we can stand up and support treatment if necessary in the US.

There has been education outreach to frontline healthcare workers around the general theme of reminding people to think about Ebola and the appropriate patient and symptom contacts and to carefully, that is protecting themselves, safety being top priority. And have had, really, we think almost 750,000 people that have been part of HHS sponsored information and training events.

We've also been doing targeted frontline work in places like New York where we've been able to reach thousands of people and videotape, and then spread word with partner organizations like the American Nursing Association about PPE usage and other important guidelines.

And then as a last thing just so that everyone knows is that we do have through the CDC essentially a SWAT Team that can go out and help hospitals that have a confirmed patient with Ebola so that they have a subject matter expert on site that can be a part of their infection control teams and care teams to help them with their appropriate practices and clinical care and other diagnostic and laboratory issues that may arise.

Just a word about abroad and then I'm going to turn it over to talk more about the current guidance.

I do want to remind everyone that we have had an ongoing set of heroes that have volunteered to work in the West African impacted countries to treat Ebola overseas and try to prevent spread there and back to the United States. This includes for the Department of Health and Human Services, more than

300 medical and healthcare and fast response experts that have been in West Africa whether from the HHS or the Department of Defense.

DOD, as you all know, is starting to deploy us and we'll send almost 4000 troops to West Africa to provide a variety of support to the US teams that of course to the countries there.

We've been working to set up a set of Ebola treatment units in Liberia, and the US Public Health Service Commission Corps has just completed the establishment of a 25-bed Ebola Treatment Unit to serve healthcare workers who may become ill overseas, and they official opened and were available to start taking healthcare workers last Friday. And will be there, we expect, for about six months or as long as is necessary to see that we're providing (unintelligible) support in the country.

We believe that all across the whole government, we're making about a billion dollar investment in the Ebola response effort, and are working with partners internationally to raise what we believe is going to be needed as about \$800 million to support the personnel and resources on the ground, and then longer-term to help build or rebuild, as the case may be, public health and healthcare systems in those countries.

This is a marathon and not a spring; we have a lot of work to do in this country and abroad to see that we're sending the ties but also shoring up and building right relationships and infrastructure so that everybody feels prepared and ready for screening treatment and beyond.

And that is part of this ongoing work by the CDC and others to see that the right guidance is available to guide you all and your work every day, and we want to really work even harder to have good feedback so we're hearing what

opportunities there are for us to provide targeted guidance or more detailed guidance or additional guidance that would help make your work easier every day.

And so with that, I'd like to turn it over to Dr. Srinivasan who is the Associate Director for Healthcare Associated Infection Prevention programs in the Division of Healthcare Quality Promotion at the CDC. And ask him if he would walk us through the ambulatory care evaluation of patients' guidelines.

And we may have other comments from some of the other folks from HHS that also report an opportunity to hear from you all about your ideas and thoughts on this guideline and other areas. Thank you.

Arjun Srinivasan: Thank you so much Dr. DeSalvo.

I'll say a few words about the guidance, and then as Dr. DeSalvo said, we would certainly welcome a discussion/dialogue/comments and questions on the Ambulatory Care Guidance.

I think where the focus of our Ambulatory Care Guidance really is is on working to ensure that patients who might have Ebola and need evaluation for potential Ebola virus disease infection do not present unexpectedly to ambulatory clinics.

We know that the overwhelming majority of ambulatory clinics are not prepared to perform this type of evaluation. They don't have the right types of personal protective equipment or the training on using that type of protective equipment, nor do they have many of the type of lab tests and ability to access the type of testing that would be required to perform this evaluation.

So we really think that the right place to evaluate patients for possible Ebola Virus Disease is not in the ambulatory care clinics. And we've certainly had lots of discussions with ambulatory practitioners who have led us to that line of thinking.

They've also pointed out of course that having a patient in this clinic would be very disruptive to the ability to provide care to the many, many other patients who need to receive care in the ambulatory setting.

So we think that a lot of the focus for our ambulatory clinics really should be working on ensuring that you have the right types of screening protocols in place that will help make sure that a patient who might have Ebola Virus Disease and who needs to be evaluated doesn't present to the ambulatory clinic.

And that can be done in a number of ways. As Dr. DeSalvo said, the increased focus on monitoring of all patients who have potential exposures to Ebola be they people who have returned from the endemic area or healthcare workers who have been caring for patients in this country, all of those people are now under some type of active monitoring by public health officials.

Some of this monitoring is direct monitoring where a public health official is observing them and watching them take their temperature every day. Others are under what we call active monitoring where there is a daily phone call to a public health official.

But all of the patients who have exposure risks for Ebola are now being monitored, which means that the public health authorities will know, at the very first moment, of someone developing a subjective fever or a low-grade temperature, or the very first signs and symptoms that might be Ebola, will

know immediately. And there are plans in place to refer those patients to an appropriate center where they can be evaluated.

So we really think that the movement and monitoring guidance goes a very long way towards making sure that we don't have patients who are unexpectedly presenting to ambulatory care clinics. So that's one component that's in place.

The other component that I think ambulatory clinics should have established, and I know many of them already do. I know my own personal doctor's office has already implemented this. But it's aggressive telephone triage; making sure that you know in your practice which patients might have risks for Ebola and making sure that they don't have symptoms of Ebola if they have appointments.

So this can be done when appointments are being made, that's a great time to do it. It can also be done when appointments are being confirmed. I know many doctor's offices do confirm appointments, either a 24 to 48 hours before a patient arrives. So that's, you know, yet another great time for this type of telephone triage to be conducted.

So that's another component we think that can help ensure that patients don't unexpectedly present in ambulatory settings.

And then a third area where we've seen this being done is ambulatory clinics is clinics that have notices on the doors or signage outside the clinics that alert people to say, "If you have traveled to one of these areas or been exposed to a patient with Ebola and you have any of these symptoms, don't enter the clinic." Perhaps, you know, there's a phone maybe that could be used for a

telephone triage. Or if you do come into the clinic let the staff know immediately on your arrival.

If we do end up in a situation where this we think unlikely scenario comes to pass and a patient with exposure to Ebola who's been in the endemic area or has been caring for a patient arrives at a clinic and has signs or symptoms of Ebola then the strategy that we are encouraging folks to employ is what we call the identify, isolate and inform so identifying that patient at the very first point of intake.

So at the very first point where they interact with your clinic it's doing the screening, making sure do you have exposure risk and symptoms?

And if you do we recommend isolating that patient immediately, putting them in a private room and closing the door.

And so this isolates the patient very quickly, gets them into a setting where they risk of transmission would be reduced because they're in a private room.

We then recommend that your next immediate step is to inform public health, to let them know you have a patient who has a - an exposure risk and has symptoms and they are in your clinic. And the public health authorities will then be able to help you get that patient safely transferred to a care setting where the evaluation can be done.

Now the public health authorities now will know who that patient is right? These - they should be doing active monitoring so they'll already know who that person is and they'll already know what the plan would be where they would want to refer that patient.

So they should be able to be done in very prompt order.

We don't recommend that you try to evaluate and provide care for that patient particularly because the right types of protective equipment probably won't be available in your care setting.

If the person is - does appear to be or seems acutely ill we actually recommend that you call EMS, call 911 so that they can come to the clinic rapidly to get the patient and transfer them to a setting where care can be provided.

Of course you'll want to alert EMS that you do have a patient who has exposures and symptoms of Ebola. But most EMS calls - I think almost all EMS call centers have also incorporated that - this into their protocol. So they will probably be asking you if these risk factors are present.

We do have some recommendations for protective equipment in the ambulatory setting built on the potential equipment that we thought folks might have available.

Again we don't recommend that you try to provide care for these patients or evaluate these patients.

What we do recommend is that in the event that someone does have to enter the room that the protective equipment that should be worn would be protection to cover the face, so a face shield and a surgical mask.

Goggles and a surgical mask could be worn or some sort of eye protection depending on what you have, a gown to protect your clothing and two pairs of gloves.

And that would be the protective equipment that we recommend if someone absolutely has to enter the room. But again, I think the focus really is to try and avoid putting our providers in the ambulatory setting into a situation where they have to try and interact with a patient who might have Ebola where we don't think they would be well equipped in order to do that.

So those are really the high points of the guidance. And I'll turn it back over to Dr. DeSalvo or others to see if there are additional comments that other folks want to make about this issue of management and evaluation in ambulatory settings.

Karen DeSalvo: Thank you. That was a nice overview - really appreciate that.

Dr. (Pollock) or Dr. (MaCalis) do you have any comments that you want to make before we open the floor to people for questions?

Dr. (Paulus): That was an excellent summary. This is Dr. (Pollock). And I did want to remind people that the one page algorithm for the identify, isolate and inform approach is available on the CDC Web site.

Karen DeSalvo: Thank you.

Gregg Margolis: And this is Gregg Margolis from ASPR. I just want to thank everybody for joining today. And in the interest of time I'd like to make sure that we leave plenty of opportunity for to address your questions.

So I'll just turn it back over to the operator and allow everybody to chime in as they - as we can help meet their needs.

Coordinator: Thank you. And at this time if anyone would like to ask a question please press Star 1 on your phone, un-mute your phone and record your name clearly when prompted.

Again for any questions please press Star 1. It'll take a moment or so for questions to come through.

Our first question is from (Barbara Cohune). Go ahead, your line is open.

(Barbara Cohune): Yes, I had noticed that you had been targeting hospitals - oh, not hospitals but airports on the East Coast. And I was wondering if you've also been looking as far as San Francisco and LA traffic coming in from overseas?

Karen DeSalvo: Thank you (Barbara). That's a great question. This is Karen DeSalvo. I'll start and then Gregg might want to step in.

What - the decision about the airports was predicated on the notion that the vast majority of travelers from West Africa from the Ebola impacted countries were already coming through those five airports.

So it was most straight forward to funnel everybody through those airports because we were already standing up screening opportunities and just a way to make sure that we covered the waterfront using those (unintelligible).

Gregg Margolis: I...

((Crosstalk))

(Barbara Cohune): I just recently traveled to Australia and back and I will tell you there's quite a few folks as far as coming in and out of LA that you probably should be screening.

Karen DeSalvo: Thank you for that feedback. It's something that the Department of Homeland Security and FAA and others are continuously working on trying to refine. So I'll make sure I flag that again for them to look at the other manifests.

They - what we have been finding in some cases is that the manifests have been overly sensitive. So finding people who perhaps haven't been to West Africa but on the other hand we certainly want to be as vigilant as possible to make sure we're doing everything we can to screen. So we'll - I'll flag that and push that back over to them. Thank you.

Coordinator: Our next question is from (Jane Stark). Go ahead. Your line is open.

(Jane Stark): Hi. I have a question. Just a week ago I think the recommendations were that if people do present to the clinic we're not supposed to turn them away out to their cars or ambulatory to take themselves to a facility and yet we're supposed to bring them into our facility.

But it's good to hear you say that the Personal Protective Equipment in facilities at clinics are not adequate to protect our employees and to provide the services for these patients.

So my first question is are - is it indeed the recommendation that these people be kept out of the clinic to the best of our ability and that that's appropriate policy?

And the other question is there appears to be a lack of response from the public health department standpoint to have public health announcements on television and radio outlining what people should do in these situations and trying to inform the general public of where they should be presenting if they have problems.

Is there a plan to have more public health announcements out there?

Arjun Srinivasan: This is Arjun. I think that's a - it's a good question. You know, I think this is an area where some degree of a clinical judgment is relevant.

You know, having a person if they show up at the clinic and they, you know, appear to be in a situation where you - they could safely wait in their car while you're calling the health department to figure out what needs to be done that to me seems like a reasonable thing to do in some situations.

So I think there's a need for some degree of, you know, judgment about what's the safest for everyone for the patient, for the staff and the clinic and for the other patients in the clinic. And I think that's a situation where your best judgment has to be used.

With respect to notifying people about where they need to go, they've actually been done in a much more direct way than, you know, kind of public service announcements.

So every traveler who comes to the US from one of these areas where Ebola is endemic and every healthcare worker who is exposed to an Ebola patient be they in Africa or in this country is directly given contact information for their local - for their public health department.

They're given a list of all the health departments and told, you know, when you reach your final destination you need to call the health department and connect with them so that this active monitoring can begin.

So there's direct communication one on one with every single person who's returning from these areas and every healthcare worker who's working with these patients in this country.

So these folks know what they're supposed to do. There's training that's being given. If you want to see what they're being given the - there's a packet that's up on the CDC Web site. You can see all the stuff that they're being given. They're being given a thermometer, directions for what to do, list of phone numbers to call.

So there is very active education of these folks so that they know what they need to do.

So again, I think that helps ensure that they're not going to just kind of come to their - to a doctor's office where they're really being instructed, you know, call this number. Someone will answer and tell you where you need to go and what you need to do.

Karen DeSalvo: Can I just add a couple of nuances to that. Thank you for sharing.

And one is that the traveler's, the information is given to the local and state health departments in addition so that on arrival back to their, you know, their home to their community the state or local health department has information about the person and their phone numbers and how to reach them and contact them.

And we're constantly working on better ways to make sure that that data and information is accurate and available for the health department.

And just a small word about language access is that the CDC has worked on availability of these educational tools in languages beyond English particularly in French which is something we want to make certain doesn't limit access because there's some more language barrier.

Coordinator: Our next question's from Dr. Warner Hudson. Go ahead. Your line is open.

Dr. Warner Hudson: Hi. I'm an Occupational Medicine Physician at UCLA. And one of the things we're hoping to get help on from a state, local or CDC is a Web based platform by which the Ebola team members that would be taking care of a patient in an ICU should one arrive here can be monitored during their tour of duty as well as for the 21 days after.

I know that various people are working on one. I think (Amir) used Google Docs. There's a red cap project that Vanderbilt and Boston Children's are working on.

But there hasn't really been yet a standard set that we would all be using since we have to interface both at the hospital, the clinic and the health department.

So just asking and also urging for help in this platform development.

Arjun Srinivasan: Thank you. That's a good suggestion as you mentioned. There are folks who are working on those currently. And I'll convey the desire to, you know, have that work move as quickly as possible.

Dr. Warner Hudson: Thank you.

Coordinator: Our next question's from Dr. (Mary McIntyre).

Dr. (Mary McIntyre): Yes, thank you. This is a follow-up to the question about or probably additional questions about the identify, isolate and inform protocol, the information that was sent out for evaluation.

And the main thing is trying to make sure that even though we're providing information to try to get them to the correct to the correct places that sometimes they may present at other locations and making sure those urgent care centers, other clinics and others are at least prepared enough to make sure that they have the information that's in the identify, isolate and inform.

I notice that his recommendations for some minimal PPE. And so how strongly how are you all pushing the need for to have at least some level of PPE and to maintain that three feet distance for primary care provider's offices and other settings?

Karen DeSalvo: Well I'll start and then I'll ask the CDC to step in.

Clearly safety is top priority here. And it's, you know, got to be balanced as was described with clinical judgment and the needs of the patient.

So the fewer members of the care team who are in contact with or involved with the patient then the less minimal PPE that needs to be available.

And I think that the recommendations from the CDC are that there's some level of protective gear for face and for gown and for gloves. But given the limited amount of expected exposure, I think the kinds of PPE that would be available in ICU may not be acquired across the healthcare setting.

And we are also working with communities to try to understand, particularly in state and local health departments, how do you strategically have PPE available, for example, for hotline providers like EMS and public safety and these are the kinds of bits of information that will be helpful for you all to feed back to us, is what do you think would make sense in your environments and what are the ways that we could help strategically see that the right resources were available (for our lives), for use, the CDC (unintelligible) or Dr. Margolis, I'm still (waiting).

Arjun Srinivasan: This is Arjun. All I'll add is that I think the second point that you - the caller raised is key, it's that idea of distance. If you have to interact, you know, doing so from a distance, talking from a distance is a very good idea.

Man: And I'll just add that, you know, this isn't only about Ebola but I would encourage everybody to remember all infectious diseases and to just - this is a really good time to think through how you manage patients that are potentially infectious from any particular pathogen and the develop policies and procedures within your practice to protect not only your staff but other patients.

So, you know, a small amount of personal protective equipment, although not commonly used in outpatient or an ambulatory care setting, is probably a proven thing to have on hand for this and lots of other eventualities.

Dr. (Paulus): This is Dr. (Paulus) and I would echo that. The PPE falls within the contact and droplet precautions with the caveat that you're avoiding direct contact as much as possible.

The other thing (all of us) can do is just to think ahead. Where would this base be that we can isolate a patient in the unlikely event that they come in? And also designating a staff person to keep up with any changes in the recommendations, perhaps the countries that are (unintelligible) or the symptoms.

Woman: Yes.

Coordinator: Our next question is from (Janet Higgins). Go ahead. Your line is open.

(Janet Higgins): Hi there. I was just wondering, what about the care for when the patient walks in the clinic until we isolate them? Do we have to be worrying about the door handles, the floor or the counter? You know, my staff is very concerned, like, what do we do with that, those areas?

Arjun Srinivasan: This is Arjun. You know, routine cleaning and disinfection would cover just those types of casual contacts, so floors, handles, countertops. If there is a situation where you have body fluids, so the patient has diarrhea or throws up or is bleeding, we do recommend, in those situations, that you call the health department to get some guidance on how to properly clean that up.

(Janet Higgins): Okay, thank you.

Woman: I just wanted to take the chance, too, to underscore that there are outpatient and clinical environments where they're making it a point to do some of this screening in advance that came up earlier on the call.

I know that can be a challenge when people call in for appointments or when you're calling to remind people of the appointments to add additional

questions. Trust me, I do know. I've run clinics before and I know that just adds time.

But on the other hand, if you live in a community that serves (unintelligible) folks who come from these Ebola impacted countries, and you think that there may be some chance that they might present with symptoms and just create the kind of concerns in the clinical environment that you're describing, the more you can do to try to upfront add this into the screening and scheduling process, I think the better off they'll be and you all will be, too.

(Janet Higgins): Fortunately it's an urgent care and we do have (protection) equipment for everybody but you never know who walks in the door.

Woman: Yes.

(Janet Higgins): People get very nervous.

Woman: That's right.

(Janet Higgins): So thank you.

Woman: Mm-hmm, thank you.

Coordinator: Our next question is from (Debra Endeem). Go ahead. Your line is open.

(Debra Endeem): Hi, I have two quick questions. One is you mentioned an aggressive telephone triage when appointments are made or reminder calls are made. What specifically should they be asking?

Arjun Srinivasan: This is Arjun. The keys are, of course, the exposure history, so travel to the endemic area or exposure to a person who might've had Ebola, if you're a healthcare worker working in this country, and then the symptoms. And those screening questions are up on the CDC Web site where you can take a look, and they're also in the ambulatory guidance document.

(Debra Endeem): Thank you. And then in the event that someone would come in suspected with Ebola, and they're isolated, it's - I've heard it's been recommended to kind of lock down the building so public health could know who potentially had exposure to that patient when they were in the building. Is that necessary?

Arjun Srinivasan: I think, you know, you need to consult with the health department to find out exactly what they would want you to do in that situation to make sure that potential exposures can be rapidly identified.

(Debra Endeem): Thank you.

Coordinator: Our next question is from (Emanuel Okra). Go ahead. Your line is open.

(Emanuel Okra): Yes, my question is about the distance. Three feet and six feet of (unintelligible) around. We don't know which one we should go by.

Arjun Srinivasan: Yes, this is Arjun. You know, the literature on how far patients can expel droplets when they cough or when they sneeze or when something happens is in that range of some studies have shown three, some have shown as far as six.

I think in this situation where what you're trying to do is talk to the person, you can very reasonably use six feet because you're just trying to talk to the person to direct them where they need to go. And so it's very easy, I think, to

say, you know, six or more feet would provide you, so no matter how far, you're still well protected.

(Emanuel Okra): Thank you.

Coordinator: Our next question is from Dr. (Say Chadrey). Go ahead. Your line is open.

Dr. (Say Chadrey): Thank you for taking my call. My question is in our health clinic, we are currently screening all patients that come in and also visitors. Are there any specific guidelines or recommendations pertaining to accompanying family members or visitors that come into the (clinic) that they don't have appointments, but they just show up with patients?

Woman: Do you mean a person who is - has been in contact with someone who has been in an Ebola impacted country in the last 21 days or who's been in contact with a person with Ebola, one of - something like that? Do you mean in asymptomatic situations?

Dr. (Say Chadrey): Yes, they're not our patients. They just are accompanying family members or friends with patients. Are there any specific guidelines like in ter- currently what we do is scre- you know, give them a questionnaire to fill out as well. But are there any specific guidelines for - I guess visitors to the facility who are not patients?

Woman: Right. The CDC may have some specific guidelines. What I would just say generally is that you would want to know if they've had any travel or direct exposure history related to a country with widespread Ebola transmission or have had contact with someone who had confirmed Ebola in the prior 21 days.

That would be the general starting point for anyone who came in that you had any suspicion or worry that that may have Ebola. But beyond that, I don't believe we have any enhanced (applications) there.

Dr. (Say Chadrey): Okay, and my second question, I think it was partly answered before, is after we isolate a patient, if we wanted to disinfect the isolation room, are there any guidelines regarding that?

Dr. (Paulus): This is Dr. (Paulus). Are you asking about what - the isolation room guidance?

Dr. (Say Chadrey): No, disinfecting the isolation room or...

Dr. (Paulus): Okay, so there are some guidelines in the CDC, let's say, about environment for infection control and (base) management. But I think the best way to know that you're doing it properly is to contact the health department who could guide you.

Dr. (Say Chadrey): Okay, thank you.

Coordinator: Our next question is from (Nancy). Go ahead. Your line is open.

(Nancy): Thank you for taking my call. My question that I have is, do - with the hospital situations, if it is a confirmed case, the CDC will come in and clean - like, do a terminal clean of your hospital area or the care area for that patient. Does the CDC offer anything like that for a clinic if it would come back to be a confirmed case?

Arjun Srinivasan: Hi, this is Arjun. Yes, I think it's important to note, the CDC actually we don't do the cleaning of these areas, the hospitals. We have guidance for how

cleaning can be done but the hospital settings have been doing the cleaning of their patient areas without assistance - direct physical assistance from CDC.

We provided guidance and input, and so this is an area where, you know, in conjunction with your state health department, they could help you do this in the unlikely event that you encountered that situation.

(Nancy): Okay, so nobody from the CDC themselves come and - like, there's no HAZMAT...

Arjun Srinivasan: No, that's correct. This does not require, right, that a HAZMAT team or that kind of stuff, the hospitals that have cared for these patients have done their own environmental cleaning.

We have guidance for how that can be done safely, the types of disinfectants you would use, the type of protective equipment and that kind of thing. But the CDC would not send a team to - has not been sending teams to do that.

(Nancy): Okay, thank you.

Coordinator: Our next question comes...

Woman: Oh, sorry, I just wanted to make sure I pointed people to the CDC.gov Web site where there's some general information about, for example, cleaning households or a clean up. It may not be as specific as an ambulatory setting. At least I'm not aware that there's anything been established but if you have some general questions, that would be a good start.

(Nancy): Thank you.

Coordinator: And our next question is from (Alyse McShurry). Go ahead. Your line is open.

(Alyse McShurry): Yes, I was wondering if there were any plans to provide specific guidance for long term care facilities. I realize that our, you know, the possibility of an Ebola resident would be remote, however, we do have employees who travel to West Africa because that's, you know, where their families are.

So that, you know, we certainly would want to be prepared. I've also contacted the local health department. I was hoping that there might be some training that - you know, specifically geared, again, to long term care so that we could ask our questions, you know, and have an opportunity because our needs are different obviously than the hospitals.

It sounds like we obviously are more (personally) aligned with an ambulatory care center but, nonetheless, there are some things that are specific to us that, you know, we would like to be sure that we are doing correctly. And I haven't been able to find any place to give me that specific guidance.

Arjun Srinivasan: Thank you. This is Arjun. You know, the guidance for your healthcare personnel would be the same as guidance for all other patients who potentially have exposure. So those folks would be under direct monitoring by the local public health department.

And it would be, I think, a very reasonable thing, of course, for you as a facility to do that same type of monitoring yourself so that, you know, before the provider begins work to make sure that they don't have any symptoms for that 21 day period. And if they do, they would, of course, be notifying you and also, of course, notifying the health department.

(Alyse McShurry): Okay, I - my other concern is, I mean, obviously we're going to is- if we would find a resident who, you know, because a family member would come in or whatever, and then they would become ill, obviously we would isolate them and we would transfer them out.

However, how - you know, my concern is what do you do - how do you protect the wheelchair? How do you get them out of here safely? You know, these are the kinds of things that I was really hoping, that on a local level, we would have an opportunity to really sit down and hammer this stuff out.

Are there any plans to provide guidance to the local health departments so that they, in turn, could invite long term care facilities because I think that, you know, we could use some guidance on our end?

I mean, I believe I have been through mountains of things on Ebola and I'm trying to put a policies and procedures together but I still have some specific questions that it's, like, I'm not really sure.

And even when I looked at the sequence for putting personal protective equipment on and off, I didn't see contained in there when you would put the (unintelligible) or when you would need remove them.

So these are the kinds of things that, you know, it would just be helpful if there would be someplace locally that you could turn to. They could have a meeting of long term care people and we'd have an opportunity to really sit down and develop something that, in fact, would be correct.

Woman: Can I ask you a question about who you think would be the right convener from the long-term post-acute care community or are there a set of folks that we'd want to bring together to help develop that guidance?

Woman: Yeah we...

((Crosstalk))

Woman: ...if we were going to pull together a public health department, who would you recommend as the folks that we'd want to call on to help us start to craft that?

Woman: This is Dr. (unintelligible) with the CDC (unintelligible) with some of our infection control guidelines, (they) work through American Medical Directories Association in a long-term care setting is that an organization that resonates with you?

Woman: The only long-term care association that I'm aware of, yes, the medical directors do have one. I have not contacted them. I have contacted the director of Nurses Association and, you know, the guidelines that we're getting from them are not really geared for long-term care. It's pretty much referring us to CDC guidelines which, again, you know, we are not to the level of the hospital so that - you know, I know that we just need to tear it down but we want to be sure that we're correct in what we're doing that's all.

Woman: Thank you very much.

Gregg Margolis: This is Gregg Margolis from (unintelligible), maybe I can also offer a suggestion. I'm not exactly sure where you are but one of the initiatives that we've been undertaking for the last couple of years is the development of local healthcare coalitions that are networks of healthcare providers in communities that come together for the purpose of emergency preparedness and we, you know, are often challenged with incorporating some non-acute providers into, and recruiting, non-acute providers in healthcare coalitions.

So, one of the things I would encourage you to do is to look into some of the resources that are in your community perhaps a healthcare coalition that has been formed for the purpose of emergency preparedness and connecting the long-term care community with the emergency management and other acute care healthcare resources like the valuable relationship to build not only for this incident but for other things that tend to also affect nursing homes and other long-term care facilities like weather emergencies and other sorts of disasters or public health emergencies.

Woman: Thank you.

Coordinator: Our next questions from (Gary Brato), go ahead your line is open.

(Gary Brato): Thank you, my question was already answered.

Coordinator: Our next question is from (Sandra Rider), go ahead your line is open.

(Sandra Rider): Hi, thanks for taking my question. I work in a boarding school and we serve nine through 12th grade students from all over the country and all over the world. Currently we don't have any students that will be traveling back to that part of the world but they will be going home to their various homes around the world during vacation. When they come back here in the health center we intend to ask every student if they've done any travel within the last 21 days. In the very rare event that they say in fact they did and they weren't picked up by the post travel CDC commission in any of those five airports, my concern is if they're asymptomatic at the time - of course this would be a question for our administration as well, but I'm not sure, what would you recommend for these students both in the boarding school level and perhaps in the college or university level?

Where do you keep these students during the 21 days that you're monitoring them?

Arjun Srinivasan: This is Arjun, I agree, I think that is a question that you'd want to ask your administration and also consult with your health department if you find someone who has not been detected by the screening that's being done at the airports.

As you've probably seen from the movement and monitoring guidance there are not specific restrictions on people who have lower risk exposures but there are some exposures that are higher risk and those exposures would require some curtailment of activities that would put them in contact with other people.

So this is, I think, a situation if you encounter that, a discussion with the health department to figure out what the most appropriate thing to do is would be in order.

(Gloria Paulus): And also this is (Gloria Paulus), there is a team that has developed some resources for parents, schools and pediatric healthcare professionals. They don't address all of your questions and having a boarding school with international population is quite unique but I would encourage you to look on that page as they are trying to work with the Department of Education and things about the whole school contact issue.

(Sandra Rider): Thank you.

Coordinator: Our next question is from Dr. (Shayshodry). Go ahead your line is open. Dr. (Shayshodry) your line is now open.

(Tonya Frazier): Hi, this is (Tonya Frazier), we've dialed in on the same line so maybe that's the confusion. My question is we did a lot of referring to the local health department in terms of questions that were mentioned previously. Our particular aid center is collocated with that local health department and I'm guessing the question is, can you give us what the guidance is for the environmental cleaning for actual coming in contact with bodily fluids like somebody's vomited walking into your center?

Arjun Srinivasan: This is Arjun, yes, that guidance is available on the CDC Web site, there's recommendations there for what would be effective for environmental cleaning and the types of protective equipment that the cleaners need to use, it's all up on the Web site. The CDC.gov/ebola and that guidance is under the section for healthcare professionals.

(Tonya Frazier): Okay, so in that instance we would refer to the guidance as being issued for our hospitals that deal with the more heavily contact of these patients, correct?

Arjun Srinivasan: If you had that situation then that - if there was a need to perform cleaning appropriate for a patient who might have Ebola that's the guidance that they would likely refer you to, yes.

(Tonya Frazier): Okay, thank you.

Coordinator: Our next question is from (Melissa Bonsol), go ahead your line is open.

(Melissa Bonsol): Hi, thanks for taking the question. Our health center has heard different information from our primary care association and state department of health, etc., on the procedures around escorting the potential exposed patient or patient at risk to the isolated area and whatnot and what PPE should be used in

that process. So I just want to clarify you talked about eth PPE to be used when encountering the patient and you're really emphasizing the place to not treat in that exam room, etc., but could you just clarify if staff should or should not be taking the time to put on any form of PPE to move those patients from the waiting area, for example, into an isolated area because we certainly have staff who are concerned that even in that short amount of time there could be something such as vomiting, etc., that could occur.

And so we just want to be clear at our end what trouble we should be going to at that point because we want to protect people but also be timely in the isolation process.

Arjun Srinivasan: This is Arjun, I think you hit it on the head. You know, the key is quickly moving the person into a private room. It would not be prudent, I don't think, to have the person continue to stand in your area where other people are going to be entering the clinic, you know, coming potentially close to that patient while your, you know, staff tries to gather the protective equipment. I think the safest thing would be to, to do, would be, again, to stand at a distance and direct that patient to the isolation room, whatever room you're going to put them in and keeping a safe distance from that patient so that you don't have that risk of exposure.

Woman: And to add to that, I've seen other guidance that came out before the CDC guidance that suggested putting a mask and gloves on the patient, but, you know, there's - we don't know that that would offer protection but we do know that it would a risk that, you know, even to hand those over to the patient so we chose not to recommend giving gloves and the mask to the patient.

(Melissa Bonsol): Okay, understood. We were just getting different advice here in our state in terms of preparing the person who's just even moving that potential patient. So we're going to need to share that with our other state health centers. Thank you for the clarification.

Coordinator: Our next question is from (Robert Phillips), go ahead, your line is open.

(Robert Phillips): Yeah, hi, this is (Rob Phillips), Chief Medical Officer at (UC) Methodist. Could you provide us a little bit more guidance with the patient who's in labor? You know, we're pretty well set up for everything that I think could occur but, you know, sometimes you can't stop the labor and it really would be helpful, I think, to set up some clinical guidelines and an algorithm. My clinical sense is that if somebody's laboring and has a normal child going on that they can't have Ebola, very unlikely, but it would help us in terms of our PPE and also, you know, how we approach that patient or the patient who comes in they're nine centimeters, they're about to deliver.

Arjun Srinivasan: This is Arjun, that's - certainly that's a difficult situation, you know, the PPE recommendations would, of course, be the same as they are for the care of other patients who might have Ebola. There is a group that's working on some of the considerations for labor and delivery and so we hope that will be forthcoming soon and please, do check back on the CDC Web site as soon as that information is prepared and ready, it'll be posted there.

(Robert Phillips): Okay, thank you.

Arjun Srinivasan: Thank you.

Coordinator: Our next question from - is from Mrs. (Toliver), go ahead your line is open.

(Toliver): Thank you. I'm a pharmacist in a community retail setting and, excuse me, we deliver medications to patients at home physically and if there was a patient of ours that was quarantined in their home I'm trying to determine the best way to deliver those medications to the patient but yet protect our staff that delivers the meds?

Arjun Srinivasan: This is Arjun, I think that that's a situation where I think, again, a discussion - these are all I think case-by-case situations, a discussion with the health department would be a good idea to figure out how to do that, I think many different ways that you can proceed, options to potentially leave the medication at the door then the patient can get it once your staff leaves, options to be able to, of course, call the patient in advance to know whether or not they have symptoms so I think lots of options to establish mechanisms where that could be done safely including, you know, providing a 21-day supply right at the start of the monitoring period so that there wouldn't have to be a follow-up visit while they're in that quarantined monitoring period.

So I think lots of ways that that could be approached safely in a good situation where a discussion with public health could be very helpful.

(Toliver): Okay, thank you very much.

Coordinator: And we are showing no additional questions at this time.

Woman: Thank you operator and thank you to everybody through CDC and (unintelligible) and everybody in the community for a good set of questions and really nice dialogue. Please feel free to reach out to us if there's more that we can be doing, good insights and health questions today and, again, we appreciate everything that you all are doing on the ground just to serve in general but to help us with this Ebola situation.

So thank you all for your time and have a nice afternoon.

Coordinator: Thank you, that does conclude today's conference. Thank you for participating and you may disconnect at this time.

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